

Committee: Economic & Social



Topic: Mandatory vaccinations & vaccination hesitancy

Summary

Mandatory vaccination is the compulsory vaccination of all people in an area or age group. It was first introduced in the UK – where no vaccines are currently mandated – through the 1853 Vaccination Act. The law required that all children ‘whose health permits’ be vaccinated against smallpox, and obliged physicians to certify that vaccination had taken place. Since then, vaccine mandates have evolved to include a variety of incentives and penalties. In some US states, children cannot access public schools without being vaccinated; in Australia, compliance with childhood immunisation schedules has been linked to pre-school admission (‘No jab, no play’) and to family assistance payments (‘No jab, no pay’).

In most instances where vaccine mandates are in force, they apply only to childhood immunisation. However, vaccination is a condition of employment in some institutions – notably in healthcare facilities. This is not a legal mandate *per se* but is a form of discrimination accepted in several jurisdictions. In principle, mandates – like vaccines – can be for people of all ages.

High vaccine uptake rates, specific to each vaccine preventable disease, are needed for community-level immunity to be achieved and sustained in order that disease risk can be lowered beyond what would be predicted by vaccine coverage alone. Even in countries with overall high national vaccine uptake rates, there may be clustered pockets or subgroups where the rates of uptake are lower than required for protection of the community.

Vaccine hesitancy refers to delay in acceptance or refusal of vaccines despite availability of vaccination services. Vaccine hesitancy is complex and context specific, varying across time, place and vaccines. It is influenced by factors such as complacency, convenience and confidence.

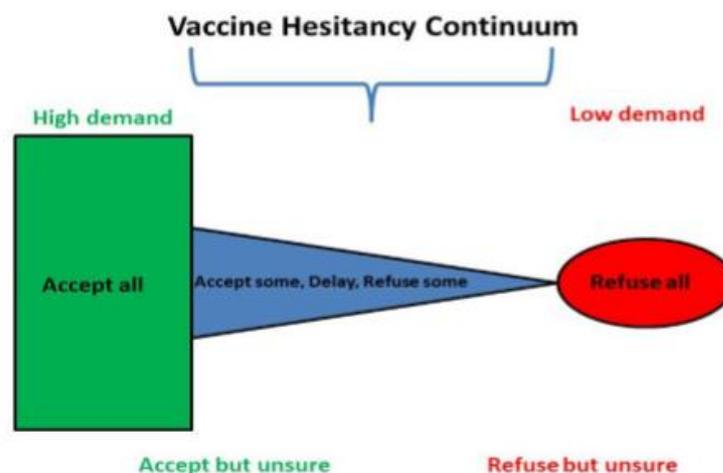


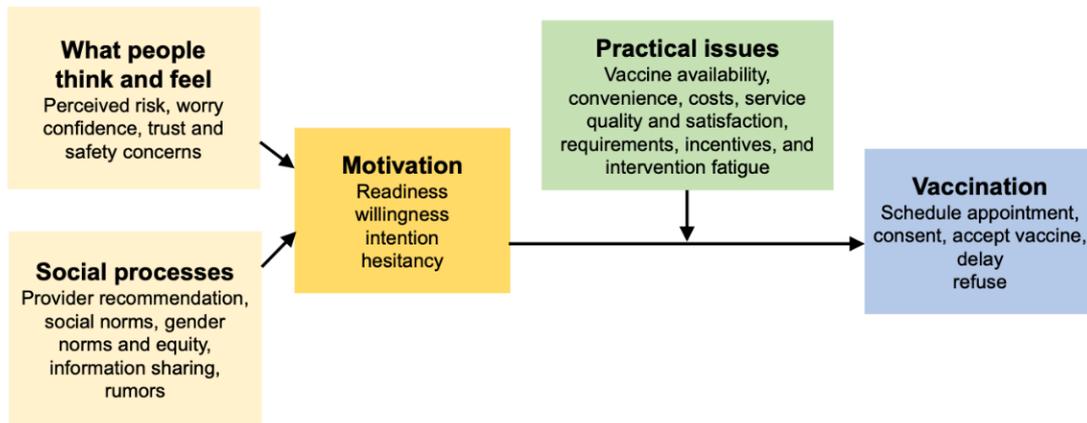
Table 1: Working Group Determinants of Vaccine Hesitancy Matrix

