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Recovering from the COVID-19 Pandemic

Overcoming vaccine hesitancy in prisons during the COVID-19 pandemic: A review of practice and our learning about the evidence base

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'Vaccination is the most important thing we can do to protect ourselves and our families against ill-health. They prevent up to 3 million deaths worldwide each year. However, if people stop having vaccines, it's possible for infectious diseases to quickly spread again'.[1]

Vaccination programmes in prisons aren't new; they have been a routine part of healthcare provision for decades. However, the COVID-19 pandemic presented the unique challenge of administering newly developed vaccines to many thousands of people in custody in England and Wales over a relatively short period of time. The vaccine roll-out required substantial efforts and collaboration between the UK Health Security Agency (formerly Public Health England), the National Health Service, Her Majesty's Prison and Probation Service, the Ministry of Justice, and the Department of Health and Social Care.

This article describes some of our understanding of the empirical evidence-base around vaccination uptake and hesitancy before the COVID-19 vaccination roll-out began in English and Welsh prisons, and our learning regarding its application and value in a prison context.

What did we know about vaccination uptake and hesitancy before the prison COVID-19 vaccination programme began?

Whether in prisons or in the community in England and Wales, individuals have a choice about whether to undergo medical treatment, and of course this includes whether they wish to be vaccinated. When COVID-19 vaccination(s) loomed, we began drawing together existing research to better understand uptake and behavioural drivers, cohorts who may be more or less likely to choose to be vaccinated, and common reasons for vaccine hesitancy. We quickly discovered that whilst there is a good body of evidence on vaccine uptake and hesitancy, almost none of this specifically related to vaccination programmes in prison settings.

Vaccination uptake and behavioural drivers

In October 2020 the World Health Organisation (WHO) published an extremely useful review and synthesis of prior evidence in this area.[2] Whilst still evolving, the evidence-base provided us with a reasonably good understanding of the barriers and enablers to vaccination, and potentially effective strategies to improve vaccine acceptance and uptake, which went beyond traditional information campaigns aspiring to change behaviours by improving knowledge.

The WHO report is well worth reading in full, but in brief, three categories of drivers of vaccine uptake were identified, which can interact and overlap, depending on contexts.

a) Enabling environment

Environmental factors play an important part in influencing people's vaccination behaviour. For example, what might seem to be reluctance or resistance to vaccination, may actually be a reaction to uptake being difficult to access or too costly for the person. Influential figures have the potential to encourage or discourage vaccination uptake by how enabling they make the environment (such as political leaders, health workers, and the media). Suggested

1. NHS (2019). Why vaccination is safe and important. https://www.nhs.uk/conditions/vaccinations/why-vaccination-is-safe-and-important/
2. WHO (2020). Behavioural considerations for acceptance and uptake of COVID-19 vaccines; BPS (2020). Delivering effective public health campaigns during Covid-19

strategies to create a more enabling vaccination environment include:

- Set up safe and accessible vaccination sites
- Make vaccination low/no cost to recipients
- Make getting vaccinated quick and timely
- Make the experience of being vaccinated a positive one
- Provide people with effective and sufficient information on the vaccination and the process of getting vaccinated
- Make getting vaccinated the default expectation

b) Social influences

Social influences play an important role too, in facilitating or acting as barriers to vaccine acceptance and uptake. Such influences include beliefs about what others in one's social group or networks do, or what they approve and disapprove of ('social norms'). Predominant narratives in the media can also skew people's perception of what the majority believe and do. Suggested strategies relating to social influence include:

- Promote social norms in favour of vaccination
- Highlight new and emerging norms in favour of vaccination
- Leverage the role of health professionals
- Support health professionals to promote vaccination
- Amplify endorsements from trusted community members

c) Motivation

An individual's motivation to get vaccinated is usually the result of a combination of factors, such as perceived risk and severity of infection, confidence in vaccine efficacy, values, and triggered emotions (for example, emotional responses to vaccinations and those involved in such programmes such as healthcare services and government authorities). Suggested strategies to influence people's motivation to get vaccinated include:

- Build timely trust and confidence in vaccines
- Leverage anticipated regret in communications (i.e. how a person might feel if they were not vaccinated and then transmitted the virus to a loved one).
- Emphasise the social benefits of vaccination

