CVDR/S6/22/17/2

COVID-19 Recovery Committee

17th Meeting, 2022 (Session 6), Thursday 23 June 2022

COVID-19 public health messaging for different audiences

Contents

Introduction and purpose of paper

The Committee launched its inquiry into COVID-19: communication of public health information in April 2022. The inquiry has the following aims:

- To understand the challenges, including the existence of any misinformation and disinformation, faced by government in communicating public health messages in the pandemic to date and to consider what could be done by government to tackle these issues going forward.

- To consider whether public health information about COVID-19 is accessible to and meets the needs of specific audiences going forward, including people in the shielding category and communities where there has been below average uptake in vaccination to date.

- To understand how scientific information about personal health risks and risks to wider society can be best used to inform decision-making and public health messaging.

On 19 May 2022, the Committee held an informal discussion with the Royal Society of Edinburgh (RSE) to discuss the findings of its Post Covid Futures Commission. A note of discussion was published following the session.

On 26 May 2022, the Committee took evidence from two panels. Discussions covered sources of misinformation, solutions, developing trusted sources of information, and government sources of information.

At its formal meeting on 23 June 2022, the Committee will take evidence on COVID-19 public messaging to different audiences. This paper summarises themes of particular interest for this discussion and suggests potential questions.

Background

Communicating public health information to different groups

Much has been written about the requirements of successful public health messaging (Royal Statistical Society, Royal Society of Edinburgh, House of Commons Health and Social Care and Science and Technology Committees, University of Leeds):

- The information should reach the intended recipients (or be accessible to them).
- The information should be clear and understandable.
- The information should be transparent and able to be trusted.

COVID-19 risks

We know that some groups in Scotland are at greater risk of catching COVID-19 and experiencing severe outcomes than other groups. Large-scale studies conducted by Prof Jill Pell and colleagues (Foster et al. 2022, Niedzwiedz et al. 2020, Jani et al. 2021) have shown that:

- COVID-19 risks are higher in more deprived areas than in less deprived areas.
- COVID-19 risks are higher for minority ethnic groups (particularly Black and South Asian) than for White people.

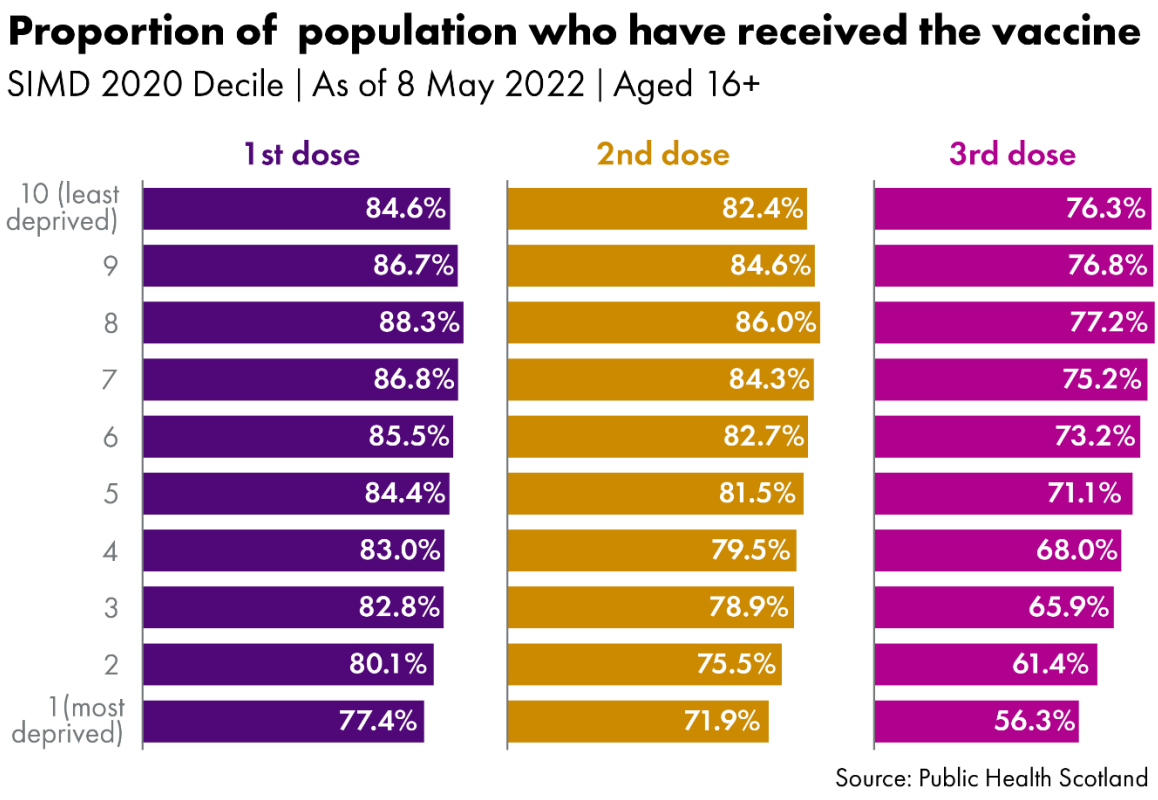
- COVID-19 risks are higher for ‘shielded’ individuals: people with specific underlying health conditions that increase their vulnerability to respiratory viruses.

