

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 26 - 35

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: Dr Mary Ross-Davie, Professor Lucy Chappell and Professor Nicola Stonehouse.

Chair: Can we move on to the second panel of witnesses this afternoon? We have Dr Mary Ross-Davie, Professor Nicola Stonehouse and Professor Lucy Chappell, who are coming to give us evidence on the take-up of vaccines amongst women.

Q26 **Alex Davies-Jones:** Thank you to the witnesses for joining us this afternoon. I wondered whether, Professor Lucy and Professor Nicola, you could perhaps give us an overview of what you are hearing about why there seems to be such fear and reluctance from women, particularly young women, to take up the vaccine and whether some of these concerns are warranted.

Professor Chappell: Thank you for the opportunity to speak. I have been listening to the conversations in the first part of this, and there are similarities. For women, it falls into those who are pregnant, breastfeeding, considering pregnancy and then the wider group of women, say those under 50, who are outside the JCVI groups 1 to 9 but for whom the vaccine will come. The considerations are a bit different in each of those groups.

For pregnant women, none of the clinical trials included pregnant women—we can come back to that point—or breastfeeding women, so it is a lack of data. The Royal College of Obstetricians and Gynaecologists, together with the Royal College of Midwives and others, are working really hard to try to get a clear message about what we do know, the benefits and the risks and how pregnant women can be helped to come to a sensible decision if they are called for vaccination.

The issue for women who are considering pregnancy has been hampered by the misinformation around the link between the Covid vaccine and fertility. I echo a lot of what was said earlier about misinformation and how we might best tackle that. Of course, there is also the wider group. We are seeing uptake, for example, in female healthcare workers. There has been presentation of data about whether women take it up less or more, but, broadly speaking, it is probably those concerns around fertility, pregnancy and breastfeeding that have been front of mind for younger women.

Q27 **Alex Davies-Jones:** Yes, that is what I am seeing on my own social media from friends and people my own age. Professor Nicola, is that something you agree with? I wonder whether you could tell us whether or not it is scientifically plausible for the vaccine to be able to impact fertility.

Professor Stonehouse: To introduce myself, I am a professor of molecular virology, not a clinician, but I have been very involved in trying to advise people in the media over the last year about different aspects of



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the virus and also more recently about vaccines, because my own research area includes vaccines.

I have also been working with healthcare providers—Barchester and Care UK. I agree: a lot of what we are hearing is concerns around pregnancy, planning a pregnancy, breastfeeding and so on. Just like we heard in the earlier panel, women are not only concerned about that. They are also concerned about all the same things that everybody else is concerned about: the side effects, the potential contraindications, the need to have a vaccine if they have already been Covid-positive and whether it will cause them harm. There is a real breadth of concerns overall.

To answer your specific question about whether there is any evidence, no, there is no evidence as to why there should be any risks whatsoever in either planning for a pregnancy, being pregnant or indeed breastfeeding, but we do not have the data for some of that. Because we do not have the data and, particularly as scientists, because of the way we frame our arguments when we do not have the data, we are naturally cautious. Some of that caution, which we consider the normal way that we speak, gets caught up in the fact that we are worried because we say we have no data.

Q28 Alex Davies-Jones: I agree. That brings me on quite nicely to my next question around data. I have been pressing my own local health board, Cwm Taf Morgannwg in south Wales, to see whether we have data and whether they are recording those who are refusing the vaccine and the reasons why they are refusing the vaccine, because that is really important. Should the vaccine data be broken down by sex specifically so we can see who is getting the vaccine?

Professor Stonehouse: That would be helpful. It could be by sex and by age, possibly, because that would then give us an indication as to whether it is particularly young women who are refusing. I have asked about this within the healthcare companies that I have been trying to advise and tried to dispel some of the misinformation. I want to know whether there is a trend here. Admittedly, it is mostly women who are working in that arena. I asked whether there is an age trend and whether there is an ethnicity trend, but they are not seeing that. They are seeing that hesitancy across the board.

We also need to remember that there will always be some people you cannot persuade. Their beliefs will be so entrenched that they will not accept the vaccine whatever. I am thinking of the anti-vaxxers and those with vaccine hesitancy. There are some people we will not be able to persuade, but there are a lot of people to whom we could provide better information.

