

Summary 1: COVID-19 vaccine acceptability among priority populations



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Centre for Social Research in Health

Summary

This report presents qualitative research data about COVID-19 vaccine opinions among several populations: people who inject drugs, people living with HIV, and Aboriginal people. The research data is drawn from three studies currently conducted at the *UNSW Centre for Social Research in Health* and *The Kirby Institute* and is aimed at providing rapid evidence to support promotional messaging to maximise vaccine uptake among priority populations. General observations from the data collaboration include:

- All groups viewed vaccination as an important way to protect self and others, although talk about protecting others was much more evident in the narratives of Aboriginal people where there are strong cultural values of collective care. Additional benefits were that vaccines permitted a return to 'normal life', which meant different things to each group.
- Participants in all groups expressed concern that vaccines were developed 'too quickly', although these concerns were less evident in the narratives of people living with HIV who were more trusting of biomedical interventions.
- Distrust was a social driver for both Aboriginal people and people who inject drugs, although the nature of this distrust was different.
- Practical factors such as travel and cost were not prominent in participants narratives, although this may be because data for two groups were collected prior to, or during the first phase of vaccine roll-out; but might also be because many participants were recruited from community-specific, trusted health care services who were thought to be able to provide vaccines for them.

Joanne Bryant
Dean Murphy
Jake Rance
Daniel Storer
Lise Lafferty
Loren Brener
Holly Seale
Reuben Bolt
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Data source and context

The research summarised here is informed by three distinct qualitative studies that have a focus on:

1. Aboriginal people in western Sydney
2. people living with HIV (PLHIV) located across Australia, and
3. people who inject drugs residing in metropolitan and regional NSW.

Further details about the method and research teams for each study is available from individual reports downloadable from [the project page](#).

Data for each study were collected at different times of the COVID-19 pandemic and vaccine opinions, in part, reflect the progress of vaccine development and rollout at that time:

People who inject drugs: Data were collected between November 2020–February 2021. COVID vaccines were not available in Australia until February 2021, meaning that participants offered hypothetical perspectives about vaccination. This data was collected prior to concerns about rare blood clots associated with the COVID-19 Vaccine AstraZeneca.

Aboriginal people living in western Sydney: Data were collected in February 2021. The staged vaccination rollout had recently commenced at this time, and was made available only to border, quarantine, frontline health workers and others essential workers; however, immunisations were not yet available to Aboriginal and Torres Strait Islander people generally. This data was collected prior to concerns about rare blood clots associated with the COVID-19 Vaccine AstraZeneca.

People living with HIV: Data were collected between February and August 2021. All PLHIV were eligible for COVID-19 vaccination during Phase 1b of the roll-out starting in late March. However, the limited supply of vaccines at the time – and uncertainty around vaccination locations – meant that getting vaccinated (even with Astra Zeneca) was not straightforward, so most participants (until recently) had not yet been vaccinated at the time they were interviewed.

Perceived risk of COVID

Perceptions of risk and severity of COVID-19 are strongly related to people's willingness to engage in risk reducing practices, including vaccination. All participants expressed concern about potentially contracting COVID, however perceptions of risk were more pronounced among Aboriginal participants and people living with HIV (PLHIV). Aboriginal participants were concerned about the high prevalence of chronic conditions in their communities and the potential serious impact COVID infections could have among older Aboriginal community members, a situation that was particularly worrying given the high value afforded to Elders and older people in Aboriginal cultures. PLHIV held similarly high-risk perceptions about COVID related to their immunosuppression – even though they were taking antiretroviral therapy – and were worried about experiencing much poorer outcomes if infected with COVID. By comparison, people who inject drugs were not as worried about COVID, instead believing that they could manage their risk by staying home. Some people who inject drugs explained how there was little community transmission in their neighbourhoods, so felt there was little risk.

Vaccine benefits

Protecting self and others.

