NIHR | Policy Research Unit in Behavioural Science

Policy Brief

April 2021

Which factors may help increase COVID-19 vaccine uptake in England?

Content analysis of free text responses to a survey delivered in Oct/Nov 2020

Recommendations to support increased COVID-19 vaccine uptake

1. Provide widely accessible information about vaccine **safety** and **effectiveness** branded by the NHS, personalised by local GP where possible
2. Implement a user-friendly vaccine booking system that details information about delivery of a jab and emphasises that it is free
3. Contextualise how vaccines will support the easing of restrictions and the return to normal life

Executive summary

In Oct/Nov 2020, prior to the availability of a vaccine, we conducted a survey on COVID-19 vaccine intention in adults living in England who either did not want or had not yet decided to be vaccinated against COVID-19.

We asked the 1,660 participants "***What might make it more likely that you, your family, or friends would have a coronavirus vaccine when one is ready?***"

Nine hundred & fourteen (55%) provided a usable response, 726 (44%) detailed at least one positive condition that would be supportive of having a vaccine.

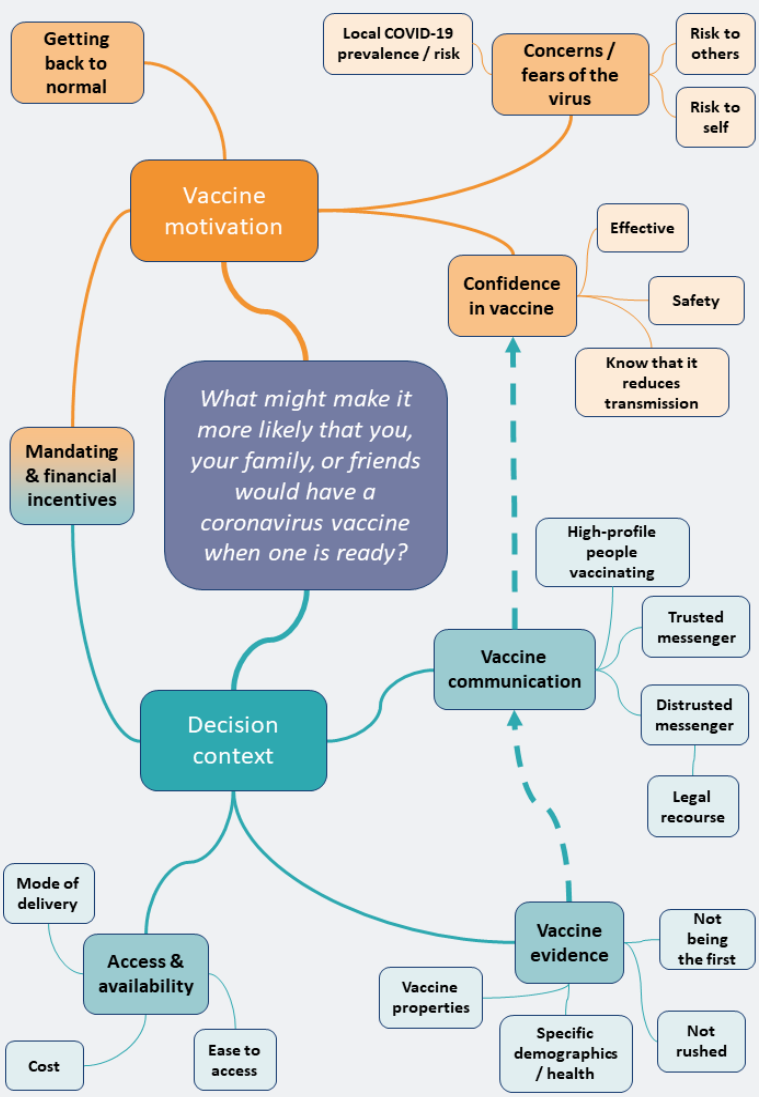
The most frequently detailed motivational factor was their confidence in a vaccine, principally, its safety and effectiveness. Other responses detailed their perceived personal and societal risk of the virus. A less frequent response was a desire to return to a more normal way of living. For a few, it would require mandating for them to be vaccinated.

Many stated that their decision to have a vaccine would be informed through the provision of scientific evidence supportive of a vaccine. They were concerned that the development of COVID-19 vaccines was rushed and many did not want to be the first to receive one.

With regards to those associated with the development and communication of a vaccine and immunisation programme, there was distrust in the Government and the pharmaceutical industry, though the NHS, personally known physicians, and scientists were highly trusted. It was stated by a few that the distrust could be overcome by seeing ministers being vaccinated.

For some, the key factor was vaccine access and being able to receive it locally was critical.

Analysis of tweets [social media posts] on Twitter from UK users between Nov 2020 and April 2021 by researchers at the NIHR Innovation Observatory, identified the same overarching themes on the subject of COVID-19 vaccines. Additionally they observed an upward trend in volume of tweets related to safety concerns in March 2021, that has continued into April. Notable new themes include: reduced adherence to social distancing guidelines; Astra Zeneca; blood clots; variants; herd immunity; and vaccine passports.