Vaccination uptake

In addition to being at higher risk of negative COVID-19 outcomes we also know that people from deprived areas and minority ethnic groups have low uptake of the COVID-19 vaccines, which could place them at even greater risk.

- **Ethnicity:** In the first five months of the vaccine roll-out (December 2020 to April 2021), 64% of the White ethnic group had received two vaccine doses, compared with 40%, 34% and 38% for Asian, African, and Caribbean/Black ethnic groups, respectively (PHS data).

- **Deprivation:** The chart below shows that vaccination rates continue to be lowest in the most deprived areas (source: Public Health Scotland).



Theme 1: Vaccine Information Fund

BEMIS – the national umbrella body supporting the Ethnic Minorities Voluntary Sector in Scotland – found that not all communities had sufficient access to information about the vaccines. BEMIS said: “As Scotland moves through its vaccination programme, it is crucial that all of the people of Scotland have informed and equal access to information about the vaccine.”

To empower communities to develop better ways of delivering vaccine information BEMIS offered grant funding through its Vaccine Information Fund. The first VIF vaccination campaign ran from March to September 2021. A second campaign ended in March 2022. BEMIS estimates that 55,000 individuals in 51 ethnic groups have been reached through the VIF.

By the end of August 2021 there had been a marked increase in vaccination uptake among ethnic minority groups. In the four months from May to August 2021 uptake increased by 92%, 95%, and 76% for Asian, African, and Caribbean/Black ethnic groups, respectively (PHS data) (compared with a 37% increase for the White ethnic group over this period).

