The UPTAKE study: a cross-sectional survey examining the insights and beliefs of the UK population on COVID-19 vaccine uptake and hesitancy

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ABSTRACT

Objective A key challenge towards a successful COVID-19 vaccine uptake is vaccine hesitancy. We examine and provide novel insights on the key drivers and barriers towards COVID-19 vaccine uptake.

Design This study involved an anonymous cross-sectional online survey circulated across the UK in September 2020. The survey was designed to include several sections to collect demographic data and responses on (1) extent of agreement regarding various statements about COVID-19 and vaccinations, (2) previous vaccination habits (eg, if they had previously declined vaccination) and (3) interest in participation in vaccine trials. Multinomial logistic models examined demographic factors that may impact vaccine uptake. We used principle component analysis and text mining to explore perception related to vaccine uptake.

Setting The survey was circulated through various media, including posts on social media networks (Facebook, Twitter, LinkedIn and Instagram), national radio, news articles, Clinical Research Network website and newsletter, and through 150 West Midlands general practices via a text messaging service.

Participants There were a total of 4884 respondents of which 9.44% were black, Asian and minority ethnic (BAME) group. The majority were women (n=3416, 69.9%) and of white ethnicity (n=4127, 84.5%).

Results Regarding respondents, overall, 3873 (79.3%) were interested in taking approved COVID-19 vaccines, while 677 (13.9%) were unsure, and 334 (6.8%) would not take a vaccine. Participants aged over 70 years (OR=4.63) and the BAME community (OR=5.48) were more likely to accept approved vaccines. Multinominal logistic regression models identified 16 key reasons for not accepting approved vaccines, the most common (60%) being the possibility of the COVID-19 vaccine having side effects.

Conclusions This study provides an insight into focusing on specific populations to reduce vaccine hesitancy. This proves crucial in managing the COVID-19 pandemic.

Strengths and limitations of this study

► This is the largest and first cross-sectional online survey in the UK that allows examination of the various factors influencing the uptake of a potential approved COVID-19 vaccine.
► This survey has allowed us to gain a deeper insight and a snapshot into the uptake of a COVID-19 vaccine, at a time prior to vaccine launch.
► This study was generally inclusive across all demographic groups, including age and ethnicity, with similar numbers to the UK population.
► The participant cohort could have benefitted from greater black, Asian and minority ethnic group diversity and representation.
► There is likely to be selection bias among the respondents completing the survey, and it provides a snapshot of the views at the time of response.

INTRODUCTION

COVID-19 is an infectious disease that is caused by the SARS-CoV-2, initially detected in Wuhan, China, in November 2019.1 The WHO declared the COVID-19 epidemic a Public Health Emergency of International Concern on 30 January 2020.2 This highly infectious disease has led to worldwide curfews and social distancing restrictions to prevent further spread of COVID-19.3 Although social distancing measures have been identified as one of the primary tools to reduce the transmission of COVID-19,4 this has led to insurmountable effects on the economy and the social and mental well-being of people’s health.5

There is little evidence to suggest that the spread of COVID-19 will stop naturally through population immunity, that is, ‘herd immunity’.6 Population immunity takes place when a sufficiently large proportion of immune individuals exists in a population.
With an estimated 0.3%–1.3% infection fatality ratio, the cost of reaching population immunity through natural infection would be very high. Men, older individuals and those with comorbidities are disproportionately affected, with an infection fatality ratio as high as 3.3%. Additionally, Public Health England revealed the death rate from COVID-19 in England to be four times higher for black people and three times higher for Asian people than for their white counterparts. Thus, an effective vaccine may offer the safest way to reach population immunity, particularly if immunity boosts are needed with virus variant formation or reinfections. The BioNTech–Pfizer vaccine has now been approved by the Medicines and Healthcare products Regulatory Agency, and on 8 December, the UK became the first country to roll out a national vaccination programme for COVID-19. Shortly following this, the Oxford–AstraZeneca vaccine was approved for use in the UK, while the Moderna vaccine has been mainly administered in the USA.

A further challenge for successful vaccine uptake, particularly with COVID-19, is vaccine hesitancy. Despite previous successful vaccines, there has been a greater shift of attention given to ‘vaccine hesitancy’, described as those people who have concerns about vaccine safety, efficacy or need. This can include those who are unsure about taking the vaccine and may have concerns or those who would refuse to take the vaccine. Obstacles to vaccination can include lack of trust towards public health authorities or government strategies and access to rumours and myths, particularly around safety. This is largely influenced by the media. Vaccine uptake rates can also vary across different communities and ethnicities, with significantly lower uptake rates in the black, Asian and minority ethnic (BAME) community. Vaccine uptake rates also vary significantly by age, gender, ethnicity (BAME and non-BAME), diagnosed practices via a text messaging service. The social media networks were used to target the general population with multiple posts during the month of September. The radio and news articles were centred on targeting BAME-specific individuals who are notoriously known to be under-represented in studies. The general practices sent a generic text to all patients in their practice asking for participation with a link to access the survey. Those without a mobile phone or internet service were unable to participate in the survey.

The interview questions were collated, reviewed and refined internally by a group of researchers. This was followed by an external review and further refinement by the CRN WM Equality, Diversity and Inclusion Research Champions Group. Feedback from this group was used to modify questions prior to the survey going live.

