A critical review of measures of childhood vaccine confidence

Gilla K Shapiro1, Jessica Kaufman2,3, Noel T Brewer4, Kerrie Wiley5, Lisa Menning6 and Julie Leask7, the BeSD Working Group8

The World Health Organization and global partners sought to identify existing measures of confidence in childhood vaccines, as part of a broader effort to measure the range of behavioural and social drivers of vaccination. We identified 14 confidence measures applicable to childhood vaccination in general, all published between 2010 and 2019. The measures examined 1–5 constructs and included a mean of 12 items. Validation studies commonly examined factor structure, internal consistency reliability, and criterion-related validity. Fewer studies examined convergent and discriminant validity, test-retest reliability, or used cognitive interviewing. Most measures were developed and validated only in high-income countries. These findings highlight the need for a childhood vaccine confidence measure validated for use in diverse global contexts.

Addresses
1 Department of Supportive Care, Princess Margaret Cancer Centre, University Health Network, Toronto, ON, Canada
2 Murdoch Children’s Research Institute, Melbourne, VIC, Australia
3 Centre for Health Communication and Participation, School of Psychology and Public Health, La Trobe University, Bundoora, VIC, Australia
4 Department of Health Behavior, Gillings School of Global Public Health and Lineberger Comprehensive Cancer Center, University of North Carolina, Chapel Hill, NC, United States
5 School of Public Health, Faculty of Medicine and Health, The University of Sydney, Sydney, NSW, Australia
6 Department of Immunization, Vaccines and Biologicals, World Health Organization, Geneva, Switzerland
7 The University of Sydney, Susan Wakil School of Nursing and Midwifery, Faculty of Medicine and Health, Sydney, NSW, Australia
8 The members of the Additional BeSD Working Group Members are given in Appendix A.

The need to assess and track the drivers of vaccination

For countries to receive the full benefit of immunization, maintaining high vaccination coverage is vital [1]. Many factors affect childhood vaccination including policies, systems, health services, access, and social and political influences. Parents’ confidence in vaccines and vaccination is one determinant of vaccination, contributing in part to both persistently low population coverage and sudden declines [2–5]. Negative vaccine attitudes and beliefs are also associated with delayed and missed childhood vaccination [6,7].

Some vaccine preventable diseases have surged in geographically concentrated areas [8**]. As a result, several countries recently lost their measles elimination status. Many children missed vaccination during the Covid-19 pandemic [9,10], and now questions exist around how to achieve high uptake of Covid-19 vaccines. The Global Vaccine Action Plan (GVAP) outlined goals for the ‘decade of vaccines’ (2011–2020), emphasizing the need for all countries to develop comprehensive national vaccine confidence management strategies, encompassing regular assessment of local hesitancy, trust building, and emergency response planning [11]. The Immunization Agenda 2030 then expanded upon these objectives [12].

Characterizing the multiple reasons for low vaccination can enable direct comparisons among different factors, and help guide the development, implementation, and monitoring of interventions to improve vaccination. An important part of this work is vaccine confidence monitoring, which should build on standardized and validated measures. Here we use the term ‘confidence’ broadly to encompass a range of factors relevant to vaccine acceptance.

The World Health Organization (WHO) and global partners are developing tools for the assessment of the range of factors that influence children’s vaccination across diverse global contexts in low-income, middle-income, and high-income countries. The tools are a quantitative
survey, qualitative in-depth interview guides, and user guidance for these tools. The aim is to support vaccine programme managers, implementation partners and funders to systematically assess the drivers of routine immunization uptake among parents and caregivers (hereafter caregivers) of children under five years of age and to provide consistent and comparable data over time [13**]. To develop these tools, WHO established the ‘Measuring Behavioural and Social Drivers of Vaccination’ (BeSD) working group, which includes partners from the Vaccination Demand Hub; UNICEF; Gavi, The Vaccine Alliance; the US Centers for Disease Control and Prevention; and the Bill and Melinda Gates Foundation.

