Vaccinations throughout a person's life have proved to be one of the most important public health tools in history - saving lives and simultaneously bringing significant social and economic benefits. They remain a vital tool in preventing infectious diseases and cancers and in the fight against antimicrobial resistance. In addition, there are new vaccines in development to prevent diseases such as malaria, RSV and combine flu and COVID jabs.

However, the benefits vaccinations can bring are not being felt equally by all groups in society across Europe. This is a risk to individuals themselves and to wider society, given the increased likelihood of vaccine preventable disease as a result of under vaccination following the pandemic and growing vaccine hesitancy. As one discussant stated, 'We are increasingly aware that the health of every single person is interconnected and that to protect everyone's health, no-one can be left behind'.

At our online written discussion Business Fights Poverty brought together 12 leading experts and practitioners from across Europe to share and explore what they believe the barriers and opportunities are to advancing vaccination equity, with a specific focus on how inequity affects vaccination amongst one of our most vulnerable populations, those affected by poverty. The session was viewed by over 1,000 members of our community and offered in-depth insights and new connections - all of which will inform the development of a public report on this issue later this year.

**THE WHY**

Discussants began by exploring why people living in poverty or experiencing social exclusion were more likely to experience lower levels of vaccination.

One discussant highlighted that global studies have regularly shown that people with low levels of vaccination can be broadly grouped into 3 categories - displaced communities, remote rural communities and the urban poor. During this European focussed discussion, particular attention was paid to two of these broad groups - migrant populations and the urban poor - which often, but not always, encompasses socially excluded communities. Discussants noted that poverty and health are inextricably linked and that health outcomes will vary greatly depending on people's experience of the social determinants of health - such as income, working conditions, housing, employment, education, social inclusion, discrimination, and access to health and social care. A number of studies have shown that the lower someone's socioeconomic position, the worse their chances are for good health. Whilst comprehensive evidence on the causal links between poverty and under-
People living in poverty and socially excluded groups are a dynamic population and cannot be viewed as homogeneous. Vaccination are sparse in Europe, a number of individual studies point to a strong correlation. Reasons for under-vaccination include affordability and access, as well as lower trust in institutions, and competing priorities other than vaccination, such as work, housing or food security. For migrant groups additional challenges include: language, literacy and communication barriers, and legal barriers to accessing and delivering vaccination services.

There was strong consensus that people living in poverty and socially excluded groups are a dynamic population and cannot be viewed as homogeneous. They have unique experiences based on gender, age, disability, whether or not that person is also a caregiver to a child or elder, culture, veteran status, religion or race. Therefore, the barriers each individual faces are multifaceted and evolving and responses need to be tailored and context specific.

THE BARRIERS

Much of the discussion focussed on 3 major barriers to advancing vaccination equity in Europe broadly categorised as access, trust and data.

Access, affordability and awareness barriers

Even if vaccinations are free, there are time and cost constraints. As one discussant said ‘Can you take off time from work to go to get your kid vaccinated when the health centre is open? And, if you can get time off, is it paid time off so as not to sacrifice vital income to get vaccinated?

Vaccination centres and health services may not be located near people living in poverty. Transportation may be unaffordable or services may be in areas that don’t feel welcoming. People living in poverty also face competing priorities that can limit their ability to access vaccines. For example, one recent polio vaccination campaign found that time was a barrier with booking vaccine appointments often deprioritised in favour of work and childcare. Migrants and refugees in particular may experience digital exclusion, language and health literacy barriers and lack of interpreting services to facilitate interactions as health/vaccination information is often provided in written and online formats and only in the local language. Migrants also face numerous practical and legal barriers to accessing healthcare: insecure housing, lack of a fixed address, uncertainty around legal entitlement to services.

Lack of trust in institutions (and misinformation)

There was a strong consensus that distrust of vaccination or the wider health system can also influence acceptance of vaccination. The effects of structural racism and contemporary and historical discrimination are significant. It was noted that confidence is rooted in trust, not just in the vaccine but also in the people and systems that administer them. For people living in poverty or socially excluded groups, many of whom have fallen through the gaps in the safety nets meant to support them, that trust may already be broken. Additionally, grievous crimes have been historically committed against people living in poverty and minority groups. Unethical clinical trials in Nigeria and the US in the past were cited as examples.

Trust is also key to understanding misinformation. If people do not trust in the scientists, healthcare professionals, governments, policy makers, and vaccine manufacturers that develop, deliver, and mandate vaccines they will look for alternative sources of information. ‘While we may not be able to combat all the conspiracy theories or misinformation running rampant on social media, we can restore trust in reputable sources’.

