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MMR AND PARENTAL VIEWS

PROJECT SUMMARY

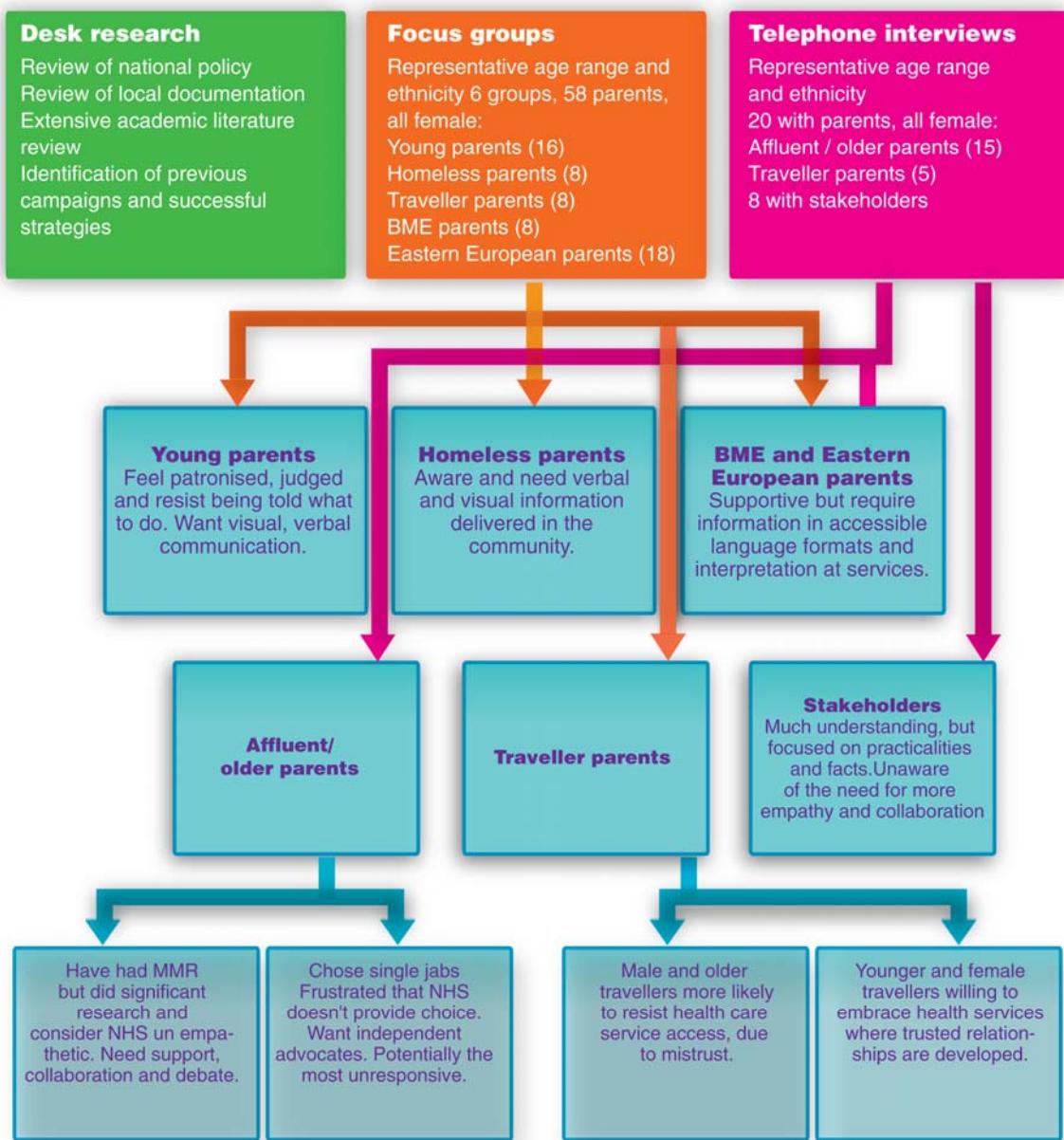
A social marketing insight report to inform development and shape a social marketing campaign to increase the uptake of MMR vaccinations in Sheffield and Doncaster.

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Executive summary

Our research methodology, resulting segments and over arching views are summarised in the diagram below.



Immunisation is generally the mother's responsibility and it is a burden that weighs heavily on all mums alike. Whilst the majority of respondents are happy in general with healthcare provision (though a key issue was long waiting times for appointments with young children, deemed unacceptable), there is a consensus among all target groups except BME and Eastern European groups, that NHS information on MMR does not recognise the pressure this decision puts them under.

A more sensitive, collaborative approach is required across all groups, using independent peers from each respective audience, to advocate MMR uptake and provide a voice of understanding, recognition and support.

This needs to be executed in a consistent fashion, in print, alongside immunisation request letters, digitally, via peers and in person, via an appropriate healthcare professional equipped to engage with each group. In all cases, except affluent/older parents the drive to MMR uptake is far greater than the barriers, suggesting great scope for marketing interventions. The most difficult group however is affluent / older mums where the scale is more balanced.

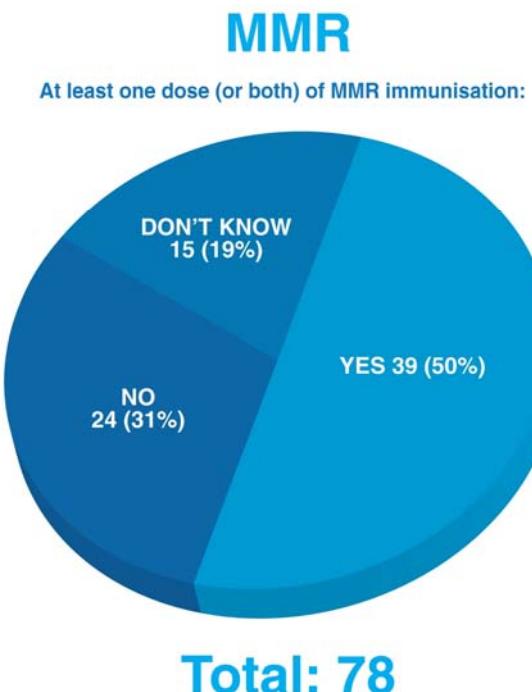
Key points from the national review

- Barriers to immunisation included negative publicity, belief that side effects outweigh the risk of disease and mistrust of health professionals and government advice.
- Parental choice over MMR is a risk/benefit analysis.
- Parents choosing to opt out feel more comfortable with the act of omission than they would if they harmed their child by giving them the vaccine.
- More information alone is not the solution, but credibility of the source and meeting the needs of parents is of high importance.
- Recognising the fact that even parents who decide to immunise experience distress is of key importance, as our findings corroborate. National research states that it is imperative that professionals provide reassurance and a supportive environment. Added to this, the non-empathetic stance of doctors and professionals is unacceptable.
- Personal experience plays a significant part in the decision. This is a recognised social marketing heuristic.... people assess the likelihood of risks by asking how readily examples come to mind. A familiar risk (in this case autism) is seen as more serious than a less familiar risk. Our research underpins this. However, this presents an opportunity to present the MMR case in a new light of increasing risk to those not immunised vs those safe having received the MMR vaccine.
- Many studies report lack of information on MMR being readily available to parents. Our research looks at this in more detail and establishes what each group wants and where they want it.
- There is considerable dissatisfaction with the way healthcare professionals provide immunisation information and answer questions. Our research confirms this and stakeholder feedback supports these findings. Health professionals see the matter as black and white, an obvious decision, whereas parents have extreme concerns

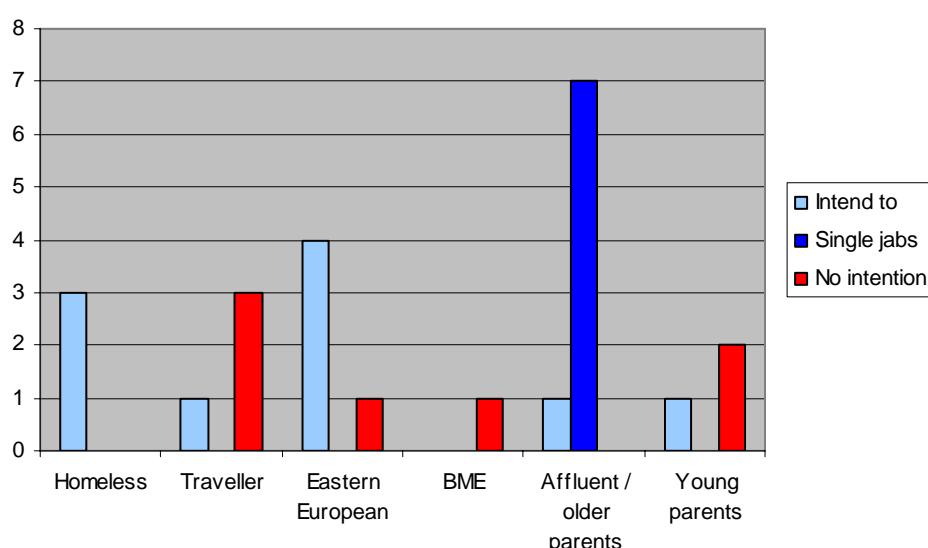
and emotions concerned with the MMR decision and require understanding, sensitivity, support, time to consider and importantly, collaborative discussion.

Uptake of MMR among target groups

There was no consistency with regard to uptake, other than the fact it related to mistrust of the NHS / Government and a desire to react to being told what to do. Half our sample had chosen to proceed with the MMR vaccine.

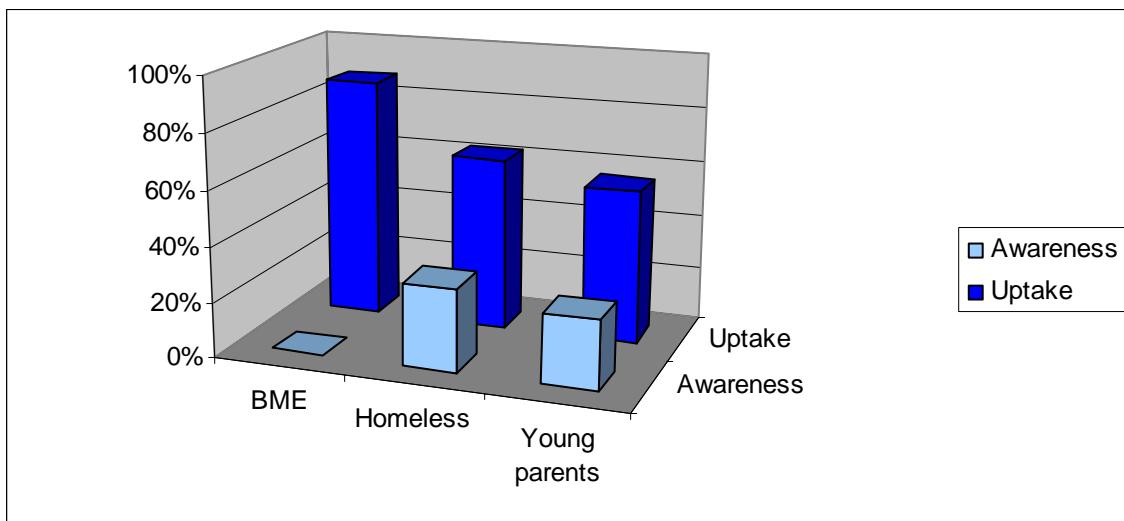


Of those not immunised, the greatest response was in affluent / older parents who had chosen the single jab. Few people had no intention of immunising their child, but it was the travelling community and younger people who were least likely to do so.

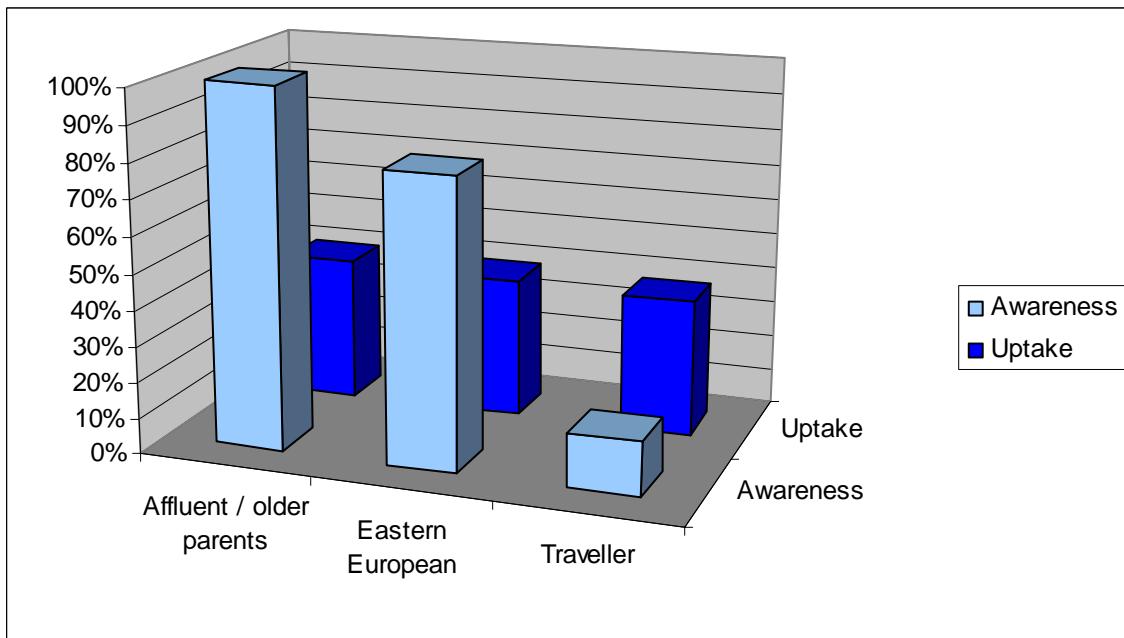


The link between awareness and MMR uptake

A fascinating insight from our research is the lack of consistency between knowledge / awareness of MMR and information vs uptake. BME parents were the highest performing group in terms of MMR uptake, yet knowledge of what MMR is was non-existent. This group trusted the NHS and took the advice of professionals without question.



Conversely, affluent / older parents (most affected by the media hype) had the highest levels of awareness and understanding, having carried out intensive research and collaborated online with other mothers, yet take up was relatively low.



Key findings by target audience			
	Barriers	Drivers	Influencers / media
Homeless {63% uptake}	Controversy Unconvinced	Compliant of medical advice Information supporting decision to immunise Risk of contracting virus and effects Debate and reassurance Outreach workers who understand and reflect their needs Interactive, collaborative, visual and verbal communication	Health visitor, friends, family, Internet, local papers, radio, DVD featuring real mums
Traveller {38% uptake}	Controversy (though limited knowledge and no desire to research) Perceived gamble Mistrust of NHS sources Feel significantly discriminated against and excluded by health-care: issue of trust and engagement Lack of understanding from GPs Temporary registration - no information or reminders	Information and advice provided by trusted health visitor / local practitioner Dedicated outreach health professional Verbal delivery of information from trusted professional	Health visitor, relatives, Internet, Mobile, DVDs with 'proper' traveller people featured, phone call
Eastern European {39% uptake}	Unpersuasive and low profile approach to immunisation vs Poland	Low knowledge of media controversy High awareness of importance of immunisation More promotion and information Compulsory immunisation Information in their language Access to interpreters for further discussion	Medical profession, Internet (native language), Polish TV

/cont

Key findings by target audience...continued

	Barriers	Drivers	Influencers / media
BME {88% uptake}	<p>Controversy Unconvinced</p>	<p>Accept medical advice (doctors valued) Desire to protect children Interpreters within healthcare Information in their own language A GP who speaks their language Visual materials and discussion</p>	<p>Friends, GP, husband Internet, libraries, local newspapers</p>
Affluent / older parents {40% uptake or 86% if single jabs included}	<p>Complexity of decision Fear over making the wrong choice An emotional decision (fear, nervousness, concern, confusion, uncertainty) Media coverage Personal experience of autism most likely to prevent immunisation. Being rushed (cannot make instant decision) Too many injections nowadays Unknowledgeable GP Access to and preference of single jabs Feeling forced into having MMR (blackmailed / bullied) - engenders protest A clinical approach - no information, support or reassurance offered Overwhelmed by information</p>	<p>Personal experience of measles Evidence / risk of disease Knowledgeable and understanding health visitor A calculated risk A personal approach (not conveyor belt!) Friend/family/peer advocacy An MMR campaign with positive messages An independent person to speak to Sign posting to independent information / services Acknowledgement that people are scared Demonstrate the benefits and how good outweighs bad Materials in reminder letters Real life experiences that acknowledge the struggle to decide Discussion groups at local children's centre More consultation and collaborative debate</p>	<p>Family, friends Internet research, parent forums, health visitors, GP, Nursery notice boards. Group most affected by media controversy. Demand independent advice.</p>
Young parents {56% uptake}	<p>Concerns over possible side-effects but reluctant to research or discuss Feel patronised, judged and observed by health visitors Resistance to being told what to do</p>	<p>Verbal information, not written</p>	<p>Mum, friends and family, Red book primary medium. New baby pack, information and advice from health professionals, Internet, Mobile, information in shopping centres / children's centres</p>

Part One: The Context for this work

Introduction

Between March and May 2009 hey moscow was commissioned by NHS Sheffield to conduct a social marketing insight exercise to inform the development of a future social marketing strategy to increase the uptake of the MMR vaccination in Doncaster and Sheffield. This work particularly focuses on the needs and views of parents from hard to reach groups to ensure effective strategies are targeted at specific populations.

The planned social marketing campaign will have three focuses; a blanket awareness approach, interventions targeting specific hard to reach communities and finally parents from affluent communities who may be influenced by negative press coverage.

This work has been commissioned because of national and local concerns over falling immunisation rates. Following a decade of relatively low vaccination uptake nationally, there is now a large number of children who are unvaccinated or partially vaccinated with MMR. Both Doncaster and Sheffield have experienced several outbreaks of measles as a consequence.

Nationally children are now required to have two doses of MMR: one at 13 months and another at three years four months to ensure adequate coverage so that children who cannot be immunised for medical reasons are also protected from getting measles.

- The [World Health Organisation \(WHO\)](#), have set a national target that both areas have to meet is 95% of children immunised against MMR by the end of 2009.

The insight findings provide a detailed picture and understanding of factors that influence and motivate local parents and parents from hard to reach communities, to decide whether to have their children immunised with MMR and considers relevant factors in their decision making process.

This report:

- Increases understanding of local parents attitudes and behavior in regard to both MMR immunisation and the health care professionals approach
- Assesses current knowledge of MMR and identifies gaps in knowledge and information needs
- Identifies specific barriers and reasons for resistance to MMR immunisation
- Identifies factors that encourage MMR immunisation
- Highlights preferred information sources
- Outlines a strategy for a local MMR social marketing campaign

The National Context

The concern about a possible link between the measles, mumps, and rubella vaccination (MMR) and autism has resulted in a substantial reduction in the uptake of MMR, putting children at risk of significant childhood diseases. It is not the objective of this insight work to review or consider this medical evidence and this work starts from the premise that this evidence has now been dismissed and focuses on parental influences. However, to fully understand parental concerns and place them in context it is necessary to briefly outline the history of the controversy.

The press history of the UK MMR debate:

MMR was first introduced in the UK in 1988, a year after a measles outbreak which had killed seventeen children. In 1994, a team of researchers from the Royal Free Hospital led by Dr Andrew Wakefield suggested that the vaccine is linked to Chron's disease and bowel disorder in a research paper, but the methodology used was widely criticised.

In 1998, Dr Wakefield's team published a second paper in the Lancet, suggesting a link between the MMR jab and autism and bowel disorders. There was a subsequent media storm and very negative coverage of the MMR jab. However, the research was only based on twelve children. Thirty experts from the Medical Research Council (MRC) met and concluded there was no evidence to suggest a link.

By 1999, the media storm had resulted in parental concern being so great that there was increased demand for single dose vaccines, the government responded by banning the only alternative to MMR. Parent groups and some medics formed a protest at this move.

Between, 1999 and 2000 numerous studies including a large scale study commissioned by The Department of Health (DH) (of 498 children) dismissed the link between autism and MMR.

Despite this, in 2000, families of over 1000 children claiming their children had been affected by MMR had their case taken up by solicitors.

In 2002, Dr Wakefield published a third paper claiming that early trials on the MMR vaccine had shown bowel problems that had not been picked up. Consequently, the first private practice began offering single jabs to parents.

In 2003, the High Court ruled that two girls should have the MMR vaccine against the wishes of their mother, this ruling effectively meant that children must be vaccinated against MMR but to date it remains unclear about how this could be enforced.

In 2004, the MRC looked at the records of 1294 children with autism and found no link with MMR; numerous other studies are published disputing the evidence.

In 2006, the government attempted to charge Dr Wakefield with professional misconduct.

By 2008, all further research undertaken had discredited the link.

Statistics on national outbreaks:

However, the media coverage of this issue had a significant impact and parent's and public confidence in the jab was shattered, resulting in some parents delaying their child's MMR immunisation or not having it, thus leading to outbreaks of measles epidemics.

Despite experts from around the world finding no credible scientific evidence showing a link with autism, the uptake of the vaccine fell in the UK for children aged under two from 92% in 1995/6 to just 82% in 2002/3. Additionally, in 2006 Tony Blair refused to say whether his own son had been given the MMR jab on the basis of his right to privacy. However, the press reported that Blair's silence did little to quell lingering doubts among parents.