<p><u>CONTEXTUAL INFLUENCES</u> Influences arising due to historic, socio-cultural, environmental, health system/institutional, economic or political factors</p>	<ul style="list-style-type: none"> a. Communication and media environment b. Influential leaders, immunization program gatekeepers and anti- or pro-vaccination lobbies. c. Historical influences d. Religion/culture/ gender/socio-economic e. Politics/policies f. Geographic barriers g. Perception of the pharmaceutical industry
<p><u>INDIVIDUAL AND GROUP INFLUENCES</u> Influences arising from personal perception of the vaccine or influences of the social/peer environment</p>	<ul style="list-style-type: none"> a. Personal, family and/or community members' experience with vaccination, including pain b. Beliefs, attitudes about health and prevention c. Knowledge/awareness d. Health system and providers-trust and personal experience. e. Risk/benefit (perceived, heuristic) f. Immunisation as a social norm vs. not needed/harmful
<p><u>VACCINE/ VACCINATION-SPECIFIC ISSUES</u> Directly related to vaccine or vaccination</p>	<ul style="list-style-type: none"> a. Risk/ Benefit (epidemiological and scientific evidence) b. Introduction of a new vaccine or new formulation or a new recommendation for an existing vaccine c. Mode of administration d. Design of vaccination program/Mode of delivery (e.g., routine program or mass vaccination campaign) e. Reliability and/or source of supply of vaccine and/or vaccination equipment f. Vaccination schedule g. Costs h. The strength of the recommendation and/or knowledge base and/or attitude of healthcare professionals

Key information

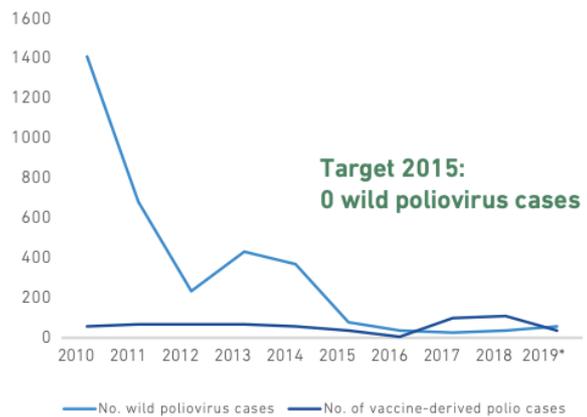
- In 2003 more than 27 million children worldwide were not immunized during the first year of their lives.
- Each year 1.4 million children under five years of age die due to diseases that could have been prevented by currently available vaccines.
- Immunization programmes currently save approximately three million lives a year and prevent approximately 750,000 cases of blindness, paralysis and mental disability annually.
- Despite the World Health Organisation (WHO)'s goal to eliminate measles, there has been an increase in the number of measles cases in recent years. 82,500 people in 47 of the 53 countries within the World Health Organisation's EU region were infected with measles, leading to 72 deaths. These are the highest numbers seen in the past decade.

Increasing Vaccination Model

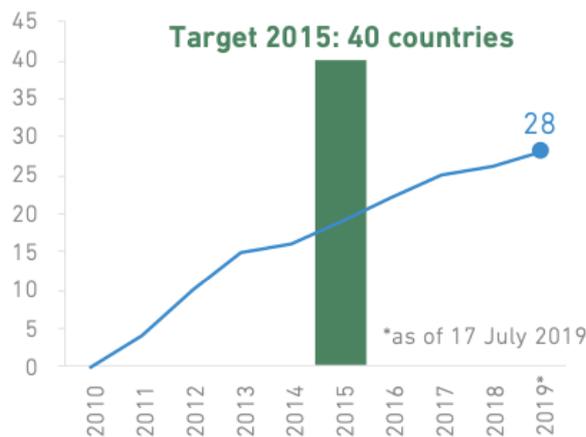


Source: The BeSD expert working group. Based on: Brewer NT, Chapman GB, Rothman AJ, Leask J, and Kempe A (2017). Increasing vaccination: Putting psychological science into action. *Psychological Science for the Public Interest*. 18(3): 149-207