Differences between cohorts

There is a good body of literature that describes which groups of people are more/less likely to be vaccine hesitant and why, and at the time of our review some (primarily survey-based) studies were beginning to be shared in relation to COVID-19 vaccination specifically.[3] Those available to us were limited in some important ways. One particularly important limitation was that the surveys were conducted before an actual vaccine was available, and so people were being asked about their intention to make a choice, rather than actually offering them a choice and seeing how they responded. A second limitation was that some of the studies had yet to be peer reviewed (i.e. they were pre-print manuscripts). Nevertheless, this work, in conjunction with prior research, helped us to begin formulating a picture of people's likely response to a COVID-19 vaccination offer.

In general, the evidence pointed to lower uptake intention/greater hesitancy for people who were:

- female,
- younger,
- from lower income households,
- with lower education levels, and
- belonging to minority ethnic groups.

And lower uptake intention/greater likelihood to decline the vaccination looked to be associated with:

- Low levels of trust in scientists, healthcare, government/state authorities, including distrust of information received from these bodies and from more traditional sources (newspapers, TV), and subsequently being less likely to access this information.
- Misinformation and agreement with disinformation, for example this may be linked to paranoia and conspiracy beliefs, holding anti-lockdown beliefs and beliefs that the threat has been exaggerated.
- The existence of much and conflicting information can leave people feeling overwhelmed, confused, distressed and thus distrustful.
- Beliefs and concerns about vaccine safety/effectiveness/side effects which may

3. Robinson, E., et al. (2021). International estimates of intended uptake and refusal of COVID-19 vaccines: A rapid systematic review and meta-analysis of large nationally representative samples. *Vaccine*, 39, 2024-2034; Williams, L., et al. (2021). Social patterning and stability of intention to accept a COVID-19 vaccine in Scotland: Will those most at risk accept a vaccine? *Vaccines*, 9, 17-28; Sherman, S., et al. (2020). COVID-19 vaccination intention in the UK: results from the COVID-19 vaccination acceptability study (CoVAccS), a nationally representative cross-sectional survey. *Human Vaccines & Immunotherapeutics*, 17, 1612-1621; Murphy, J., et al. (2021). Psychological characteristics associated with COVID-19 vaccine hesitancy and resistance in Ireland and the United Kingdom. *Nature Communications*, 12, 29-44; Neumann-Bohme, S., et al. (2020). Once we have it, will we use it? A European survey on willingness to be vaccinated against COVID-19. *The European Journal of Health Economics*, 21, 977-982; Lockyer, B., et al. (2021). Understanding Covid-19 misinformation and vaccine hesitancy in context: Findings from a qualitative study involving citizens in Bradford, UK. *Health Expectations*, 24, 1158-1167.

be linked to the speed of vaccine development, lack of information about the effects for specific groups/at-risk cohorts, or available information in appropriate formats/languages.
- Perceptions of being low risk of infection, such as if currently healthy and implementing safety precautions.
- Lack of understanding of the benefits of vaccination/low perceived benefits of uptake.
- Lack of understanding about eligibility for the vaccine.

Prison-based vaccination research

Unfortunately, vaccination research within prison settings is scarce. In late 2020 and early 2021 however, a small number of prisons surveyed the people in their care to gauge perceptions of, and reasons for, likely COVID-19 vaccination uptake or hesitancy.[4] Reassuringly the findings, although not necessarily generalisable across the entire prison estate, seemed very consistent with the non-prison and more established evidence base.

The limited prison-based published work we were able to source focussed primarily on logistical or practical barriers to delivering vaccination programmes in custodial settings, rather than on a person's reasoning for taking up or declining vaccinations.[5] However, understanding practical barriers in our specific context was still helpful for consideration and planning within HMPPS. The main practical barriers identified included:

- Insufficient staffing numbers for escorting prisoners to, and administering, vaccinations.
- Insufficient vaccination doses available.
- Insufficient space to store and administer the vaccine.
- Cost of vaccination/valid health insurance of prisoners.[6]
- Inaccessibility of up-to-date medical records.
- Language/cultural barriers.
- Conflicting priorities of the organisations/staff (such as health vs. security).
- Transfer between, and release from, prison.
- Lengthy security checks/bureaucracy of processes for additional/external healthcare staff to enter prisons.

