

Community Attitude Research on Childhood Immunisation 2022

Research Report

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1. EXECUTIVE SUMMARY

1.1 Project background

The National Immunisation Program (NIP) provides free vaccines to eligible people to help reduce diseases preventable by vaccination. A key cohort for the NIP is children. Previous research in 2017 identified a typology framework for parents of children, based on attitudes:

- > **Strong advocates:** highly accepting, highly engaged and marked out by their willingness to advocate for immunisation;
- > **Active acceptors:** engaged and accepting, and have determined that immunisation is the right choice for their family;
- > **Passive acceptors:** not particularly engaged, but accept immunisation as 'the thing that you do' based on the expert advice of health professionals;
- > **Cautious considerers:** less accepting of immunisation and not overly engaged with it, though they do have 'niggles' that can prevent them from fully immunising their children;
- > **Naturalists and Convinced naturalists:** have a preference to live their lives as naturally as possible, hence less interest in the topic. Their decision not to immunise is often based on a positive frame of mind
- > **Worriers and Convinced worriers:** characterised by anxiety about the potential for misadventure due to immunisation, to varying degrees;
- > **Outright rejectors:** tend to exist on the fringes and often see immunisation as a conspiracy hatched by governments and the pharmaceutical industry.

The impact of the COVID-19 pandemic upon attitudes toward vaccination in general, and specifically influenza vaccination, is currently unknown. The Department of Health identified a need to conduct qualitative and quantitative research to inform an up-to-date understanding of current attitudes and intentions relating to vaccination among parents of children aged 0-12 years.

1.2 Research approach

The research included an initial qualitative stage with a series of 12 x online mini-group discussions with parents / prospective parents (four with parents of children aged 0-5 years; four with parents of school-aged children; and four with pregnant women). Each included 4-6 participants and ran for 1 ½ hours. Fieldwork was conducted between 25 and 28 October 2021.

The quantitative component was the primary element in this study and included a national online survey among n=1,019 parents of children aged 0-12 years. The survey was in field from 1st February to 15th February 2022. The survey mirrored the online data collection method and sampling framework from the original 2017 study to ensure comparability of key measures.

1.3 The impact of COVID-19

Levels of engagement with the topic of immunisation overall appear higher due to the pandemic. Six in ten parents claim to be either somewhat or much more engaged, and there is evidence of an increase in self-reported engagement in 2022 compared with 2017. In addition, a majority of parents believe their understanding of vaccines has improved across a number of dimensions: how vaccines work; the development and approval process; the benefits; and the potential side effects.

1.4 Attitudes and perceptions toward childhood immunisation

Support for childhood vaccination has dropped significantly among all parents, regardless of the age of their children. On closer inspection, it is clear that *strong* support has seen a significant decline,

with parents now significantly more likely to simply 'support' or 'neither support nor oppose' than in 2017.

The fundamental positive perceptions about childhood immunisation remain intact – parents continue to see it as effective and safe and believe that it improves the health of the whole community. While these perceptions hold firm, it is very clear that parents are now much more likely to hold negative perceptions and concerns than they did in 2017. There have been significant increases in the proportion of those who agree with almost all negative sentiments included in the survey – including that children receive too many vaccines in early years; that some vaccines are not necessary; that the risk of vaccination seems worse than the disease; and that vaccination is only encouraged because of pressure from pharmaceutical companies.

Parents were also asked to rate a range of vaccines included on the childhood schedule in terms of their overall importance. Compared with 2017, the perceived importance of all vaccines included in this question have declined significantly in 2022.

1.5 Parent typologies

Qualitative research determined that the fundamental drivers of the typology framework (acceptance of childhood vaccines, and engagement with the topic) had not changed, and that no new typologies had obviously emerged since 2017. So, the original typologies were measured in a consistent manner to the 2017 research. For the purposes of analysis, two broad groupings were created which merge the smaller segments - 'On the Fence' (OTF) and 'Rejectors'. OTF includes the Cautious Considerers, Worriers and Naturalists, while Rejectors includes Convinced Worries, Convinced Naturalists and Outright Rejectors.

Compared with 2017, there are now significantly more Strong Advocates and Active Acceptors, and fewer Passive Acceptors among parents of children aged 0-5 years. The size of the OTF and Rejector groups are not significantly different to 2017.

The drop in support for childhood immunisation is evident across all typologies, with significant reductions across the board – though the decline is more prominent among OTF and Rejectors.

Self-reported engagement has not increased uniformly across the typologies since 2017. Strong Advocates have significantly increased, while Passive Acceptors and Rejectors have significantly decreased in their claimed levels of engagement. In keeping with their increased levels of engagement, Strong Advocates are now more likely to be conducting research prior to immunising their children.

Positive perceptions of childhood immunisation largely fall out as expected across the typologies - Strong Advocates demonstrate the highest levels of agreement with various positive statements, largely followed by Passive Acceptors, Active Acceptors, then OTF and Rejectors. However, increases in negative perceptions have not been distributed equally, or as expected across the typologies. In particular, Strong Advocates hold a range of unexpected negative perceptions and concerns, at significantly higher levels than in 2017 – and in some cases, they hold stronger concerns than OTF parents.

1.6 Claimed immunisation behaviour

The proportion of families with children aged 0-12 who claim that *all children* have been vaccinated has dropped significantly since 2017. This decline is apparent across all typologies, with significant decreases across the board. There has also been a significant drop in the proportion of parents who claim that all of their children have been immunised on-time. Consistent with 2017, the vast majority of parents with children aged 0-5 years claim that their child will be likely to have all the vaccinations on the schedule before they are five years old. However, this view is held with far less certainty in 2022 than in 2017.

The decision about whether or not to immunise children is straightforward for most parents, with a clear majority claiming that the decision is either easy or very easy. However, it is clear that this decision is less straightforward for parents in 2022 than it was in 2017. Parents of children across the age spectrum are significantly less likely to claim that they made their decision without seeking any information at all. There has been a corresponding significant increase in those claiming to have undertaken a little or a lot of research, which is clearly driven by a significant increase in those who claim to have done *a lot* of research.

1.7 Motivators and barriers to childhood vaccination

The most frequently identified parental motivators for vaccination include protecting their child from disease, protecting the community from disease, and a belief that it is the right thing to do. However since 2017, protecting the wider community from disease has significantly declined as a reason among parents of children aged 0-5 years. Strong Advocates are significantly more likely than any other typology to believe that vaccinating is expected, while OTF and Rejector parents clearly see the prospect of losing government benefits, or their child not being able to start school as more influential.

Among parents of children aged 0-5 years who are not fully vaccinated, the largest barriers are a desire to limit the number of vaccinations their child receives; concerns about going out during COVID restrictions; and a dislike of the idea about annual vaccinations. Parents of unvaccinated children aged 6-12 years cite a belief in herd immunity; concerns about side effects; and a desire not to go out during COVID restrictions.

OTF and Rejectors have quite specific concerns relative to other typologies. These groups are clearly far more concerned about the potential for negative reactions; the number of combined vaccines given at once; the young age at which vaccinations commence; and the potential for vaccine ingredients to have long-term health impacts.

1.8 Key influences on parental attitude and behaviour

GPs and other health professionals remain the key influence on childhood immunisation for parents. It is clear that parents who are OTF and Rejectors turn to a broader range of influencers than those from other typologies - including friends, midwives and the media.

1.9 Adherence to the NIP schedule

Around half of all parents claim to have difficulty in remembering when their child's next vaccination is due. The 'blue book' remains the number one resource used for a reminder, but significantly higher numbers of parents are using diaries and mobile phones in 2022.

Parents of children aged 0-5 years appear to have an increased understanding of the importance of on-time vaccination. However, an increasing proportion of parents believe that it doesn't matter if the vaccination is a few weeks late – suggesting that further work is required to explain precisely what 'on-time' actually means.

Overall, there appear to be two core reasons behind delayed vaccination in 2022 – child sickness; and difficulties in obtaining a timely appointment, exacerbated by issues related to COVID.

1.10 Information sources and needs

Consistent with 2017, parents are most frequently seeking general information about childhood vaccination, though it is clear that many have questions about risks, side effects and vaccine safety. GPs remain the go-to resource for parents seeking information about childhood vaccination. Other sources include nurses and midwives, family, as well as government websites and other collateral. Overall satisfaction with all sources of information is relatively high.

2. PROJECT BACKGROUND

2.1 Overview

The National Immunisation Program

Australia has one of the most comprehensive publicly funded immunisation programs in the world. As a result of years of successful vaccination programs, many diseases such as measles, diphtheria and poliomyelitis either no longer occur or are extremely rare in Australia. Vaccination not only protects individuals but also protects entire communities by increasing overall levels of immunity and thereby minimising the spread of infection. Immunisation is a successful and cost-effective health intervention.

The National Immunisation Program (NIP) provides free vaccines to eligible people to help reduce diseases that can be prevented by vaccination. The NIP Schedule is a series of immunisations provided to eligible Australians at specific times throughout life, with immunisations that range from birth through to adulthood

Previous research

Previous research conducted by Snapcracker Research & Strategy in 2016 and 2017 included qualitative and quantitative activities that provided insights across a range of key audiences.

Qualitative research aimed to understand knowledge, behaviour and intentions regarding immunisation among target audiences, and to uncover any information needs, gaps and overall preferences. This research included two stages with discussion among stakeholders (stage 1) and members of the public, including parents, first time pregnant mothers, adolescents, adults 70+, people from Cultural and Linguistically Diverse (CALD) communities and Aboriginal and Torres Strait Islander people (stage 2). This research included identification of key typologies among parents of children.

Following on from the qualitative phase, quantitative research was designed to build upon the findings from the qualitative phase of research undertaken in 2016 to identify immunisation information needs. This included work to validate the proposed typologies and 'size' the prevalence of the attitudes and behaviours uncovered among parents of children regarding childhood immunisation. The previous research is published on the Department's website¹.

Immunisation typologies

The previous research conducted by Snapcracker identified a typology framework for parents of children, which was based on attitudes to childhood immunisation overall. This framework included the following typologies:

- > **Strong advocates:** highly accepting, highly engaged and marked out by their willingness to advocate for immunisation;
- > **Active acceptors:** engaged and accepting, and have determined that immunisation is the right choice for their family;
- > **Passive acceptors:** not particularly engaged, but accept immunisation as 'the thing that you do' based on the expert advice of health professionals;
- > **Cautious considerers:** less accepting of immunisation and not overly engaged with it, though they do have 'niggles' that can prevent them from fully immunising their children;

¹ National Immunisation Research — Qualitative (2016) and quantitative (2017) research reports | Australian Government Department of Health

- > **Naturalists and Extreme naturalists:** have a preference to live their lives as naturally as possible, hence less interest in the topic. Their decision not to immunise is often based on a positive frame of mind
- > **Worriers and Extreme worriers:** characterised by anxiety about the potential for misadventure due to immunisation, to varying degrees;
- > **Outright rejectors:** tend to exist on the fringes and often see immunisation as a conspiracy hatched by governments and the pharmaceutical industry.

Vaccination and COVID-19

Prior to this research, the impact of the COVID -19 pandemic upon attitudes toward vaccination in general, and specifically influenza vaccination, is currently unknown. Tracking of attitudes toward the COVID-19 vaccines has shown a high level uptake and intentions to take up COVID-19 vaccines. However the speed with which vaccines have been developed, highly publicised side-effects and associated misinformation related to COVID-19 vaccines have resulted in a level of hesitancy among some Australians. The potential impact upon uptake and intentions related to other vaccines is not currently known.

2.2 Need for research

The Department of Health identified a need to conduct qualitative and quantitative research to inform an up-to-date understanding of current attitudes and intentions relating to vaccination among Australians. The research aimed to update previous qualitative research conducted in 2016 and replicate previous quantitative research conducted in 2017.

The research was required to understand current attitudes, barriers, motivators and information needs relating to uptake of vaccines. This understanding will inform strategies to maximise and maintain immunisation rates in Australia. The findings from the research will be used to inform strategic approaches to promote and encourage uptake vaccines among key target audiences.

This report details the findings from this latest piece of research.

3. RESEARCH OBJECTIVES

The core objectives of this study were to:

- > provide an updated understanding of childhood immunisation attitudes, intentions and typology representation among parents of children aged 0-12 years;
- > understand the perceived need, and motivations for childhood vaccination, including key influences;
- > gauge the extent to which parents are up-to-date with their children's vaccinations according to the NIP schedule;
- > identify parents' reasons not to vaccinate their children, including any barriers.

4. RESEARCH APPROACH

4.1 Overview

A staged approach was taken to conducting this research, with qualitative research preceding the quantitative component. The qualitative component included a series of group discussions that enabled the research team to conduct a deep dive into relevant issues among key audiences, in a loosely structured way. These group discussions were conducted as part of a concurrent study focused on influenza, and so included a strong focus on the influenza vaccine (findings for this study are reported separately). However, the qualitative research nonetheless yielded considerable insight to inform this report. A subsequent quantitative survey enabled the research team to reliably validate findings among parents, and to conduct a direct comparison to previous research in this space.

4.2 Qualitative research phase

Overview

The relevant elements of the qualitative stage were a series of 12 x online mini-group discussions with parents / prospective parents, as follows:

- > 4 x mini-groups with parents of children aged 0-5 years;
- > 4 x mini-groups with parents of school-aged children; and
- > 4 x mini-groups with pregnant women.

Each mini-group included between 4-6 participants, and ran for 1 ½ hours. All were conducted online using Zoom. Qualitative fieldwork was conducted between 25 and 28 October, 2021.

It is noteworthy that during this period, COVID and restrictions associated with it were very much top of mind for many people. In NSW and Victoria, official lockdowns had only very recently been lifted after an almost four-month lockdown, and many restrictions were still in place. International borders were closed, and interstate travel was significantly curtailed, with borders closed (certainly to NSW and Victoria) during this time.

Rationale for methodology

Through considerable experience conducting research on the topic of immunisation with a wide range of different population groups, the research team concluded that a group-based approach would offer the best means by which to gather qualitative insight about the topic. Given limitations on face-to-face meetings and travel due to the ongoing COVID-19 pandemic, all sessions were conducted online using Zoom.

The decision was made to run slightly smaller sessions for two main reasons. The online approach is better suited to smaller groups. In addition, smaller groups are more intimate and allow researchers to explore the responses of individual participants in a more nuanced way.

Research sample

The exact sample design for the mini-groups was as follows:

| Grp | Audience | Immunisation Attitude / Influenza Uptake | Parental Experience | Gender | SEG | Location | State |
|-----|---------------------|--|---------------------|--------|-------|-------------|-------|
| 1 | Pregnant women | Acceptor | Mix | Female | White | Regional | QLD |
| 2 | Pregnant women | Acceptor | Mix | Female | Blue | Metro | SA |
| 3 | Pregnant women | Acceptor | Mix | Female | Mix | Outer Metro | NSW |
| 4 | Pregnant women | On the fence | Mix | Female | Mix | Metro | VIC |
| 5 | Parents 0-5 | Acceptor | First-timers | Female | Blue | Regional | VIC |
| 6 | Parents 0-5 | Acceptor | Experienced | Male | White | Outer Metro | QLD |
| 7 | Parents 0-5 | On the fence | Mix | Female | Mix | Regional | NSW |
| 8 | Parents 0-5 | Rejectors | Mix | Female | Mix | Mix | Mix |
| 9 | Parents 0-5 | Acceptor | First-timers | Female | White | Regional | WA |
| 10 | Parents school-aged | Acceptor | Experienced | Female | Blue | Metro | NSW |
| 11 | Parents school-aged | On the fence | Mix | Female | Mix | Metro | SA |
| 12 | Parents school-aged | Rejectors | Mix | Female | Mix | Mix | Mix |

Sampling specifications

Mix of audience types

A broadly even mix of the different audiences identified in the brief was deliberately sought. The sample comprised a total of eight groups with parents, and an additional four groups with pregnant women.

Attitude toward immunisation

The research was required to review the typologies identified in previous research, to reveal any subtle shifts that may have occurred since the research was originally conducted. However, it was important to have some level of attitudinal segmentation in the groups, so as to ensure broadly homogenous attitudes to immunisation within sessions and avoid any conflict.

For parent groups and pregnant women, the sample was split into three core groups - acceptors, on the fence and rejectors.

Parental experience

For parents of children aged 0-5, a good mix of those with children of different ages was included, to ensure that findings did not skew to those with newborns or those with older children. The sample also included those with a mix of parental experience as previous research has shown that this can influence attitudes and perceptions around immunisation. Two key groups of parents were recruited:

- > first-timers, with a single child under two years;

- > experienced – a roughly equal mix of those who are more experienced (with more than one child but all to be aged under five years) and highly experienced (with more than one child, with at least one aged over five years).

For on the fence and rejector parent groups, those with a broad mix of experience were recruited as this audience can be difficult to find based on their relatively low incidence in the population.

Pregnant women

Interviews with pregnant women included women at different stages of their pregnancy and those with a mix of parental experience.

Gender

Given that males today play an increasingly prominent role in decision making and primary caregiving, it was considered important that the research took their perspective into account. However, the majority of sessions were with females given that they are generally the primary caregiver and decision maker around immunisation.

Family structure

Previous research indicated that family structure can have a big impact on parents' ability to comply with the childhood immunisation schedule – for example, it can be difficult for a working mother to secure an appointment that does not clash with other commitments. The sample included a mix of people with different family circumstances and in particular covered single parent families, as well as working parents and those who stay at home to care for their children.

Socio-economic background

Previous research revealed that socio-economic status can play a role in attitudes and behaviour toward immunisation. The sample was broadly split by blue and white collar households.

Aboriginal and Torres Strait Islander Peoples

The brief did not specifically call for the inclusion of Aboriginal and Torres Strait Islander people in the qualitative component of the study. As a result, this group was allowed to fall out naturally in the qualitative sample.

Culturally and linguistically diverse populations

CALD groups fell out naturally within the population overall. While people with different cultural backgrounds tend to fall out quite easily, especially in metro areas, some quotas were included to ensure this occurred. Groups in metro areas were required to include at least two people who speak a language other than English at home.

Research locations

Research was conducted in both metropolitan and regional areas in a total of five states (NSW, QLD, VIC, SA and WA). While representation from this number of jurisdictions is customary in a qualitative study of this scale, specific care was taken to ensure that those with varying experiences of the COVID-19 pandemic were included (e.g. WA and QLD where impacts on daily life were relatively minor vs NSW and VIC where extended lockdowns were in place).

Recruitment of participants

Participants were recruited using experienced, accredited specialist recruitment agencies.

Recruitment screening questionnaires were developed in consultation with the Department, which were used by the recruiters to determine the suitability of participants. These questionnaires included demographic questions, as well as a range of questions to ensure the sampling criteria outlined above were met. Screening questionnaires used can be found in the Appendix.

Online research platform

Zoom was used to conduct all research sessions. Participants were recruited to ensure they were able and comfortable to participate in this way. All sessions were video recorded.

Approach to the discussions

Groups were run by experienced moderators. Discussion guides used can be found in the Appendix to this report. The discussions broadly followed the outline below:

- > a broad examination of knowledge, attitudes, beliefs and behaviour around immunisation including the examination of any myths and misconceptions;
- > examination of the impact that COVID-19 (and COVID vaccines) have had on perceptions and intentions around immunisation more broadly;
- > a specific focus on the influenza vaccine, including knowledge, perceptions, beliefs and behaviour, as well as any specific issues about these vaccines – including the impact that COVID has had on these perceptions;
- > a projective exercise (using personas similar to the demographics of the group) to examine any barriers and motivators to influenza immunisation, taking into account any impacts from COVID identified previously; and
- > spontaneous examination of perceived information needs when it comes to immunisation, including reliable sources of information.

4.3 Quantitative research phase

Overview

The quantitative component included a national online survey among n=1,019 parents of children aged 0-12 years. The survey was in field from 1st February to 15th February 2022. It is noteworthy that at this point in time, the majority of pandemic-related restrictions had been lifted around Australia. With the exception of WA, people were free to travel around Australia and international borders were open. There was however a widespread Omicron outbreak in most parts of the country.

This survey originally ran in November 2021, however key metrics carried over from the comparable study in 2017 yielded highly unexpected results. The Snapcracker team determined that COVID-19 had potentially coloured responses, and we determined to re-run the survey with clear notices for respondents not to factor in COVID-19 vaccines when answering broader questions about childhood vaccinations.

Rationale for methodology

The quantitative phase was a repeat of the 2017 research with refinements made to the survey to ensure they provided up to date findings on the behaviours, attitudes, needs and perceptions of the key target audiences in relation to influenza and the influenza vaccine.

By using the questionnaire from the 2017 research, consistency and comparability of key metrics over time were ensured as well as the ability to identify any significant changes in these metrics. Central to ensuring this consistency and comparability of results was the sampling framework employed for the study - with this in mind, the final sample profile from the 2017 research for each target audience was replicated.

Sample profile

| | Parents of children 0-5 (n=619) | Parents of children aged 6-12 (n=400) |
|-----------------------|---------------------------------|---------------------------------------|
| Male | 49 | 51 |
| Female | 51 | 49 |
| Under 35 years | 45 | 12 |
| 36-49 years | 49 | 71 |
| 50-69 years | 6 | 17 |
| 70+ years | <1 | <1 |
| NSW | 32 | 31 |
| VIC | 29 | 28 |
| QLD | 19 | 24 |
| WA | 9 | 9 |
| SA | 7 | 7 |
| ACT | 2 | 2 |
| TAS | 2 | 1 |
| NT | <1 | 0 |

Survey design

The survey mirrored the data collection methodology and sampling framework from the original 2017 study, to ensure comparability between key measures over time. An online survey methodology was used, as well as a consistent sample profile for the sample of parents.

Questionnaire

Given the importance of tracking any changes in parents’ perspectives on childhood immunisation since the 2017 research, the existing questionnaire was used as a starting point. The full questionnaire can be found in the Appendix to this report.

The core elements of the 2017 research that were replicated in this study included:

- > childhood vaccination perceptions and choices;

- > childhood vaccination schedule adherence;
- > drivers and barriers to childhood vaccination;
- > typology classification;
- > childhood vaccination knowledge; and
- > the impact of COVID-19.

After the initial launch of this questionnaire in late 2021, the Snapcracker team identified a number of highly unexpected results in the data compared with the 2017 study. The Snapcracker team determined that COVID-19 vaccines had potentially coloured responses. As a result the data from this initial survey launch was discarded, the survey was amended to limit the impact of COVID-19 vaccines and re-run in its entirety.