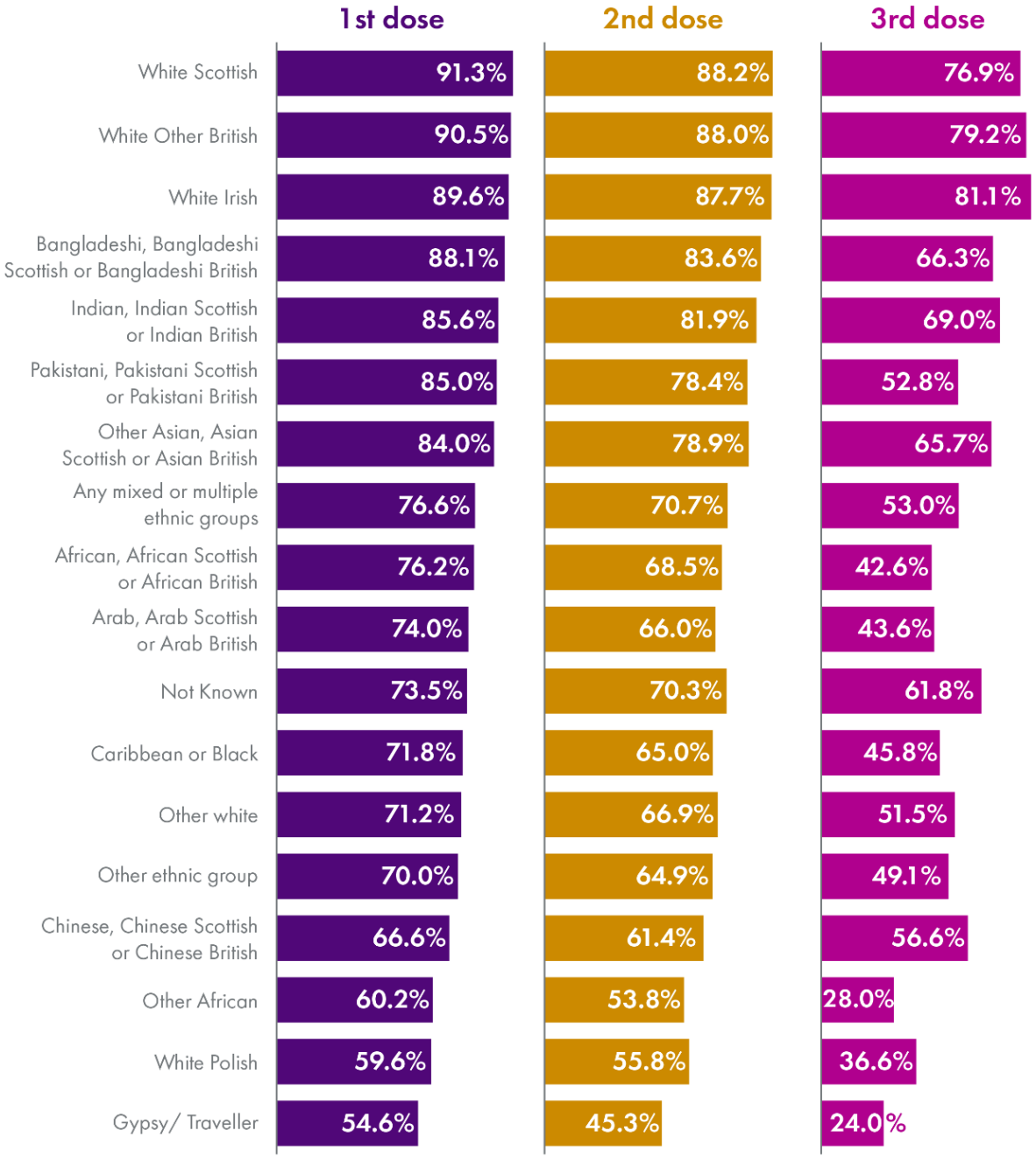
However, the latest data for vaccination uptake by ethnic group (up to 8 May 2022: almost 1.5 years since vaccine roll-out began) show that vaccine coverage is still lower in ethnic minority groups than in White British people (see chart below; source: Public Health Scotland). Vaccination rates are lowest among White Polish and Gypsy/Traveller communities.

At the 9 December 2021 meeting, the Committee heard a number of reasons why vaccine uptake in the Polish community was so low:

- Lack of reliable official information that answered the community's questions/fears:
    - Little or no official national or local outreach to ethnic communities (until June 2021).
    - Unable to discuss with GP or another trusted healthcare worker.
    - Fears that the vaccines are unsafe as they hadn't been properly trialled.
- Information gap filled by other sources:
    - Strong anti-vaccination messaging from Poland.
    - Social media myths
- Practicalities:
    - Precarious employment and childcare constraints makes it difficult to attend appointment or risk any side effects.
    - No choice of vaccine offered: this would have helped counter trust issues.
    - Translated information couldn't be searched for in Polish.