The survey (online supplemental appendix A) was designed to include several sections to collect demographic data and responses on (1) extent of agreement regarding various statements about COVID-19 and vaccinations, (2) previous vaccination habits (eg, if they had previously declined vaccination) and (3) level of interest in participation in vaccine trials.

**Patient and public involvement**

Patient and public involvement was through review of our research questions by the CRN WM Equality, Diversity and Inclusion Research Champions Group. This consists of a group of volunteers made up of patients and public and user groups.

**Ethical approval and patient consent**

This study was approved by local approval processes by the CRN WM. No ethical-related issues were identified. The Health Research Authority decision tool also indicated that there was not a need for National Health Service (NHS) Research Ethics Committee review (online supplemental appendix B). Participants were provided with information about the study and how the data were going to be disseminated in the initial page of the survey. This was an entirely anonymous survey with no identifiable material or information collected. No individual consent was obtained as the patients participated without providing any identifiable material. However, implied consent was taken as participants proceeded to complete the survey after reading what the survey was about and how the data were going to be used.

**Statistical analysis**

The statistical analysis was done in five phases. The first described the data of the participants of the COVID-19 survey, including the various factors considered in the analysis. The second phase investigated the various factors influencing the respondents’ interest in approved vaccines. This analysis was done using a multinomial logistic regression model. The analysis was done on the overall data, considering various factors such as age, gender, ethnicity (BAME and non-BAME), diagnosed...
Results

The survey had 4884 respondents. We received complete responses for each section, as participants were not able to submit the survey without completing all of the parts. The majority were women (n=3416, 69.9%) and of white ethnicity (n=4127, 84.5%). There were 461 BAME respondents (9.4%), with 49 (1%) respondents chose not to disclose their ethnicity. Among the BAME community, 258 (5.3%) respondents were Asian/Asian British–Indian, and overall, only 67 (1.4%) respondents were black/African/Caribbean/black British. The majority of the respondents were non-university degree holders (n=1574, 32.2%), while there were 1780 (36.4%) university undergraduate degree holders and 1010 (20.7%) postgraduate respondents. The age group 50–59 were the largest participant age group (1101 responses, 22.5%), with 552 (11.3%) responses from those aged 70 and above. Ninety-two percent (n=4495) of the respondents were non-smokers, and 39.9% (n=1949) of the respondents stated diagnosed health issues. See Table 1 for the full breakdown.

Overall, 3873 (79.3%) respondents were interested in taking approved vaccines, while 677 (13.86%) respondents were unsure, and only 334 (6.9%) stated that they were not going to take the vaccine. Figure 1 presents the OR of the various factors that significantly influence interest in taking the approved COVID-19 vaccines. The results indicate that except for factors of ‘no health issues’ (OR=0.70) and ‘smokers’ (OR=0.45), the rest of the factors have OR >1. Among those respondents who declared their educational qualification, graduates were more likely to take the vaccine compared with the non-graduates (considered as the reference group). Similarly, of those respondents who declared their gender, men were more likely to take the approved vaccine. Respondents belonging to the age groups 50–69 (OR=5.45) and 70 and above (OR=4.63) were more likely to accept the approved COVID-19 vaccine compared with the respondents below 50 years old, which is considered as the reference group. Among the ethnicity groups, it is evident that the BAME community was more likely to accept the COVID-19 vaccine (OR=5.48). Within the BAME community, the South Asian ethnicity, that is, Indian, Pakistani and Bangladeshi, showed more interest towards uptake of the approved COVID-19 vaccine. The figure shows the reference categories against which the ORs have been estimated.

Table 2 reports the mean scores of the survey questionnaire. For the survey, a 5-point Likert Scale was used, that is, strongly disagree (1), disagree (2), neutral (3), agree (4) and strongly agree (5). The mean scores for all the questions are above three, and the SD was very low for the general questions on vaccine, such as ‘vaccines are safe’ and ‘vaccines keep you healthy’. However, for the questions specific on COVID-19, the SD was higher. This indicates that even though the respondents tend to agree on the importance and necessity of the COVID-19 vaccine, the responses varied considerably more than the generic ones. There was a significant difference in the mean score of the responses between the BAME and the non-BAME community, with mean scores of the former significantly higher than that of the latter community, although SDs were lower. That the variation of the scores of the BAME community was higher than the non-BAME community could possibly indicate that perception of vaccines differs widely across the BAME community.

The reliability coefficient range of the questionnaire is 0.91 (value of Cronbach’s alpha). The latent variables were estimated using principal component analysis. For the questionnaire, the null hypothesis of Bartlett’s test of sphericity was rejected at 1% significance level (P value <0.01), stating that the variables are not orthogonal, that is, they are correlated. The Kaiser-Meyer-Olkin value is 0.89, indicating that the sampling is adequate. The findings show that the OR of impact of ‘perception of COVID-19 vaccine on overall health’ (OR=3.34) on uptake of approved COVID-19 vaccine is considerably higher than the impact of ‘perception of generic vaccine on overall health’ (OR=1, reference category).

