Sheffield Hallam University | Centre for Regional Economic and Social Research

An Evaluation of Sheffield's COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds

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Knowledge Applied

An Evaluation of Sheffield's COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds

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1 Introduction

This report provides the detailed findings from an independent evaluation of Sheffield's COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds. The evaluation was undertaken by researchers from the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University between October 2021 and March 2022 on behalf of the 'BAMER5' group of voluntary, community and faith organisations working in the city.

1.1. About the BAMER5 in Sheffield

The BAMER5 are a group of Sheffield-based voluntary, community and faith (VCF) organisations whose work is focussed on supporting people from different Black, Asian and Minority Ethnic (BAME) communities and refugees (R). The five organisations are:

1. ISRAAC Somali Community Association.
2. Sheffield and District African Caribbean Community Association.
3. Aspiring Communities Together.
4. Pakistan Muslim Centre.
5. Firvale Community Hub.

Each organisation has a long history of supporting people from ethnic minority backgrounds, communities of place, interest and faith in the city, are deeply embedded in a range of public, community and social networks, and are well versed in promoting health and wellbeing in partnership with other key stakeholders in the city.

1.2. About the Sheffield COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds

In early 2021 the BAMER5 received funding (£95,000) from local public sector partners (namely Sheffield City Council and the NHS Clinical Commissioning Group) to establish a 'Vaccine Taskforce'. The Taskforce was delivered in the spring-summer of 2021 to support the roll-out and uptake of COVID-19 vaccines in communities in Sheffield with a high proportion of people from ethnic minority backgrounds. Their brief was to deliver communications that raised awareness of the vaccine and to support vaccine uptake in communities where vaccine hesitancy had been identified as a key risk. Some activities focussed on the North-East of Sheffield, but the intended reach was citywide. Key partners in the health system - Sheffield City Council Public Health team and the NHS Clinical Commissioning Group (CCG) - provided the BAMER5 with key messages to convey to their communities and relied upon them to employ the methods they deemed to be most effective based on their knowledge and understanding of their communities.

1.3. Evaluation approach

The evaluation aimed to address a number of objectives:

- To understand the work undertaken by the BAMER5 in the delivery of the Taskforce.
- To discuss why the BAMER5 were well placed to deliver this work and identify the added value they brought.
- Where possible, to assess the outcomes and impact of the Taskforce, including the contribution to increasing COVID-19 vaccine uptake amongst Sheffield's main ethnic minority groups.

A mixed methods research strategy was developed covering:

- Qualitative interviews with representatives of the BAMER5 to map and understand the range of work undertaken (n=5).
- Qualitative interviews with representatives of key public sector stakeholders to capture their insights on the rationale for and impact of the Taskforce (n=4).
- Secondary analysis of population level data about local and vaccine uptake, accessed via NHS Sheffield Clinical Commissioning Group (CCG) and NHS England National Immunisation Management System (for more details see Appendix 1).

1.4. Report structure

The remainder of this report is structured as followed:

- Chapter 2 discusses key aspects of the work undertaken by the BAMER5 to deliver the Taskforce.
- Chapter 3 considers how the BAMER5 approach their work and how their position in relation to communities and the local public sector enabled them to deliver Taskforce activities effectively.
- Chapter 4 draws on the available evidence to assess the outcomes and impacts of the Taskforce, including its contribution to vaccine uptake across the city.
- Chapter 5 considers the implications for the future engagement and involvement of organisations led by ethnic minority groups in public health issues.
- Chapter 6 concludes the report by summarising the key messages from the evaluation.

2 What they did: the delivery of the Sheffield COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds

This chapter discusses key aspects of the work undertaken by the BAMER5 to deliver the Taskforce. It focusses on the challenges associated with vaccine uptake by people from ethnic minority backgrounds that the Taskforce needed to overcome before describing the key activities delivered as part of the Taskforce.

2.1. The challenges associated with vaccine uptake by people from ethnic minority backgrounds

The COVID-19 pandemic presented local and national governments around the world with an unprecedented challenge of how to protect populations from the health impacts of coronavirus infection alongside the social and economic impacts of multiple 'lockdowns' and social distancing. In Sheffield, the Public Health team recognised that *"there would be inequalities in uptake of vaccination between the rich and poor, between black, Asian and white, between disabled, not disabled"* and this would compound the fact that people from ethnic minority backgrounds had already been disproportionately affected by the virus across the country.[1] To help mitigate this, work began with the BAMER Public Health Group, including the BAMER5 *"to get the right message out because at that time there was a bucket load of vaccine misinformation out there and there still is"* (PH SCC 1).

Misinformation and vaccine hesitancy in Sheffield's ethnic minority groups was rooted in various explanations. In the Yemeni community, a distrust in pharmaceutical companies and the 'system' (including the NHS) emerged as an issue (BAMER5 Rep 2). Rumours were rife that the vaccine was not good for black people, particularly pregnant women, and that, eventually the vaccine would shorten life expectancy. It was reported that some members of the local Somali community who had been diagnosed with COVID-19 refused to go in ambulances as they feared what might happen to them in hospital:

[1] UK Government analysis published in December 2022 confirmed that BAME people were disproportionately affected by early waves of the pandemic: https://committees.parliament.uk/publications/3965/documents/39887/default/

> *"There was a rumour in the community…don't seek any help because you will catch COVID-19 in the hospital wards. So, there was a lot of misinformation, misunderstanding, misapprehension, and lack of accurate and proper information…all those compounded together with the pressure of the pandemic, the unknown, uncertainty factor just contributed to their [lack of] psychological wellbeing (BAMER5 Rep 3).*

An increase in mental ill- health was reported, particularly in lone elderly people from ethnic minority backgrounds who became housebound. A lack of understandable information led to significant apprehension during the lockdown for those unable to speak English and understand the messages conveyed via mainstream television - *"they couldn't follow the news…the government guidelines"* (BAMER5 Rep 3).

Language emerged as a significant barrier for all the communities served by the BAMER5. It created difficulty in understanding and navigating the health care system prior to and during the pandemic. Many people were self-isolating due to contracting COVID-19 but could not speak English and were unable to navigate the NHS system for support. The BAMER5 adapted their services to comply with guidelines during the pandemic whilst providing their communities vital support, for example, the Fir Vale Community Hub ran a phoneline, undertaking welfare checks, advising people being furloughed and so on. ISRAAC supported members of their community who were hospitalised and unable to speak English. Although these services were not funded as part of the Taskforce, it is clear that the BAMER5 had laid strong foundations for supporting local community members prior to the Taskforce being established. Each of the BAMER5 had employed methods to effectively engage with and support their respective communities before embarking on the Taskforce project. This was summed up by one of the BAMER5:

> *"We as a community organised actively, much more than the system [mainstream] did, mainly because we were connected on the ground and so we knew what was going on, we knew people's fears, we knew their anxieties, we knew the way they were treated, we knew they would be isolated". (BAMER5 Rep 2).*

Resistance to the vaccine was encountered from various sections of the BAMER5's communities, for instance, from the mosques (leaders) and mosque users, and the under 50s, particularly pregnant women (BAMER5 Rep 1). Changing messages from the government exacerbated resistance in the communities. A BAMER5 leader reported:

> *"The government have got to be very careful with its own communication strategy because so far for me it's been very inadequate because the message changes every three months and for public confidence in the vaccine it's not good, it's rather damaging, it's making our life at community level very difficult". (BAMER5 Rep 6).*

Another challenge was preventing congregations of people from coming together for cultural and religious festivals such as Eid, Christmas, Ramadan, etc, to avoid the spread of the virus. However, Public Health representatives recognised that they would not be able to effectively influence conversations without the spokespeople for the communities (PH SCC 2).

The BAMER5 partnership worked with other groups and organisations led by ethnic minority communities. However, some of these groups obtained their own funding for very specific targeted work, for example, supporting women fleeing domestic violence. The BAMER5 had more generic targets, but this did not preclude them from supporting women suffering domestic violence, for example.

2.2. Key activities delivered by the Taskforce

Communication, community engagement and outreach formed the core strategy of the Taskforce. This included the BAMER5 focussing on collectively creating an information leaflet; door-knocking and speaking to their respective communities; conducting radio interviews targeting local ethnic minority communities; delivering conferences; producing a video; and holding local community events. Individually, the BAMER5 organisations carried out other activities to meet the specific needs of their communities, however, the following core activities were undertaken.

2.2.1. 'Don't Hesitate, Vaccinate' leaflet

With support from the NHS CCG, the BAMER5 designed a *'Don't Hesitate, Vaccinate'* leaflet **translated** in the main languages of the communities they intended to engage with. What set this leaflet apart from other generic leaflets was the use of imagery to convey messages, succinct communication of the facts about the vaccine, part translation into community languages, and the contact details for Vaccine helplines run by the BAMER5. By calling a helpline, local people were given information in relevant languages about the vaccine and / or signposted to correct vaccine sites. A **'tackling the myths'** section countered incorrect understandings of the COVID-19 vaccine, such as a common view amongst Muslim communities that *"the vaccine contains alcohol and therefore it's impermissible"*, even though such tiny amounts were permitted religiously (BAMER5 Rep 1).

Another BAMER5 leader reported routine door knocking by his staff when leafleting to ensure that households were aware of how to deal with the pandemic, for instance, who to ring in the community if someone was experiencing mental ill health. He went on to explain:

> *"When we gave a leaflet to one neighbour, they would tell us about another that we didn't know about and hence that worked very well…People were very supportive of each other, even though they couldn't talk to each other, couldn't meet each other, they were very supportive of each other". (BAMER5 Rep 2).*

The benefits of this 'referral system' were two-fold; firstly, neighbours were more likely to be receptive knowing that someone they trusted had sent the BAMER5 representative, and secondly, they received vital and correct information about COVID-19, the support available, and in some cases alerted services to the most vulnerable and those who needed them most.

Not only did the leaflet go into peoples' homes, but the information was also used for publicity on the 'Community COVID Bus', and in other agencies (BAMER5 Rep 1). Beyond distributing it to the BAMER5 organisations' membership, the leaflet went out to wider communities covering large geographical areas.

