



Short communication

Evidence of decreased HPV vaccine acceptance in Polish communities within Scotland

K.G. Pollock^{a,d,*}, B. Tait^c, J. Tait^c, K. Bielecki^b, A. Kirolos^b, L. Willocks^b, D.R. Gorman^b^a Health Protection Scotland, Meridian Court, Cadogan St, Glasgow, UK^b NHS Lothian, Directorate of Public Health and Health Policy, Edinburgh, UK^c Information Services Division, Gyle Square, Edinburgh, UK^d School of Health and Life Sciences, Glasgow Caledonian University, Cowcaddens Road, Glasgow, UK

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ABSTRACT

Human papillomavirus (HPV) vaccines are currently utilised globally in national immunisation programmes. Many new European migrants have settled in the United Kingdom (UK) since the 2004 European Union expansion with approximately 91,000 Polish people resident in Scotland. Following anecdotal reports from several NHS Boards within Scotland of lower HPV vaccine uptake in Polish communities compared with other ethnic minorities, an extract containing both forename and surname, was taken from the Scottish Immunisation Recall System (SIRS) for all girls in S2 and S3 in school years 2014/15 to 2016/17. We then used the OnoMap algorithm software to derive ethnicity. OnoMap identified between 289 and 321 age-eligible girls as Polish with significant disparity noted for completed HPV vaccine uptake between UK (87.2–89.8%) and Polish ethnicities (69.7–77.2%) ($P < 0.01$). Preliminary discussions with Polish families suggest that vaccine programme differences, trust in medical/healthcare practitioners, and cultural influences may be important drivers of acceptance.

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1. Introduction

In Scotland, since 2008, school-based uptake of both the bivalent and quadrivalent HPV vaccines in girls aged 12–13 has been impressive, with vaccine uptake sustained at levels exceeding 90% [12]. Implementation of the programme began as soon as the school session started in August 2008 following an extensive communication campaign with eye-catching, age-appropriate TV, radio and news coverage over the summer holidays. Nearly all HPV vaccines for this age cohort in Scotland are offered in the school setting.

Despite recent communications to head teachers and school nurses from anti-HPV vaccine groups in the UK, those involved in the programme remain committed to ensuring high uptake of the vaccine continues. Although the vaccine programme has been successful within the UK, the Republic of Ireland has observed considerable disparities in school uptake associated with socioeconomic disadvantage [9]. Furthermore, while parental intent and knowledge of the HPV vaccines has increased over time, lack of perceived importance of HPV vaccination and parental concerns

about vaccine safety remain barriers to both HPV vaccination series initiation and completion, especially in the USA [4].

Many new European migrants have settled in the United Kingdom since the 2004 European Union expansion with approximately 91,000 Polish people now resident in Scotland [10]. Following anecdotal reports from several of Scotland's 14 regional NHS Boards of lower HPV vaccine uptake in Polish communities, we aimed to formally assess uptake of HPV vaccine in Polish girls through ethnicity analysis at the national level.

2. Methods

An extract, containing both forename and surname, was taken from SIRS, for all girls in S3 in the school years 2014/15 to 2016/17. S3 is the third year of secondary school in Scotland (year 10 in England) and girls are aged 13–14. These extracts were then fed through OnoMap Name Classification software to derive ethnicity (Onomap; PublicProfiler Ltd, UK). Onomap offers an effective methodology for identifying population groups in both health-related and educational datasets, categorizing populations into a variety of ethnic groups. Previous evaluations have suggested that it can successfully assist health researchers, planners and policy makers in identifying and addressing health inequalities [6]. The

* Corresponding author at: School of Health and Life Sciences, Glasgow Caledonian University, Cowcaddens Road, Glasgow, UK.

E-mail address: Kevin.pollock@nhs.net (K.G. Pollock).

surname and forename recorded in the SIRS database for each person were matched to an Onomap subgroup, which is the lowest level in the Onomap classification system. Furthermore, as a sense check, one of the Polish speaking authors assessed forename/surname composition in the SIRS extract, confirming that Onomap was an appropriate tool for estimation of ethnicity. Ethnicity was categorised into UK, Eastern European, and Polish.

The cohort data was based on girls registered in S3 in Scotland on Child Health Schools Programme-School (CHSP-S) as at mid-May of the relevant school year. The vaccination data by ethnicity was based on the SIRS extract as at mid-August following the end of each school year. The published Scotland totals refer to uptake rates reported for the S3 cohort at the time the data for each school year were first published as national statistics. A completed course of HPV in 2014/15 was three doses of HPV, while in 2015/16 and 2016/17 it was two doses [2]. Ethical approval was obtained from the Public Health Intelligence Information Governance committee and approved by the relevant Caldicott Guardian.