These revised survey included a notice at the start of the survey highlighting that *unless specified, the term 'childhood vaccination' does not include COVID-19 vaccines and only relates to the national schedule of routine vaccinations recommended for children under the age of 5 years.*

A number of individual questions in the survey were also modified to include a direction for participants not to factor COVID-19 vaccinations into their answers.

All data presented in this report is from the subsequent run of the survey, based on the updated survey.

5. GUIDE TO READING THIS REPORT

5.1 Statistical significance

Throughout this report, we have conducted significance testing of results between the 2021 and 2017 results, or between individual subgroups within the sample. For all testing, a two-tailed Z-test of proportions has been used, with a 95% confidence interval. Practically, this means that for any significant difference identified in the report, there is a 95% chance that the difference is real, and not simply a result of sampling error (i.e. a quirk in the sampling).

Throughout the report, significant differences are described as such and notated as follows:

 = a significant increase / significantly higher at the 95% confidence level

 = a significant decrease / significantly lower at the 95% confidence level

5.2 Identification and notation of audience subgroups

Throughout the report, the sample of parents has been split into two separate groups – those with children aged 0-5 years, and those with children aged 6-12 years. This enables us to look at differences between those with younger families vs older families. Parents who qualified for both age groups (i.e. those with children aged 0-5 and 6-12 years) were allocated a group on a 'least fill' basis during fieldwork, which essentially means they were put into whichever group required more participants to fill the quota at that point in time.

Throughout the report, iconography has been used to denote these two subgroups within the sample. The table below provides a key for the iconography used throughout.

| Sample group | Iconography |
|-------------------------------------|---|
| Parents of children aged 0-5 years |  |
| Parents of children aged 6-12 years |  |

DETAILED FINDINGS

6. THE IMPACT OF COVID-19

6.1 Engagement with the topic of vaccination

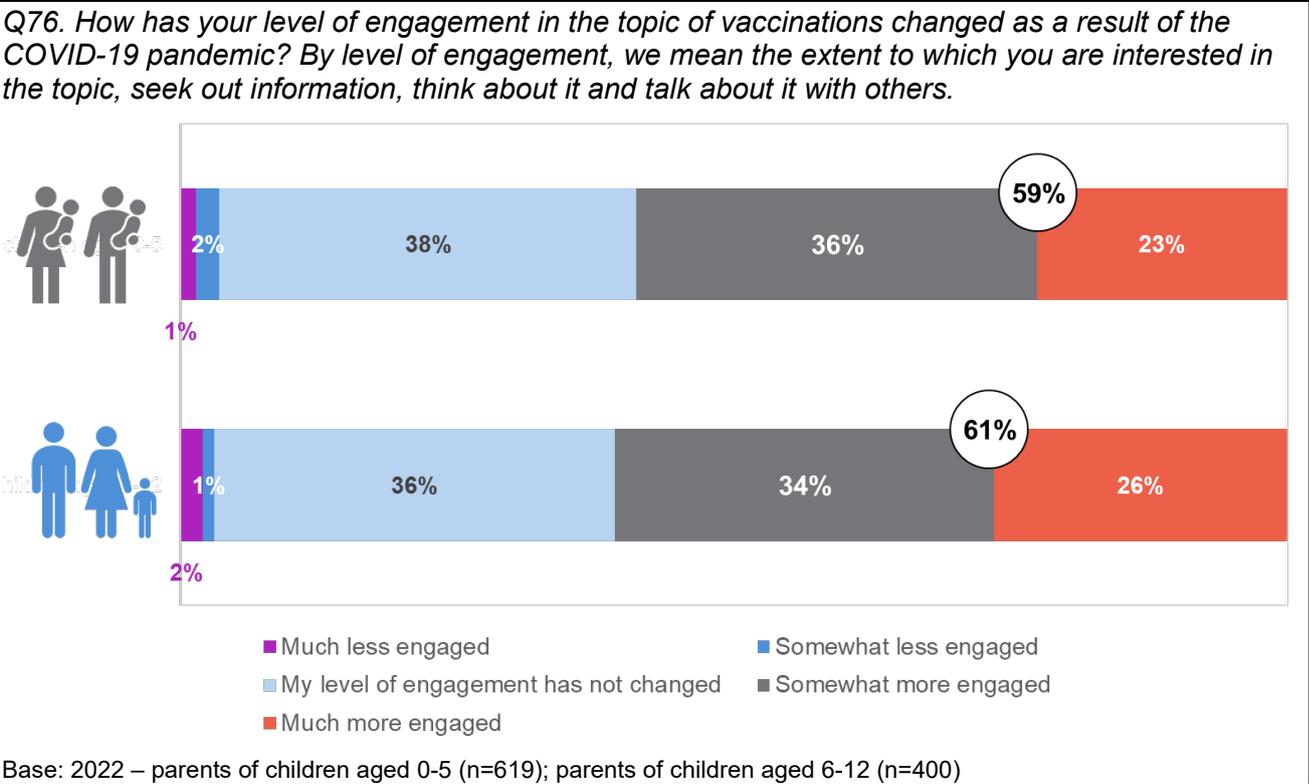
COVID-19 has had a clear impact on the vaccine landscape. In the context of daily media attention for over 18 months and an extremely high level of scrutiny of the development of vaccines, COVID has created significant shifts in how vaccines are perceived among Australians. This appears to have resulted in two outcomes. On some issues relating to immunisation, people can readily identify that their attitudes have changed. In many other cases, less obvious shifts have occurred which are not immediately or spontaneously identified by people.

Qualitatively, a key apparent shift is that levels of engagement with the topic of vaccines and immunisation seem almost universally higher. Across the board, people are now at least a little more knowledgeable and informed about vaccines than they were before COVID-19. It appears that even those who claim to be no more interested in the topic than they were before have a better understanding of it and are able to talk in a more informed way. For example, many now acknowledge that there are different types of vaccine (mRNA vs ‘others’) and now use terms that have been widely reported in the media - such as ‘vaccine hesitancy’ when they were unlikely to be aware of them prior.

“I never really used to pay any attention, I just got on with the schedule but now you hear so much more you can’t help but take it in.”

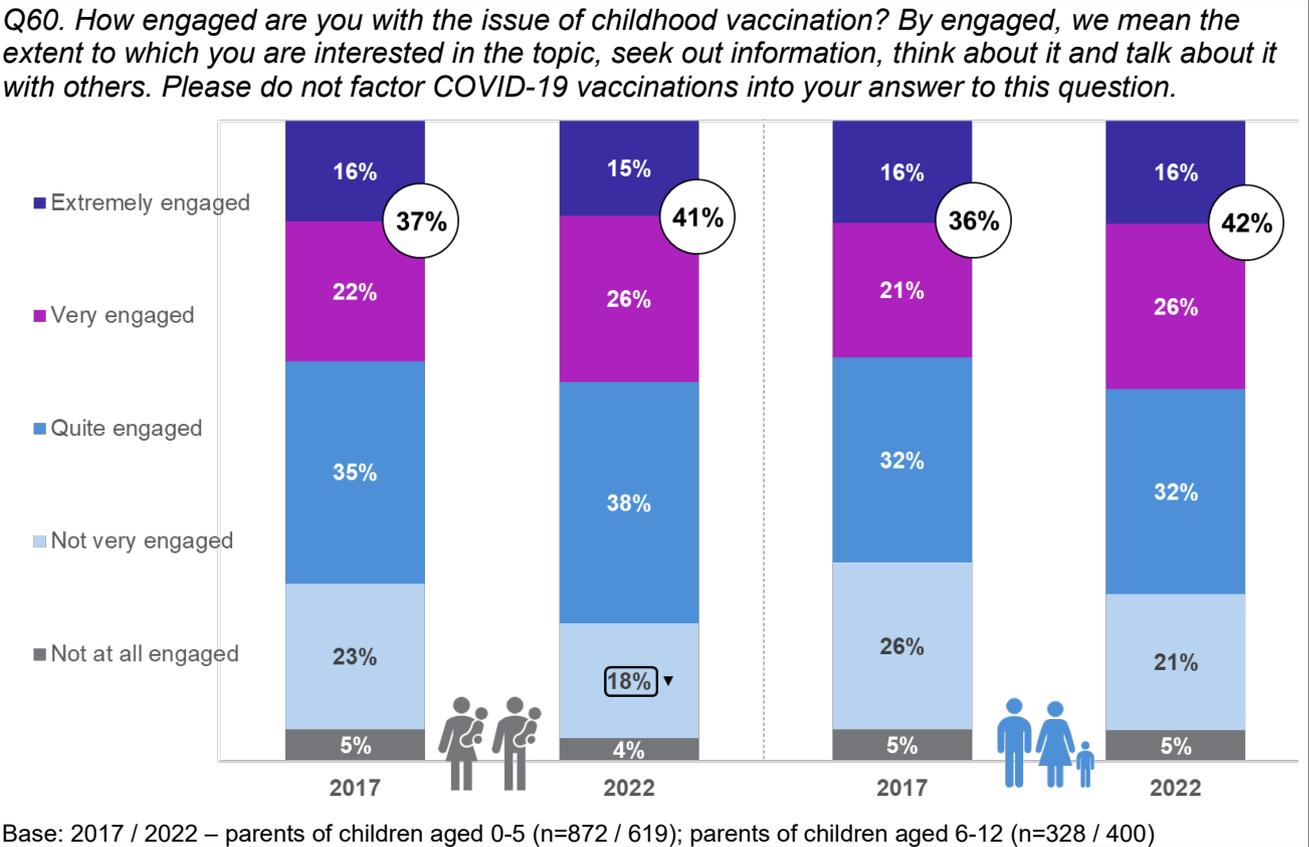
This shift is clearly borne out in the quantitative data. Around six in ten parents claim to be either somewhat or much more engaged with the topic of vaccinations as a result of the pandemic. The figure below shows a breakdown of responses by the age of children.

Figure 1. Level of engagement in the topic of vaccinations as a result of the pandemic



In addition to this self-reported shift, there is some directional (though not significant) evidence of an increase in levels of engagement with the topic between 2017 and 2022. The figure below shows the shift in claimed levels of engagement, broken down by the age of children.

Figure 2 Parental engagement with the topic of childhood vaccination



Only 1 in 5 parents of children aged 0-5 years who claim their level of engagement in the topic of vaccinations has not changed as a result of the COVID-19 pandemic claim to be extremely or very engaged in the issue of childhood vaccination. In comparison, just over half of parents who claim their level of engagement in vaccinations has increased as a result of the pandemic claim to be extremely or very engaged in the broader topic of childhood vaccinations. This suggests there is a correlation between parents’ levels of engagement with vaccinations in general following the pandemic and their level of engagement specifically with childhood vaccinations.

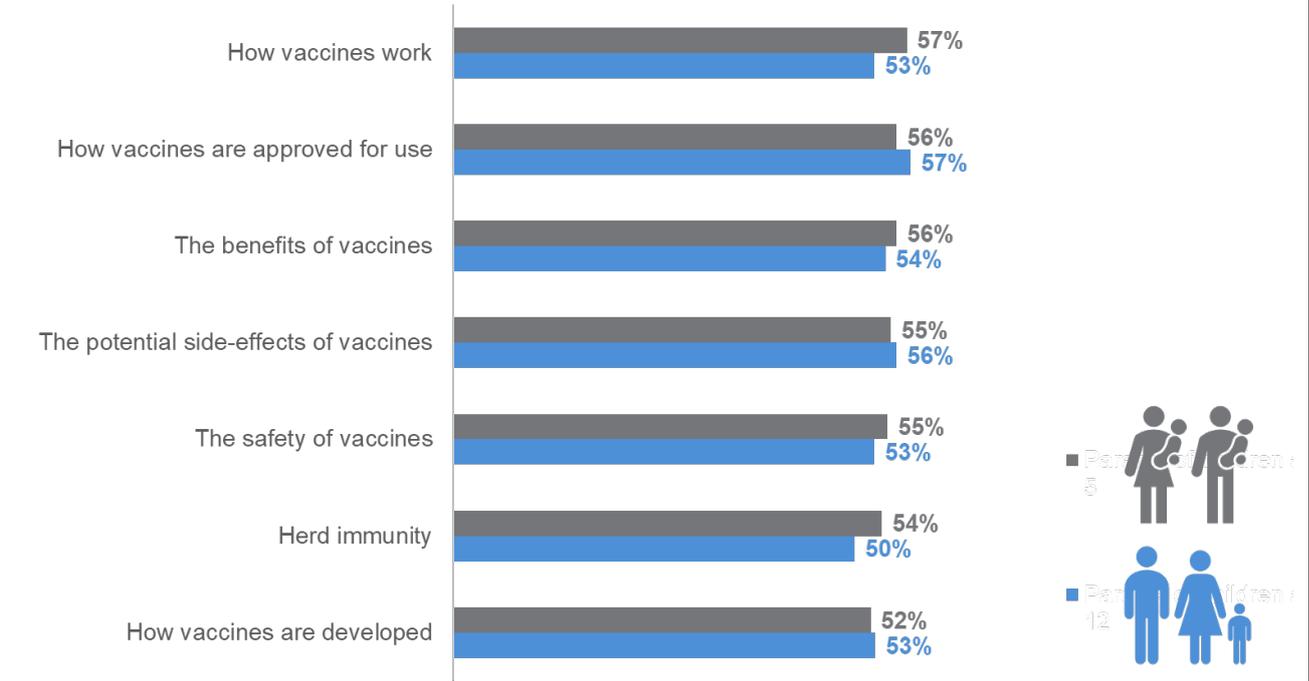
6.2 Knowledge and understanding around key aspects of vaccination

In addition to their levels of engagement, a majority of parents believe that their understanding of vaccines has improved across a variety of dimensions including how they work, the development and approval process, as well as the benefits and potential side effects. The figure below shows the proportion of parents who believe they have a much / slightly clearer understanding of these key aspects of vaccination.

Parents of children aged 0-12 years who claim to have a clearer understanding of at least one aspect of vaccinations are more likely to be male, under the age of 35 and to have sought out information before making the decision of whether or not to get their children vaccinated.

Figure 3 Understanding of vaccinations following the pandemic

Q75. Following the COVID-19 pandemic, how has your understanding of the following aspects of vaccination changed?



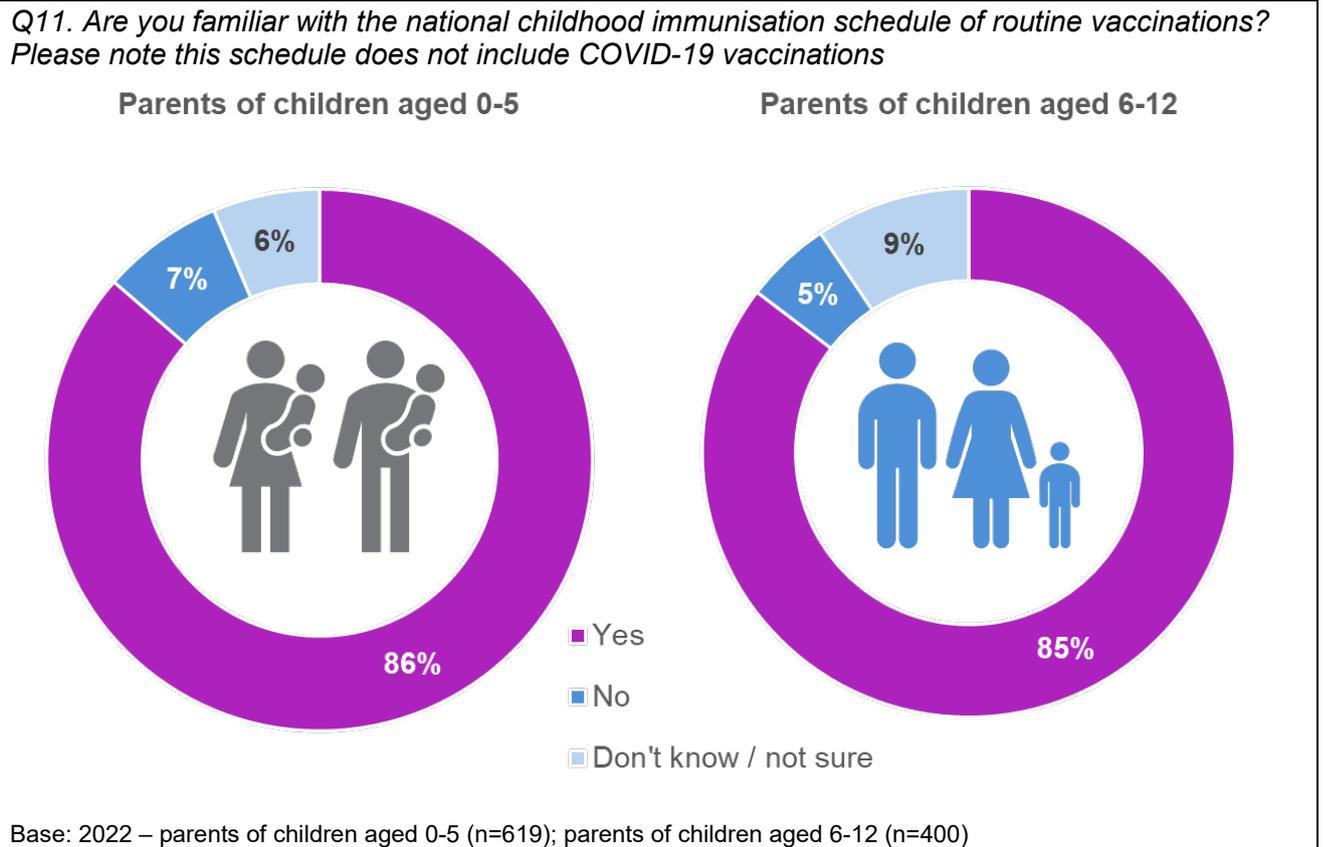
Base: 2022 – parents of children aged 0-5 (n=619); parents of children aged 6-12 (n=400)

7. ATTITUDES AND PERCEPTIONS TOWARD CHILDHOOD IMMUNISATION

7.1 Familiarity with the NIP schedule

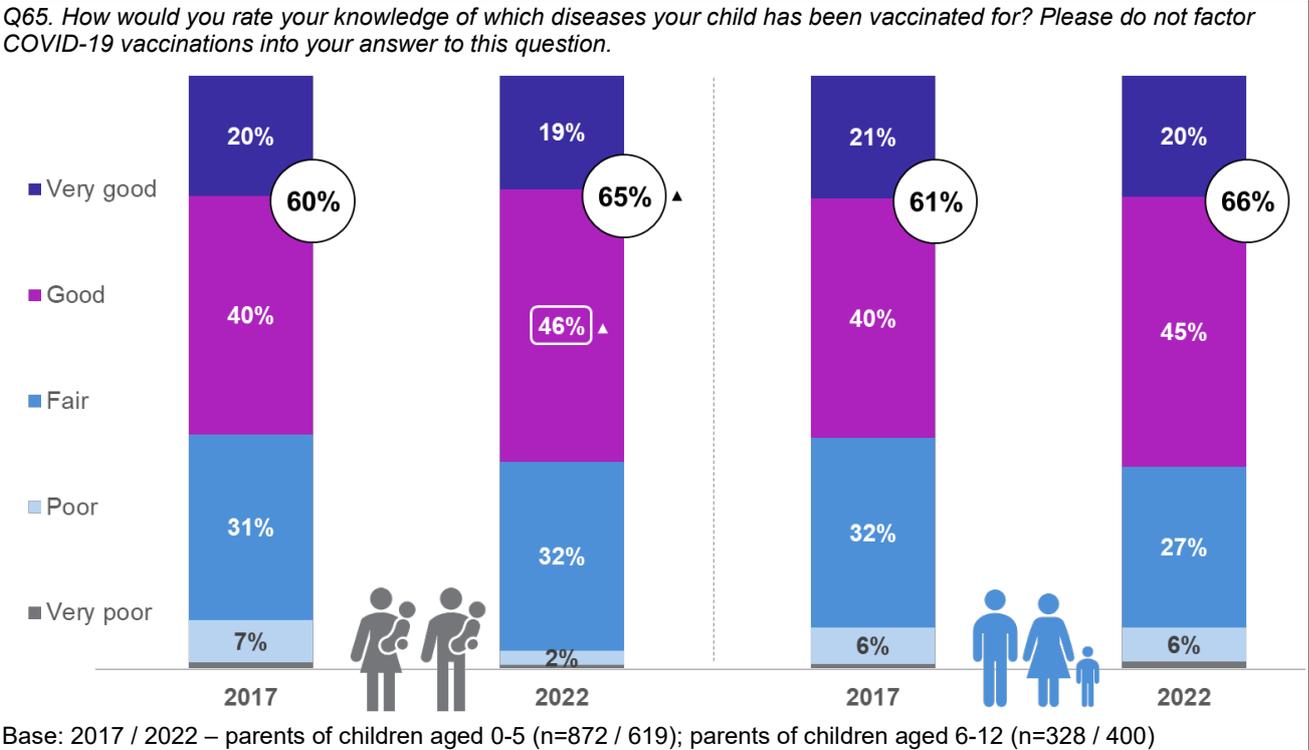
Overall, over eight in ten parents of children aged 0-12 years claim to be familiar with the national childhood immunisation schedule (excluding COVID-19 vaccines). The figure below shows a breakdown of awareness by age of children.

Figure 4 Familiarity with the national childhood immunisation schedule of routine vaccinations



In addition, two-thirds of parents now claim to have a solid understanding of the diseases their children have been vaccinated against. Among parents of children aged 0-5, this is a significant increase from 2017. The figure below shows the breakdown by age of children.