Summary

Despite the lack of empirical evidence relating to vaccination in custodial settings, or the COVID-19 vaccination specifically, the existing evidence provided a reasonably solid starting point for the vaccination programme for people living in prison, such as understanding what strategies might best facilitate uptake/acceptance, and who might need particular support to overcome hesitancy and why. Within HMPPS, the evidence and the implications of this were summarised and shared in the form of leaflets (see figures 1 and 2[7]).

4. The prisons included: Maidstone, Send, Exeter, Rochester, Swaleside, Huntercombe, Elmley, Stanford Hill, Grendon, and Spring Hill.
5. Madeddu, G., et al. (2019). Vaccinations in prison settings: A systematic review to assess the situation in EU/EEA countries and in other high income countries. *Vaccine*, 37, 4906-4919; Moore, A., et al. (2019). HPV Vaccination in Correctional Care: Knowledge, Attitudes, and Barriers Among Incarcerated Women. *Journal of Correctional Health Care*, 25, 219-230; Emerson, A., et al. (2020). Barriers and facilitators of implementing a collaborative HPV vaccine program in an incarcerated population: A case study. *Vaccine*, 38, 2566-2571.
6. This is not a relevant barrier in England and Wales but can be in countries with different healthcare service provision schemes.
7. With thanks to Lydia Baxter (HMPPS Evidence-Based Practice Team) for creating them.

Figure 1: Vaccination evidence review: summary of findings and recommendations (front and back of leaflet)

Vaccinations evidence review

Findings and recommendations

"Vaccination is the most important thing we can do to protect ourselves and our families against ill-health. They prevent up to 3 million deaths worldwide each year. However, if people stop having vaccines, it's possible for infectious diseases to quickly spread again" - NHS, 2019

Based on scientific evidence from the UK and around the world, we have a good understanding of why people are reluctant to be vaccinated, and what helps to overcome this.

The most common reasons include:

- ☒ Low levels of trust (such as in authorities, government and healthcare etc.)
- ☒ Concerns or lack of understanding about vaccine safety, potential side effects, effectiveness, eligibility and the speed of development
- ☒ Lack of information and misinformation
- ☒ Perceptions of being at low risk of infection
- ☒ Fear of needles

The strategies that are most likely to help encourage uptake include:

Increasing people's motivation

- **Build timely trust in vaccines**
- **Respectfully highlight the consequences of inaction** (such as increased risk of becoming ill)
- **Emphasise the social benefits of vaccination**
- **Help people to understand the risk** of getting and spreading the illness

Develop environments that encourage take up

- **Provide effective and sufficient information**
- **Use health regulations or mandates**
- **Make vaccination the default position**
- **Offer the vaccination in a timely manner**
- **Remind people to get vaccinated** and help them plan to do this
- **Administer the vaccine in safe and accessible locations**
- **Ensure people have a positive experience** when being vaccinated

Using social influences to shape behaviour

- **Publicise that the majority of people are being vaccinated** or are intending to get vaccinated
- **Publicise that people are increasingly engaged with vaccination** as roll-out progresses, including within specific groups
- **Use health professionals and management to model uptake** by vaccinating them early on
- **Support health professionals to promote vaccination** (making sure they have the right information to share and promote)
- **Amplify support from trusted community members**

If you have any questions or would like further information, please contact: Evidence@Justice.gov.uk

Practical recommendations for HMPPS

Communication

- Offer multiple methods and means of delivering critical vaccination information (such as using notices, tannoy announcements, Inside Times, TV, Prison radio, *in addition to in-person conversations*).
- Provide translated materials (for non-English speakers) and support for those with reading, writing and comprehension difficulties.
- Identify and involve trusted messengers/respected others early on to create or deliver briefings and encourage others (this might include health reps, residents, staff, and families).
- Communicate regularly about uptake rates and progress, focussing on numbers completed rather than refusals.
- Use the principles of procedural justice in all communications.
- Liken vaccine practice to something familiar, like the flu vaccine which is routine and repeated each year.
- Communicate stories from trusted/respected messengers (such as council members, chaplaincy, healthcare, Governors) about their endorsement of vaccination.
- Accurately promote the benefits of vaccination for residents (but be careful to manage expectations).
- Create specific communications and actions about second vaccination doses (due to lower uptake trends for second jabs).