Proportion of population who have received the vaccine

Ethnicity (dis-aggregated) | As of 8 May 2022 | Aged 16+



Source: Public Health Scotland

Theme 1: Vaccine Information Fund

The Committee may wish to ask:

1. Question for BEMIS initially: How much of the increased vaccine uptake among ethnic minorities can be attributed to the Vaccine Information Fund?
2. Question for BEMIS initially: What lessons have been learned from the Vaccine Information Fund about how to communicate public health messages to ethnic minority groups?
3. What has worked to increase vaccine uptake?
4. Vaccine uptake rates among Polish people remain low, but the issues around reaching this audience are well known: why then are we making little progress in vaccinating this group?

Theme 2: Targeted communications

A consistent message heard by the Committee has been that there is no 'one size fits all' approach to public health messaging that will meet the needs of all communities. For example, speaking on vaccine uptake among minority groups, Derek Holliday (Homeless Network Scotland) told the Committee:

> "There is no one-size fits-all approach; we need more specialised, tailored approaches. We need to understand communities' needs, and we cannot do that from afar."

In its written submission to the Committee, the ALLIANCE stated:

> "People have shared that there has been a lack of tailored and person centred communication during the COVID-19 pandemic. People have reported receiving blanket information provision, which is too general, ambiguous and does not consider the needs of different population groups, including people at high clinical risk, disabled people, people living with long term conditions, and unpaid carers."

Social scientists from the University of Leeds studied COVID-19 messaging and concluded:

> "The key message from this report is that attempts to address the public as a homogeneous recipient of information and guidance relating to the pandemic are bound to fail."

They expanded:

> "… it makes sense to adopt a communication strategy in response to the current crisis that takes account of divergence between distinct population groups. Such a strategy would be consistent with public communication experts' well-established understanding that 'campaigns that target specific

> audiences and tailor their materials accordingly are more likely to achieve their public engagement objectives than campaigns that do not'"

The Committee asked witnesses how maximum vaccine roll-out could be achieved given the significant number of distinct groups that would need to be specifically targeted. Hilda Campbell (COPE Scotland) answered:

> "It is a huge problem. We can become overwhelmed by everything that is happening and by trying to find a solution for every distinct group. There are common themes across all groups, and perhaps we could provide bespoke responses to those themes to address the concerns of individual groups. If we agreed on an effective communication strategy, we could adapt it depending on who it is being targeted at."

At the 26 May 2022 meeting, Will Moy (Full Fact) told the Committee about audience fragmentation in terms of the opportunities it presents for people to be confused and misinformation to spread (emphasis added):

> "Every source of information in the world that is growing—social media, Netflix or whatever—supplies different experiences to different users. Every source of information that is shrinking provides the same experience to all its users—traditional newspapers, television, radio and so on. That means that **it is easier and cheaper to reach small numbers of people than it has ever been and harder and more expensive to get the same message to everybody**. That is a profound challenge for public authorities, which are essentially used to thinking that if they can get on the "Today" programme, the front pages of the newspapers, BBC Scotland or whatever, they have got their message out there. That is just not true any more. … Public authorities have to work harder to get good information out in this new environment. I do not think that we have yet adjusted to that reality of audience fragmentation."

The Committee may wish to explore whether these "cheap and easy" audience fragmentation approaches that are possible through social media could be effectively used for public health messaging.

Theme 2: Targeted communications

The Committee may wish to ask:

1. Do the witnesses consider that COVID-19 public health messaging was adequately targeted to different groups?
2. How can public health messaging be most effectively targeted to different groups in Scotland?
3. Could social media and the audience fragmentation it offers be more effectively used to target different groups?

Theme 3. Accessible information

Accessibility in different languages

At the time of the 2011 Census, 96% of people in Scotland said they could speak English well or very well. After English, Scots and Gaelic, Polish was the most commonly spoken language at home (1% of the population), followed by Urdu (0.4%), Punjabi languages (0.4%), Chinese languages (0.3%), French (0.3%) and British Sign Language (0.2%).

A SOAS University of London study found that the majority of people (71%) within linguistically diverse communities (in London) obtained COVID-19 information from outside of the UK. Policy recommendations from the study include:

- Working with language and culture specialists for advice on communicating with each community.
- Providing audio translations of material and making these available through websites and by telephone.
- Providing an advice hotline that can be accessed in different languages.