Figure 4. Self-rating of knowledge about the vaccinations their children have received

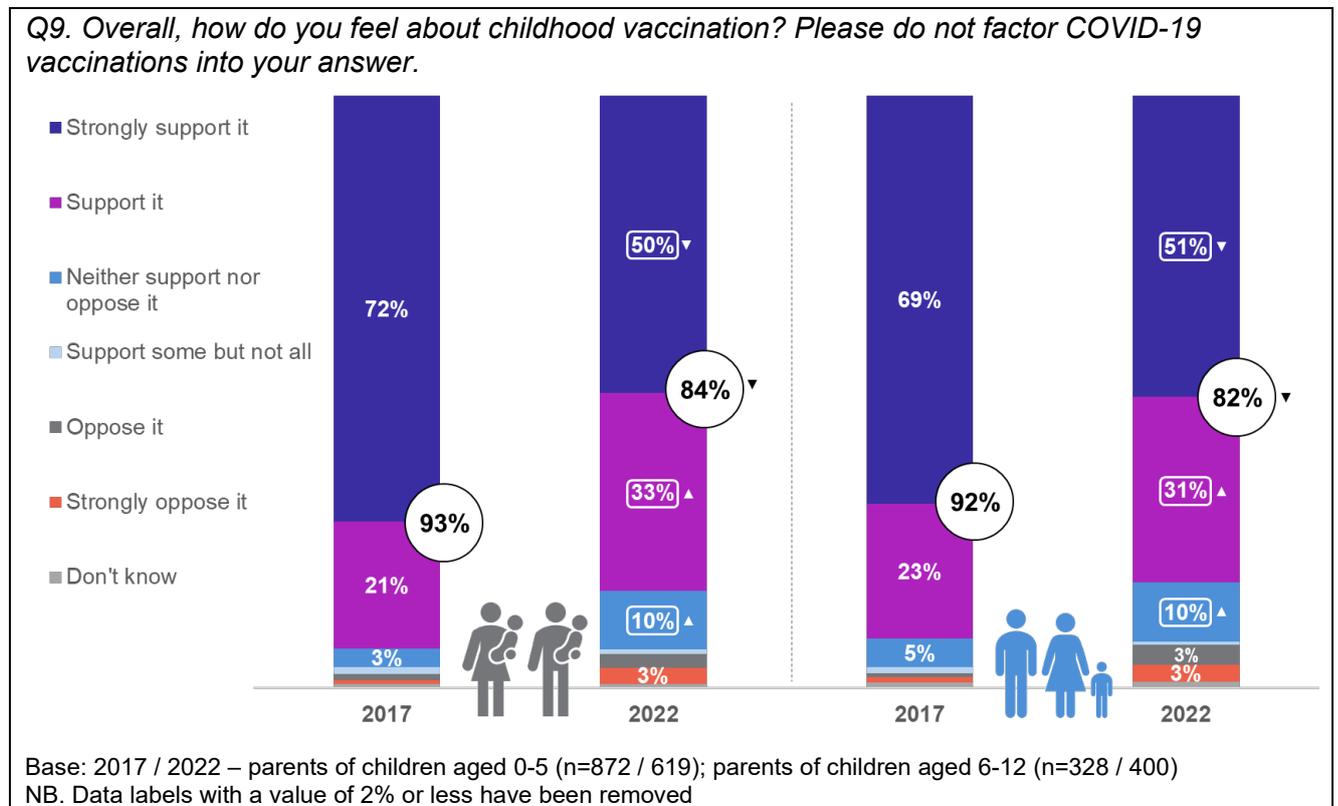


7.2 Support for childhood immunisation

As part of the survey, parents were asked about their levels of support for childhood vaccination. This question specifically asked parents to exclude COVID-19 vaccines from their answer. Compared with 2017, outright support for childhood immunisation has softened – suggesting that many parents now hold a more nuanced viewpoint than they did before. Levels of support have dropped significantly among both parents of children aged 0-5 and 6-12 years. On closer inspection, it is clear that *strong* support has seen a significant decline across both age groups, with ‘support’ and ‘neither support nor oppose’ significantly increasing since 2017.

The figure below shows the shift in overall support since 2017.

Figure 5. Support for childhood immunisation



7.3 Positive perceptions vs concerns

Positive perceptions of childhood vaccination

Looking more closely at the data reveals that the fundamental positive perceptions that parents have about childhood immunisation remain intact – among both groups of parents. There has been no significant reduction in any positive perceptions among either group since 2017. A clear majority of parents continue to see childhood vaccination as being effective and safe, and believe that it improves the health of the whole community. In fact, parents of children aged 0-5 years are now significantly more likely to believe that vaccination is safe for children, and that it is important to vaccinate their child to protect unvaccinated children.

The figures below show levels of positive sentiment held by parents of children aged 0-5 years and parents of children aged 6-12 years respectively.

Figure 6. Positive immunisation perceptions / attitudes – parents of children aged 0-5 [% strongly agree / agree]

Q63. Below are some beliefs that some parents hold about childhood vaccination and vaccines. Please indicate how strongly you agree or disagree with each statement.
 Q67. Please indicate how strongly you agree or disagree with each of the following statements about childhood vaccination

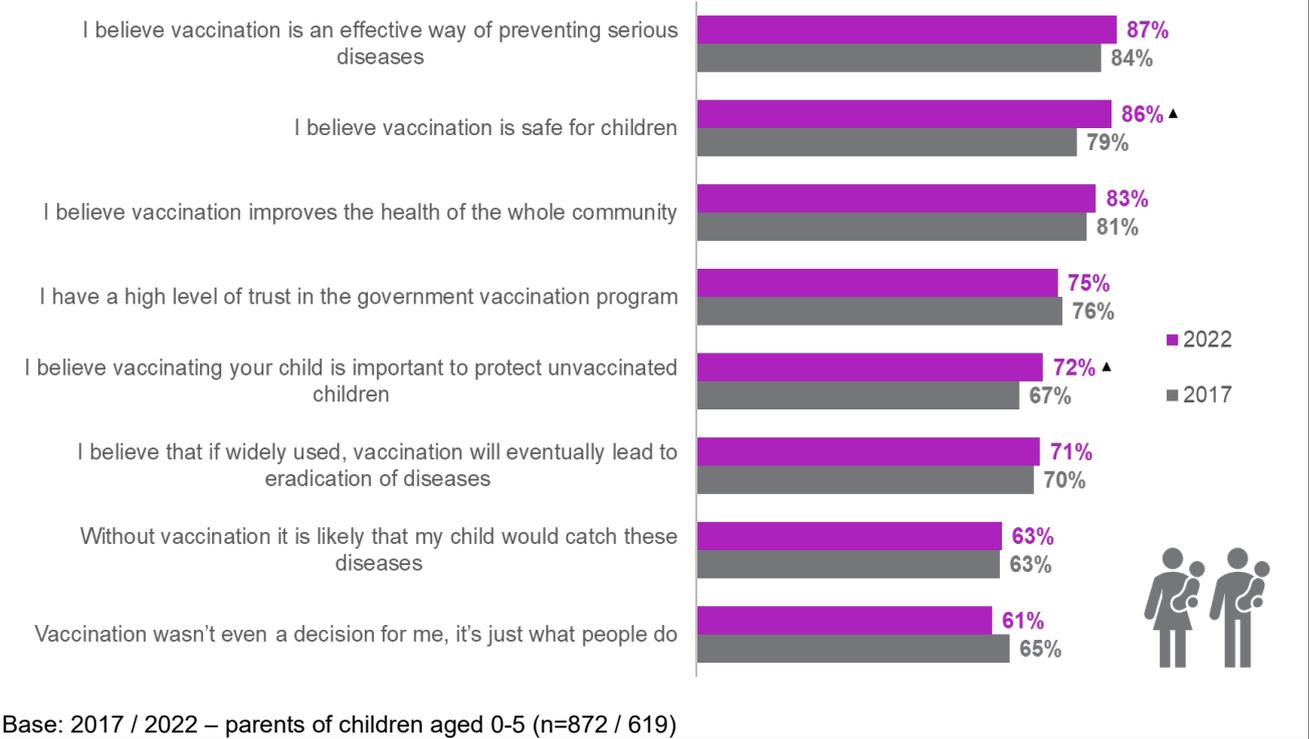
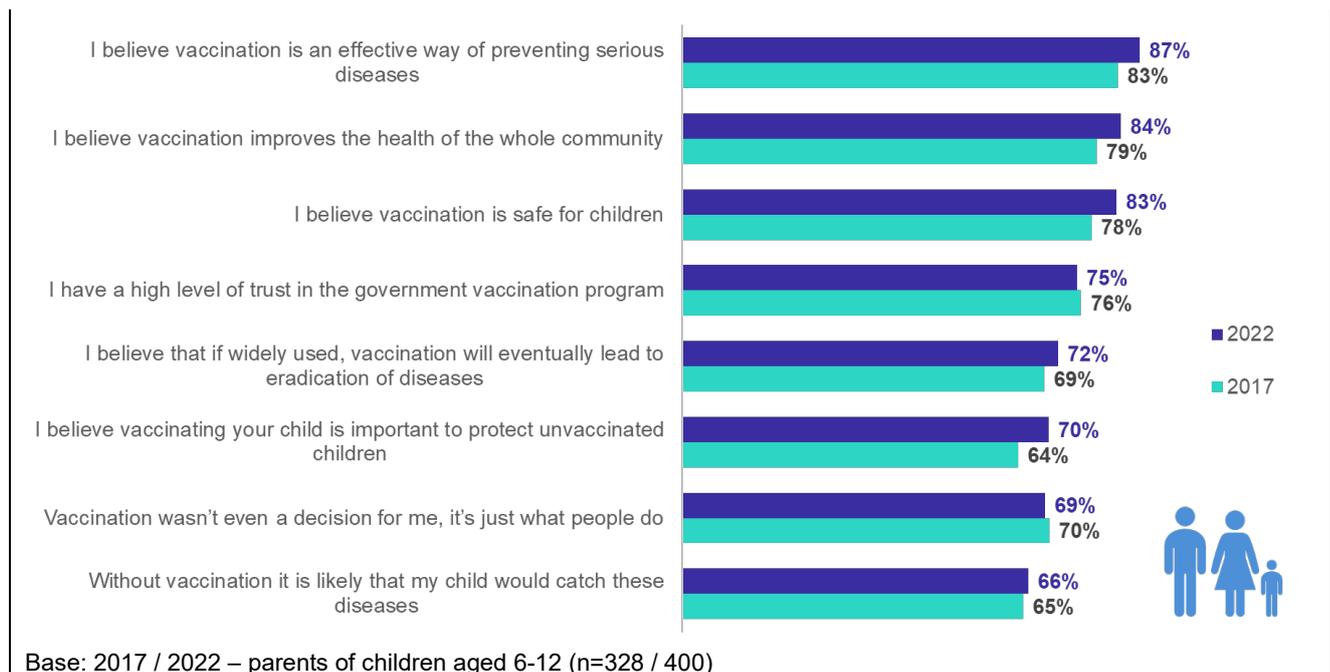


Figure 7. Positive immunisation perceptions / attitudes – parents of children aged 6-12 [% strongly agree / agree]

Q63. Below are some beliefs that some parents hold about childhood vaccination and vaccines. Please indicate how strongly you agree or disagree with each statement.
 Q67. Please indicate how strongly you agree or disagree with each of the following statements about childhood vaccination



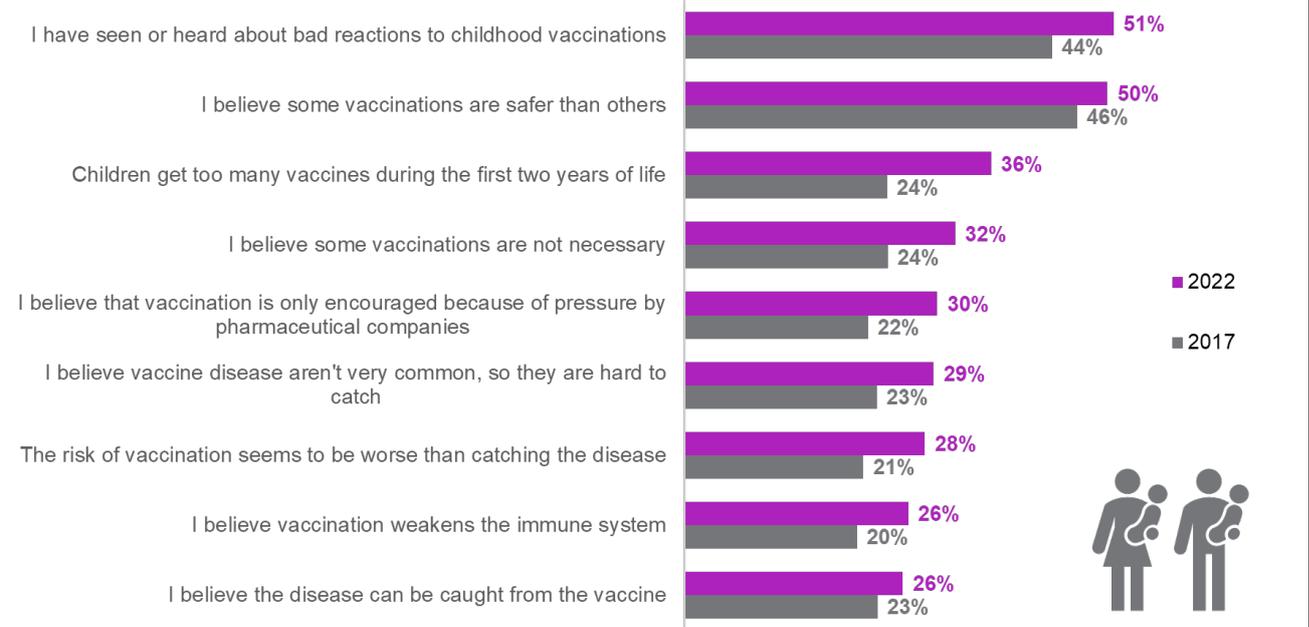
Negative perceptions and concerns

While positive perceptions remain firm, it is very clear that parents are now much more likely to hold negative perceptions and concerns about childhood vaccination than they did in 2017. There have been significant or directional increases on almost every measure included in the survey which relates to concerns and negative perceptions about childhood vaccines – including that children receive too many vaccines in their early years, that some vaccinations are not necessary, that the risk of vaccination seems worse than catching the disease, and that vaccination is only encouraged because of pressure from pharmaceutical companies. Further breakdowns of precisely who in the community holds these perceptions are provided in the next chapter.

The figures below show levels of negative sentiment and concern held by parents of children aged 0-5 years and parents of children aged 6-12 years respectively.

Figure 8. Negative immunisation perceptions / attitudes – parents of children aged 0-5 [% strongly agree / agree]

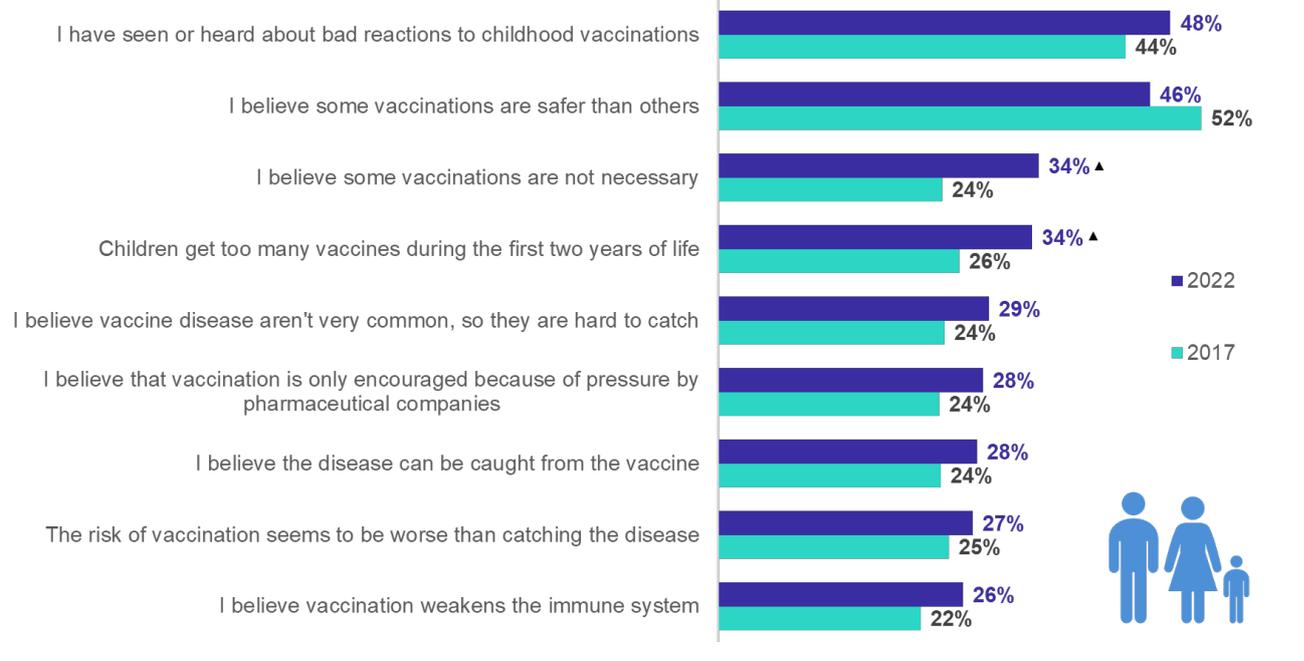
Q63. Below are some beliefs that some parents hold about childhood vaccination and vaccines. Please indicate how strongly you agree or disagree with each statement.
 Q67. Please indicate how strongly you agree or disagree with each of the following statements about childhood vaccination.



Base: 2017 / 2022 – parents of children aged 0-5 (n=872 / 619)

Figure 9. Negative immunisation perceptions / attitudes – parents of children aged 6-12 [% strongly agree / agree]

Q63. Below are some beliefs that some parents hold about childhood vaccination and vaccines. Please indicate how strongly you agree or disagree with each statement.
 Q67. Please indicate how strongly you agree or disagree with each of the following statements about childhood vaccination.

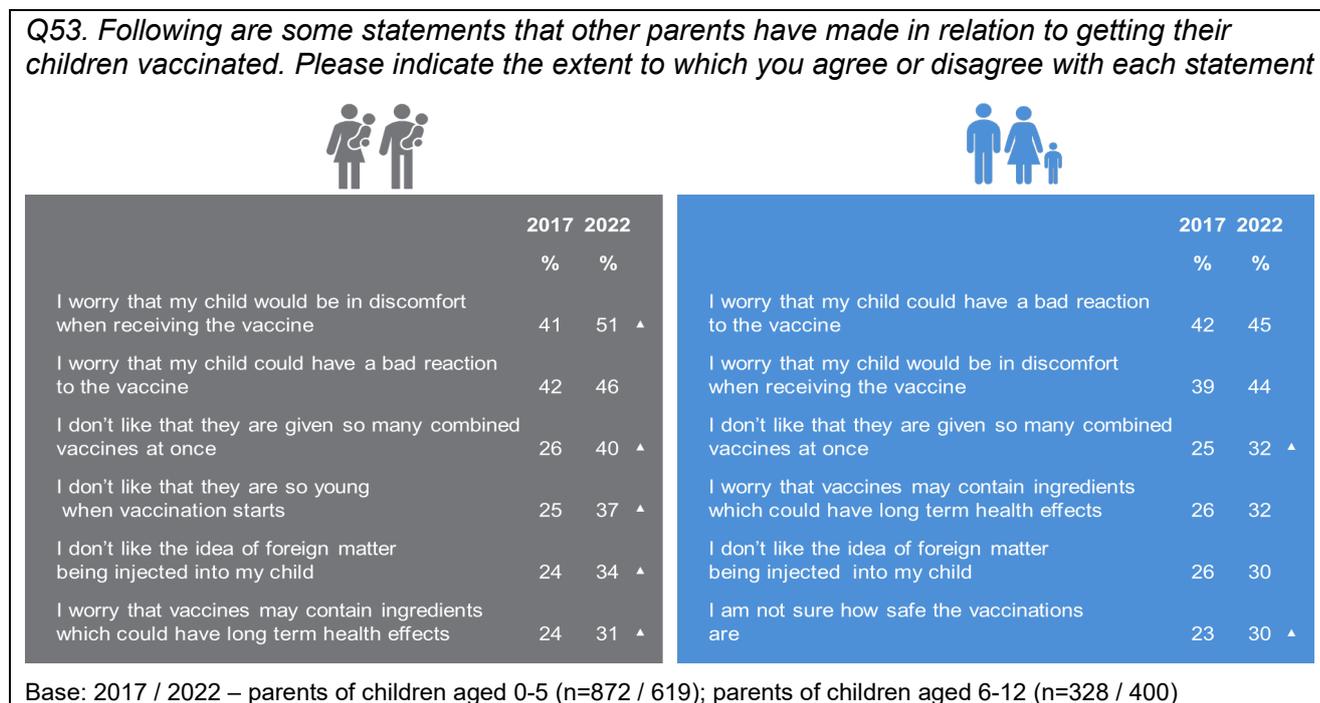


Base: 2017 / 2022 – parents of children aged 6-12 (n=328 / 400)

Parents were also asked to identify the extent to which they agreed with a range of potential concerns about childhood vaccination. A number of concerns have significantly increased in their prevalence since 2017, with a directional increase seen on all others. The top concerns for parents are that their child would experience discomfort, and that their child could have a bad reaction to the vaccine.

The tables below provide a breakdown of the concerns held by each parent group.

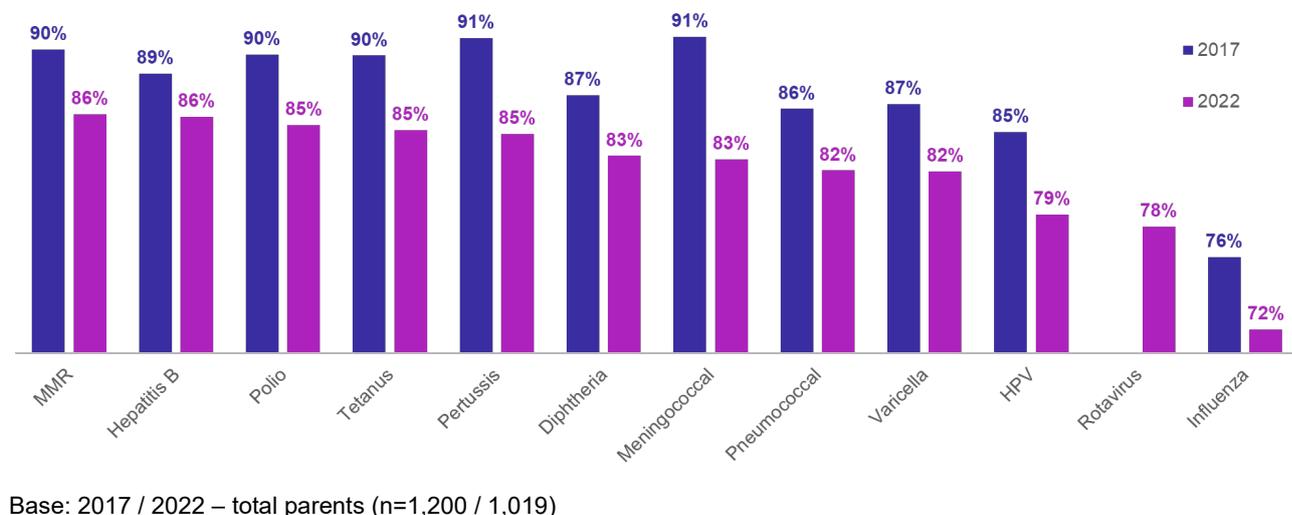
Figure 10. Vaccination concerns – top 6 [% agree strongly / slightly]



7.4 Perceived importance of individual childhood vaccines

Parents were asked to rate the extent to which they believed individual vaccines on the NIP schedule were important. Significantly fewer parents now believe that childhood vaccines found on the schedule are important compared to 2017 – this can be seen across all vaccines included in the question, with the exception of Rotavirus which was not included in the question in 2017. This drop in perceived importance is concerning, particularly as it so clearly applies to all vaccines included. The figure below shows the breakdown of perceived importance for each vaccine compared with 2017.