Management

- Have a coordinated and clear leadership message (such as joint support from heads of Healthcare and Governing Governors).
- Encourage a culture where people's concerns are treated with respect, empathised with, and given time for discussion.
- Provide question boxes (or something similar) and named contact(s) for questions and concerns (ideally encouraging in-person conversations).
- Clearly, sensitively and consistently explain the potential health consequences for opting-out of vaccination.
- Coordinate and facilitate security clearances for additional health staff if needed – streamline and make this as straightforward as possible.
- Create plans for post-transfer/release vaccination completion.

Training & staffing

- Create staff briefing materials so they can provide confident, accurate and consistent information (such as written guidance, myth buster and Q&A sheets, videos on intranet, etc.).
- Make sure there are enough staff to provide briefings and answer questions (such as healthcare staff, contact tracing leads and, keyworkers).
- Target special attention on younger people, women, and people from minority ethnic groups who tend to be more hesitant to be vaccinated.
- Have staff issue reminders to individuals about the date and time of 1st and 2nd doses.

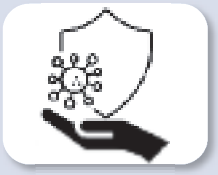
If you have any questions or would like further information, please contact: Evidence@Justice.gov.uk

Figure 2: Evidence-informed leaflet for staff supporting the vaccine roll-out to people in prison.

COVID-19 Vaccine: Supporting Residents

The COVID-19 vaccine has been clinically tested and found to be safe and effective.

It gives us, our loved ones, and the people in our care the best protection possible against coronavirus.



Scientific research tells us that there are lots of different reasons why people might feel reluctant to have the vaccine. These groups of people maybe even more likely to refuse the vaccine:

- Women
- Young people
- People from low income households
- People with lower education levels
- People from ethnic minority groups

Reasons might include:

- Lack of trust in authorities
- Concerns or lack of understanding about vaccine safety, potential side effects, effectiveness, eligibility, and the speed of development
- Lack of information or misinformation
- Perceptions of being at low risk of infection
- Fear of needles

Evidence-based strategies can help us to support residents and encourage uptake during the vaccination rollout:

Reduce or remove any environmental barriers

Provide timely, easy to understand, and relevant information on how they will be vaccinated, and why.

Be responsive to people's language, literacy, and comprehension

Remind people to get vaccinated and help them plan to do this.

Ensure people have a positive vaccination experience, and that they are treated with kindness, understanding and respect.

Help to increase motivation

Build trust by communicating early, consistently and by answering any questions

Take time to have in-person conversations.

Accurately promote the benefits of vaccination (carefully managing expectations), and normalise the practice by likening it to getting the flu jab.

Respectfully highlight the consequences of inaction (such as increased risk of becoming ill)

Use Social Influences

Remind residents that most people are being vaccinated or are intending to.

Publicise that people are increasingly engaged with vaccination as roll-out progresses.

Ask trusted community members (staff & residents) to voice their support.

For more information or to provide feedback, please contact: Evidence@Justice.gov.uk

What did we learn about how the evidence-base applied to prison settings during the COVID-19 vaccination roll-out?

By mid-May 2021, around 35 per cent of prisoners in England had received their first vaccination dose, and 12 per cent had received their second. Although there was some variation in which age groups were being offered their vaccination (due to differing circumstances, and complications in who qualified for early eligibility), the roll-out in prisons by this point was well through the 40 years plus age group and making inroads into the 30 years plus cohort.

As the roll-out progressed, official data showed some prisons to have higher uptake rates (and lower decline rates) amongst prisoners than in other sites. While some of this may be explained by the types of prison and the populations living there (e.g. gender, age and ethnicity, transfer frequency in and out of the sites, the quality of pre-COVID-19 relationships with staff and the culture of the prisons), we hoped to understand what specific local practices, approaches or efforts may have been helping them. In May 2021 we approached six sites with higher than expected uptake rates to explore their vaccination-related practices and understand what was working for them. These prisons included ones of different purposes, populations and security categories.[8] The accounts from the prisons (governors, heads of healthcare, operational staff and people living in prison) can be grouped into the nine themes described below and also summarised in figure 3.