Therefore it is critical that accurate information is delivered in ways that can reach people in a culturally relevant way and is from credible and trusted sources.
VACCINE EQUITY

Migrant populations have fear and distrust of health and other services due to the threat of legal repercussions, including arrest, detention or deportation. This was evidenced during COVID-19, despite governments making clear that vaccines would be available regardless of immigration status.

Data gaps

There was broad consensus that currently data collection on vaccination rates often masks the reality that many groups such as migrants and urban poor are under vaccinated. Disaggregated data on vaccination uptake is sparse and not being effectively captured in countries across Europe. This makes it difficult to identify pockets of under-vaccination and design appropriate responses. One discussant noted that they experience lots of challenges accessing local data on subpopulations, due both to poor data quality (e.g. not coded by ethnicity), and the right data not being collected, e.g. country of birth. Another noted that the lack of data on length of residence, made it very difficult to measure immunisation rates among migrant populations, despite migrants making up more than 14% of the population’ (UK).

Challenges with capturing data amongst the urban poor were also recognised, including identifying caregivers and unimmunized children in crowded and highly mobile areas; and the fact that transient groups utilise fewer health services, further complicating identification.

Vague terms to describe segments of the population experiencing social exclusion such as ‘hard to reach communities’ were viewed as unhelpful. As one discussant noted ‘Without recognizing the characteristics and needs of the various populations that compose it, it is not possible to guarantee effective access to vaccination’.

RECOMMENDATIONS AND ACTIONS

‘We need to take vaccinations to socially excluded people, not expect them to come and get them’

Broad recommendations at the EU level included:

- Advancing universal health coverage across the EU regardless of people’s legal, social and housing status, e.g. in Italy this would reduce the barriers to accessing healthcare for those with registered residence permits.

- Making funding available for long term programmes that are directed towards hyperlocal community based organisations to co create programmes which effectively reach underserved populations with a focus on increasing vaccine coverage across the life-course.

National level recommendations included

- Learn from the COVID-19 experience and be responsive to service user needs to access vaccination. For example, extending operating hours at vaccination sites. Extending mobile services developed during such as Italy’s ‘On The Road’ campaign to protect homeless people. And, bringing vaccination services into the community. Pharmacies could also play a role.

- Enhancing the role of cultural mediators, including providing interpreters, training healthcare professionals in migrant health and cultural competence.

- Empowering the communities directly affected by poverty and social exclusion to identify and implement novel solutions that work for them. Putting power back in the hands of those who have been marginalised. Community ‘experts by experience’ must be involved in finding solutions and adequately recognised and compensated for their valuable contributions.

‘Restoring trust, and indeed addressing any of these barriers, requires substantial investments in time and resources’
RESOURCES SHARED

Health and Vaccine Inequity

- Area-based socioeconomic factors and Human Papillomavirus (HPV) vaccination among teen boys in the United States
- Equity Reference Group for Immunisation: Tackling inequities in immunisation outcomes in urban contexts (2018)
- Social Determinants of Health to Advance Equity (2021)

Vaccination Hesitancy, Confidence, Uptake

- Misinformation on vaccination: A quantitative analysis of YouTube videos
- Identifying False Human Papillomavirus (HPV) Vaccine Information and Corresponding Risk Perceptions From Twitter: Advanced Predictive Models
- WHO: Tailoring immunisation programmes (TIP) (examples promoting a community tailored approach)
- Vaccine confidence: the keys to restoring trust (2020)
- The 5As: A practical taxonomy for the determinants of vaccine uptake

COVID-19 Vaccine Uptake and Migrant Populations

- Codesigning an intervention to strengthen COVID-19 vaccine uptake in Congolese migrants in the UK (LISOLO MALAMU): a participatory qualitative study protocol (2022)
- Clinical outcomes and risk factors for COVID-19 among migrant populations in high-income countries: A systematic review (2021)
- Health Inequalities Strategy Implementation Plan - Case Studies (UK, 2021)
- Racism row as French doctors suggest virus vaccine test in Africa (2020)
- Reducing COVID 19 transmission and strengthening vaccine uptake among migrant populations in the EU/EEA (2021)
- Defining the determinants of vaccine uptake and undervaccination in migrant populations in Europe to improve routine and COVID-19 vaccine uptake: a systematic review (2022)

OTHERS

- Towards the ‘Global Health Charter’ from a citizen’s perspective (Italy, 2023)
- BMC Public Health. Evaluation of the impact of immunisation policies, including the addition of pharmacists as immunizers, on influenza vaccination coverage in Nova Scotia (Canada: 2006 to 2016)

UPCOMING REPORTS

VACCINE EQUITY

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