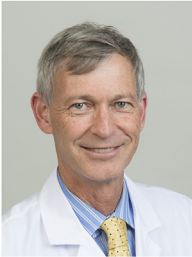




Preface

Addressing Vaccine Hesitancy for Child and Adolescent Vaccines: The Next Big Challenge



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When safe and effective COVID-19 vaccines were developed, it was easy to imagine that we were at the beginning of an era when everyone would recognize the stunning power of immunization to prevent illness and death from infections and to reduce societal costs. Vaccine hesitancy would be replaced by tickertape parades for everyone essential to vaccination—from the scientists who develop vaccines to the health care providers in public health, medical offices, and pharmacies who translate the scientific developments to practical protection. Antivaccine forces would lose their power as people recognized that COVID-19 vaccination saved millions of lives worldwide in the first year of use, just as smallpox, polio, measles, influenza, and pneumococcal vaccines, to specify a few, have drastically reduced morbidity and mortality from these scourges.

That, however, is not what happened. Vaccine hesitancy grew in the face of vaccine success (please see the article in this issue on the state of vaccine hesitancy in the United States). Even prior to the pandemic, the World Health Organization had designated vaccine hesitancy as one of the top 10 threats to public health, and the threat level has increased since March 2020.

This issue of *Pediatric Clinics of North America* takes a deep look at vaccine hesitancy, how it affects vaccine uptake, and what we know about strategies to address it. The articles provide an overview of vaccine hesitancy from both a public health and a clinical perspective. You will see in this issue that authors define vaccine hesitancy in different ways. However, each group of authors highlights how the factors that lead to vaccine reluctance or refusal differ depending on the vaccine (please see the articles in this issue on influenza, HPV, and COVID-19 vaccination) as well

as factors associated with the vaccination target population and decision makers. The human factors include, for example, age (please see the articles in this issue on adolescent and maternal vaccination), racial identity, culture, geography, politics, and religion. This entire journal issue, and one article in particular, emphasizes that vaccine hesitancy needs to be understood in the context of historical and contemporary racism, as well as other lived experiences, including medical exploitation, that have engendered mistrust (please see the article titled “A Structural Lens Approach to Vaccine Hesitancy and Identity”).

Many authors note the important role of trust in vaccine acceptance. As trust is predicated on empathy, those of us giving vaccines are called upon to strengthen our capacity to understand the perspectives of reluctant or refusing patients, which can be a tall order when we are simultaneously drained by the poignant consequences of infectious diseases. We are being challenged by new antigens and outbreaks, such as COVID-19 and monkeypox, while confronting new and rapidly changing communication channels, such as social media and false news reports, which our patients and their families consume in large quantities prior to our brief clinical encounters (please see the articles in this issue on clinician communication, technology, and social media).

Addressing vaccine hesitancy in pediatric offices and clinics is not for the faint of heart. There is no “secret sauce” that makes interventions successful and sustainable (please see the article in this issue on optimizing your pediatric office). However, some principles seem to echo in this issue and are discussed in multiple articles. Usually more than a single-pronged approach is needed (eg, communication skills training for nursing staff and providers, including trainees, changes in practice workflow, reaching out to parents using online tools, and community-based outreach with trusted messengers). It has become clear that piling on more parent/patient education by itself is insufficient and may even be counterproductive, especially when psychological factors, including cognitive biases, are ignored.

Where do we go from here? We need a comprehensive, equity-grounded effort to address vaccine hesitancy and vaccine confidence across the lifespan. Connections between basic, social, and public health sciences must be nurtured. Partnerships must be fostered between governments, community organizations, and a wide range of sites where vaccines can be given safely (please see the article in this issue on community-based efforts). We need an infusion of fresh ideas and an exchange of cross-discipline expertise that extend far outside traditional health care. As evidence-based approaches evolve, we need to train the next generation of health care providers to do better (please see the article in this issue on training). To understand the breadth of vaccine hesitancy, a fourth C, critical consciousness, should be considered in addition to confidence, convenience, and complacency (please see article in this issue “A Structural Lens Approach to Vaccine Hesitancy and Identity”). The evolving issues related to vaccine hesitancy reflect social trends that have effects in other medical domains. What we learn from efforts to address vaccine hesitancy may be useful in these arenas, too.

A bit more than 60 years ago, an American president stood before Congress and presented a transformational challenge—to send people to the moon and bring them back safely. Today, we face a similar challenge regarding vaccine hesitancy. We need a moonshot global effort to address vaccine hesitancy even as scientific

discoveries are launching new generations of vaccines. We hope this issue provides evidence to support this moonshot effort.

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