The uptake has remained low with the UK currently having the lowest MMR immunisation rate across Europe. However, the NHS reported a slight increase in the numbers of children vaccinated in 2006-7, which is the third successive year it has risen. For the year ending 2007, the MMR vaccine rate was reported as 85 %, (an increase of 1% from the previous year). Prior to the controversy ten years ago, the rate of vaccination was 92 %. The current minimum recommendation by the World Health organization is at least 95 % 28.

Consequently, in 2008, there were 1370 cases of measles in England and Wales. It is reported, the numbers of measles cases in the UK are now at a twenty year high 24.

The Health Protection Agency reports the rise in cases of measles in the UK in 2008, demonstrating a rise from 990 cases in 2007 to 1370 in 2008. The majority of cases were reported from London, (48%), with 13 % from the North West. They reported that regions outside London continue to have clusters of cases linked to travelling communities and particular nurseries 19.

28. NHS Information Centre. March 2008. 'Latest Statistics on triple-jab MMR vaccinations published.' www.ic.nhs.uk/news-and-events/press-office/press-releases/archived-press-rele

24. Joint Committee on Vaccines & Immunization (JCVI) – Minutes of the Meeting December 2008)

19. Health Protection Agency. (HPA). News archives. 'Confirmed measles cases in England and Wales: update to end-March 2009'. Volume 3, No. 17. May 2009.

**Confirmed measles cases by region and month of onset, in England and Wales:
January 2007 to January 2009**

Month	London	East Midlands	East of England	North East	North West	South East	South West	West Midlands	Wales	York & Humberside	N/K
Jan 2008	53	2	6	1	1	1		3		6	
Feb	48		6	3		4			1	8	
March	71	1	1			8	1	1	1	5	
April	74		7	3		6	14	2		14	
May	117	1	6		22	4	7	3		5	
June	106		11	1	24	7	4	5		3	
July	63	1	10		19	13	2	8		1	
August	35	7	6		17	21	1	6		3	
September	30	5	4		7	2		9	21		
October	42	12	4	2	31	8	1	8	14	1	1
November	14	8	9	3	36	26	2	34	1	2	
December	11	11	20	4	22	28	9	34	1	2	
Total 2008	664	48	90	17	179	128	41	113	39	50	1
January 2009	33	7	2	1	7	16	3	13		6	

Source: Health Protection Agency. (HPA). News archives. 'Confirmed measles cases in England and Wales: update to end-March 2009'. Volume 3, No. 17. May 2009.

The table below from the HPA shows how all three diseases that MMR immunises against have rapidly risen in the last decade.

All laboratory confirmed cases of measles, mumps & rubella. England & Wales, 1996 - 2008.

	Measles	Mumps	Rubella
1996	112	94	3922
1997	177	182	117
1998	56	121	119
1999	92	373	162
2000	100	730	62
2001	70	784	45
2002	319	500	64
2003	437	1541	16
2004	118	8129	14
2005	78	43378	29
2006	740	4420	34
2007	990	1476	35
2008	1370	2440	27

Source: Health Protection Agency. (HPA). News archives. 'Confirmed measles cases in England and Wales: update to end-March 2009'. Volume 3, No. 17. May 2009.

The Policy approach:

The Joint Committee for Vaccines and Immunisation (JCVI) is charged with the responsibility for immunisation throughout the UK. In January 2007, Chief Medical Officers and Communication Officers from sixteen Western countries met in London for a high profile conference to set the immunisation agenda and communications strategy. One of their conclusions was that anti-vaccination lobbyists were proficient in gaining mass media attention, something health professionals were less able to do as well. Hence, they decided that for the future, all communications and advocacy for immunisation should be handled by mass media professionals who understand both how to access the media and which messages to communicate. They also highlighted that individuals and groups that reject vaccination can be divided into two clear sub-groups: 'vaccine sceptics' and 'vaccine opponents'.

In August 2008, DH launched the MMR Catch-up campaign, the DH MMR Catch-up programme is designed primarily to increase the uptake of the vaccine in all children from 13 months to 18 years of age who are unimmunised, but also in children aged from three years seven months (at the start of the programme) to 18 years who have missed out on one of their MMR vaccinations. DH has also supported the measles catch-up campaign with a managed communications approach, launching a new website for measles and MMR. London's Strategic Health Authority has also commissioned the London Social Marketing network to provide a more vigorous approach addressing London's particular problems where uptake is low.

A major planned PR campaign is also under way which focuses on online media, radio and marketing (announced October 2008), DH is reportedly spending £400,000 on Trimedia services to promote MMR jabs and defuse some of the remaining concerns 33.

Further details of the DH Catch up campaign and previous evaluation of strategies employed to increase the MMR uptake will be discussed in the good practice section.

33. PR Weekly UK. 'Government plans comms blitz on MMR vaccination'. www.prweek.com/uk/sectors/publicsector/article/889754/governemnt-plans-co

The Local Context

The localities:

Doncaster: The Doncaster area is covered by one Acute Trust, one community based Trust and the PCT. Doncaster PCT was created on 1st October 2006 following the merger of the two PCTs. It covers the same geographical area as Doncaster Metropolitan Council serving approximately 300,000 patients living there 1.

Around 4 % of the population are from ethnic communities, but the largest ethnic group in the area is gypsies and travellers which represent 1.4 % of the population with Indian and Pakistani groups the largest at 3.7% of the population. There has also been a significant increase in the numbers of economic migrants from Eastern Europe in recent years 12. Indeed it has been reported that Doncaster has the largest travelling community in the UK. (Cited in 14.)

It is an area with a mix of rural and urban communities marked by high deprivation and the inheritance from the decline of the mining history 23. The economy has changed rapidly over the last 20 years with coal-mining and engineering being replaced with service sector employment. Doncaster is the 41st most deprived district in England with 21 % of neighbourhoods amongst the 10 % of the most deprived in the country 12.

Sheffield: Sheffield is the third largest metropolitan district and the largest city in England with a population of 520,000. The index multiple ranked Sheffield as the 63rd most deprived local authority area in the country in 2007. However, there are particular areas within the locality with significantly higher levels of deprivation than others. Sheffield also suffered economic change with the decline of the industrial industry in the early 1980's resulting in substantial areas of multiple deprivation in the north, north east and central regions which contrasted sharply with more affluent areas in the South 34.

The Black, Minority, Ethnic population (BME) is estimated to be about 14% and there has been significant migration from the European Union and increased numbers of refugees and asylum seekers 3.

Ethnic minority populations:

As Doncaster has one of the biggest travelling communities in the country, NHS Doncaster are currently attempting to penetrate this group by having discussions with other agencies that have good contacts with the traveller communities 5. NHS Sheffield does not currently use any specific methods to target hard to reach groups and are keen to ensure this piece of insight captures the views of people in these groups 5.

It is established nationwide that travelling communities have low access to health services generally. Dutton carried out qualitative research, 14 on the factors that promote access to general healthcare for the Gypsy / Traveller population in Doncaster and the barriers to access for this group. The results showed that health professionals who have worked with this group and developed a relationship of trust are valued and held in high esteem. Barriers to access included lack of continuity due to travel, lack of continued medical records, lack of information and understanding, leading to concerns about safety of different treatments and reliance on or conflicting advice from friends / relatives as opposed to health professionals. Participants also reported dismissive attitudes, discriminatory practice and lack of cultural awareness among health professionals. It was recommended that the PCT develop a long-term health strategy targeting this group, eradicating discriminatory practice, developing cultural awareness training and developing methods to engage this group in mainstream healthcare 14.

This insight work aims to focus on four of the hard-to-reach groups in the Doncaster / Sheffield localities to find out more about their views, so targeted initiatives can be implemented.

1. A guide to Doncaster PCT www.nhs.uk/ServiceDirectories/Pages/Trust.aspx?id=5N5
12. Doncaster Metropolitan Borough Council. 'Community Safety'. (2009). January
23. Improving Supportive & Palliative Care across Doncaster & Bassetlaw Health Communities: The vision & Strategic Direction for the future. (2007).January.
34. Sheffield Director of Public Health Report. (2008). 'Assessing Need, Leading Change.'
3. Audit Commission. Benefits inspection. Sheffield City Council. (2008). November.
5. Brief for agency to provide a piece of social marketing insight around increasing the uptake of MMR vaccinations in Sheffield and Doncaster.
14. Dutton, Angela. Sheffield Halam University. (2006/7). 'An investigation of the health experience'

Local outbreaks and the press:

In 2003 in Sheffield there was an outbreak of mumps at Sheffield Hallam University among students, affecting at least 250 people. At the time Dr Rosie Mcnought said in The Times, that future student cohorts would be protected via MMR 35.

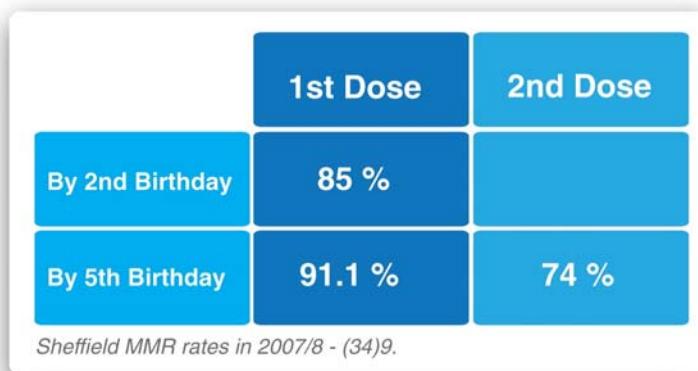
In 2006, there was a national outbreak of measles as a direct result of the low uptake of MMR with cases running into the hundreds compared to 77 cases the previous year.

However, the press reports showed that Sheffield and Doncaster were among the worst hit areas in the country. In Sheffield it was reported that there were as many as 80 cases with over 100 cases in Doncaster. Most were children under five and babies with the outbreak seemingly beginning in a local nursery 25. At the time, Dr Peter English, consultant for the Health Protection Agency said; “*We have not had an outbreak as big as this in this country since the MMR jab was introduced in 1998*” (Cited in 4.)

Several of the outbreaks in Sheffield have been among the travelling communities and indeed the first death in fourteen years in the UK from measles happened in 2006 and was a boy from a travelling community outside of Sheffield.

Local statistics:

In Sheffield, current figures to date for 2008/09 show that in children up to two years old 83.5% have had their first dose of the MMR vaccine. In children up to five years old 90.9% have received the first dose. However, in children up to five years old, only 77% have received the second ‘booster’ dose of the vaccine which is required to be fully immunised against MMR 34. Doncaster currently has 2600 children missing their first dose of the MMR vaccine and 5236 missing their second dose 5. Childhood immunisation rates in Sheffield are above national averages but MMR uptake is still extremely low.



However, there is wide variation between localities within Sheffield PCT data which shows that the percentage of children aged 2 immunised with the first dose of MMR by practice in 2007/08 in the most deprived locality was between 47% to 76 % falling way below the national average. Research data has shown that the uptake is lower in rural Doncaster and that there are variations between ethnic communities 13.

Local Policy and NHS work: NHS Sheffield has developed an action plan for immunisation improvement; ‘Action plan for immunisation and vaccination improvement’, this largely involved improving IT systems and data collection in GP surgeries, including establishing numbers of school age children with only one MMR and those with none, and ensuring all surgeries had an implementation plan, immunisation champion, system for alerting parents of due dates, designing a school nurse strategy for school aged children, immunisation campaigns and designing a communication strategy to support campaigns.

All parents registered with GP practices in Sheffield have recently received letters outlining the importance of the MMR vaccination. Doncaster’s Child Health Records Department has sent out information leaflets, consent forms and letters of invitation to all the school age children who are not up to date with their MMR. The Doncaster School Nursing Service has arrangements in place with their schools to immunise this group within the next couple of months. GPs with patients under five years and over 16 to 25 years have received a letter from the Child Health Records Department urging them to invite and put on extra clinics for children and young people, to immunise the ones either with no MMR history or only one dose.

- 35. The Times Higher Education. ‘Sheffield tackles mumps outbreak.’ (2003.). 22.08.03. www.timeshighereducation.co.uk/story.asp?storyCode=178745
- 25. Mail Online. [www.dailymail.co.uk/news/article-390711/Parents-urged-children-vaccinated](http://www.dailymail.co.uk/news/article-390711/Parents-urged-children-vaccinated.html) (2006). 14.06.06.
- 4. BBC News. ‘UK in grip of measles outbreak.’ (2006). 14.-6.06. www.news.bbc.co.uk/1/hi/england/5081286.stm
- 34. Sheffield Director of Public Health Report. (2008). ‘Assessing Need, Leading Change.
- 5. Brief for agency to provide a piece of social marketing insight around increasing the uptake of MMR vaccinations in Sheffield and Doncaster.
- 13. Doncaster PCT. Public Health Intelligence Unit. Hargreaves,S. ‘Analysis of the variation in the Uptake of the MMR Vaccine in Doncaster’. www.doncasterpct.nhs.uk/phiu.asp

National literature review

In this section we explore the national literature and knowledge on influences on parental choice in relation to the MMR attitudes towards healthcare professionals and communication strategies and preferred sources of information and routes to promotion. It has been undoubtedly established with the case of MMR that the media does indeed have an important influence on individuals' assessment of risk. It has been argued since that the media support of those against MMR was not matched by an examination of the case against it and hence the public were often misinformed. Additionally, this led to a loss of trust in politicians and health professionals and a mistrust of the credible evidence on MMR safety. At the very least, it is clear that attainment of health targets has clearly been compromised.

It has been established from research that single parenthood, deprivation, high birth order, family size and ethnicity are related to lower uptake of MMR. However, as highlighted in the UK cohort study 31, uptake has declined since 1998 among parents living in more affluent areas with more highly educated residents. This is because evidence suggests that it is these more affluent parents that have been most significantly affected by the press coverage and Wakefield affair. This group of affluent parents have also been identified as the group most likely to use extensive sources of information to educate themselves about the issue 32. Hence, there are a variety of sub-groups within the context of the MMR debate who may require specific interventions designed to meet their particular group needs.

Additionally, it has been established nationally that there is a lower uptake of the 2nd MMR booster. (The first occurs between five and twelve months and the second dose between 21-35 months.). Reasons for this have not been clearly established yet, however, one research paper found some evidence 36 to suggest that this could be because by the time of the second jab, parents have had longer to discuss their decision with friends and colleagues, refer to research and consider the decision more carefully at a less hectic time.

31. Pearce, A, Ellman, D, Bedford, H et al. BMJ. (2008). 'Factors associated with uptake of measles, mumps and rubella vaccine (MMR) and use of single antigen vaccines in a contemporary cohort: prospective cohort study.'

32. Petts, J & Niemeyer, S. Health, Risk, Society. (2004). 'Health Risk communication and amplification: learning from the MMR vaccination controversy.'

36. Tickner, S, Leman, P & Woodcock, A. (2006). Science Direct. 'Facts underlying suboptimal childhood immunisation.' Volume 24, 7030-7036.

McMurray, 26 found that at the second dose there was no information provided to the parents' in his research compared to the first dose and that most could not recall the advice given three years previously and were subsequently not aware of importance. However, no study to date has answered the question of what happens to mothers' attitudes and beliefs between the two doses and how their opinions can change over time.

Some research has indicated that MMR uptake is lower in rural areas and indeed the uptake is lower in the more rural parts of Doncaster. A study by Henderson 20, concluded that this could largely be due to the established difficulties in rural areas in accessing healthcare, but they also found immunisation was higher in practices using the national recall system and suggest that rural practices engage with regional or national systems.

A study in the BMJ 31 found reasons for choosing not to immunise given by parents mainly included; negative publicity, belief that side effects outweigh the risk of disease, mistrust of health professionals and government advice. However, interestingly they also concluded that the same reasons were given by both parents who chose the single vaccines and those who chose not to immunise at all. A focus group study of parental perspectives on MMR reported in the British Journal of Medical Practice, 15 concluded that all parents in their sample found the decision on MMR difficult and stressful, felt unwelcome pressure from health professionals and were not convinced by DH reassurances on MMR. They identified four similar key areas that influenced parents' choice;

- Beliefs about the risks compared to contracting the disease,
- Information from the media on MMR, confidence and trust in health professionals and views on the importance of individual choice in government policy.
- They also found that parental choice in this area was far more than a risk/ benefit analysis and was highly dependent on their personal attitudes
- Beliefs and perceptions and hence the significant impact of the media on these groups

26. McMurray, R. Cheater, F, Weighall, A & Nelson, C. (2004). British Journal of General Practice. 'Managing controversy through consultation: a qualitative study of communications and trust around MMR vaccination decisions.'

20. Henderson, R. Oates, K. MacDonald, H et al. British Journal of General Practice. (2004). 'Factors influencing the uptake of childhood immunisation in rural areas.' Vol 54, 114-118.

31. Pearce, A, Ellman, D. Bedford, H et al. BMJ. (2008). 'Factors associated with uptake of measles, mumps and rubella vaccine (MMR) and use of single antigen vaccines in a contemporary cohort: prospective cohort study.'

15. Evans, J. Stoddart, H. Condon, L & freeman, E et al. British Journal of General Practice. (2001). 'Parent's perspectives on the MMR immunisation: a focus group study'. November 2001.

Interestingly, those parents in their group who choose not to immunise at all reported feeling more comfortable with this act of 'omission' rather than the thought of taking an action that they perceived could directly harm their children. Cassidy,⁷ carried out a further qualitative study of UK parent views and found there was a high level of ambivalence about safety of MMR, even by those who had immunised their children.

Guillaume,¹⁶ through a series of 18 in-depth interviews found that parent information needs in relation to the MMR had increased because of the health scare. The media was found to be the primary and first source of information for parents but parents were also critical and sceptical of it. This increased their need for further information on various different aspects of the MMR vaccine, which he concluded remained largely unmet. The main source of traditional information sought on MMR was then through health care professionals, seen as 'agents of the Government'. This paper also highlighted Blair's refusal to reveal whether his son had the vaccine and the BSE scare as key factors in creating distrust in Government sources of information. The paper concludes that information needs are high and can play an important part in helping parents to make the decision to vaccinate. However, the government and health care professionals need to develop further understanding of parents' information needs rather than develop resources to try and change behaviour.

"Information alone is not sufficient and parents must believe what they are receiving is the truth".¹⁶

7. Cassidy, R. Creswell, T, Wilson, D & Brick-Panter, C. (2006). Science Direct. 'A survey of UK parental attitudes to the MMR vaccine and trust in medical authority.' www.sciencedirect.com
16. Guillaume, R & Bath, P. (2004). 'The Impact of health scares on parents' information needs and preferred information sources: a case study of the MMR vaccine scare.' Vol 10: 5-22.

Similarly, Hilton 21 in a study on parent's views on MMR found that it was parents' trust that was shattered during the Wakefield scandal and concluded that the provision of information is only one aspect of increasing the immunisation uptake. He concluded, re-establishing trust in the information on offer is also vital and ensuring that people are able to accept it is from a credible source should precede development of further information sources. In the same way parents may not know which health professionals to identify as impartial. Importantly, he also found that it is not just the MMR issue that has weakened public trust in health information and government sources and refers to the government's handling of the BSE, Foot and Mouth and Salmonella outbreaks in which consumers did not perceive they were put first, which has also contributed to this growing culture of mistrust.

Hilton, 21 suggests that for future campaigns to be successful they will need to address the trust issue and be explicit about sources of information, conflicts of interest etc. He suggests that future communications strategies could be based on Lupton's risk and trust analysis which suggests that when people perceive 'expert knowledge' to be failing, they turn more readily to local sources of information such as their known Health Visitor. Hence, he identifies an opportunity for Health Visitors to be issued guidance and training on clear messages to communicate to their patients. A further, qualitative study on UK parental attitudes to MMR found considerable parental mistrust in the government in relation to this issue, with as many as one in five believing that the government would not stop MMR if there was any risk 7. However, this sample of parents' did display more faith and satisfaction of information from their own doctor. The tendency to trust individuals' doctors while questioning the medical profession as a whole has been found in a Kings Fund report in 2004. A paper that focuses specifically on this issue of trust; 'Leap of Faith and MMR', 6 expands this concept further empathising that parents feel in a 'no win' situation with risks either way and that trust becomes a more significant issue when one cannot make an accurate assessment of probabilities. His research highlighted that parents have significant knowledge gaps. However, he also emphasises that for some health professionals in the aftermath of Wakefield they also wanted reassurances and were unsure of which sources of information to turn to and hence were unable or unwilling to provide clear assurances.

21. Hilton, S. Petticrew, m & Hunt, K. BMC Public Health. (2007). 'Parent's Champions vs. vested interests: Who do parents believe about MMR? A qualitative study.'
7. Cassidy, R. Creswell, T, Wilson, D & Brick-Panter, C. (2006). Science Direct. 'A survey of UK parental attitudes to the MMR vaccine and trust in medical authority.'
6. Brownlie, J. Howson, A. (2005). Sociology. 'Leaps of Faith and MMR: An empirical study.'