Figure 11. Perceived importance of childhood vaccines [% very / moderately important]
Q62. How important do you think the following childhood vaccines are?



8. PARENT TYPOLOGIES

8.1 Qualitative analysis around the typologies

The qualitative research sought to understand whether there had been any changes in the fundamental bedrocks of the typologies in 2022 vs 2017. Ultimately, the clear finding was that these remain consistent with the original findings that first developed the typologies.

Two key variables are at the heart of different attitudes towards immunisation. The first is level of engagement, which is determined by the extent to which parents are interested in the topic, seek out information, talk about it, feel the need to be informed, believe they are informed and are prepared to think about the topic. The second is acceptance, which is determined by the extent to which parents accept the idea of immunisation, see it as a fundamentally good thing and expect to immunise their child. Qualitatively, there is no evidence to suggest that these fundamentals have changed since 2017 – no new attitudinal dimensions have emerged, and COVID does not appear to have altered these dimensions.

In addition, qualitative analysis determined that there did not appear to be any new typologies in 2022 - there is no evidence to suggest that new groups have emerged post-COVID when it comes to childhood vaccines.

Ultimately, it seems that the segmentation remains robust and intact. That said, the qualitative research indicated a possibility that people may have moved between the typologies. For example, it could be that some 'Passive Acceptors' have shifted into 'Active Acceptors', or it could be that some 'Cautious Considerers' have learnt more about vaccines which has caused them to become 'Worriers'.

8.2 Quantitative approach to sizing the typologies

As a result of the clear findings from the qualitative phase, parents were asked to self-classify into the original typologies, using the statements shown in the table below.

Figure 12. Parent typologies

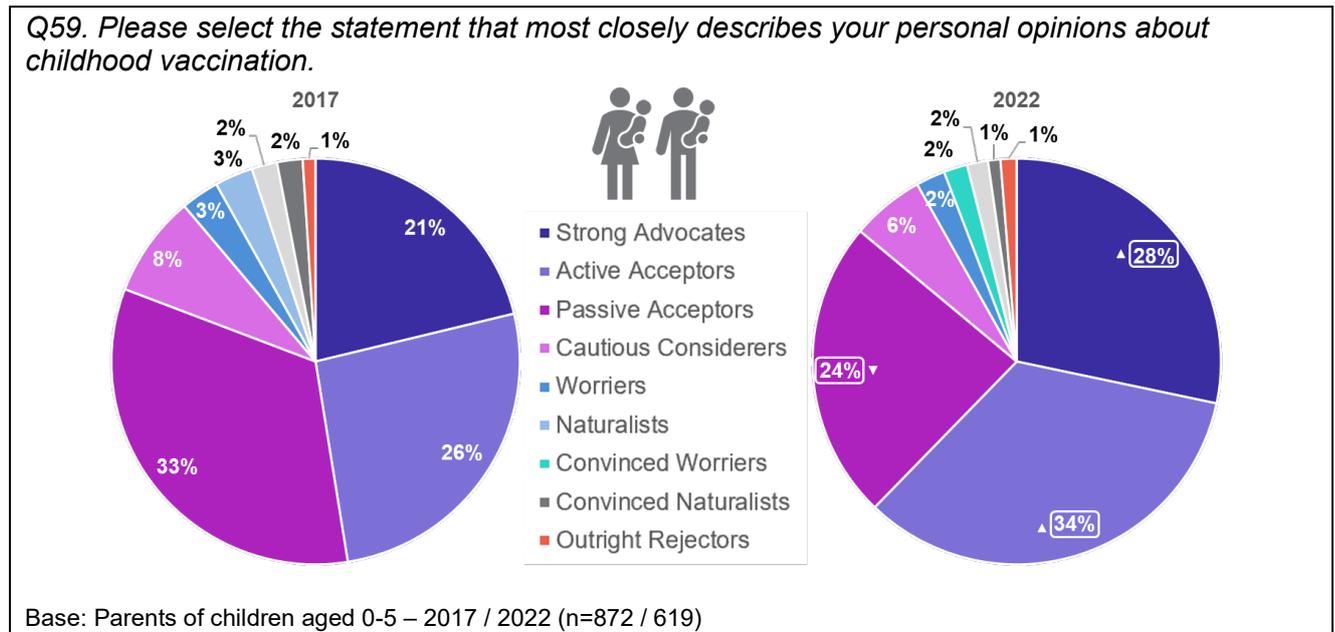
| | |
|------------------------------|--|
| Strong Advocates | I am strongly in favour of childhood vaccination. I have done a lot of research and have a good understanding of the issues. I am comfortable sharing my views and will try to persuade others to change their opinions of vaccination if they are against it. |
| Active Acceptors | I am in favour of childhood vaccination. I have done a bit of research from which I feel well enough informed to be comfortable in my choices. I don't go out of my way to talk about it but am happy to discuss with others if the topic comes up. |
| Passive Acceptors | I am in favour of childhood vaccination and see it simply as something you have to do for your children. I don't tend to think about it much, beyond making the necessary appointments. I trust the healthcare system to do the right thing and don't feel the need to understand all the details. |
| Cautious Considerers | I am not against childhood vaccination but I do worry a bit about things that could potentially go wrong. I haven't done a lot of research into the subject. I would like to feel reassured that it is okay for my children. |
| Worriers | I don't really know where I stand on childhood vaccination. On the one hand I can see the benefits for my children, but at the same time I worry a lot about the risk of something going wrong. Because of this I like to know all the details of any vaccination that my child receives. Thinking about it makes me feel anxious. |
| Naturalists | While I sometimes think vaccination is right, I prefer not to over medicalise my children and look for alternative approaches to medicine and wellbeing as far as I can. |
| Convinced Worriers | I do not believe in childhood vaccination. There are far too many risks involved that I believe outweigh the benefits. I do a lot of reading on the subject and am horrified by the personal reports of negative experiences. For these reasons, I tend to warn others against having their children immunised. |
| Convinced Naturalists | I am opposed to childhood vaccination and pharmaceutical medicine in general. I try to live a natural life and encourage my children to do the same. We avoid artificial foods and substances and instead use natural remedies. |
| Outright Rejectors | I am strongly opposed to childhood vaccination. It is nothing more than propaganda designed to control the population and only serves the interests of politicians and pharmaceutical companies, not the people. I don't often share my views with others as they may react badly. |

When comparing the profile of individual typologies to the rest of the total parents' sample, we see some demographic skews emerge. Parents who self-classify as Strong Advocates are significantly more likely to be male (65%) and skew slightly younger (under the age of 35). Parents who self-classify as Active Acceptors or Passive Acceptors are significantly more likely to be female (55% and 59% respectively) when compared to the rest of the parents' sample. Parents who self-classify as being On the Fence do not show any significant difference by age, gender or the age of their children when compared to the rest of the parents' sample. Parents who self-classify as Rejectors skew slightly younger than the rest of the parents sample (43% under the age of 35 compared to 31%) and are significantly less likely to be aged 35-49 years compared to all other parents in the sample.

8.3 The typologies in 2022

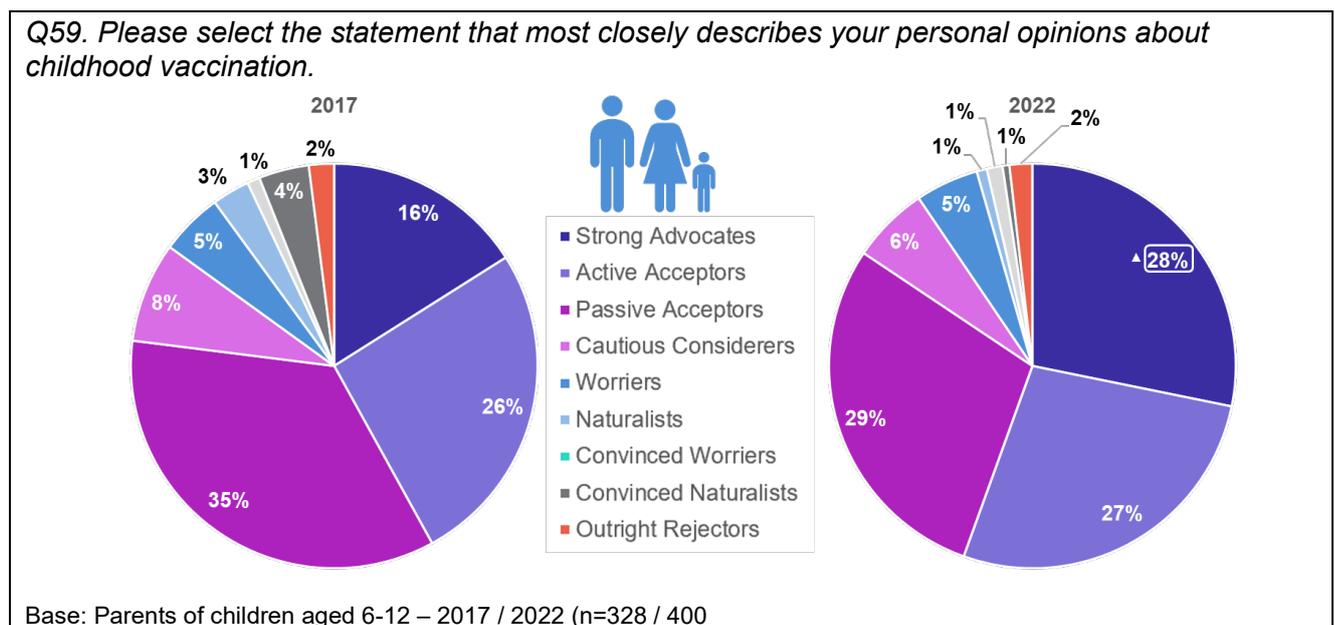
Compared with 2017, there are now significantly more Strong Advocates and Active Acceptors, and fewer Passive Acceptors among parents of children aged 0-5 years. Essentially this finding further supports that parents are now more engaged with the topic than they have been in the past. The figure below shows the breakdown of typologies among parents of children aged 0-5 in 2017 and now in 2022.

Figure 13. Parent typology classification – parents of children aged 0-5



Among parents of children aged 6-12 years, there are fewer significant changes in the sizes of the typologies, though directionally the shift is similar and there are significantly more Strong Advocates than in 2017. The figure below shows the breakdown of typologies among parents of children aged 6-12 years in 2022 vs 2017.

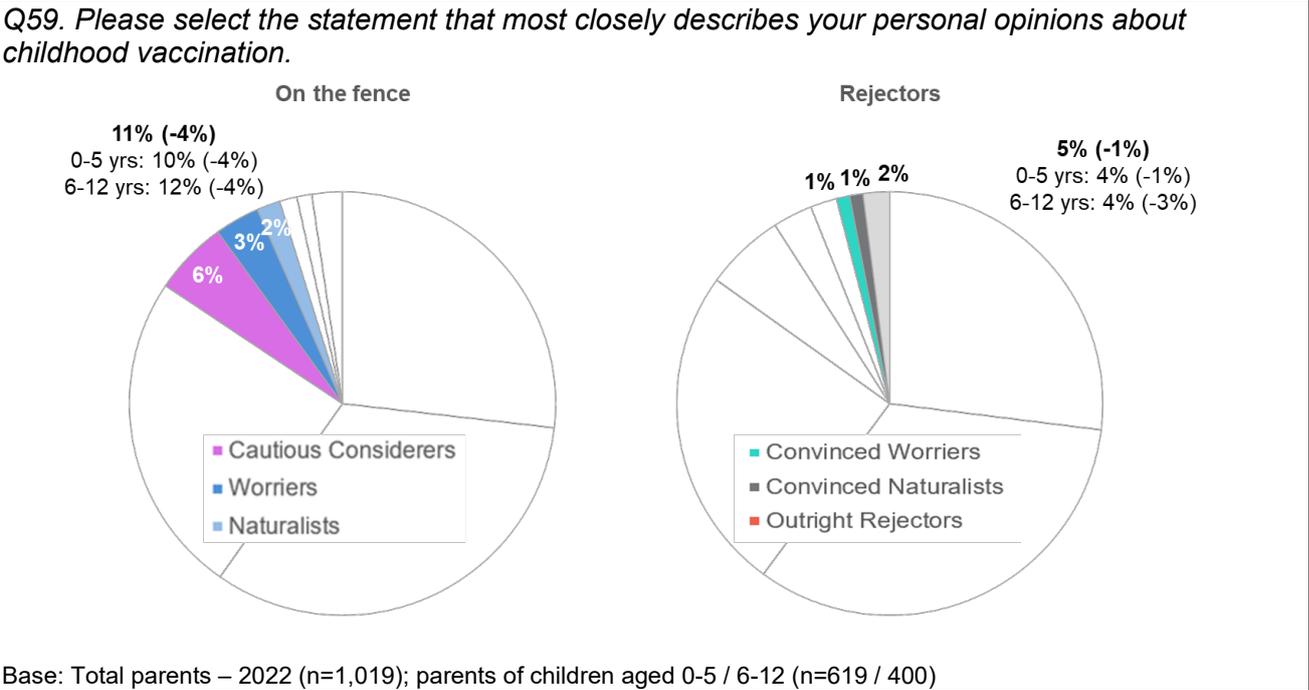
Figure 14. Parent typology classification – parents of children aged 6-12



Consistent with previous research, several of the smaller typologies have been aggregated into groups for further analysis throughout the report. The Cautious Considerers, Worriers and Naturalists have been rolled into 'On the Fence' (OTF), while Convinced Worriers, Convinced Naturalists and Outright Rejectors have been rolled into 'Rejectors'.

Critically, these two groups are largely unchanged in their size since 2017, with no significant differences apparent. The figure below shows these two aggregated groups, with data labels indicating the differences in 2022 compared with 2017.

Figure 15. Parent typology classification – smaller typologies (difference vs. 2017)



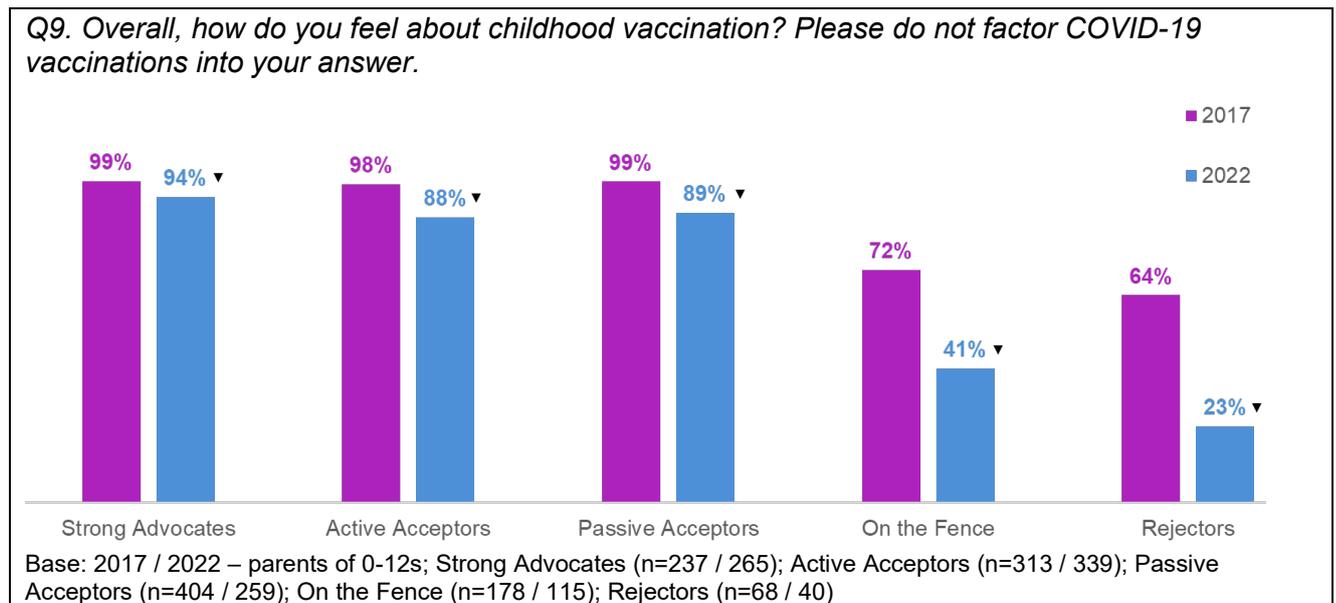
8.4 Support for childhood immunisation by typology

The drop in overall support for childhood immunisation is evident across all typologies – all typologies are significantly less likely to agree that they strongly support or support childhood immunisation than they were in 2017.

The reduction in support is clearly more pronounced among OTF and rejector groups. It seems likely that support among these groups was relatively weak to begin with – and therefore more likely to decline in the context of heightened discussion about vaccines during the pandemic.

The figure below shows the breakdown of support for childhood immunisation by typology.

Figure 16. Total support for childhood immunisation[% strongly support it / support it]



8.5 Levels of engagement and research conducted by typology

Self-reported engagement with the topic of childhood immunisation has not increased uniformly across the typologies. Compared with 2017, Strong Advocates have significantly increased in their claimed level of engagement in 2022, while Passive Acceptors and Rejectors have significantly decreased in their claimed levels of engagement.

In keeping with their increased levels of engagement, Strong Advocates are also now more likely to be conducting research prior to making the decision about immunising their children than they were in 2017. Active Acceptors and Passive Acceptors are also claiming to do more research in 2022 than they did in 2017, though Passive Acceptors remain the most likely to say they have done no research at all.

The table below shows percentages of each typology who claim to be extremely / very engaged with the topic of childhood immunisation, as well as those who claim to have done a lot / a little research prior to immunising their children.

Figure 17. Engagement and research around childhood immunisation (Differences vs. 2017)

| Engagement and research around childhood immunisation (Differences vs. 2017) | Strong Advocates | Active Acceptors | Passive Acceptors | On the Fence [NET] | Rejectors* [NET] |
|--|----------------------|----------------------|----------------------|--------------------|----------------------|
| | % | % | % | % | % |
| Extremely / very engaged in the topic of childhood immunisation | 76 ▲ (+17) | 35 (+4) | 17 ▼ (-13) | 29 (-2) | 27 ▼ (-22) |
| Did a lot of research / a little research | 76 ▲ (+14) | 78 ▲ (+13) | 53 (+6) | 77 (+2) | 74 (-12) |

8.6 Perceptions of childhood immunisation by typology

Positive perceptions

Positive perceptions about childhood immunisation largely fall out as expected across the typologies - Strong Advocates demonstrate the highest levels of agreement with various positive statements, largely followed by Passive Acceptors, Active Acceptors, then OTF and Rejectors. This breakdown further supports the overall finding that the fundamental perceived strengths of childhood immunisation remain firm. The data show no major changes in 2022 compared with 2017.

Figure 18. Positive perceptions about immunisation (difference vs. 2017)

| Positive perceptions of childhood immunisation (differences vs. 2017) | Strong Advocates | Active Acceptors | Passive Acceptors | On the Fence [NET] | Rejectors* [NET] |
|--|------------------|------------------|-------------------|--------------------|------------------|
| | % | % | % | % | % |
| I believe vaccination is an effective way of preventing serious diseases | 95 (+7) | 89 (-1) | 93 (+4) | 67 (+3) | 27 (-34) |
| I believe vaccination improves the health of the whole community | 93 (+5) | 88 (+2) | 89 (-) | 53 (-2) | 21 (-36) |
| I believe vaccination is safe for children | 96 (+9) | 90 (+3) | 91 (+1) | 48 (+7) | 25 (-26) |
| I have a high level of trust in the government vaccination program | 86 (-1) | 79 (-2) | 83 (-3) | 36 (-5) | 26 (-27) |
| I believe that if widely used, vaccination will eventually lead to the eradication of diseases | 86 (+7) | 77 (+2) | 70 (-3) | 45 (-) | 26 (-33) |
| I believe vaccinating your child is important to protect unvaccinated children | 85 (+12) | 75 (+7) | 73 (+4) | 40 (-6) | 33 (-24) |
| Vaccination wasn't even a decision for me, it's just what people do | 70 (+1) | 61 (-4) | 77 (-2) | 44 (-5) | 38 (-18) |
| Without vaccination, it is likely that my child would catch these diseases | 80 (+2) | 69 (+4) | 62 (-4) | 33 (-14) | 19 (-30) |

Negative perceptions

When examining the breakdown of negative perceptions / concerns by typology, it is clear that the increases seen at the overall level have not been distributed evenly, or as expected, across the typologies.

In particular, Strong Advocates hold a range of unexpected negative perceptions and concerns, at significantly higher levels than in 2017 – and in some cases, they hold stronger concerns than parents who are On the Fence.

It may be that greater engagement and research into the topic, coupled with blanket COVID media coverage has allowed some concerns and negative perceptions to take hold among this group. While at this point it seems that Strong Advocates remain relatively firm in their support for childhood immunisation and continue to hold strong positive convictions, this increase in negative perceptions clearly represents an area of potential concern.

The table below shows the breakdown of agreement with negative statements by typology in 2022, with differences compared with 2017 shown in brackets.

