

Differences among racial and ethnic groups in vaccine hesitancy among parents of children with autism spectrum disorder

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Achieving and maintaining recommended vaccination coverage is a major public health goal [1]. Indeed, rates of childhood vaccine coverage in the U.S. among young children have remained high and stable in recent years [2]. While racial/ethnic disparities in recommended childhood vaccine coverage in the general population have been absent or reduced over time, income disparities have changed at different rates within racial/ethnic groups and in some cases have increased [3]. In addition to vaccination access barriers posed by low socioeconomic status, parental vaccine hesitancy occurs in a significant proportion of the general population and is an important factor in the underimmunization of children [4]. Thus, there is a need to identify groups of caregivers who are vaccine hesitant to inform targeted intervention approaches.

In the issue of Vaccine journal, Goin-Kochel et al. (2021) in their publication, *Beliefs About Autism and Vaccine Hesitancy Among Parents of Children with Autism Spectrum Disorder*, examined vaccine hesitancy among 225 caregivers of children with autism spectrum disorder (ASD) who participated in the SPARK (Simons Foundation Powering Autism Research for Knowledge) study given concerns about vaccines causing ASD contributes to vaccine hesitancy. Strengths of the study include an investigation of a national sample of families from 32 states and the implementation of a standardized and widely-used questionnaire (PACV; Parent Attitudes about Childhood Vaccines) to assess vaccine hesitancy. Results indicated that greater than 25% of parents of children with ASD report vaccine hesitancy. A noteworthy finding was that compared to non-Hispanic white caregivers, those who identified as African American/Black, Asian, Hispanic/Latinx, Hebrew/Jewish, and multiracial, collectively, were more likely to report vaccine hesitancy. Overall, this finding raises important questions for future research that seeks to understand racial/ethnic subgroups of parents of children with ASD who are most likely to be vaccine hesitant and thereby, at greater risk of having children who are under immunized. Next steps in this line of research should enhance study rigor informed by the general health disparities literature in pediatric care and childhood vaccinations among racial/ethnic minority and low socioeconomic status (SES) families.

A limitation of the examination of racial differences in vaccine hesitancy in the Goin-Kochel et al. study is the small number of African American/Black, Asian, Hispanic/Latinx, Hebrew/Jewish, and multiracial parents, which did not allow examination of vaccine hesitancy separately for each group. Combining the diverse families into one category makes it difficult to determine whether the findings apply to each group. Indeed, research focused on other preventive services for children indicate that patterns of racial differences vary among different racial/ethnic minority groups [5]. Future investigation should aim to recruit sufficient representation of racially/ethnically diverse families to allow reliable statistical examination and specified conclusions. If sample size limitations prevent separate racial/ethnic group analyses in future research, culturally sensitive language to describe the combination of different groups should include "racially/ethnically diverse parents" or "parents of color," as appropriate [6].

A second limitation is no report of SES characteristics by race/ethnicity. Thus, it is difficult to determine whether the findings related to greater proportions of vaccine hesitant parents occur

among socioeconomically diverse, higher SES, or lower SES African American/Black, Asian, Hispanic/Latinx, Hebrew/Jewish, and multiracial parents. In previous research, longitudinal examination of changes in vaccine uptake over time showed differences in the degree of SES disparities among racial/ethnic groups. For example, income-related disparities in vaccine uptake among Black youth have increased while income-related disparities among Hispanic youth have decreased [3]. This suggests the need for more nuanced examination of vaccine hesitancy by conducting within-racial/ethnic group analyses and cross-racial group analyses in socioeconomically diverse groups. Such research can inform whether interventions should seek to provide culturally tailored information and support informed decision making among high, low, or diverse SES groups of African American/Black, Asian, Hispanic/Latinx, Hebrew/Jewish, and multiracial parents.

Finally, The American Academy of Pediatrics recommends that providers deliver informative, caring, and respectful care to address vaccine hesitancy and influence vaccine acceptance [7]. However, African American and Latinx families of children with special health care needs, such as ASD, have much lower family-centered care even after adjusting for socioeconomic factors and health care access [8]. African American and Latinx families are less likely to have adequate time with the child's healthcare provider or receive care that is sensitive to the family's values, which could limit informed decision making around vaccines. Future research should examine whether lower rates of informative and culturally tailored care that addresses vaccine safety among African American and Latinx contribute to racial/ethnic differences in the proportions of parents who are vaccine hesitant.

In addition to limited experiences of informed decision making in context of healthcare encounters as a potential contributor to vaccine hesitancy among racial/ethnic minority parents, lower access to information about vaccines provided by sources that are trusted and influential among racial/ethnic minority parents (e.g., religious and community leaders) of children with autism could also play a role. Moreover, a current context of limited access to information might be compounded by a history of inhumane medical treatment as well as past and current healthcare and social policies that disproportionately negatively impact racial/ethnic minority communities.

Overall, the findings reported by Goin-Kochel et al. that point to higher proportions of African American/Black, Asian, Hispanic/Latinx, Hebrew/Jewish, and multiracial parents who are vaccine hesitant highlight the need for future research with parents of children with ASD. Examining larger numbers of socioeconomically and racially/ethnically diverse families, conducting within-and between-racial/ethnic group analyses, and exploring the impact of family-centered and culturally sensitive care on vaccine hesitancy, informed decision making related to vaccines, and actual vaccine uptake are fruitful directions for future study.

References

1. Healthy People 2030. Infectious Disease. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available from: <https://health.gov/healthypeople/objectives-and-data/browse-objectives/infectious-disease>
2. Hill HA, Elam-Evans LD, Yankey D, Singleton JA, Kang Y. Vaccination coverage among children aged 19–35 months—United States, 2017. *Morbidity and Mortality Weekly Report.* 2018 Oct 12;67(40):1123.
3. Walsh B, Doherty E, O'Neill C. Since the start of the vaccines for children program, uptake has increased, and most disparities have decreased. *Health Affairs.* 2016 Feb 1;35(2):356-64.
4. Natbony J, Genies M. Vaccine Hesitancy and Refusal. *Pediatr Rev.* 2019 Oct;40(Suppl 1):22-23.
5. Flores G. Racial and ethnic disparities in the health and health care of children. *Pediatrics.* 2010 Apr 1;125(4):e979-1020.
6. Madowitz J, Boutelle, KN. Ethical Implications of Using the Term "Non-white" in Psychological Research. *Ethics & Behavior* 2014. 24:4, 306-310.
7. Edwards KM, Hackell JM, Committee on Infectious Diseases, Committee on Practice and Ambulatory Medicine. Countering vaccine hesitancy. *Pediatrics.* 2016 Sep 1;138(3): e20162146.
8. Coker TR, Rodriguez MA, Flores G. Family-centered care for US children with special health care needs: who gets it and why?. *Pediatrics.* 2010 Jun 1;125(6):1159-67.