In the wake of the controversy over this issue and in light of the research evidence presented it is clear that even parents who decide to immunise experience distress. Therefore, it is imperative that professionals provide reassurance and a supportive environment. Woodman et al, 38 found that many mothers experience severe emotion and upset at time of immunisation and they reported that the non-emphatic stance of doctors and professionals was unacceptable to them in this study. Lunt, 30 consulted Health Visitors and GPs to ascertain their perceptions of why parents refuse the MMR. Both groups concluded that negative publicity had influenced parents' choice but the author concluded there was a need for much greater communication between the two parties.

Research has also shown that personal experience plays a significant part in the decision-making process, Tickner 36 found parents with firsthand experience of autism either through family, friends or work were far more likely to refuse the MMR. These parents perceived the long-term impact of autism as far worse than any perceived consequences from the three childhood diseases. Other studies have shown personal experience of autism or indeed other learning difficulties made it more difficult for individuals to ignore the media. McMurray interviewed seventy mothers 26 and found prior parental experience of autism was the primary reason why parents across his sample would decide not to vaccinate.

This group perceived mumps, measles and rubella as comparatively harmless and something children would survive. Research suggests that it is clear that parents want clear and detailed information about the immunisation process. This could be done prior to appointment and discussed further during consultation. The DH websites and information sources are important and health professionals can signpost patients to them, however, this does not address the gap in reaching parents who actively miss appointments and do not engage. These parents may be more likely to be influenced by advertising campaigns.

38. Woodman, C & Shannon, F. (2000). Journal of Epidemiology and Community Health. 'Low Immunisation uptake: is the process the problem?

30. Lunts, E & Cower, D. (2002). Community Practitioner. 'Parents refusing MMR: do GPs and Health visitors understand why?' March 2002, Vol 75 (3).

36. Tickner, S. Leman, P & Woodcock, A. (2006). Science Direct. 'Facts underlying suboptimal childhood immunisation.' Volume 24, 7030-7036.

26. McMurray, R. Cheater, F, Weighall, A & Nelson, C. (2004). British Journal of General Practice. 'Managing controversy through consultation: a qualitative study of communications and trust around MMR vaccination decisions.'

32. Petts, J & Niemeryer, S. Health, Risk, Society. (2004). 'Health Risk communication and amplification: learning from the MMR vaccination controversy.'

Additionally, other studies 36 have shown that providing information on the importance of immunisation can be really effective and in Italy mothers who received such information were more likely to opt for the MMR. This research concludes that both the media and government approach to MMR has historically been fuelled by dispelling the myths of the media controversy and that now may be the time to drop this focus and move on in favour of more detailed information on the process of immunisations and benefits generally.

It is clear from the research that not all parents understand the purpose of MMR, despite being familiar with MMR through media coverage and information needs were evident. Petts 32, showed groups of parents a video on MMR and found that the most commonly cited piece of new learning was on the effects of the three diseases and long-term consequences.

Many studies have found that parents report that information on MMR was not readily available to them, particularly directly and verbally from GPs. This has been found to be a particular issue among the lower socio-economic groups and with Asian mothers and these groups in particular felt that their GP did not help with their decision. Whilst white British women from higher socio-economic groups tend to engage more with their GP in this decision making process. Other papers looking at MMR information needs 36 have found parents have a preference for longer appointment times to discuss MMR, fact sheets and statistics accompanying the reminder cards and full appreciation of their concerns, reflected in both information from professionals and targeted resources.

36. Tickner, S. Leman, P & Woodcock, A. (2006). Science Direct. 'Facts underlying suboptimal childhood immunisation.' Volume 24, 7030-7036.

32. Petts, J & Niemeyer, S. Health, Risk, Society. (2004). 'Health Risk communication and amplification: learning from the MMR vaccination controversy.'

Alfredson, 2 found that parents expressed considerable dissatisfaction with the way staff provided immunisation information to them and answered questions. Some parents made a further appointment to see the doctor before having the immunisation via the nurse. He also found that some parents delayed the vaccination decision because of safety concerns, however, in his sample they found one fifth of those who chose not to vaccinate had not made up their mind at the time of their health visit but their need for information and discussion was not met, identifying a missed opportunity within the healthcare system. Postponers and abstainers may well have different reasons for their decision and the role of trained professionals in getting the right advice to these parents at the right time is vital.

McMurray, 26 identified similar unmet information needs; the majority of his sample relied on everyday / media knowledge and had insufficient contact with primary care. Hence, he concluded the decision for many parents was not representative of an informed choice. The information provided in the form of leaflets within primary care was perceived as dull and uninformative. He concluded that these parents did view primary care as potentially important sources of knowledge, but parents did not require more medical information, rather he found parents required information that could be worked into their pre-existing knowledge, understanding and experience and suggests that much of the existing information needs to be reworked and made relevant to parents.

"Information must take account of the 'tangible facts', observed by people in their own communities, and be presented in such a way as to inform the experimental information parents bring to medical consultation." 26

2. Alfredson, R. Svensson, E. Trollfors, B & Borres, MP. Acta Paediatrica. (2004). 'Why do parents hesitate to vaccinate their children against measles, mumps and rubella?'

26. McMurray, R. Cheater, F, Weighall, A & Nelson, C. (2004). British Journal of General Practice. 'Managing controversy through consultation: a qualitative study of communications and trust around MMR vaccination decisions.' Vol, 54: 520-525.

Furthermore, he identified a desire among parents for new approaches to supporting decisions when faced with conflicting information. His sample of parents identified a number of collaborative approaches that would influence their decision. These included:

- Drop-in sessions and forums at local nurseries answering parental concerns
- Written information in the days prior to vaccination
- Information with case studies that parents could relate to
- Opportunities to discuss the vaccination with practitioners prior to the vaccine (some parents felt attendance at the clinic was perceived as informed consent which prevented discussion)
- The use of intermediaries or independent advocates where parents would feel safe to access independent advice.

A literature review and intervention feasibility study,⁷ examined six specific interventions to increase MMR uptake. These included; a decision aid website, an information-based discussion pack, parent-led discussion groups, immunisation champions, mobile vaccination units and compulsory vaccination. In their literature review they highlighted that parents wanted clear, balanced and independent information, explaining why it is a three in one jab, why it is in two doses and assessing the evidence. The most commonly used media sources were health professionals and the media. They concluded that to date there has been limited evaluations of interventions employed and hence a lack of knowledge of evidence-based techniques for increasing MMR uptake. However, they highlighted the value to some parents in discussion groups to relieve conflict and that web-based decision tools were perceived to be useful.

7. Cassidy, R. Creswell, T, Wilson, D & Brick-Panter, C. (2006), Science Direct. 'A survey of UK parental attitudes to the MMR vaccine and trust in medical authority.' www.sciencedirect.com

It is clear that various aspects of the socio-economic system exert powerful influences on the groups currently missing out on immunisation and minority parents are the most likely to be socially deprived. These are reflected in differences in healthcare use including; differential access, take-up of services and lack of support to use services. Additionally, there are cultural norms among particular communities and differences that create persistent barriers to immunisation and greater understanding of these cultural norms is required.

Condon,⁹ through focus group methodology looked at the attitudes of parents from specific ethnic groups and his sample included Pakistani, Somali and Afro-Caribbean ethnicity. They found the Pakistani group did not use media as a source of health information and were consequently not aware of any controversy. The Somali and Afro-Caribbean women had seen some of the negative news on the TV and were worried,, but decided to go ahead anyway and consulted family prior to this decision rather than health professionals. However, they all had a favourable view of health professionals and saw this as the best place to seek support. All groups were pro immunisation.

A study focusing on the general health-related behaviour of Gypsies and Travellers⁸, concluded that cultural beliefs ‘underpin’ all their health-related behaviour. These norms included stoicism, self-reliance and staying in control. Ill-health is perceived as normal and fatalistically accepted. They also had an overriding expectation of negative attitudes and cultural discrimination within healthcare which limited their use of health services

Henderson,²⁰ examined attitudes to MMR immunisation among the Orthodox Jewish Community in Hackney, North London through a series of interviews. Whilst this Insight does not focus on this group it is useful to draw findings from a community relatively isolated from direct media influence. Only one participant in this group had the immunisation and there was fear around the notion of injecting their children with a foreign substance. This was quite symbolic within a community that wished to remain insular and applied to all vaccinations. Information flow was through social networks primarily and this was seen as the key influencer on this group of parents in relation to immunisation and cultural norms.

9. Condon, L. *Health Education Journal*. (2005). ‘Maternal attitudes to preschool immunisation among ethnic minority groups. SAGE.

8. Cleempunt Van, p. Parry, G, Thomas, K & Peters, J. *Journal of Epidemiology and community health*. ‘Health related beliefs and experiences of Gypsies and Travellers: a qualitative study.’ Vol 61, 205-210.

20. Henderson, R. Oates, K. MacDonald, H et al. *British Journal of General Practice*. (2004). ‘Factors influencing the uptake of childhood immunisation in rural areas.’ Vol 54, 114-118.

Other factors that have been identified to influence MMR uptake include organisational factors such as the effectiveness of database systems and reminder / recall systems and cards,¹⁷. Whilst some parents may well miss the MMR through forgetting appointments and such factors, rather than active choice, these organisational factors alone cannot account for the low uptake as other childhood vaccinations do not have the same low uptake. However, in the circumstances it is worthwhile ensuring that everything possible is done to remind parents when this is needed.

Another study,² examining reasons why parents fail to immunise with MMR has proposed that some of the low uptake may simply be with the fact that it is the last vaccine on offer (the second jab) and numerous studies have reported that parents are concerned about the number of jabs children currently have.

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17. Gardner, B. Davies, A. McAteer, J & Mitchie, S. UCL. (2008). 'How can MMR uptake be increased? A literature review and Intervention Feasibility study. September 2008.
 2. Alfredson, R. Svensson, E. Trollfors, B & Borres, MP. Acta Paediatrica. (2004). 'Why do parents hesitate to vaccinate their children against measles, mumps and rubella?'

Campaign Identification & good practice

The national approach to MMR promotion:

The World Health Organisation, (WHO) launched European Immunisation Week in 2005 which has proven to be an effective mechanism for advocacy for immunisation and for sharing promotional strategies. This initiative involves over twenty five countries.

As previously highlighted; In August 2008, DH launched the MMR catch-up campaign it is designed primarily to increase the uptake of the vaccine. DH has also supported the measles catch-up campaign with a managed communications approach, launching two new websites for measles and MMR as a response to the demand for information on MMR and acknowledgment that numerous parents used the internet to search for information on this topic. The dedicated MMR site contains a reference library of articles and research on the topic, including articles that have linked the jab with autism and provides detailed information on the consequences of measles, mumps and rubella. DH has also developed the 'Green Book' for professionals - an updated guide on all aspects of immunisation.

The two primary sites launched are; www.immunisation.nhs.uk and www.mmrthefacts.co.uk (the latter is no longer being updated and refers back to the former)

As part of this work in August 2008, the Chief Medical Officer wrote to all PCTs asking them to help reduce measles epidemics by offering every child the MMR vaccine. DH will help each PCT to catch up by providing them all with additional supplies of vaccines, information materials and up to £30,000 additional funding for this work per PCT.¹¹ This was also supported with an information leaflet, surgery poster and online with a question and answer 'Big Facts' sheet and measles infection timeline ²². London's Strategic Health Authority has also commissioned the London Social Marketing Network to provide a more vigorous approach addressing London's particular problems where uptake is low.

A major PR campaign is also under way which is focusing on online media, radio and marketing (announced October 2008), DH is reportedly spending £400,000 to Trimedia to promote MMR jabs and defuse some of the remaining concerns. (PR Week UK. 'Government plans comms blitz on MMR vaccination'). This PR campaign also incorporates a national televised advertising campaign ³³.

11. (DH. (7.8.08). 'National MMR vaccine catch-up campaign launched.' www.dh.gov.uk/en/News/Recentstories/DH_086861)
22. House of Commons Hansard Written Answers. (3.02.09). www.publications.parliament.uk/pa/cm200809/cmhänsard/cm090203/text/90203
33. PR Weekly UK. 'Government plans comms blitz on MMR vaccination'. www.prweek.com/uk/sectors/publicsector/article/889754/governemnt-plans-co

It is too early for this campaign to have had significant impact or to have been evaluated, however, some early press reports have indicated it is not having the anticipated impact and uptake has only risen slightly (1.8%) since its launch in August 2008. In December 2008, a PULSE investigation found the campaign was having little impact in urban areas most at risk of measles epidemics and the Joint Committee Vaccination Immunisation (JCVI) warned the modest programme and coverage would only enable the vaccine to increase slightly and would still fall way behind the 95% target.

Prior to this in 2004, DH collaborated with NHS London on their 'MMR Capital Catch-Up', as MMR uptake of the vaccine has been historically low in London. This campaign involved thirty-one local PCTs forming an umbrella body. A regional communications plan was developed and the initiative was led by the North Central Strategic Health Authority with support from the DH Immunisation Team and at local level support was provided by Health Protection Units. The PCTs agreed to act together with similar timeframes, agreed objectives and similar methodologies. The scope / objective was that

'Immunisation should be offered to all children of primary school age with an incomplete MMR vaccination history, in the identified PCT districts'.

It was acknowledged from the outset, that there had been a general lack of success in achieving this within primary care and therefore PCTs were encouraged to use a variety of interventions and strategies to achieve this including consideration of alternatives such as school-based clinics.

26 PCTS used a school-based universal approach to invite and identify eligible children. These initiatives were subsequently evaluated in 2007 29. Together, these PCTs vaccinated an additional 40,000 school aged children (including 16,000 first vaccinations), for first doses and second doses representing an increase of 2-35 and 6-12 % respectively. This equated to a reduction in the number of primary school aged children susceptible to measles in London by an estimated 20,500. However the evaluation concluded this was a modest reduction and in several areas the risk had not been reduced sufficiently to prevent measles

epidemics. The evaluation highlighted a number of procedural difficulties which made the catch up programme difficult identification and invitation of pupils and obtaining parental consent in relation to unaccompanied children in school settings was the single most significant barrier.

They made a series of recommendations for future catch up campaigns which included;

To increase uptake in pre-school children

- PCTs should initiate regular systems for checking and updating vaccination status

To improve information

- PCTs need to ensure that they have sufficient resources to maintain an accurate population register for scheduling vaccination
- GPs need to inform all patients with school aged children about immunisation in a timely manner
- SHA need to ensure all PCTs have child health systems that are fit for purpose

To better understand the effectiveness of future catch up programmes

- Further research is undertaken to better understand the demographics and views of those who did not respond to invitation
- Further research is undertaken to understand the characteristics of those who participated in the catch-up programme successfully
- Evaluation programmes need to be planned from the outset

29. NHS: Health Protection agency. (2007). 'Capital Catch-up: MMR catch-up Vaccination Campaigns by London Primary Care Trusts, winter 2004-2005. Evaluation Report of the Campaign Regional Technical Planning Groups

Case Studies of local PCT action:

A number of PCTs across the UK now involved in the national catch-up programme have put in place promotional strategies to increase the MMR uptake. However, it is too early for any of these initiatives' to have been evaluated. The examples below provide some insight into the type of promotional / marketing work currently being undertaken in PCTs.

Nottingham City PCT

Nottingham City organised a local 'MMR Challenge Event' hosted by the chief executive in June 2008. This involved gathering all senior local stakeholders (healthcare and schools) and a debate was held which led to the development of a local action plan. This included a review of local data collection systems for identification, discouraging the practice of single vaccinations, GP reminder notes, drop in clinics, health visitors specifically targeting hard to reach groups, development of links to school nursing services and the development of a targeted local social marketing campaign.

NHS Brent

NHS Brent has the highest number of confirmed measles cases across the UK. In conjunction with the HPA they have developed a borough-wide awareness campaign to highlight the fact that measles is spreading throughout the Borough and why. A series of posters, leaflets and adverts hit the streets in November 2008, to encourage parents to make an appointment with the GP. Schools have been written to as part of the campaign and offered promotional materials, local radio and media targeted and ethnic minority media have been sent materials.

NHS South West Essex

NHS South West Essex launched a mobile MMR immunisation programme on the 9th May 2009, which will visit primary and secondary schools across the region. It has two private consultation rooms and a waiting area and carries the slogan 'Watch Out Measles About'. At the weekends the van visits community locations such as shopping centres. Prior to the launch, dozens of schools were contacted to secure their involvement. It has been launched by Event Marketing Solutions (EMS) and they have also organised a 'hit squad', of promotional staff who visited schools during the first week of the tour.

Southwark NHS

Southwark NHS has teamed with mobile solutions company IPlato to design a text messaging solution to invite parents (via GP records) for their MMR jab and to alert them of local measles outbreaks. Every quarter, all surgeries receive a list from a centrally developed system indicating all the children due for immunisation. By running a search on their clinical practice notes, practices are then able to send out text messages to the identified groups of parents.

NHS Bury

As part of a catch-up programme, NHS Bury are offering mobile clinics with no appointments needed to take place in health centres throughout May – July 2009. Local literature has been distributed, advertising the dates of these clinics.

City and Hackney NHS Teaching PCT

City and Hackney NHS Teaching PCT launched a touring immunisation unit in 2007 which visited local schools and nurseries for a six week period. It was staffed by a team of nurses.

Hillingdon PCT

Hillingdon PCT has set up a telephone hotline for parents, GPs, nurses, health visitors and school nurses with any queries on MMR. They aim to respond to queries the same day.

Lambeth, Southwark and Lewisham PCT

Lambeth, Southwark & Lewisham PCT has commissioned a full review of immunisation uptakes in particular groups with the aim of increasing uptake rates among these groups e.g. refugees and looked after children. They have also commissioned a research study into parental attitudes to MMR.

East London and City

East London NHS has identified particular groups of the population where uptake is low and are designing targeted education and community training programmes to be held in specific geographical areas, delivered by community leaders.

Kensington, Chelsea and Westminster

Kensington, Chelsea and Westminster are running immunisation sessions for parents in different localities to answer questions on immunisation and improve MMR uptake. Localities include schools and nurseries as well as community venues.

Brent and Harrow

Brent and Harrow have developed an MMR video pack and are exploring promotion.

Darlington PCT

Darlington PCT along with five other PCTs in the borough have developed a new model of care for health visitors. This involves making contact prior to birth, maintaining regular contact and supporting families with information and training on particular topics such as immunisation and MMR.

Part two: The Insight Research

Insight target audience:

- Parents of all ages of children under five years old, living in Sheffield and Doncaster who have either had, not had their child(ren) immunised against MMR or have partially had their child(ren) immunised against MMR
- Parents of all ages of children under five years old who are homeless in Sheffield and Doncaster
- Parents of all ages of children under five years old who are part of a travelling community
- Parents of all ages of children under five years old who are part of a BME community
- Parents of all ages of children under five years old who are part of an Eastern European community (Roma, Slovak, Polish)
- Healthcare professionals and other service deliverers (e.g. doctors/health visitors etc)
- Influencer's on parents & community leaders

Methodology

The main aim of the insight work was to inform a social marketing campaign in order to ensure the subsequent campaign is tailored to the needs of the target audience. The insight included assessment of attitudes and behaviour towards MMR immunisations, identification of barriers and gaps in health provision and reviews of the impact of current local promotional activity and recommendations for future service development and marketing campaigns.

hey moscow adopted a multi-method qualitative approach in order to gain in-depth understanding of decision making and behaviour in regard to MMR immunisation and consulted 86 local people on this issue. This approach enabled us to draw evidence from a variety of sources to ensure that the recommendations were based on the most robust findings possible. It comprised interviews and focus groups with parents, stakeholders and parents from specific communities. Additional information was drawn from a literature and documentary review and review of previous campaigns. The report primarily draws from the interviews and discussions with parents and incorporates findings from these three interlinked elements: Desk based research, focus groups and telephone interviews.

1. Desk based research included:

- Review of national policy and statistical data in relation to MMR immunisation and review of the MMR press coverage to date.
- Review of a variety of local documentation, including population and locality data, local statistics and strategies and local press coverage of outbreaks.
- An extensive academic literature review on parental attitudes to MMR vaccination and factors that influence them in this area.
- Identification of previous campaigns in this area and successful campaign strategies.

2. Focus groups:

- Six focus groups took place with 58 parents (including those from specific target communities). A topic guide for the discussions was developed utilising the research data collected as part of the desk-based research and professional expertise. The guide included; parents' understanding of the evidence of the safety of MMR vaccine and the decision they had made, perceptions of the role of the media, government, health professionals, information needs and media consumption and views on promotion of the MMR.

3. Telephone interviews:

- 20 telephone interviews were carried out with parents and hard to reach parents. An interview schedule was developed which included the above topics and enabled exploration of their personal decision making process in more depth.
- The insight also included interviews with eight stakeholders and health care providers involved in MMR work. Interviews focused on current provision, views on health promotional materials available, the needs of this group and strategies to improve MMR uptake. (Topic Guides are included in Appendix B)

Recruitment

Affluent / older parents were engaged via a poster recruitment campaign which was displayed in Children's Centres in the two localities (with approval) and via local parenting websites and forums. This recruitment method was highly successful and we were inundated with responses. Therefore, we could have consulted with at least 50 parents if the brief permitted.

Parents from more hard to reach communities were targeted through relevant local forums and through the use of identified community leaders and health care professionals. Links provided by the PCT were also utilised. Again, we were oversubscribed with volunteers and could have consulted more.