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Response coding framework description

Content coding overview

The components of each response that contained a positive condition were coded thematically as factors: that would motivate a person to have a vaccine; or relate to the context in which a decision to have a vaccine would be made, and then quantified.

Vaccine motivation

The most common influence on decision making related to confidence in a vaccine. Primarily respondents detailed a desire for a safe vaccine, with either mild or no side effects, but also for it to be effective at protecting against infection. Additionally, some wanted vaccination to mean that they would not be able to pass the virus on to others.

Over one-in-ten responses analysed stated either fears or concerns regarding the virus. While some feared for their own health, more were concerned about the risk to either those close to them, or wider society, particularly the vulnerable. A small number of people commented that local infection rate would be instrumental in the choice whether to have a vaccine.

Although less numerous, there were comments about returning to something that approximated '*normal*'. People wanted a relaxation of social distancing to see friends and family and also increased freedom to travel.

Mandating & financial incentives

A small number of responses related to enforcing vaccination through mandating by those in a position of authority, either by the Government or their employer, would have on both their motivation and the context in which they would make a vaccine decision. With most stating that it would take this level of authority to force them to receive, though two respondents stated that mandating would have the opposite effect on them. A few felt that some form of financial incentive would be supportive to them in having a vaccine.

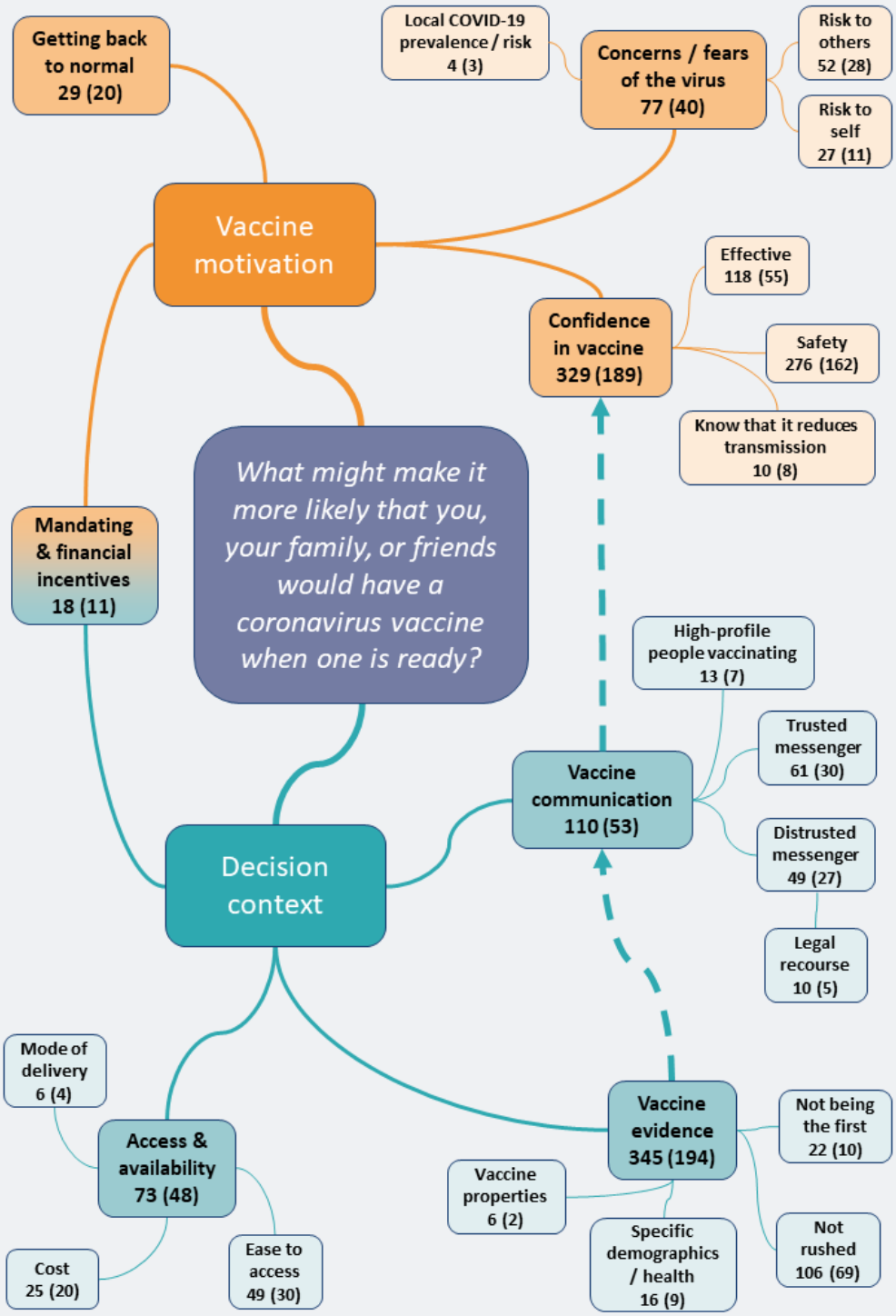
Decision context

The majority of responses suggesting a desire for information that supported the safety and effectiveness of a vaccine. Participants wanted proof that vaccines had been produced rigorously to exacting safety standards, and that it was safe and effective for different demographic groups, e.g. "*If Black and Asian people have been fully involved in the making and testing of the vaccine*" and "*My current health living with lymphoma means… I am unable to have any vaccine that contain a live virus*". There were a very small number of comments about the content/properties of a vaccine to ensure that it matched with their personal ethics, e.g. vegan.

