

COMMUNICATION STRATEGIES FOR REDUCING VACCINE HESITANCY AMONG PARENTS IN PEDIATRIC PRACTICE

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Abstract. Vaccine hesitancy in pediatrics is rarely “fixed” by more data alone. In everyday practice, parents’ decisions are shaped by trust, prior experiences, social influence, perceived risk, and how clinicians communicate under time pressure. Evidence supports a set of communication strategies that increase acceptance while preserving the therapeutic relationship: giving a strong presumptive recommendation, using empathetic listening and respectful correction of misinformation, applying motivational interviewing (MI) techniques when resistance persists, and pairing conversation with practical systems such as reminders, standing orders, and convenient scheduling. This article summarizes evidence-based, clinic-ready communication approaches to reduce vaccine hesitancy among parents, including language examples, visit structure, and follow-up tactics. It emphasizes differentiating hesitant parents from refusers, focusing on shared values (child safety, healthy development), addressing “good-faith questions” without argument, and documenting a clear plan for continued dialogue. Guidance is aligned with resources from the American Academy of Pediatrics, the CDC, and WHO communication tools, alongside evidence reviews on provider–parent vaccine conversations.

Keywords: vaccine hesitancy; pediatric practice; communication; presumptive recommendation; motivational interviewing.

INTRODUCTION

In pediatric practice, vaccine conversations are not an occasional event; they are a repeated clinical task that shapes population health one family at a time. Most parents vaccinate, many have questions, and a smaller group are hesitant or resistant. The problem is not simply a “knowledge gap.” Hesitancy is often an emotional risk assessment (“Will my child be harmed?”) in a noisy information environment, where dramatic anecdotes travel faster than statistics and where mistrust can be inherited from prior healthcare experiences. Clinicians often respond by increasing the amount of factual information, but evidence suggests that persuasion-by-data can backfire when parents feel judged, rushed, or “talked at.” Effective communication is therefore less about winning a debate and more about guiding a decision in a way that is confident, respectful, and structured. The American Academy of Pediatrics (AAP) emphasizes building vaccine confidence through trust, clear recommendations, and tailored responses to different parent types, including examples for countering misinformation without escalating conflict [1].

MATERIALS AND METHODS

An evidence-based vaccine conversation begins with a strong, presumptive recommendation, because clinician confidence is itself a signal. Instead of asking, “What do you want to do about vaccines today?” a presumptive opening treats vaccination as the expected standard: “Today your child is due for the MMR and varicella vaccines.” The CDC’s guidance cites evidence that parents are more likely to accept vaccination when clinicians use presumptive language rather than opening with a

participatory question that invites negotiation before any recommendation has been made [2]. This is not coercion; it is clinical leadership. Parents generally come to pediatric clinicians expecting clear guidance, and a confident recommendation reduces uncertainty for the many parents who are mildly anxious but not strongly opposed. If parents accept, the conversation stays brief and positive. If they hesitate, the clinician pivots to step two—listening and responding—without abandoning confidence or turning the visit into a fight.

RESULTS AND DISCUSSION

The second step is empathetic listening and “values first” framing, which keeps the relationship intact and reduces defensiveness. The AAP recommends beginning by affirming shared goals (child safety, healthy development), then addressing specific concerns and correcting misinformation in a way that does not repeat false claims more than necessary [1]. A practical structure is: (1) ask an open question (“What worries you most?”), (2) reflect (“You’re worried the vaccine could cause harm”), (3) affirm (“It makes sense to want to be careful”), and (4) respond with a clear, short explanation tied to the child’s benefit and community protection. This sequence is faster than it looks—because it prevents the parent from feeling dismissed and reduces the urge to escalate. It also helps clinicians identify the true barrier: safety fear, pain/needle anxiety, overload from too many shots, distrust of institutions, religious concerns, or misinformation about a specific vaccine. Different barriers require different responses; treating them all as “anti-vax” is a communication error.

When hesitation persists, the most evidence-based next move is motivational interviewing (MI) techniques—especially for parents who are uncertain rather than ideologically opposed. MI works by guiding parents to voice their own reasons for protecting their child, while the clinician remains nonjudgmental and collaborative. WHO training materials explicitly promote motivational interviewing-style strategies for addressing safety and effectiveness concerns, emphasizing respectful engagement rather than confrontation [3]. In clinic language, MI looks like: “On a scale from 0 to 10, how ready do you feel to vaccinate today?” Then: “Why not a lower number?” This invites the parent to articulate pro-vaccine motivations (protecting the child, avoiding disease) instead of repeating objections. The clinician can then ask permission to share information (“Would it be okay if I explain what we know about side effects?”), offer a targeted fact, and check understanding. Reviews of vaccine communication note that providers often feel unprepared for these conversations and that approaches emphasizing empathy and tailored engagement are promising, especially for hesitant parents who still value medical guidance [5].

A frequent challenge is misinformation—social media claims, cherry-picked “studies,” or conspiracy narratives. Here, a useful approach is what the AAP describes as a “truth sandwich”: lead with the correct information, briefly address the misinformation without amplifying it, then repeat the truth with a clear recommendation [1]. Example: “Vaccines are tested in large clinical trials and continuously monitored for safety. Some online posts misuse small or outdated claims to suggest harm, but the best evidence consistently shows vaccines prevent serious disease with a very low risk of severe side effects. I recommend we vaccinate today.” This style avoids deep engagement with every false detail (which can accidentally reinforce it) and keeps the clinician anchored to the medical decision. It also helps to acknowledge uncertainty honestly: “No medical intervention is zero risk, but the risk of the disease is higher than the risk of the vaccine.” Parents do not need perfection; they need credible, transparent guidance delivered calmly.

Another evidence-based technique is anticipatory guidance, delivered before the moment of decision. Instead of waiting until a parent is upset in the exam room, clinics can normalize questions early—during prenatal visits, newborn visits, or well-child visits before major vaccine milestones. Written materials and short videos can support the conversation, but they should never replace the clinician's recommendation. The Canadian Paediatric Society emphasizes working with vaccine-hesitant parents through respectful discussion, understanding parental concerns, and maintaining engagement even when vaccines are delayed, rather than abruptly terminating care in ways that reduce future opportunities for vaccination [4]. This is the long game: many hesitant parents move over time when trust is maintained and when the practice consistently communicates the same clear message.

CONCLUSION

Reducing vaccine hesitancy in pediatric practice requires communication that is confident, empathetic, structured, and supported by clinic systems. Evidence-based strategies include a strong presumptive recommendation, careful listening that identifies the parent's true concern, respectful correction of misinformation using concise framing, and motivational interviewing techniques when uncertainty persists. Clinicians should differentiate hesitant parents from committed refusers, focus on shared values, and protect the therapeutic relationship so that trust can grow over time.

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