



Parents' involvement in the human papillomavirus vaccination decision for their sons



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ABSTRACT

Objectives: Parents are critical to ensure sufficient human papillomavirus (HPV) vaccine coverage. No studies to date have examined how mothers and fathers perceive their own, their partners' and their sons' involvement in HPV vaccination decision-making process.

Methods: An online survey methodology was used to collect data from a national sample of Canadian parents (33% fathers, 67% mothers, $M_{age} = 44$) who had a 9–16 years old son ($n = 3117$).

Main outcome measures: Parent's perception of their *self-involvement*, *partner-involvement* and *son's involvement* in the decision to get their son the HPV vaccine were measured on a Likert scale and were classified as 'no involvement', 'moderate involvement' and 'high involvement'.

Results: Mothers and fathers both perceive that they themselves and their partners should be highly involved in their son's HPV vaccination decision. Son's involvement was reported as moderate and influenced by age. Significant gender differences were found for self and partner involvement, but the effect sizes were small.

Conclusion: Mothers and fathers both perceive that they themselves and their partners should be significantly involved in their son's HPV vaccination decision. A dyad decision-making model involving both parents for HPV vaccine decision-making is suggested with a stronger recommendation for a triad decision-making model involving both parents as well as the child/adolescent. Gender stereotypes of females perceiving themselves as the sole decision-maker or fathers not wanting to be involved in their children's health decision were not supported.

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Introduction

As the most prevalent sexually transmitted disease, the human papillomavirus (HPV) is responsible for approximately 5.2% of all cancers worldwide, notably cervical, anal, vaginal, penile, and head and neck cancers [1]. Public health institutions globally endorse the HPV vaccine as safe and effective in preventing HPV-associated cancers as well as genital warts, and recommend HPV vaccination for females and males ages 9–26 [2,3]. Worldwide, HPV vaccine uptake among males is below public health goals and also lower compared to females and/or other recommended immunizations [4,5].

In Canada, by winter 2010, all provinces and territories had free school-based HPV vaccination programs for girls using the quadrivalent vaccine, Gardasil. Each province implemented slightly different variations of the program i.e., different school grades were targeted (grades 4–6), different dosing schedules (e.g., Quebec offered 2 doses as of 2015) and catch up programs were also offered to older females (grades 8–11). The commonality across the country was that all HPV vaccination programs were free, school-based and for *females only*. In ~2010, there was a major shift to “defeminize” the HPV vaccine [6], and to highlight the growing evidence supporting the HPV-associated disease burden among males: the role males play in female transmission and the need to protect men who have sex with men. As of February 2014, only one of the 10 provinces in Canada was offering school-based HPV immunization for boys in Grade 6 only.

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Parents play a critical role in the HPV vaccine decision-making process as HPV vaccination for their child/adolescent typically requires parental consent and the vaccine is most effective if administered prior to sexual debut [1]. The HPV vaccine also requires multiple doses (2 or 3 depending on jurisdiction) and therefore requires the continued involvement of the parent(s). Despite universal public health recommendations for young boys to be vaccinated [2], some parents perceive HPV's potential consequences as less severe for their sons than daughters, are hesitant because HPV is sexually transmitted, and many parents are even unaware the HPV vaccine is available and recommended for males [7–9].

Over the past few decades, the study of fathers' involvement in their children's healthcare has increased and has been associated with improved child adjustment and better child health outcomes [10,11]. However, in the field of HPV vaccination fathers' role in the HPV vaccination decision-making process remains largely unexamined.

Garcini's [12] systematic review of parents' perspectives towards HPV vaccination found that the vast majority of studies reviewed sampled mothers only, or had an over-representation of mothers (83–95%) in comparison to fathers. This research bias of over sampling mothers, as compared to fathers, may skew our current understanding of what has been defined as *parents'* HPV vaccination decision-making, which in reality appears to be *mothers'* HPV vaccination decision-making [12,13]. In a recent study, when mothers were asked who makes the decision to vaccinate against HPV (or who would make the decision), 40% of mothers responded they were the sole decision-maker, 22% made a joint decision with their husband/partner (no child involvement), 31% responded they made it with their child (no partner involvement) [14]. These findings support the perception of an over-involvement of mothers and a limited role of children/adolescents in the context of HPV vaccine decision-making [15]. To the best of our knowledge, no study has examined to what extent fathers perceive their role in the HPV vaccine decision-making process for their sons.

