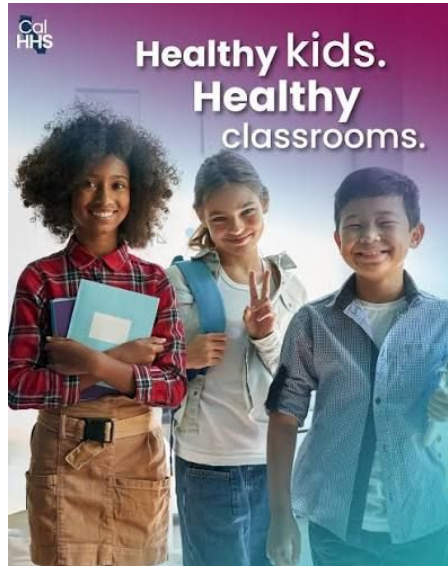


Vaccine Hesitancy: Building Trust and Supporting Confident Decisions



Learning Objectives

By the end of this session, participants will be able to:

- Define vaccine hesitancy
- Recognize common reasons families have vaccine concerns.
- Use effective, nonjudgmental communication strategies.
- Respond to common questions about vaccine safety.
- Identify practical school-based strategies to improve vaccine access and uptake.
- Learn how to prepare should there be a case of measles at a school

Kindergarten Data, 2025-2026

County	Number of Schools *	Number of Children	5 DTaP	4 Polio	2 MMR	3 Hep B	2 Varicella
Barnstable	34	1,446	95.0%	95.3%	95.2%	96.8%	94.8%
Berkshire	35	949	93.9%	94.1%	92.6%	96.4%	91.6%
Bristol	102	5,748	97.4%	97.9%	97.8%	98.7%	97.6%
Dukes	7	125	92.0%	90.4%	91.2%	91.2%	92.0%
Essex	169	8,083	96.3%	96.7%	96.5%	97.8%	96.1%
Franklin	26	495	89.3%	88.9%	89.7%	92.5%	88.7%
Hampden	101	4,552	93.7%	93.2%	94.2%	95.7%	93.6%
Hampshire	31	994	94.1%	94.2%	94.8%	96.7%	93.9%
Middlesex	312	16,569	98.0%	98.2%	98.1%	98.7%	97.9%
Nantucket	3	119	95.0%	93.3%	94.1%	91.6%	88.2%
Norfolk	138	7,119	97.6%	97.7%	97.7%	98.6%	97.8%
Plymouth	80	5,546	95.5%	95.7%	95.7%	97.4%	95.5%
Suffolk	127	5,159	94.8%	93.5%	94.2%	95.8%	93.6%
Worcester	161	8,418	96.0%	96.2%	96.2%	97.7%	95.8%
Grand Total	1,326	65,322	96.4%	96.5%	96.5%	97.7%	96.2%