We report here on the first stage of the BeSD work informing the development of the Childhood Immunization Survey. The aim is to measure caregivers’ experiences and perspectives that affect vaccine uptake, of which one is confidence. We report on the findings of a critical literature review aimed at identifying a comprehensive set of key measures of vaccine confidence. Specifically, we 1) identified available measures of vaccine confidence; 2) described and compared the development methods, scope, replication, and psychometric validity of these measures; and 3) identified gaps in the available measures to be addressed by the Childhood Immunization Survey.

A critical review provides an opportunity to assess the available evidence and a starting point for the conceptual development of a novel tool [14]. We carried out the search in April 2019, before a BeSD working group meeting to agree on overall constructs. We searched PubMed using terms related to vaccination (vaccine, immunization, immunisation), confidence (attitude, belief, confidence, trust) and measurement (psychometric testing, measure, scale, validation) for articles in English published in the peer-reviewed literature with no date restriction. Experts from the working group and author team supplemented the search with further relevant confidence measures. Citations and reference lists of the included articles were then searched to locate additional measures and relevant validation studies. Inclusion criteria for articles were general measures of confidence in childhood vaccination and related concepts. Articles were excluded if they pertained only to a specific vaccine or if they only measured vaccine knowledge. The evidence synthesis process focused on identifying (1) the publication year and country in which measure development took place, (2) the method used to develop a measure, (3) the main underlying constructs in the measures, (4) the questions and response options used to measure these constructs, and (5) the psychometric methods used to examine the validity and reliability of measures.

Available measures of vaccine confidence

We identified 14 published measures of caregivers’ confidence in childhood vaccination, all published between 2010 and early 2019 (Table 1). The measures were all developed in high-income countries, except the Caregiver Vaccination Attitudes Scale, which was developed in Ghana, a middle-income country (Table 1). For half of the measures \( (n = 7) \), the developers explicitly reported the use of theoretical or conceptual frameworks that informed the development of their tools.

The methods used to create or select items were reported for 11 of the 14 measures. Developers of all 11 of these measures reviewed the literature for items used in previous surveys. Most also used at least one other method to refine or confirm items, including expert consultation \( (n = 5) \), conducting cognitive interviews \( (n = 3) \), evaluating qualitative themes from interviews or focus groups \( (n = 3) \), and pilot testing items \( (n = 7) \). Measures were relatively short, with a mean of 12 items (range = 4–39) (Table 1). Four measures had long and short forms. Short forms of measures included a maximum of 10 items.

The survey items and associated constructs appear in Table S1. Measures included one to five constructs each. The most common constructs were beliefs in the benefits or importance of vaccination; trust in vaccines, healthcare providers, the scheduling of vaccines, and trust in the legitimacy of authorities to require vaccination; vaccination harms; and perceived risks of infectious disease. The measures typically assessed each construct using one or two items.

Developers of the measures used conceptually overlapping terms such as attitudes, beliefs, confidence, hesitancy, and acceptance in ways that were often inconsistent and unclear [15]. For example, three measures included ‘behaviour’, ‘behavioural intention’ or ‘past behaviour’ as attitudinal constructs assessed with items such as ‘have you ever delayed having your child get a shot for reasons other than illness or allergy?’. However, what people think (e.g. attitudes) and what they do (behaviour) are conceptually distinct, representing cause and effect. Clear conceptualization is critical to achieve meaningful measures. The BeSD working group adapted and proposed definitions of key terms, as shown in Table 2.

