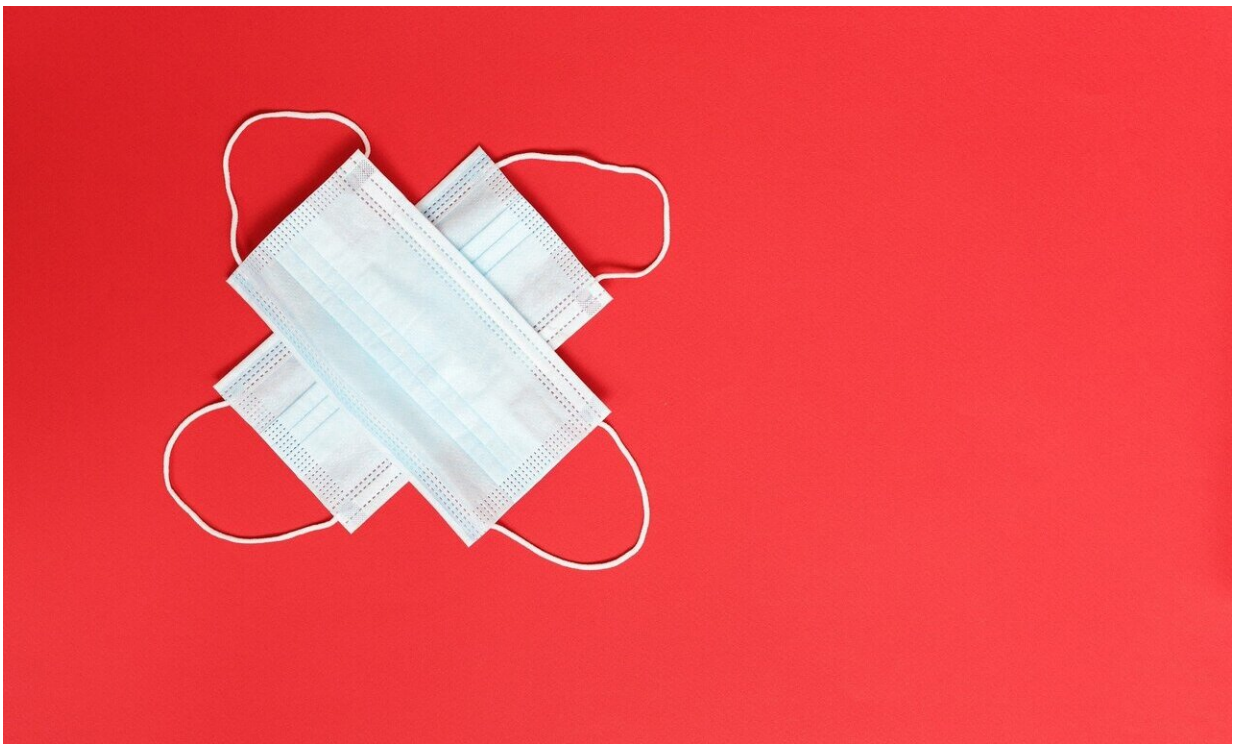
Methodists and Church of England followers more likely to have COVID vaccinations than Muslims and Pentecostals

April 24 2024, by Steve Pickering and Martin Ejnar Hansen



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There are many factors which affect how successfully a vaccine is rolled out. One of these is the public health communication strategy. Surprisingly, a key factor in determining the success of these strategies is

religion. While some religious groups were keen to be vaccinated against COVID-19, others were much more hesitant.

During the height of the pandemic, getting vaccinated against COVID-19 quickly became the social norm. Having experienced pandemic life, most people were keen to get a full series of vaccinations as soon as they were made available.

Yet our new research, based on surveys of over 12,000 people found that there has been significant difference in vaccine uptake between religious communities.

Members of the Methodist and Church of England denominations are more likely to have been vaccinated, while Pentecostal, evangelical and Muslim respondents have received far fewer vaccinations. Methodists, on average, have had 3.48 vaccinations, while Pentecostals have only had 1.88.

Why is this the case? This is the difficult part of the story. We know that some minority groups have faced discrimination and this, in turn, can lead to lower levels of trust in authority figures. For instance, our recently published research shows that ethnic minorities have lower levels of trust in the NHS.

In terms of religion, we have noticed some unusual trends. Members of the Pentecostal denomination have high levels of trust in medical doctors but low levels of trust in scientists. This is an area we hope to explore further in future research.

How can we fix this?

Once we accept that there are differences in vaccine uptake across religions, we can then move on to the equally difficult question of what

to do about it. We argue that health authorities, such as the NHS, need to actively engage with religious leaders and religious communities.

There are examples of community-based success stories. For instance, early in the pandemic, mosques in Birmingham were used as vaccination centers. This kind of religious community engagement in public health can be of vital importance.

Amid concerns during the pandemic that ethnic minority groups were more likely to be targeted with misinformation (sometimes from faith leaders outside the UK) and to be hesitant about getting vaccinated, religious leaders were deployed with great success. They were well placed to counter inaccurate information and encourage vaccine uptake.

We argue that there needs to be more formal recognition of such community-based public health messaging. When there are such stark differences in a vital area of public health such as vaccination, we really need health bodies to do all they can to reach out to the community. Sometimes, as in the case with religion, they cannot do this themselves with a traditional top-down communication model; they need to work with religious leaders.

There's still much that we don't know. For instance, the interplay between religion and ethnicity is complex. This is an area we intend to explore in more depth in future research.

Apart from some notable exceptions, religion is often something of an elephant in the room in the political sphere. It is easy to see how it could also be ignored in a public health setting—and perhaps why it became an issue during the COVID-19 vaccination rollout.

The NHS is clearly a secular organization, and there would be no desire to change that. But we cannot ignore that, in terms of COVID-19

vaccine rollout, certain religious communities have been let down, or left behind. Future public health campaigns need to acknowledge this and find ways to overcome it.

Provided by The Conversation