Professor Chappell: I strongly support that, and I would like to create a virtuous circle, a little similar to what the earlier panel were talking about. If we can show that there is uptake and we can particularly report the numbers of pregnant women and breastfeeding women being offered



the vaccine and taking up the vaccine, then we have the opportunity to make it about something that is happening, not just about what is not happening.

The RCOG and the RCM have been asking for this to happen. When a woman turns up, she is asked, "Could you be or are you pregnant?" We are asking that question, but at the moment it is not being pulled through to be counted. We are working hard with Public Health England, NHS England and the National Immunisation Management Service to try to ensure that is happening. We went to the MHRA, which has been very supportive. On Tuesday, they were with Mary, myself and others. The MHRA was very surprised, particularly the lay members, that this information as of Tuesday was still not being linked.

As soon as those of us on the front line who are counselling women can say, "We are collecting the data, we will be reporting the data and we will do that transparently", it starts that virtuous circle.

Q29 Alex Davies-Jones: I agree. Professor Lucy, where are women receiving this information about the vaccine? I can point to my own examples. Like I have said, I am seeing people sharing things on social media, on TikTok and on Instagram. Is it anywhere else? Is this in society at large? What could we be doing to tackle this? What could the Government be doing to tackle this?

Professor Chappell: This is such an important point, and it goes back to something Dr Christine Ekechi said earlier. I am sure Mary will have a similar perspective on this from a midwife's perspective. What we think is important is that the first contact counts. When a pregnant woman or a woman who is considering pregnancy has that first interaction, it is so vital to get a trusted professional to be able to give her accurate information and have a sensible conversation.

Although pregnant women, breastfeeding women and all women are being vaccinated in vaccination centres, the challenge is getting that information across at that first contact. For example, in Scotland they have a model whereby that happens through an obstetrician, because it is my day job, and similarly for Mary as a midwife, to have those conversations about unlicensed medicines in pregnancy. That is what I do.

For this phase, we are trying to push using really good information sheets that have been designed with women at the heart. There is very good information on the RCOG and RCM websites about the benefits and risks and how women might make that decision. At the moment we think that should take place with a maternity care provider, because that is who women trust. It is particularly important that we do not widen the gap so those who are more hesitant do not get pushed further away.

Q30 Alex Davies-Jones: Dr Mary, Professor Lucy mentioned the leaflet there that has just been created. Are you seeing this as being effective? Is it



working in reassuring women and getting women to want to take the vaccine?

Dr Ross-Davie: I am Mary Ross-Davie. I am a director with the Royal College of Midwives and I have been working really closely with the RCOG and service users during the pandemic to understand their concerns.

What Lucy has said there is absolutely key. When women are pregnant, what they need to have is that trusted professional. That came across very strongly in the last session. That is more important than throwing a leaflet at people. It is about that trusted person having a conversation and weighing up a person's individual risks and benefits. This does need to be a conversation that is individualised to the woman about her particular concerns and her particular risk factors.

We know that not all women are equally likely to become severely unwell with Covid-19, so we need to explore with women whether they are at greater risk. We know that is true for BAME women but also women with a high BMI and older women. Women with significant medical conditions are also at higher risk. It is about having that individualised approach, creating that virtuous circle and building trust.

The leaflets are of help to professionals. They are helpful to midwives in terms of framing that conversation, but they should not be there to replace a conversation. We know that women really value and trust midwives as a trusted source of information during their pregnancy. All women meet their midwives during pregnancy, and some women also have obstetricians. It is really important that we make sure that midwives are empowered with that information, that they are very clear about the evidence base and that they can give women that really good advice. Women can then reach an informed choice.

Q31 **Alex Davies-Jones:** That is really good to hear. From your perspective, what will the consequences be for female-dominated sectors? Women are much more likely to work in our front-line public-facing roles. What impact is it going to have on wider society if we see young women refusing the vaccine?

Dr Ross-Davie: Yes, midwifery is an extremely female-dominated profession. It is around 99% of us. We are very much experiencing the impact of Covid on women in our profession.

We should not overstate the risks here around young women declining the vaccination. This was talked about very eloquently earlier. This is a journey that people are on, and older people in the population have moved along that journey already in their thinking. What we are seeing is just that delay, possibly, in younger people. It is not just young women; it is younger people generally as well. As that information journey comes along and trust builds in the vaccine, we will see a shift there as well, just as colleagues were talking earlier in terms of the shift in uptake among BAME people.