The psychometric properties, including reliability and validity, of the 14 measures, were examined in 29 studies conducted in the United States \( (n = 15) \), Europe \( (n = 6) \), Canada \( (n = 3) \), China \( (n = 1) \), Malaysia \( (n = 1) \), Guatemala \( (n = 1) \), Ghana \( (n = 1) \), or across multiple countries \( (n = 1) \) (Table 3, Table S2). The majority of validation studies focused on the Parent Attitudes about Childhood Vaccines (PACV) measure \( (n = 10) \). The other 13 measures had few validation studies, with a mean of 1.4 studies per
<table>
<thead>
<tr>
<th>Name of measure</th>
<th>Authors</th>
<th>Year published (# of citations)</th>
<th>Country</th>
<th>Development method as described by the authors</th>
<th>Conceptual basis</th>
<th>Constructs included in the final measure, as named by the authors</th>
<th>Number of items</th>
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| The Immunisation Beliefs and Intentions Measure (IBIM) [30] a | Tickner et al.     | 2010 (34)                      | England         | Developed using initial items based on central components of the Theory of Planned Behaviour, which were refined through cognitive interviews and pilot testing. | Theory of Planned Behaviour                               | 1. Behavioural intention (3 items)  
2. Attitude (8 items)  
3. Subjective norm (3 items)  
4. Perceived behavioural control (2 items)  
5. Beliefs (23 items): a) Behavioural beliefs (6 items), Normative beliefs (3 items), and Control beliefs (14 items) | 39 items       |
| Parent Attitudes about Childhood Vaccines (PACV) survey [19,31] | Opel et al.        | 2011 (205)                     | United States   | Developed using a four-step process: a) Review of previous studies and surveys on parental health beliefs to develop content domains and draft initial survey items (17 items, 12 from previous instruments and 5 constructed de novo); b) Two focus groups of parents and two of pediatricians generated additional themes and survey items (10 additional items, 27 items total); c) Six immunization experts reviewed the items and ranked them on a 1–5 scale. The lowest third of ranked items were dropped (18 items); d) The revised survey was pretested with 25 parents to assess face validity, usability and item understandability. Psychometric evaluation of the measure resulted in 15 items. | Health Belief Model                                        | 1. Safety and efficacy (4 items)  
2. General attitudes (9 items)  
3. Behaviour (2 items) | 15 items in long form, 5 items in short form |
| Vaccine Confidence Scale (VCS) [32] b              | Gilkey et al.      | 2014 (71)                      | United States   | Developed using items that were drawn from an existing large national survey (2010 National Immunization Survey-Teen). Eleven items were conceptualised according to the Health Belief Model, with two items of the Parental Attitudes Module assessing parents’ relationship with healthcare providers also included. Psychometric evaluation using data from a nationally representative sample of parents of adolescents reduced items to 8, corresponding to three constructs. | Health Belief Model                                        | 1. Benefits of vaccination (4 items)  
2. Harms of vaccination (2 items)  