At the 9 December 2021 meeting on below-average vaccination uptake in some groups, the Committee heard that translated information, when available, was not sufficient: the information also needs to be discoverable in that language. Magda Czarnecka (Feniks) explained:

> "… although materials were translated into Polish and other languages and have been made available in PDFs on the NHS inform website, they are pretty much not searchable in the sense that all the files are titled in English. ... Someone who does not use English well and is looking for information in Polish will not find it."

Accessibility for those with sensory loss

The ALLIANCE wrote about communication barriers faced by people with sensory loss, in its written submission to the independent inquiry into the handling of the COVID-19 pandemic in Scotland. It noted that telephone and video-based communication was often not accessible, and social distancing and face masks presented further barriers.

British Sign Language interpretation increases the accessibility of audio-visual information. BSL interpretation was provided for the First Minister's briefings: the ALLIANCE noted this was "a welcome change". BSL interpretation was not provided for the UK Government briefings.

Jonathan Reid (the ALLIANCE) writes:

> "As we learn to live with Covid-19, and as society develops new strategies and solutions, the voices of people living with sensory loss must be central in

the design process. We must aim to develop truly inclusive communication in our public health messaging and beyond."

Theme 3. Accessible information

The Committee may wish to ask:

1. Do witnesses think that COVID-19 public health messaging was accessible enough to groups that communicate in languages other than English, or those with sensory loss?

2. What lessons should be learned about how to improve the accessibility of public health information to different groups?

Theme 4: Trusted communicators

During the Committee's 9 December 2021 meeting on below-average vaccination uptake in some groups, witnesses mentioned "trust" 46 times.

Witnesses acknowledged the fact that many ethnic and other minority groups had little to no trust in public authorities, which made them reluctant to follow government guidance, particularly on vaccination. Dr Eman Hani (Central Scotland Regional Equality Council) explained:

> "The main one [reason for not getting vaccinated] is a lack of trust in the national health service or anything coming from an authority, mainly because of where the people in question have come from. They either grew up under communism or fled their countries because of war or because they were oppressed by their own Governments, so they often tend to see things that come from the Government as being against them, which, in turn, creates a hesitancy and resistance to anything that the Government might do and a feeling that it is not for their benefit."

Witnesses were agreed that the best way to communicate important information to these communities was through trusted local organisations or senior figures (e.g., religious leaders) with which they had ongoing relationships. Derek Holliday (Homeless Network Scotland) told the Committee:

> "We have talked a lot about trust in people and environment, which is the key component to people taking a risk and putting themselves outside their comfort zone. We must focus on place-based approaches, using all the relationships around a community such as family, friends and peer networks, as well as local health and pharmacy staff who people see for their wellbeing, and spiritual, faith and recovery networks. That is where trust is."

Dr Carey Lunan (Scottish Deep End Project) added:

> "In addition to [earlier evidence] about the importance of community networks and lived experience, we should not underestimate the importance of relationships of trust. I listened to parts of your earlier session. A theme that consistently came across was people wanting to speak to people who they knew and could recognise so that they could have conversations with them in which they could unpick some of the things that they were struggling with."

Related to these comments, at the Committee's 26 May 2022 meeting on COVID-19 misinformation, Callum Hood (Center for Countering Digital Hate) talked about the need for a wider variety of messengers:

> "The NHS is spread throughout the country, and lots of different communities and types of people are involved in it, so there were lots of potential messengers. We could have selected a wider variety of messengers to deliver good information to people—messengers who looked and sounded like them and were closer to them in their local communities"

A key learning point on communication from the Royal Society of Edinburgh's Post Covid Futures Commission was "…being mindful about who is best-placed to communicate including the value of peer communicators".

Theme 4: Trusted communicators

The Committee may wish to ask:

1. How can trust in public health messaging be improved among the hard-to-reach groups the Committee has heard about?
2. What lessons should be learned about who communicates public health messages, to ensure the messages are trusted and acted upon?