In total, 1011 respondents (20.7%) were classified into the ‘non-uptake’ group; within this group, 334 (33%) would choose not to take the approved vaccine (‘refusers’), and 677 (67%) respondents were ‘unsure’. The ‘unsure’ group was two times larger than the ‘refusers’. In the ‘non-uptake’ group, women accounted for 75% (n=759), with 33.6% (n=340) reported to have diagnosed health issues. Smokers were at 8.3% (n=84). Among the qualification classifications in the ‘non-uptake’ group, university graduates accounted for 75% (n=759), with 33.6% (n=340) reported to have diagnosed health issues. Smokers were at 8.3% (n=84). Among the qualification classifications in the ‘non-uptake’ group, university graduates accounted for 75% (n=759), with 33.6% (n=340) reported to have diagnosed health issues. Smokers were at 8.3% (n=84). Among the qualification classifications in the ‘non-uptake’ group, university graduates accounted for 75% (n=759), with 33.6% (n=340) reported to have diagnosed health issues. Smokers were at 8.3% (n=84). Among the qualification classifications in the ‘non-uptake’ group, university graduates accounted for 75% (n=759), with 33.6% (n=340) reported to have diagnosed health issues. Smokers were at 8.3% (n=84).
have previously declined vaccinations. The details are reported in Table 3.

The survey identified 16 reasons cited by the respondents for not taking approved COVID-19 vaccines. The details are reported in Table 4. Panel A provides the percentages for the not sure category, whereas Panel B reports the details of the not interested category. In both categories, ‘unless completely tested with no proven side effect’ was the reason with the greatest response (71% for Panel A and 54.2% for Panel B).

At the end of the survey, there was an opportunity for free text comments. Some free text comments regarding reasons for not taking the vaccine revolved around the idea of the BAME community being used as ‘guinea pigs’ for trials to verify vaccine results and mistrust around government strategies.

### Table 1 Description of the survey respondents for the whole sample

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Percentage (%)</th>
<th>Respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interested in approved COVID-19 vaccine</td>
<td>79.3</td>
<td>Gender</td>
<td>69.9</td>
</tr>
<tr>
<td>Not interested</td>
<td>6.8</td>
<td>Man</td>
<td>29.2</td>
</tr>
<tr>
<td>Unsure</td>
<td>13.9</td>
<td>Prefer not to say</td>
<td>0.9</td>
</tr>
<tr>
<td>Age group</td>
<td>Ethnicity</td>
<td>84.5</td>
<td></td>
</tr>
<tr>
<td>Under 18</td>
<td>Caucasian—English/Welsh/Scottish/ Northern Irish/British</td>
<td>10.7</td>
<td></td>
</tr>
<tr>
<td>18–29</td>
<td>Caucasian—Irish</td>
<td>14.5</td>
<td></td>
</tr>
<tr>
<td>30–39</td>
<td>Caucasian—Gypsy or Irish Traveller</td>
<td>21.3</td>
<td></td>
</tr>
<tr>
<td>40–49</td>
<td>Caucasian—Roma</td>
<td>22.5</td>
<td></td>
</tr>
<tr>
<td>50–59</td>
<td>Caucasian—others</td>
<td>18.7</td>
<td></td>
</tr>
<tr>
<td>60–69</td>
<td>Asian/Asian British—Indian</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>70 and above</td>
<td>Asian/Asian British—Pakistani</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>Asian/Asian British—Chinese</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>BAME community</td>
<td>Asian/Asian British—Bangladeshi</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Non-BAME</td>
<td>Mixed/multiple ethnic groups</td>
<td>89.6</td>
<td></td>
</tr>
<tr>
<td>BAME</td>
<td>Black/African/Caribbean/black British—African</td>
<td>9.4</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>Prefer not to say</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Qualification</td>
<td>Smoker</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>No formal qualifications</td>
<td>Smoker</td>
<td>7.9</td>
<td></td>
</tr>
<tr>
<td>Up to A level</td>
<td>Non-smoker</td>
<td>32.2</td>
<td></td>
</tr>
<tr>
<td>University degree (undergraduate)</td>
<td>Prefer not to say</td>
<td>36.4</td>
<td></td>
</tr>
<tr>
<td>Postgraduate</td>
<td>Health issue</td>
<td>36.4</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>No diagnosed health issues</td>
<td>20.7</td>
<td></td>
</tr>
<tr>
<td>At least one diagnosed health issue</td>
<td>8.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The table above reports the demographic insights of the respondents of the COVID-19 survey. There were 4884 respondents, and the table is based on the full data collected.

BAME, black, Asian and minority ethnic.

### DISCUSSION

This is the largest UK-based population survey, examining the views surrounding COVID-19 vaccination and providing a focus on key factors to drive vaccination uptake. This survey allows us to compare the UK with other countries that have similarly gained perceptions and potential vaccine uptake through an online survey. China had the highest rate of perceived vaccine uptake, where 91.3% would accept an approved and available COVID-19 vaccination. A survey done across seven European countries found that 74% of participants would be willing to get vaccinated against COVID-19—a similar finding to our results. A recent survey undertaken in the USA showed the lowest COVID-19 vaccine acceptance rate of 67% with men, older adults, Asians and college and/or graduate degree holders more accepting of the vaccine.
This is also the first survey to focus specifically on the BAME population and other high-risk groups identified as the government’s priority for vaccination. The 79.2% of participants willing to be vaccinated exceeds the threshold required for COVID-19 population immunity, estimated to be 74% in Europe.17 It is important to overcome the barriers to vaccine uptake and to target the non-takers, known as the ‘non-uptake’ group, in order to ensure that the population immunity threshold is met across the population.