Participants in all groups shared the view that COVID vaccines were important to protect one's health and that there was an obligation to be vaccinated in order to protect others. This view was particularly strong among Aboriginal participants where collective care is a strong cultural value and there was emphasis on protecting Elders and other older people. Participants in other groups also talked about protecting 'loved ones' and others in the community and, in this way, to a certain extent shared the belief in the communal obligation to get vaccinated.

Permitting a return to "normal life".

Even among those who expressed hesitancy about COVID vaccines – or skepticism about COVID generally – there was a view that vaccination would be needed to regain freedom from COVID- restrictions. The return to "normal life", as it was described by participants, meant different things to different people. For example, among younger Aboriginal participants, this was about returning to travel and other social activities, whilst for older Aboriginal participants it was about work obligations and living longer and healthier lives. By contrast, for people who inject drugs, expressions of wanting to return to 'normal life' were less prevalent as they often reflected that life had not changed substantially for them anyway.

Vaccine like any other.

A few participants in each group conveyed a view that COVID vaccines were no different to other vaccines, identifying how they would get a flu vaccine so why not a COVID vaccine. For these participants, COVID vaccines were seen as an important preventative measure and should be thought of as a regular part of maintaining one's health.

Vaccine safety

Vaccines were developed too quickly.

Both Aboriginal participants and people who inject drugs were apprehensive about the speed at which vaccines were developed, believing that the safety of vaccines has been compromised because of this. Both groups expressed views that 'good quality' scientific technologies take years to perfect. By contrast, this belief did not feature in the interviews of PLHIV, possibly because of the high degree of trust they had in biomedical technologies (described below). However, while concerns about the speed of vaccine development were present, this did not mean participants were unwilling to be vaccinated.

Not enough information about vaccines.

Participants from all groups expressed concern over the lack of information about vaccines, although this was more evident in the narratives of Aboriginal participants and people who inject drugs than for PLHIV. The kind of information needed was particularly well-described by participants from Aboriginal communities in western Sydney, including needing to know more about:

- What vaccines contain
- How vaccines are made and the rigour of vaccine development processes
- What happens to a person's body when receiving the COVID vaccine
- Whether a person will feel sick after being vaccinated and why that might be so.

In response to the perceived lack of information, participants talked about using a 'get to the back of the line' approach to see how others respond to vaccination before considering getting vaccinated themselves.

In addition, both Aboriginal participants and PLHIV wanted information about vaccine tolerance that was specific to their own communities, wanting safety data collected in Aboriginal populations and/or among PLHIV. For example, some

PLHIV were concerned about the impact of vaccines on the immune system, or how vaccines might interact with HIV treatments. Similarly, Aboriginal participants spoke of needing risk data that was specific to the conditions and challenges of Aboriginal peoples' health and wellbeing.

Other reasons given for vaccine hesitancy included:

- Wanting to leave vaccines for people who were perceived to need them more, e.g. elderly people, those who are socially active or who wish to travel overseas.
- Believing the risk of catching COVID-19 was low.

Social processes

Distrust of government and medical authority.

Distrust of authorities was an important driver among participants who were hesitant about COVID-19 vaccines. Aboriginal participants, and those who inject drugs, expressed distrust in authorities while, in contrast, PLHIV were generally more trusting, especially of the health system.

While both Aboriginal participants and those who inject drugs talked about distrust, the nature of the distrust was different in these two groups. Aboriginal participants were specific in their distrust, identifying medical authorities and governments as untrustworthy, and described how this distrust rested in intergenerational experiences, handed down through families and based in historical injustices experienced in the health care system and other institutions. One Aboriginal participant interpreted the prioritisation of Aboriginal people in early-stage vaccine roll-out as a strategy to 'test out' the vaccines on Aboriginal people. In comparison people who inject drugs expressed a more generalised suspicion or conspiratorial thinking, with for example, one participant believing that the virus had been released on the population through an organised act of a foreign government.

Comparatively, most PLHIV expressed high levels of trust in biomedical developments, including COVID vaccines, since they had benefited from medical advancements and were highly clinically engaged because of their positive HIV status. For these participants, the idea of not getting vaccinated was more worrying since they are at greater risk of significant illness from COVID.