2.2.2. Local community radio

The Pakistan Muslim Centre led on the community radio station work. This method reached peoples' homes during a time when they were restricted to their homes, in some cases, socially isolated, and apprehensive about COVID-19 and the vaccine. By dedicating programmes to raising awareness of the virus, necessary precautions, government guidelines, misinformation and the vaccine, an effective dialogue was established with community members, encouraging questions and answers to dispel conspiracy theories, myths and resulting hesitancy to be vaccinated:

> *"The radio station that we used was set up by the communities…it was just not about people listening, it was about getting people to phone in as well and get a*

rapport going [to discuss risk factors related to COVID] …people were ringing in on the phone lines, people were ringing in on the radio station asking us questions". (BAMER5 Rep 1).

Having received training from the NHS CCG, to help address hesitancy, the BAMER5 organisations were able to provide culturally and religiously appropriate information, to encourage vaccine uptake – *"when people had a question, they [the BAMER5] knew exactly what the latest science was or how they should respond to it"* (NHS CCG).

One of the BAMER5 organisations, consulted with local taxi drivers from ethnic minority backgrounds (listening in to the programmes), encouraging them to use personal protective equipment, regularly sanitising, putting up protective screens and to be vaccinated. As trusted community leaders, the clear messages of the BAMER5, shared directly and through their staff, were received by members of their communities who showed engagement with the subject matter by calling in to the programmes, expressing their concerns and asking questions.

Underpinning this method for successfully engaging with people from ethnic minority backgrounds was the centrality of language. The Radio programmes were delivered in local community languages, overcoming one of the most significant barriers to engagement with many individuals from ethnic minority backgrounds i.e. the inability to speak and/or understand the English language.

2.2.3. Dialogue with the local community

Of note, large numbers of volunteers, from local BAMER5 communities, gave up their time to support the work of the BAMER5 organisations. In ACT, for example, 12 volunteers, referred to as street champions, directed by their organisation, distributed food parcels, and talked to people in relevant community languages to get key messages across about COVID-19, social distancing, and later, the importance of being vaccinated against the virus.

Extensive and consistent dialogue was necessary to overcome hesitancy in some groups. An account highlighted that, "*groups were hesitant, but it didn't ever mean they weren't ever going to have it [the vaccine] they just needed a lot of time and a lot of conversations to think about it. It wasn't something where they needed a week they needed quite a lot of conversations, a lot of input and that's what did it"* (NHS CCG). Trust was central to those conversations happening in the first place (Other VCF).

To overcome fear of the vaccine within their communities, the BAMER5 were trained in *"how to have conversations with people about the vaccine, dos and don'ts, behavioural change…not to repeat myths"* to avoid reinforcing them (NHS CCG) and being very cautious about who to spread the messages to, especially those with underlying health conditions such as blood clots who were advised to seek medical advice before vaccination (BAMER5 Rep 1)

Drawing on extensive knowledge of their communities, the BAMER5 used counter narratives that were socio-culturally and faith relevant to challenge vaccine hesitancy. The following narrative was a case in point:

"You're going to Pakistan - we brought it [the message] really home to them, you don't hesitate [to get vaccinated], you don't ask a question…you've got to look at that and think it's just a vaccination to build your immunity against this virus". They responded, "we don't know what's in it". BAMER5 leader: "have you ever questioned the rest [other vaccines]" (BAMER5 Rep 1).

Evidently, the interviews exemplified how well the voluntary and community sector (such as the BAMER5) worked with the public sector (e.g., the NHS CCG) to impart knowledge and expertise by acting as a conduit to the diverse local communities that they served and were trusted by. An important lesson emerged about innovation not always being necessary as some tried and tested methods work(ed) repeatedly - a point acknowledged in one of the accounts where the ***"****old door knocking method and face to face conversations"* were deemed to be very effective for sharing information (NHS CCG).

Insider knowledge of the BAMER5 on their communities helped them to focus their efforts on specific community provision to maximise the reach of their messages. Mosques, for example, as important institutions for Muslim populations, run by trusted faith leaders, were key in establishing dialogue with, and influencing, their local communities. The following narrative conveys the reach of the mosques and the snowballing effect, spreading the message even further:

> *"When you have traditional people from the community and imams, I had four mosques, four Arabic mosques…working every Friday every sermon to tell people about vaccination and that got to thousands of people and then these mosques told other mosques…through that we were able to pass on the message. How would the system [mainstream] have ever done that?"*

2.2.4. Conferences

Two conferences for people from ethnic minority backgrounds were organised by the BAMER5, in the heart of local communities, to ensure accessibility, familiarity and comfort. Local community members could ask GPs, or the Public Health team questions and share their concerns. It was reported that the conferences *"directly put people in touch with those people who in theory should know all of the facts and all of the science and be able correct misinformation that was out there in a careful, sensitive way"* (PH SCC 1). A Pfizer representative and a CCG spokesperson attended one of the conferences to provide clarification on the Pfizer vaccine.

Recognising that the local community would potentially have more confidence in the explanations provided by qualified medical practitioners in relation to the importance of taking up the vaccination, the support of health professionals was mobilised to provide accurate information, answer any questions, and allay the concerns of community members:

> *"We invited doctors to come to our conferences…who speak the Somali language, Arab language…give the information why it's important to take the vaccine…answering all the questions they [community members] had" (BAMER5 Rep 4).*

Further, they were aware that religious barriers led to vaccine hesitancy in certain sections of their communities, and hence, a Sheikh (a religious authority) was invited to their conferences to dispel any religious concerns, for example, about the vaccine containing alcohol and therefore being prohibited – a BAMER5 leader recounted, *"When we spoke to doctors as well as the Sheikhs together, they both told the community and everybody that it is halal to take the vaccine"* (BAMER5 Rep 4). These messages were recorded and circulated far and wide by the BAMER5 organisation amongst members of their local communities using social media.

2.2.5. Leading by example

In several accounts it was stressed that good leaders led by example, and it was vital for earning the trust of their communities. In one example, the BAMER5 leader

recalled his own hesitancy (in early 2020) to take up the vaccine when it was being trialled, they explained, *"I wasn't vaccinated because I didn't trust the vaccine and I was reluctant…after a month or two I received my first jab, when I received my first jab I…put it out there in the community that I'm leading the way, I'm vaccinated and you guys can do the same"*. This influenced many members of their local community to get vaccinated, and, when receiving their double jab, they sent out a strong message again, emphasising the benefits of the jab and the evidence behind it. They stated, *"it was about convincing them that if you're vaccinated, you're less likely to end up in hospital compared to someone who is not vaccinated"* (BAMER5 Rep 6).

In another case**,** one of the BAMER5 organisations attempted to overcome vaccine hesitancy in some of its communities by showing them people that they could identify with culturally, i.e., community leaders being vaccinated. This sent out a powerful message: *"Some of the Imams and some of the elders and some of the leaders of the community when they were taking their own jab, some of them we took videos and shared with the community and therefore to say, the imam of this mosque was highly respected, has got big followers, if he can take the jab…trusted leaders of the community, therefore, surely you can be safe with it"* (BAMER5 Rep 3).

By getting vaccinated themselves, and publicising it, the BAMER5 were able to offer reassurance to anxious members of their communities. As public arenas began to reopen, including their community centres, reassurance and correct information was provided face-to-face in the languages that their communities understood (Other VCF).

2.2.6. Use of social media

Social media was used by the BAMER5 organisations to convey key messages to their respective communities. In one narrative the extensive use of social media to deliver the Taskforce objectives was stressed**:**

> *"We used a lot of our social media, our Instagram, Facebook and TikTok account to put the message across." (BAMER5 Rep 6).*

One organisation reported that their WhatsApp group of community members *"was a way of reaching out to the communities who don't speak English".* They were also aware that the local mosques all had WhatsApp groups, hence, they shared valuable information through their groups. When they heard anti-vaccine rumours, that, for example, the vaccine would shorten life expectancy, they sent messages via WhatsApp in various community languages to counter those rumours. (BAMER5 Rep 4).

The account of a key stakeholder underlined how the BAMER5 used social media when working beyond their core work hours to be responsive to emerging information, shifting work boundaries to get things done:

> *"Because of the situation we were in, our relationship was really close, and we were WhatsApping and their availability was really key, because I could WhatsApp and send them information…so there were phone calls and messages at all times and I guess we all let that work boundary move for the right reasons."*

They went on to describe their creativity and adaptability when attempting to reach their communities, in light of the changing government guidance when delivering the Taskforce work. The following example was relayed, *"they created a video which was then used on WhatsApp and it was for the Slovak community, and the rules changed that much that they must have changed the video three times...So the work that really stands out for me is that, all of them are leaders in their own right in their own communities and are absolutely reaching those communities"* (PH SCC 2).

2.2.7. Vaccine drop-in sessions

Consistent with the principles of taking services to communities to ensure accessibility and ease in familiar venues, the BAMER5 arranged vaccine drop-in sessions in the heart of their communities. In one case, a vaccination clinic was set up in a mosque. Public Health reported, *"up until then, it had all been done on NHS premises"* (PH SCC 1). On the first day, vaccination did not take place, instead, NHS professionals talked to local people about their fears and worries to build trust with them. They emphasised it was the enabling work by the BAMER5 that allowed the drop-in sessions to happen. In another example, a Roma drop-in session for vaccination was organised by one of the BAMER5 leaders to initially facilitate dialogue between health professionals and the Roma community, providing information and encouraging them to be vaccinated. Fundamentally, the BAMER5 influenced decisions to ensure the vaccine was accessible.

Summary of Key Findings

People from ethnic minority backgrounds have been disproportionately affected by the health, social and economic impacts of the COVID-19 pandemic. The **Sheffield COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds was established to help overcome a number of barriers to uptake** including awareness, understanding, misinformation, language and a lack of trust in the health system.