3. Trust in healthcare providers (2 items) | 8 items in long form, 4 items in short form |
<table>
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<tr>
<th>Name of measure</th>
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<th>Conceptual basis</th>
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<th>Number of items</th>
</tr>
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<tr>
<td>Vaccine Conspiracy Beliefs Scale (VCBS) [33] b</td>
<td>Shapiro et al.</td>
<td>2014 (45)</td>
<td>Canada</td>
<td>Developed by conducting a scan of the literature. Six items were drawn from existing study on vaccine-specific conspiracy beliefs [34] and one item added by the authors [33].</td>
<td>Not reported</td>
<td>1. Vaccine conspiracy beliefs (7 items)</td>
<td>7 items</td>
</tr>
<tr>
<td>Concerns, attitudes, beliefs and intentions of parents about vaccines for their child (CABI-V) [35] a</td>
<td>Shoup</td>
<td>2015 (205)</td>
<td>United States</td>
<td>Developed in three phases: (1) literature review, expert consultation and cognitive interviews; (2) pilot test with 120 pregnant women, followed by revisions; (3) revised survey administered to pregnant women and parents of children under twelve months of age, and psychometrically evaluated.</td>
<td>Theory of Planned Behavior and Health Belief Model</td>
<td>1. Beliefs about vaccinating (6 items) 2. Evaluation of vaccine-preventable diseases (VPD)/vaccine adverse events (VAE) (8 items) 3. Subjective norms about vaccinating (5 items) 4. Perceived control of vaccinating decisions (4 items)</td>
<td>23 items</td>
</tr>
<tr>
<td>Vaccine Hesitancy Scale (VHS) [36,37] b</td>
<td>The SAGE Working Group on Vaccine Hesitancy</td>
<td>2015 (216)</td>
<td>Switzerland</td>
<td>Developed by conducting a systematic review of existent research, piloting questions in the WHO UNICEF Joint Reporting Form, and through expert consultation. Three different types of survey questions were included: Core Closed Questions; Likert-type Scale Questions (evaluated below); and a set of Open-Ended Questions.</td>
<td>Health belief Model and Theory of Planned Behaviour; gaps in these models also identified</td>
<td>1. Confidence (7 items) 2. Risks (2 items)</td>
<td>10 items (9 in subsequent validation)</td>
</tr>
<tr>
<td>Vaccination Scale (VS) [38]</td>
<td>Horne et al.</td>
<td>2015 (221)</td>
<td>United States</td>
<td>Method of development not described. Intention of this study was not specifically to develop a measure but to evaluate intervention to counter antivaccination attitudes.</td>
<td>Not reported</td>
<td>1. General vaccine attitudes (5 items)</td>
<td>5 items</td>
</tr>
<tr>
<td>Vaccine Confidence Project™ [39]</td>
<td>Larson et al.</td>
<td>2016 (498)</td>
<td>67 countries</td>
<td>The measure is adapted from the ten-question Likert-type survey proposed by SAGE. Intention of this study was not specifically to develop a measure but to develop a global monitoring tool. It has been applied in multiple countries; the data are publicly available (<a href="http://www.vaccineconfidence.org">www.vaccineconfidence.org</a>).</td>
<td>Not reported</td>
<td>1. Vaccine importance (1 item) 2. Vaccine safety (1 item) 3. Vaccine effectiveness (1 item) 4. Religious compatibility (1 item)</td>
<td>4 items</td>
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### Table 1 (Continued)