In late September, the UK government published interim advice on high-risk groups that will be prioritised with the COVID-19 vaccination programme.19 A combination of clinical risk stratification and an age-based approach was used in determining these groups, placing clinically vulnerable and over 70 age cohort as priority groups. Both of these groups, according to our findings, are more likely to uptake the approved vaccine. Several studies have found that groups over the age of 55 are more willing to get vaccinated.17 In a UK survey done with older adults and patients with chronic respiratory disease, 86% of respondents wanted to receive a COVID-19 vaccine.20 This may be due to the awareness that older adults with comorbidities are at greater risk of COVID-19 complications.

While the overall proportion of BAME participants was relatively low in our study, the BAME recruitment was greater than any other UK COVID-19 vaccination-based study thus far. Our results found that the BAME community in general is more likely to accept approved vaccines when compared with the non-BAME community. This contrasts with previous literature suggesting generally poor vaccination uptake rates in the BAME community, such as for child and influenza vaccinations.14 There has also historically been racial disparities surrounding trust in vaccines, where the BAME community is less likely to trust pharmaceutical companies and government strategies.21 A primary reason for a potential increase in uptake with the COVID-19 vaccine may be due to the disproportionate amount of COVID-19 deaths in the BAME population with a third of these patients being admitted to the intensive care unit.11

However, examining the individual ethnic groups, there are clear disparities with potential uptake. Our results showed that the South Asian groups showed more interest towards uptake of the approved COVID-19 vaccine. The South Asian population made up most of the BAME participation, and historically, these groups have a higher uptake in vaccination programmes in the UK and also in their home countries, where trust in the medical profession is high.18 22 Only 1.4% of our study participants were black British, making it difficult to fully deduct the views of this community with such a limited sample size. However, our findings support previous literature surrounding the black community and their lower vaccine uptake rates.23 There is a deep-rooted mistrust
### Table 2 Comparing the responses of the survey questionnaire on COVID-19

<table>
<thead>
<tr>
<th>Related questions</th>
<th>Overall Mean Score</th>
<th>Overall SD</th>
<th>BAME Mean Score</th>
<th>BAME SD</th>
<th>Non-BAME Mean Score</th>
<th>Non-BAME SD</th>
<th>BAME vis-à-vis non-BAME Mean Score</th>
<th>BAME vis-à-vis non-BAME SD</th>
<th>(P value)</th>
<th>Latent variable</th>
<th>OR (P value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccines are safe</td>
<td>3.97</td>
<td>0.938</td>
<td>3.67</td>
<td>1.036</td>
<td>4.01</td>
<td>0.904</td>
<td>(0.000)</td>
<td></td>
<td></td>
<td>Perception of generic vaccine on overall health</td>
<td>1 (reference category)</td>
</tr>
<tr>
<td>Vaccines keep you healthy</td>
<td>4.07</td>
<td>0.951</td>
<td>3.79</td>
<td>1.067</td>
<td>4.11</td>
<td>0.916</td>
<td>(0.000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines are imp. for overall health</td>
<td>4.14</td>
<td>0.963</td>
<td>3.86</td>
<td>1.070</td>
<td>4.19</td>
<td>0.925</td>
<td>(0.000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved COVID-19 vaccines are safe</td>
<td>4.04</td>
<td>1.019</td>
<td>3.77</td>
<td>1.120</td>
<td>4.09</td>
<td>0.986</td>
<td>(0.000)</td>
<td></td>
<td></td>
<td>Perception of COVID-19 vaccine on overall health</td>
<td>3.34 (0.000)</td>
</tr>
<tr>
<td>Vaccine is a necessity for COVID-19</td>
<td>4.08</td>
<td>1.069</td>
<td>3.77</td>
<td>1.147</td>
<td>4.13</td>
<td>1.035</td>
<td>(0.000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine is best to prevent COVID-19</td>
<td>4.17</td>
<td>1.058</td>
<td>3.82</td>
<td>1.183</td>
<td>4.22</td>
<td>1.016</td>
<td>(0.000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only vaccine can control COVID-19</td>
<td>4.11</td>
<td>1.098</td>
<td>3.80</td>
<td>1.201</td>
<td>4.16</td>
<td>1.061</td>
<td>(0.000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COVID-19 vaccine won’t harm me</td>
<td>3.94</td>
<td>1.022</td>
<td>3.67</td>
<td>1.159</td>
<td>3.98</td>
<td>0.986</td>
<td>(0.000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The table reports the mean scores of the responses of the COVID-19 survey. In total, there were 4884 respondents. A 5-point Likert Scale was used for this survey, that is, strongly disagree (1), disagree (2), neutral (3), agree (4) and strongly agree (5). The reliability coefficient range of the questionnaire is 0.91 (value of Cronbach’s alpha). The latent variables were estimated using principal component analysis. For the questionnaire, the null hypothesis of Bartlett’s test of sphericity was rejected at 1% significant level, stating that the variables are not orthogonal, that is, they are correlated. The Kaiser-Meyer-Olkin value is 0.89 indicating that the sampling is adequate. The OR of the latent variables was computed employing binary logistic regression model.