1. Robust and detailed administrative planning and coordination

Robust daily preparation and organisation increased efficiency and coverage, avoided a scattergun approach, and ensured no one was inadvertently missed. For example, having a dedicated person or group creating daily lists of names for vaccination (having checked suitability against all contra-indicators, inclusion/exclusion criteria), a backup/secondary list so that vaccines were not wasted if individuals declined, and recording uptake/decline databases accurately to ensure planning for second approaches could be organised.

Sufficient resources and effective staffing of the process helped with efficiency and accuracy, and continuous review of necessary data and processes (e.g. repurposing offices to have a central planning location, involving people with access to health records, administrative staff, and utilising people on restricted duties[9]).

Clarity around expectations and responsibilities for all staff facilitated effective vaccination delivery (such as operational staff supporting vaccination times at unusual hours or acting as 'runners' to unlock and bring individuals to on-wing vaccination clinics).

Actively listening out for misinformation enabled the prisons to intervene quickly before rumours and incorrect information circulated too widely.

2. Proactive and responsive communication

Taking a range of approaches to communication helped to improve effectiveness. For example, sharing specific information rather than everything available (e.g. different leaflets on the same topic) so not to overwhelm or confuse people, using information suited to specific needs (e.g. easy read materials for people with dyslexia or reading difficulties, and translated versions), having available information for the different vaccines on offer, and using relatable materials/personalised communication (e.g. posters with pictures of similar age groups shown).

Communicating empathically and specifically about the needs and priority concerns of local prisoners enabled teams to proactively address reasons for hesitancy (e.g. concerns about the vaccination and fertility, or religious adherence). Actively listening out for misinformation enabled the prisons to intervene quickly before rumours and incorrect information circulated too widely.

Targeted and routine methods of communication (e.g. in-person conversations, and weekly short

8. The prisons included: Ford (open prison holding men), Liverpool (category B local prison holding men), Buckley Hall (category C prison holding men), Eastwood Park (women's prison), Brixton (category c resettlement prison holding men), and High Down (category B local prison holding men).
9. Where a person is restricted to carrying out only some of their regular duties (which can be for a range of reasons).

newsletters designed by a Contact Tracing Lead[10] with articles, pictures and a QandA sections on a topical issue/concern) helped to get important information to everyone, with the personal and responsive conversations used additionally for those who were more concerned or hesitant. Using trusted and respected staff and prisoners as primary messengers, alongside dedicated healthcare staff, also worked well (e.g. gym staff, healthcare and gym orderlies, prisoner council members, peer mentors and wing representatives).

Helping people to understand complex information by likening it to something familiar (e.g. breaking down the statistics for the risk of blood clots with the AstraZeneca vaccination, or comparing the risk against the that from using certain illegal substances) combated unhelpful media influence and help people to make informed decisions.

In addition to the main messaging in the early days which focussed on the benefits of vaccination in protecting the community and the more vulnerable, later communications and forums (general and targeted) also focussed on helping people to think through the personal benefits of vaccination/possible cost of not being vaccinated to motivate acceptance/uptake (e.g. sentence progression, taking holidays in the future, being released to a home shared with a vulnerable or older loved one, being released without accommodation and the risks this brings regarding health vulnerability, possible complications with current medication if infected with the virus).

Using trusted and respected staff and prisoners as primary messengers, alongside dedicated healthcare staff, also worked well

3. Accessibility and flexible timing of vaccination

Administering vaccinations in certain places and at different times made it as easy as possible for people in prison to get vaccinated, and reduced the likelihood of them having to choose between conflicting priorities (e.g. taking showers, making phone calls or attending employment). Altering/being flexible with the timing of vaccinations was appreciated by prisoners also, as it allowed them to not miss other things that were important to them. Examples included: vaccinating on the wings rather than in Healthcare departments, vaccinating in the evenings and weekends, 'blitz' vaccination days of entire units, and running multiple vaccination clinics at the same time around the prison. Further, these approaches reduced demand on operational staff to escort prisoners to other locations, and when vaccinations were visible to others this could have a social norms effect also.

4. Consistent, knowledgeable and pro-vaccination staff

A sufficient number of staff who had completed training on the vaccine(s), and involving those with a good level of knowledge, meant they could talk about vaccinations and answer related questions or respond to worries in a way that was perceived to be credible and convincing. Such staff were also able to provide ad hoc verbal information on the different types of vaccine (enabling them to overcome spikes in hesitancy when a new one was offered in the prison) without having to rely on written information.