Figure 19. Negative perceptions of childhood immunisation (difference vs. 2017)

Q63. Below are some beliefs that some parents hold about childhood vaccination and vaccines. Please indicate how strongly you agree or disagree with each statement. Q67. Please indicate how strongly you agree or disagree with each of the following statements about childhood vaccination.

| Negative perceptions of childhood immunisation (differences vs. 2017) | Strong Advocates | Active Acceptors | Passive Acceptors | On the Fence [NET] | Rejectors * [NET] |
|--|--------------------|--------------------|--------------------|--------------------|--------------------|
| | % | % | % | % | % |
| I have seen or heard about bad reactions to childhood vaccinations | 55 (+17) | 50 (+5) | 44 (+10) | 50 (-10) | 61 (-10) |
| I believe some vaccinations are safer than others | 56 (+7) | 51 (+3) | 39 (-3) | 54 (-5) | 33 (-33) |
| Children get too many vaccinations during the first two years of life | 42 (+22) | 29 (+11) | 22 (+7) | 57 (+11) | 66 (-4) |
| I believe some vaccinations are not necessary | 37 (+16) | 28 (+8) | 22 (+8) | 58 (+15) | 62 (-2) |
| I believe that vaccination is only encouraged because of pressure by pharmaceutical companies | 38 (+18) | 22 (+6) | 17 (+5) | 46 (+2) | 72 (+4) |
| I believe vaccine diseases are not very common, so they are hard to catch | 41 (+14) | 24 (+6) | 23 (+6) | 30 (+4) | 30 (-36) |
| The risk of vaccination seems worse than catching the disease | 40 (+14) | 20 (-1) | 18 (+5) | 35 (+7) | 60 (-4) |
| I believe vaccination weakens the immune system | 40 (+23) | 17 (-) | 15 (+3) | 42 (+8) | 54 (-16) |
| I believe the disease can be caught from the vaccine | 37 (+11) | 20 (+1) | 18 (+6) | 35 (+2) | 63 (-7) |

Base: 2017 / 2022 – parents of 0-12s; Strong Advocates (n=237 / 265); Active Acceptors (n=313 / 339); Passive Acceptors (n=404 / 259); On the Fence (n=178 / 115); Rejectors (n=68 / 40)

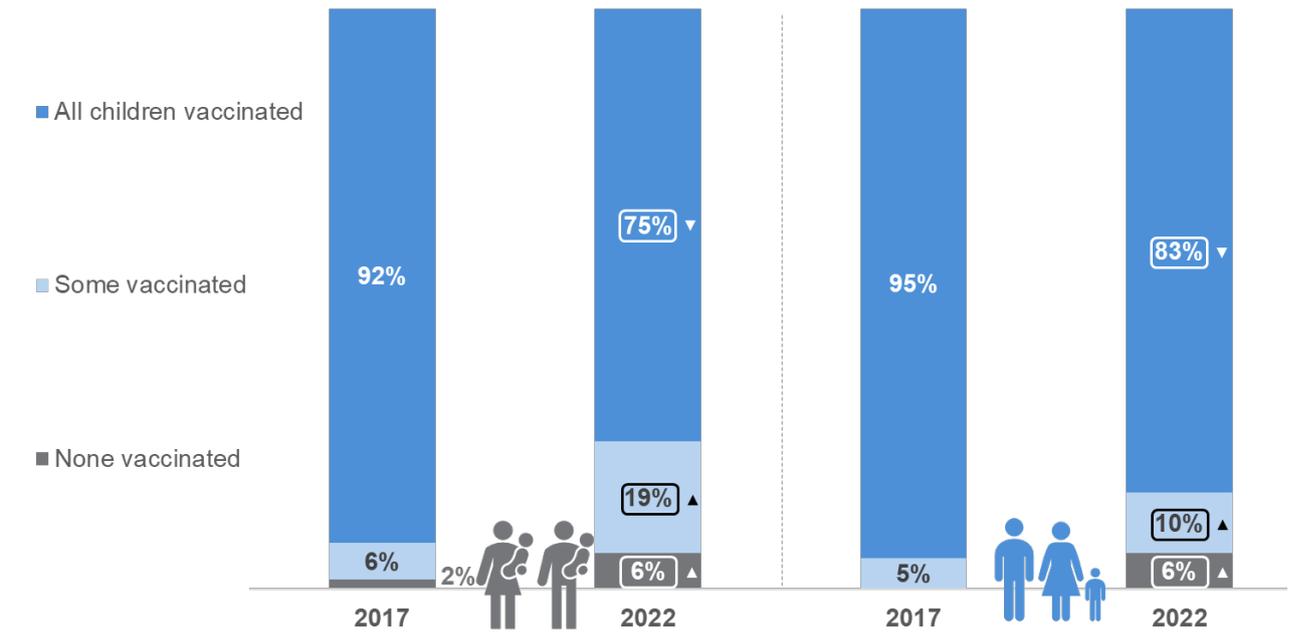
9. CLAIMED IMMUNISATION BEHAVIOUR

9.1 Levels of immunisation

The proportion of families with children aged 0-12 who claim that *all children* have been vaccinated has dropped significantly since 2017. Those with children aged 0-5 and those with children aged 6-12 are significantly more likely in 2022 to claim that some children are vaccinated, and that none have been vaccinated. The figure below shows self-reported vaccination status by age of child.

Figure 20. Vaccination status

Q12. Have your children been immunised? Please note this does not include COVID-19 vaccinations, it only refers to the national childhood immunisation schedule of routine vaccinations recommended for children under the age of 5 years



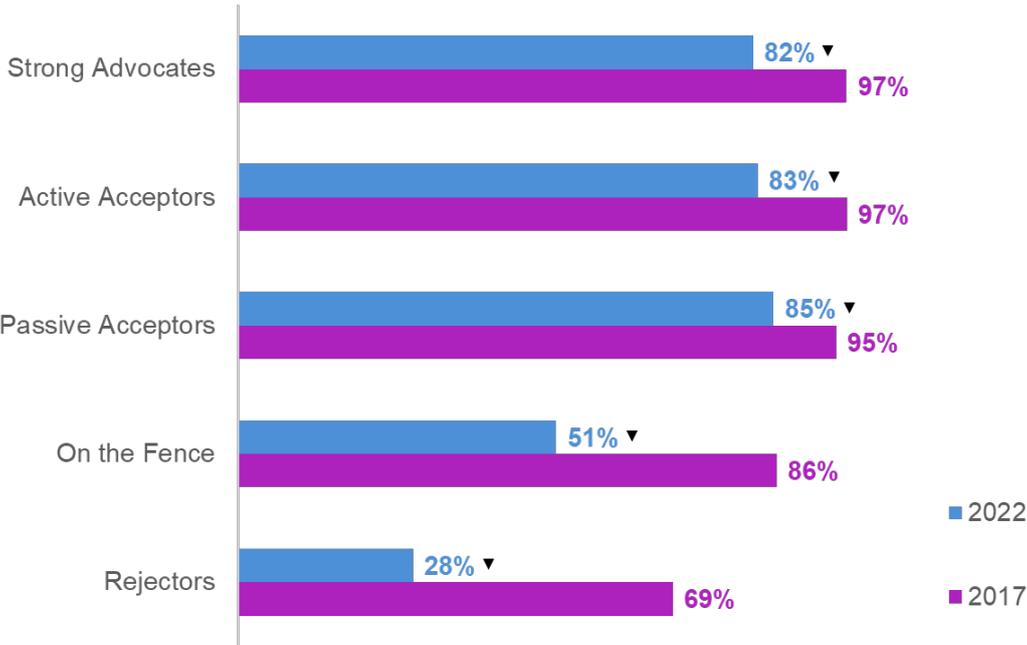
Base: 2017 / 2022 – parents of children aged 0-5 (n=872 / 619); parents of children aged 6-12 (n=328 / 400)

Whilst COVID-19 restrictions were tighter in certain states and territories in 2021 (e.g. New South Wales and Victoria), vaccination status according to parents of children aged 0-5 years and parents of children aged 6-12 years by location shows no significant differences by jurisdiction.

Upon further investigation, it is clear that this decline is apparent across all typologies – with a significant reduction across the board. The figure below shows the proportion of all children vaccinated by typology, comparing 2017 to 2022.

Figure 21. % all children vaccinated by Parent Typology – Total Parents

Q12. Have your children been immunised? Please note this does not include COVID-19 vaccinations, it only refers to the national childhood immunisation schedule of routine vaccinations recommended for children under the age of 5 years.

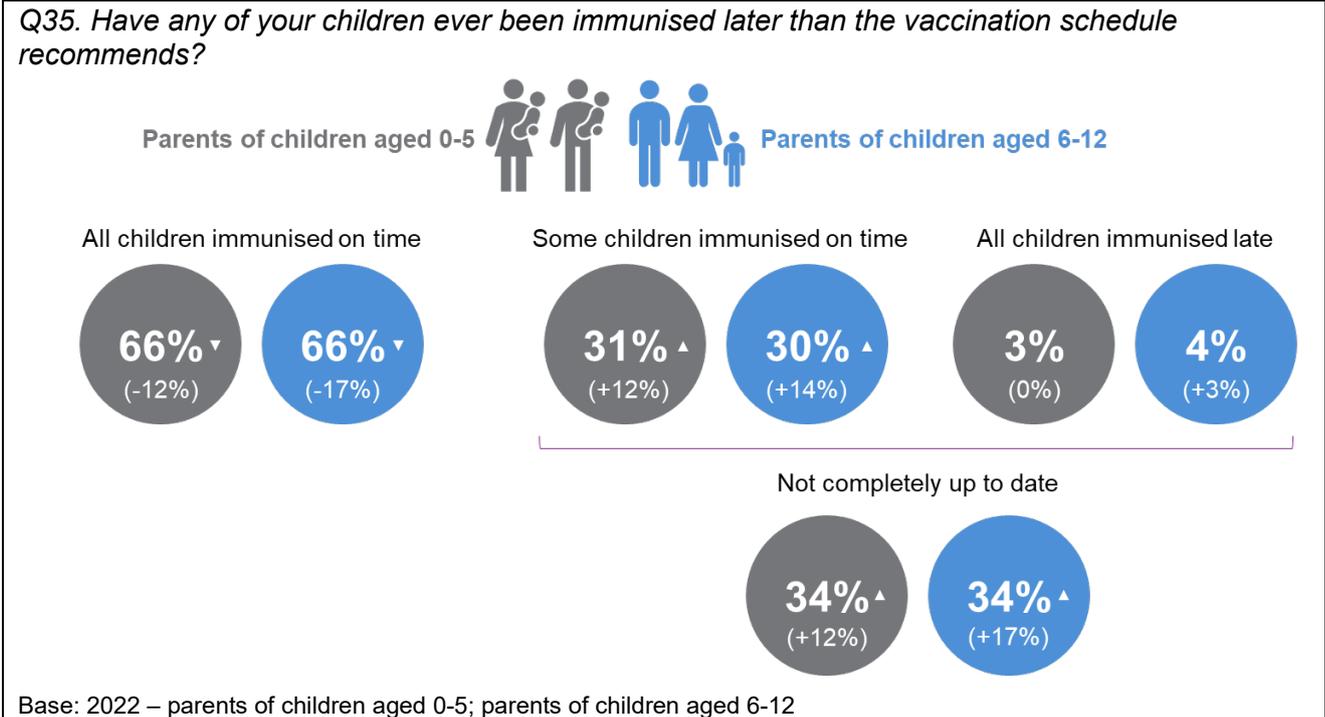


Base: 2017 / 2022 – Strong Advocates (n=237 / 265); Active Acceptors (n=313 / 339); Passive Acceptors (n=404 / 259); On the Fence (n=178 / 115); Rejectors (n=68 / 40)

9.2 On-time immunisation

There has also been a significant drop in the proportion of parents who claim that all of their children have been immunised on-time. There has been a corresponding increase in the proportion of parents who claim that *some* of their children have been immunised on-time - those who claim that none of their children have been vaccinated on-time remain stable, with no significant change since 2017. This may indicate a temporary shift in behaviour due to circumstances rather than a more fundamental shift. The figure below shows the breakdown of responses by the age of children.

Figure 22. Immunisation scheduling status (difference vs. 2017)

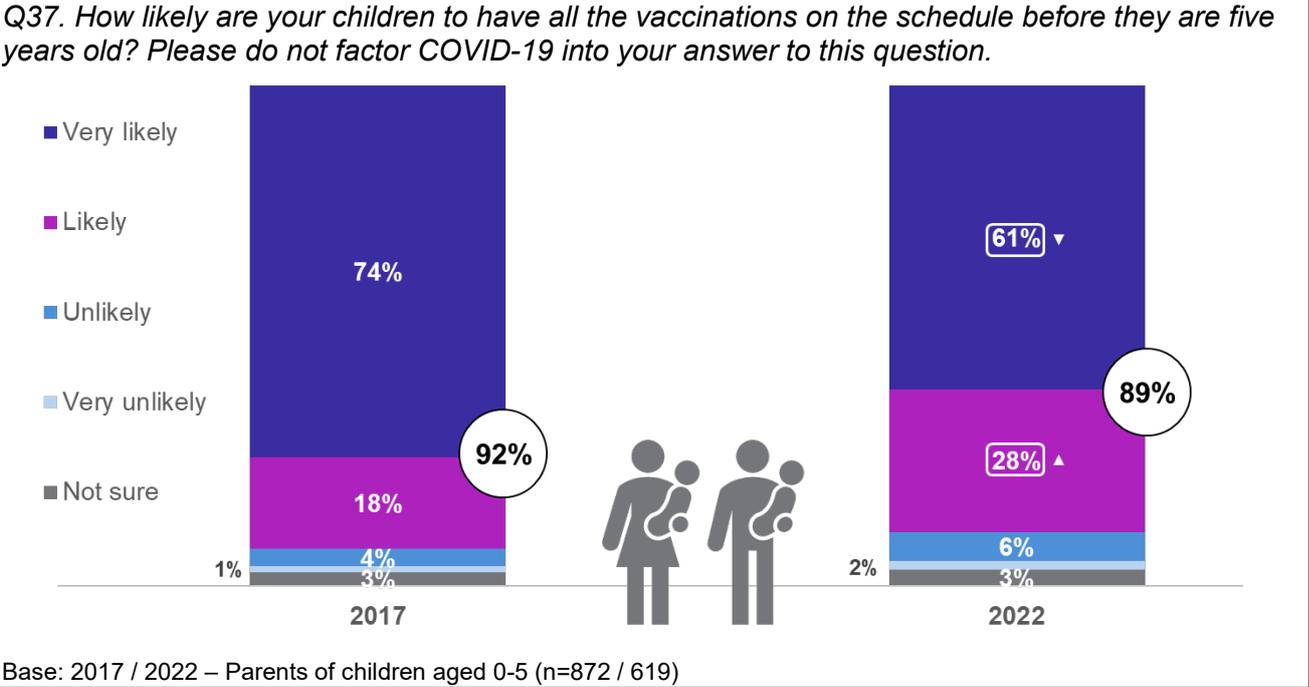


Base: 2022 – parents of children aged 0-5; parents of children aged 6-12

Parents in Victoria show slightly stronger levels of adherence to the vaccination schedule compared to parents in other states and territories, with 71% claiming that all of their children have been immunised on time.

Consistent with 2017, the vast majority of parents with children aged 0-5 years claim that their child will be likely to have all the vaccinations on the schedule before they are five years old. However, this view is held with far less certainty in 2022 than in 2017. There has been a significant decrease in those who claim it is very likely, with a corresponding increase in the proportion of those who claim it is likely. The figure below shows the breakdown of responses in 2017 and 2022.

Figure 23. Likelihood of children being up to date with the vaccination schedule before they turn 5 years old

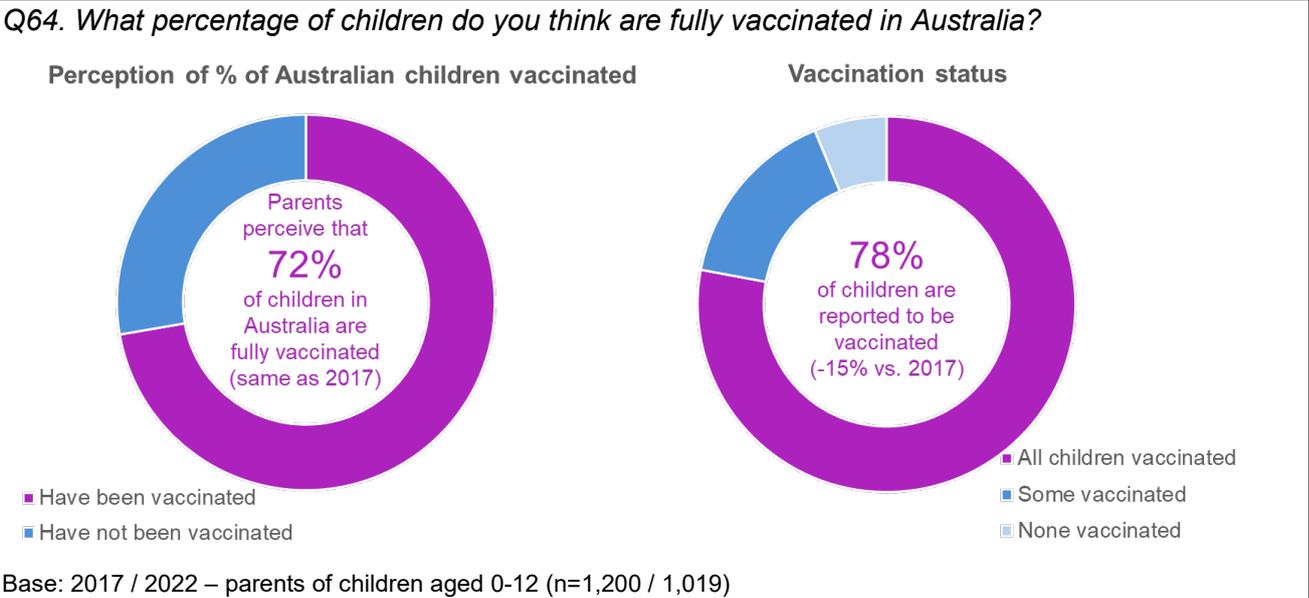


9.3 Perceived levels of childhood immunisation in the community

In 2017, the research identified a significant gap between perceived levels of childhood vaccination, vs claimed levels of vaccination – on average, parents of children aged 0-12 believed that 72 per cent of children were fully vaccinated, vs 93 per cent who claimed their children were fully vaccinated.

In 2022, the perceived levels of childhood vaccination have not changed – on average, parents of children aged 0-2 believe that 72 per cent of children are fully vaccinated in Australia. However, in 2022 only 78 per cent claim their children are fully vaccinated. While the gap between perceived and actual levels of childhood vaccination has narrowed, it has clearly not shifted in a desirable direction. The figure below shows perceived vs claimed levels of vaccination.

Figure 24. Perception of % of Australian children vaccinated



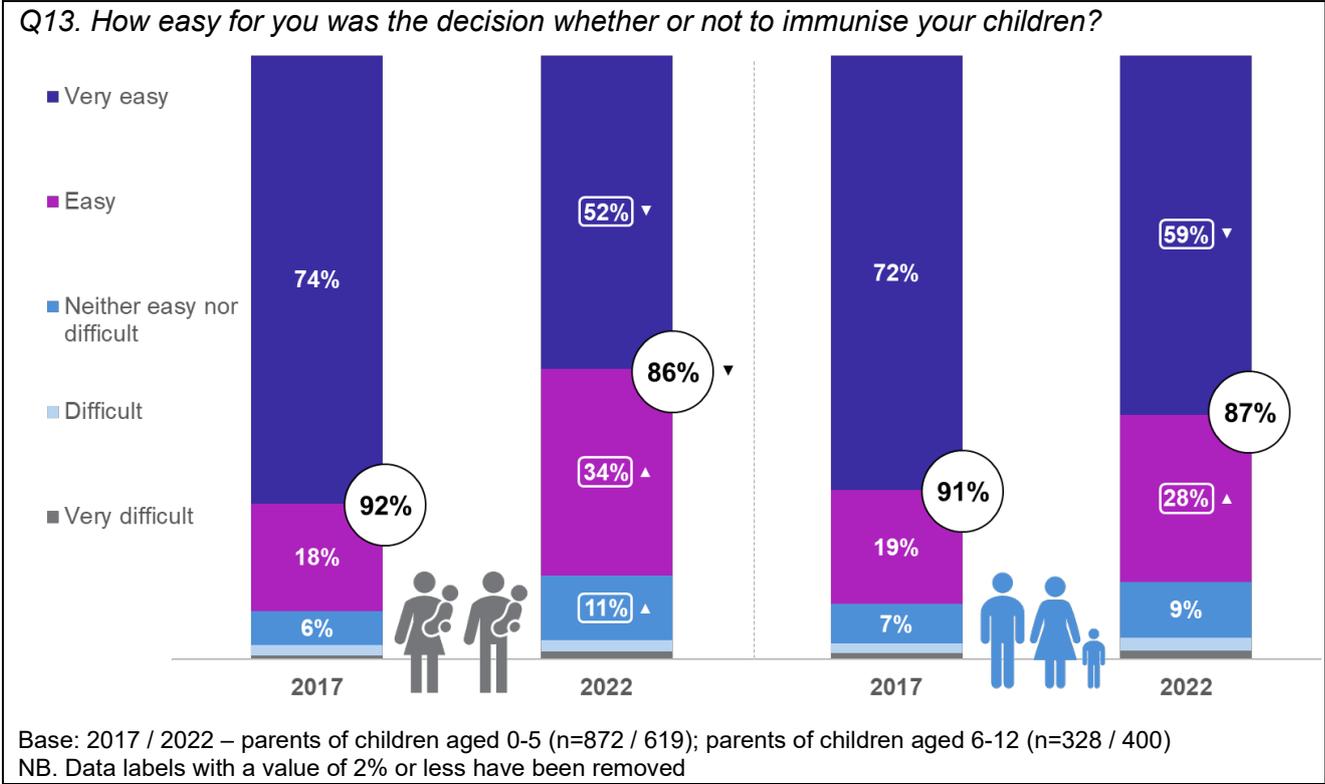
9.4 The decision of whether or not to vaccinate

Ease of the decision

The decision about whether or not to immunise children is straightforward for most parents, with a clear majority claiming that the decision is either easy or very easy. However, it is clear that this decision is less straightforward for parents in 2022 than it was in 2017. Significantly fewer parents of children aged 0-5 claim to find it easy or very easy, and within this group there has been a significant shift away from those who see the decision as being very easy. This significant shift is also evident among parents of children aged 6-12 years.

The figure below provides a breakdown of responses in 2017 and 2022, by the age of children.

Figure 25. Ease of decision whether or not to immunise children?



