

ADDRESSING VACCINE HESITANCY TO IMPROVE MMR VACCINATION UPTAKE

QI project by Chidera Ezepue

Aim: Improving MMR vaccination uptake through addressing vaccine hesitancy

PURPOSE

There has been a decrease in the uptake of the measles, mumps and rubella (MMR) vaccination whereby a proportion of individuals have not received the first MMR vaccine that is given from 1 years of age.

Nationally, the coverage for the MMR vaccination remains below the 95% target (Lind, 2022).

PROBLEM

Burngreave Surgery serves a population of approximately 8,000 patients. This includes an ethnically diverse group with many patients and a significant number of refugees. Amongst the patients, a common reason found for the decrease in uptake is the perception of MMR vaccination can cause autism and ADHD (Attention-Deficit/Hyperactivity Disorder). However, clinical studies show no causal link between MMR vaccination and autism/ ADHD (DeStefano and Shimabukuro, 2019).

The '5C model' has been used to assess vaccine hesitancy behaviors. This model provides five main individual person-level determinants for vaccine hesitancy: confidence, complacency, constraints, risk calculation, and collective responsibility (Betsch et al., 2018).

METHODS

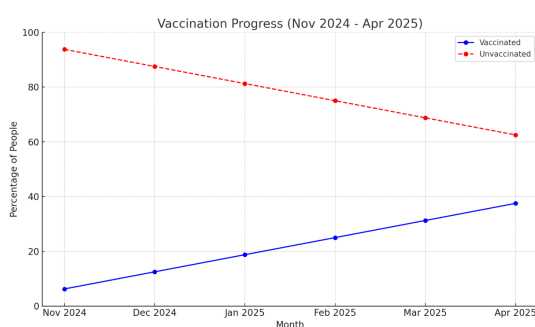
Drawing from some aspects of the 5C model, education is used to address the concerns about the MMR vaccine. Low confidence can stem from misinformation and it is therefore essential to address the myths using evidence-based information. In regards to complacency, some individuals may feel that their child is not of risk of the disease or may believe natural immunity is better. Therefore, it is important to emphasize the potential seriousness of the disease and long-term complications.

There are possible constraints whereby individuals may want their child vaccinated but face barriers such as time and availability. Perhaps they also need time to understand about the vaccine and for myths to be addressed before considering vaccination for their child. To overcome such barriers, I incorporated adequate time and flexible appointment times.

Methods are as follows:

- Education delivered through one-to-one patient consultation with option of F2F/telephone call.
- Sending out messages using Accurix (messaging system) with information about MMR vaccination with booking link provided. This information is also provided in different languages.
- Administering the MMR vaccine opportunistically through new patient health check appointments and ensuring adequate time provided for these appointments. These appointments have the option of booking via a booking link on Accurix.

DATA



Data shows the outcome of 12 out of 32 (37.5%) individuals, who were initially hesitant about vaccinating their child, received the first MMR vaccination.

CONCLUSION

Prior to undertaking this project I anticipated that even with educational efforts, some individuals will still choose not to consider the MMR vaccination. However, some initially hesitant individuals have had their child vaccinated which shows an improvement in the uptake of the MMR vaccination in practice.

NEXT STEPS

1. Collaborate locally by working closely with community leaders, local authorities and work with schools to help identify children who may be missing vaccinations. In addition
2. Liaise with local public health teams who may offer resources or help with campaigns to raise awareness of MMR and vaccination.
3. Meanwhile regularly review uptake data.
4. Use social media to promote educational content using trusted information/ websites.

REFERENCES

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