The Vaccine Taskforce developed a core strategy based on communication, community engagement and outreach and used their existing reach into and understanding of the communities they work with, to deliver a range of activities including:

- Setting-up a **helpline** local people could call to access information in relevant languages about the vaccine and / or signposted to other websites.
- Developing and distributing a **'Don't hesitate, Vaccinate' leaflet** in a number of languages that tackled myths and provided information about available support.
- Using local **community radio** to share information in audible formats.
- BAMER5 staff and volunteers maintain ongoing dialogue with local communities, drawing on counter narratives that were socio-culturally and faith relevant.
- Holding **conferences in community settings** where people could hear about the vaccine benefits and risks first-hand.
- **Leading by example** by getting vaccinated themselves, and publicising it, to offer reassurance to anxious members of their communities.
- Using **a range of social media channels** to share information with community members.
- Organising **vaccine drop-in sessions** in appropriate community settings.

3

How they did it: the BAMER5's approach and position in relation to communities and the health system

This chapter discusses how the BAMER5 approach their work and how their position in relation to communities and the local public sector enabled them to deliver Taskforce activities effectively. It discusses the history and track record of the BAMER5 as individual organisations before highlighting some key features of their work – what might be described as 'mechanisms of change' – that underpin their work and the outcomes and impact it has.

3.1. The history and track-record of the BAMER5

When considering the benefits that the public sector gains from working with 'established' voluntary, community and social enterprise (VCF) organisations such as the BAMER5, there is often a failure to acknowledge their individual histories and their long track records of working with local communities. By providing activities, facilities and services over many years they gain knowledge and insights that are critical for contextualising and understanding how best to meet needs in the community. This is particularly important for work with people from ethnic minority backgrounds whose needs and circumstances, and the strategies that best support them, may be different from the (mainly white British) populations that mainstream services are designed support.

To bring the history and track record of the BAMER5 to light the following section provides a synopsis of the origins and types of provision of each organisation.

Aspiring Communities Together (ACT) established in 1971 was initially called the Yemeni Workers Union (YWU) and formed by Yemeni workers in the steel industry who felt poorly represented by the unions. They came together in 1970 in a meeting of 200 workers and set up the YWU, each contributing to the purchase of a building on Burngreave Road. The building is still in use for activities. Later (in 1986), called the Yemeni Community Association (YCA) services were provided specifically for Yemeni communities, including health care, family support, learning English, and community language. The YCA acquired buildings in Attercliffe (in 1993) and in Fir Vale (in 2000) whilst serving the Yemeni community city-wide. In 2006, the organisation broadened its remit to work with the wider BAMER communities in Sheffield, in addition to the Yemeni community and so its name changed to what it is currently known as: Aspiring Communities Together (ACT).

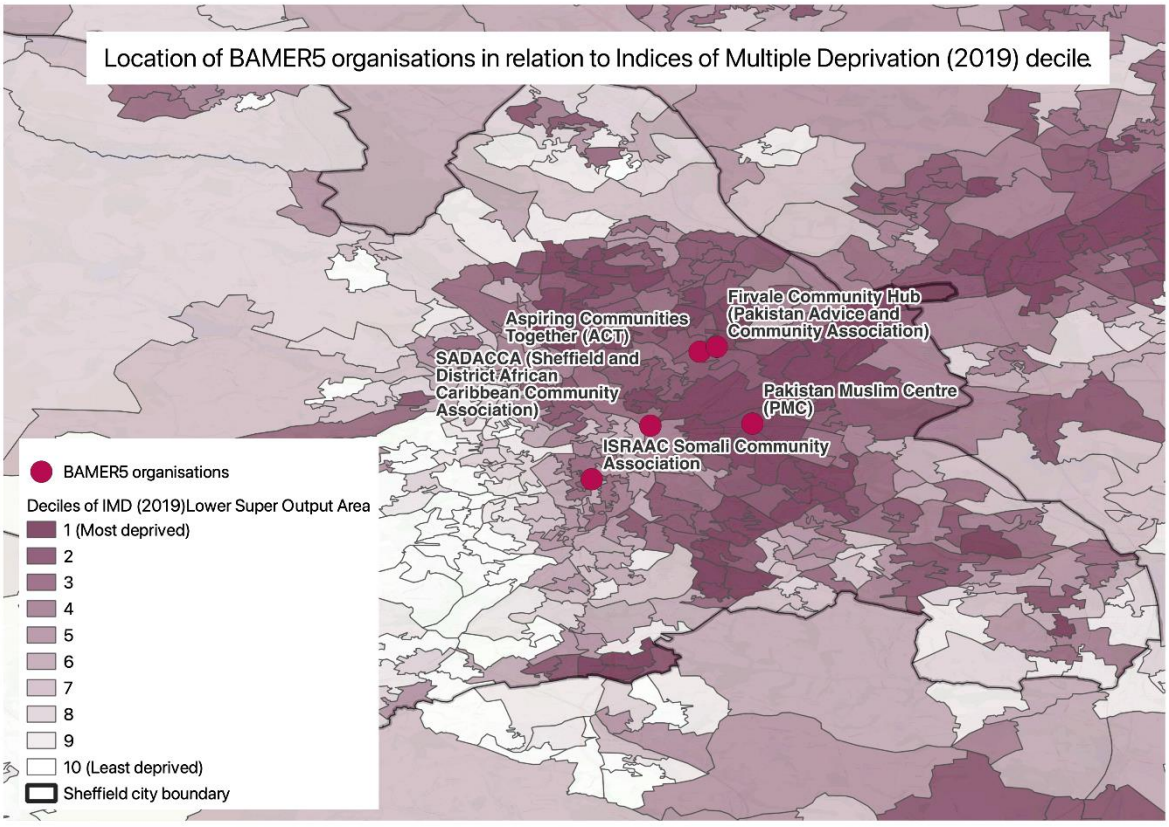
The Fir Vale Community Hub (FCH) was founded in 1989 by ex-steel workers who worked in the Darnall steel industry. It was established due to mainstream services failing to adequately resource and meet the needs of the Pakistani community. Initially set up from a shopfront and moving to larger premises in 2008, the FCH provision included benefits and welfare advice and advocacy, an immigration service, English for Speakers of Other Languages (ESOL) and employability pathways. In addition, the organisation currently delivers youth projects, health and wellbeing initiatives, and cohesion projects. To reflect the evolving populations of Fir Vale and to meet their needs (e.g., financial, health and housing), the FCH works closely with the Roma and Slovak communities, white working-class communities, and those disadvantaged due to their first language not being English.

Israac (meaning unity) Somali Community Association was established in 1987 in response to the inadequately met needs of Sheffield's Somali communities by mainstream providers. They set up services for advice and advocacy for those unable to speak English, lunch clubs for the elderly, health and wellbeing activities: coffee mornings, aerobics, zumba sessions, and walking and swimming. A women's programme, film courses, and holiday activities for young people amongst other provision cater for people of different generations and other ethnic minority groups are supported by Israac, including, Ethiopian, Sudanese, and Eritreans. The organisation undertakes multi-agency work with the police, the local authority, the NHS, and both of Sheffield's universities, contributing to citywide strategies and initiatives. Israac plays an important civic role for the advancement of the city.

The roots of the **Sheffield and District African and Caribbean Community Association (SADACCA)** go back to 1955 when it began as the West Indies Association. Formally constituted in 1986, SADACCA serves the social, educational and health and wellbeing needs of African and Caribbean communities of Sheffield, particularly those of the Windrush generation, a large population of new migrants into Sheffield and young people from all communities. Three core services are provided: business, education, and care. Businesses hire office space and SADACCA provides or signposts those with new businesses to mentors in the African diaspora community. Established in 1998, the day care (mainly adult) service consists of domiciliary care to running day care and mental health services.

The **Pakistani Muslim Centre (PMC)** was set up over 40 years ago, operating from premises that were eventually bought from the council. Various projects and services delivered by the PMC, include health and wellbeing initiatives, training and education, sports activities, and events and entertainment. Office space is available for hire by small businesses as well as hall hire for celebratory events i.e., weddings and parties. Trained volunteers from the local community run the community radio station, producing, and presenting programmes in local community languages, meeting the local community's information, education, and entertainment needs.

Figure 3.1: The location of the BAMER5 organisations in relation to Indices of Deprivation decile (2019)



As figure 3.1 demonstrates, the BAMER5 organisations are physically located in some of the most economically and socially deprived areas of the city.

3.2. Being trusted by BAMER communities

Trust emerged as a central theme when exploring why the BAMER5 were ideally placed to deliver the taskforce. Built up over 30 years or more, the trust between different generations of local communities and the BAMER5 organisations was premised on providing safe spaces in community premises for welfare advocacy, health, education, and employment services amongst other provision to meet their holistic needs, particularly, those needs not met by mainstream providers. This was reiterated in the account of one of the BAMER5 representatives (BAMER5 Rep):

> *"We have trust within our communities. We have something that institutions [mainstream] don't have" (BAMER5 Rep 1).*

They stressed how community level trust in the BAMER5 allowed them to "*reach where they [mainstream providers] can't reach"* and the importance of mainstream providers working closely with the BAMER5 to address health inequalities by continuing to invest in them. Essentially, the interviews revealed a consensus that these organisations played a critical role in brokering trust between the public sector and their local communities in the past and present day.

To understand the context of reluctance for people from ethnic minority backgrounds in observing health guidance and vaccine take up, the impact of racism must not be ignored or downplayed. The narratives behind 'reluctance' are embedded in historical and present experiences of racism and therefore must be acknowledged and understood to make headway in changing perceptions of mainstream providers,

including the National Health Service (NHS). Highly publicised cases and personal experiences of racism continue to live in the psyches of ethnic minority groups which has undoubtedly led to the messages of health agencies being ignored or perceived with distrust.

The BAMER5 leaders recounted that discrimination (particularly racism) was endemic at an individual (community member) level, for instance, in barriers to accessing healthcare, but also at a community level, demonstrated by a lack of effective consultation with, and funding for, local organisations led by ethnic minority groups by the NHS and Public Health in the past. This led to poor relationships with health bodies, compounding feelings of distrust. Whilst the BAMER5 made inroads during the pandemic in improving their relationships with public sector health bodies, their reassurance and testimony provided as 'trusted' community leaders played a crucial role in diminishing the negative perceptions amongst their local communities, arguably improving the NHS Clinical Commissioning Group's (NHS CCG) access into communities and helping to increase vaccine take-up (BAMER5 Rep 2).