BAME, black, Asian and minority ethnic.
Several US studies have supported this, with the black community having higher levels of COVID-19 vaccine hesitancy. The perception surrounding vaccines differs widely across the BAME community and remains a challenge for this high-risk group. Aside from ethnic differences, our study identified that smokers, those aged 40–49 and those with no known illness were less likely to accept approved vaccines. This is the first study to identify smokers being less likely to accept approved vaccines and could be an area of concern. Smokers are 1.4 times more likely to have severe symptoms of COVID-19 and approximately 2.4 times more likely to be admitted to an intensive care unit. A younger and healthy cohort being less willing to vaccinate has also been supported by study findings in Europe and the USA, and may reflect the perception from these groups that they have less complications of COVID-19 or may die from it. However, with the infectious nature of COVID-19, having these groups not vaccinated poses a greater risk of spreading to those susceptible to greater complications from COVID-19.

Contrary to previous studies, educational qualifications did not have an influence on vaccine uptake in our study. This may suggest that vaccination attitude is more likely to be influenced by motivational and psychological factors, including a feeling of individual responsibility for population-wide health, rather than education. The 52.1% of the non-takers had a recorded history of declined vaccination in the past, making it more likely that this is a long-term view held about vaccinations, with a similar trend found in other studies.

<p>| Table 3: Non-uptakers of approved COVID-19 vaccine |</p>
<table>
<thead>
<tr>
<th>Non-uptakers category</th>
<th>Not sure (677 respondents)</th>
<th>Refusers (334 respondents)</th>
<th>Total (1011 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>20.38</td>
<td>26.05</td>
<td>22.26</td>
</tr>
<tr>
<td>Woman</td>
<td>78.29</td>
<td>68.56</td>
<td>75.07</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1.33</td>
<td>5.39</td>
<td>2.67</td>
</tr>
<tr>
<td>Smoker (%)</td>
<td>5.61</td>
<td>13.77</td>
<td>8.31</td>
</tr>
<tr>
<td>Diagnosed health condition (%)</td>
<td>35.45</td>
<td>29.94</td>
<td>33.63</td>
</tr>
<tr>
<td>Qualification (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No qualification</td>
<td>2.22</td>
<td>0.60</td>
<td>1.68</td>
</tr>
<tr>
<td>School graduates</td>
<td>31.17</td>
<td>26.35</td>
<td>29.57</td>
</tr>
<tr>
<td>Graduates</td>
<td>37.81</td>
<td>35.93</td>
<td>37.19</td>
</tr>
<tr>
<td>Postgraduates</td>
<td>19.20</td>
<td>18.26</td>
<td>18.89</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>9.60</td>
<td>18.86</td>
<td>12.66</td>
</tr>
<tr>
<td>Age group (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18</td>
<td>0.00</td>
<td>0.30</td>
<td>0.10</td>
</tr>
<tr>
<td>18–29</td>
<td>13.00</td>
<td>15.87</td>
<td>13.95</td>
</tr>
<tr>
<td>30–39</td>
<td>18.46</td>
<td>20.66</td>
<td>19.19</td>
</tr>
<tr>
<td>40–49</td>
<td>23.63</td>
<td>26.95</td>
<td>24.73</td>
</tr>
<tr>
<td>50–59</td>
<td>25.26</td>
<td>20.06</td>
<td>23.54</td>
</tr>
<tr>
<td>60–69</td>
<td>11.67</td>
<td>8.98</td>
<td>10.78</td>
</tr>
<tr>
<td>70+</td>
<td>6.50</td>
<td>2.99</td>
<td>5.34</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1.48</td>
<td>4.19</td>
<td>2.37</td>
</tr>
<tr>
<td>Ethnicity (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAME</td>
<td>9.45</td>
<td>16.77</td>
<td>15.63</td>
</tr>
<tr>
<td>Non-BAME</td>
<td>83.31</td>
<td>76.05</td>
<td>80.91</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>7.24</td>
<td>7.19</td>
<td>3.46</td>
</tr>
<tr>
<td>Record of declined vaccination (%)</td>
<td>20.53</td>
<td>52.09</td>
<td>30.95</td>
</tr>
</tbody>
</table>

Note: The table reports the demographic details of respondents who chose not to take the COVID-19 vaccine. Overall, 1011 respondents chose not to take the vaccine.

BAME, black, Asian and minority ethnic.
Table 4 Key reasons cited by the non-uptakers category of 1011 respondents