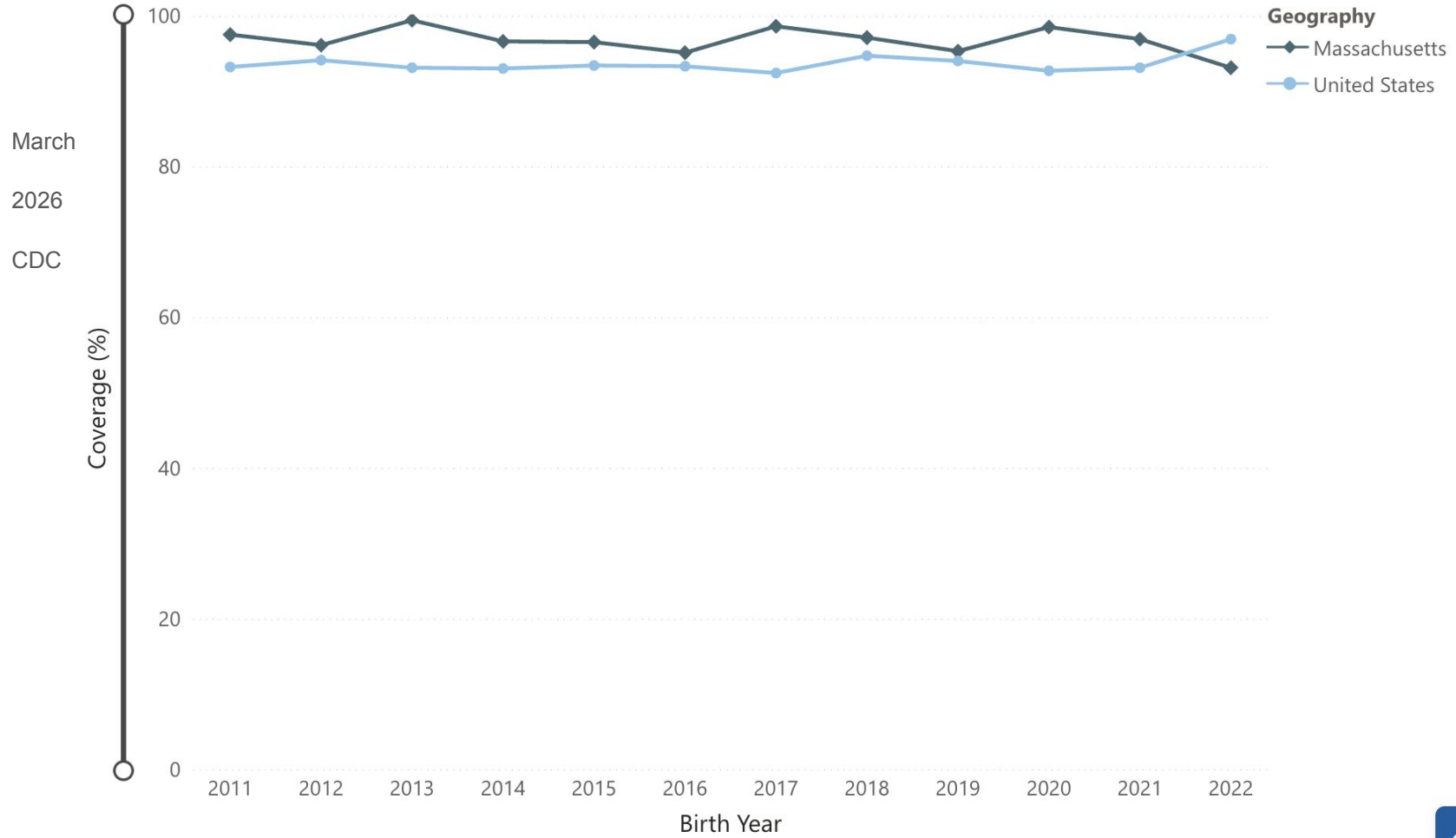
7th Grade Data, 2025-2026

County	Number of Schools *	Number of Children	2 MMR	3 Hep B	2 Varicella	1 Tdap	1 MenACWY
Barnstable	21	1,614	97.0%	97.5%	96.7%	91.1%	88.0%
Berkshire	26	1,115	94.0%	93.7%	93.6%	84.4%	84.2%
Bristol	70	5,427	98.5%	98.6%	98.2%	94.9%	94.5%
Dukes	7	142	96.5%	95.1%	95.1%	95.8%	93.7%
Essex	107	9,437	98.6%	98.4%	98.3%	94.8%	93.8%
Franklin	13	714	94.5%	96.5%	95.4%	88.1%	87.8%
Hampden	70	4,908	97.1%	97.0%	97.1%	89.8%	88.9%
Hampshire	21	1,358	98.3%	98.3%	98.4%	95.1%	94.5%
Middlesex	217	17,757	98.9%	98.9%	98.8%	96.5%	96.1%
Nantucket	2	135	95.6%	97.8%	94.1%	83.0%	80.0%
Norfolk	95	8,346	98.9%	99.1%	99.0%	95.8%	95.0%
Plymouth	62	5,548	97.8%	97.9%	97.7%	92.0%	90.5%
Suffolk	97	5,100	96.6%	96.6%	96.0%	90.4%	89.2%
Worcester	115	9,048	97.9%	98.4%	98.1%	93.5%	92.3%
Grand Total	923	70,649	98.1%	98.2%	98.0%	94.0%	93.1%

