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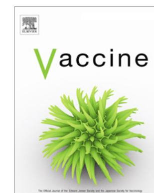

Reasons for non-vaccination: Parental vaccine hesitancy and the childhood influenza vaccination school pilot programme in England

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ABSTRACT

Introduction: In 2013, the annual influenza immunisation programme in England was extended to children to reduce the burden of influenza, but uptake was sub-optimal at 53.2%.
Aim: To explore the reasons some parents decided not to vaccinate their child against influenza as part of the pilot programme offered in schools.
Methods: Cross-sectional qualitative study conducted between February and July 2015. 913 parents whose children were not vaccinated against influenza in the school pilots in West Yorkshire and Greater Manchester, England, were asked to comment on their reasons for non-vaccination and invited to take part in a semi-structured interview. 138 parents returned response forms, of which 38 were eligible and interested in participating and 25 were interviewed. Interview transcripts were coded by theme in NVivo.
Results: A third of parents who returned response forms had either vaccinated their child elsewhere, intended to have them vaccinated, or had not vaccinated them due to medical reasons (valid or perceived). Most interviewees were not convinced of the need to vaccinate their child against influenza. Parents expressed concerns about influenza vaccine effectiveness and vaccine side effects. Several parents interviewed declined the vaccine for faith reasons due to the presence of porcine gelatine in the vaccine.
Conclusions: To significantly decrease the burden of influenza in England, influenza vaccination coverage in children needs to be >60%. Hence, it is important to understand the reasons why parents are not vaccinating their children, and to tailor the communication and immunisation programme accordingly. Our finding that a third of parents, who did not consent to their child being vaccinated as part of the school programme, had actually vaccinated their child elsewhere, intended to have their child vaccinated, or had not vaccinated them due to medical reasons, illustrates the importance of including additional questions or data sources when investigating under-vaccination.

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1. Introduction

Influenza causes considerable morbidity and mortality worldwide and represents a public health problem with significant socio-economic implications [1]. A core strategy for controlling influenza is annual seasonal influenza vaccination, recommended in high risk groups (individuals with specific chronic medical conditions, pregnant women, children, adults over 65 years old, and health care workers) [1]. The groups targeted in national influenza immunisation programmes vary by country [1,2] and vaccination coverage rates differ according to target group, country and region [1,3]. There have been numerous studies exploring reasons for non-vaccination with influenza vaccine globally, with the majority focused on healthcare workers [4].

The Strategic Advisory Group of Experts (SAGE) on Immunisation's vaccine hesitancy working group has defined vaccine hesitancy as: "a behaviour, influenced by a number of factors including issues of confidence (do not trust vaccine or provider), complacency (do not perceive a need for a vaccine, do not value the vaccine), and convenience (access)" [5]. Vaccine hesitancy is complex and context specific, varying across time, place and vacci-

Abbreviations: LAIV, live attenuated influenza vaccine; NHS, National Health Service; PHE, Public Health England.

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nes [5,6], and has the potential to pose a significant threat to global efforts to reduce the burden of seasonal and pandemic influenza. Hence, it is vital to understand the reasons people are hesitant about receiving influenza vaccines across different contexts [5,7,8].

In 2012, the Joint Committee on Vaccination and Immunisation (JCVI) recommended the extension of the influenza immunisation programme to children, based on an analysis which highlighted the cost effectiveness of vaccinating children due to direct and indirect benefits to the individual and the population [8]. Due to the scale of the programme (~9 million children aged 2–17 years), the programme is being implemented in phases [9]. The first phase started in 2013/14, with 2–3 year olds offered the influenza vaccine through general practices (GPs) and a pilot of 4–11 year olds in seven geographical areas across England, mostly offered through children's primary schools apart from one very rural area where the vaccine was offered through local pharmacies and GPs [9]. In 2014/15, the national programme was expanded from 2 to 3 year olds to include 4 year olds (provided through GPs as before). The pilot of primary school aged children continued, and an additional 16 pilot areas introduced vaccination for secondary school students in years 7 and 8. As vaccine uptake was low at 53.2% [10], we conducted this qualitative study to explore the reasons some parents decided not to vaccinate their child against influenza as part of the school pilot programme, and how these could be addressed.

2. Methods

2.1. Study population, recruitment and sampling

The study population consisted of parents, in West Yorkshire and Greater Manchester, who chose not to vaccinate their child against influenza in the school pilot programme in the 2014/15 season, but were willing to be contacted for further information. We chose West Yorkshire and Greater Manchester as vaccine uptake in the school influenza pilots had been had been low in these areas and the regions were diverse demographically. The pilot programme took place in 20 schools in West Yorkshire and 94 schools in Greater Manchester. The providers were community based health organisations that administered and delivered immunisations in schools.