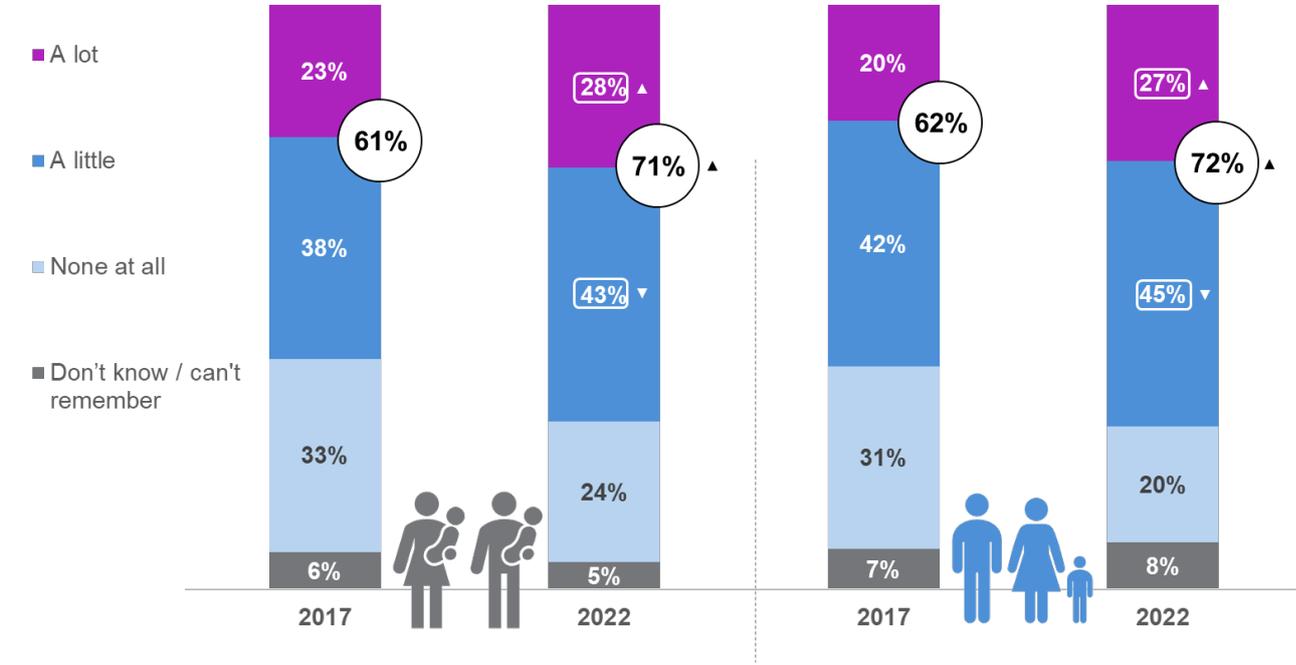
Information seeking to inform the decision

Parents are increasingly likely to have sought information to inform their decision about whether or not to vaccinate their children. Parents of children across the age spectrum are significantly less likely to claim that they made their decision without seeking any information at all. There has been a corresponding significant increase in those claiming to have undertaken a little or a lot of research, which is clearly driven by a significant increase in those who claim to have done a lot of research.

The figure below provides the breakdown of responses in 2017 vs 2022 by the age of children.

Figure 26. Research undertaken

Q14. How much information did you seek out before making the decision of whether or not to get your children vaccinated?



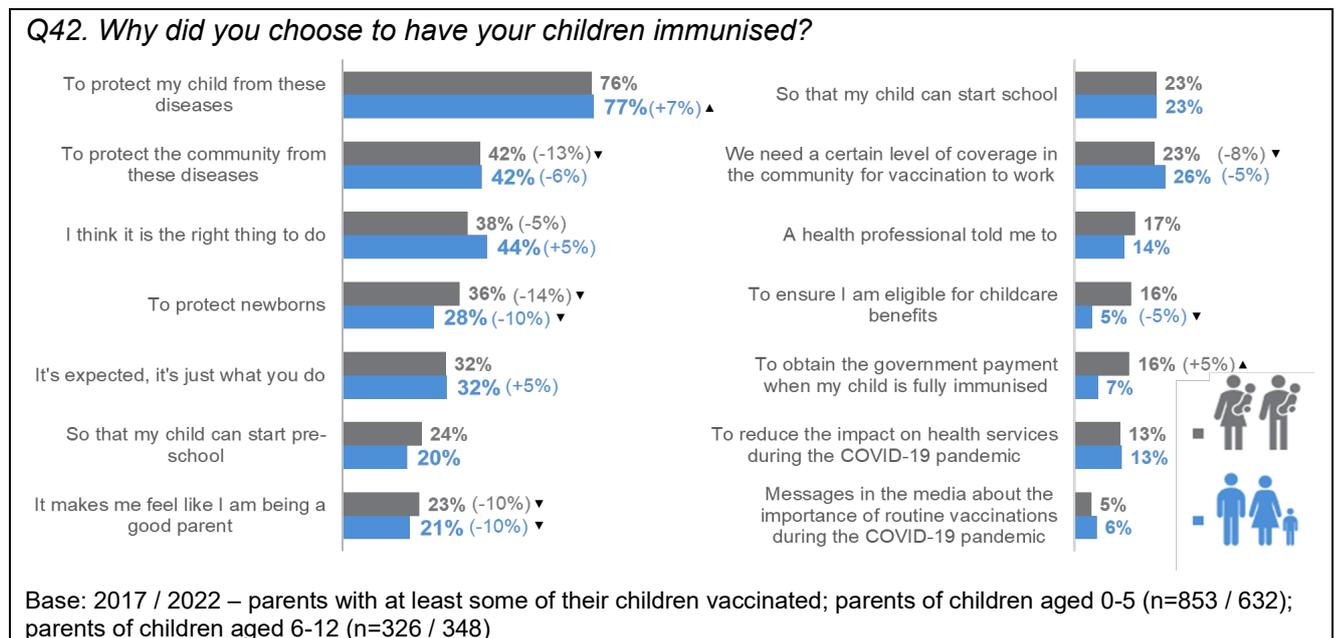
Base: 2017 / 2022 – parents of children aged 0-5 (n=872 / 619); parents of children aged 6-12 (n=328 / 400)

10. MOTIVATORS AND BARRIERS TO CHILDHOOD VACCINATION

10.1 Key motivators for childhood vaccination

Parents who had vaccinated at least some of their children were asked to identify their reasons for choosing to vaccinate. Largely consistent with 2017, the most frequently identified reasons include protecting their child from disease, protecting the community from disease, and a belief that it is the right thing to do. However since 2017, protecting the wider community from disease has significantly declined as a reason among parents of children aged 0-5 years. The figure below shows the breakdown of reasons for vaccinating.

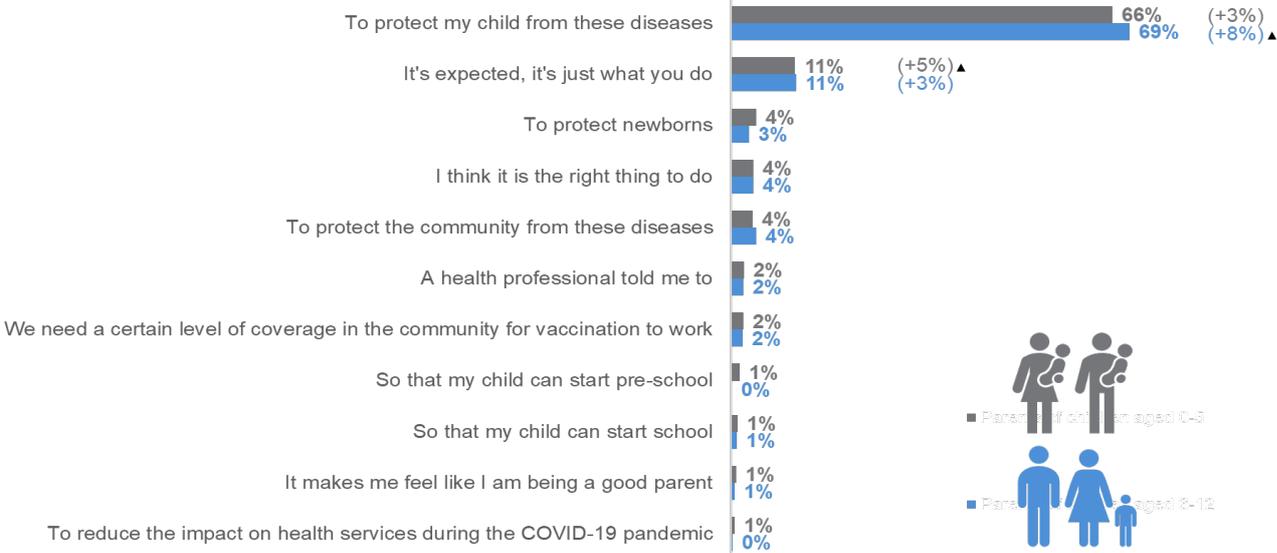
Figure 27. All reasons for vaccination (key differences vs. 2017)



Parents were subsequently asked to select the single main reason they chose to vaccinate their child(ren). Unsurprisingly, 'to protect my child from disease' is far and away the most important reason for parents of both age groups. The figure below shows the breakdown of responses.

Figure 28. Main reason for vaccination (key differences vs. 2017)

Q43. What is the main reason for having your children immunised?



Base: 2017 / 2022 – parents with vaccinated children; parents of children aged 0-5 (n=826 / 566); parents of children aged 6-12 (n=316 / 364)

When the main reason for vaccinating is examined by typology, some clear differences emerge. Strong Advocates are significantly more likely than any other typology to believe that vaccinating is expected and something you do, while OTF and Rejector parents clearly see the prospect of losing government benefits, or their child not being able to start school as being more influential than other typologies. Critically, protection from disease is the most commonly identified reason across all typologies. The table below provides a breakdown of responses by typology.

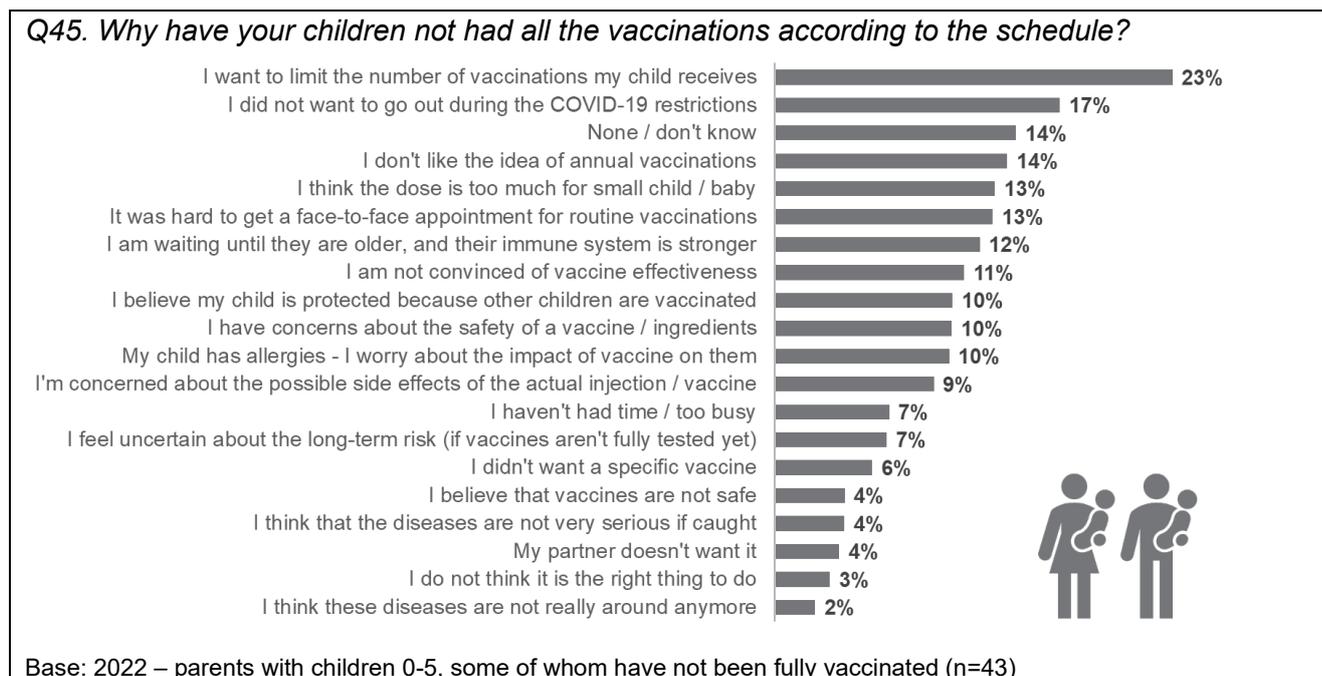
Figure 29. Main reason for having your child immunised (sig diffs vs. 2017)

| Main reason for having your child immunised (sig diffs vs. 2017) | Strong Advocates | Active Acceptors | Passive Acceptors | On the Fence [NET] | Rejectors * [NET] |
|---|------------------|------------------|-------------------|--------------------|-------------------|
| | % | % | % | % | % |
| To protect my child from these diseases | 61 | 73 | 69 | 54 | 43 ▲ |
| It's expected, it's just what you do | 17 | 5 | 13 | 11 | 14 |
| To protect the community from these diseases | 7 | 3 | 2 | 6 | 15 |
| I think it is the right thing to do | 5 | 4 | 6 | 1 | - |
| To protect newborns | 3 | 5 | 2 | 9 | 3 |
| We need a certain level of coverage vaccination to work | 3 | 2 | 1 | 2 | 6 |
| Government benefits / school start restriction (NET) | 2 | 3 | 3 | 11 | 7 |
| A health professional told me to | 1 | 4 | 1 | 2 | 8 |
| To reduce the impact on health services during the pandemic | 1 | - | - | 1 | - |
| Messages in the media about the importance of routine vaccinations during the COVID-19 pandemic | 1 | - | - | - | - |
| It makes me feel like I am being a good parent | - | 2 | 1 | - | - |

10.2 Key barriers to childhood vaccination

Those parents who had not vaccinated all of their children according to the schedule were asked to identify the reasons why. Among parents of children aged 0-5 years, the largest issues are a desire to limit the number of vaccinations their child receives, concerns about going out during COVID restrictions, and a dislike of the idea about annual vaccinations. The figure below shows the breakdown of responses for parents of children aged 0-5 years.

Figure 30. Reasons to why their children have not been vaccinated according to the schedule [all reasons amongst parents of children aged 0-5 years]



When parents of children aged 0-5 who were not fully vaccinated were asked to select their main reason for not having their child fully immunised, the role of COVID restrictions becomes more pronounced, closely followed by a desire to limit the number of vaccinations their child receives. The table below provides a breakdown of responses among this group of parents.

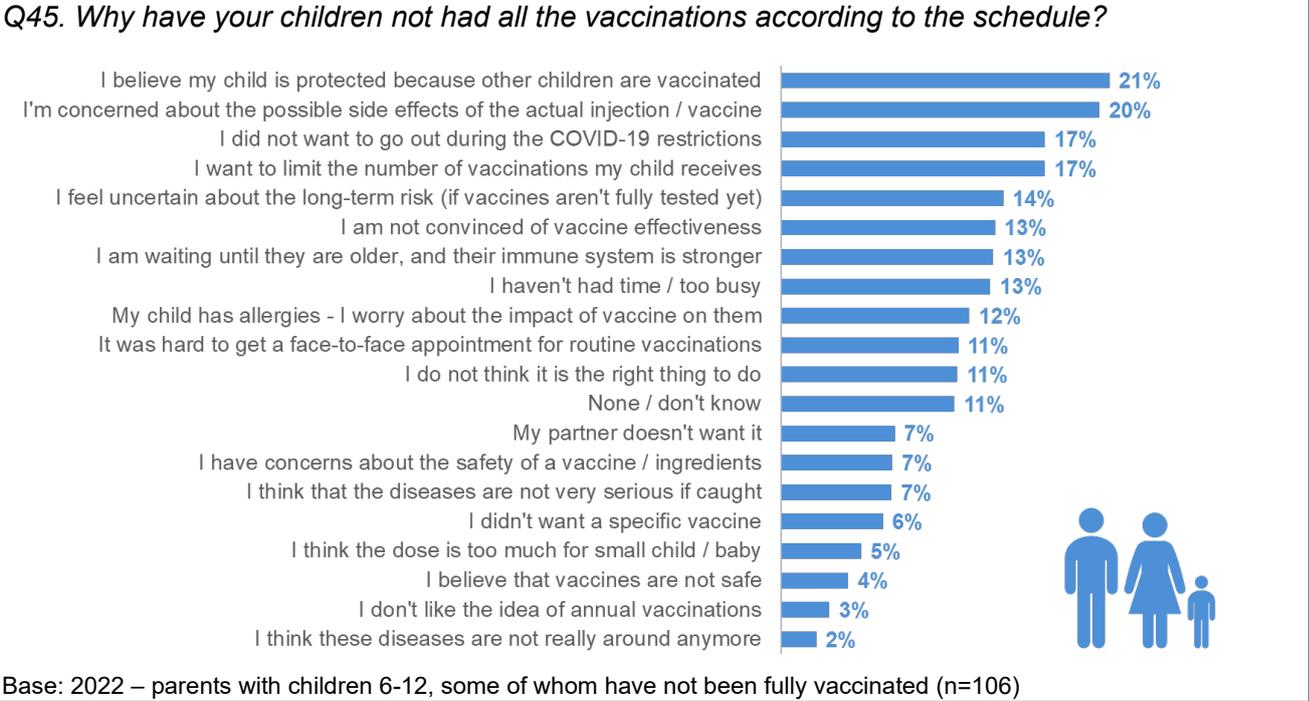
Figure 31. Main reasons why children have not been vaccinated according to the schedule

Q46. What is the main reason for not having your children fully immunised?

| Main reason for not having your children fully immunised | % |
|---|----|
| I did not want to go out during the COVID-19 restrictions | 13 |
| I want to limit the number of vaccinations my child receives | 12 |
| I am waiting until they are older and their immune system is stronger | 1 |
| I believe my child is protected because other children are vaccinated | 9 |

When asked to identify their reasons, parents of unvaccinated children aged 6-12 years also cite a number of barriers – with a belief in herd immunity, concerns about side effects and a desire not to go out during COVID restrictions topping the list of reasons. The figure below shows the breakdown of responses for parents of children aged 6-12 years.

Figure 32. Reasons why children have not had all the vaccinations according to the schedule [all reasons amongst parents of children aged 6-12 years]



When parents of children aged 6-12 years were asked to identify their main reason for not vaccinating their child, a lack of time and a belief in herd immunity are most frequently cited. The table below provides a breakdown of responses.

Figure 33. Main reason for not having your children fully immunised

Q46. What is the main reason for not having your children fully immunised?

| Main reason for not having your children fully immunised | % |
|---|----|
| I haven't had time / too busy | 15 |
| I believe my child is protected because other children are vaccinated | 15 |
| I'm concerned about the possible side effects of the actual injection / vaccine | 11 |
| I did not want to go out during the COVID-19 restrictions | 10 |

Looking at barriers by typology, it is clear that parents who are OTF and Rejectors again have quite specific concerns relative to other typologies. These groups are clearly far more concerned about the potential for negative reactions; the number of combined vaccines given at once; the young age

at which vaccinations commence; and the potential for vaccine ingredients to have long-term health impacts. The table below shows a breakdown of concerns by typology.

Figure 34. Vaccinations concerns by typology

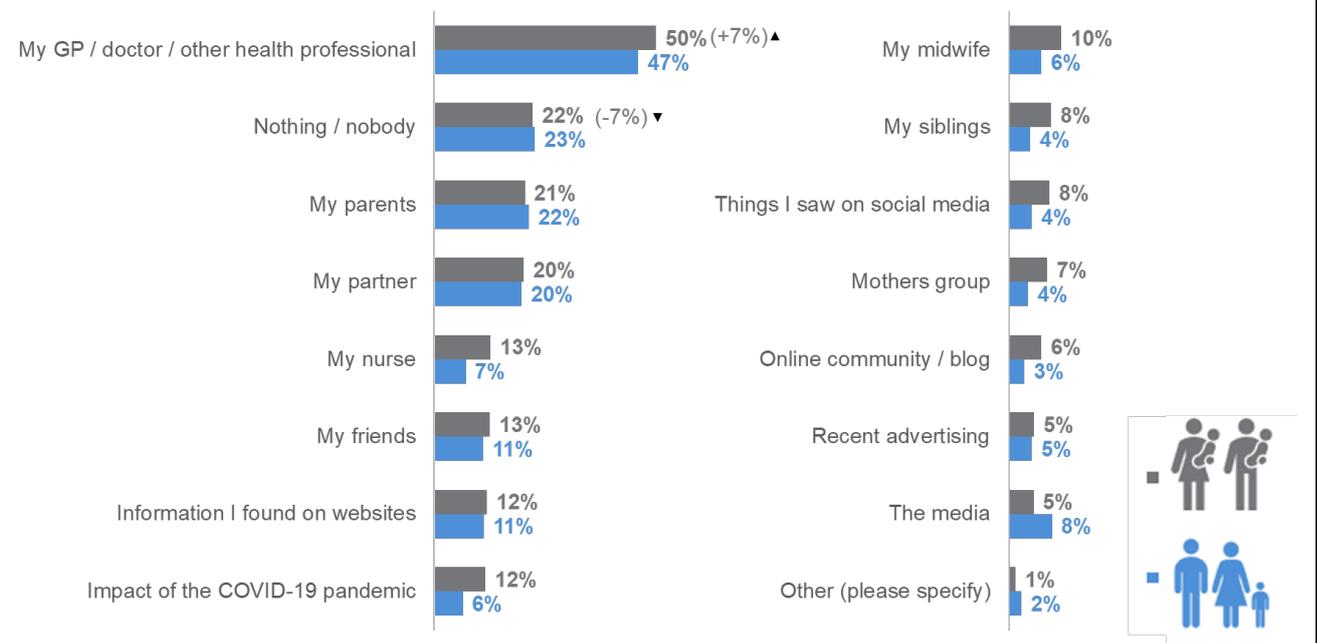
| Vaccination concerns by typology | Strong Advocates | Active Acceptors | Passive Acceptors | On the Fence [NET] | Rejectors* [NET] |
|---|------------------|------------------|-------------------|--------------------|------------------|
| | % | % | % | % | % |
| I worry that my child would be in discomfort when receiving the vaccine | 39 | 56 | 38 | 65 | 66 |
| I worry that my child could have a bad reaction to the vaccine | 36 | 46 | 41 | 71 | 76 |
| I don't like that they are given so many combined vaccines at once | 33 | 34 | 24 | 67 | 73 |
| I don't like the idea of foreign matter being injected into my child | 32 | 29 | 20 | 62 | 69 |
| I don't like that they are so young when vaccination starts | 30 | 31 | 21 | 66 | 70 |
| I worry that vaccines may contain ingredients which could have long-term health impacts | 28 | 25 | 19 | 70 | 82 |
| I am not sure how safe the vaccinations are | 26 | 24 | 18 | 58 | 57 |

11. KEY INFLUENCES ON PARENTAL ATTITUDES AND BEHAVIOUR

11.1 The important role of health professionals

Consistent with 2017, GPs and other health professionals remain the key influence on childhood immunisation for parents, with parents of children aged 0-5 significantly more likely to nominate them as an influence than they did in 2017. While there are clearly other influencers, none come close to the role played by health professionals, as shown in the figure below.