A different perspective on trust emerged from another account. Here, it was emphasised that the issue of trust in people from ethnic minority backgrounds migrating to the UK was perhaps exacerbated by their previous experiences of unreliable governments and hence their reluctance to engage with the health messages of the British government. By acting as a conduit, the BAMER5 – given credence by their local communities – passed on vital health messages to those perceived hard-to-reach:

> *"A lot of people come into this country, and they come from places where they have no trust in their government…so why would they believe our government? It's a new country…the hubs [BAMER5] are able to give out that message…the message that the health people are giving out is actually to keep you safe - it's the trust thing." (Other VCF)*

The BAMER5 perspective on the high level of trust they had built with their communities and resulting ability to 'influence' them was reinforced in the interviews with public health representatives. Identified as key to influencing and changing mindsets, 'trust' with local communities was based on *"relationships established for decades"* - something that the public sector recognised they did not have (Public Health, Sheffield City Council - PH SCC 1). Another interviewee commented, *"even if we had the resources, even if we took / had the same number of staff doing the same sort of work it wouldn't have the same impact, we are just not trusted like they are, they are trusted, they are part of the community, they live in the community"* (NHS Sheffield Clinical Commissioning Group - NHS CCG).

Crucially, the health system required the involvement of the BAMER5 to raise awareness, connect them to people from ethnic minority backgrounds, making the health system more accessible. They were trusted by the public sector to do a good job, using the methods they knew would be most effective reaching and influencing their communities - *"It was they who understand their audience and it's all tried and tested…we did trust them to use the methods that they knew and they did come up with some good ideas"* (NHS CCG).

3.3. Knowledge of 'their' communities

After decades of work with their communities, often sharing lived experiences based on race, culture, religion, multiple disadvantage and so on, the BAMER5 leaders know their communities very well and understand their challenges and their needs. This in-depth 'knowing' was unanimously echoed in all the accounts and regarded as a basis for the BAMER5 being best placed to deliver the Taskforce objectives. The following

account reinforced that knowledge held within the BAMER5 organisations of their respective communities served to improve access into, and understanding of the hesitancy (to engage with public health messages) in, those communities during the pandemic:

> *"They understand their communities they know their needs…their issues, and just because of that they have the knowledge and skills how best to reach them, how to get through to them, how to work together, which we just don't. We would never have that as such a small population level. So, we see them as the groups helping to connect us to communities and to make us more accessible and more understanding of what's going on." (NHS CCG)*

A thorough understanding of their communities, for example, their culture, allowed the BAMER5 to employ the methods which most effectively got across the key health messages. One of the BAMER5 (BAMER5 Rep 1), providing the example of the local Roma Slovak community, explained that they liked *"to watch dramas instead of watching him on 10 Downing Street"* – a pertinent point as the messages were not coming through the correct channels, by the right people, in relevant language(s) to be received by the target audience.

With limited resources and specific knowledge on ethnic minority communities, Public Health found it hard-to-reach those communities disproportionately impacted by the pandemic and were therefore reliant on those who knew their communities best to act as a conduit, sharing vital information from public health in the language(s) and form that were easily understood:

> *"We understand our communities much better…we understand the language of the mainstream and we articulate that to the needs of our communities" (BAMER5 Rep 3).*

Indeed, the following comment summarises why the BAMER5 were in the best position to serve their respective communities during the pandemic – through close relationships based on shared knowledge and fine-grained understandings of their circumstances, experiences, and beliefs:

> *"We are better connected, best placed, we have the community knowledge, the community information, the community understanding, and I think that puts us in a much better position than anybody else." (BAMER5 Rep 2)*

3.4. Communication and engagement

Knowing their [BAMER5] communities was very much tied in with knowing how best to communicate and engage with them, using resources that would prove most effective in capturing the attention of their local populations. A stakeholder (NHS CCG) stressed that the BAMER5 were trusted to employ the methods proven previously to be effective in reaching their communities and whilst aspects of this work occurred collectively, some was tailored to the individual communities.

Drawing on extensive experience, the BAMER5 generated numerous ideas for activities for the Taskforce with minimal input from the key stakeholders as they were deemed to be experts on their own communities. In one account, the NHS stakeholder emphasised that although they did provide a steer on the methods used, the BAMER5 were relied on to opt for those methods that would work best at engaging their communities. A public health stakeholder reiterated this view in their interview – *"They hold knowledge and experience of how to get work done in specific communities and specific contexts"* (PH SCC 1).

Language was central to specific contexts when engaging with the different communities due to the wide range of languages spoken, read, and written. The BAMER5, for example, all played a role in the translation of the information leaflet, a key tool which aimed to provide vital information on the virus and dispel myths which had led to hesitancy in their communities to listen to, and act on essential health messages. The BAMER5 also conveyed information verbally i.e., face-to-face during door knocking activities. This method gave members of the local communities an opportunity to share any concerns and ask questions, which in turn allowed the BAMER5 teams to offer counter narratives and alleviate concerns.

Significantly, the messages were received if they came from trusted sources where a strong sense of identification existed between members of the local communities and representatives of local community organisations. An effective method for communication, in a relevant context (for example, responsive to gender-segregation norms in specific communities) in a relevant community language by a respected member of the community successfully delivered the message:

> *"They [the public sector] have dug deep into our cultural resources and we have been able to use them to deliver a message. Get vaccinated get inoculated, get the booster. Definitely a strong message. It makes more sense when a Yemeni is giving that message to the Yemeni community particularly when its someone who is respected in the community as their community leader… but also its important when people also see staff, see volunteers giving that message. We have used traditional women… we have used them as traditional Yemeni women to talk to other Yemeni women about vaccination." (BAMER5 Rep 2).*

The expertise of the BAMER5 in communication and engagement with their communities was echoed in the various accounts. A local community radio station using multi-lingual presenters to deliver programmes in relevant community languages, sharing information face-to-face, providing information in a translated leaflet, using Facebook and WhatsApp, and encouraging dialogue between health professionals and community members in community conferences, all facilitated communication and engagement with the key messages.

Information gained through social media platforms that the stakeholders (PH SCC and NHS CCG) would not have had access to was shared with them by the BAMER5 to raise awareness of the questions, concerns, and emerging issues in their communities in relation to vaccine hesitancy. This was evidenced in a stakeholder account:

> *"They also gave us a huge amount of insight into what they were seeing on Facebook and WhatsApp which we would just not have that access." (PH SCC 2)*

Clearly, the interviews evidenced that the BAMER5 held detailed knowledge about the communication channels of their respective communities. Indeed, one narrative stressed this point, *"for the Roma Slovak community, they were listening to everything in Slovakia"* (BAMER5 Rep 1). Consequently, direct messages from the UK's media were likely to prove futile in reaching the Slovak community, hence, a different approach was taken to engaging them. A key lesson here was the BAMER5's focus on the specific circumstances and needs of their local communities rather than using a broad-brush approach to communication and engagement.

3.5. Located in the heart of communities

By being in the heart of the communities served, the BAMER5 were familiar faces to members of their communities and accessible should they need advice, support, services and so on. This centrality of location and geographical proximity allowed the BAMER5 to witness first-hand, and be closer to, the issues experienced by their

communities, consequently, placing them in a strong position to deliver initiatives such as the Vaccine Taskforce. When conveying this connection, one of the BAMER5 stressed the following:

> *"We are the best to deliver because we are connected right in the middle of the community…we live in the community, so we breathe their problems every day, we feel their issues, we understand the pain they go through." (BAMER5 Rep 2).*

Another BAMER5 leader explained that first and foremost their organisation was a cultural hub for a specific diaspora, drawing those local populations to a place of shared cultural heritage, languages, experiences, and understandings – *"we are the hub for those people, we are where they gather in Sheffield and if you want anything…we serve the needs of that particular community"* (BAMER5 Rep 6). As a go-to place for the community, the organisation was best placed to deliver the VTF project to a captive audience that trusted its local community leader(s). Similarly, the other organisations constituting the BAMER5 were go-to familiar places, easily accessed and trusted by members of the local communities to provide advice and information in their best interests.

Key stakeholders from Public Health (SCC), the NHS CCG, and a social enterprise, concurred that the BAMER5 were best placed to deliver the VTF due to their location in the heart of their communities - a draw for employment, education and leisure services amongst others. The women's or men's groups for instance, in such organisations were identified as providing opportunities for *"the message to be given in a more informal way…[in] community languages…for people that can't necessarily speak English as a first language"* (Other VCF).

3.6. The BAMER5: greater than the sum of their parts?

Arguably, by pooling their reach, knowledge, skills and expertise, and working closely with the local public sector, the BAMER5 and partners were able to deliver a Vaccine Taskforce that was 'greater than the sum of its parts'. With in-depth knowledge of, and a strong belief in, their communities, and connections formed with different generations spanning decades, the BAMER5 organisations were able to build relationships of trust whilst providing diverse services and activities in the heart of their communities – in familiar, easily accessed venues. These factors stood them in good stead to deliver the Vaccine Taskforce project. The BAMER5 were cohesive in their response and provided consistent messages when working jointly and in individual organisational work.

Having recognised that *"a single monolithic approach to encouraging high uptake of vaccination was not going to get the message across to all the communities"* Public Health (SCC) drew on the good relationship it had established with the BAMER5 during the pandemic (PH SCC 1). As emphasised by one of the BAMER5, *"they [the public sector] needed us to have those conversations [with the BAMER5 communities]"* (BAMER5 Rep 1). Both the NHS CCG and Public Health (SCC) were investing in voluntary and community sector organisations during the pandemic and the aim was to get the money out to organisations led by ethnic minority groups to support this work.

The interviews revealed that the BAMER5 showed great leadership by reaching their communities with enthusiasm, sharing their knowledge on the vaccines, having informal conversations to influence and change minds, and, as one of the stakeholders concluded, *"nothing was too much trouble for their own communities. They were essentially public health warriors because they were out there doing the work that we couldn't do. They were really innovative; they were reaching into the faith community again in a way that we couldn't"* and paving the way for the public sector to be trusted and be involved in constructive dialogue with ethnic minority groups (PH SCC 2).

Summary of key findings

Many voluntary, community and social enterprise (VCF) organisations led by ethnic minority groups such as the **BAMER5 have rich histories and long track records of working with local communities**. This is particularly important for work with people from ethnic minority backgrounds whose needs and circumstances, and the strategies that best support them, may **be different from the (mainly white British) populations** that mainstream services are designed to support.