Data Analysis

Where permission was granted or where we were able, focus groups and interviews were recorded and transcribed. To enable systematic comparisons to be made across the large amounts of data, data was thematically coded, following the principle of the constant comparative method, and rigorous analysis, each transcript was repeatedly re-examined and cross compared to identify common themes and explore parents' underlying reasoning. We developed a coding framework to explore parental concerns and views on MMR.

Methodological Limitations

The employment of a qualitative methodology and one of the advantages of using focus group methods was to ensure the generation of rich and dynamic data by facilitating discussion. However, the large amount of data generated meant that it was neither feasible nor possible to present it all and core themes that ran throughout were identified and focused on. Additionally, because of the sometimes chaotic nature of focus group conversation it was not always possible to identify participants and collect clear quantifiable information (such as the numbers whose children had the second dose of the vaccine). Therefore, we have presented some statistics on the sample to provide a flavour but these are not as rigorous or detailed as we would like. The level of interest in this topic locally was high, as demonstrated in the recruitment process. It may be worthwhile at a later date to follow this study with a quantifiable parental survey on MMR, as the two would be complementary.

The findings may represent some bias as we were reliant on volunteers and those most likely to have strong views on MMR, either pro or against. Additionally, the traveller parents' were recruited using an existing link and specialist Health Visitor. Hence, this group may be more inclined to engage with health services than the travelling community more generally. The other hard to reach groups were also recruited using experienced community workers and thus again they may not be typical representatives of these groups.

The sample

hey moscow consulted with 78 local parents and eight local stakeholders either by telephone or as part of a discussion group. The profile of the sample is given below.

- The largest group consulted were Eastern European parents (23%), followed by young parents (21%), Affluent / older parents (19%), traveller parents (17%) and homeless and BME parents (10%) each. The sample was therefore reasonably evenly distributed between the target groups.

A. Overall sample

Total parent participants consulted from specific groups:

PARENT GROUP	NUMBER & %
Homeless	8 (10%)
Traveller	13 (17%)
Easter European	18 (23%)
BME	8 (10%)
General / professional parents	15 (19%)
Young parents	16 (21%)
TOTAL	78

Gender:

- Most participants were female, despite advertising for parents generally. Two male participants responded for telephone interviews but were then unfortunately unavailable at the pre-booked times. This does indicate that this is a decision that predominately falls within the female domain. However, there were male participants in the traveller and homeless focus groups.

Age range:

- The majority of parents consulted were 18-21 or 25-30 (22%) for each age category, however (19%) were 35-40 and (14%) 35-45. Overall, (13%) of parents consulted were over 40. Therefore, a representative age range was covered.

Age range:	Overall Sample	Homeless	Traveller	Eastern European	BME	Parents /General	Young Parents
18-21	17 (22%)			1 (6%)			16 (100%)
22-25	8 (10%)	3 (37%)		3 (17%)	1 (13%)	1 (6%)	
25-30	17 (22%)	4 (50%)	2 (15%)	5	4 (50%)	2 (13%)	
30-35	11 (14%)	1(13%)	1 (8%)	1 (6%)		8 (57%)	
35-40	15 (19%)		4 (30%)	6 (33%)	2 (25%)	3 (20%)	
40-45	3 (4%)		2 (15%)			1 (6%)	
45-50	3 (4%)			2 (11%)	1 (13%)		
NK	4 (5%)		4 (31%)				
Total:	78	8	13	18	18	15	

Ethnicity:

- The largest ethnic group in the sample was White British (38%), with (23%) Eastern European and (17%) Romanian/Traveller. The ethnic breakdown shows that there was a fair representation from each of the target groups.

NB. Travellers in Doncaster did not fill in the qualifying forms correctly, some were British travellers.

Ethnicity	Overall Sample	Homeless	Traveller	Eastern European	BME	Parents / General	Young Parents
White British	30 (38%)	4				15	11
British Traveller	13 (17%)		13				
White / Black Caribbean	1 (1%)						1
White / Asian	1 (1%)				1		
Black African -Caribbean	1 (1%)				1		
Indian / Pakistani	2 (3%)				2		
Somalian	1 (1%)				1		
Iranian	1 (1%)				1		
Polish	18 (23%)			18			
Emeni	1 (1%)				1		
NK	9 (12%)	4			1		4
Total	78	8	13	18	8	15	16

Home town:

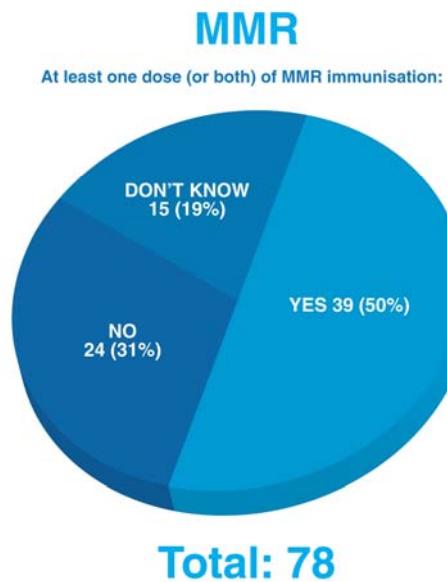
- The majority of participants were from Doncaster (62%) and (38%) were from Sheffield.

Location	Overall Sample	Homeless	Traveller	Eastern European	BME	Parents / General	Young Parents
Doncaster	49 (62%)	8	8	18		7	8
Sheffield	29 (38%)		5		8	8	8
NK							
Total	78	8	13	18	8	15	16

MMR Immunisation

NB: Unfortunately, It is not always clear from the focus group transcripts whether participant parents had the first / partial MMR or full MMR including the second dose, despite this being distinguished in the topic guide. Parents were also asked this (whether participant parents had the first / partial MMR or full MMR including the second dose) on their consent forms. Therefore, we have indicated whether parents have had at least one dose of MMR but are unable to provide data on whether this is a first or second dose for all participants. However, we can provide more detail for parents from interview data and will provide data on the numbers who have had the single jab. The issue of first and second dose was also discussed in each group.

- Half of the sample, (50%) had vaccinated their children with at least one or two doses of MMR at the time of research. For some, children may not have been old enough for a second dose but all those who had the first dose expressed a willingness to have the second dose in discussions. We also asked participants if they intended to immunise and therefore we have broken this down further in a subsequent table.



- A further breakdown of the sample by target groups, shows that those most likely to have had their children vaccinated with MMR were the BME parents from Sheffield (88%), followed by the homeless parents from Doncaster (63%), and the young parents from Sheffield (56%).
- Those least likely to have had their children vaccinated with at least one dose or both doses of MMR were the Affluent / older parents group from Sheffield (33%)

followed by the homeless parents from Doncaster (38%) and the Doncaster Eastern European parents (28%).

Summary of vaccination status

Location	Overall Sample	Homeless	Traveller	Eastern European	BME	Affluent / Older Parents	Young Parents
Doncaster YES	20 (25%)	5 (63%)	3 (23%)	7 (39%)	7 (88%)	5 (33%)	
Sheffield YES	19 (24%)		2 (15%)			1 (7%)	9 (56%)
Doncaster NO	12 (15%)	3 (38%)	1 (8%)	5 (28%)		3 (20%)	
Sheffield NO	12 (15%)		3 (23%)			5 (33%)	3 (19%)
NK	15 (19%)		4 (31%)	6 (33%)	1 (12%)	1 (7%)	4 (25%)
Total	78	8	13	18	8	15	16

However, some people who said they had not immunised their children with MMR expressed an intention to do so (this could have been related to the age of their child). Others said they did not intend to do so and some had opted for the alternative single jabs. Therefore, we have broken this down further overleaf.

- The breakdown shows that of those that said they had not had their children immunised with MMR, the homeless parents were most likely to intend to do so. The traveller parents were the least likely to intend to do so and the affluent / older parents from the more affluent areas in Sheffield who had not had the MMR were the most likely group to have had or intend to have single jabs instead.

Summary of those not immunised: status / intention

MMR	Overall Sample	Homeless	Traveller	Eastern European	BME	Parents / General	Young Parents
Doncaster NO	12 (15%)	3 (38%)	1 (8%)	5 (28%)		3 (20%)	
Intends to Immunise		3 (100%)	1 (100%)	4 (80%)		1 (33%)	
Single jabs						2 (67%)	
No intention to immunise				1 (20%)			
Sheffield NO	12 (15%)		3 (23%)		1 (12%)	5 (33%)	3 (18%)
Intends to Immunise							1 (33%)
Single jabs						5 (100%)	
No intention to immunise			3 (100%)		1 (100%)		2 (67%)
Intends to Immunise							
Total	24	3	4	5	1	8	3

- Therefore within our sample overall there are 7 people (9%) who have not had their children immunised and said that they had no intention to immunise.
- 7 people (9%) overall had opted for single jabs instead.

Participant Findings

NB: All focus groups were recorded and transcribed apart from the Eastern European group, where all participants were Polish, with no spoken English. With a large group of 18 and one interpreter, we were unable to obtain direct quotes from these participants. Instead we focused on priority information.

Theme 1: MMR immunisation decision made & reasons why

Affluent /older parents:

Summary of decisions made: (Sample = 15)

- 6 had immunised with MMR (40%)
- 8 had not immunised with MMR (53%)
- 1 was unknown (7%)

- From the 8 who had not immunised, 7 (88%) had single jabs & 1 (12%) did intend to immunise.

The findings demonstrate that the decision making process as to whether to have the MMR was by far the most complex for these parents than any of the other groups. All of these parents did extensive research prior to their decision and many also consulted health professionals and friends and family, which supports the national research evidence. This group was the most affected by media controversy. Those that had decided to have the MMR for their children found the decision equally complex.

Affluent / older parents who had their children vaccinated & the decision making process:

"I was concerned about it. My husband and I talked it over. My understanding was that the research had been discredited and lots of flaws had been discovered. (My husband was knowledgeable as he has had poor health and as a result of that I have had the jab as an adult with no side effects). I also did research and spoke to health professionals so it wasn't an instant decision. I have a good relationship with my health visitor and she explained the evidence had been discredited and why and then consulted my GP."

"It's one of the worst decisions I have ever had to make. I spoke to the health visitor after doing research and she calmed me down but to be honest I was still iffy."

"I did a lot of research on the internet, read books, and consulted the midwife. When I actually had it done it was all very quick, it was like 'next please, jog on', but to be honest by that point I had already made my mind up and it would not have made any difference."

"I was so torn you know but there is a general feeling among mums that our children are having too many injections these days anyway, so then I thought it's not fair to have the single jabs and put more pressure on my child's system because of my own irrational fear."

"If they offered me the single jab there is no doubt in my mind I would have preferred it."

Some respondents made the decision based on significant personal experience. The research evidence found that personal experience of autism was most likely to influence parents not to immunise. However, our evidence shows that personal experience of measles can work in the same way i.e. in influencing people to be pro-immunisation.

"I am really rather militant about this issue. I knew that the Wakefield research was all a load of tosh from what I read and the sample size was ridiculous in scientific terms. I also have personal experience of measles. I am partially deaf because of childhood measles so I knew all about it. I looked on the internet for information though; locally I have never seen a thing. I am quite single minded though, I didn't need to consult the doctor, I tend to go on my own opinion and not be influenced by others."

"I was aware of the issue through the media. I did extensive research myself in light of the Wakefield concern. After doing the research I was not entirely convinced and so I thought it just makes more sense to do the single jab. Also, I had discussions with my mum who is a speech therapist and so I am well aware of autism and it's personal to me and we discussed it and I just felt more comfortable not risking it."

Our findings clearly demonstrated that after making the decision those that decided to immunise were still very emotional about the issue and fearful of their choice. Some respondents reported a lack of empathy from medics at the time of immunisation which supports some of the national research. They perceived there to be a general lack of recognition of the significance of immunisation for them. This highlights a need for emotional support and reassurance for this group, which appears to be a higher unmet need than information, which most of them have themselves.

"I did it but was so scared I knew in my head the fear was unfounded but I couldn't do anything to control it."

"I was so nervous and concerned. I went with a friend, we went together and she held my child and I held hers, that's how we got through it. This was with my first child though; it was entirely the media coverage that caused all that fear. However logical you are, the thought of your baby getting autism or bowel disease is hard to bear. But by the time I had my second child I was calmer I actually talked to the GP about how I felt, but found he was a bit woolly about it all and didn't seem to know much about the evidence. Luckily, I have a friend who is a health visitor and she gave me much better information and explained the research was funded by parents of children with autism who were trying to find something to blame. I was much more reassured but it still felt like I was hedging my bets a bit. I can never say I was entirely certain but I do believe children need to be vaccinated."

"I had seen the coverage, yep. I don't believe in not being immunised though even though I didn't like the idea of this one. In the end I felt pressured into it I guess, the health visitor told me of the timeline at nine months. I believe the NHS should offer more options and realise

how difficult it is. In the end when I took her it was like a conveyer belt system, all done quickly & very officially. There was no discussion on side effects or anything and no one asked if I felt happy. I was anxious and nobody reassured me. If anything had happened to my child I would have been devastated. Afterwards, I went on a parenting forum as I needed to express and share how I felt.”

Young parents:

Summary of decisions made: (Sample = 16)

- 9 had immunised with MMR (56%)
- 3 had not immunised with MMR (19%)
- 4 were unknown (25%)
- From the 3 who had not immunised, 2 did intend to immunise and 1 did not intended to immunise.

Among younger parents the decision making process was far less complex, but this group had very low level awareness of the media controversy and appeared to not question things as readily as the other parents. Their age was inevitably a factor in avoiding the media storm, as much of this would have occurred when they were children. Some had heard about it but not researched it any further and they seemed generally accepting and compliant of the medical advice given in regard to immunisation. Only one mother was so concerned that she had opted not to immunise but was reluctant to explore this further with the medical profession and had not opted to do any research independently.

“I was not worried, me mum said we all had it done when we were small, I have not heard of anyone getting ill.”

“I just got it done because that’s what it said in the book, I follow what it says, I aint got time to research why.”

“It said about it in the bumper pack.”

"I am just worried about all the stuff said. No, it wouldn't help to talk to anyone because I don't believe they are going to tell me the truth, they are just going to persuade me and make me feel like a bad mum."

Homeless parents:

Summary of decisions made: (Sample = 8)

- 5 had immunised with MMR (63%)
- 3 had not immunised with MMR (38%)
- From the 3 who had not immunised, they all intended to immunise but 1 was very unsure.

This group were similar to the young parents in that they largely accepted that this should be done following medical advice without further examination. However, they were more aware of the controversy and wanted more information on this.

"Yeah I went and looked it up on the internet before I took me son"

"Yeah you just get that pink slip and it's always the same. So you go along"

"Haven't you heard on the news though about children that aint had it being really poorly?"

"Yeah but I aint heard nothing for sure about that child or this child. not for sure"

"I'm not going to do it just in case. I need to know for sure"

Traveller parents:

Summary of decisions made: (Sample = 13)

- 5 had immunised with MMR (38%)
- 4 had not immunised with MMR (31%)
- 4 were unknown (31%)
- From the 4 who had not immunised, they all did not intend to immunise.

Decision made based on the information given by the health visitor / media not used.

Among the traveller parents interviewed there was some knowledge of the controversy but again as with the homeless parents, they had not felt compelled to explore this further. This group were generally not reliant on the media. Some had been persuaded by health professionals to have it.

"My grandson was one, they both ended up in hospital before they had the jab. So I basically got bullied by the Doctor and Nurses. They said that we aren't getting these kids out of hospital till they get their shots. So I put my other two that I had, which was younger than her to get immunised. Now my daughter has had hers immunised in the meantime because she knows the effects."

"I don't think I would give the immunisation to my children. I would only give the tetanus injection to them. It prevents you if you cut yourself."

"I am very wary to be honest, I have seen the news and papers, all this link to autism and the guy who said it is from Cambridge I think. I know they say it's not proven but it's not proven that it doesn't either so it's a gamble."

"My health visitor told me all about it and when I should go to the clinic and I took it from there really, I trust her and she told me all about the side effects of mumps and measles."
(Female)

BME Parents:

Summary of decisions made: (Sample = 8)

- 7 had immunised with MMR (88%)
- 1 had not immunised with MMR (12%)
- The 1 person who had not immunised did not intend to immunise

The BME parents in our sample were similar to the young parents in their approach to the decision making process; they had limited knowledge of the controversy but were accepting of the medical advice that it was required.

"Going to help your kid."

"Doctor says it and you have to say yes."

"Yes to protect our kids."

"My second child is six years old now and my friend said she must be vaccinated. I said I did not get a letter from the GP, she said you must go along and get one. That's when I went to the doctor and got it done."

"They said I had to have injection for the kids and I went."

Eastern European parents:

Summary of decisions made: (Sample = 18)

- 7 had immunised with MMR (39%)
- 5 had not immunised with MMR (28%)
- 6 were unknown (33%)
- From the 5 who had not immunised, 4 did intend to immunise and 1 did not intend to immunise.

The Eastern European parents were also largely unaware of the controversy. However, they had a higher level of awareness of the importance of immunisation than the travelling and younger parent groups. It was explained that the approach to immunisation in Poland is very persuasive and there is a lot of promotion and they were used to immunisation being actively promoted and did not question this. Some were so pro-immunisation that they suggested it should be compulsory in this country. The one person who did not intend to immunise had heard about the controversy and the fact that it was perceived to be linked to 'mental illness', but because of the language barrier did not really understand it and was desperate for information.

Theme 2: Views on risks/benefits in regard to immunisation & how these are assessed

Most participants in the sample perceived there to be benefits and disadvantages to either making the decision to immunise or not. Therefore, we explored with some participants how they decided which risks are most significant.

Affluent /older parents:

The findings show that whilst most affluent / older parents were worried about the autism links they were knowledgeable about childhood diseases and some decided that this risk was more significant. Hence, this identifies an opportunity to focus promotional work on the effects of childhood disease.

Affluent / older parents who had their children vaccinated

"I had seen the negative coverage but my sister had done it with her kids and I spoke to my mum anyway. I also looked on various websites. In the end I was a bit confused really and couldn't make my mind up but then I thought from what I read that the risks from measles and mumps was worse really."

"At the end of the day I had to weigh up the evidence and decide which was the biggest risk and for me it was childhood measles."

"The thing that persuaded me was a local outbreak of measles. My youngest one was too young to have it and I was really scared about protecting him, I didn't want to take him to pick up the older one from nursery but had too. That's how I decided I knew then the fear of measles was greater and you would do anything to protect them. I knew fears the other way were probably unfounded but the side effects of measles are not folk law. I will be honest though if I had been offered the single jab I would have taken it like a shot."

"When I did it I did see there being an element of risk but I coped by reminding myself about the consequence of measles, people go deaf for goodness sake and I constantly had to remind myself of that."

"Both my children have had it done. I looked into it myself, spoke to the health visitor and got a feel for other parents views through forums on the internet. I also spoke to my family and they were happy that it was safe. In the end I decided it was more dangerous not to."

Young parents:

"I heard there is no evidence behind all that stuff. Anyway, a kid in my child's nursery got really sick with measles and that scared me more."

"I was told it was only boys that get problems after so I wasn't worried for my daughter."

Homeless parents:

Some of the homeless parents also acknowledged that the risks of childhood disease would be worse but their analysis of the risks was less coherent and they still had questions in regard to risks and what these were.

"That's what I have just been talking to my mates about. I'm a bit worried cos I have heard some bad things about it. So I would want to talk about it."

"I were already worried about it before I come here."

"I didn't know it's dangerous but it's better them having the injection rather them being ill for weeks on end. Know what I mean?"

"Yeah I want to know how high the risks are. I want to know what the risks are before I give my baby anything. I actually want a bit of reassurance."

Traveller parents:

Some of the traveller parents also weighed the risk up in terms of risk of childhood disease but also still perceived there to be a risk either way.

"Once I heard how dangerous measles could be I decided it would be safer."

"Thanks to my Mum being stronger willed than the Mother in Law. She went to my sister in Law who had four kids who had already been done, they were all healthy. So she risked the doctors giving them the MMR rather than them getting ill."

"I saw stuff on the television. I was petrified to tell you the truth, really scared about it all but I chatted to the health visitor and she explained it was safer to have it, talked me through

measles and mumps and everything. My GP also explained it all to me and in the end I was happy.” (Female).

Hence, these responses on risks do not demonstrate that any of these groups of parents have entirely dismissed the evidence linking MMR and autism but are able to assess the probability against the likelihood of childhood diseases.

BME Parents:

In the BME groups they all said they felt confident in the vaccination, did not fear any risks at all, but they had heard rumours that some British people had concerns. However as they did not understand fully what these were, they did not need to assess these in terms of risks.

“European says it’s bad.”

“My friend said the white people said it’s bad.”

Eastern European parents:

Like the BME parents (apart from one participant), none of the Eastern European parents perceived that there were any risks to weigh up in regard to immunisation.

The Notions of Trust

Theme 3: Parental influences and views on credibility of these sources

All parents were asked about the significance and levels of influence of identified sources on their decision and their views and opinions on the credibility of these sources including; friends and family, media and health professionals and government.

A. Other parents as credible sources/ family & friends

Affluent /older parents:

The general parents were not homogeneous in their response to the influence of friends/family and it seemed to depend on individual circumstances, but for some it was significantly influential and others less so. Hence, it is difficult to draw any conclusions about the level of influence on this group. Although interestingly, some did reveal a reluctance to discuss their final decision with those close to them as it was perceived as such a personal choice.