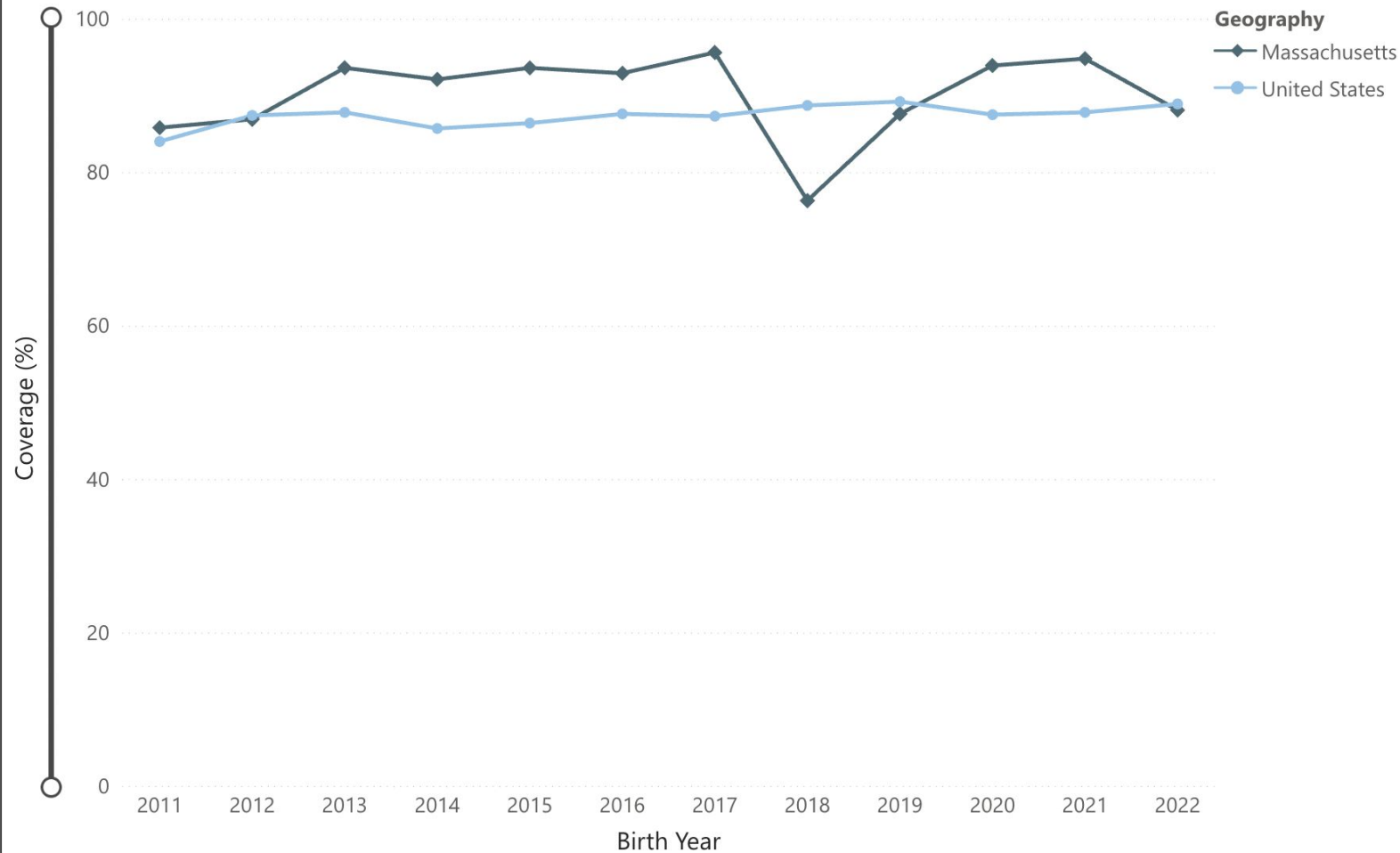
National Rates—CDC

During the 2023-2024 school year, kindergarten vaccination coverage in the United States decreased for all reported vaccines compared with the previous year, ranging from **92.0% for DTaP to 92.4% for MMR and polio**