<table>
<thead>
<tr>
<th>Name of measure</th>
<th>Authors</th>
<th>Year published (# of citations)</th>
<th>Country</th>
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<th>Constructs included in the final measure, as named by the authors</th>
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<tr>
<td>Vaccination Psychological Empowerment Scale (VPES)</td>
<td>Fadda et al.</td>
<td>2017 (5)</td>
<td>Italy</td>
<td>Developed an initial item list by examining previous qualitative data (on themes of meaning, competence, impact, and self-determination), literature about psychological empowerment, existing validated empowerment scales and feedback from expert psychologists. The initial item pool was evaluated for content and face validity by a panel of experts in 2015 (57 items). A pretest reduced the initial pool to 9 items, eliminating items without an endorsement frequency between 0.2 and 0.8, and those items without an item-total value higher than 0.3. Three additional items were excluded due to their loading on multiple factors in the principal component analysis.</td>
<td>Empowerment Theory</td>
<td>1. Perceived influence of personal and family experience (2 items) 2. Desire to know peers’ opinion and experience (2 items)</td>
<td>4 items</td>
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<tr>
<td>The Vaccination Attitudes Examination (VAX) Scale</td>
<td>Martin and Petrie</td>
<td>2017 (33)</td>
<td>United States</td>
<td>Developed an initial item-list pool (45 items) by conducting: 1) three 30-min focus groups (one with a group of individuals who favoured vaccination and two with groups of individuals who identified as vaccine-hesitant) recruited from GP waiting rooms, and organized responses into themes; 2) literature review on attitudes towards vaccination; and 3) informal evaluation of the content of anti-vaccination websites and blogs. Developed items underwent psychometric evaluation and they retained the three items that best reflected each subscale.</td>
<td>Not reported; Used Necessity-Concerns Framework to frame findings</td>
<td>1. Mistrust of vaccine benefit (3-items) 2. Worries about unforeseen future effects (3-items) 3. Concerns about commercial profiteering (3-items) 4. Preference for natural immunity (3-items)</td>
<td>12 items</td>
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<tr>
<td>5C Antecedents of Vaccine Acceptance (5C)</td>
<td>Betsch et al.</td>
<td>2018 (81)</td>
<td>Germany</td>
<td>Developed using definitions derived from psychological theories, health behaviour models and existing measures, an item pool (of 35 items) was developed and underwent psychometric evaluation.</td>
<td>Health Belief Model, Theory of Planned Behaviour, 3Cs, 5As</td>
<td>1. Confidence (1 or 3 items) 2. Constraints (1 or 3 items) 3. Complacency (1 or 3 items) 4. Calculation (1 or 3 items) 5. Collective Responsibility (1 or 3 items)</td>
<td>15 items in long-form and 5 items in short form</td>
</tr>
<tr>
<td>Name of measure</td>
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<tr>
<td>Vaccine Acceptance Instrument (VAI) [44]</td>
<td>Sarathchandra et al.</td>
<td>2018 (24)</td>
<td>United States</td>
<td>Developed by reviewing literature on existing instruments used to measure vaccine confidence, employing expertise in an iterative fashion to identify most important facets of vaccine acceptance or hesitancy, and producing a set of Likert-type scale items that tap five theoretical and empirical dimensions of vaccine acceptance. Each dimension is measured by 4-item subscale of forward-worded and reversed-worded statements. Pilot tested instrument with 196 American adults in 2015.</td>
<td>Not reported</td>
<td>1. Perceived safety of vaccines (1 or 2 items) 2. Perceived effectiveness and necessity of vaccines (1 or 2 items) 3. Acceptance of the selection and scheduling of vaccines (1 or 2 items) 4. Positive values and affect toward vaccines (1 or 2 items) 5. Perceived legitimacy of authorities to require vaccinations (1 or 2 items)</td>
<td>20 items in long-form and 10 items in short form</td>
</tr>
<tr>
<td>Caregiver Vaccination Attitudes Scale (CVAS) [45]</td>
<td>Wallace et al.</td>
<td>2019 (7)</td>
<td>Ghana</td>
<td>Developed items in a multi-step process: 1) initial draft developed with expert study team; 2) review of existing measures; 3) addition of six items based on discussions with immunization professionals with expertise in African countries; 4) input from caregiver focus group discussions; 5) final review by Ghana Health Service immunization program focal points; 6) pilot tested (reducing 11-item version to 6-items based on validity testing).</td>
<td>Not reported</td>
<td>1. Vaccine benefits (2 items) 2. Past vaccination behaviour (2 items) 3. Vaccine efficacy and safety (2 items)</td>
<td>6 items</td>
</tr>
<tr>
<td>Emory Vaccine Confidence Index (EVCI) [46]</td>
<td>Frew et al.</td>
<td>2019 (6)</td>
<td>United States</td>
<td>Classified 30 individual survey items as they corresponded to the constructs ‘Information Environment’, ‘Trust’, ‘Healthcare Provider’, ‘Attitudes and Beliefs’, and ‘Social Norms’, key components of vaccine confidence as defined by the United States National Vaccine Advisory Committee. Methods for developing the specific items are not described. These 30 items were narrowed to 8 items using factor analysis, assessment of coefficients of variation, and the deliberate retention of items related to healthcare providers in order that the measure remained aligned with the advisory committee’s definition.</td>
<td>Not reported; items classified according to the advisory committee’s definition of vaccine confidence</td>
<td>1. Trust 2. Importance 3. Confidence</td>
<td>8 items</td>
</tr>
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Note. This table includes only measures for childhood vaccination in general (and not for specific vaccines such as measles, mumps, and rubella). Number of citations from Google Scholar as of January 30, 2021.