What we know is that the great majority of women are saying that they will take up the vaccine. It is certainly not a very high proportion, so we should not overstate it.

Q32 Alex Davies-Jones: That is good to hear. It is very reassuring. It fits with what I am seeing as well among my own peers and friends. They are more curious. They are trying to find more information out. They are asking for this information, but whether or not social media is the right place to be going for that information, like you said, is another challenge.

Professor Nicola, I will bring you in. Maybe you can help me answer this one at the same time. We know that women are more likely to use social media to find information out and they are more likely to make up the majority of the anti-vaxx presence online in general. Is this something that we are seeing as a broader issue? Are young women more likely to decline vaccines of any nature, or is this Covid vaccine the first one to create this type of fear historically?

Professor Stonehouse: To my knowledge, the Covid vaccine is the first to target this fear. The worry is that this could have a knock-on effect to other vaccines. At the moment we have a very good vaccine uptake, certainly in children; it is not so good, for example, for the HPV vaccines, which people get a bit later, when they are teenagers. It is a real worry that that is going to be the case.

That personal messaging is so important. It is so important to get those messages out. As Mary said, midwives play a critical role, but of course not everybody is at the stage of being able to have a conversation with a midwife. They might not be considering getting pregnant for many years to come or indeed may have already completed their families but yet still be very vulnerable and still have all those other questions around long-term effects, for example, outside of fertility.

When I have had talks or conversations with groups of women, I have found that often they will ask exactly the same questions as I have just given information on. What people want is they want an answer to them. They do not want a blanket response. They want a tailored answer to their particular needs. Of course, in some cases that can be their doctor or their midwife, but in some cases they do not have that access. That is the gap that social media is filling rather too well, because social media is that friend. It is that person. You all have friends on social media who can answer all those questions and fill the gap that perhaps should be filled by somebody who is a little more informed.

Alex Davies-Jones: That is the problem, is it not? It is there 24/7 and you have instant access to it.

Professor Chappell: I have seen the research about women and anti-vaxxers, but it is really clear that the message is that we need to fix the system, not that we need to fix the women. It is not the women who need sorting out; it is the messaging, our approach to it and how we as a community, sitting here but also much more widely, can use all the



approaches we heard about from the first panel. The communities know what is needed, whether it is the faith communities or just from all sorts of sources. It is a bottom-up approach just to understand why women are making these choices.

Mothers are very strongly motivated to do what is right for their children when it comes to childhood vaccinations. Of course they are. No mother wants to do bad by their child, and it is the same, for example, for a pregnant woman or a woman considering fertility. Let us look at how we empower women to make those informed decisions rather than stigmatising them further and driving them into the misinformation on social media. We can think about the positive approach rather than saying, "Let us fix the women."

Alex Davies-Jones: Hear, hear. I completely agree.

Q33 **Angela Crawley:** Thank you to the panel. The comments you have made today are incredibly helpful to women who no doubt are sat at home with questions. Whether they are going through fertility or they are planning their pregnancy, your clarity will be greatly appreciated.

Can I turn to the wide issue of perceptions about women's healthcare? It has been reported to the Committee that women's healthcare concerns are often taken less seriously. Is this the case? How might that affect vaccination rates?

Professor Chappell: I agree, and there is clear evidence that there is a gap around some specific examples of women's healthcare. A very good example that has been highlighted, with real support from Parliament, is endometriosis and the gap between presenting with these non-specific symptoms and reaching a diagnosis. There has been phenomenal work and awareness-raising on that in the last year.

There is another data gap around conditions that affect men and women. Take heart attacks or strokes, where women may present a bit differently. Women are often differently represented in the clinical research. Even in 2021, you can see reports from the UK of research in heart attacks where 95% of participants are white and male. That is fine for the white men, but there is a huge proportion of the population, both women and those from ethnic minorities, where those results may not be applicable. In fact, Nadine Dorries has been a real champion for saying, "Show us the data," and I really support that. The academic community will do everything they can to say, "Here is the data, and this is what we are going to do about it."

Of course, that can spill over into uncertainty. We have come on to why there were no pregnant women in the trials. There are good reasons for that. We know about Baroness Cumberlege's report *First Do No Harm*, which documented what happened around valproate, mesh and diethylstilbestrol. I acknowledge the absolute need for safety before we



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go testing in pregnant women, but, equally, we do not women and pregnant women to be at the back of the queue permanently.