Some of the key 'mechanisms of change' that underpin their work include:

- In depth **knowledge of their communities** enabling them to identify the most appropriate strategies for promoting health messages.
- An approach to **community engagement and communication** based on an understanding of how best to reach and share information with different population groups.
- **Embeddedness in communities of people from ethnic minority backgrounds** where they act as hubs for culturally tailored information, advice, guidance and support.

The combination of these factors enabled the BAMER5 and partners to deliver a Vaccine Taskforce that was 'greater than the sum of its parts'.

4

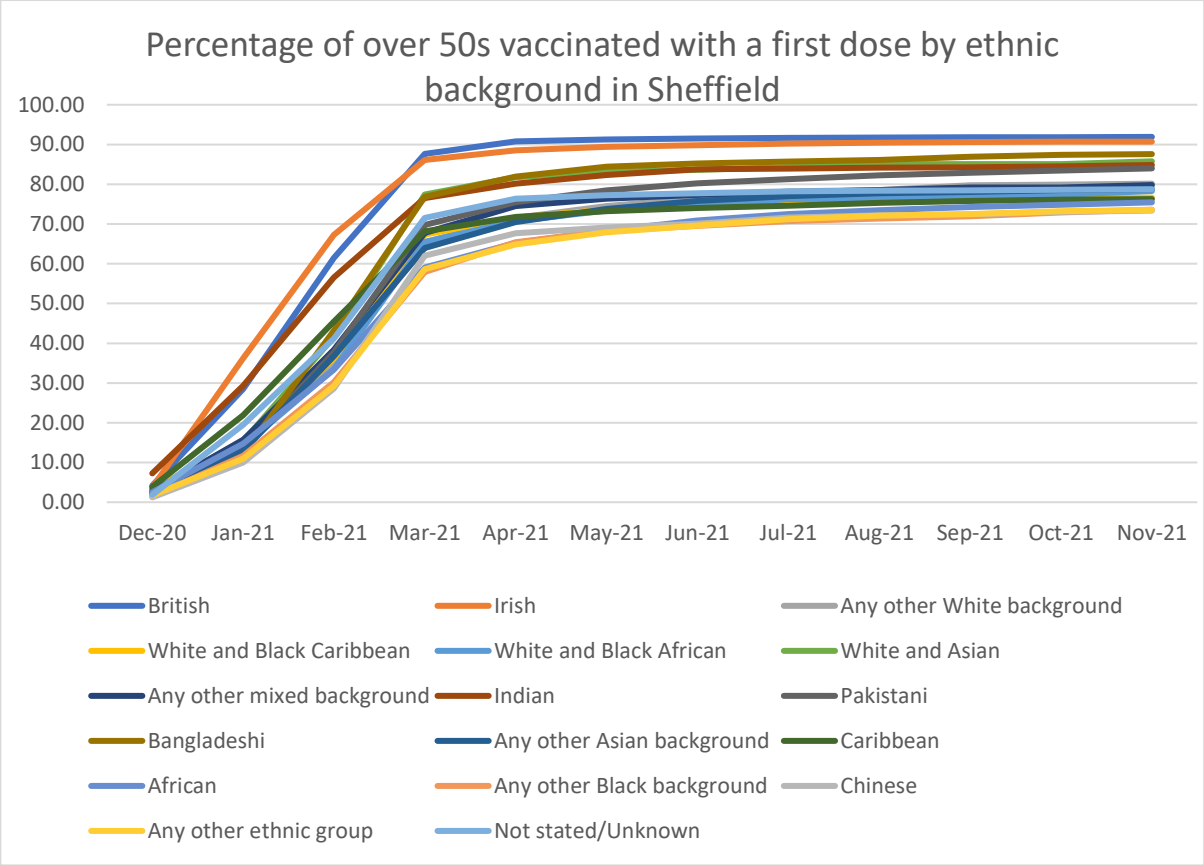
Understanding the impact of the Sheffield COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds

This chapter considers the overall impact of the Sheffield COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds by using a range of data to understand the contribution it may have made to COVID-19 vaccine uptake by people from ethnic minority backgrounds across Sheffield. It starts by using quantitative data to explore patterns of vaccine uptake across Sheffield over time before comparing Sheffield as whole to other 'core cities' outside of London. It then draws on qualitative insights from key stakeholders in the NHS and Public Health to consider the overall contribution of the Vaccine Taskforce to vaccine uptake amongst Sheffield's ethnic minority population, including whether it could be considered value for money.

4.1. Patterns of vaccine uptake

Figure 4.1 provides an overview of the percentage of first dose vaccinations per ethnic background by the eligible population in Sheffield over 50 years old between December 2021 and November 2021. The overall pattern indicates that the take up of first dose vaccinations by people from white backgrounds has consistently remained higher than for people from ethnic minority backgrounds, but the difference in levels of take-up reduced over time.

Figure 4.1: Percentage of first dose vaccinations per ethnic background by eligible population over 50 years



In March 2021, the percentage point difference between the group with the highest percentage take-up of first dose vaccinations (white background) and the lowest percentage take-up of first dose vaccinations (any other black background group) was 29.73. By comparison, in November 2021 this had decreased to 18.31 percentage points.

The first dose vaccine take-up by those aged over 50 from a white background increased by 4.49 percentage points over the time period while the greatest gains in vaccine take-up were by the African background group (16.4 percentage points) and the any other black background group (15.71 percentage points). Similarly large gains in the percentage of adults over 50 years who received a first vaccine are seen in the any other white background, any other ethnic group, Pakistani and any other Asian background groups. This data is presented for ethnic minority population groups in table 4.1 below.

Table 4.1: Estimated percentage of population aged over 50 vaccinated with a first dose in March and November 2021 based on NIMS population estimates for March 2022

	Estimated percentage of population aged over 50 vaccinated with a first dose March 2021	Rank March 2021	Estimated percentage of population aged over 50 vaccinated with a first dose November 2021	Rank November 2021	Percentage point difference
British	87.62	1	91.91	1	+4.29
Irish	86.13	2	90.71	2	+4.58
Any other White background	65.40	12	80.15	7	+14.75
White and Black Caribbean	67.34	10	76.63	12	+9.29
White and Black African	65.46	11	78.29	11	+12.83
White and Asian	77.37	3	85.77	4	+8.4
Any other mixed background	67.76	9	79.80	8	+12.04
Indian	76.49	6	84.83	5	+8.34
Pakistani	69.73	7	83.99	6	+14.26
Bangladeshi	76.84	4	87.58	3	+10.74
Any other Asian background	63.95	13	78.78	9	+14.83
Caribbean	68.14	8	76.26	13	+8.12
African	59.04	15	75.44	14	+16.4
Any other Black background	57.89	17	73.60	15	+15.71
Chinese	62.04	14	73.37	17	+11.33
Any other ethnic group	58.66	16	73.55	16	+14.89
Not stated/Unknown	71.51	5	78.75	10	+7.24

Source: NHS Sheffield CCG and National Immunisation Management System, UK Health Security Agency

There were also changes evident in which groups had the highest take-up of first dose vaccines in the over 50s. While the white British group retained the highest percentage take-up, the Bangladeshi background group were the third highest take-up by November 2021. The lowest take-up of vaccinations in March 2021 was the 'Any other black background' group however in November this was the Chinese background group.

4.2. How does Sheffield compare regionally and nationally?

The Evaluation Team sought to compare the data presented in table 4.1 with nationally produced data for the North-East and Yorkshire and England as whole. However, this was fraught with difficulty due to variation over time in the estimated population figures for each ethnic minority group. Whilst the national figures were derived from November 2021 NHS population estimates the Sheffield figures were derived from March 2022

NHS population estimates (November 2021 estimates were not available[2]), meaning direct comparison was not possible.

However, the Evaluation Team was able to consider vaccine take-up across the core cities and the success of Sheffield in higher vaccine rates was raised in a number of the research interviews as a likely impact of projects such as the Vaccine Taskforce.

> *"Sheffield actually has the highest uptake, 1st,2nd and booster jabs of any of the core cities in England. So the major cities outside London and they count London differently… I think the universal view in NHS and public health is because of the investment and great work of the community sector, I think their reach into the communities that we couldn't reach, we are not trusted, or we wouldn't be listened to and they just nail how to have those conversations and they just know it ". (NHS CCG).*

As table 4.2 shows, between December 2020 and March 2022, Sheffield had the highest vaccine uptake of the core cities for each of the three doses.

Table 4.2: Core city vaccine uptake for doses one, two and three (December 2020-March 2022)

	Number of people who have had at least 1 dose (12+)	Number of people who have had at least 1 dose (12+) CORE CITY RANK	Number of people who have had at least 2 doses (12+)	Number of people who have had at least 2 doses (12+) CORE CITY RANK	Number of people who have had at least 3 doses (18+)	Number of people who have had at least 3 doses (18+) CORE CITY RANK
Birmingham	68.50%	7	62.10%	7	45.20%	7
Bristol	78.80%	2	73.50%	2	60.80%	2
Leeds	77.80%	3	72.50%	3	59.90%	3
Liverpool	71.60%	5	65.80%	5	50.20%	5
Manchester	68.30%	8	61.80%	8	44.50%	8
Newcastle	75.10%	4	69.40%	4	55.20%	4
Nottingham	69.90%	6	63.80%	6	46.60%	6
Sheffield	**80.20%**	**1**	**75.00%**	**1**	**62.00%**	**1**

Source: Sheffield City Council 14/3/22

4.3. Did the Vaccine Taskforce have an impact on vaccine uptake amongst BAMER communities?

It is not possible to answer this question directly or establish causation based on the available evidence. However, there are some indications that the Vaccine Taskforce did make a positive contribution to vaccine communities in Sheffield. The proportion of people (aged over 50) taking up the vaccine in Sheffield increased over time amongst all population groups, but **the gap between the majority white population**

[2] The NHS system is 'live' and population data is continually updated, meaning our data could not be backdated.

and key ethnic minority populations reduced significantly following the delivery of the Taskforce.