<table>
<thead>
<tr>
<th>No.</th>
<th>Reasons</th>
<th>Panel A: not sure (677 respondents)</th>
<th>Panel B: refuser (334 respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Responses (%)</td>
<td>Woman (%)</td>
</tr>
<tr>
<td>1</td>
<td>Unless completely tested and no proven side effects</td>
<td>71.00</td>
<td>67.50</td>
</tr>
<tr>
<td>2</td>
<td>Impaired immune system</td>
<td>4.00</td>
<td>68.00</td>
</tr>
<tr>
<td>3</td>
<td>Undisclosed reasons</td>
<td>2.28</td>
<td>45.60</td>
</tr>
<tr>
<td>4</td>
<td>COVID-19 doesn’t need vaccine</td>
<td>2.00</td>
<td>55.45</td>
</tr>
<tr>
<td>5</td>
<td>Don’t believe in vaccines</td>
<td>2.00</td>
<td>62.67</td>
</tr>
<tr>
<td>6</td>
<td>Religious reasons</td>
<td>2.00</td>
<td>66.82</td>
</tr>
<tr>
<td>7</td>
<td>Vaccine development is being rushed</td>
<td>10.00</td>
<td>55.22</td>
</tr>
<tr>
<td>8</td>
<td>Below 50 years old, so not important for my age</td>
<td>1.00</td>
<td>65.20</td>
</tr>
<tr>
<td>9</td>
<td>Already infected, so not sure of vaccine side effects</td>
<td>1.00</td>
<td>55.64</td>
</tr>
<tr>
<td>10</td>
<td>Cautious of age (65+)</td>
<td>2.00</td>
<td>55.88</td>
</tr>
<tr>
<td>11</td>
<td>Don’t trust the government and pharmaceuticals</td>
<td>0.20</td>
<td>59.72</td>
</tr>
<tr>
<td>12</td>
<td>Concerned about the impact to health of family members</td>
<td>2.00</td>
<td>61.08</td>
</tr>
<tr>
<td>13</td>
<td>BAME will be used as trials to verify vaccine results</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>14</td>
<td>Pregnancy-related and motherhood-related worries</td>
<td>0.40</td>
<td>100.00</td>
</tr>
<tr>
<td>15</td>
<td>Bad experience of influenza vaccine</td>
<td>0.10</td>
<td>71.05</td>
</tr>
<tr>
<td>16</td>
<td>Unethical measures used</td>
<td>0.02</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Note: This table reports the key reasons cited for not willing to take the COVID-19 vaccine. Panel A reports the reasons cited by the not sure category, and Panel B reports the findings for the refuser category.

BAME, black, Asian and minority ethnic.
Our study reports 16 key reasons for not accepting approved vaccines, with the main one being fear of side effects. Other studies have also identified safety as a key reason for vaccine hesitancy. At the time of the survey circulation, news channels were publicising the Oxford–AstraZeneca trial being paused due to participants having side effects, and this was widely circulated in the media at the time. Specifically, there were concerns of side effects of transverse myelitis that, although may not be directly linked to the vaccine, could also not be ruled out. This could have influenced participants’ view on the safety of vaccines.

This survey was done at the time when an approved vaccine had not yet been made available. However, now that vaccines have been licensed and shown to be safe and effective, recent surveys have shown the intention to vaccinate is higher. Nguyen et al’s study showed that from September to December 2020, intent to receive COVID-19 vaccination increased by around 10% and non-intent decreased by 6%. Similar numbers from our ‘non-uptake’ group were found in another UK-based study. However, in our study, the ‘unsure’ group is twice the size of the ‘non-uptake’ group. An Australian study by Attwell et al demonstrated that respondents were more likely to be in the ‘maybe’ group versus the ‘no’ group for vaccination if they perceived COVID-19 to be a severe disease and not a ‘hoax’, were more likely to have the influenza vaccination and had greater trust in science. In the case of our study, the ‘unsure’ group, which makes a significant portion of the ‘non-uptake’ group, may change their mind about the vaccine once further details on an approved vaccine become available, particularly information on safety and efficacy. Furthermore, they may be more willing to take the vaccine if it is positively promoted on social media. This is reinforced by a repeat of Attwell et al’s survey in November 2020, compared with May 2020, that found more respondents being in the ‘maybe’ category for vaccination, conveying how dynamic and changing the decision making process can be.

The next most common reason (16.1%) was having an ‘impaired immune system’. This would include patients who are on immunosuppressant medication or have a cancer diagnosis. However, similar to the influenza vaccine, those with an impaired immune system are still encouraged to have the annual influenza vaccination. The hesitancy in vaccine uptake in this immunocompromised cohort may also be linked back to safety and the belief that vaccines may be suboptimal and ultimately whether the risks of taking the vaccine may outweigh the benefits. However, this may well sway the ‘unsure’ group into the ‘uptake’ group as they see more people with various comorbidities taking the vaccine without any adverse effects.

Participants added their own reasons for not accepting approved vaccines. This revolved around the idea of the BAME community being used as ‘guinea pigs’ for trials to verify vaccine results and mistrust around government strategies, which has been supported in other studies. These views may have also been influenced by social media views at the time, particularly those highlighting vaccines as being rushed and rolled out quickly to the public without adequate testing. Furthermore, in terms of the views surrounding vaccines in general compared with a COVID-19-specific one, there was more variety in the responses related to the COVID-19-specific statements compared with the generic vaccine ones, and this was particularly found in the BAME responses. The topical nature surrounding COVID-19 vaccinations specifically is likely to draw more polarised opinions, particularly given the constant focus on COVID-19 in social media and news channels. Twitter reported a COVID-19-related tweet every 45 milliseconds, and the hashtag #coronavirus is the second most used in 2020. There are also greater anti-vaccination sentiments shared on social media compared with those promoting uptake, which can lead to considerable public health concerns and the consequent potential to downstream vaccine hesitancy.