a Measure added to our review based on expert feedback.
b Measures that authors of this review developed.
measure. The studies most often examined internal consistency \((n = 13)\), criterion-related validity (i.e. correlation with vaccination intentions or behavior, \(n = 12\)), and factor structure \((n = 11)\). Fewer studies examined convergent and discriminant validity \((n = 7)\), used cognitive interviewing to confirm the meaning that participants ascribe to survey items matches that intended by the researchers \((n = 3)\), and assessed test-retest reliability \((n = 3)\). Notably, psychometric validation may be especially informative when adapting measures to other languages or for new populations [16,17]. For example, after adapting the PACV for adolescent vaccination, Roberts et al. found it was not associated with adolescent vaccination [18], though it had been associated with vaccination of young children [19,20].

### Shortcomings of reviewed measures

Existing confidence measures have important shortcomings. These measures were developed within and for specific geographic populations with none developed in a low-income country and only one developed in a middle-income setting. Psychometric validation and replication were also limited for most measures and largely conducted in high-income settings. The BeSD Working Group will develop and psychometrically validate the Childhood Immunization Survey to be useful in different cultures and languages in low-income, middle-income, and high-income country settings. Ongoing review of emerging evidence and evaluation of tool implementation will be needed to ensure the tools continue to improve.

Measures of vaccine confidence examine what people think and feel, but this is only one aspect of a holistic approach to understand the causes of coverage gaps. Studies focusing on other factors such as practical issues have found coverage is affected by available vaccine supply, cost of vaccination, and time to access services [21]. To address some of these shortcomings, the BeSD working group developed a comprehensive framework of vaccine uptake that includes what people think and feel, social processes, motivation, and practical issues (Figure 1). In this framework we present beliefs and behaviour as distinct and separable constructs, with confidence belonging to the ‘thinking and feeling’ domain [13**]. Social processes illuminate the gender barriers to vaccination such as travel and decision autonomy as well as the role of healthcare provider recommendation. Social processes also include family and community norms. Motivation refers to the intention or hesitancy to receive recommended vaccines. Practical factors include awareness of when and where to get a vaccine and the number of vaccinations children should receive, ease of access to a clinic, opportunity costs, and clinic experiences such as waiting time and quality of service, as well as respect from health workers towards caregivers. The caregiver journeys model which charts the process before, during, and after an immunization encounter assisted the development of these practical factors [13**].

This review highlighted that not all potentially relevant confidence constructs have been identified and included in previous measures of vaccine confidence or comprehensively investigated in large, representative, population-based studies. Many existing measures were developed by scanning items used in previous published surveys. Items and constructs measured in earlier tools may have held greater input in the development of later

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<th>Table 2</th>
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<tr>
<td>Definitions of key terms used in vaccine confidence measures</td>
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<tr>
<td><strong>Term</strong></td>
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<tr>
<td>Thinking and feeling</td>
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<tr>
<td>Motivation</td>
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<td>Behaviour</td>
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<td>Coverage</td>
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<td>Refusal</td>
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<td>Un-vaccinated</td>
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<tr>
<td>Intention</td>
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Sources: Adapted from Refs. [1,13**,47,48].
tools with certain constructs (e.g., perceived risk, perceived vaccine benefits, perceived vaccine harms, and trust) receiving greater emphasis due to precedence rather than established validity (e.g., relationship with vaccine uptake). The prominence of these constructs may also be due to their emphasis in well-regarded health psychology theoretical models (i.e., the Health Belief Model). Existing reviews of the qualitative literature on vaccine confidence and behaviour [22,23], in consultation with the BeSD Working Group, revealed