≥1 Dose MMR Vaccination Coverage by Age 35 Months by Birth Year, National Immunization Survey-Child



≥3 Doses Hep B Vaccination Coverage by Age 13 Months by Birth Year, National Immunization Survey-Child



What Is Vaccine Hesitancy?

Vaccine hesitancy is **delay in acceptance or uncertainty about vaccines**, despite availability of vaccination services.

It exists on a spectrum:

- Families with questions or uncertainty
- Families who wish to delay selected vaccines
- Families who decline vaccines

Hesitancy may vary by vaccine, setting, prior experience, and trust in institutions.

Key message: Hesitancy is often rooted in concern and uncertainty, not lack of caring.

Why School Nurses Matter

School nurses are trusted, accessible health professionals who can:

- Answer questions in a familiar setting.
- Identify students who are behind on required or recommended vaccines.
- Support families navigating records, appointments, insurance, and transportation.
- Communicate school immunization requirements clearly.
- Partner with primary care offices, public health departments, and community organizations.
- Reduce stigma and maintain a supportive school environment.

Common Reasons for Hesitancy

Safety, side effects, or long-term effects.

Number of vaccines given at one visit.

Misinformation online or through social networks.

Distrust based on historical or personal experiences.

Religious, cultural, or philosophical beliefs.

Fear of needles or prior difficult vaccination experiences.

Lack of time, transportation, insurance, or access to appointments.

Belief that the disease is no longer a threat.

Acknowledge Historical and Structural Reasons for Distrust

- Trust is influenced by more than facts.
- Some communities have experienced discrimination, inequitable care, and harmful medical practices.
- Families may have had prior experiences of not being heard or respected.
- A respectful conversation begins with curiosity, humility, and listening.

Avoid: Assuming that a question reflects ignorance or opposition.

Do: Ask what experiences or information are shaping the family's concern.

The Goal Is Not to “Win” the Conversation

A productive conversation aims to:

- Preserve trust.
- Understand the family’s perspective.
- Correct misinformation respectfully.
- Help the family make an informed decision.
- Keep the door open for future discussion.

A hesitant family who feels heard is more likely to return for reliable information.

Communication Approach: Ask–Listen–Respond

Ask

“Would it be okay if I asked what concerns you most about this vaccine?”

Listen

Use open-ended questions and avoid interrupting.

Respond

- Acknowledge the concern.
- Provide a clear, brief response.
- Check understanding.
- Offer next steps or credible resources.

Example:

“It makes sense that you would want to know about side effects before making a decision. The most common effects are temporary soreness, fatigue, or low-grade fever. What side effect worries you most?”

Use Motivational Interviewing Skills

Use **OARS**:

- **O — Open-ended questions**

“What have you heard about this vaccine?”

- **A — Affirmations**

“You are being thoughtful about your child’s health.”

- **R — Reflections**

“It sounds like you are worried the vaccine may cause more harm than the illness.”

- **S — Summaries**

“You want protection for your child, but you need reassurance about safety and timing.”

Start With a Clear Recommendation

A confident, presumptive recommendation is helpful:

- “Your child is due for the recommended vaccine”
- “This vaccine is an important way to protect your child and classmates from a preventable illness.”
- “I strongly recommend staying up to date because school-aged children can spread infections quickly.”

Then pause and invite questions.

Avoid overly technical explanations unless the family asks for more detail.

Responding to “I Want to Wait”

Possible response:

“I understand wanting to be cautious. The challenge with waiting is that it leaves your child unprotected during the time when they could be exposed. Can you tell me what would help you feel more comfortable moving forward?”

