

Parental Refusal of Human Papillomavirus Vaccine: Multisite Study

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ABSTRACT

Introduction: The purpose of this study was to explore reasons why parents may refuse administration of the human papillomavirus vaccine to their children. The data from this multisite study will contribute to our understanding of why parents may refuse administration of the vaccine.

Methods: This mixed-methods study took place in several pediatric settings after a pilot study was completed. After a health visit in which the vaccine was refused, a survey was provided to the parent in a private room. The survey was kept confidential and anonymous.

Results: There were 72 surveys completed. Demographic data were reported. Data were analyzed for descriptive statistics, and themes were extracted. Overall, 58% of parents refused the vaccine because it was too new, and 50% believed the vaccine required more research.

Discussion: The data from this study correlated with the pilot study regarding parental perceptions of the vaccine; however, it appears that with new public campaigns and education, parents' perceptions are improving. Nurse practitioners are in an excellent position to clarify information about human papillomavirus vaccination. *J Pediatr Health Care.* (2017) ■■, ■■-■■■.

KEY WORDS

Human papillomavirus, parental refusal, vaccine refusal

BACKGROUND

According to the [Centers for Disease Control and Prevention \(2017\)](#), human papillomavirus (HPV) is the

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Conflicts of interest: None to report.

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most common sexually transmitted disease in the United States. Some genital warts are low risk, but others are high risk for cancer. During 2013 and 2014, prevalences of any and high-risk genital HPV for adults aged 18 through 59 years were 45.2% and 25.1% in men and 39.9% and 20.4% in women, respectively. Papanicolaou tests are important for detecting HPV infection and cervical cancer in women. The development of the HPV vaccine has become valuable in decreasing the rates of cancer in women and men. The vaccine was first approved in 2006 by the U.S. Food and Drug Administration for use in females 9 through 26 years old; however, in 2009 males of the same ages were eligible. In December 2014, the U.S. Food and Drug Administration approved a 9 valent HPV vaccine, which covers nine HPV types that are high risk for cancer. According to [Johnson \(2017\)](#), this vaccine has the potential to prevent approximately 90% of cervical, vulvar, vaginal, and anal cancers. The series was composed of three doses until October 2016, when the Centers for Disease Control and Prevention and Advisory Committee of Immunization Practices recommended that 11- and 12-year-olds receive two doses at least 6 months apart. Despite the recommendations by the [American Academy of Pediatrics \(2015\)](#), data suggest that 44% of parents would not vaccinate their teen. Among the reasons are fear of the vaccine being too new, needing more research, and weak recommendations from health providers. Social media is also playing a role in the activity of producing anxiety and mistrust. The combination of these reasons set off an alarm of uncertainty and skepticism in parents, not only for this highly controversial vaccine, but also for many others. Recently, TV campaigns, media, and health provider education have been used to raise the vaccination rates.

REVIEW OF LITERATURE

A literature search was performed using the Summon database using the key words *human papillomavirus* and *vaccine refusal*. Ten articles were found to be useful for this full multisite study. The aim of the literature

search was to discover new information with a larger sample since the pilot study was completed in 2015. Vaccine hesitancy seems to stem from weak recommendations from health care providers. Many new parents did not have experience with any of the devastating childhood diseases, and they fear that their autonomy is being infringed upon by health officials mandating vaccines. In the literature, positive communication between health providers and parents seems to be the key to informed health decisions and less anxiety when it is time for the HPV vaccine. Several articles highlight new tools to educate health providers and families. Multimodal approaches and strategies are discussed in the literature.

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Dempsey et al. (2016) performed a cross-sectional survey of 183 pediatric and family medicine primary care providers in the Denver metropolitan area. The survey was used to explore their current use of HPV vaccine communication tools and how these tools related to their HPV vaccine recommendation. According to the researchers, vaccine communication tools can take many forms, including print, video, and Web-based education. The authors suggested that there was a gap in the research in describing how providers communicate with their clients and which tools were currently used to promote vaccine usage.

Surveys were distributed to each practice, and the practices were randomized into intervention and control groups of a cluster-randomized trial. The response rate was 82% (150 participants). According to Dempsey et al. (2016), most providers (59%) used a presumptive vaccine recommendation more than 75% of the time, and 76% reported continuing to offer the HPV vaccine even after parent refusal. Fewer than two thirds of providers “strongly” recommended the vaccine to 11- to 12-year-olds (60% for females, 55 % for males; $p = .02$). The HPV vaccine information sheet from the Centers for Disease Control and Prevention was the most frequently used communication tool during visits (64% used it at least 75% of the time). Between visits, parents were directed to preferred Web sites. Use of communication tools during or between visits was not associated with any measure of HPV vaccine recommendation quality; however, communication tools were associated with longer HPV vaccine discussion times. High-quality, stronger recommendations should be part of the longer discussion times.

Fiks et al. (2013) developed a family-focused clinical decision support system for participants in 22 practice sites through a multisite randomized trial. The system included phone reminders and referrals to an educational Web site for families of HPV-eligible girls. An electronic medical record–based HPV vaccine decision support intervention targeted clinicians and included immunization alerts, education, and feedback. The parents who were randomized to receive the family-based intervention had increased vaccination rates compared with the control group. The combined intervention groups increased the rates from 16%, 65%, and 63% to 25%, 73%, and 76% for each HPV dose, respectively ($p < .001$).

Kreuer et al. (2012) reported that using a community-based intervention increased HPV vaccination rates. Participants were from 28 community organizations serving African American or Hispanic young women who were parents of girls aged 9 to 17 years from the St. Louis area. The participants and community groups were provided with community resources and specifically given a toll-free cancer information number (1-800-CANCER) for additional information about the HPV vaccine. Calls increased from an average of 24 calls per month before the intervention to 33 calls a month the year after the intervention (+38%; $p = .004$). Calls regarding questions about the HPV vaccine and cervical cancer increased. Intention to vaccinate within 1 month increased among parents ($p = .002$).

Krawczyk et al. (2015) explored the reasons why parents accepted or refused the HPV vaccine for their daughters in a free, school-based vaccination program in Quebec. A random sample of parents of 9- to 10-year-old girls completed a mail-in questionnaire responding to two open-ended questions. Of the 806 parents, 708 (88%) parents accepted and 98 (12%) refused the vaccine for their daughter. Of those who accepted the vaccine, most ($n = 499$) reported benefits of the vaccination as the reason for their decision. The health benefits included general health protection, associating the vaccine with HPV or cancer protection, positive attitudes toward vaccines, and the belief that the benefits outweigh the risks. The next most common factors in accepting the vaccine ($n = 214$) were trusting the school vaccination program, influence by the media, doctor’s recommendation, experience with HPV infection or cancer, and pressure to comply with the norms.

Reasons given by the 98 participants who refused the HPV vaccine were safety of the vaccine, effectiveness, duration of vaccine protection, and adverse effects. The parents also cited being suspicious of pharmaceutical lobbying, believing that their daughter was too young and not sexually active, upholding family values, and having no knowledge about the severity and rate of cervical cancer. Parents reported that they instilled moral values in their daughters surrounding abstinence

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