This positive 'contribution story' was reinforced in numerous different qualitative stakeholder accounts. For example, Public Health stakeholders in Sheffield City Council said they knew with certainty that they could not have achieved the outcomes they did without the BAMER5. In one of the accounts, a key stakeholder stressed, *"it would have been a far worse situation both the pandemic, and the impact of the pandemic and also the vaccination uptake rates"* (PH SCC 2). So many people from ethnic minority backgrounds served by the BAMER5 were uncertain about the vaccine and / or anti-vaccination and changing their views required numerous conversations to dispel rumours and correct misinformation. When asked about the type of misinformation encountered, several examples were provided, concerned mainly with the adverse side effects of the vaccine:

> *"The lady was saying, I don't want to lose my baby, if I take the vaccine my baby will either have disability or maybe I will lose the baby, so I don't want to take the vaccine." (BAMER5 Rep 4).*

In this case, and in similar ones, the organisation (one of the BAMER5) improved understanding within their community by seeking guidance from doctors about the safety of the vaccine. Women who were breastfeeding their babies were also reluctant to be vaccinated in fear that the vaccine would present risks to their nursing infants. Again, the organisation sought medical advice and cleared up any misconceptions. The other BAMER5 organisations were also a bridge between their communities and the healthcare profession, going to great lengths to overcome vaccine hesitancy:

> *"We have to speak to the doctors either by calling the doctors and then liaising and connecting that telephone line between the person who was complaining about it [the vaccination."] (BAMER5 Rep 4).*

In another example, a man who led an active life prior to the pandemic (attending mosque, driving a taxi) became isolated and suicidal during the lockdown as he had no family and lived alone in a flat. He refused to go to the hospital and was sectioned under the mental health act. With medical support and the BAMER5 organisation's intervention he was stabilised, and the organisation reported that, *"when things calmed down, we urged him to take the jab"* (BAMER5 Rep 3). In such instances, the most vulnerable members of BAMER5 communities were offered wider support in addition to help getting vaccinated.

Whilst the NHS and primary care worked long hours and set up pop up clinics to make vaccination as accessible as possible it was the BAMER5's hard work having conversations with their communities that reduced hesitancy. Sheffield City Council Public Health stakeholders concurred that the BAMER5 engaged more members of their communities by investing a great deal of time in conversations about the vaccine to allay concerns and possessing the right language skills was crucial to this engagement.

> *"They just got far more people to engage and listen and be part of the process and they have [taken] time. I think the other thing is through their community helpline and obviously, they have language skills" (PH SCC 2).*

The BAMER5's own experiential accounts of the effectiveness of their work were consistent with those of the NHS and Public Health stakeholders. A case in point was relayed in a narrative about distributing the health leaflet to people from ethnic minority backgrounds which contained guidance that was reported as being well received and acted upon, by members of the local communities:

"[The translated leaflet] tells them about social distancing and how they need to be careful because in terms of our culture, many BAME communities congregate, they get together…so we made sure that people got the information that they mustn't congregate and they must social distance and that worked. People really did abide by this (BAMER5 Rep 2).

Additionally, the BAMER5's accounts revealed that their social media platforms were extremely active during the Vaccine Taskforce for constructive debates within local communities on vaccine concerns, misinformation, and education – another indication that 'hesitancy' was being challenged positively and possibly addressed in some cases. An excerpt from an interview underscores this point:

"The communication around the vaccine was very, very active in the community, that means we could see it on Twitter, on Instagram, on Facebook and even in our centre here, a lot of elders together with the young people, people were for or against the vaccine engaging, it was great to see that learning becoming very, very active." (BAMER5 Rep 6).

In another example, 48 Roma people received vaccinations over two hours in a vaccine drop-in clinic organised by the Fir Vale Community Hub in conjunction with the NHS. By taking vaccination services into the community, a place of familiarity and easily accessed, a usually hard-to-reach community was reached.

When considering the overall impact of the Taskforce public sector stakeholders (from the NHS CCG and Public Health) stressed that whilst it was difficult to identify causality or quantify how many people were vaccinated and the number of lives saved because of the BAMER5's work, but unquestionably, vaccine uptake had increased due to their actions. There was a recognition that without their involvement the situation for many people from ethnic minority backgrounds would have been dire. The following account clearly conveyed this view:

"If you look at outcomes the vaccine rates in Sheffield, we have been at the top of the core cities all the way through and we have vaccinated far more people than we ever thought possible, it is such a good news story. There is still a 10-20% difference between different black, Asian and minority ethnic communities and white populations which is really disappointing given the level of work that we have done however had we not done this amount of engagement, had we not had these organisations to support us, it would have been disastrous. It would just have been far worse… They have helped us overcome the misinformation, they have helped those communities trust the council, public health." (PH SCC 2).

4.4. Value for money

Given the limits and uncertainty around the quantitative data it is not possible to undertake a traditional assessment of value for money through a cost benefit analysis. However, within the narratives of the BAMER5 and significantly, those representing the public sector, there was recognition of the considerable value the voluntary and community organisations provided for the funding that they received, often going above and beyond the call of duty and contractual obligations to meet the needs of their communities. Evidence revealed that the BAMER5 leaders, large numbers of volunteers and paid staff invested considerable personal time and energies to respond to the multiple and complex needs of their communities who for example, due to language barriers, previous experiences of racism and resulting lack of trust in mainstream services required greater explanation and reassurance rather than simple messages and signposting. Clearly, the narratives from the public sector acknowledged that mainstream services could not have met local community needs in the way that the BAMER5 provided support on 'shoe-string' budgets:

"They have just been so creative with [the small amount of funding provided]. I have been astounded, knowing through the [names of projects], I deliver a huge amount of campaigns and it costs a lot of money to deliver campaigns…and you think wow, what they did and the reach they have was into the 100s, just on WhatsApp groups it could be 500 and on their social media platforms as well. They just got far more people to engage and listen and be part of the process and they have took time" (PH SCC 2).

Unlike the statutory sector, operating within the constraints of bureaucracy, the BAMER5 demonstrated responsiveness and flexibility, usually associated with their sector, by delivering on the objectives of the VTF round the clock within the parameters of the challenging and complex circumstances of the pandemic. Their unrelenting commitment was conveyed in several accounts, including the following:

"Their responsiveness as well, they just get on with it they are great, they are not bogged down with bureaucracy…They are up for it. They don't say well we have not done that before or where I think you have a lot in the statutory sector where they say we don't do it like that you don't hear anything like that. They just want to help and are really, really helpful" (NHS CCG).

Serving large local populations with many concerns, questions and mistrust in mainstream services and the national media, the BAMER5 provided answers and reassurance to quell vaccination hesitancy, doing so in real time with little funds. The local communities responded with *"increased engagement, people were ringing the station [local community radio], people were participating more in discussion groups, people were engaging more online…"* (BAMER5 Rep 5). By working longer hours, during weekdays and at the weekends, using paid and voluntary workers, the BAMER5 accommodated the additional burden created by increased engagement.

Summary of key findings

Sheffield is a COVID-19 vaccine 'success story': it has the **highest vaccine rates of all of the core cities** in England. Vaccine uptake (first dose) increased across the whole of the Sheffield population between March and November 2021 but during this period **the gap between the majority white population and key ethnic minority groups narrowed significantly**.

Although it is not possible to establish causation, these data, along with numerous positive qualitative insights, indicate that **the Vaccine Taskforce did make a positive contribution to higher levels of vaccination** amongst key ethnic minority groups in Sheffield.

It seems likely that **the Vaccine Taskforce indirectly saved lives and prevented serious illness** amongst the target population. Given that the amount of money invested was relatively small it should be considered **extremely good value for money**.

5

Implications for the future

The BAMER5 representatives and the key stakeholders that we engaged with during the evaluation each stressed the importance of taking the lessons from the Vaccine Taskforce forward in their future work. This chapter highlights some of the key themes from these discussions including the relationship between VCF sector organisations led by ethnic minority groups and the public sector, the BAMER5's sustainability, how services might be commissioned differently, increased visibility of the BAMER5 and recognition of the value they create, the strength of partnership working, and the need to reduce bureaucracy for VCF organisations.

5.1. The relationship between BAMER5 and the public sector

A consensus emerged from the interviews that prior to the pandemic the relationship between the BAMER5 organisations and the public sector had not been ideal. One of the BAMER5 reported being *"isolated by the public sector"* (BAMER5 Rep 1) whilst another explained, *"for 5 years we have had no funding, we were in a desert island all by ourselves, no one engaged with us, nobody worked with us, the council didn't want to know us"* (BAMER5 Rep .5). This experience was echoed in a further account, the BAMER5 leader recounted *"the public sector completely neglected us before the pandemic, we felt [we were] working in isolation…The LA did not reach out to the organisation, and this was explained away as resulting from funding cuts…No funding, no support, no reach out"* (BAMER5 Rep 3).

A Public Health stakeholder acknowledged that having newly established a Public Health Group (of 25 BAME led organisations), which included the BAMER5, during the first meeting, *"there was a huge amount of anger, feeling left behind, isolated, not feeling connected with Sheffield City Council or VS [voluntary sector] anchor organisations and also with the NHS and essentially the lack of trust was across the board"* (PH SCC 2). Overall, the evidence collected suggested that whilst a few senior officers from the public sector had relationships with the VCF, this wasn't the case across the board.

The tremendous efforts of local organisations and groups for people from ethnic minority backgrounds in supporting their communities in a time of crisis did not go unnoticed by Public Health (SCC) and was described as 'humbling'. By joining forces, the organisations and Public Health worked towards addressing the disproportionate impact of COVID-19 on people from ethnic minority backgrounds in Sheffield. More specifically, the BAMER5 had raised awareness of the vast work they were doing to support their communities by regularly posting information on social media and this resulted in securing funding from Public Health SCC and the NHS CCG. A collaborative effort between the parties followed and the BAMER5 are now considered as 'equals' by some and adequately knowledgeable to challenge incorrect information. The following narrative reinforced this:

"They [the BAMER5] worked with us week in week out, they saw that we care and that we are trying to do the best that we can for our communities and to protect public health and I do mean that they became mini public health warriors, because they knew just as much information as us, they knew when people were saying something which was incorrect and they would let me know if (there was) misinformation." (PH SCC 2).