Interventional educational and public health campaigns need to be targeted towards populations at risk of vaccine hesitancy and challenge the key reasons for not accepting approved vaccines. Furthermore, policymakers and shareholders need to be aware that these key reasons cited by the non-uptake cohort are potential barriers to vaccine uptake. This is to combat misinformation, particularly those circulated on social media platforms in an uncensored manner. Our study also reveals that the perception of vaccine on one’s overall health plays a significant driver in the decision for uptake of an approved vaccine. There is an understanding in our population cohort that vaccines are important in the fight against COVID-19 and that vaccines are needed to prevent COVID-19. This needs to be highlighted further in promotion and education of vaccines.

A limitation of this study is that, while this is one of the most BAME-inclusive COVID-19 vaccination-related studies, our BAME participant percentage (9.44%) is still below the overall BAME representation in the UK, which is approximately 14%. In particular, we received a very small amount of black and East Asian (eg, Chinese) participants, so it is difficult to fully deduce the views of the entirety of the BAME community. From the data that we have, however, it appears that the UK black community follows a similar trend to the USA in higher levels of vaccine hesitancy, but this can be difficult to generalise with such a small data set. Regardless, further work is needed to engage the black community in research participation and, from the limited data we do have, also in vaccine promotion.

Similar to other published surveys, there was also selection bias, as a computer or smart phone was needed to complete the survey. This may have excluded the older population, who is less likely to be digitally literate, and also economically marginalised groups. There are data suggesting these groups engage the least with the UK NHS digital resources, and it remains a challenge to provide
reliable and updated information to them. This survey is also more likely to attract responses from those who are motivated to complete this survey and who are more likely to have stronger opinions related to the COVID-19 vaccination, attracting selection bias. Furthermore, there is a clear skew towards women and those more educated, so it may be difficult to generalise our results to the entire UK population. This survey also remains a snapshot of what the view was as of September 2020, but it may have likely changed since the vaccination programme has started or even in the early phases of the trials as other studies have suggested.

Strengths of our study include the ability to stratify on demographic factors to predict COVID-19 vaccine uptake. Exploring key reasons towards vaccine hesitancy provides policymakers and key shareholders an insight into how to effectively target public health campaigns.

CONCLUSION

The uptake of approved vaccines is crucial in the fight against the COVID-19 pandemic. These novel findings regarding public insight on vaccines, including key barriers and facilitators towards vaccination, have the potential to shape future policy, practice and intervention development. This study provides necessary policy recommendations essential for the UK government and the UK medical advisory team on designing strategies. This study emphasises policies targeting the needs of increased participation from the BAME community, young people and those with no diagnosed health conditions to uptake approved COVID-19 vaccines. This will allow the UK to effectively reach population immunity thresholds nationwide and in controlling further outbreaks of this rapidly spreading disease. Widespread vaccine uptake will be a crucial turning point in rebuilding the nation’s social, health and financial losses from this unprecedented pandemic.

Twitter Sonika Sethi @sonika_sethi

Contributors SS and AK—involved in designing the survey questions and distributing the survey. They conducted literature reviews and wrote up the study and were involved in manuscript revisions. AM—ran the statistical analysis and was involved in writing the study and in manuscript revisions. MS—involvement in designing the survey questions, running the survey online and manuscript revisions. CAH—distributed the survey on official networks and involved in manuscript revisions. PM—involvement in manuscript revisions. JM, MB and SB—involvement in designing the concept of the study, distributing the survey and manuscript revisions.

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Provenance and peer review Not commissioned; externally peer reviewed.

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REFERENCES


23 Ensuring your trial is designed for all who could benefit. include ethnicity framework worksheet. Available: https://www.trialforge.org/trial-forge-centre/include/


34 Bosseme M, Kumar D. Seasonal influenza vaccine in immunocompromised persons. *Hum Vaccin Immunother* 2018;14:1311–22.


Appendix

Appendix A: Screenshots of Survey

This form was completed via Google Forms, and at different stages of completing the form, one was redirected to the next page with a progress bar underneath. Below are the screenshots.

![COVID-19 Vaccination Survey](image-url)
COVID-19 VACCINATION Survey

* Required

Please share your views on COVID-19

1. Do you agree with the following statements (on a scale of 1-5, where 1 is strongly disagree and 5 is strongly agree), *

- [ ] 1: Strongly disagree
- [ ] 2: Disagree
- [ ] 3: Neutral
- [ ] 4: Agree
- [ ] 5: Strongly agree

I want to help out in the fight against COVID-19

Never submit passwords through Google Forms.

This form was created inside of National Institute for Health Research. Report Abuse
Table: Attitudes Towards COVID-19 Vaccines

<table>
<thead>
<tr>
<th>Statement</th>
<th>1: Strongly Disagree</th>
<th>2: Disagree</th>
<th>3: Neutral</th>
<th>4: Agree</th>
<th>5: Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccines are safe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines keep you healthy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines are important to my overall health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An approved vaccine will be safe and protect me and others from getting ill with COVID-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventable diseases like COVID-19 won't be eradicated without vaccines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe that vaccines offer the best opportunity to prevent COVID-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An effective vaccine is the only way to control COVID-19 in the long term</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines won't harm me. Rather they're designed to help protect me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having more people involved in a vaccine trial will lead to a better vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People from all backgrounds are important in the vaccine trial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Have you declined any vaccines in the past? *
   - [ ] Yes
   - [ ] No
   - [ ] Prefer not to say