A joined-up service amongst teams (e.g. physical healthcare, mental healthcare and substance misuse services) helped to ensured consistency in messaging, understanding of activities and decisions, and reduced the potential for misinformation.

Having a small core group of staff who administered vaccinations brought consistency in messaging about vaccination and reduced the risk of unintentional misinformation, as well as aiding relationship building. This also enabled easier planning and sharing of incremental learning (e.g. what questions are being asked often so to agree a response to then give proactively in future, reflecting on some terms being more confusing and so to all avoid them, and so on).

5. Staff visibility and relationships

Staff involved in vaccinations (usually from Healthcare departments) being active and visible on the wings outside of vaccination-administration events, having positive relationships with prisoners, speaking often with them (including approaching them rather

10. The Contact Tracing Lead was a new role established during the pandemic in each prison: a Band 5 operational colleague supporting their establishment's COVID-19 response, including delivering contact tracing, overseeing COVID-19 testing and promoting vaccination. The role has more recently been expanded (and renamed 'Health Resilience Lead') to also include working with local health teams and supporting staff by offering advice and wellbeing support.

than waiting to be approached), really understanding concerns and respectfully taking time to work through these without feeling rushed, helped to build relationships and trust in vaccination and the prison's motivations, and through this facilitated vaccine uptake.

Ensuring people knew that any adverse reactions would be noticed and acted upon also fostered trust; for example, doubling the number of night-time checks after a person had been vaccinated.

6. Involving and collaborating with people living in prison to support vaccination efforts

Establishing a prisoner working group, and senior staff meeting frequently with representatives chosen by each wing/unit, facilitated the prisons' understanding of primary concerns and worries, provided a chance to respond, and have this channelled back to other prisoners.

Prisoner council members having access to their peers so they could approach them to discuss vaccination, particularly with those who had declined, helped important messages and information to be communicated directly by, and discussed with, trusted and respected peers.

Involving prisoners with good relationships with Healthcare (such as Healthcare representatives and orderlies), prisoner councils, mentors and representatives helped to support the vaccination drive, engage people who were hesitant, and amplifying the prison's/vaccination team's messages.

7. Quality and timing of first engagement

Giving people advance notice of their scheduled vaccination, and then seeing people in-person the day before or earlier on the day of their appointment to discuss and obtain consent, meant those living in prison did not feel rushed or pressured, gave them the chance to discuss with others, and to speak to staff about worries or questions before making a decision. This helped also with quick identification of people who were hesitant, enabling a concerted and responsive engagement plan to be devised sooner.

8. Careful timing and responsive re-engagement (for people who declined the vaccine)

For those who declined the vaccine, or felt hesitant, repeated in-person conversations to discuss and respond to their specific concerns helped them to feel validated and genuinely cared about, and ensured accurate information was shared with them and myths could be combatted.

Figure 3: Summary of practices aiming to increase vaccine uptake rates

Quality and timing of first engagement
- Advance notice of their scheduled vaccination
- Healthcare (or dedicated team) seeing people in-person before or earlier on the day of their appointment to get consent

Careful timing and responsive reengagement
- In-person conversations to discuss and respond to their specific concerns
- Avoiding second (or repeated) approaches without a personalised conversation
- Choosing the right person for the follow-up
- Dedicating time for the follow-up and time for reflection (before/after)

Accessibility and flexible timing of vaccination
- Flexible and responsive identification of time and place for vaccination
- Vaccinating on the wings
- Vaccinating in the evenings and weekends
- 'Blitz' vaccination days of entire units
- Running multiple vaccination clinics at the same time around the prison

Staff visibility and relationships
- Vaccination staff being frequently active and visible on the wings
- Proactive and regular conversations with prisoners
- Respectfully understanding individual concerns and taking time to work through
- Ensuring people know that their best interests are being considered, and they will be cared for if they experience adverse effects

Proactive and responsive communication
- Sharing specific information not everything
- Using information suited to specific needs
- Using relatable materials
- Communicating specifically about priority concerns (including for different vaccines)
- Targeted, routine and varied methods
- Using trusted messengers
- Explaining complex information by likening it to something familiar
- Actively listening for and getting ahead of misinformation
- Emphasising the personal benefits of vaccination/possible cost of not being vaccinated (as well for others)