Responses indicated which methods of communicating about the vaccine would influence decision making in favour of having the vaccine. The NHS, doctors (particularly those with an established relationship with the respondent, e.g. GP, clinical specialist), scientists that were independent of government were viewed as trusted sources of information. Government sources (including politicians), pharmaceutical companies and private health care providers were viewed as less trustworthy sources. Examples of high-profile individuals receiving the vaccine, regardless of who they were, were viewed as effective ways of communicating effectiveness and safety.

Approximately one-in-ten responses analysed were concerned with access to a vaccine. Most of these responses stated a need for it to be easily accessible to where they lived and inexpensive (note, the survey was delivered Oct/Nov 2020 before any were approved for use and potential costs had not been detailed). For a small number, they simply did not like needles and desired an alternative form of delivery.

Response coding framework diagram



"If the vaccine was recommended by my GP"

This diagram illustrates the inductive framework used to code the content of participant responses and the associations between factors.

The numbers are a count of the number of respondents for each code: all participants (those under 50 and not been shielding).

"Information on the testing done, number or participants, etc. I have a fear that it is being rushed and would need strong proof of its safety. I would personally prefer to continue distancing"

A summary table of counts of all survey participant responses to the free text question by their stated COVID-19 vaccine decision status: 'no response' was coded for blank, indecipherable, or inappropriate response; 'don't know' for those that stated they did not know what would make them more inclined; 'negative unconditional' for those that responded that nothing would make them more inclined to have the vaccine; 'positive conditional' for those that provided at least one suggestion; and 'positive unconditional' for those that had made the decision to have a vaccine regardless.

		No response	Don't know	Negative unconditional	Positive conditional	Positive unconditional	**Total**
COVID-19 vaccine position at time of survey (Oct/Nov 2020)	I've not thought about getting a vaccine	207 (50.9%)	27 (6.6%)	12 (2.9%)	158 (38.8%)	3 (0.7%)	**407** (24.5%)
	I'm not sure, but will probably have a vaccine	351 (44.8%)	25 (3.2%)	3 (0.4%)	391 (49.9%)	13 (1.7%)	**783** (47.2%)
	I'm not sure, but will probably NOT have a vaccine	103 (39.6%)	15 (5.8%)	19 (7.3%)	122 (46.9%)	1 (0.4%)	**260** (15.7%)
	I don't want a vaccine	85 (40.5%)	2 (1.0%)	68 (32.4%)	55 (26.2%)	0 (0.0%)	**210** (12.7%)
	Total	**746 (44.9%)**	**69 (4.2%)**	**102 (6.1%)**	**726 (43.7%)**	**17** (1.0%)	

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Socio-demographic characteristics of those who provided 'positive conditional' responses

		Count (%)	
		All	Under 50 & not shielding
Gender	Female	417 (57.4)	250 (61.9)
Age	Under 50	472 (65.0)	404 (100)
	50-64	162 (22.3)	-
	65 and over	92 (12.7)	-
Ethnicity	White	587 (80.9)	303 (75.0)
	Mixed / multiple ethnic groups	42 (5.8)	32 (7.9)
	Asian / Asian British	64 (8.8)	48 (11.9)
	Black / African / Caribbean / Black British	27 (3.7)	17 (4.2)
	Other ethnic group	6 (0.8)	4 (1.0)
England region	London	119 (16.4)	80 (19.8)
	East Midlands	57 (7.9)	27 (6.7)
	East of England	69 (9.5)	37 (9.2)
	North East	28 (3.9)	13 (3.2)
	North West	84 (11.6)	43 (10.6)
	South East	126 (17.4)	73 (18.1)
	South West	85 (11.7)	38 (9.4)
	West Midlands	79 (10.9)	41 (10.1)
	Yorkshire and the Humber	79 (10.9)	52 (12.9)
Deciles of Indices of Multiple Deprivation	1 (most deprived)	50 (6.9)	24 (5.9)
	2	74 (10.2)	38 (9.4)
	3	61 (8.4)	35 (8.7)
	4	70 (9.6)	47 (11.6)
	5	65 (9.0)	39 (9.7)
	6	68 (9.4)	37 (9.2)
	7	71 (9.8)	36 (8.9)
	8	87 (12.0)	45 (11.1)
	9	75 (10.3)	42 (10.4)
	10	103 (14.2)	61 (15.1)
	Missing	2 (0.3)	0 (0.0)
Shielding from COVID-19	Yes	134 (18.5)	-

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