TOOLS FOR PRACTICE

PEER PATIENTS EXPERIENCE EVIDENCE RESEARCH

Vaccine hesitancy in the office: What can I do?

CLINICAL QUESTION

What office-based interventions in primary care help reduce vaccine hesitancy?

BOTTOM LINE

Clinicians should explicitly recommend vaccination and focus discussion on the disease-prevention benefits to the individual more than correcting misinformation or on benefits to society. Interventions are more likely to be effective in those with neutral attitudes towards vaccination than those opposed.

EVIDENCE

- Focus on RCTs of interventions implementable in primary care.
- 315 participants, online, given information on disease risk [measles, mumps, and rubella (MMR)], information correcting vaccine-autism link, or control; baseline vaccine attitude score 4.84 (6-point scale, higher more likely to vaccinate):[1]
    - Improvement in vaccine attitude scores:
        - Disease risk: 0.25, statistically different.
        - Autism risk: 0.08, not statistically different.
        - Control: 0.05.
    - Reanalysis[2] shows biggest change among participants with "neutral" baseline vaccine attitude scores.

- 1759 participants, online, randomized to one of four pro-vaccination messages: correcting misinformation (i.e., autism risk), MMR illness education, visual images of MMR, sick child story, or control:[3]
    - No intervention improved intent to vaccinate.
        - In those with least-favorable vaccine attitudes, correction of misinformation decreased intent to vaccinate from 70% (control) to 45%.
- 802 participants, online, randomized to vaccine information statement on MMR (control), statement plus information on benefits to child, statement plus information on societal benefits, or all three:[4]
    - Likelihood of vaccinating child with MMR (on a 100-point scale): 86.3 (control), 91.6 (benefits to child), 86.4 (benefits to society), 90.8 (benefits to child and society).
        - Only statements including benefits to the child statistically different from control.

LIMITATIONS

- Studies looked at proxy measures (example: intention to vaccinate) rather than vaccine uptake.
- No study was completed in a primary care office with a trusted healthcare provider.
- No RCTs involved COVID-19 vaccines.

CONTEXT

- Vaccine hesitancy is a spectrum, not a binary "pro/anti."[5]
- "Strong" physician recommendations are associated with higher likelihood to vaccinate.[6-8]
- Discussion about vaccination ideally begins during pregnancy and continues in the neonatal period.[9-11]
- A presumptive approach (example: "Jane is due for her vaccines today") is recommended over participatory (example: "Are we going to do Jane's vaccines today?").[7,12]

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