Having received funding from the public sector the BAMER5 demonstrated their ability to do the job and undoubtedly, their relationships with the Public Health SCC and NHS CCG improved. As a BAMER5 leader stressed, *"people are seeing us for who we are and me for who I am"* (BAMER5 Rep 1). Whilst trust was built during a difficult time, uncertainty was expressed in all the BAMER5 interviews about the permanency of their relationship with the public sector, and whether in the future it might revert to the pre-pandemic situation:

"We were very disconnected from the [wider health] system and now we are very connected to the system…there is an issue that we need to remember, how long will we remain connected to the system?" (BAMER5 Rep 2).

In this narrative, the BAMER5 representative articulated their concerns about, and their hopes for, their work with Public Health (SCC) post pandemic, in stating, "*I hope that after the vaccination process that they don't leave us where they left us before but start thinking right these people have made inroads into their communities and their connections have helped us so much to get access into those communities, in a way that they have never been able to do and they recognise that and so If we can keep hold of that and see how we can build resources around that, that would be fantastic*".

5.2. Sustainability

Sheffield's Public Health leaders stressed that in light of the Council's constrained financial situation, the challenge moving forwards for the Council would be to keep sustaining such groups as the BAMER5. However, a commitment to continue working together emerged from the narratives, whilst recognising that some thought would be required (by the Voluntary, Community & Faith-based (VCF) anchor organisations and NHS also) to *"cleverly collaborate and do things differently, given the Council situation…"* to continue to fund organisations led by ethnic minority groups appropriately (PH SCC 2). Crucially, they recognised that the remit of the BAMER5 alliance was to ensure local authority adherence to the *"properly co-produced norm"* (PH SCC 1) on matters concerning their communities.

A similar working relationship with organisations led by ethnic minority groups was proposed by the NHS CCG stakeholder, one where the continual input of the organisations (articulating their communities' needs) shaped the decisions and priorities of the NHS. They explained, *"we set our priorities by what is happening nationally and not always… what's happening on the ground, and if they can help us with gathering that intelligence and feeding it in".* Further, the aspiration to ensure that such organisations were well funded was expressed, to do the identified work with their communities *"to make sure they are well funded and are not working on ad hoc projects and that they are funded for at least for a year and that funding does include some money for running their organisation's infrastructure, training and development of their staff… not just to cover the resources for the project"* (NHS CCG).

The BAMER5 reported that the Vaccine Taskforce had led to other funding opportunities for example, one of them shared that, *"as a result of this work, there are other offers of funding".* A BAMER5 representative expressed his confidence in the availability of future funding opportunities, stating, "*since we came together, we became a force and many of these funders are wanting now to hear from us"* (BAMER5

Rep 6). Whilst this optimism was shared, the BAMER5 acknowledged that much of this work was related to the pandemic, and inadequate for the longer-term sustainability of their organisations – *"they are offering us quite a bit of money at the moment, but it's just to do that specific thing of vaccination, not money to survive with"* (BAMER5 Rep 2).

5.3. Commissioning services differently

Significantly, the dialogue before and during the Vaccine Taskforce work resulted in a number of realisations for public sector stakeholders. First, the BAMER5 organisations were not small. In fact, by working directly with them, Public Health leaders appreciated that each organisation was well established, effectively serving large sections of Sheffield's communities from ethnic minority backgrounds. Second, that Sheffield's VCF anchor organisations had not been inclusive enough when distributing funds, and that this had affected the engagement and involvement of organisations led by ethnic minority groups. And finally, that concerted efforts were necessary to avoid the same situation repeating itself once the pandemic was over. Indeed, senior Public Health stakeholders stressed in their narratives the need to be held to account if they backtracked on their commitment to work closely with the organisations - *"if anybody starts going backwards, hold our feet to the fire and question us on it".* (PH SCC 2). They went on to describe their passion *"to change things [in Sheffield City Council] and…hold them to account on behalf of those organisations".*

By establishing a direct relationship with the BAMER5 (and BAME Public Health Group) and hearing their concerns Public Health (SCC) leaders realised that funding one large organisation to sub-contract services to other organisations was not necessarily the best way forward, particularly as organisations such as the BAMER5 had the connections, understanding and experiences from being rooted in their communities - *"it opened everyone else's eyes in the right way to say this a massive asset for Sheffield that we are just... not utilising the skills and talents of this group in the way that we need to be doing. Nor should they feel that they are not recognised"* (PH SCC 2). Since then, two services were commissioned differently by Public Health due to the learning gained during the Vaccine Taskforce. In both instances, organisations were able to directly secure funds, engage with commissioners and deliver services. Future commissions around specific health issues were planned by contracting with organisations like the BAMER5 directly:

> *"What this work has shown me is that actually going to the VCF meetings yourself, going to these different groups and having these conversations is far richer." (PH SCC 2).*

Moving forward, wherever possible, community organisations would be funded directly for language services, interpretation, and translation services.

Where colleagues within the council became aware of the extensive work of Public Health with the groups and organisations led by ethnic minority groups, they began to reflect on their own work in relation to equality, diversity and inclusion (EDI) considerations. The following account conveyed this:

> *"More and more people have realised how important it is to 1) have the connections and 2) to have the conversations and 3) to look at their own work and make sure they are reflecting back…and that it is in so many ways culturally competent." (PH SCC 2).*

5.4. Increased visibility and recognition of the (added) value of VCF organisations led by ethnic minority groups

Given that for many years, the BAMER5 had been battling with the public sector (NHS CCG and PH SCC) to make them aware of their communities' needs for specific services they were surprised that during the pandemic they began to receive letters from MPs commending them on doing great jobs and from Public Health (SCC) and the NHS acknowledging their invaluable work encouraging people from ethnic minority backgrounds to be vaccinated. It seemed that their value was finally being recognised. Undoubtedly, the delivery of the Vaccine Taskforce has placed the BAMER5 'on the map' in terms of the public sector. As one of the BAMER5 reported, "*people automatically recognised our presence"* (BAMER5 Rep 2). Further, successful collaboration prompted key stakeholders to consider how they might tailor their services through community organisations to meet the needs of people from ethnic minority backgrounds in the future.

Another BAMER5 leader explained that the community lacked visibility because it often failed to document achievements – *"we BAME do a lot of work practical, we don't document things".* However, the work that the BAMER5 did during such challenging and unprecedented times pushed them beyond their limits, and out of their comfort zones to deliver the services but instead of downplaying their efforts, the BAMER5 created opportunity from the crisis by enhancing their visibility in social media, reports, videos and so on, resulting in more potential funders and partners becoming aware of them – *"we positioned ourselves well, we strategised and mobilised"*. Even both universities (of Sheffield) started taking notice of the work of the BAMER5 organisations, realising that *"there's a lot of work that can be done in collaboration with the community"* (BAMER5 Rep 3).

This commitment to collaboration between VCF organisations led by ethnic minority groups and the public sector means that the experiences and needs of people from ethnic minority backgrounds have become more visible. It has also influenced decision making, for example, information from the BAMER5 was used in strategic public sector meetings where patient stories and /or videos were played or read. An aspiration was expressed to ensure that all public sector work reflected the populations of people from ethnic minority backgrounds in the city and wherever possible, lived experience be used to influence meaningful change. By involving leaders from organisations led by ethnic minority groups in their decision-making committees, an NHS stakeholder recognised that their organisation would be more receptive to direct communication from 'community experts' rather than reading information summarised in reports. They reiterated, *"people do listen, and I have noticed that the narrative is changing, people do talk about what impact that will have on inequality, on communities, on reducing health inequalities, which we didn't hear 18 months ago, two years ago"* (NHS CCG).

Significantly, in the above account, the NHS CCG stressed its drive to involve leaders from organisations led by ethnic minority groups, in its committees to influence decisions at a strategic level. Achieving this aspiration would begin to overcome the frustration expressed by the BAMER5 about a lack of involvement in such structures and a lack of opportunity to influence meaningful change for their communities. The disheartenment felt by one of the BAMER5 was conveyed in the following narrative:

> *"Are we going to just keep going to meetings or are we going to demand that we are in some of the power structures, and we try and get involved more in that way." (BAMER5 Rep 5).*

In this example, the BAMER5 representative emphasised the importance of being valued and seen on a par with some of those VCF organisations perceived as major players, they stated:

"I see us as being on a par with the bigger organisations, so called bigger organisations. If you look at (XXXX BAMER5 organisation), I think [they] ha[ve] X pounds going through [their] account, some of the other organisations have the same amount. It's not about money, it's not about buildings, it's about respecting and valuing and seeing that we can make a difference and make a better difference to the landscape of Sheffield if we are included rather than excluded from all those conversations and meetings and money." (BAMER5 Rep 5).

The accounts collected through the evaluation suggested that new opportunities to influence decisions were becoming available for those involved in the BAME Public Health Group (including the BAMER5) to become Race Equality Commissioners or to sit on other strategic boards in Sheffield – an opportunity reported as being, *"really valuable, because then it's giving a voice to certain communities that didn't have it before"* (Other VCF). Indeed, all of the interviews revealed how the relationship between the public sector (PH SCC and NHS CCG) and the VCF had begun to change since working together closely during the height of the pandemic. For example, previously, the NHS CCG had predetermined its priorities in terms of the work they intended to undertake with local populations of people from ethnic minority backgrounds but had now shifted their approach to consulting with organisations led by ethnic minority groups to understand needs and issues in different communities before firming up priorities. A move towards a co-produced rather than a prescriptive model to meeting the needs of people from ethnic minority backgrounds was articulated:

"We work more in collaboration whereas before the CCG would decide this is our priority, we are going to review urgent care and we want the views of the South Asian community so we might work with PMC and we might work with ACT and Fir Vale [Community Hub] and say this is our piece of work, these are our questions, please can you go and speak to people for us. Whereas now we have a conversation before, where we will say, this is a piece of work we are thinking about, what's going on in your areas, how can you help us, what does that funding look like, whereas before I think we were quite prescriptive. Not always, a bit more prescriptive." (NHS CCG).