Collective care.

Altruistic notions of care were evident across all groups, and this was a strong driver towards vaccination. Narratives of collective care were most clearly and strongly expressed by Aboriginal participants who described vaccination as a way for families and communities to look after Elders and older people in their communities. Other participants similarly described protecting 'loved ones' as a primary motivation for getting vaccinated.

Privacy and confidentiality.

For some PLHIV participants, the staged vaccination process meant that, to be vaccinated, they needed to disclose their HIV status. This was something to be navigated rather than a definite barrier to vaccination. Some described a preference to get vaccinated through their usual HIV clinical care provider or GP so as to avoid disclosing that they were eligible for COVID vaccination in the early phase of the roll-out.

Practical factors

Aboriginal participants and people who inject drugs did not talk much about practical factors of getting vaccinated, although PLHIV had more to say on this issue. This difference could be related to the period in which data were collected (late 2020 and early 2021) whereby, among the three participant groups, only PLHIV actually had access to vaccines (unless participants met other eligibility criteria for phases 1a or 1b of the rollout, such as having a chronic health condition). A few participants who inject drugs identified cost as a potential barrier, indicating that vaccination would need to be free-of-charge if they were to get it; and several Aboriginal participants identified transport to and from vaccination appointments would aid in vaccine access. PLHIV who had been vaccinated reported uncertainty around the process of determining eligibility, obtaining a referral, and booking an appointment. However, most participants across all three groups were connected to a health service that they trusted (AMS, primary NSP, HIV clinical care) and may have felt confident that their vaccine needs would be handled by the health system once they were eligible.

Implications for vaccine roll-out

Our analysis of qualitative data, collected from three populations, provides nuanced detail about the perceptions of COVID vaccination, based on each groups' experience at a particular point in time. Although there were some similarities and differences, we suggest the following health promotion responses.

Messaging to increase positive perceptions of COVID-19 vaccination:

- Positive messages based on benefits of protecting yourself and others, and the prospects of returning to “normal life” including emphasis on activities that are currently restricted (e.g. travel). Real world examples from countries with high vaccination rates and where COVID restrictions are being removed could provide compelling examples. However, care will be needed to manage expectations about post-vaccine life since some ongoing restrictions will likely be required.
- Clear accessible information about the science of vaccines, including the rigour of vaccine production technology, what vaccines contain, and how they act on the body.
- Support understanding about what happens after the vaccination encounter, about potential adverse events, what to look out for and about the impact of vaccination.
- Where possible, provide specific information about vaccine safety among specific populations (such as Aboriginal peoples and PLHIV).
- Develop messages that encourage people to tell others when they've been vaccinated and to encourage others to do so. This will build on existing attitudes of vaccination being a collective endeavor as well as enabling peer-to-peer conversations the benefits and risks.
- Be mindful of who has expertise to talk about vaccines in different settings and communities, for example using peer messages for PLHIV, PWID and community messages from Aboriginal communities.
- Encourage people to talk about vaccination with health care providers, families and others, since some participants used the research interview as a first opportunity to talk through pros and cons about vaccines.

Messaging to increase perceptions of risk in relation to COVID:

- Reinforce how the virus can spread, even to unaffected geographic areas, hence highlighting the risk to everyone.
- Reinforce the need for everyone to be vaccinated and not just those who are seen to be at risk (such as older or vulnerable people, and those who socialize and travel).
- Reinforce the fact that the current pandemic is evolving at a rapid rate and new variants can pose risks that we do not yet understand fully.

Practical rollout:

- Support access by ensuring vaccines are available across a range of service options. This may include the need for mobile services or pop-up clinics at sites relevant to the community.
- Roll out through a range of services since trusted services are different for different groups of people.
- Understand that some people will be unwilling regardless of the scope of vaccine availability and quality of messaging.

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Rapid qualitative assessment of COVID-19 health needs in the western Sydney Aboriginal community

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Assessing the impact of COVID on harm reduction services

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