**Table 3**

<table>
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<tr>
<th>Vaccine confidence measure, year published</th>
<th>Factor structure</th>
<th>Internal consistency reliability</th>
<th>Test-retest reliability</th>
<th>Cognitive interviewing</th>
<th>Convergent and discriminant validity</th>
<th>Criterion validity</th>
</tr>
</thead>
</table>
| The Immunisation Beliefs and Intentions Measure (IBIM), 2010 [30]  
Parent Attitudes about Childhood Vaccines (PACV) survey, 2011 [19,20,31,49-56]  
Vaccine Confidence Scale (VCS), 2014 [32,57,58]  
Vaccine Conspiracy Beliefs Scale (VCBS), 2014 [33]  
Concerns, attitudes, beliefs and intentions of parents about vaccines for their child (CABI-V), 2015 [35]  
Vaccine Hesitancy Scale (VHS), 2015 [36,37,59-61]  
Vaccination Scale (VS), 2015 [38]  
Vaccine Confidence Project [34], 2016 [39]  
Vaccination Psychological Empowerment Scale (VPES), 2017 [40,41]  
The Vaccination Attitudes Examination (VAX) Scale, 2017 [42,62]  
5C Antecedents of Vaccine Acceptance (5C), 2018 [43]  
Vaccine Acceptance Instrument (VAI), 2018 [44]  
Caregiver Vaccination Attitudes Scale (CVAS), 2019 [45]  
Emory Vaccine Confidence Index (EVCI), 2019 [46]| ✗ ✔ ✔ ✔ | ✔ ✔ ✔ | ✔ ✔ ✔ | ✔ ✔ ✔ | ✔ ✔ ✔ | ✔ ✔ |

*Note. ✔ = Examined in at least one study. ✗ = Not examined. Internal consistency reliability: Examined a measure of the average correlations between pairs of items in the measure. Test-retest reliability: Examined the correlation of the measure administered at two different times. Cognitive interviewing: Used cognitive interviewing techniques to see whether participants assigned the same meaning to the items that researchers intended (see Table 1). Convergent and discriminant validity: Examined whether the measure correlated with conceptually similar scales and not with conceptually unrelated measures. Criterion validity: Examined the correlation of the measure with vaccination intention or behaviour. These definitions came primarily from two sources [47,48]. The codes are based on two coders independent evaluation of the studies. Supplementary Material S2 provides more information on the measures’ reliability and validity. Factor structure: Examined whether the measure had subscales. 

a Measure added to our review based on expert feedback. 
b Measure that authors of this review developed.

Figure 1

The Behavioural and Social Drivers of Vaccination Framework.

Source: The WHO BeSD Working Group [13**]. Based on the Increasing Vaccination Model [1].

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additional constructs relevant to vaccine confidence, such as profit (i.e. whether vaccination is motivated by financial gain of pharmaceutical companies or other entities), compatibility of vaccination with religious beliefs and cultural practices, moral intuitions of purity (i.e. disgust in vaccination) and liberty, self-efficacy (i.e. belief in one’s capability to receive a vaccine) as well as descriptive and subjective social norms. These additional constructs were included in the initial development of the BeSD tools to establish their relevance and whether they are distinct constructs of vaccine confidence [13**].

Surveys can quantify the relevant factors but cannot provide an in-depth and contextualised understanding of how people perceive and experience vaccination for their children. Therefore, qualitative methods are needed to provide a complementary understanding of how people experience vaccination and their reasons for under-vaccination [24]. The BeSD tools will also include qualitative childhood immunization in-depth interview guides. Accumulation of emerging qualitative evidence assessed over time with similar methods will also help to refine future versions of the Childhood Immunization Survey with new or modified constructs of relevance that may have been missed or not fully captured.

Other aspects that are important to evaluate in the future development and piloting of quantitative measures, that were not consistently reported upon in available confidence measures, include the average length of time to complete the measure, readability (reading level), central tendencies and distribution of the measure in the population (with particular attention to ceiling or floor effects), non-systematic presentation of items, and counterbalancing endpoints to reduce response bias. Furthermore, response options used by many of the confidence measures (i.e. response scales with multiple options) may not be appropriate for use in some low-income settings for sociocultural and linguistic reasons, among other considerations [25].

Review strengths and limitations
Our critical review identified measures of vaccine confidence, related constructs, and items from the recent literature. The review has informed the adaptation of the BeSD Framework from the Increasing Vaccination Model by Brewer et al. [1] to include the main factors informing uptake of childhood vaccines (Figure 1). Our review is only one aspect of developing the BeSD tools [13**]. We conducted needs assessment interviews with regional and in-country stakeholders, reviewed the grey literature and qualitative measures of under-vaccination, and enlisted expert feedback in the development and reduction of items. In addition, we completed cognitive interviews in the United States, Australia, and Sierra Leone, and elicited feedback on the translatability of items from WHO and UNICEF regional and country offices [13**]. Additional efforts are planned to test these tools in diverse countries—in Pakistan, India, Nigeria, Democratic Republic of the Congo, Angola, and Ethiopia—to assess the psychometric properties of the Childhood Immunization Survey, and ascertain global feasibility, suitability, and comparability.