Beyond the parents, recent health models have also begun to recognize the role of the adolescent as a potential partner in his healthcare decision-making [16,17]. Regarding HPV immunization, Fortenberry recommends a shared decision-making model in which adolescents play an active and interactive role in helping to choose whether or not to be vaccinated [18]. Despite the benefits of increasing adolescents' healthcare taking responsibility as well as providing a platform for sexual education/communication between parents and children, only 24% of mothers collaborated with their sons on the decision to vaccinate [15]. Similarly, Moss, and Brewer's study of parent-son dyads suggested that their sons' input played a minimal role in parents' decision regarding the HPV vaccination [16]. The roles of sons is further complicated because the age when HPV vaccination occurs can vary widely between 9 and 16 years old, a period when children shift into adolescence and are beginning to have more understanding and in turn more autonomy about their own sexual behaviours. To our knowledge, there is no quantitative evidence examining parents' perceptions of sons' involvement as well as potential gender differences on parents' involvement with respect to HPV vaccination decision-making.

The present study objective was to assess parents' perception related to their own, their partners' and their sons' involvement in the HPV vaccine decision-making process for their son. Specifically, we wanted to: (a) examine if there are gender differences in parents' perceptions of the role of self, partner and son involvement in the HPV vaccine decision-making process and (b) evaluate if the parents' perception about their son involvement in the HPV vaccination decision differs based on son's age.

Methods

Sample and participant recruitment

The study sample was Canadian parents who had a 9–16 years old son ($n = 3117$) for whom the HPV vaccine was recommended. The study protocol and methodology can be found in detail elsewhere [19]. In short, an online survey methodology was employed to collect data in February 2014. At the time of data collection, HPV vaccination for boys in Canada was just beginning. PEI had just started a school-based HPV vaccination program for Grade 6 boys only five months before (~Sept 2013) data collection.

The survey included quantitative and qualitative items such as socio-demographics, Precaution Adoption Process Model (PAPM), a health behavior theory which categories health/vaccination decision-making in a series of different stages, HPV and HPV vaccine knowledge, attitudes and health behaviors, which are described in greater detail elsewhere [19]. The items that are pertinent to the present study analysis were: basic socio-demographics e.g., parents' gender, son's age, and parent's perception of their self, partner and son's involvement.

Measures

Parents answered socio-demographic items including their gender by indicating if they were 'a man' or 'a woman'. Parents were also asked to specify the exact age of their 9–16 year-old son. Parents also specified their current PAPM decision-making stage for their son with response options: unaware that the HPV vaccine could be given to males, aware but have not thought about this decision, undecided, decided to or decided not to vaccinate their son, and vaccinated their son.

Self-involvement i.e., the parent's perception of their own level of involvement was measured using the item "How involved do you feel you should be in the decision to get *son's name*¹ the HPV vaccine?"

If parents had indicated earlier in the questionnaire (on their PAPM decision-making stage item) that they had decided to/decided not to or had already vaccinated their son, the item was worded as: "How involved were you in the decision to get *son's name* the HPV vaccine?"

Partner involvement i.e., the parent's perception of their partner/spouse's level of involvement was measured using the item "How involved do you feel your *son's* other parent should be in the decision to get *son's name* HPV vaccine?" or "How involved was your partner/spouse in the decision to get *son's name* the HPV vaccine?" (for those parents who already decided to, decided not to or vaccinated their son).

Son's involvement i.e., the parent's perception of their son's level of involvement was measured using the item "How involved do you feel *son's name* should be in the decision to get him the HPV vaccine?" or "How involved was *son's name* in the decision to get him the HPV vaccine?" (for those parents who already decided to, decided not to or vaccinated their son).

For self, partner and sons' involvement items, we used a 5-point Likert scale where 1 = 'Not at all involved', 2 = 'A little involved', 3 = 'Moderately involved', 4 = 'Very involved', and 5 = 'Extremely involved'. For partner involvement, there was an additional response option of 'Not applicable, I am the only parent involved in decisions for my son'.

¹ Participants were asked at the start of the questionnaire to provide a name, nickname, or initials for their son who is between the ages of 9–16 and who has had the nearest birthday (if they had more than two sons in this age range). The questionnaire was individualized so that items that included '*son's name*' were replaced with the chosen nickname/initials provided by the participant (e.g., *Dan, JT*).

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