Theme 5: Trusted information

People are more likely to comply with guidance if they understand and trust it.

Transparency

In the first year of the pandemic, the Royal Statistical Society (RSS) identified five key lessons, the third of which was (emphasis added): "When referring to data, **transparency and clarity in Government communication are vital for maintaining public confidence** – these are worth investing time, money and political capital in."

The RSS outlined how to transparently communicate information in a manner likely to build trust. This involves explicitly communicating:

- What you know (including the evidence for this)

- What you don't know yet
- What you are planning to do
- What people should do
- That the advice will change as you learn more.

A key learning point on trustworthy information from the Royal Society of Edinburgh's Post Covid Futures Commission was:

> "Transparency is critical for public understanding and building trust. This includes: transparency around the collection and use of data; transparency around the basis on which decisions are made including levels of confidence in data; and transparency on the structures, membership and discussions of advisory groups."

But Tracey Brown (Sense about Science) told the Committee that the evidence on which UK Government decisions were made was typically not published in full:

> "For example, the UK Government was pointing to SAGE but, if you read the SAGE minutes—once you finally could—you could not get from those to the decision, so people thought, "Hang on—there must have been an economic calculation in there somewhere." The policy and economic advice were not published; only the science advice was published. There was a real lack of transparency elsewhere. People could not see clearly what the motive or the chain of reasoning was behind why decisions, particularly those that seemed to have quite adverse effects on them, were made."

Scientific evidence

Related to this lack of transparency about the evidence base for decisions was the UK Government's insistence that their decision-making "followed the science".

- The RSE said this message risked people losing trust in science and scientists, because the science and the advice based on it was evolving rapidly.
- The RSS said this obscured the distinction between scientific advice and government decision making. It said: "This is another area where transparency is important: it should be made clear what advice the government is receiving and what other considerations are being brought into the decision-making process."

A SOAS University of London study of linguistically diverse communities found that most who said they would not get vaccinated said this was because they were worried about vaccine safety or didn't have enough information. The lead researcher, Dr Nana Sato-Rossberg, said:

> "Overall, we see that the survey participants were seeking more reliable information on Covid-19 and vaccinations. Building trust and conveying reliable information seem to be the key."

In evidence given to the Health, Social Care and Sport Committee, BEMIS also reported on concerns from ethnic minority groups about vaccine safety information. Its work on vaccine hesitancy found that people did not believe the vaccines had been tested on a diverse enough population, so they did not trust that the vaccine would be safe for them.

Communicating uncertainty

A key problem in maintaining trust in the public health messaging was that the evidence (including modelling) was uncertain and evolving over time. This meant that the guidance sometimes had to change.

One example concerns the safety of the vaccine for pregnant women. Initial justifiable caution, due to a lack of evidence, was mis-communicated, according to Will Moy (Full Fact), who told the Committee:

> "There is a difference between saying, out of an abundance of caution, and although we have no reason to believe that there is a risk, "Hold off a bit for the time being," and then running some special tests in order to give people the best possible advice, and saying, "Here's the vaccine. Pregnant women: don't take it." The public health messaging was much closer to the second of those. That naturally plants a seed of doubt in reasonable people's minds"

Dr Dawn Holford (SciBeh) told the Committee:

> "It may be counterintuitive, but we need to learn that sometimes we have to acknowledge the uncertainty. The research shows that it is not necessary to avoid presenting uncertainty in the information or evidence that is currently available. People are receptive if we are able to explain what it is that we know and do not know, and why that is going to change quickly. That could also be a way to signpost to people that they need to stay updated, and to let them know where the trusted information sources are that they should go to for the latest updates"

The Royal Society of Edinburgh said:

> "It is important to be honest with the public about what is and is not known but to do so in a way that maintains public confidence, for example by talking about risks or levels of risks. This also implies the need for a wider public understanding of how to assess risks. Transparency in communicating the rationale for a particular approach or intervention is vital to maintain trust."