Robust and detailed administrative planning and coordination

- Accurate daily lists of people to be vaccinated
- Back-up lists to avoid wasted vaccinations
- Detailed recording of data, and planning for people who decline
- Sufficient resources and effective staffing for monitoring and planning
- Continuous review and data monitoring
- Clarity around expectations and responsibilities for all staff

Consistent, knowledgeable and pro-vaccination staff

- Sufficient numbers of staff who are trained and have good vaccines knowledge
- Joined up service amongst teams
- Consistency in messaging, and understanding of activities and decisions
- Consistent core group of staff administering vaccinations
- Sharing of learning and good practice

Involving and collaborating with people living in prison to support vaccination efforts

- Prisoner working groups
- Frequent meetings with representatives
- Trusted peers having access to prisoners
- Prisoner councils, mentors and representatives giving and amplifying the necessary messages
- Involving prisoners with good relationships with Healthcare

Using, reinforcing and modelling positive norms and expectations

- Dedicated, clear and consistent drive and messaging from leaders
- Expectations of a whole prison effort to roll-out the vaccine
- Plenty of recognition, reinforcement and encouragement
- Normalising the vaccine as a routine part of public health delivery
- Vaccinations offered with enthusiasm and the expectation of this being accepted
- Vaccinating people where they can be seen by others
- All staff role modelling by getting their vaccinations and communicating and pro-vaccination messages

Avoiding second (or repeated) approaches without a personalised conversation minimised the chance of people feeling pressured, not listened to, or that their concerns were being dismissed. Carefully choosing the right person for the follow-up conversation, who was perceived to be credible and trustworthy in the eyes of that specific individual, made this more likely to be successful. Dedicating time for these conversations and follow-up, although resource intensive, was felt to be effective in the long run.

9. Using, reinforcing and modelling positive norms and expectations

Dedicated, clear and consistent drive from leaders (e.g. Governing Governors and Heads of Healthcare), conveying expectations of a whole prison effort to roll-out the vaccine, actively recognising efforts and achievements, and repeating the core messages often, helped to motivate everyone involved.

Normalising the vaccine as a routine part of public health delivery no different to any other vaccination programmes (e.g. flu) or health service helped to reduce anxiety and disproportionate thinking.

Vaccinations communicated about and offered with positivity and enthusiasm and the expectation of this being accepted helped this to be normalised, and could be done whilst respecting a person's right to decline (e.g. 'this is so exciting, and you'll be fully vaccinated before you leave the prison and go back to your family…' vs. 'I'm here to vaccinate you, do you want it?')

Celebrating being vaccinated (e.g. having photographs taken which that person could keep copies of), using plenty of encouragement and reinforcement, and making involvement special (e.g. choosing the best prisoner cleaners to help with the clinics) was identified as helpful. And vaccinating people where they could be seen (e.g. on the wing) could influence others through the power of social norms.

More generally, the wider staffing group helpfully encouraged uptake by role modelling getting their vaccinations and communicating positive, encouraging and pro-vaccination messages (rather than seeing this as the responsibility of Healthcare or discrete groups of colleagues).

Conclusion

Our evidence review and exploration of practice in a small number of English prisons during the COVID-19

vaccination roll-out, indicates that prior research relating to vaccination uptake and hesitancy is transferrable to custodial settings. Although the experiences of the six prisons we spoke with will not account for every vaccination-related activity in all prisons in England and Wales that has helped with uptake, the similarity of these sites' activities and efforts, and the alignment of these with the wider evidence-based suggestions, suggests we can be reasonably confident in their value in our current, and any potential future, vaccination programme. We have also seen that the context in which these strategies are used, by who, when, and in what combination, matters in prisons.

Of course, the COVID-19 vaccination programme in prisons has not been without challenges. Even with these strategies in place, just like in the community, there are people living and working in prisons (including these six sites) who remain hesitant. This includes younger people, who at the time of our investigations were only just starting to be approached with the offer of vaccination.

Finally, in this work we did not explore the possible stigma experienced by people who cannot, or chose not to, be vaccinated. It is vitally important that in our efforts to encourage and reinforce vaccination uptake, we do not unintentionally contribute to, or reinforce, negative attitudes or behaviours towards those who decline.