Figure 35. Influencers for childhood vaccination (key differences vs. 2017)
 Q44. Which, if any, of the following influenced you to have your children vaccinated? Please do not factor COVID-19 into your answer to this question



Base: 2017 / 2022 – parents with vaccinated children; parents of children aged 0-5 (n=853 / 578); parents of children aged 6-12 (n=326 / 375)

When examining responses by typology, it is clear that parents who are OTF and Rejectors turn to a broader range of influencers than those from other typologies. In particular, these groups seem more likely to nominate friends, midwives and the media. The table below shows the breakdown of responses by typology.

Figure 36. Influencers for childhood vaccination by typology

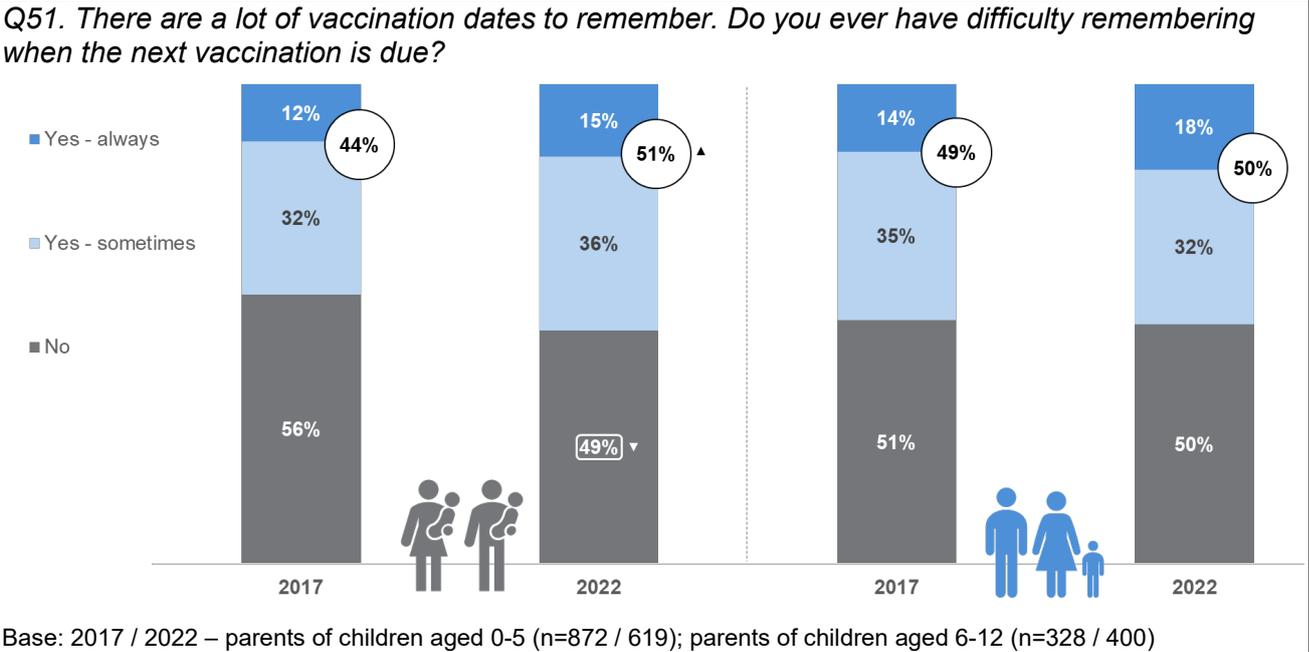
| Influencers for childhood vaccination by typology | Strong Advocates | Active Acceptors | Passive Acceptors | On the Fence [NET] | Rejectors* [NET] |
|---|------------------|------------------|-------------------|--------------------|------------------|
| | % | % | % | % | % |
| My GP / doctor / other health professional | 49 | 50 | 46 | 43 | 35 |
| Nothing / nobody | 17 | 21 | 34 | 27 | 18 |
| My parents | 19 | 23 | 18 | 27 | 24 |
| My partner | 22 | 21 | 15 | 18 | 30 |
| My friends | 12 | 11 | 11 | 23 ▲ | 23 |
| Information I found on websites | 14 | 12 | 8 | 11 | 12 |
| My nurse | 12 | 11 | 7 | 16 | 13 |
| Impact of the COVID-19 pandemic | 17 | 7 | 2 | 13 | 28 |
| My midwife | 9 | 8 | 8 | 11 | 22 |
| The media | 10 | 4 | 6 | 8 | 17 |

ADHERENCE TO THE NIP SCHEDULE

11.2 The role of reminders

Around half of all parents claim to have difficulty remembering when their child's next vaccination is due. Among parents of children aged 0-5, there has been a significant increase in those who claim to experience this difficulty since 2017. The figure below shows the breakdown of responses by age of children.

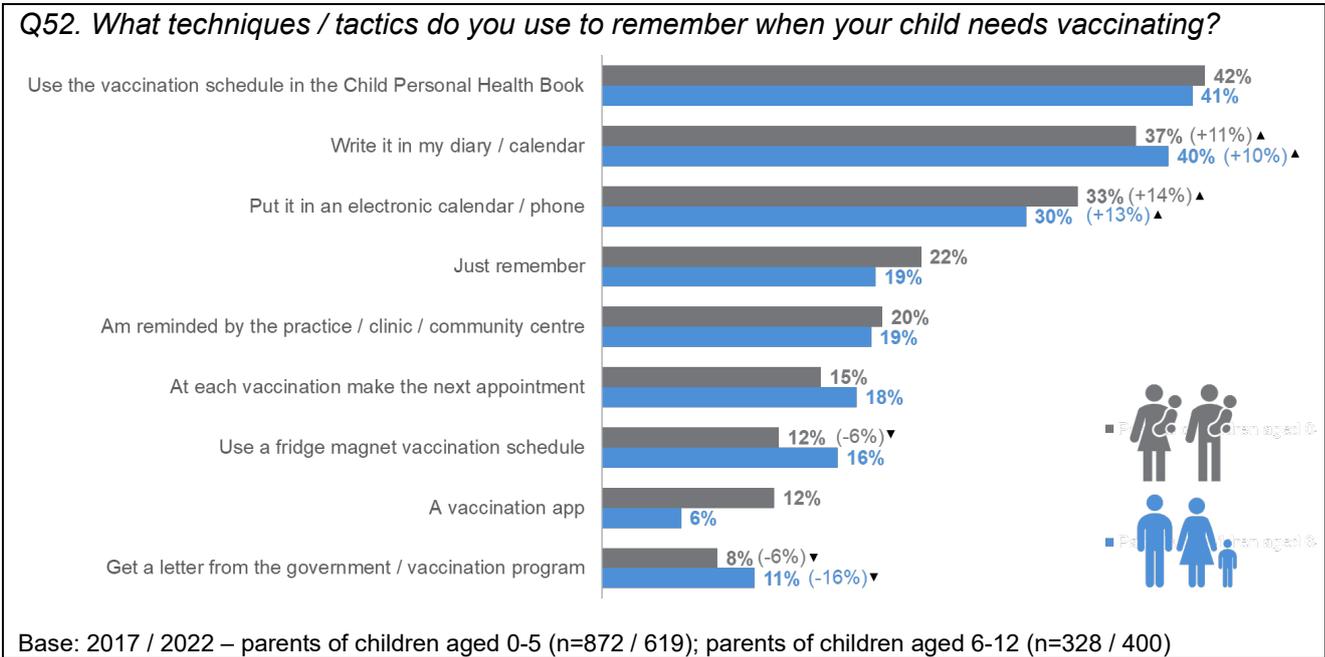
Figure 37. Vaccination date memory



There are various techniques and tactics used by parents to remember when their children are due for vaccinations. Consistent with 2017, the 'blue book' remains the number one resource for parents, but it is clear that in 2022 digital tools are increasingly prevalent, with significantly higher numbers of parents using diaries and mobile phones as reminder tools.

The figure below shows the breakdown of responses by age of children.

Figure 38. Techniques used to remember when child needs vaccinating (key differences vs. 2017)



11.3 The perceived importance of on-time vaccination

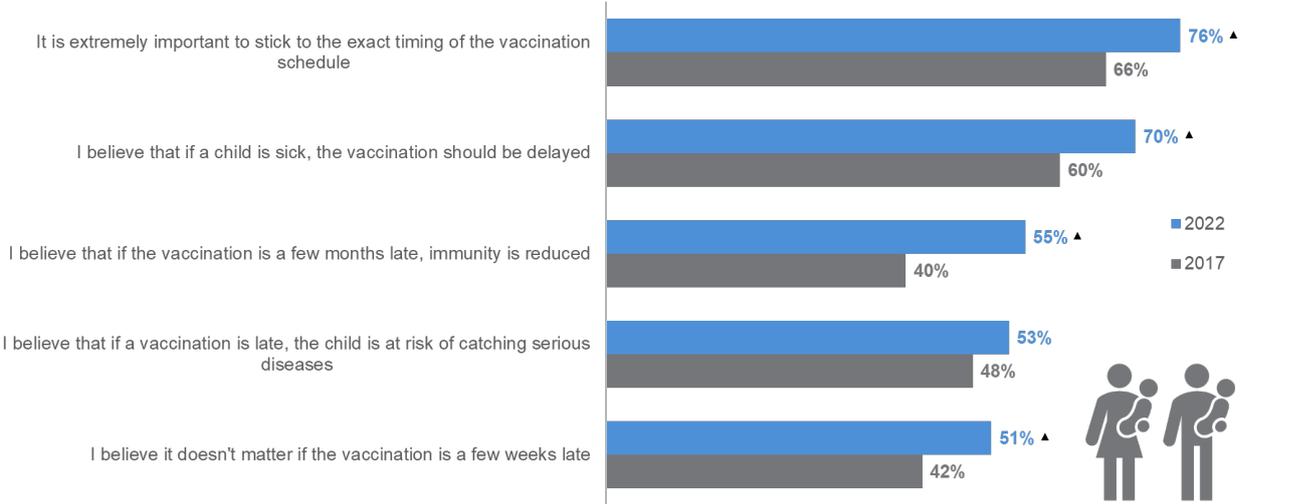
Parents of children aged 0-5 years appear to have an increased understanding of the importance of on-time vaccination. In 2022, significantly more parents agree that it is important to stick to the exact schedule; and that if the vaccination is a few months late, immunity is reduced. However, it seems apparent that while ‘on-time’ is broadly seen as important, an increasing proportion of parents believe that it doesn’t matter if the vaccination is a few weeks late – suggesting that further work is required to explain precisely what ‘on-time’ actually means.

Significantly more parents of children aged 0-5 are also more likely to agree that if a child is sick, the vaccination should be delayed. Based on qualitative findings in this study, it seems likely that the definition of ‘sick’ varies from parent to parent, with some likely to see minor illness, rather than a fever, as the threshold at which immunisation should be delayed.

The figure below shows levels of agreement with a range of statements about vaccine timing among parents of children aged 0-5 years, with comparisons between 2017 and 2022.

Figure 39. Attitudes to the immunisation schedule – parents of children aged 0-5 [% strongly agree / agree]

Q63. Below are some beliefs that some parents hold about childhood vaccination and vaccines. Please indicate how strongly you agree or disagree with each statement. Q67. Please indicate how strongly you agree or disagree with each of the following statements about childhood vaccination

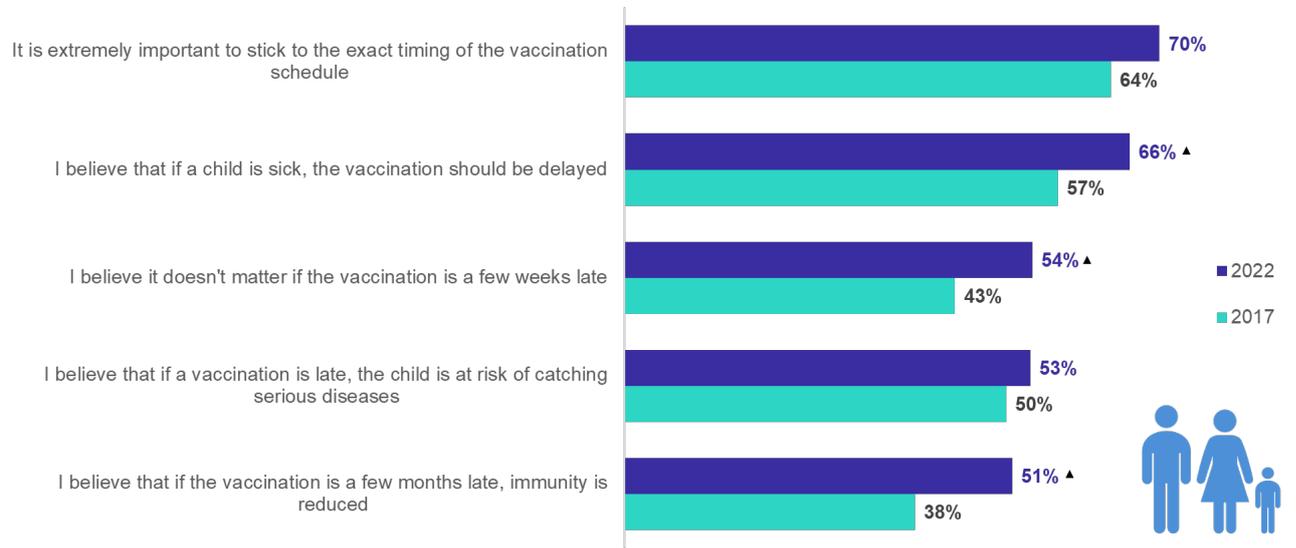


Base: 2017 / 2022 – parents of children aged 0-5 (n=872 / 619)

Findings among parents of children aged 6-12 years are largely consistent, with fewer significant changes than seen among parents of children aged 0-5. The figure below shows the breakdown of responses among this group of parents.

Figure 40. Attitudes to the immunisation schedule – parents of children aged 6-12 [% strongly agree / agree]

Q63. Below are some beliefs that some parents hold about childhood vaccination and vaccines. Please indicate how strongly you agree or disagree with each statement. Q67. Please indicate how strongly you agree or disagree with each of the following statements about childhood vaccination



Base: 2017 / 2022 – parents of children aged 6-12 (n=328 / 400)

11.4 Claimed reasons for late vaccination

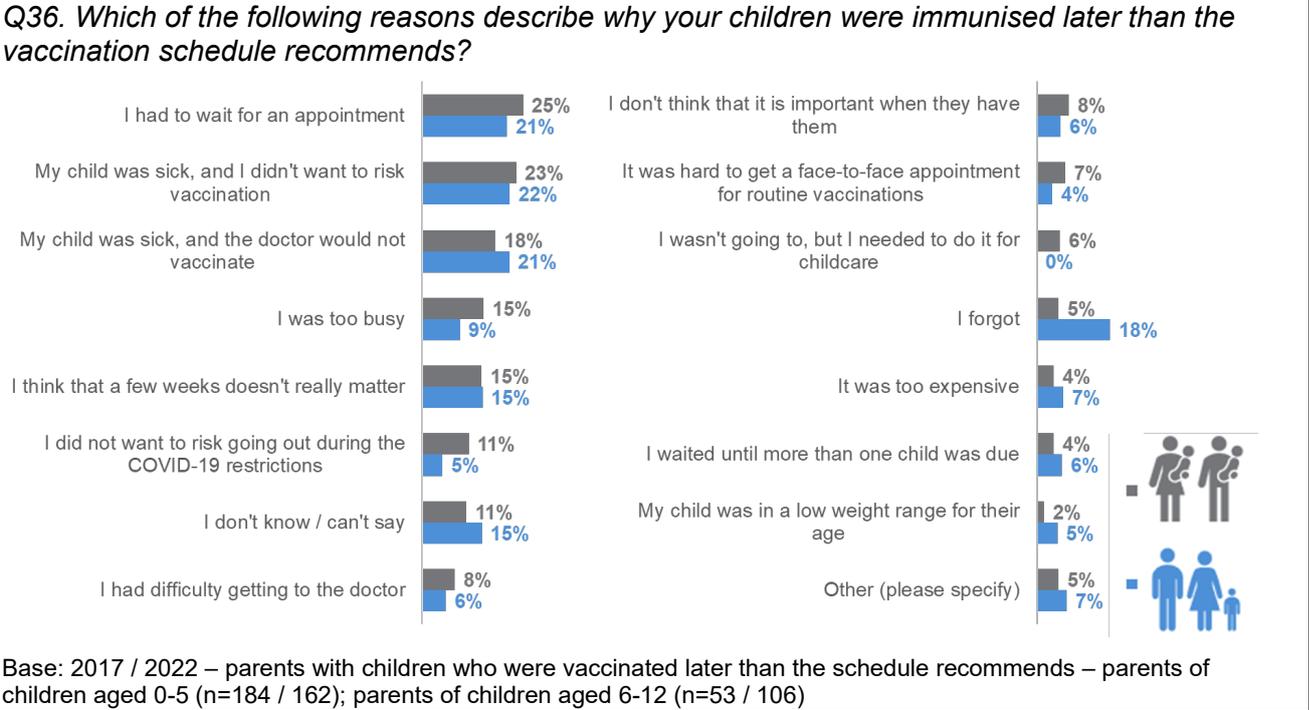
Parents of children who were vaccinated later than the schedule recommends were asked why. Overall, there appear to be two core reasons behind delayed vaccination in 2022 – child sickness; and difficulties in obtaining a timely appointment, exacerbated by issues related to COVID.

The single largest reason for delays in 2022 was childhood sickness. 37 per cent of parents of children aged 0-5, and 33 per cent of parents of children aged 6-12 claim to have delayed due to sickness – either based on their own judgement or that of a health professional.

Issues related to appointments were highlighted for 30 per cent of parents of children aged 0-5 years; and for 25 per cent of parents of children aged 6-12 years, with COVID-related issues clearly driving this to a point.

The figure below shows all reasons for delays, cut by the age of children.

Figure 41. Reasons for late childhood vaccination (key differences vs. 2017)



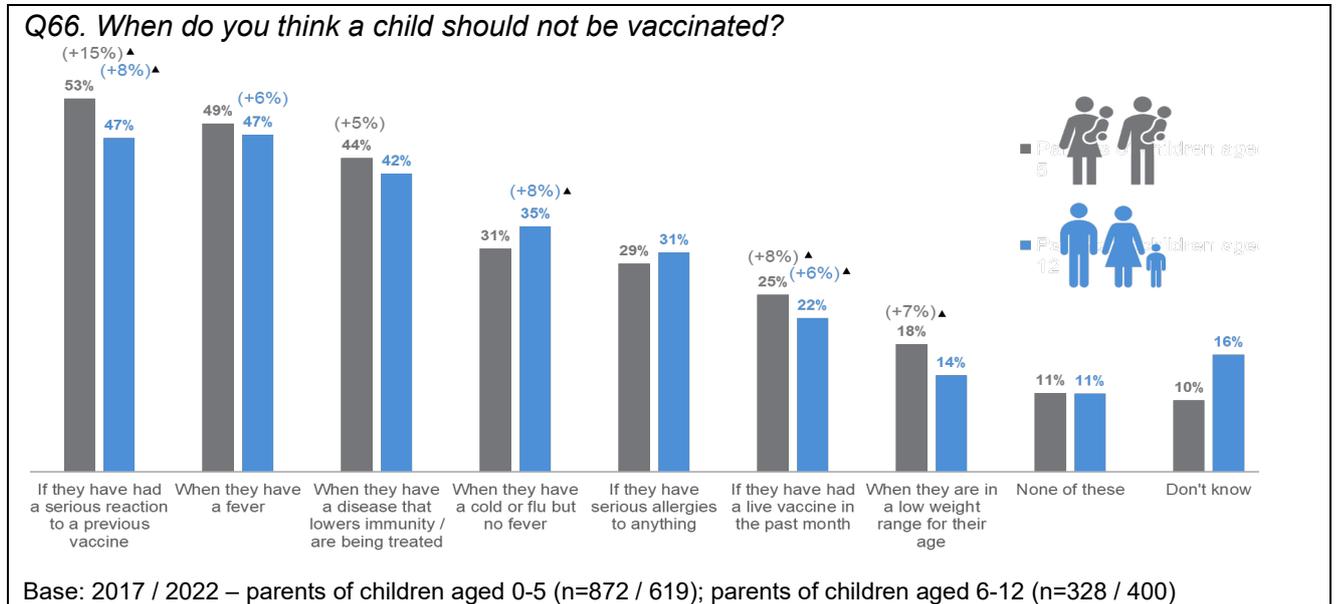
11.5 Opinions about when children should not be vaccinated

Parents were asked when they believe a child should not be vaccinated. Roughly half of parents believe that children should not be vaccinated if they have experienced a bad reaction in the past, or if they currently have a fever.

In 2022, significantly more parents believe that previous reactions should preclude vaccination, as well as if children have received a live vaccine in the past month. Based on qualitative findings, the live vaccine issue is likely to be driven by a consistent message during the initial national COVID vaccine rollout about the importance of separating COVID vaccines from other vaccines (e.g. influenza).

The figure below shows when parents believe a child should not be vaccinated – data in brackets shows the percentage change in 2022 from 2017.