Scientific literacy

The need for greater understanding about science and how to assess risks was raised by the RSE and RSS. Both agreed that scientific literacy should be improved

among not only the communicators (the media and decision-makers) but also among the general public.

- The RSS said statistical and data skills should be taught more widely.
- The RSE said communicators should be trained in communicating complexity, uncertainty and (competing) risks, and that a wider public understanding of how to assess risks was needed.

Theme 5: Trusted information

The Committee may wish to ask:

1. What lessons have the witnesses learned about how to communicate in a way that people can understand and trust?
2. Could uncertainty have been communicated better during the pandemic?
3. If the general public don't understand a public health message should the onus be on improving scientific literacy across the population, or improving how the message is communicated?

Theme 6: Communicating to high risk individuals

The Highest Risk List

The Scottish Government introduced shielding in March 2020 to protect people at the highest risk of negative COVID-19 outcomes. The terms 'shielding' has now been replaced by the term 'highest risk'.

The shielding programme aimed to reduce the risk of infection, severe illness and death by providing the highest risk individuals with guidance to help minimise interaction between them and others. This group were asked to strictly self-isolate. The programme also aimed to provide individuals with the necessary support to enable them to follow the guidance: e.g., home delivery of free food boxes, home delivery of medication and priority access to supermarket home delivery slots (Public Health Scotland 2020).

The range of treatments and health conditions that were believed to place people at the highest risk (based on the limited evidence available at the time) included specific cancers, respiratory conditions, lung diseases, organ transplant recipients, immunosuppression therapies, and renal dialysis. Around 177,000 people – 3% of Scotland's population – were placed on the list as a result.

In its 2022 review of the shielding programme prepared for the Scottish COVID-19 inquiry, the Usher Network for COVid-19 Evidence Reviews (UNCOVER) notes the

differences between the criteria for inclusion on the Shielding List and the JCVI's prioritisation criteria for vaccination roll-out (i.e., more age-based). The review recommends:

> "The Inquiry may wish to look closely at the ethical and other factors used to inform decision-making about who should be on the shielding list, and what steps (if any) were taken to assess whether these remained valid in light of the differing approach to prioritisation for vaccinations."

As the pandemic progressed and restrictions changed, individuals at high clinical risk reported being in the dark about the risks to themselves. In its written submission to the Committee, the ALLIANCE writes:

> "Further, as restrictions to respond to the virus have been reduced, many people who were on the shielding list and who are at high clinical risk have indicated that there has been a complete lack of public health communication. As a result, many people are receiving information from online platforms and undertaking their own research to inform their decision to continue to shield."

Discontinuation of the Highest Risk List

The Scottish Government's April 2022 review of advice for those on the Highest Risk List describes how the situation in 2022 was markedly different from two years previously, meaning that most on the Highest Risk List no longer had a higher risk of negative COVID-19 outcomes than other people in Scotland:

> "The rollout of the vaccine programme has changed the context significantly. The evidence on the effectiveness of vaccines for people on the Highest Risk List, coupled with the availability and efficacy of new treatments such as antivirals, immune modulators and monoclonal antibodies, has allowed us to take a different approach. There is now, two years on, a far better understanding of the range of risk factors that may put someone at increased risk of becoming seriously unwell from COVID-19."

As a result, in May 2022, those on the Highest Risk List were written to inform them the list would end. The Chief Medical Officer said:

> "I'm very pleased we're now in a position where I can confidently say the Highest Risk List is no longer needed, which is a positive step forward after a very difficult two years."

Evidence and guidance

In the first three months of the pandemic (March to May 2022), Prof Jill Pell and colleagues compared COVID-19 outcomes between shielded (Highest Risk List) and non-shielded populations. They found shielding had been less effective than hoped, concluding:

> "in spite of the shielding strategy, high risk individuals were at increased risk of death. Furthermore, to be effective as a population strategy, shielding

> criteria would have needed to be widely expanded to include other criteria, such as the elderly."