Helpful follow-up:

- Clarify the concern.
- Discuss the risk of disease during delay.
- Offer a plan for follow-up if the family is not ready today.

Responding to Misinformation

Recommended approach

- Do not repeat or amplify myths unnecessarily.
- State the accurate information first.
- Briefly address the misconception.
- Return to the evidence-based message.

Example:

“Vaccines are carefully monitored for safety before and after they are authorized. Large studies have not shown that routine childhood vaccines cause autism. I understand that this claim is still widely shared online, so it is reasonable to ask about it.”

Common Questions: “Are There Too Many Vaccines?”

- Children encounter far more antigens through normal daily life than through vaccines.
- The recommended schedule is designed to protect children when they are most vulnerable.
- Giving vaccines together has been studied and is standard practice.
- Delaying vaccines can extend the period when a child is susceptible to disease.

Common Questions: “Are Vaccines Safe?”

Key points:

- Vaccines undergo testing before authorization and ongoing safety monitoring afterward.
- Most side effects are mild and short-lived.
- Serious adverse events are uncommon but are monitored closely.
- The risks of vaccine-preventable illnesses can include hospitalization, missed school, disability, and death.

“No medical intervention is completely risk-free, but recommended vaccines have a strong safety record and provide important protection.”

Common Questions: “Why Vaccinate if the Disease Is Rare?”

Many vaccine-preventable illnesses are rare **because vaccination has worked**.

Outbreaks can occur when vaccination rates decline.

International travel and community transmission can reintroduce infections.

Vaccination protects the individual and helps protect vulnerable individuals and those who cannot be fully vaccinated.

Religious Reasons

If parents cite religious reasons, give them the space to discuss

Porcine products are a concern for some Muslim and Jewish families—MMR and MMRV

Ask permission to clarify “Some vaccines use gelatin or other ingredients that may be animal-derived. Would you like to review the specific product ingredients? There is porcine-derived gelatin used as a stabilizer, not in the vaccine antigen itself.

Do not generalize—diversity within every faith

Religious scholars almost univervsally permit use of medically important vaccines when an alternative is unavailable when preventing meaningful harm. Interpretations may vary by family and religious authority.

“From a medical perspective, I recommend this vaccine to prevent serious illness and spread of disease. I also want to respect your religious practice and help find the most acceptable option.”

Getting a vaccine while observing a religious fast – acknowledge-may choose to delay

Addressing Practical Barriers

Not every delayed vaccine reflects hesitancy.

Ask:

- “Has it been difficult to schedule an appointment?”
- “Do you need help locating a vaccine clinic?”
- “Do you have concerns about cost, transportation, or records?”

School-based supports may include:

- Reminder and recall systems.
- Assistance obtaining immunization records.
- Referral to local vaccine programs.
- Translation and interpreter support.
- Flexible clinics or school-based vaccination events.
- Coordination with primary care practices and public health departments.

When a Family Declines After a Discussion

Remain respectful and professional.

Provide accurate written information.

Explain school requirements and exclusion policies according to local regulations.

Encourage discussion with the child's primary care clinician.

Revisit the conversation later; preferences may change.

Protecting the School Community

High vaccination coverage helps:

- Reduce outbreaks and school disruptions.
- Protect students with immunocompromising conditions.
- Protect infants and others unable to receive certain vaccines.
- Reduce staff absenteeism and family burden.
- Maintain consistent learning and extracurricular participation.

Vaccine conversations are part of creating a safe, inclusive learning environment.

Preparing for Measles

Identify measles risk factors and early clinical features

Verify school readiness before a suspected case occurs

Implement immediate isolation and reporting procedures

Coordinate with public health authorities, families, and school leadership

Support vaccination, exclusion, and return-to-school processes

Why Schools Must Be Prepared

- Measles is highly contagious and can spread rapidly in underimmunized school communities.
- **Measles virus can remain viable in the air of an enclosed space for up to 2 hours after an infected person has left the area**, a persistence duration that underlies its classification as one of the most contagious airborne pathogens
- Outbreaks often begin after importation from travel and spread within clusters of susceptible people.
- High two-dose MMR coverage is essential; **approximately 95% coverage** is needed to prevent sustained transmission. [1](#)
- Most recent U.S. cases have occurred in unvaccinated students or those with unknown vaccination status.