I welcome the companies and the researchers who are looking at clinical trials of the vaccine this year. In the UK, we can do safe research under the regulatory authorities to get the answers that pregnant and breastfeeding women deserve.

Dr Ross-Davie: One of the issues, rather than hesitancy, is to do with practicalities for women in being able to access services. Particularly at the moment, the fact they are not able to bring other children along to appointments can really put barriers in the way of people accessing healthcare. It is about thinking about how services can make themselves as successful as possible for everyone and about providing one-stop-shop services that are very much based in the community, so that women do not have barriers in their way to access care. That is more significant than actual hesitancy about attending for care.

Q34 Angela Crawley: On that point, if a woman was unable to attend when she was called for a vaccination, if the healthcare provision could give clear guidance and an explanation on how she could access the vaccination at a later date, would that assist women in being able to come forward for the vaccination at another time?

Dr Ross-Davie: Yes. It is really important to do that, yes.

Professor Stonehouse: I totally support making vaccination as easy as possible. People will accept things a lot more readily and willingly if it is easy for you to do so.

In terms of the issues with clinical trials, it was completely appropriate not to include women in these clinical trials. That is the same that has happened for previous vaccine trials. Especially in the case of the speed that was needed here, there would have needed to have been additional checks, or there should have been additional checks, for example, on pregnant animals, which takes some considerable amount of time. It is totally appropriate.

There has not been enough made, perhaps, of the vaccines that are recommended in pregnancy, either for the benefit of the mother or the child. That is something that a lot of women seem to be a little unaware of. There are many, many vaccines that we recommend in pregnancy. There may be a little bit more on messaging that we could do there.

One of the things that has been said to me is, "It is all very well and good that you are vaccinating pregnant women now if they want to, but have there been any children born yet from vaccinated mothers?" Of course, there is a delay involved in that. Therefore, if we are not careful, we might have to wait a year before we get the result of some of these trials. There is more messaging that needs to be done during that year period, which we could do.



Q35 Angela Crawley: My last question is to Dr Mary Ross-Davie. It is specifically on the uptake of the influenza vaccine in pregnant women during the 2018-19 flu season. It was only 45%. What can be done to ensure that the uptake of the Covid vaccine is much higher? You might perhaps want to say more on what Professor Nicola said there about the general uptake of vaccines.

Dr Ross-Davie: Yes, that is right. It does seem that it is probably around that same rate in terms of pregnant women stating that they would be likely to have the Covid-19 vaccine if it was offered to them. It would probably be around that figure you mentioned for flu.

What we do have to see in a positive way is that we want women to be thinking very carefully about what they put in their bodies when they are pregnant or when they are thinking about becoming pregnant. It is very encouraging that women are thinking so carefully about this, and we need to use that as a positive way of getting across other public health messages about preparing for pregnancy, looking after yourself in pregnancy and what you can do to keep yourself and your baby safe.

On the flu vaccine, it is really interesting that this year we did see a much higher uptake of that vaccine generally across the population. I hope that people will begin to understand much more the huge benefits that vaccination can bring them individually but also as a society. As one of the other panellists mentioned earlier, there is a huge motivation for women, when they are pregnant, to do the right thing for their baby. That leads to all sorts of improved health behaviours during pregnancy and that we hope will be sustained after pregnancy. It is about being really clear about the messaging around what those benefits are.

We also need to have maternity services where the practitioners and midwives have adequate resourcing and time to have these conversations and to build relationships with the women in our care. We are an under-resourced service. We are around 3,000 midwives short in England. That really limits the time midwives have to spend with women to explore their fears and what the benefits might be and what the risks are for them. That is really needed.

We also need to provide women with very easy access to vaccination. At the moment, we often require them to attend separate appointments for different aspects of their care. Flu vaccination is one of those things where we will say, "I have seen you today as your midwife, but I am not going to be giving you the flu vaccine. You will need to go somewhere else on a different day, trailing your three children, to go and have that vaccination". It is really important that we think about how we offer those services so they are really easy and accessible.

Chair: Can I thank all of our panel? It feels very unfair that you have had such a short time compared to the previous panel, but your evidence has been really helpful and really constructive. I will just conclude by thanking you for taking part in today's evidence session.