Nearly two years later, the evidence presented in the April 2022 review suggests that the risks for those on the Highest Risk List are still high in comparison with the general population:

> "there remains an increased risk of COVID-19 mortality for the Highest Risk List after vaccination compared to the general population. The COVID-19 mortality ratio has fallen in the last few months from 17 times higher in June 2021 (highest in the time series) [to 9 times higher in January 2022]."

People who are immunosuppressed/immunocompromised may be at higher risk from COVID-19, as vaccination will not have invoked the same protective immune response in them as in others. The Scottish Government published specific guidance for this group on discontinuation of the Highest Risk List. Some people in this group will be eligible for monoclonal antibody and antiviral treatments. The key Scottish Government guidance for this group is to:

- Take up the extra vaccination doses they are offered.
- Avoid meeting people with COVID-19 or COVID-19 symptoms.

The Scottish Government guidance for immunosuppressed/immunocompromised individuals talks about other protective measures (social distancing, face coverings) being a personal choice for the individual. For each person this would entail assessing the risk for themselves and acting accordingly. The guidance suggests the individual may choose to wear a Distance Aware badge.

Navigating 'the new normal'

However, the practicality and effectiveness of these suggested protective measures often relies on other people taking similar precautions: behaviours that are becoming less common with the loosening of general restrictions. As a result, Dr Sally Witcher cautions that navigating COVID-19 risks amidst the general public's "new normal" is fraught with danger for those on the Highest Risk List:

> "… removal of restrictions, more freedom and a return to 'normal' for some means, for others, the loss of protections, less freedom and that the prospect of a 'return to normal' is further away"

Dr Witcher also comments that it is not solely clinical risk that makes a person on the Highest Risk List 'vulnerable':

> "Instead, vulnerability is imposed on people at high clinical risk by exposing them to unsafe environments; leaving them without enforceable rights with which to assert and exercise active equal citizenship, the equipment that could make us safe, equitable, reliable access to the full range of treatment, and the information we need to understand and manage our own risk."

Dr Witcher has written about the opportunity to live safely and inclusively with COVID-19: she proposes an "Inclusive New Normal" based around clean air, real rights, and clinical risk.

In a tweet on 14 June 2022, Dr Sally Witcher sought views about the removal of restrictions from people at high clinical risk, unpaid carers and people with long COVID. In her written evidence to the Committee she notes: "This is clearly not a scientific study, but it provides a compelling snapshot, and a damning verdict on government communication, misinformation, lack of information, the subsequent rise and perpetuation of disinformation, and the consequences." Responses included:

- Continued requirement for protective measures:
    - High risk individuals feel they can't re-join society or access healthcare facilities safely due to the absence of protective measures (mask wearing, testing, etc.)
    - Requests for more protective measures to keep them safe: HEPA filters, improved ventilation, access to anti-virals and vaccine boosters.
- Public health messaging to high risk individuals:
    - Lives depend on getting the messages right, as "living with COVID" is not an option for the clinically extremely vulnerable.
    - Mixed messages: being told they're high risk but also seeing government remove all protective measures.
    - Risks of long COVID being downplayed and not publicised.
- Public health messaging to the general public:
    - The general public don't realise that caution is still needed to protect the vulnerable: they've been told everything is OK now.
    - Requirement for public discourse around kindness, thoughtfulness and empathy.
    - Reframe 'restrictions' more positively as 'protections'.

Theme 6: Communicating to high risk individuals

The Committee may wish to ask:

1. How effective was the Scottish Government's communication of risks, and guidance on staying safe, for people on the Highest Risk List throughout the pandemic? What lessons could be learned?
2. How effectively has the decision to discontinue the Highest Risk List, and the evidence behind it, been communicated?

3. How well is the Distance Aware scheme working for those who used to be on the Highest Risk List?

4. Question for Dr Sally Witcher initially: What would an Inclusive New Normal look like?

5. Would prioritisation of vaccine boosters to those who used to be on the Highest Risk List be a welcome recognition of their ongoing higher risk or confirmation that the Higher Risk List is still needed?

6. How can the needs of higher risk individuals be better communicated to the general public?

Elizabeth Richardson, SPICe Research,

16 June 2022