Sources:

1. [Measles-United States. January 1, 2020-March 28, 2024](#). MMWR: Morbidity and Mortality Weekly Report, 2024

Identify Gaps Before an Outbreak

Work with administration and the local health department to:

- Review MMR coverage by school, grade, classroom, and program
- Identify clusters of unvaccinated or underimmunized students
- Contact families with incomplete records
- Promote catch-up vaccination through primary care offices, public health clinics, or school-based clinics

Typical measles features

- Fever, often high
- Cough
- Coryza
- Conjunctivitis
- Malaise
- Koplik spots: small white lesions in the mouth
- Generalized maculopapular rash beginning on the face/hairline and spreading downward

Maintain suspicion when fever and rash occur with

- Recent international travel
- Known measles exposure
- Underimmunization or unknown MMR status
- A local measles alert or outbreak

Measles Transmission Essentials

- Spread occurs through airborne respiratory particles.
- Measles can remain infectious in the air for up to 2 hours after an infected person leaves the area.
- A person with measles is generally contagious from **4 days before through 4 days after rash onset**.
- A susceptible close contact has a high likelihood of infection after exposure.

Prepare the Health Office

- A private room away from the main health office, if possible
- A route that minimizes contact with others
- Supplies: surgical masks, tissues, hand hygiene supplies, gloves, screening forms, and current public-health contact information

Immediate Response: Suspected Measles at School

Separate immediately

- Place a mask on the symptomatic person, if tolerated.
- Move the person to a private area away from others.
- Limit staff entering the room.
- Avoid transport through busy hallways whenever possible.

Notify promptly

- Contact the parent/guardian for urgent pickup.
- Contact the local or state health department immediately for guidance.
- Advise the family to call ahead and explain that there is a suspicion for measles before taking the student to a medical office or emergency department.

Information to Collect

- Symptoms and rash onset date
- Arrival and departure times
- Locations visited
- Classes, bus route, activities, and other close contacts
- Vaccination status, if available
- Other students with fever/rash illness

All suspected cases should be reported promptly to public health for testing guidance and exposure management.

Managing Exposed Students and Staff

Follow local and state public health guidance.

- Verifying evidence of immunity
- Excluding students or staff without evidence of immunity
- Monitoring symptoms through the incubation period
- Recommending MMR vaccination when eligible
- Recommending immune globulin for certain high-risk exposed people
- Supporting remote learning during exclusion

During outbreaks, MMR vaccine may provide post-exposure protection if administered within 72 hours; immune globulin may be considered within 6 days for eligible high-risk persons.

Exclusion and Return-to-School Principles

Suspected or confirmed measles

- Exclude from school and follow public-health direction.
- Return only when medically cleared and consistent with health department guidance.

Exposed students or staff without evidence of immunity

- May require exclusion for the public-health-defined monitoring period.
- Students without documented immunity may not to return for **21 days after exposure**. [1](#)

Sources:

1. [Notes from the field: initial public health response to a measles outbreak in a close-knit west Texas community-January-February 2025](#). MMWR: Morbidity and Mortality Weekly Report, 2026

Take-Home Messages

Vaccine hesitancy is common and often reflects uncertainty, not opposition.

Trust, listening, and a clear recommendation are central to effective communication.

School nurses can address both informational concerns and practical barriers.

Avoid shame and confrontation; keep the door open.

Every conversation is an opportunity to protect a child and the school community.

Outbreak preparedness

Discussion Questions



What vaccine concerns are you hearing most often from families?



What makes these conversations challenging in the school setting?



Which resources or partnerships would improve vaccine access?



How can we ensure that communication is culturally responsive and nonjudgmental?