“My mum is a nurse with four children so I really trust her and use her more than the family health book, but I have always found the GP helpful too.”

“My sister had it done five months before me with no side effects and to be honest that had a massive influence on me, even more so than the health visitor. I know that sounds awful but I have that deep level of trust in her.”

“I did discuss it with friends and family but at the end of the day I think there is a lot of fear around revealing your decision to people. I know a lot of friends who had the single jabs and when I heard I felt panicked and thought oh god maybe I should have done the same as them. I like the anonymity of parent forums: it feels quite liberating to say exactly what you think without feeling you are being judged.”

“You know, once I had decided to have the single jabs, I kept quiet about it and felt really alone in my decision. I felt certain mums at the nursery might think I was a snob for paying for it. Also, I really don’t believe in no immunisation and I was worried that if I told any mums what I had done and they couldn’t afford it, they might decide not to have it which I disapprove off. I couldn’t help it though, I am well educated and know all about mumps and measles, I can also honestly say I didn’t think the risk was great in my head but I was so emotional about it, the fear was all-consuming and I just thought ‘why go through this for the sake of it?’ I knew if I had it I would then be watching my child howl and it would not end.”

"I am very independent. I didn't even ask my husband. It was my choice."

Young parents:

In contrast it was clear from the analysis of transcripts with all younger parents that friends/family and peers were by far the most influential factor. They were more likely to consult friend / family first prior to a health professional.

"I trust my friends and family best."

"Word of mouth is always best, like loads of issues I have had like with breast feeding I have just talked to the other mums here about it. They have done it, it's so much better than the health visitor. Some of those health visitors don't even have kids, I think that's wrong: I don't think you should be allowed to be one if you are not a mum."

"My mum always tells me what she did with me and my brother and sister and I trust that, as we were all ok."

Homeless parents:

For the homeless / parents' knowledge from their families was also held in high esteem but in regard to health matters there was some acknowledgement that things had moved on and their families may not always have the most up-to-date information in regard to health.

"Yeah. My mum had four kids she said "look, you all had it and it were fine."

"When I had a kid I didn't know what to do and me mum said 'ya do this ya do that' and you listen to them."

"When you have your lot (of kids) then you talk to ya mum."

"Everyone I know, me family, me friends, that lot has had the jab and not one's got ill"

"Your parents might have a different aspect to you. They had a sugar lump for polio and so on. Things were not that far advanced."

"Yeah suppose. It's all changed now 'cos my daughters three and me sister has just had a baby and she is getting things told to her that I didn't get told."

Traveller parents:

It should be noted that among the traveller parents it was a clear and consistent theme throughout that women were the decision makers and influencers in terms of child health within these communities. The women in this sample also appeared to be more willing to embrace health services and the men more likely to revert to historical cultural attitudes to health. Hence, it would seem appropriate to target the women within this community in regard to any MMR promotional work.

“Men don't have anything to do with it. If you asked them they would have an input. They tend not to think about it. They regard it as a women's job to deal with things like that.”

“It's individuals in every family. It's mostly the mums saying what we should do.”

“Like with all communities it's your mum / aunt and your sister then.”

“I wouldn't talk to my parents about it. All the older generation in our community didn't have injections so there is no point talking to them I know what they would say. I spoke to the health visitor and she explained it was safe. I had seen quite a lot on this MMR, it really got bad press but in the end it was OK I was fine with it.” (Female)

“The women are in charge of the kids and their health. I do chat to friends but the men and older generation don't really believe in injections so I listen to the health visitor more.”

“If two women went to the doctors because they were pregnant and one said they would not give the MMR they both wouldn't. We have rules about everything but when it comes to medical stuff we make it up as we go along. We are trying to figure out what is acceptable in our culture.”

BME Parents:

Among the BME parents' in our sample, they did not perceive the influence of friends or peers to be particularly significant but it was clear decisions were made jointly between partners.

"Yes he does."

"Your partner is part of your child and they have an interest in what's going on."

"We talk together."

"Not just the women, we talk with the husband."

Eastern European parents:

The Eastern European parents interviewed were unanimous in their view that friends / family were not influential in regard to health and their primary source would always be a medical professional, even disregarding their mother's views in preference to that of a professional.

B. The influence and credibility of the media

Affluent /older parents:

The majority of the participants were clear that they were sceptical of media sources and that these were not particularly influential. However, it is possible that this influence is underestimated as it was this group who were most affected by the media storm in this sample. However, this may be simply as highlighted in the national research that the media messages increased their need for other information and they were not readily accepted as truths.

"You can't ignore the media, it worried me but I would not rely on just that. I just got straight on the internet."

"For me I did so much research it negated the negative press but from talking to other parents the media is still the biggest barrier. I know it's been discredited but people think there is no smoke without fire, it's going to take a really long time to get over all of that."

"The media did worry me. I was quite apprehensive of the whole thing and couldn't block it from my mind."

"You know I think the media hype has calmed down and maybe if I didn't have a one year old when I did, I would have had the MMR instead of the single jabs, but at the time of all that hype I didn't want to go to my doctor because of it. I knew my doctor was very pro MMR and the NHS wouldn't give the single injections. At that time I needed someone independent."

"I ignore the media in terms of health, this is where all this scaremongering comes from. I like factual information and go on the internet. I do understand parents' fear and blame the media. Before I went on the internet I was actually in two minds because of news headlines, it is damaging and wrong."

Young parents:

The young parents in the group had low consumption of media in terms of newspapers and news items and hence were not heavily influenced by this.

Homeless parents:

The homeless parents in this sample were clearly aware of media messages / headlines on MMR but had not felt compelled to investigate these further, suggesting that perhaps this influence was not strong.

"Oh right I heard it gives you that autism."

"I read that they had the MMR injections in loads of other countries and it wasn't a problem. It was a load of lies (about autism) really."

"Yeah but if he did give them, injections to his children and he believed in them why did he not want the country to follow him? It's not a bad thing that he gave his kids them injections."

"When ya get two sides all they print is the negative cause that's what it's all about int it!"

"Yeah there are some papers you can believe in and some you can't."

Traveller parents:

Some of the traveller parents explained that the media is not a strong influence on their culture and messages rarely permeate this. Additionally, because of low literacy levels in terms of use the main source was TV.

"All the bad stuff comes through on the TV, all stuff that says they are wrong comes through the newspaper. This is the order that we get our information."

Eastern European parents:

The Eastern European parents said they watch Polish TV and used the internet most frequently. However, as they did not speak English they did not really access the British press or news and hence the media had not influenced them in terms of MMR.

C. The influence and credibility of government & health care professionals

Affluent /older parents:

There are two broad distinct responses from general parents in regard to the credibility of government and NHS sources. Those that had the jab trusted the NHS / government but some tended to rely heavily on faith placed in their local practitioner. The research demonstrated that when there are questions of faith in the medical system as a whole, people turn more readily to trusted professionals within their locality.

Those that had immunised with MMR:

"I don't think the NHS information is biased. I am not a smoker but I think that the smoking campaign is really good actually. They are only campaigning on issues that will improve people's health."

"I spoke to friends about it but it was the health visitor who really helped me, she spoke to me about it at length and it was really helpful, she is also a mother herself so I believed what she was saying was authentic."

"I respect my doctor, I went to him with my concerns and he really did take a lot of time to talk to me. He explained the research was based on a handful of children and the doctor had been struck off and that the age of the second MMR coincided with the time those

children were identified with autism anyway. I was really happy with the discussion we had. I had already inquired locally about the single jab but after our chat I realised there really was no real value in doing it.”

“You know I understand why the government won’t offer the single jab: it would completely undermine their argument on the safety of MMR. People perceive it as arrogant but I see it as evidence of their conviction.”

“You know I don’t really see how people can say the NHS are biased in their information. They are not conspiring to sell us mistruths! I think an MMR campaign with positive messages would be a great idea.”

“I trust the government in terms of health. I may not like their political approach at the moment but they are not going to risk lives of babies for goodness sake.”

“You have to trust the NHS, OK there have been some mistakes but overall it’s not a commercial business, it’s there to help people. I can’t contemplate that they would do anything to risk harming children in this day and age as a cost cutting exercise.”

In contrast, those parents in our sample that had opted for the single jab were frustrated that this was not an option on the NHS, cynical about NHS information and highly sceptical of government. This group in our sample are the group who are going to be least receptive to any NHS funded MMR initiatives and there is a need for independent advice options.

“You know I think the NHS should be offering single jabs at your general practice where you feel safe at an additional cost. I know that’s not entirely fair as it excludes those in lower economic groups but they are never going to offer it free. It would be nice to have an option and I think this policy of forcing MMR on everyone is deeply flawed and contributing to the low uptake. I think some parents are protesting.”

“You know I feel frustrated with the NHS. I had to go private for the single jab even though the Doctor can order them in if you request it. It is 100% clear the NHS are never going to offer it and I think they just dilute the MMR message. Healthcare must offer individual choice.”

“You know I debated for ages, I know a little boy with autism so it was deeply personal to me and all the bad media coverage was scary. You know what did it for me was thinking about Tony Blair when he would not say about his own little boy, I don’t believe that was for any other reason than he was having private single jabs or he would have owned up. With my second child it had all calmed down a bit and I looked at the evidence on the internet. To be

honest I was happy enough then to have had it but I felt I couldn't do a different thing with each child, I thought it would be wrong to give it to one and not the other, so I felt compelled to do the single jab again. "

"One of the things that still makes me cynical of the NHS on this issue is that I know they have targets to meet and they want their statistics to be right, so they are never going to tell you the truth. They are going to tell me it's safe at all costs."

"From my personal perspective I want an independent person to speak to. As far as I am concerned a single person who is funded by government sources is not going to give me that. They should provide people who can sign post you in the right direction for information and services, not just give you the NHS blurb."

Young parents:

All of the young parents as previously identified had low awareness of the MMR controversy and hence gave no reason why they would question the credibility of NHS / government sources.

"Never heard a thing."

"What's bad about it, does it make the kids sick?"

Homeless parents:

Similarly, the homeless parents in our sample were trusting of these services with only one person in this group displaying any scepticism.

"What worried me is Tony Blair not wanting to have his kids immunised with the same injection. That's a bit worrying isn't it?"

"Yeah, you have to trust the doctors like the health visitors because you haven't experienced it like. And if she is having her first child she is probably going to listen to them because they are professionals."

Traveller parents:

The traveller parents in our research did display some significant mistrust in NHS sources and questioned their credibility. However, this was not in light of the MMR controversy but reflected their general lack of trust in healthcare services and was also a result of them feeling discriminated against and excluded by healthcare as was highlighted in the research by Dutton. However, the females interviewed were more progressive in their attitudes where they had an established relationship with a local practitioner.

“You know targets for immunisations and screenings. They lose money, the GPs lose money. They don’t get extra money.”

“Strangers are strangers though. All it takes for you to build trust with a doctor is for them to say something like ‘yeah I understand, let’s see what we can do’. We would like someone who is not desperate to get rid of you.”

“If you feel discriminated against we don’t trust them.”

“I think the gypsy people want trust with the doctors. The doctors that come to your house or site, we feel that they do want to get to know us. But if you get one bad health person it ruins the trust.”

“I am OK about the GP; I especially get on with the health visitor. The only problem I have is I can’t read or write so any problem I have, I have to think and ask and you can’t always get through.” (Female)

BME Parents:

On the other hand BME parents did not display any trust issues with these sources.

“Well the doctor says yes so we listen.”

“We trust the doctor.”

Eastern European parents:

This group also had complete faith in government / health sources and felt they would not misrepresent themselves. They perceived NHS information to be helpful and did not consider these messages could be interpreted as propaganda.

D. Religion

All participants were asked about religious influence and whether this had any impact on their decisions to immunise. However, none of the participants across groups identified any religious boundaries to immunisation. A few of the travellers said that for some there may be cultural norms that are influential, but religion was not a factor.

"The young women who was supposed to come was Catholic and she has had hers done. It's not about religion."

"Some people in the community say they don't have it done because it's against what they believe. No if's, why's or maybe's, that was the end of it."

Theme 4: Use of & views on local healthcare provision

Participants were asked about their use and views on local healthcare more generally; this was to enable us to identify appropriate opportunities and challenges in NHS MMR promotions for these groups.

On the whole the majority of participants across groups were relatively happy with local healthcare provision. One frustration that came up most frequently across groups was the considerable waiting times to make a GP appointment. Some reported that this could be up to two weeks and with young children found this unacceptable. At least seven participants in the group had ended up in A & E with a relatively minor concern with their child as they could not access a GP.

Affluent /older parents:

On the whole the affluent / older parents were happy with healthcare provision with only a handful of participants raising concerns about the approach of healthcare professionals in regard to child health issues they had experienced.

"I am very happy with local services. We are lucky as well in that we have a new well funded children's centre. In there they run a drop in with midwife and health professionals, it's really very good. They also have drop in baby clinics where you can discuss things."

"It is important though that they keep up to date with the reminders if they want to improve things, they are very poor with them."

"Sometimes I have found the health visitor a little bit patronising. I was really worried about my child and called her and she said I was panicking because I was inexperienced and a first time mum. I ended up going to A & E and being there hours, I feared meningitis and to be honest the whole experience was so horrible I have not spoken to her since."

"When I had it done I was a bit disappointed. I had made the decision obviously by then anyway and found my own information but I got the reminder, went along it took about 2-3 minutes and I wasn't offered any information or support. If someone was really worried I think that clinical approach would really put them off. It's a time when mums are looking for reassurance."

Young parents:

Most of the young parents in the sample had young babies and hence considerable contact with health visitors. There was considerable dissatisfaction across this group about the approach of health visitors whom they felt patronised, judged and observed them. If a subsequent MMR promotional initiative is put in place, careful consideration needs to be given to the appropriate professional to deliver this to this group.

"My health visitor is useless; she just pokes her nose into your business."

"I feel the same. I have to clean up if she is due 'cause I think she is judging me on my house."

"I do too, mine didn't even want to sit on my sofa, and she kind of turned her nose up and carried on standing."

"She makes me constantly jumpy."

"I had to tell mine I didn't like her attitude, always telling me what to do and treating me like I am stupid. She didn't say anything back though."

"I can't stand mine and you don't get any choice in it, it's not like I can change her, I am stuck with this right cow."

"I find that the nurse doesn't take me seriously, I went there and said my child has got asthma, I knew because it runs in the family but she wouldn't listen to me. I ended up going to hospital in the end and getting an inhaler there."

"Oh god those health visitors patronise you and tell you what you must do. I find they all give different information as well which is confusing."

"Yeah I know, my one told me I should be feeding every three hours and everyone else has told me that's rubbish."

"My one only visits to look around my house."

"Health visitors and midwives don't help you."

Homeless parents:

None of the homeless parents had any concerns in regard to healthcare and approach. However, the majority of these participants linked into healthcare via outreach workers who would be specifically trained in working with this group and understanding and reflecting their needs.

Traveller parents:

Among the traveller parents a significant local issue that was raised was in regard to temporary registration which represented a barrier to use and could present a problem in terms of MMR immunisation as some of these participants said that the temporary resident status resulted in them not receiving information and reminders.

"One of my problems is I always have to register as a temporary patient so you never see the same person and you don't get to know them and chat to them."

"The NHS needs to look at how if funds surgeries which have lots of travelling communities"

or hard to reach communities. They can't take money off them. They need to try their best to give travellers a good service. At present they register them, work with them but because they are not meeting their immunisation requirements they get their funds cut."

"It's not that they are not interested they just can't register. The new surgeries in Doncaster are only registering them as temporary residents so they don't get other letter, inviting them to things. So that's a big problem in Doncaster."

"If you don't get the letter you don't know you're invited for it."

The issue of trust also re-emerged with some participants revealing that they perceived there to be such a high level of discrimination with health care services to their community that they were not even willing to reveal their status as travellers. This issue of discrimination and trust is significant and would need to be addressed prior to delivery of any MMR intervention.

"Only when we need them, as little contact as possible."

"If you don't say what you are they don't know what you are. A lot of people who live in house's don't admit to the fact of what they are. They don't want people to know. Especially if they live in villages, you keep your head down."

"I wouldn't tell my doctor I was a gypsy."

"I wouldn't tell them either as you wouldn't get an appointment for love or money."

However, some of the females in the group demonstrated that this trust issue could be overcome with a dedicated health professional doing outreach work within this community

"I'm permanently registered with a doctor so I get all the letters. As I have so many children sometimes I get a young woman (health visitor) come out to me. I wouldn't have none of the other ones come out to me only her." (female)

"I have a good GP and the health visitor is very nice." (female)

BME Parents:

The English worker present in this group said they highly prize doctors as they are a luxury back home. They are viewed to be always right so they register the moment they arrive in the UK. However, many do not share common languages with a lot of the Pakistani community.

"Yes they need to improve more on getting interpreters."

"And you sometimes have to travel, long time."

Eastern European parents:

The Eastern European parents said they found the GPs and surgeries very good in providing leaflets in their own language which is vital, as they have no English. An example of the NHS Stop Smoking service website was given, which some had accessed in Polish. Even the interpreter present said she prefers to read Polish. They appreciated this and it had made them feel part of the NHS. However, none of the group had access to interpreters at their local GP and hence they were unable to engage with practitioners in any discussions or find out more through consultations.

Additionally, there was an overall perception that Polish doctors were more qualified (as they had better medical training and their knowledge was perceived to be wider. Some described scenarios in which they felt British doctors had missed symptoms and not fully explored conditions. However, they concluded there were pros and cons within each system, they valued UK specialists and were appreciative of the principle of a free NHS system which included referral to specialists such as physiotherapists. In Poland they have to pay and medicine and specialist access is very limited. They described the principle behind the system as 'wonderful'.

Theme 5: Information

All participants were asked about their knowledge of MMR, childhood disease and where they obtained this information from. The information does demonstrate that MMR knowledge and knowledge of childhood disease was incredibly low among young, BME and homeless parents and perhaps identifies a targeted need for information on this.

A. MMR awareness and information sources

Affluent /older parents:

Knowledge of both MMR and childhood disease was highest among the affluent / older parents group who as previously identified were most likely to have carried out extensive research on the internet. Hence, some of the NHS resources seemed comparatively basic.

"I looked on the DH immunisation website, it didn't help massively. It didn't tell me anything I didn't already know i.e. about measles and it felt impersonal."

Young parents:

Young parents knowledge was low of both and it was something they did without full knowledge of its purpose. The most utilised information source was their red book / baby folder.

"I know it's for measles and that."

"What is it for? We have so many injections to give them."

"I don't know a lot about it but I bet it's in my red book."

"If anything goes wrong or I want to know something I read my pack."

Homeless parents:

All of the homeless parents knew that the MMR jab was against measles, mumps and rubella but their knowledge about it was limited. Some had obtained information from friends, family and the internet. Most said when they had it done they did not receive any further information from professionals.

"It's a liquidised down form of the diseases and put into the injections."

"Yes lasses at school had to have that injection at school."

"Yeah I had to have it when I were about 12 at school."

"Before I spoke to me family like and they told me what I were getting the jabs done for. But I didn't know it caused owt."

"The internet."

"Me family."

"Me mates."

"I think before I gave birth to our Nellie I didn't get now."

"When ya go in they like give you these little leaflets don't they?"

Traveller parents:

Similarly, most of the traveller parents knew what MMR was for but their knowledge of childhood disease was low and it had been confused with chicken pox within their community.

"I know it's against Measles, Mumps and Rubella. It's to protect them against that."

"To immunise against Mumps, Measles and Rubella. It's not a live virus of it anymore; it's just a version of it."

"No I didn't know what it was, until I took him to the doctors at the end of it. I thought it was Chicken Pox."

"I thought Measles was Chicken Pox you know."

"Three germs in one is better."

"It's not a germ anymore is it? I don't know anything about it. I just know it's terrible when you get it."

BME Parents:

From the sample of BME parents no-one in the room knew what MMR was despite their high level of compliance in having this for their children. Consequently, none of them understood that it involved having three jabs together but they accepted it was good for their children based on medical advice. Additionally, no-one in the room knew what any of the three childhood diseases were and there was lots of confusion around this.

“Yeah having these injections is the best thing. You do what ya told and that’s the best thing. That’s what ya do init.”

“When I first come here the doctor said that in our country we have load of animals that have diseases and we need injection.”

“Chicken spots.”

“Yes a very hot rash. Spots everywhere.”

“Spots like loads.”

“Blood poison.”

“Yes my friend’s child got spots and rash on her face she had to lie down and her eyes swelled. Blinded.”

Eastern European parents:

This entire group understood what MMR was, that it was three injections in one and what the three childhood diseases it immunised against were, probably because immunisation is high on the political agenda in Poland. However, some did have further questions as to why the three injections had to be given together.

B. Information needs & sources & preferred information sources:

Affluent /older parents:

As identified these parents used a wide variety of information sources from newspapers, to televised news, the internet, research papers and books. There were not really any significant gaps in their knowledge identified in regard to MMR. However, the evidence does demonstrate that they had a desire for further consultation and collaborative debate on the subject in light of the extensive body of information they had accessed, which sometimes appeared to be overwhelming.