This commitment to open and constructive dialogue between the different parties had wider benefits. For instance, the BAMER5 were made aware of opportunities for funding, training and so on. The multiple benefits that were gained through open and direct communication were conveyed in the following narrative:

"Before the pandemic, we didn't know that [NHS CCG stakeholder] existed, [they] didn't know that we existed…Now [they are] sending us emails, [they] said, "have you heard about this good practice, this funding, are you aware of this training?"…Now they are engaging with us in a constructive way at the level we wanted them to be and not going through intermediaries." (BAMER5 Rep 3).

In recognising the contributions of the BAMER5, a Public Health (SCC) stakeholder stressed that lessons should be learnt from the collaborative effort, for example, the methods for engagement, and be transferable to addressing other public health issues for people from ethnic minority backgrounds:

"There will be ethnic differences in MMR uptake, in flu jab uptake, in cancer screening uptake. The way in which we've done this, you can apply the lessons to all sorts of other things…lessons that we should carefully document" (PH SCC 1).

5.5. Strength in partnership working

Prior to the pandemic, VCF organisations led by ethnic minority groups were largely working in isolation, competing for funding, and attempting to sustain themselves; there was little or no collaboration. Challenges stemming from Covid-19 brought together organisations serving populations of different cultures, value bases, expectations and needs to address the unfolding crisis. The beginnings of the partnership between the BAMER5 were recounted in an interview:

> *"During the pandemic we saw a rebirth of exactly what community organisations should be focusing on, that means we unite, and it was a beautiful thing to see, communities from different faiths, different origins, different agendas came together to solve the Covid-19 problem in the city." (BAMER5 Rep 6).*

Whilst acknowledging the differences, the BAMER5 realised that they shared some similar experiences and issues and therefore formed a unified partnership approach to dealing with the issues. By employing a unified approach, they were noticed and able to secure support from Public Health SCC and the NHS CCG. In one example, the BAMER5 representative recalled that although his organisation had been proactive in meeting their community's needs at the start of the pandemic by partnering with the Muslim chaplaincy in hospitals, holding meetings with local mosques, and so on, when they approached the local authority for financial support, they were unsuccessful. Success followed when they formed the BAMER5.

As a collective, the BAMER5 produced a strategy highlighting how they could support delivery of some of the NHS CCG and Public Health's medium and long-term objectives, and this helped them to secure funds. A BAMER5 representative explained, *"we were able to write a strategy document…we said, let's sit together, let's be positive and constructive, and tell them [the public sector] what we've done, what we are doing, and, how we can help them collectively to deliver the services, so that they see us as a positive, constructive partnership rather than just complaining about resources*" (BAMER5 Rep 6).

Much of the BAMER5 work involved challenging the council and the NHS on inequality issues in relation to funding, representation in decision making etc. However, evidence from the interviews suggested this was done in a constructive manner. A statement revealed the extent of this aspect of their role, *"as a BAMER5 we have done a lot of work pushing and prodding and challenging, a lot of our role has been around challenging the status quo in the city"* (BAMER5 Rep 5).

All five BAMER5 leaders expressed optimism about their future as the BAMER5, particularly as their collaborative efforts had led to productive dialogue with the Council and NHS leaders, recognition of their expertise in their respective communities, and widened access to funding opportunities. A continued role for the BAMER5 in future work with Public Health and other sectors was anticipated:

> *"I am very optimistic about the future, I don't think we will fall, I don't think that we will be divided again. I think there is a big chance that the BAMER5 will grow… we are in a position collectively now to look for resources together." (BAMER5 Rep2).*

5.6. Reducing bureaucracy

Although the evaluation uncovered a range of positive findings about the approach to partnership between the public sector and VCF organisations led by ethnic minority groups, some concern was expressed that the level of bureaucracy associated with the Vaccine Taskforce did inhibit some of the work. For example, the monitoring

requirements proved challenging, particularly as each of the BAMER5 organisations were required to submit separate figures for activities even though they had been funded as a collective. One account revealed that, *"there was no breathing space between getting a foot on the ground [to deliver services] versus the monitoring and then they started wanting it every other week"* (BAMER5 Rep 1).

Both the NHS and Public Health stakeholders recognised that monitoring requirements had been onerous, and they conveyed efforts to reduce the burden on the BAMER5 by accepting verbal updates during weekly group meetings and recorded data on a quarterly basis. The trusting relationship between all parties was emphasised in a couple of accounts, and ought to provide a template for how future projects are monitored:

> *"Because the groups were coming together every week, we knew what they were doing, they were telling us and one of the things that I think has been quite revolutionary for the council and the NHS is that we have done monitoring but we have done it on a more trusted basis, where it has been you tell us what you are doing, you work with us, you collaborate and we'll just let you get on with it and just send us the monitoring at the end of the quarter." (PH SCC 2).*

Summary of key findings

There are a number of lessons from the Vaccine Taskforce that could be taken forward in future partnership work between the public sector and the VCF sector led by ethnic minority groups to ensure that it is more equitable. Key stakeholders recognised that, prior to the pandemic, these relationships had been far from ideal but that there was now an opportunity to make changes that would be of real benefit to the health of people from ethnic minority backgrounds.

1. Maintaining a **commitment to partnership working between the public sector and VCF sector led by ethnic minority groups**, based on trust and understanding of each other's strengths and challenges.
2. **Supporting VCF organisations led by ethnic minority groups to be more sustainable** through more equitable funding practices and wider support.
3. **Commissioning services differently** so that the needs and circumstances of people from a variety of ethnic minority backgrounds, are considered along with the strengths of VCF organisations led by ethnic minority groups.
4. Recognising the **added value that VCF organisations led by ethnic minority groups can provide for the health system** due to their reach into, and knowledge and understanding of people from ethnic minority backgrounds.
5. Encouraging and **enabling VCF organisations led by ethnic minority groups to work together in partnership** rather than in silos or in 'competition' with each other.
6. **Minimising the bureaucracy associated with funding** so that it doesn't become a burden or detract from frontline delivery.

6 Conclusion

This evaluation report has explored the work undertaken through Sheffield's COVID-19 Vaccine Taskforce for people from ethnic minority backgrounds. Overall, it paints **a very positive picture about the effectiveness of the Taskforce** but the findings are limited by the availability of quantitative data which means it has not been possible to establish a direct causal link between the Taskforce and increased vaccine uptake, levels of serious illness, or deaths. These caveats notwithstanding, the evaluation has produced the following key messages.

1. Overcoming barriers to health promotion

The **Vaccine Taskforce was able to overcome a number of barriers to vaccine uptake** including awareness, understanding, misinformation, language and a lack of trust in the health system. This was achieved through a core strategy based on **communication, community engagement and outreach** that utilised the BAMER5's existing reach into and understanding of their communities, to deliver a range of activities that directly addressed some of the key factors associated with vaccine hesitancy.

2. Utilising existing community 'health assets'

VCF organisations such as the BAMER5 are an example of community 'health assets' with **rich histories and long track records of working with local communities to promote health**. They have in depth knowledge of their communities which enables them to identify the most appropriate strategies for promoting health messages to different population groups. This is particularly important for work with people from ethnic minority backgrounds whose needs and circumstances, and the strategies that best support them, are very often different from the majority population that access mainstream services.

3. Making a contribution to increased vaccination levels in people from ethnic minority backgrounds

Key stakeholders believe that the **Vaccine Taskforce made an important contribution to Sheffield's COVID-19 vaccine 'success story'**. Sheffield has the highest vaccination rate of the English core cities and saw a significant narrowing of the gap between the majority white population and key ethnic minority groups between March and November 2022 – the time period when the Taskforce was active. **It is likely that the Vaccine Taskforce indirectly saved lives and prevented serious illness amongst the target population groups**. For the small amount of money invested the Taskforce represented extremely good value for money.

4. Implications for the future

The findings of this evaluation have important implications for the **future engagement and involvement of organisations led by ethnic minority groups in public health issues**. It was widely recognised that, prior to the pandemic partnership with the public sector had largely broken down but that there was an opportunity to change this in ways that would benefit the health of people from ethnic minority backgrounds in the longer-term. Key to this will be **maintaining a commitment to partnership working based on trust and understanding of each other's strengths and challenges**.

Key stakeholders recognised the importance of **supporting VCF organisations led by ethnic minority groups to be more sustainable** through more equitable funding practices and wider support, including commissioning services differently so that the needs and circumstances of different ethnic minority groups are taken into account. Other enabling factors included a **recognition of the added value that VCF organisations led by ethnic minority groups provide** for the health system, **enabling VCF organisations led by ethnic minority groups to work together in partnership** rather than against each other, and **minimising bureaucracy** so that it doesn't become a burden or detract from frontline delivery.

A1 Appendix: Notes on Quantitative Data Sources and Analysis

A1. Sources of data

The evaluation team were provided with an extract of data from NHS Sheffield Clinical Commissioning Group containing anonymised details of vaccinations in Sheffield from 8 December 2020 to 30 November 2021. The data provided the count of vaccinations per ethnic background by Primary Care Network. Using this data, we produced a count of the number of first dose vaccinations for adults aged over 50, per month by ethnic background in Sheffield. We then used the National Immunisation Management System (NIMS, UK Health Security Agency) population estimates for March 2022 to produce a percentage of vaccinations per population for each ethnic background.

We also downloaded national data to create a comparison with the regional and national percentages by ethnic background for adults over 50 receiving a first dose vaccine, as at the end of November 2021.[3]

The analysis was focussed on first doses for adults aged over 50 as this enables comparison across datasets. All adults over 50+ became eligible for a vaccination from March 2021, under 50 age groups started to become eligible from April 2021.

A2. Ethnicity reporting

We were advised by NHS Sheffield CCG that the recording of ethnic background for those receiving a vaccine has not been systematically taken from the beginning of the vaccine programme and this adds further uncertainty to the data. This can also be seen in the significant numbers for whom there is no ethnicity recorded: 11,022 adults over 50+ were recorded as missing data on ethnic background in November 2021.

Further information on recording ethnicity in the NHS is available here: https://digital.nhs.uk/news-and-events/latest-news/nhs-digital-publishes-information-on-ethnicity-recording-in-the-nhs-to-aid-planning-and-research-for-covid-19

[3] See: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/covid-19-vaccinations-archive/