Our review identified measures of childhood vaccine confidence but was not a systematic review. The review also excluded confidence measures for specific vaccines. While such measures can predict vaccine intentions and coverage beyond general vaccine confidence [1], we aimed for the Childhood Immunization Survey to be usable in many contexts and for many vaccines. In addition, the search date excluded more recently developed measures such as the Vaccine Attitudes Scale, which was developed in Pakistan [26]. Two scoping review protocols in the past two years have identified the need to synthesize measures of what the authors describe as vaccine hesitancy [27] and vaccination-related psychosocial factors [28], though neither have published their findings to-date. Lastly, we noted the presence or absence of psychometric data for the measures but did not evaluate these findings.

Conclusions
Vaccination is a pivotal health intervention in preventing disease, morbidity, and mortality [29]. Global demand is strong for a standardized, high-quality measure to understand the social and behavioral drivers of vaccination, including vaccine confidence. Our review of vaccine confidence measures and their psychometric validation can support the advancement of vaccination research and interventions to increase childhood vaccination.

Our review has guided the development and validation approach of the BeSD tools which include what people think and feel (including confidence and other constructs) as well as social processes, motivation, and practical issues (Figure 1). Development of the BeSD Childhood Immunization Survey will consider additional potentially relevant confidence constructs not commonly included in previous measures of vaccine confidence. Lastly, the field needs measures validated for use in multinational, multiregional, and multicultural contexts for inclusive and equitable approach to measurement. BeSD tools will be designed for global usability.

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Conflict of interest statement
NB is a paid consultant on vaccination for Merck, CDC and WHO. GSF’s husband is a minority owner of a consulting firm that does some work for Eli Lilly. NS is the director of the London Safety and ‘Training Solutions Ltd, which offers training in patient safety, implementation solutions and human factors to healthcare organisations and the pharmaceutical industry, including Sanofi-MSD and Merck. NS also holds an unrestricted educational research grant by Sanofi Pasteur for the project ‘Social and psychological determinants of vaccination uptake – Linking attitudinal and behavioural data to policy analysis and implementation’, 2021–24. CW is a Vaccines’ Section Editor for Current Opinion in Immunology, but he was not involved in the assessment of the suitability of this article for publication. All other authors report no conflict of interests.

Appendix A
The BeSD Working Group

Appendix B. Supplementary data
Supplementary material related to this article can be found, in the online version, at doi:https://doi.org/10.1016/j.coi.2021.04.002.

References and recommended reading
Papers of particular interest, published within the period of review, have been highlighted as:

- of special interest
- of outstanding interest


This manuscript describes the development and validation of a measure to assess childhood vaccine related attitudes in Pakistan, a low-income country setting. The authors validated the measure with 901 parents of children 4-12 months of age, and examined the internal validity, factor structure, and criterion validity. The final measure had two subscales that the authors named vaccine perceptions and concerns and vaccine preventable disease salience and community benefit.


This manuscript describes the development and validation of a measure to assess childhood vaccine attitudes in Ghana, a middle-income country. The authors conducted a cluster survey of 373 households with children aged 12-35 months, and examined the internal consistency, factor structure, and criterion validity and used cognitive interviewing. The final measure had three factors that the authors named vaccine benefit, past vaccination behaviour, and vaccine efficacy and safety.


This manuscript describes the development and validation of a measure to assess parental confidence towards childhood immunization in the United States, a high-income country setting. The authors conducted a web-based national poll of 893 parents of children less than age 7 years, and examined the internal consistency, factor structure, and criterion validity. The final measure had three factors that the authors named trust, importance and confidence.