Information needs:

"To be honest I got a bit confused with the amount of information that's out there anyway, it's a huge topic on the internet. In the end I talked to my mum and sister to get things clear in my head which helped. I think it's a case of information over load at the moment. We know the information it's just a struggle with your conscience really and an emotional process as you would feel responsible if you got it wrong."

Young parents:

Young parents tended to use the red book and family in regard to child's health as primary sources. On a wider level they did not report accessing news items and were most likely to use mobiles and the internet as daily media use. They did not demonstrate a particular thirst for further knowledge on this subject and found written literature to be a bit of a burden and appeared more responsive to verbal information.

Information sources:

"Red book."

"I pick up a lot from chatting to mums and my mum. I don't like reading big leaflets."

"Not keen on paperwork, rather someone just tell me what needs to be done and when."

"I do Google stuff if I am worried about the kid's health."

"I ask the health visitor, quickest way."

Homeless parents:

The homeless participants interviewed reported that they were most likely to access local papers and radio as media sources generally.

Media use:

“Radio”

“Ohh magazines”

“Like magazines and papers”

They demonstrated a greater thirst for knowledge on MMR than the younger parents but some felt it was an individual's responsibility to seek this information out, whilst others disagreed.

Information needs:

“Parents need to be responsible and look to find out.”

“So they panic half the world to death and leave you to find out on ya own?”

“I don't agree. I think that if ya a mum ya got to find out what's what, ya know what I mean.”

“Its important the doctors should tell ya... You ain't got time to look about.”

Information sources on MMR:

“No not really happy it's all shit what I got them.”

“All I got was this pink slip saying he was going in for his jabs 'n that's that.”

“I got that pink slip and the doctor says ya going on so n so date n that's that.”

“The only way to get proper information is to look up on the internet.”

“Yeah but what if ya don't know to look?”

“They should provide something or get together and talk about it.”

“Yeah but ya in and out and that's that.”

“And the Tony Blair confusion added to the argument, him being the head of our country. So a pink bit of paper with no details is not going to convince you!”

Like younger parents they preferred information that was interactive, collaborative, visual and verbal.

Preferred sources of information:

"Yeah, cause you can see if anyone else has had bad experiences but doctors they have debates just between each other then tell you what's what. I'd rather sit and hear it from the horse's mouth."

"Put it another way I can't resist a gossip, I'm an only child and I like to get together."

"Yeah you wait ages to see the doctor anyhow, it takes ages and they are all infectious."

"Yeah a DVD with real mums."

"Spose you could end up with thousands and thousands of DVD's."

Traveller parents:

Interestingly despite, reported low levels of literacy the traveller parents did report using the internet for information and they all had mobile phones. [During the 80's it was made illegal to sell door to door or be a rag and bone man as many gypsies were. This took away a key part of their lively hood. This has since been replaced by ebay. A huge proportion of the community buy and sell on eBay and are very internet savvy.

Apart from this the television was the only other media form really utilised.

Media use:

"The younger ones do use the internet."

"Generally travelling people are internet savvy."

"We use email, Ebay, yes and facebook."

"Yes we all have phones."

Most of the older generation of traveller parents had very low levels of literacy and therefore reported that written information such as leaflets was no good for them.

Consequently, they would prefer to receive DVDs with health information or have information delivered to them verbally by a trusted professional; they emphasised that materials developed must be relevant to their community to have any impact.

Additionally, as a relatively insular community some participants reported that beyond the GPs they don't go to wider community venues such as shopping centres. Hence the best way to receive materials was via the post or in person.

Information needs:

"The older generation there is a lot of illiterate people, the younger more knowledgeable, have much better reading and writing. But even if they can read something like that is not going to appeal because it's too wordy."

"I have to keep telling my son that when he is in school and can't read something he has to tell the teacher. And tell the teacher to use words that he can understand."

"We have done university level courses but still with certain wordings and certain ways of putting things we still have trouble. It needs to be very plain and straight forward: you need to put words in the way you understand them. We do speak English but with a history of an Indian dialect."

"Where ever you go when you travel there are always health people that come out to you. They give you health leaflets and tell you about health centres."

"If the leaflets aren't aimed at you you're never going to listen."

Preferred information sources:

"I think a DVD with traveller people on it; it has to be proper traveller people, not people pretending to be traveller people. The DVD should say this is my child, I had it done because of this....and then other people saying this is my child who has had it. You could also get images - the nasty stuff that measles can do. You would go somewhere in getting people to think, I know which I would rather them have."

"I can't read leaflets so I just rely on what the health visitor tells me. A DVD would help."

"I was never given an explanation as to why he had an allergic reaction. I think it would be good to let people know why it might happen."

"Well we have asked that when we register with a doctor we should be asked what the best way to communicate with us should be. We should be asked how we prefer to get info. Not just for people like us but for anyone."

"I think we would prefer a phone call. Not 0845 call numbers or even 0800 numbers as they are expensive from mobiles."

BME Parents:

In terms of media use, the BME parents used the internet, local libraries and accessed local newspapers predominately which they reported were easy to read or understand.

In terms of information needs, BME parents had some similar problems with literacy although most of them spoke some English or would have a family member that did, but they highlighted a need for interpreters within healthcare and information in their own language.

Information needs:

"Yes they say these things and that and you don't always know what they mean."

"Can't read English so you can't understand it."

"Need interpreters."

"Doctor language is complicated anyway."

"Yes they need to improve more on getting interpreters."

"If they make the leaflets, must be in different language like Pakistani language or Somali language. They should be easy to read."

"I am Iranian and they have nothing in my language."

"Someone in your house speaks English."

"It's important someone speaks English."

"It's OK to have something in English."

In terms of preferred information sources, they all said they would welcome a community centre within their community with a doctor who spoke their language. They also demonstrated a preference for visual materials and discussion.

Eastern European parents:

The Eastern European participants in the sample spoke no English and so did not access English media. They did use the internet and watch polish television. They utilise NHS websites where they were represented in their own language and expressed a need for more information and future NHS work to be provided to them in this way.

D. Views on a local MMR social marketing campaign / local promotional activity

All parents were asked about their views on a local social marketing campaign and preferred types of promotional activities in regard to MMR. They were also asked to make suggestions on strategies for promotion.

Among the affluent / older parents, there was wide spread support and a recognised need for local campaign work on this issue from those who had the MMR but inevitably there were greater cynics among those who had the single jabs and these parents demonstrated a need for independent information and were unlikely to engage with an NHS campaign,

Affluent /older parents:

Views on local MMR promotion:

"We need to get the information out there. I am not scared but people are genuinely scared still and this needs to be acknowledged. This autism thing has left a big aftermath. We need to work together in communities; schools, parents, nurseries and health professionals and share information and experiences. There is a notice board in every nursery that could be a starting point. 'I know the uptake of MMR in Doncaster is low and that annoys me really, I think something is needed here."

"Where I live in Sheffield is a very affluent area and very different to the part I grew up in but the children's centre is kind of in the middle and there are a lot of single mums and young mums that go who are struggling. I think education does make a difference and from what I have observed if one person is strong willed a lot of the mums follow. We have had child

health matters courses there and it has really taken off. People are listening to the diary advice and it is making a difference, it just takes one to start it. I think they could do something there with this injection and the midwife."

"I don't object to adverts locally to be honest. A lot of my friends have heard really shocking stuff, they need to be shown the benefits and that the bad is outweighed by the good and how serious and bad measles can be."

"I would welcome a local campaign, it annoys me that people cop out of this and won't take responsibility. Mumps and measles are really serious and our kids have to go to school with kids that are not immunised but I really think we need a positive awareness campaign. It would be helpful if there were materials with the reminder letters."

"Local action might work. I can't say health advertisements have ever effected me and would form the very bottom of the pile of things that influence my opinions. Independent people at schools might help. I think any campaign would have to be delicate you know. There was this stuff about animal by - products and it was very strong and I think if people are too staunch it really turns people away."

Those who had single jabs were far more resilient to MMR campaign work.

"I think that MMR advertising campaigns are equivalent to blackmail. They are totally transparent. It is just a way to bully you into not having single vaccinations. It is actually irresponsible. It is important people don't take risks and immunise and they are backing them into a corner."

"Because of the influence my sister had on me, I think it would really help to hear from a parent that's done it, so much more so than a leaflet. Real life experiences that acknowledge the struggle it is to decide."

"I would have really welcomed a discussion group at the local children's; centre but not with health professionals with someone independent - a parent maybe. I am not interested in materials and promotional stuff from the NHS pushing MMR. I want a debate. A good place to do that is the internet."

Young parents:

The younger parents were less enthusiastic about campaign work on this issue but this was largely because they were compliant with MMR immunisation despite lack of knowledge and hence did not really understand the need. Additionally, they were cynical about prescriptive health advertising more generally.

“The thing is most of us here have had it done ‘cause it says so in the book and the health visitors and that. We are not going to argue about it if that’s what everyone does, so I don’t really get why they need to promote it?”

“To be honest I don’t like being told what to do and that’s what those campaigns do.”

“To be honest those pictures on the fag packets annoy me and make me want to smoke more. We are not stupid, they have to let people make choices.”

“I agree, I think I tune off more if someone tries to shove something down my throat.”

“It gets on my nerves all these health information campaigns. The information changes anyway.”

“Yeah, I just saw something on the baby biscuits I use; apparently they are full of fat. It’s annoying that they change their mind all the time and you just don’t know what’s true.”

However, some of this group did make useful suggestions on where they would like to access promotional materials and the type of approach they would respond to.

“I don’t think I would like drop in vaccination.”

“No me neither. I am not being funny but it’s a bit like having an operation at the bus stop.”

“Yeah, I want doctors on hand just in case.”

“I would like to pick up information locally in shopping centres and that as I am going through.”

“It would be good if there was NHS information here and in the children’s centres cause we have time to sit down here and have a look, we could also ask the others stuff if we don’t understand it rather than reading on your own.”

Other groups of parents were supportive of local MMR campaign work and said they would be interested in it but did not have any particular suggestions on promotional strategies that could be employed.

Summary and discussion

The findings are complex and highlight distinct needs for each of the target groups. Even within each group there are sub-groups with distinct variations in opinions and further divisions based on other factors such as gender and age.

The affluent / older parents in our group could be divided into two distinct categories; those who had gone through the MMR immunisation process with their children and those who had opted for single jabs. The two groups were similar in behaviour in that they both did considerable research prior to the decision making process in light of the media controversy and consulted both health professionals and friends and family. They both also experienced the decision as having a high level of emotional impact. However, the former group whilst still perceiving there to be risks involved largely based their decision to go ahead on the inherent risks of childhood disease which they perceived to be greater. However, some were critical of the un-emphatic response of professionals at the time of immunisation, whilst others valued the approach of their local practitioners. This group were well informed and rather than any identified need for further factual information on the issue they demonstrated support needs and a need for collaborative approaches with other parents to debate the information they had accessed further and a recognition of the emotion involved in the decision making process for them. Most of this group were supportive of a local MMR campaign and promotional activities.

The latter group of parents who had opted for single jabs were frustrated at the lack of choice within the NHS, cynical about NHS information and approaches and expressed a desire for access to independent advocates on this issue. They were perhaps the single group within this research that are likely to be most resistant to any intervention.

For younger parents on the other hand the decision making process was far more simplistic, partly as they had largely missed the media storm. They co-operated with MMR immunisation as it was the advice they were given by professionals. Their knowledge on MMR and childhood diseases was low and they did not express any particular desire for further information, identifying a need for targeted information. However, they were part of a parenting group and appreciative of the approach there and the support of other parents,

they preferred to receive information verbally and some made suggestions for their preferred settings for receiving information such as children's centres.

The BME parents' were largely compliant with MMR immunisation and like the younger parents did not question this or seek further information. They placed high value on medical professionals and trusted them as a source of knowledge. However, their knowledge of childhood disease was incredibly low and needs some improving. Additionally, whilst respecting medical professionals, this entire group had limited English and were not offered interpreters and hence could not engage in discussion with professionals. They would prefer information delivered to them in community settings by those who spoke their language.

The travellers interviewed also had comparatively low awareness of the MMR controversy and childhood diseases and the purpose of MMR. They did not perceive that the media was a strong source of influence on their community. The male participants in particular had a strong resistance to health care services more generally and described experiencing considerable discrimination which limited their access and highlights there is still a significant trust issue to be addressed prior to information delivery. Some of the female participants on the other hands were more willing to embrace health services where they had a strong and trusted professional to engage with in their own community setting. It was clear women were responsible in terms of child health in this community, so they could be more readily targeted on this issue. Levels of literacy were low and hence their preferred information source was verbal or visual and delivered in their community rather than within wider settings. There was no particular cultural or religious barrier to immunisation identified and opinions varied widely. However, it appeared that historically older generations had not taken up immunisation programmes and some of this habitual behaviour had been passed down.

The homeless parents had slightly more awareness of MMR and the disease it immunises against than the younger parents and BME groups but were more aware of the media controversy but had not explored this with further research. Hence, they did demonstrate a need to hear more about this. Overall, they were not cynical about immunisation but demonstrated a desire for knowledge. They also preferred verbal and visual information delivered in the community. They were not resistant to MMR promotional activity.

Like the BME parents, the Eastern European parents in our sample trusted medical sources and valued them. They described medical sources as far more influential than their friends / family. This was largely due to a strong immunisation programme in their home country Poland and some even supported compulsory immunisation. None of this group spoke English and hence they too had missed the media controversy. Consequently, their access

to UK media sources was limited; they tend to use Polish sources but recognised the value of NHS campaign materials and leaflets being available to them in their own language. They would welcome further materials in their own language.

If we were to generalise it could be argued that the young parents, BME, Eastern European and Homeless parents have similarities in terms of their information needs. They all have low awareness of MMR and childhood disease. However, they all had different needs in terms of information delivery; they appeared to need tailored approaches and had specific information needs which they tended to prefer being met within their own community settings.

These groups were largely compliant with MMR immunisation as long as they were provided with the information on when it was required and would not require persuasive methods but rather more informative approaches.

The affluent / older parents on the other hand require intervention to re-establish trust and provide support and collaboration.

Stakeholder Findings

As part of this research local professionals and stakeholders involved in MMR delivery or in specialist work with the target communities were also consulted. We were particularly interested to hear about their knowledge of the target groups and compare their perceptions with the findings from parents'.

Interviews took place with;

- A Communication Consultant in Public Health
- A Health Improvement Worker
- A Family School / Liaison Officer
- A District Nurse Team Leader
- A Doctor
- A Commissioner in Public Health
- A Family Resource Team Leader
- An Extended Schools Support Leader

Theme 1: Target groups

Knowledge and understanding of the target groups

All participants were asked about their knowledge of the four hard to reach target groups. Knowledge was low and of all those interviewed knowledge was only in part about the Doncaster travelling community, apart from one participant commenting that the BME group identified 'was full of different cultures'. This highlights a need for a greater understanding of these target groups and health behaviour more generally.

- The Doncaster Traveller population was described as the key ethnic group and the most hard to reach. Health needs assessments have highlighted the need to build personal relationships with this community.
- Assessing information was perceived to be more difficult for English and Irish travellers.
"They just do not get the information. If they are nomadic it makes it even worse."
- There was a recognised need for advocacy work with this community and employment of a specialist worker.

- It was known that this group have no literacy skills and there have reportedly been communication problems even with those who speak English because of different communications styles.

Example - “The reason for delays in maternity care of a young girl ‘did not want them scans’ – It turns out she was afraid of having a vaginal examination and did not understand what a scan was.”

- There is recognition of the need for visual aids when working with this group.
- There was broad recognition that health care professionals do not always have the training, skills or understanding to work effectively with this community. There is a need for health professional education.

“The health professionals may seem as ‘strangers’ rather than people there to help – they need to know they are on their side.”

Perceptions of the key influencers on parental behaviour

Media

Stakeholders where asked about their perceptions from working with these groups of key influencer's and levels of influence on them. Some stakeholders acknowledged the remaining significance of the media controversy on some parents. However, they were also aware that the more hard to reach groups were low users of the media and largely unaffected by this. This supports our findings.

“Newspapers. I have intelligent women telling me they have read all the research and when I ask where they read it they say ‘They read it in the Daily Mail.’”

“There are parents who go all the way to France with a name and telephone number. No idea who this is, track down this individual for some clear liquid (single vaccine) and allow someone to put this in, pay a fortune and come back to London thinking they have done their child good.. How gullible can someone be!!! And totally crazy – what a stupid thing to do.”

“Press has caused the negative views.”

“A lot comes from the media but also this is a follow on from family and peers.”

“Sometimes people refuse to discuss MMR (it is a closed subject). This may be with more affluent parents. They are aware of the information but they have accepted the negative information and now refuse to discuss it. Health Professionals find this group very hard to crack because they have already made up their mind and do not want to be challenged. Information is the main challenge – there is not enough information.”

“There was more awareness 10 year ago report when there was a lot of negative views on MMR. There is a big split with the white families and HTR communities. The white families seem to remember it and talk about it a lot, but the BME don’t know about it. This is probably because they don’t watch TV – cooking, or at mosque. They are not as aware of it.”

“They also don’t read newspapers – the dads are out working and the mum is at home looking after the kids. It is very common in these communities.”

“They just don’t come into contact with media.”

Family and friends

Some stakeholders felt that family and friends were key influences on parental choice, particularly in hard to reach communities. Our evidence suggests that some of the hard to reach communities such as BME and Eastern European parents placed higher significance on the influence of healthcare professionals, so this influence may perhaps be overestimated.

“Family members are key too - family is important in certain cultures and they rely on the families decisions and follow those decisions. Some people look to older members of family.”

“To be honest I think it should be everybody who has contact with the family as most communities I deal with are very close.”

“Most people get information from their family or peers.”

“The wider family is also key - mother-in-laws and friends.”

"Friends are big influencers as they all tell each other things – the word spreads fast amongst friends and they take it seriously if advice comes from someone they know and trust."

Healthcare professionals

There was no consensus on the influence of healthcare professionals, with some stakeholders perceiving them to be highly influential and others less so. Our participant findings showed that particular groups were highly influenced by medical professionals.

"I don't think GPs are influencing, if they decide not to, then its up to medical practitioners to convince the parent that MMR is a good thing."

"Only when - 999 there is a sick child or disease do parents think maybe they should have my child vaccinated. So only when a child gets sick!"

"Health visitors have to be the first and then health services."

"Doctors and GPs are key influencers. In my experience everything revolves around the GP. As soon as they arrive they register with a GP – it seems to be their priority; perhaps because they are not used to good medical health."

Theme 2: Immunisation

Perceptions of the barriers to immunisation for the target groups

All stakeholders were asked about the low MMR uptake in their localities and what they perceived to be the key barriers to immunisation for parents. Again, professionals still believed there to be a media impact but they did not distinguish as to whom this coverage was most likely to effect.

Negative media effect & culture of mistrust

“There is a lot of misinformation in the public about the effects of MMR. The media have not helped this. They always refer back to the one piece of research. The info to challenge the misperception is not out there.”

“There has been a problem with HP’s, who are educated people having their confidence damaged when the research first came out from Wakefield and it was not challenged.”

“Headlines from a few years ago.”

“Fear.”

“Old news in the newspaper.”

“Autism.”

“Culture of distrust and authority – most companies who make the vaccine rely on the other products to make profit. They think a profit from MMR is making a profit from the back of children’s health.”

“I don’t believe you is the difficult answer to deal with which we hear from parents.”

“Need trust otherwise there is a barrier.”

Lack of understanding, knowledge & information on childhood diseases

Stakeholders were also aware that there was confusion and lack of understanding of the significance of childhood diseases among some parents. However, they perhaps underestimated how low knowledge was among some of the target parental groups. Our findings show many did not even know what these diseases were and hence would not have been able to effectively evaluate the risk in an informed manner.

“I don’t think people are aware that children die of measles.”

“You don’t see children dying of measles. It is not publicised and you do not ‘think it is going to happen to me!’”

“People forget and don’t know about it enough (children’s medical and health issues).”

“Many parents think its not going to happen to them especially as you don’t hear about that much as not many children get it any more (due to the MMR vaccine) so you don’t think about it as much - ‘out of mind out of site.’”

“Some are still quite old fashioned – better for them to have the infection (might come from their parents) – better to have Measles!”

“Don’t understand.”

“Don’t know the advantage and disadvantages.”

“They only need treatment if they are ill, not to prevent illnesses.”

“There is not enough information around and when they do get bits of material they can’t understand it. Parents/mums don’t ask enough questions – mums often have to be given the information on a plate rather than investigate a particular topic.”

Fear of side – effects and safety issues:

Some stakeholders felt that parents feared side-effects from the MMR jab. However, interestingly none of the parents involved raised this as an issue.

“There is not a single pharmaceutical product in the world that has been made that someone has not had a nasty reaction to – that drug will eventually find someone that will have a nasty reaction.”

“It has happened and children have been known to have nasty reactions but these fears need to be resolved and we need to work on parent’s intelligence. It is possible to have a very rare reaction but this can’t be the reason be why they don’t have it! There are rare circumstances.”

“We have used so much of it and if it has caused so many problems we would know about it on the amount we have given.”

“Terrible side effects – these views come from people who don’t know about it fully.”

Staff delivery & approach:

Some stakeholders perceived staff delivery and training to be an issue in terms of knowledge imparted. However, they did not mention staff approach in terms of support which was raised by some parents as an issue.