Study invitation packs were distributed by the organisations who were administering the pilot programmes in these areas. They included a cover letter introducing the research topic, an information sheet giving further details about the study, and a response form (Appendix 1). The response form allowed respondents to register their interest in participating in an interview, and also included the question "We would be grateful if you could tell us why you decided not to vaccinate your child as part of the school immunisation programme".

We applied a purposive sampling approach to ensure that our sample reflected a wide range of socio-demographic characteristics and supplemented this with snowball sampling, asking parent participants if they knew anyone else who had refused vaccination that might be interested in participating in the study.

Study data were collected through semi-structured interviews using an interview topic guide (Appendix 2). The topic guide captured basic socio-demographic information and covered five main subject areas: (1) Participants understanding and experience of the childhood flu immunisation pilots, (2) decision-making about participation in the flu pilots, (3) reasons for not accepting the flu vaccine, (4) risk–benefit considerations, and (5) where they considered themselves on the spectrum of vaccine hesitancy. The interview guide was developed to encourage participants to talk and give their views and opinions, and not with the intention of convincing parents to immunise their child. With the permission of study participants, interviews were recorded verbatim with the use of a digital recorder. Interview recordings were transcribed anonymously by a professional transcription service.

In total, 1223 invitation packs were sent to 913 parents, in West Yorkshire and Greater Manchester, who did not consent to their child being vaccinated against influenza as part of the childhood pilot programme but agreed to be contacted (January – February 2015). 138 parents returned response forms, of which fifty-nine parents expressed interest in being interviewed as part of the study, and 38 of the 59 were eligible (they did not want their child to be vaccinated as part of the childhood flu pilot programme) (Fig. 1). We approached all 38 eligible parents. Thirteen parents were unavailable (either did not answer the phone or were unable to meet) and one parent was no longer interested. One additional parent was identified through snowballing and agreed to be interviewed.

In total, we interviewed 25 parents. Twenty-two interviews were audio-recorded face-to-face, two interviews were audio-recorded over the phone, and one interview was carried out face-to-face with note taking and no audio recording. Of the 25 parents interviewed, 21 were mothers, four were fathers, 16 were from West Yorkshire and nine from Greater Manchester. The parents ranged in age from 33 to 49 years (mean 43 yrs, median 44 yrs). Two parent's children were in primary school and 23 were in secondary school. Thirteen interviewees were 'White-British', six 'Asian British – Indian' and three 'Asian British – Pakistani'. Eleven parents interviewed were Muslim (adherent of Islam), nine were Christian, and five stated they had no religion.

2.2. Data analysis

Interview transcripts were coded with a thematic analysis technique [11] using the qualitative analysis software QSR International's NVivo 11. Two investigators (PP & TC) coded the transcripts, when developing the coding framework, to develop an initial codebook with consensus around the key themes of the analysis.

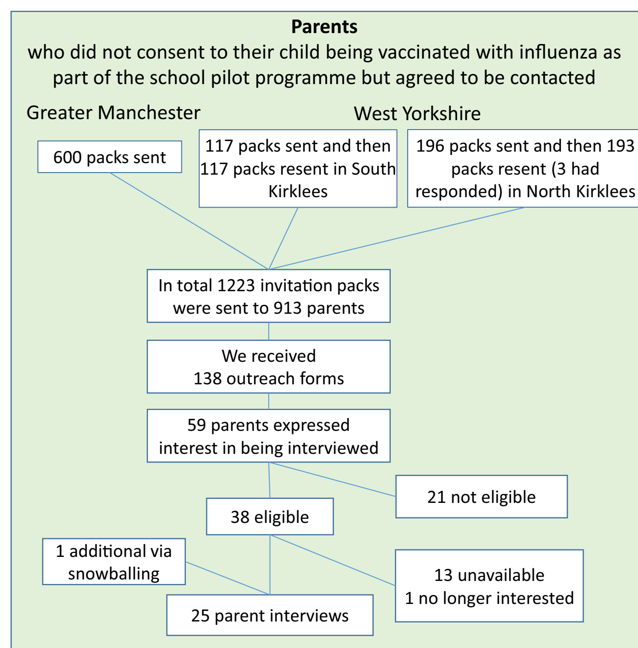

Fig. 1. Flow chart of study participants.

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