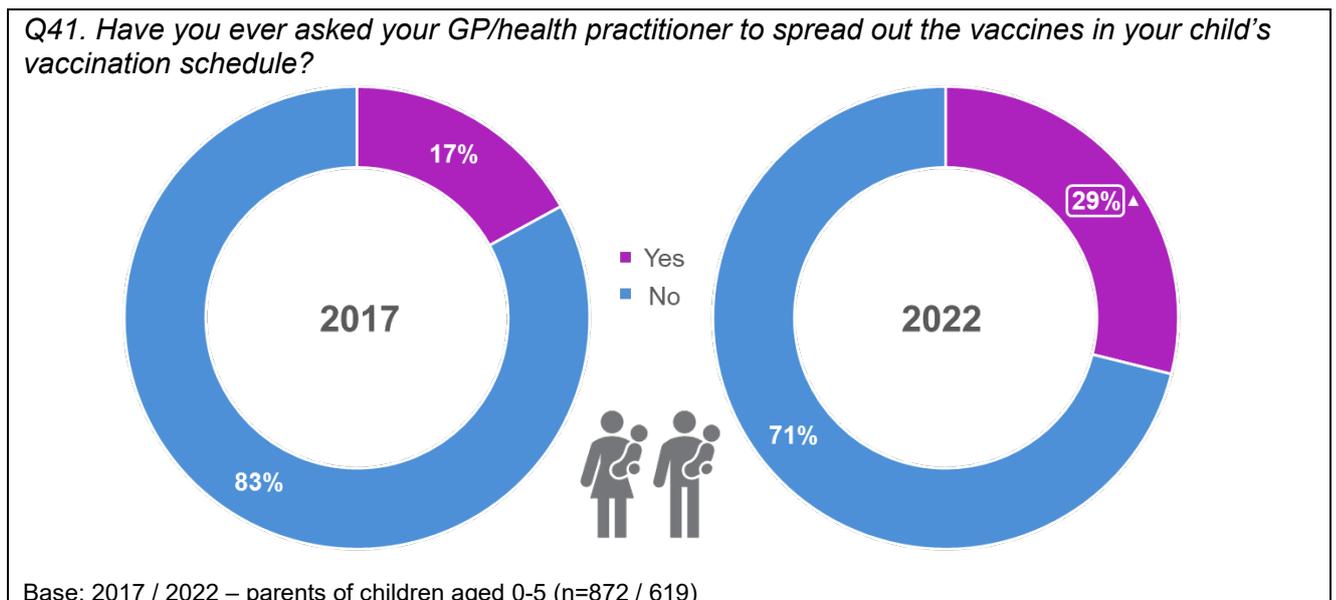
Figure 42. Opinion of when children should not be vaccinated (key differences vs. 2017)



11.6 Requests to spread out the timing of vaccines

Parents were asked whether they had ever asked their GP or health professional to spread out the vaccines in their child's schedule. In 2017, 17 per cent of parents indicated that they had done so, while in 2022 this has significantly increased to 29 per cent. This increase further reinforces the growing sense of concern about childhood vaccination, and demonstrates that these concerns are having a practical impact on behaviour. The figure below shows the breakdown of responses across the two periods.

Figure 43. Requests to spread out the timing of vaccines

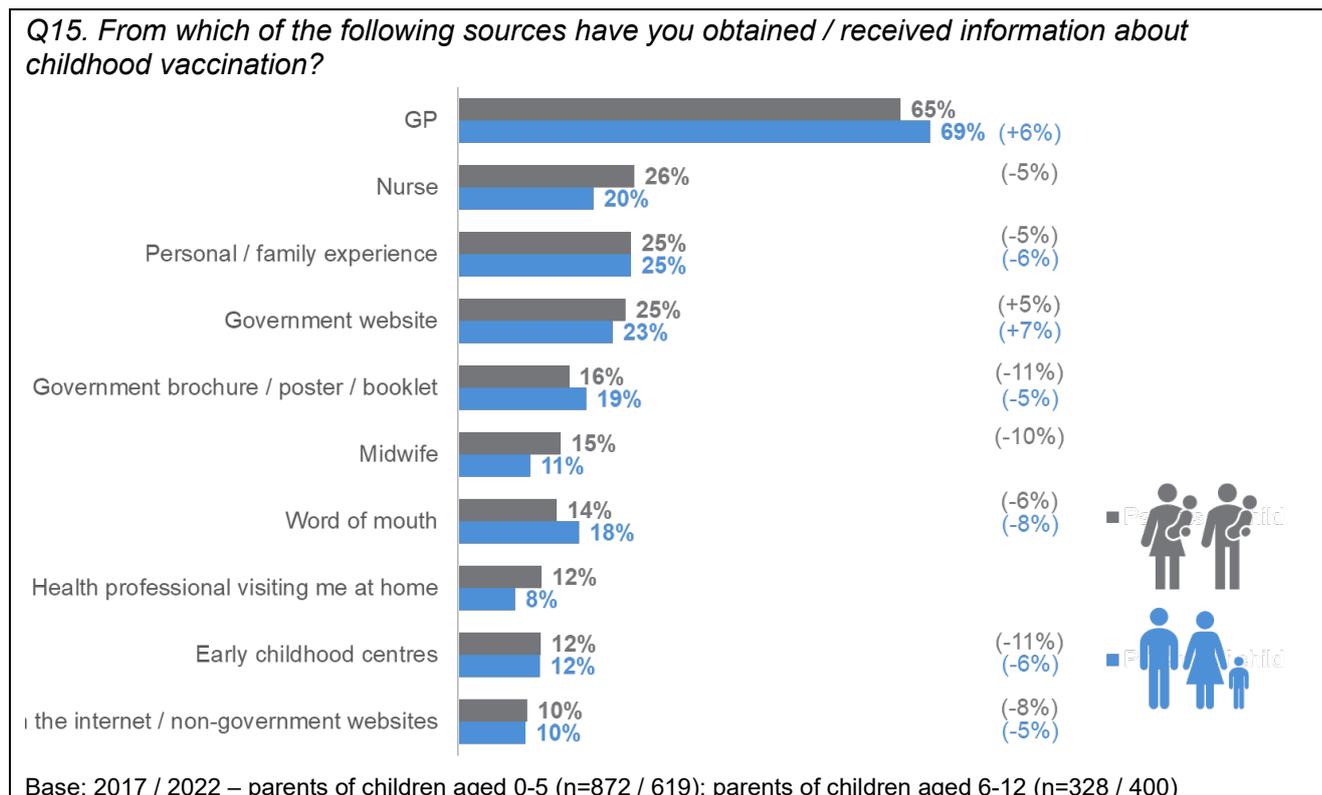


12. INFORMATION SOURCES AND NEEDS

12.1 Key sources of information about childhood vaccination

GPs remain the go-to resource for parents seeking information about childhood vaccination – when asked to nominate all of the sources they obtain or receive information about the topic, parents resoundingly identify GPs as the most common source. Other sources include nurses and midwives, family, as well as government websites and other collateral. The figure below shows key sources of information, split by age of child.

Figure 44. Information sources – top 10 (key differences vs. 2017)

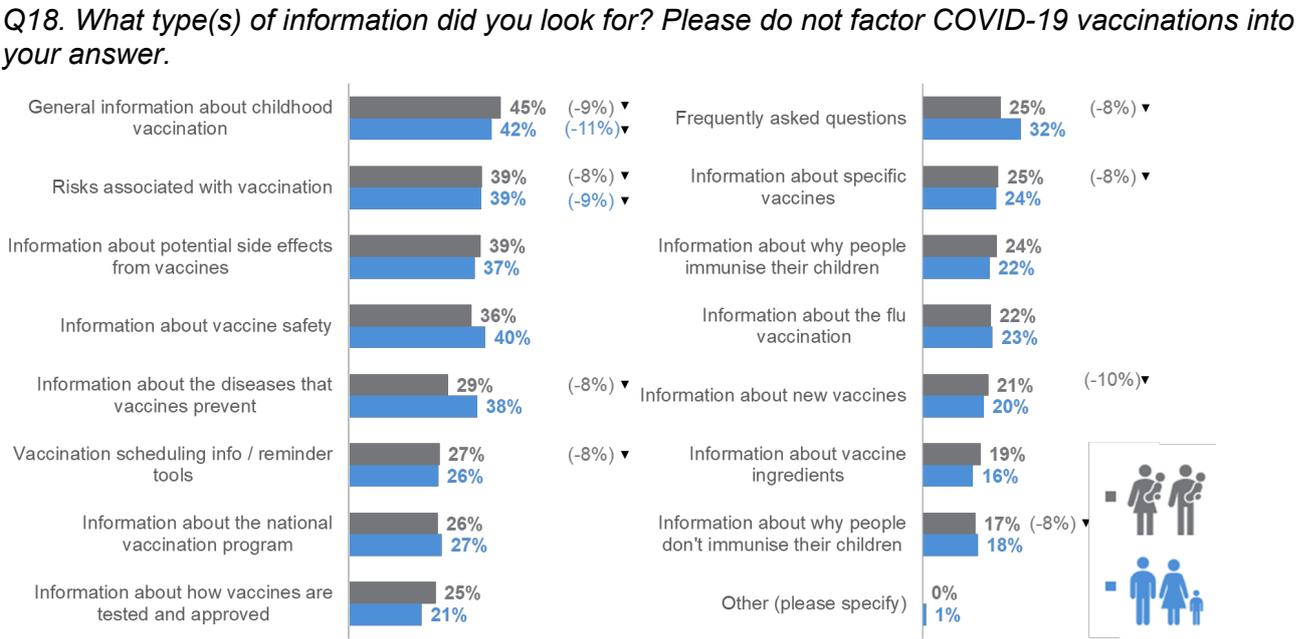


12.2 Types of information sought

Those parents who indicated that they sought a lot / a little information before deciding whether to vaccinate their children were asked about the type of information they were interested in. Consistent with 2017, parents are most frequently seeking general information about childhood vaccination, though it is clear that many have questions about risks, side effects and vaccine safety. Since 2017 there have been a range of significant decreases in levels of interest in certain types of information, with no obvious corresponding increases.

The figure below shows the types of information sought, with key differences since 2017 identified in brackets.

Figure 45. Types of information sourced (key differences vs. 2017)



Base: 2017 / 2022 – sought a lot / a little information before making the decision of whether or not to get your child vaccinated; parents of children aged 0-5 (n=530 / 442); parents of children aged 6-12 (n=204 / 291)

When responses to this question are broken down by typology, it is clear that OTF and Rejectors are more likely to seek out information about vaccine safety, ingredients, and reasons why other people choose not to vaccinate their children.

The table below shows the breakdown of responses by typology.

Figure 46. Types of information sourced (key differences vs. 2017)

| Types of information sourced | Strong Advocates | Active Acceptors | Passive Acceptors | On the Fence [NET] | Rejectors* [NET] |
|--|------------------|------------------|-------------------|--------------------|------------------|
| | % | % | % | % | % |
| General information about childhood vaccination | 38 | 49 | 43 | 41 | 46 |
| Risks associated with vaccination | 44 | 37 | 30 | 48 | 39 |
| Information about the potential side effects from vaccines | 36 | 38 | 39 | 41 | 37 |
| Information about vaccine safety | 36 | 37 | 32 | 51 | 47 |
| Information about how vaccines are tested and approved | 26 | 24 | 18 | 26 | 31 |
| Information about why people immunise their children | 27 | 19 | 18 | 35 | 24 |
| Information about new vaccines | 31 | 20 | 9 | 19 | 14 |
| Information about vaccine ingredients | 18 | 14 | 14 | 30 | 35 |
| Information about why people don't immunise their children | 16 | 15 | 13 | 29 | 31 |

Base: 2022 – sought a lot / a little information before making the decision of whether or not to get your child vaccinated; Strong Advocates

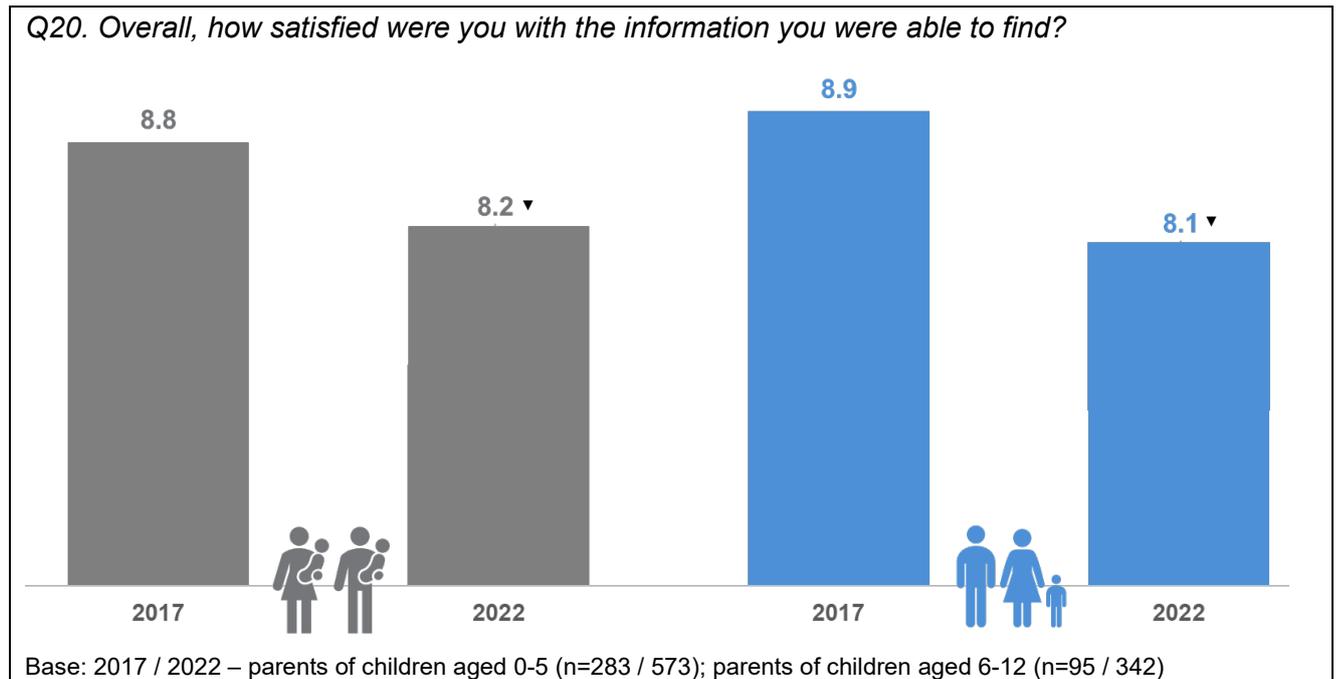
* Caution: Low base

12.3 Satisfaction with information obtained

Overall satisfaction

Parents who sought information were also asked to score their levels of satisfaction with it, using a 10-point scale. In 2022, overall satisfaction with the information obtained remains positive, despite a significant decline in this rating across both age groups since 2017. The figure below shows satisfaction scores, split by child age.

Figure 47. Satisfaction with information obtained



Rating of specific information sources against key measures

Parents who indicated that they had used a particular information source were asked to rate that source of information against a number of key measures including the extent to which the information was balanced, fact-based, easy to understand, trustworthy, easy to find, up-to-date and engaging, among others.

Analysis of these responses among parents of children aged 0-5 indicates that overall satisfaction with all sources of information is relatively high – almost all mean scores are above 8. However, it is clear that information obtained from GPs and nurses, as well as government brochures / booklets is particularly highly rated across the majority of measures.

The figure below shows the mean score for each source of information across these key measures. For ease of interpretation, any measure which obtains a mean score above 8.5 is highlighted in green.

Figure 48. Government information source – performance rating (mean score out of 10)



| Government information source – performance rating (mean score out of 10) | GP | Nurse | Gov't website | Midwife | HCP visiting me at home | Gov't brochure/poster / booklet | Early childhood centres |
|---|-----|-------|---------------|---------|-------------------------|---------------------------------|-------------------------|
| Information was balanced | 8.5 | 8.5 | 8.0 | 8.1 | 8.3 | 8.4 | 8.4 |
| Information was fact-based | 8.6 | 8.6 | 8.3 | 8.3 | 8.4 | 8.6 | 8.9 |
| Information was easy to understand | 8.6 | 8.5 | 8.3 | 8.5 | 8.1 | 8.7 | 8.6 |
| Information was trustworthy | 8.7 | 8.6 | 8.4 | 8.5 | 8.5 | 8.6 | 8.4 |
| Information was easy to find | 8.4 | 8.5 | 8.3 | 8.4 | 8.2 | 8.6 | 8.5 |
| Information was consistent with government / official sources | 8.5 | 8.6 | 8.3 | 8.5 | 8.2 | 8.7 | 8.2 |
| Information was up-to-date | 8.7 | 8.6 | 8.5 | 8.2 | 8.4 | 8.5 | 8.5 |
| Information was well-researched | 8.5 | 8.6 | 8.0 | 8.0 | 8.3 | 8.5 | 8.4 |
| Information answered my questions | 8.7 | 8.6 | 8.3 | 8.3 | 8.5 | 8.5 | 8.4 |
| Information was engaging | 8.3 | 8.2 | 8.3 | 7.8 | 8.3 | 8.0 | 8.4 |

Base: 2022 – parents of children 0-5 and selected information source in their top 3 sources; GP (n=231); Nurse (n=99); Government website (n=86); Midwife (n=51); Health professional visiting me at home (n=44); Government brochure / poster / booklet (n=44); early childhood centres (n=42)

Analysis of responses among parents of children aged 6-12 similarly indicates a strong response overall across the board, with stand-outs being information received from GPs, Nurses, government brochures etc as well as early childhood centres – suggesting that for older parents, these centres have played an important role in delivering high-quality information about childhood immunisation. While parents may not currently be engaging with early childhood centres, it is entirely likely that they have been an important source of information in the past. The table below provides the breakdown of mean scores, again using a green highlight for any scores above 8.5.

Figure 49. Government information source – performance rating (mean score out of 10)



| Government information source – performance rating (mean score out of 10) | GP | Nurse | Gov’t website | Midwife* | HCP visiting me at home* | Gov’t brochure/poster / booklet* | Early childhood centres* |
|---|-----|-------|---------------|----------|--------------------------|----------------------------------|--------------------------|
| Information was balanced | 8.2 | 8.2 | 8.0 | 8.3 | 7.7 | 8.2 | 8.5 |
| Information was fact-based | 8.4 | 8.5 | 8.4 | 8.5 | 8.1 | 8.5 | 8.8 |
| Information was easy to understand | 8.5 | 8.7 | 8.4 | 8.6 | 7.9 | 8.6 | 8.8 |
| Information was trustworthy | 8.6 | 8.7 | 8.5 | 8.4 | 7.7 | 8.7 | 8.7 |
| Information was easy to find | 8.6 | 8.5 | 8.6 | 8.4 | 8.1 | 8.7 | 8.8 |
| Information was consistent with government / official sources | 8.5 | 8.3 | 8.6 | 8.3 | 7.8 | 8.6 | 8.7 |
| Information was up-to-date | 8.5 | 8.6 | 8.5 | 8.4 | 7.9 | 8.8 | 8.7 |
| Information was well-researched | 8.4 | 8.5 | 8.4 | 8.4 | 7.8 | 8.5 | 8.4 |
| Information answered my questions | 8.5 | 8.6 | 8.3 | 8.5 | 8.2 | 8.4 | 8.6 |
| Information was engaging | 8.0 | 8.1 | 8.0 | 8.5 | 8.1 | 8.4 | 8.3 |

Base: 2022 – parents of children 0-5 and selected information source in their top 3 sources; GP (n=126); Nurse (n=48); Government website (n=55); Midwife (n=29); Health professional visiting me at home (n=22); Government brochure / poster / booklet (n=38); early childhood centres (n=28)
 *Caution: Low base

13. RECOMMENDATIONS

13.1 Consider an intervention to reinforce support for the program

It is very clear from this research that support overall for childhood vaccination has declined – largely due to an increase in negative perceptions and concerns about childhood vaccination which seem to stem from enhanced levels of engagement and understanding of the topic, mainly due to COVID. While at this point the fundamental positive perceptions of childhood immunisation remain, there is now far more uncertainty than there has been before.

Critically, attitudes and perceptions also appear to have directly impacted claimed behaviour – according to parents, fewer children are being fully vaccinated in 2022 than in 2017, and they are more often late according to the schedule than they have been before.

In this context, there is an obvious need to arrest these declines, and rebuild parental confidence in the childhood immunisation program.

There are also clear structural barriers such as access to services which appear to have been exacerbated by the pandemic – while many of these issues may have naturally resolved themselves as restrictions have eased, it will be important to ensure a continued focus on these more structural aspects of the program.

13.2 Consider four key communication tasks

In seeking to arrest these declines, there are four key messages to deliver – listed below in order of importance.

1. Highlight the positives of childhood immunisation – while these perceptions are currently strong, any reinforcement will be extremely valuable in cementing the program's importance in the minds of parents
2. Provide a strong reminder about the serious nature of the specific diseases covered by the NIP schedule in order to drive and reinforce the perceived importance of each – there may be value in leveraging COVID as an anchor point for each disease
3. Counter the negative perceptions and concerns that seem to be growing, bearing in mind that some of these are legitimate, and based on the very real experiences that parents have had during COVID – as a result there is likely to be a need for some debunking, and for some rebalancing the risks of immunising vs the risks of not immunising, and potentially catching the diseases
4. Continue efforts to reinforce the importance of on-time vaccinations, bearing in mind that this is likely to be a lower-order priority in the current context where the primary focus should be on reinforcing support for the childhood vaccination program at a more fundamental level

13.3 Aim for a broad-targeted approach which covers all typologies

Previously, Advocates and Acceptors have required only gentle reinforcement, and OTF have been the core target for communications – this is no longer the case, given that perceptions of concern are now seen right across the typologies.

Of particular concern, Advocates are now far less 'black or white' in their support of childhood immunisation than they once were. While this group are holding their levels of support for now, it is critical that this group are directly provided with reminders and reassurance about the value of childhood immunisation.

OTF parents are now more precarious than ever before, with strong declines in claimed support for childhood immunisation, as well as claimed vaccination behaviour. It will be vital not to lose sight of this important audience segment in future communications.

13.4 Consider three key channel 'layers'

There are likely to be three core approaches required to deliver the key messages to this broad audience group.

The first is a high-level, broadly targeted media campaign. This should be pitched at all typologies and be focused on reinforcing the strong positives of childhood immunisation and providing a reminder about the severe nature of the diseases covered by the schedule. There is likely to be very little value in directly tackling negative perceptions in such a campaign given the strong potential to drive consideration of these concerns among those who do not currently think about them.

The second level is a content strategy for Departmental websites and printed materials. This should be targeted at those people who are looking for more information. It is imperative that this group find Departmental information when they go looking, and that they find it to be engaging and easily understandable. This information should provide a greater level of detail, and be more focused on countering the negative perceptions and concerns held by parents.

The third level is working through GPs and other health professionals. These health professionals are clearly highly trusted sources of information, and there is considerable value in seeking their assistance to actively reinforce support for the program. So, consider 'sounding the alarm' with health professionals about the risks to the program due to COVID, and providing them with tools and materials that can help them to reaffirm the positives of childhood immunisation, and help to directly counter negative perceptions.