“This links to how professionals understand the challenge and are they are up-to-date.”

“It is about values and understanding of the professions. Staff confidence in relating to challenging and passing on the right message.”

“We know that some staff have passed on this misinformation.”

“Staff not skilled in carrying out the process.”

"Professionals are the baddies in this situation. They just may not have the right equipment to deal with the situation."

Other reasons given were practical reasons and culture.

Practical reasons:

"There are some parents who are disorganised and do not get their children to the surgery."

"Disorganisation."

Culture:

"Language is very important!! The leaflet should be in mother tongue."

"Lack of information – very isolated communities."

"Communities don't like talking about 'bad things/illnesses."

"Cultural barrier (with Irish, circus, fairground and gypsy travellers.)"

Theme 3: Information provision

Perceptions of Information and knowledge among the target groups

Stakeholders were asked if they felt parents had adequate knowledge of MMR and childhood diseases. As identified above, it is likely that they have underestimated the lack of knowledge within these communities.

"Yes I think they are. I'm not sure if they fully understand it. Adamant they are not having it. I think they understand it's a triple injection. I'm not sure if they realise what would happen if they caught any of them. Some know if the boys caught Mumps they will be infertile. They panic as they think their kids will be handicapped."

"Some think it is Measles only."

"If they were going to take up the vaccine they would just take Rubella – because they know that it affects the unborn child."

"On the whole yes. I think they probably under-estimate the seriousness of some of the diseases."

"Parents saying 'I have no idea my child was going to be so ill - they just don't realise."

"Over-estimate the vaccine and under-estimate the disease and illness."

Perceptions on sources of information for the target groups

Stakeholders were asked where they believed participants got their information from on MMR. Some felt that parents were most likely to use the internet, (our findings show this is only true for the affluent / older parents) and were concerned by this. However, there was acknowledgment that locally there are very limited MMR resources out there in the community.

"Most parents go online to get information."

"Web (problem with web is parents who Google there are a lot of anti-vaccine websites – which is bad as they will believe the first thing they see) These websites are terrible and include rubbish information."

"Other parents."

"There are no leaflets at the school, never seen any around."

"I have seen a few leaflets about child weight and eating, 5-a-day but not the medical side of things – especially MMR."

"Not enough messages about MMR around locally."

Views on responsibility for health information provision

Following this, stakeholders were asked whose responsibility they perceived information provision to be. The majority perceived this to be the role of healthcare professionals.

"There should be no excuse re information: we can give them leaflets, can give them more information and in different languages, accessibility: we can make it more accessible – these are the easy things to do. It's the knowledge, ignorance that is not easy."

"It is the Health Professional's responsibility."

"It is the primary responsibility of the Midwives, Health Visitors, GPs, Practice Nurses, School Nurses."

"It is the secondary responsibility of the PCT and health services who should also be informing the community."

"Healthcare responsibilities – everybody should take ownership."

"It is the duty of the practice to follow up on why children are not coming to the service."

"Health/community workers."

"Good practices should have a practice policy and a practice champion."

Others perceived the wider community needed to be engaged and involved:

"The whole community needs to be on board. It is their duty to inform and influence."

"Health professionals should be straight forward doctors, practice nurses – they used to use innovative ways to pass the information to them, but depends on where they are."

"Children's centres are used mostly for support."

"Good to have the support from families and friends but not the number one."

"There are also volunteers who can support but it is not their duty and main job."

"Parents."

"It is everybody's responsibility."

"It is about trying to understand why people are not vaccinating."

Theme 4: MMR promotion

Strategies to reach the target groups

Stakeholders were asked if they had either any experience or suggestions on reaching the harder to reach communities. Again, the only group mentioned were travellers, demonstrating perhaps less experience and knowledge of the other groups.

"The travellers will not take immunisation so we have to go to the sites. We go there and vaccinate them. They still stay 'no thanks.'"

"The services are available and do a lot more now than 10 years ago. There are a number of people's lives who are chaotic and can't get kids to clinic. You need to dance around a bit, grab them and jab them. We have to be prepared to be flexible and willing to be flexible."

"Need to have carefully targeted communication for the different communities."

"The information needs to be in different languages – as there are so many mixed communities in Sheffield."

"Contacting community groups using different languages."

"Be more culturally aware."

"Travellers haven't immunised as there is a fear of autism, they can't read so they are not aware of the problems."

"Events wouldn't help as the travellers are travelling; we would have to go to them."

"Councils could make themselves available at the traveller's events."

"If the leaflet says its 'good for your child' then they go for it, they tend to just listen to what they are told."

Suggestions on promotional activities and campaigns

Work undertaken:

"An effective campaign (run by the PCT) - with school age children (when parents have missed the booster) the PCT wrote to all parents again and reminded them!! Approx just under 2,000 had been targeted and had further conversations for immunisation (between the ages of 5 – 16). This is as a direct response to being written to. This did not register as figures because they were late!! Some parents rung back and were quite irate and abusive and said they didn't want it. Other parents have wanted to find out more and discuss it – talk to the school nurse."

"The Doncaster PCT has done quite a bit with the media – with TV and posters (TV is good for the travellers)."

Stakeholders were also asked for suggestions on future promotion:

Increasing access:

"Half the time is accessibility problem – they just don't know what is available."

"A lot of nurses just give them the MMR when they come to the clinic for other things."

"Must be where parents are like coffee morning or parents evening. We have to go to them."

"Mosque, GPS are the best place to promote."

"The information/service have to come/reach the parents, parents won't go to the 'location'."

"Home visits and working very closely with other health organisations."

Places for promotion

"Facebook."

"Young children's TV shows although you don't want to scare the kids so maybe not a good idea."

"Magazines – parent and baby magazine."

"Adverts in TV – there needs to be a big push around it and increase uptake even more."

"Health departments."

Promotional strategies

"How can we promote – yummy mummies you need to just keep feeding them with the relevant proper research?"

"Parents as advocates is key."

"Champions work alongside the professionals and have a big campaign around it."

"Use common situations and themes rather than something they are not familiar with. Make it personal."

"Professionals need to bear it in mind and have MMR high on their agenda and promote it."

Part three: Social Marketing Intervention

1. Encouraging people to seek the advice of health professionals

a) Preparing health professionals

The first stage in this process is to share the findings of this report with health professionals, enabling them to better empathise with parents.

Our contact with stakeholders illustrated a sound understanding of most aspects of dealing with these groups, but there appears to be a sense of frustration on all sides as to what is currently happening. Stakeholders cannot understand mothers seeking out single jabs via unconfirmed sources (understandably) when a perfectly good solution is on offer. Parents however feel 'backed into a corner' by the NHS and some feel so provoked that they withdraw from access to MMR.

By fostering greater understanding of the difficulties parents face in reaching a decision, health professionals will be well equipped to serve different audiences and will enjoy a more positive and productive dialogue with them.

b) Building in time

Time is an issue that needs to be addressed. People feel rushed into a decision and find the process similar to a 'conveyor belt'. Most parents would welcome the opportunity to discuss MMR in detail with someone before making a final decision and time needs to built in to the process to enable this.

c) Demonstrate understanding and empathy

GPs in particular need to show more understanding of people's feelings and, despite busy workloads, make every patient feel their opinions are valued and respected.

d) Make health professionals more accessible by giving them a relevant context

Selecting appropriate professionals to target each group carefully, and using them as spokespeople to engage parents, will build trust and start the conversation in the right way. For example, for traveller groups, using an outreach worker with extensive experience and success accessing travelling groups, ideally also a parent, to convey

an understanding of the parental concerns, whilst also presenting the case for MMR, would be a good place to start in terms of materials accompanying the invitation letter.

This could be in the form of a very word-light, visual printed piece which linked to a website, or facebook, for more information and dialogue. By presenting all aspects, credibility understanding will improve. Show the fear to factual response to remove barriers one by one.

2. Encouraging more parents to immunise their children

a) Giving MMR immunisation a high profile locally

Eastern European respondents felt that, in comparison to Poland where immunisation has a high profile, there needed to be a greater awareness of the importance of immunisation and supporting materials to promote access.

Media ideas included:

- Internet inc parent forums, social networking sites, decision-aiding interactive tools
- Local papers
- Radio
- DVDs featuring real mums (proper travellers for this group) – not just immunisation champions but ordinary people presenting all aspects of the difficult decision
- Mobile phones
- Health visitors / outreach workers
- Local libraries
- GP surgeries
- Nursery notice boards
- New baby packs
- Red book (the definitive source for young people)
- Shopping centres
- Children's centres
- Information sent with invitation letters (discussion packs)
- Parent lead discussion groups

Service ideas included:

- Mobile vaccination units
- Compulsory vaccination
- More outreach
- Translation service / GPs speaking other languages
- More understanding / empathy

b) Being sensitive, respectful, interactive and engaging

Most groups wanted visual, interactive, collaborative materials backed up by verbal communication. With all groups citing the Internet as a preferred media source, this can be established at low cost in a way that can be extended and adapted over time.

Outreach workers play a vital role in engaging homeless and travelling parents.

Their success can be built upon to educate health professionals in practices.

c) Removing barriers

Temporary registration for the travelling community was a big issue, with no information or reminders being sent.

For affluent / older parents, the sheer volume of information made the decision even more complex, so taking a 'less is more' approach to messaging and communication, whilst offering interactive support, will serve this group well.

Both BME and Eastern European groups want materials in their language and either interpreters at health practices or ideally, a GP who speaks their language.

Stakeholders identified significant problems with such groups misunderstanding medical terminology.

All groups need to be empowered to make the right choice, by giving them a simple, convincing argument which honestly weighs up the risks vs benefits from the parent's perspective.

3. Encouraging more parents to immunise their children with the second dose

Giving feedback to parents who have had their first MMR jab would be an ideal way to identify with them and frame MMR within the context of peer confirmation. Just as people can experience post purchase dissidence, a parent can continue to question whether or not they made the right choice. Confirming they did, supporting this with evidence of peers doing so, will set the scene for future communications.

Sending information again with reminders for the second jab will underline the positive choice. This could be reinforced by peer testimonials.

Offering parents the chance to discuss their concerns at this stage is just as important as the first stage, though it is likely there will be less need. Again, this can be achieved in a resource light way via the internet.

One of the main reasons parents delay the second jab could simply be a matter of time. With a busy family life, it's hard to keep on top of everything. So offering flexible alternatives to a surgery appointment could lift response.

Equally, sending more than one reminder is a tactical suggestion.

4. Recruiting peer educators to communicate the MMR message

Outreach workers and community groups are an obvious place to start, recruiting advocates of MMR.

The recommendation made previously in 1d) has potential for extension to peer recruitment.

Selected role models could kick off debate online, via a forum, which also captured comments from parents and encouraged them to report back. The website could offer them an opportunity to share their experience, or simply record their details for possible contact in the future. You could also utilise YouTube as a low cost means of showcasing real life perspectives / case studies / advocates (and suspects) in action.

The essential point here is sensitivity and respect for the varying perspectives people will have and their propensity to engage. Trust will need to be built up over time in small increments.

5. Encouraging new parents to recognise the importance of MMR

The red book is a key tool for all groups, particularly young mums.

All groups were receptive to a positive MMR campaign that reflected their concerns and addressed them in an empathetic way.

Verbal information was popular with all groups. Interactivity was also valued.

The key to visual communication is clearly around two key themes:

- The risk vs the reward – a balanced view which features all the elements but presents MMR as the viable option without doubt
- The impact of disease

We presented a number of campaign visuals to focus group attendees to capture specific feedback to various creative approaches. Each generated positive and negative views but even though the groups were very diverse, they all seemed to share remarkably similar thoughts on the creative as summarised in the recommendations below:

DO

- Have a large photograph of the condition and a sufferer. Not only did this provoke shock and debate it also made it clear what the condition looked like and literally gave it a human face.
- Have large copy delivering the name of the condition
- Deliver a few punchy and sobering facts on the condition
- Deliver clear call to actions
- Make it clear and brightly coloured

DON'T

- Have large paragraphs of copy
- Use complicated words or medical terminology
- Have a medical look and feel
- Have text only with no photography
- Be patronising
- Assume the public are aware of the conditions and dangers

Packaging information in a simple format such as the table below would address information gaps which exist, as long as the context is sensitive and appreciative of the difficulty people have in reaching a decision.

Cause	Symptoms	Complications
Measles is caused by a very infectious virus - one of the most infectious diseases known. A cough or a sneeze can spread the measles virus over a wide area. Because it's so infectious, the chances are your child will get measles if he or she is not protected.	Nearly everyone who catches it will have a high fever, a rash and generally be unwell. Children often have to spend about five days in bed and could be off school for ten days. Adults are likely to be ill for longer.	It is not possible to tell who will be seriously affected by measles. The complications of measles affect one in every 15 children and include chest infections, fits, encephalitis (swelling of the brain), and brain damage. In very serious cases, measles kills. In 1987 (the year before the MMR vaccine was introduced in the UK), 86,000 children caught measles and 16 died.
Mumps is caused by a virus and is spread in the same way as measles. It is about as infectious as flu.	Mumps lasts about seven to ten days. The virus can lead to fever, headache, and painful, swollen glands in the face, neck and jaw. It can result in permanent deafness, viral meningitis (swelling of the lining of the brain) and encephalitis. Rarely, it causes painful swelling of the testicles in males and the ovaries in females.	It can result in permanent deafness, viral meningitis (swelling of the lining of the brain) and encephalitis. Rarely, it causes painful swelling of the testicles in males and the ovaries in females. Before the MMR vaccine was introduced, about 1200 people a year in the UK went into hospital because of mumps.
Rubella (German measles) is a disease caused by a virus, spread in the same way as measles and mumps. It is about as infectious as flu.	In children it is usually mild and can go unnoticed. It causes a short-lived rash, swollen glands and a sore throat. Rubella is very serious for unborn babies. It can seriously damage their sight, hearing, heart and brain. Rubella infection in the first three months of pregnancy causes damage to the unborn baby in nine out of ten cases. This condition is called congenital rubella	Can cause infertility in women

syndrome (CRS). In many of the cases, pregnant women caught rubella from their own, or their friends, children. In the five years before the MMR vaccine was introduced, about 43 babies a year were born in the UK with congenital rubella syndrome.

Focus group creative feedback

Poster 1

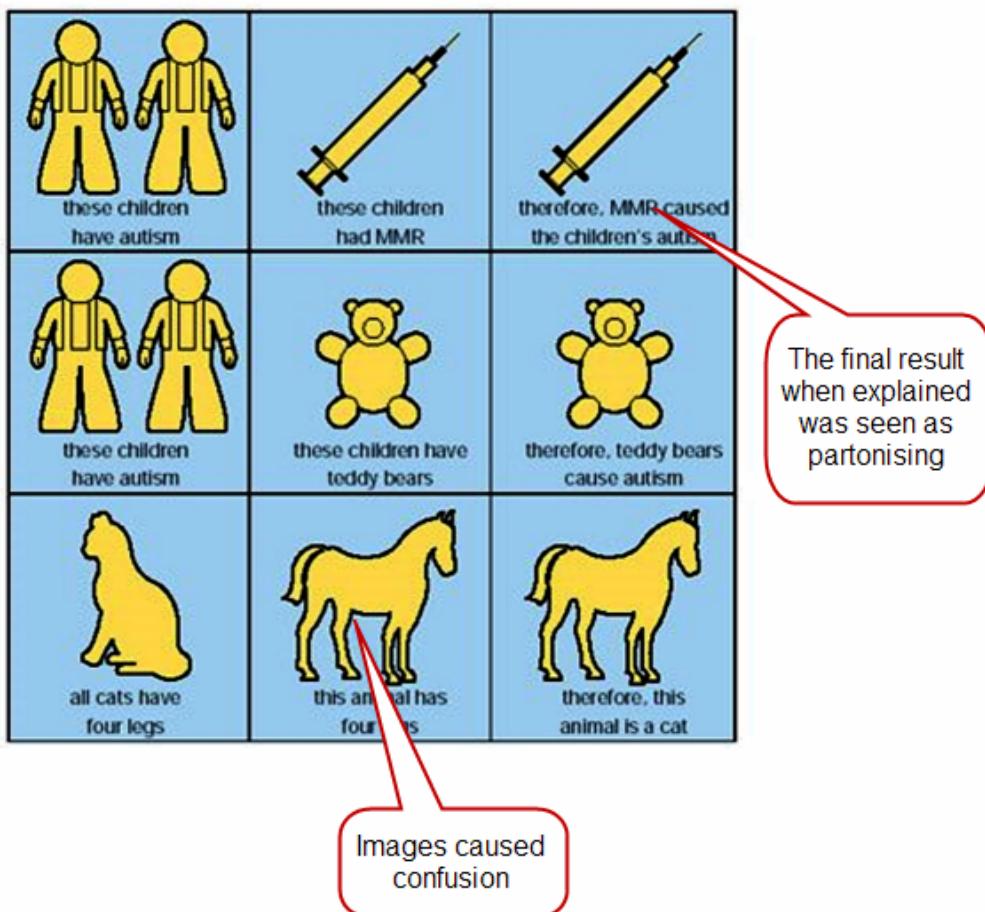
This was an Internet campaign (we think) directed at healthcare professionals to counteract negative publicity and deliver the real facts. The online campaign was promoted by among others counterknowledge.com

Focus group response:

This poster and campaign idea caused complete confusion across all the groups. They did not understand it at all. Main complaints were:

- It had no title
- It took ages to digest and if you were at the doctors looking at it with your children with you there is no way you will have a chance to take on board the message
- There was no call to action or advice to go to for more information
- It was seen a patronising and dictatorial

On a positive note it was seen as clear and colourful with the use of images



Poster 2 - Brent Council

NHS Brent, Brent Council and the Health Protection Agency have teamed up to roll out a borough-wide awareness campaign to highlight the worrying fact that measles is spreading in the borough.

Low levels of immunisation uptake over the last decade have led to a significant increase in the number of children who are not protected against measles. The more children that are not protected, the more rapidly measles will spread.

This is an ongoing campaign and results have not been published.

Focus group response:

The clear presentation of this copy was seen as a good thing, and the fact that it was bright, colourful and noticeable. If a parent was with their child then this could be noticed and read clearly.

On the not so positive side it had no credible statistic just “it can kill”. Interestingly none of our groups (except attendees in our BME group) were fully aware of the dangerous statistics and side effects of measles or even Rubella so the “It can kill” comment was passed by.

All groups felt that the illustration was not effective in creating a sense of urgency or enough concern to change behaviour. It was viewed as a “cartoon” and they could not relate to it.



Poster 3 – NHS national campaign

This is the NHS national resource on promotion of the MMR vaccine. If a council or PCT wishes to promote the vaccine then these are available to use.

There is a large range of posters, fact sheets and contact details. Also provided are scientific papers for the more curious.

All the communications are available in a range of 12 languages.

It appears to be popular with many councils although none give details of their distribution or any evidence of effectiveness.

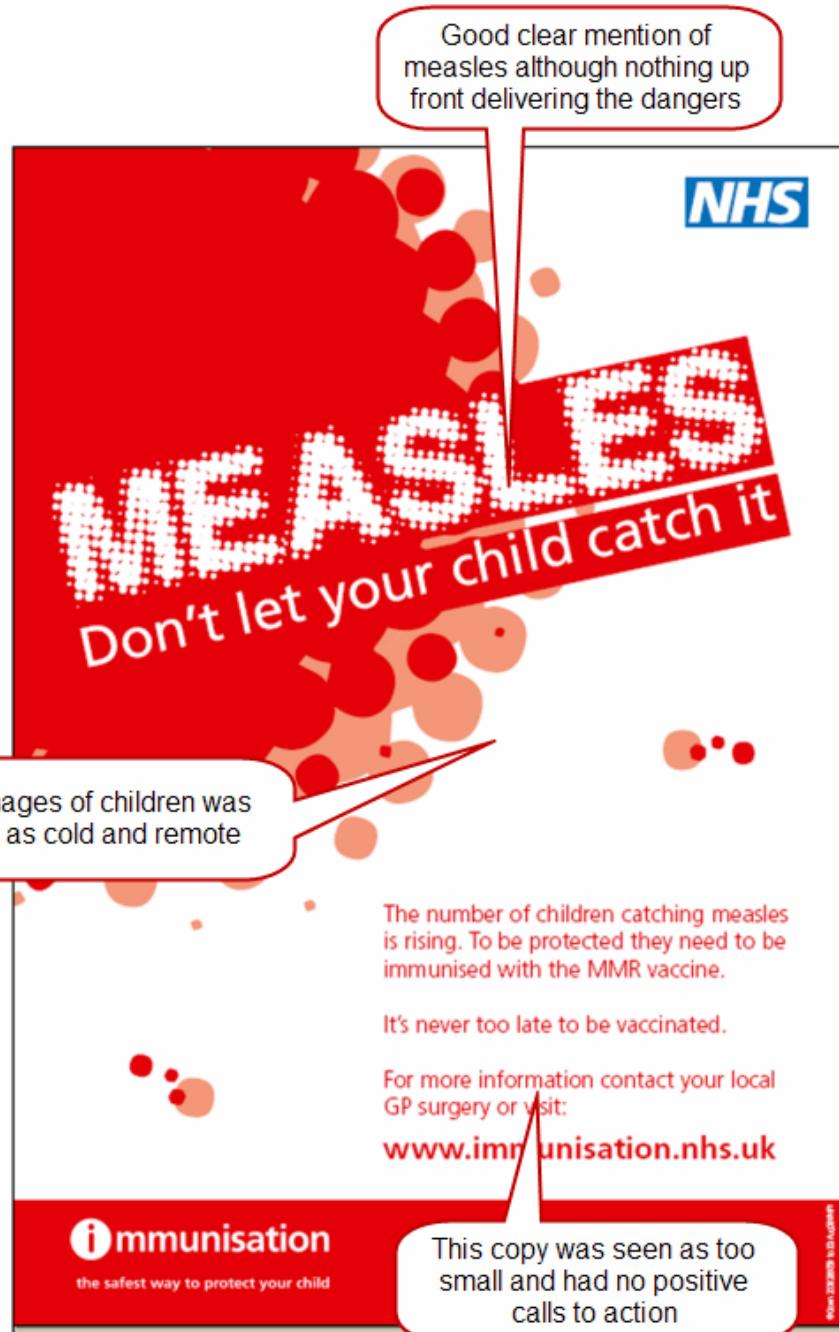
There are no results available on any increases in uptake with these communications.