4. Would you be interested in participating in any potential trials for COVID-19 vaccination? *
   - [ ] Yes
   - [ ] No
   - [ ] Unsure

5. If you answered yes to the above question: How would you prefer the research to be conducted with the research team? If you did not answer yes, please choose the ‘not applicable’ option.
   - [ ] Virtual (e.g. through phone/online)
   - [ ] In hospital/research centre
   - [ ] Not applicable

6. Would you be interested in having the COVID-19 vaccine once it is approved? *
   - [ ] Yes
   - [ ] No
   - [ ] Unsure
7. If you have answered no or unsure to the question 6 please select the main reason(s) why you not be comfortable to take an approved COVID-19 vaccine. Please select all that apply:

- [ ] I dont believe vaccines work.
- [ ] Vaccines are against my beliefs/practices.
- [ ] The content/ingredients are not permissible according to my religious/non religious beliefs.
- [ ] Vaccines can increase my risks of other conditions.
- [ ] Vaccines might not always protect against the disease COVID-19.
- [ ] The safety and potential long term side effects of a vaccine still concerns me.
- [ ] Vaccines are not important for people of my age and health.
- [ ] I am worried about taking vaccines due to my other health condition(s).
- [ ] Prefer not to say
- [ ] Other:

---

Google Forms

COVID-19 VACCINATION Survey

Please tell us about yourself:

7. Please tick the relevant box that describes you:

- [ ] Male
- [ ] Female
- [ ] Prefer not to say
- [ ] Other:
8. What is your age group? *

- Under 18
- 18 - 29
- 30 - 39
- 40 - 49
- 50 - 59
- 60 - 69
- 70 +
- Prefer not to say

9. Which of the following best describes your ethnic group? *

Choose

10. What is the level of your highest educational qualification? *

- No formal qualifications
- Vocational qualification
- GCSE/D-level
- A-Level
- University Degree (Undergraduate: B/A; BSc; Other undergraduate degree)
- Postgraduate degree (Masters; PhD; Other postgraduate degree)
- Prefer not to say
11. What are the first 3-4 characters of your postcode? (such as WV10 or B19)*

Your answer

12. Do you smoke? *

Choose

13. Do you have any of the following health conditions? *

- Asthma
- Cancer
- COPD
- Diabetes
- High blood pressure
- Obesity
- Prefer not to say
- Not Applicable - I do not have any of these health conditions

Please feel free to share any comments about the COVID-19 vaccinations and its trials in the box below.

Your answer
COVID-19 VACCINATION Survey

Thank you for taking the time to complete this questionnaire.

Please click on the following links if you would like to know more information about research taking place in your area and would like to volunteer and sign up on the NHS national vaccine studies register.

National Institute for Health Research - Be Part of Research
https://beapartofresearch.nihr.ac.uk/

NHS - Coronavirus Vaccine Studies
https://www.nhs.uk/sign-up-to-be-contacted-for-research
Appendix B: HRA decision tool

Go straight to content.

Do I need NHS REC review?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:
The UPTAKE study

IRAS Project ID (if available):

Your answers to the following questions indicate that you do not need NHS REC review for sites in England.

This tool only considers whether NHS REC review is required, it does not consider whether other approvals are needed. You should check what other approvals are required for your research.

You have answered 'YES' to: Is your study research?

You answered 'NO' to all of these questions:

**Question Set 1**

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?

**Question Set 2**

- Will your study involve potential research participants identified in the context of, or in connection with, their past or present use of services (NHS and adult social care), including...
participants recruited through these services as healthy controls?

- Will your research involve prospective collection of tissue (i.e. any material consisting of or including human cells) from any past or present users of these services (NHS and adult social care)?
- Will your research involve prospective collection of information from any past or present users of these services (NHS and adult social care)?
- Will your research involve the use of previously collected tissue and/or information from which individual past or present users of these services (NHS and adult social care), are likely to be identified by the researchers either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve potential research participants identified because of their status as relatives or carers of past or present users of these services (NHS and adult social care)?

**Question Set 3**

- Will your research involve the storage of relevant material from the living or the deceased on premises in England, Wales or Northern Ireland without a storage licence from the Human Tissue Authority (HTA)?
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent for research from the donors?
- Will your research involve the analysis of human DNA in cellular material (relevant material), collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor? And/or: Will your research involve the analysis of human DNA from materials that do not contain cells (for example: serum or processed bodily fluids such as plasma and semen) and this analysis is not within the terms of consent for research from the donor?

**Question Set 4**

- Will your research involve at any stage procedures (including use of identifiable tissue samples or personal information) involving adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving offenders?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health and Social Care (England)?
- Will the research involve processing confidential information of patients or service users outside of the care team without consent? And/or: Does your research have Section 251 Support or will you be making an application to the Confidentiality Advisory Committee (CAG) for Section 251 Support?

If your research extends beyond **England** find out if you need NHS REC review by selecting the 'OTHER UK COUNTRIES' button below.
If, after visiting all relevant UK countries, this decision tool suggests that you do not require NHS REC review follow this link for final confirmation and further information.

NOTE: If using Internet Explorer please use browser print function.