3. Results

The majority of girls in S3 in each of the three annual cohorts were classed as British Isles, ranging from 90.2% to 91.8%. The percentage of S3 girls who were identified as Eastern Europe ranged from 1.4% to 1.6%. Approximately 75% of those identified as Eastern European were identified as Polish (Table 1).

Uptake in Eastern European and Polish S3 girls (range 68.1–75.5%; 69.7–79.2%) was significantly lower than in girls categorised as UK (87.2–89.6%) ($P < 0.01$). The trend in uptake across the three years was similar for the three different, with uptake falling in 2015/16 then increasing in 2016/17. The decrease in uptake in 2015/16 was larger among girls classed as Eastern European and the Polish sub-group, compared with UK girls. Although uptake rates rebounded in 2016/17 among all three groups, it was only the uptake among UK girls that recovered to the level observed in 2014/15 (Table 1).

4. Discussion

In this study, we confirmed a significant disparity in HPV vaccine uptake amongst Eastern European and Polish communities within Scotland, a country with high uptake since programme inception. This phenomenon appears to be uniquely associated with Polish and Eastern European communities, since uptake of the HPV vaccine in girls from the Indian sub-continent was comparable (86% for two doses) to those identified as being UK born. Within the EU, Poland is one of eight countries where HPV vaccination is yet to have been made part of a free-of-charge mandatory

form of immunisation programme [3]. Consequently, HPV vaccination coverage in adolescent Polish girls is estimated at 1.5–10%. This is much lower than those reported in countries where the cost of vaccinations is covered from the national budget. Poland has recognised issues with vaccine hesitancy and an active anti-vaccination movement [1,5].

However, notwithstanding that, the recent study by Ganczak and colleagues demonstrated that attitudes regarding their child being vaccinated against HPV were generally positive among Polish parents, even though awareness and knowledge of HPV in this group were low. If a girl wants vaccination the vaccine must be purchased by the parents and administered through primary health care or outpatient clinic. Most of the significant factors that influenced their willingness were modifiable, such as being informed about HPV and having positive attitudes toward vaccines.

These findings have important implications for the transnational study of vaccine uptake and the drivers of these, especially in countries that experience significant immigration. The main aim of characterizing the nature and scale of vaccine acceptance issues is to appropriately inform the development of strategies and policies to address the concerns expressed, while sustaining confidence in vaccination [7]. Reducing inequalities is also a key aim of generating and maintaining equitable uptake of vaccines, and where cervical cancer disproportionately affects the most deprived, it is even more important to ensure uptake of the HPV vaccine is evenly distributed across national populations.

One of the main limitations of our study was the reliance on the Onomap naming algorithm to accurately identify ethnicity. The utility of Onomap has been validated in several studies [13]. Combining ethnicity from multiple sources results in a more complete estimate of ethnicity than the use of one single source but we believe that this does not significantly affect the main findings of this study. The phenomenon of decreased vaccine uptake is prevalent in the Polish communities within Scotland, as is demonstrated in another study that was performed simultaneously for childhood influenza vaccine (Bielecki et al. 2018 – manuscript submitted to Vaccine). This study only involved administrative uptake data and not parent interviews. Consequently, this study was unable to discern the actual reasons behind the lower HPV uptake among Polish girls and was not able to identify whether, and to what extent, parents were reluctant or concerned about HPV vaccination.

Despite higher rates of HPV vaccine uptake compared to those residents in Poland, this study demonstrates significantly lower rates of HPV vaccine uptake in girls of Polish and Eastern European ethnicity compared to others in Scotland. We have conducted an explorative qualitative study with Polish families, which suggest that vaccine programme differences between Poland and the UK,

Table 1
Uptake of completed course of HPV by S3 by Ethnic Groups and Academic Year.

School Year	Ethnicity	S3 cohort	Completed HPV		95% CI
			n	%	
2014/15	UK	24,377	21,840	89.6	(89.2–90.0)
	Eastern Europe	376	284	75.5	(70.9–79.6)
	Polish	289	223	77.2	(72.0–81.6)
	Published Scotland Total	26,554	23,588	88.8	
2015/16	UK	23,816	20,775	87.2	(86.8–87.6)
	Eastern Europe	382	260	68.1	(63.2–72.5)
	Polish	300	209	69.7	(64.2–74.6)
	Published Scotland Total	26,104	22,570	86.5	
2016/17	UK	23,389	20,998	89.8	(89.4–90.2)
	Eastern Europe	418	304	72.7	(68.3–76.8)
	Polish	321	231	72.0	(66.8–76.6)
	Published Scotland Total	25,932	23,040	88.8	

trust in medical/healthcare practitioners, and cultural influences may be important drivers of acceptance. Furthermore, this qualitative study has revealed that Polish women expressed fears in relation to the side-effects of the HPV vaccine, an independent predictor of parental willingness to have their child vaccinated. Strategies to promote uptake of HPV vaccines amongst Polish and Eastern European communities should be promoted, especially given poor uptake of cervical screening in these communities [8].

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