Focus group response:

The large prominent copy was positive and the groups were left in no doubt of what it is about, however many BME parents did not understand what measles was although were very aware of the condition in their own language.

Here again the lack of information on the real dangers of the condition was seen as negative.





The image shows a poster for measles awareness. The top half features a large red background with the word 'MEASLES' in white, pixelated letters. Below it, a diagonal banner reads 'Don't let your child catch it'. The bottom half is white with a pattern of small red dots resembling measles. The NHS logo is in the top right corner. The poster includes the following text:

- Good clear mention of measles although nothing up front delivering the dangers**
- No images of children was seen as cold and remote**
- The number of children catching measles is rising. To be protected they need to be immunised with the MMR vaccine.**
- It's never too late to be vaccinated.**
- For more information contact your local GP surgery or visit:**
- www.immunisation.nhs.uk**

immunisation
the safest way to protect your child

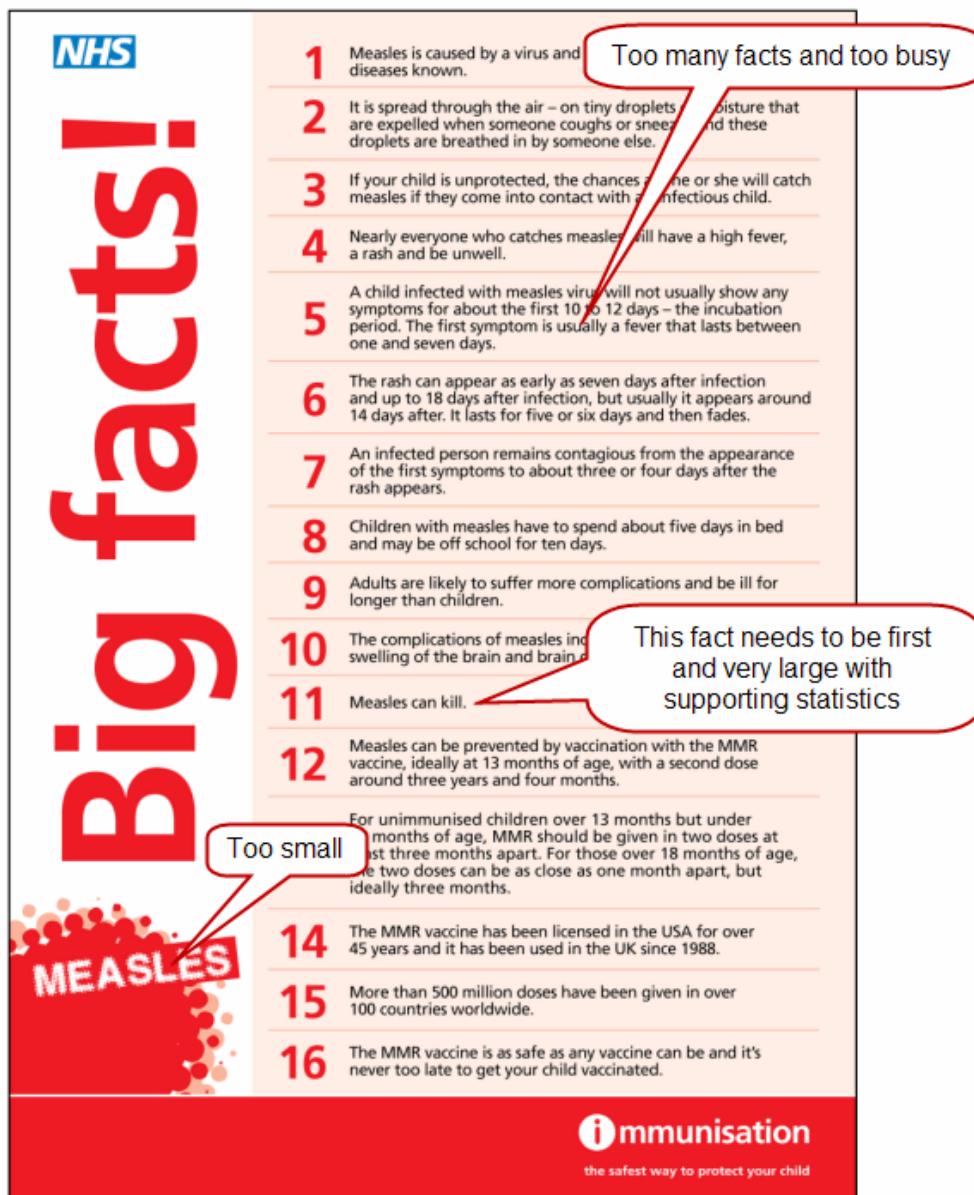
This copy was seen as too small and had no positive calls to action

Poster 4 – NHS campaign: The Facts

Focus group response:

All groups found this too much to read for a busy mum. There were too many facts. They felt that five at the most would suffice. The word 'Measles' was far too small. In some cases it had to be pointed out as they simply didn't see it.

The lack of images was a big negative too, especially with the BME mothers as it left them confused.



Poster 5 - Hounslow Feb 09

Hounslow is one of 12 primary care trusts taking part in the pilot, led by NHS London. In Hounslow, the campaign will include phone box advertising, bus shelter posters and letters to parents.

If it is successful in boosting uptake in the participating PCT it will then be extended across London.

The website <http://www.mmrjab.com/> delivers messaging on MMR. However the pages on the site do not carry the same powerful look and feel. They simply go through to the NHS <http://www.immunisation.nhs.uk/>

No results are currently available

Focus group response:

This was by far the most popular poster. The photography was especially emotive and there was much discussion on the condition. Very few realised it could be so serious and felt motivated to tell others and take immunisation more seriously after seeing the photography.

The supporting paragraph was viewed as being too small and many said they would not read it. However when we all read it out together it stimulated much conversation and concern about the facts it contained.

Very powerful image

ONE IN 10 CHILDREN WITH MEASLES END UP IN HOSPITAL

Measles is highly contagious and it spreads rapidly

If your child does catch measles, there's a one in 10 chance they will need hospital treatment - for anything from chest infections and fits to encephalitis (swelling of the brain) and brain damage. While for one in 1,000 - measles can kill.

You can protect your child by having them immunised with a free MMR jab.

To learn more about the MMR jab and measles, [click here](#).

To find your local surgery, [click here](#).

MEASLES. DON'T TAKE THE CHANCE.

HOSPITAL
19 JAN 2009
ADMISSION

A surprising fact that provoked much conversation

Copy is far too small

Shocking fact no one was aware of

If your child is one in 10 and catches measles there's a one in 10 chance they will need hospital treatment – for anything from chest infections and fits to kidney failure and brain damage. Tragically, for one in 1,000 – measles can kill.

A simple cough or a sneeze is all it takes to spread the virus, so there's a high chance your child will get measles if they are not immunised.

Shocking fact no one was aware of

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Appendix A:

**TOPIC GUIDE FOR TELEPHONE INTERVIEWS WITH
PARENTS**

Consultation on parent's views on the MMR vaccination

Thank you for agreeing to being interviewed. My name isand I work for hey moscow.

I want to explain what this work is about and why we are interviewing parents. NHS Sheffield and NHS Doncaster want to increase the uptake of MMR vaccinations in Sheffield and Doncaster. We are an independent marketing company who have been commissioned to find out about the views of parents of under 5's in Sheffield and Doncaster on MMR Immunisation who have either had their child(ren) immunised or not. We will also be talking to parents of under 5's from specific target groups.

The aim of the discussion is:

- *To find out about your views on MMR immunisation and to discuss where you have got information from on this topic.*

All information that is collected from you as part of this interview will be kept under the strictest confidence. In writing up and reporting to NHS Sheffield and NHS Doncaster, your name will not be associated with any of the information you provide and we will not reveal the identity of anyone we consulted. Each interview will be assigned an anonymous code. We would like to record the interview using a digital recorder so that we can concentrate on the discussion. However, if you are not happy for us to do this we will take notes during the discussion; it is entirely your choice. The interview will take about thirty minutes, and I'd like you to relax and to use it as an opportunity to share your experience..

- Are you still happy to go ahead with the interview?
- Are you happy for me to record the interview?
- Do you have anything else you want to check out or ask before we start?

Finally, we also need to obtain your verbal consent to take part.

THANK YOU FOR YOUR PARTICIPATION AND TIME

Part one: MMR Immunisation and influences on behaviour

1. Immunisation:

- How many children do you have and how old are they?
- Have you had your child(ren) fully or partially immunised against MMR?
- Do you intend to have your child(ren) fully or partially immunised against MMR?
- Have you had or are you going to opt for the single jab?

MMR awareness and sources of information/ knowledge:

- What do you know about the MMR vaccination? Do you know why these vaccinations take place together? What do you know about the benefits and/ or disadvantages of having all three vaccinations in one?
- What do you know about the single jabs? Where did you get your information from and what do you see as the benefits and/or disadvantages of having single jabs?
- What do you know about the three diseases MMR immunises against? Are you aware of or what do you see as the benefits of immunisation? What do you know about the negative consequences and impact of not having any immunisation against these diseases?
- Where have you got your information on the MMR vaccine from? What type of information did you receive or see? Were you happy with the information you saw / have seen or were given?
- What other information would you have liked?

Decision making process and influences:

- Why did you decide to have your child(ren) immunised with MMR? What did you see as the benefits? Did you feel confident in your decision? Did you consult a health professional beforehand? Or

- Why did you decide to have your child(ren) partially immunised? Did you feel confident in your decision? Did you consult a health professional beforehand? Or
- Why did you decide not to have your child(ren) immunised with MMR? What did you see as the barriers to immunisation which influenced your decision? Did you feel confident in your decision? Did you consult a health professional? What do you see as the possible risks of not having your child (ren) immunised? How did you weigh this risk up against the perceived risks of MMR immunisation? Do you have any views on other ways to protect your children if they are not immunised? Are there any factors that would encourage you to change your mind and immunise your children?
- What factors influenced your decision and how did these impact on you? Who did you discuss your decision with? (*Prompt: Peers, Friends & family, media coverage, research etc*)
- What is your opinion on all the media coverage there has been on this issue? How has this affected you and your decision?
- What is your opinion on the Government approach to this issue? How has this affected you and your decision?

Use of health services and support required:

- Which local health services do you use most? (*Prompt: are you registered with a GP, do you access health visitors? What other services do you use?*)
- Are you happy with the staff approach and the information you have been given from local health services generally?
- Are there barriers to healthcare service use for you? Are there any factors that would encourage you to use health services or seek advice from health professionals?
- What support would you require or like from professionals to prioritise vaccination & what would be your preferred type of support / model of healthcare delivery?
- Do you have any ideas on service improvements?

Part two: Media use and health campaigns

Media consumption & campaign knowledge:

- What media do you use most in your daily life? Are there any barriers to media use for you or reasons why you don't use particular media?
- Which media do you use most for health care information? What other sources of information do you use to access health care information?
- What is your preferred source of health information? Where is your preferred location (s) to receive healthcare information? What format do you like to receive information in?
- Are there any healthcare campaigns that you can recall that influenced you or had an impact on you? Do you think healthcare campaigns do impact on your healthcare choices and behaviour?
- Have you seen the national campaign on MMR? What is your view on this campaign? Has it or do you think it will affect your decision? Do you see this information as independent?
- Have you seen any local campaigns on MMR? What is your view on these campaigns? Has it or do you think it will affect your decisions? Do you see this information as independent?
- Have you seen any local information resources on MMR? What did you think of these? Where did you see them?
- Do you have any suggestions for campaign improvements / campaign messages that would be likely to influence you in the future?

Service promotion:

- Do you have any ideas on how local health care services could promote the MMR vaccination? What are your views on them running a social marketing campaign on this topic? Would this influence you?
- Where would you like to receive information and in what format?
- Who would you most like to give you information on MMR locally?



TOPIC GUIDE FOR FOCUS GROUPS WITH PARENTS

Consultation on parent's views on the MMR vaccination

Thank you for agreeing to participate in this group and welcome. My name is and I work for hey moscow.

We will now give you an overview of what this work is about, why it is being done and why we have asked you to come along today. We will outline the things we would like to discuss and how this group is going to be structured. If any one has any queries or suggestions, please let us know.

The aim of the discussion is:

- *To find out about your views on MMR immunisation and to discuss where you have got information from on this topic.*

We would like this discussion to be informal, so there's no need to wait for us to call on you to respond. We encourage you to respond directly to the comments other people make. We are here to facilitate the discussion, ask questions, listen and make sure everyone has a chance to share. We have a list of topics we would like to cover but welcome your direction on issues that are important to you. We also have some materials to show you that we would like your views on.

Finally, we also need to obtain your written consent to take part and have provided a consent form for you to complete. If you are willing we would also like you to complete the second part of this form with your contact details but that is entirely your decision. We will not pass your name on to any one.

THANK YOU FOR YOUR PARTICIPATION AND TIME

Part one: MMR Immunisation and influences on behaviour

Introduction - Group Status:

(Interviewer notes: record numbers below)

- Have they fully immunised their child(ren) against MMR? Yes No
- Have they partially immunised their child(ren) against MMR? Yes No
- Do they intend to or plan to fully immunise their children? Yes No
- Do they intend to or plan to partially immunise their children? Yes No

HTR Groups:

- Accommodation & living situation & how this may impact on their decision (s) or ability to make decisions.

MMR awareness and sources of information/ knowledge:

- Knowledge of the MMR vaccination
- Knowledge of why the three vaccinations take place together
- Knowledge of the diseases it immunises against
- Knowledge of the importance / benefits of MMR immunisation
- Sources of information on the MMR vaccine
- Types of information on MMR received
- Views on the information received

Decision making process and influences:

- Reasons for having their child(ren) having the MMR vaccination, not having it or decided to partially immunise
- Barriers to immunisation
- Views on other methods to protect their children if they have opted not to immunise
- Views on media coverage and whether this has influenced their decisions
- Levels of confidence about the MMR vaccination
- Factors that would encourage them to change current habits / immunise their children

HTR Groups:

- *Key Community Influencer's & impact on their decision*
- *Impact of culture & or / religion on their decision*

Use of health services and support required:

- GP registration

HTR groups:

- *Barriers to GP registration i.e. living situation, community norms & impact on GP registration*
- Support required from professionals to prioritise vaccination & preferred types of support
- Contact with health professionals
- Barriers to accessing healthcare services
- Factors that would facilitate / encourage access to health services
- Ideas on service improvements

HTR groups:

- *Perceptions of health professionals & barriers to access / Preferred model of healthcare delivery*

Part two: Media use and health campaigns

Media consumption & campaign knowledge:

- Preferred type of media
- Preferred source of health information
- Preferred location for health information
- Knowledge and feelings about local / International MMR campaigns (visuals)
- Suggestions for campaign improvements / campaign messages that would be likely to influence them in the future

HTR groups:

- *Barriers to media use*

Service promotion:

- Professionals & service promotion
- Responsibility for service promotion
- Ideas on service promotion

HTR groups:

- Specific suggestions on service promotion to their community



Sheffield

**TOPIC GUIDE FOR TELEPHONE MMR INTERVIEWS WITH
STAKEHOLDERS AND PROFESSIONALS**

Insight around increasing the uptake of MMR vaccinations in Sheffield and Doncaster

Thank you for agreeing to being interviewed. My name isand I work for hey moscow.

Let me explain what this work is about and why we are interviewing professionals. NHS Sheffield and NHS Doncaster want to increase the uptake of MMR vaccinations in Sheffield and Doncaster. Following this Insight work, the intention is to launch a social marketing campaign with three anticipated focuses: a blanket awareness approach, a tailored approach for hard to reach groups including; Travelling Communities, Black Minority Ethnic (BME)/Eastern European communities, and the homeless and a targeted approach for parents from affluent communities who may have formed opinions on the MMR vaccine as a result of past negative media coverage. We have approached you to take part in this interview as you have particular knowledge and expertise in the locality on MMR (or with the specific HTR communities we are targeting).

We want to find out more about your experience of working with these groups or with MMR and your perceptions and knowledge of barriers and facilitators to MMR vaccination. We will also ask you about what would help you with service delivery (aimed at the target group) and if you have any ideas about service promotion and strategy.

As part of this we will also be talking to local parents of under fives from all of the target groups in a series of focus groups who have either had their child(ren) immunised or not.

All information that is collected from you as part of this interview will be kept under the strictest confidence. In writing up and reporting to NHS Sheffield and NHS Doncaster, your name will not be associated with any of the information you provide and we will not reveal

the identity of professionals we consulted. Each interview will be assigned an anonymous code. We would like to record the interview using a digital recorder so that we can concentrate on the discussion. However, if you are not happy for us to do this we will take notes during the discussion; it is entirely your choice.

- Are you still happy to go ahead with the interview?
- Are you happy for me to record the interview?
- Do you have any thing else you want to check out or ask before we start?

THANK YOU FOR YOUR PARTICIPATION AND TIME

Professional Status and role:

- Please can you give us an overview of your role and your involvement in MMR vaccination delivery? (Prompt: including where you work, aims of your work, how you are involved in MMR vaccination delivery or promotion.)
- Alternatively, please can you explain your role and involvement with the target group and whether you have been involved in any MMR work with them?

1. Knowledge and experience of the target group (s) and challenges faced when working with them:

- How much experience do you have of working with parents and with parents from the target groups?
- What is your knowledge and understanding of the main challenges of working with parents and encouraging the uptake of MMR vaccination?
(Prompt: how would you summarise the key barriers to vaccination? Please, include your perceptions of how attitudes among the HTR groups may differ from Affluent / older parents if you work with them?)
- Who do you see as key influencers on both parents & parents from the HTR groups?
(Prompt: family, peers, colleague, media, etc).
- From your professional experience, which factors are most likely to influence this target group to access health services & have the MMR vaccination?
(Prompt: health care services, socio-demographic factors, organisational factors, healthcare professionals, service access, media coverage, local information family & peers, etc).

2. Perceptions of parental sources of knowledge and information and media use:

- Does your service have specific information on MMR for parents? Where is this information distributed? Do you think this information distributed locally has influenced parents & HTR parents in making their decision to have the MMR vaccination? If not, why not? What is your view on the appropriateness of information you disseminate to the target groups? (*Prompt: do you think it is appropriate & relevant to their lives?*)
- Do you think most parents understand the purpose/ benefits of MMR vaccination and understand the three diseases to be immunised against? If you think they do have this information, what other information do you think influences their decisions?
- Where do you think most parents (& HTR parents) get their information on MMR vaccination from? (*Prompt: family, peers, media, etc.*)
- How do you think media coverage has affected local people in making the decision to have the MMR vaccination? Do you think particular media are used more readily by these groups?
- How do you think Government messages on MMR have influenced the target groups? What is your perception of these messages?
- Do you think there has been sufficient information on the negative outcomes of failure to vaccinate? (*Prompt: Locally and nationally*)

3. Service delivery:

- What is your overall impression, of how effective local health services have been in your area in encouraging the uptake of MMR to parents generally & to the HTR groups? (*Prompt: through GPs ,community health care services, midwives etc*)
- How accessible do you think health services are for these parents and for the HTR groups? If not, easily accessible why not?
- What specific support / advice does your service offer you and how helpful do you think these approaches are for the target groups?

- What are the main gaps in provision or knowledge in your opinion for these groups and how could these obstacles be overcome?

4. Service promotion and future strategies:

- Have you ever asked clients to give feedback on their views on MMR to your service?
- Whose responsibility do you think promotion should be? Do you have any capacity within your remit for service promotion?
- Have you ever been directly involved in promotional activities for this group and which strategies were successful / unsuccessful? Do you ever actively recruit or target the HTR groups?
- From your experience of service delivery, how do you think services could be improved to increase uptake of the MMR vaccinations among the target group?
(Prompt: to make them more accessible to this group? Where do you think they would prefer to receive services and why? Who do you think should deliver the support? What are your views on the value of incentives?)
- What do you think could be done to promote services in the local area? Where do you think the target group are most likely to see information and in what format they would like it?

Is there anything else you want to talk about or say before we end?

Was the interview ok for you? Thanks for all your help and for your time. We are going to be letting NHS Sheffield know our findings and suggestions for service improvements.

(End)