Letter to the Editor.

NEW SOLUTIONS: A Journal of Occupational and Environmental Health Policy

Response to comment on:

A qualitative study of the views of ethnic minority healthcare workers towards COVID-19 Vaccine Education (CoVE) to support vaccine promotion and uptake.

By Holly Blake.
School of Health Sciences, University of Nottingham, Nottingham, UK.
NIHR Nottingham Biomedical Research Centre, Nottingham, UK.

Our study and the COVID-19 Vaccine Education (CoVE) is very timely as at the time of writing, according to UKHSA statistics updated on 17 October 2024, the number of SARS-CoV-2 confirmed acute respiratory infections had increased in England (compared to the previous week). Vaccine uptake remains low in healthcare workers, ethnic minority communities, and specifically, ethnic minority healthcare workers (EMHCW). There is an urgent and ongoing need to promote the COVID-19 vaccine and this intervention supports this national, and indeed global, effort.

In response to the comments made, we respectively disagree that our study has significant content and methodological limitations. We believe that our sample size of 30 is sufficient for the analytic approach we undertook, and to address our qualitative research question. The comment that our sample “does not represent the different experiences and viewpoints of all EMHCW in the UK” is not relevant as this qualitative research is not intended to be “representative”, but rather to reflect the views and insights of EMHCW participants who accessed CoVE, with diversity in age, gender, occupation, and level of seniority, which was largely achieved. It is proposed that “oversampling of female participants may have skewed the study's conclusions”. While we agree that it would have been beneficial to engage more participants who identified with other genders, research shows that vaccine hesitancy is higher in women. Importantly, we purposely over-sampled female participants to appropriately reflect the gender balance in the health and social care workforce, in the UK and internationally.

It was suggested that CoVE “could consider including EMHCW in the creation process to ensure that the content is more directly relevant to their specific requirements and concerns”. The commentator seems to have overlooked the detail in our paper’s background section, and our signposting to the original paper which reports on the development of CoVE. The creation process involved an ethnically diverse expert peer review panel from seven countries, and an evaluation with users from 26 countries: therefore, we have therefore involved individuals from diverse cultural groups and geographic regions.

We recognise in our paper that the individuals who came forward for interview expressed pro-vaccination views. It is a limitation of our study that we are unable to represent the views of those who are more vaccine hesitant or anti-vaccination. With regards the comment relating to self-reports, qualitative studies are by nature based on self-reports. It is beyond the scope of a qualitative study design to collect objective outcome measures, such as data on vaccination outcomes. As we have already proposed, a different study design would be needed for such endeavour; a randomised controlled trial is required to determine the ‘effectiveness’ of CoVE in increasing vaccination uptake in EMHCW. This would, however, be a useful and appropriate next step.

Utilising CoVE to support EMHCW to become immunisation champions is a valid proposition. Future research could consider mechanisms through which CoVE could be used to train and support the work of immunisation champions in engaging with minoritised communities and to identify best routes to encouraging EMHCW to engage with occupational vaccination programmes.