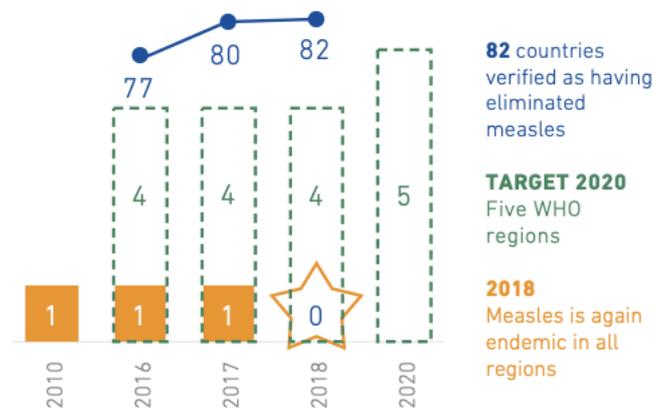
In spite of tremendous progress (Figure 1), polio eradication efforts face major security and community acceptance challenges in the last remaining sites of wild poliovirus transmission. Wild poliovirus type 2 was certified as eradicated in 2015 and wild poliovirus type 3 has not been detected since 2012. Wild poliovirus type 1 currently appears to be circulating only in Afghanistan and Pakistan.



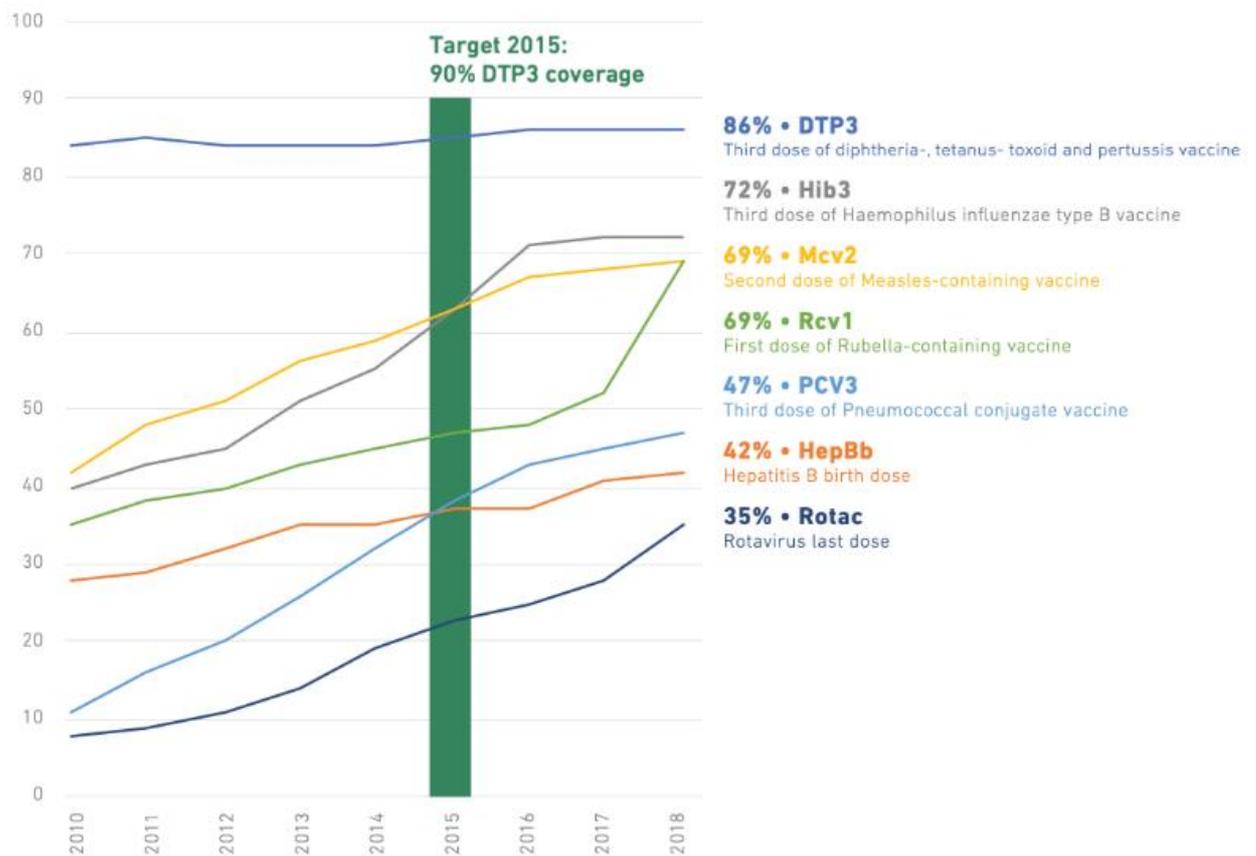
Number of priority countries having validated maternal and neonatal tetanus elimination



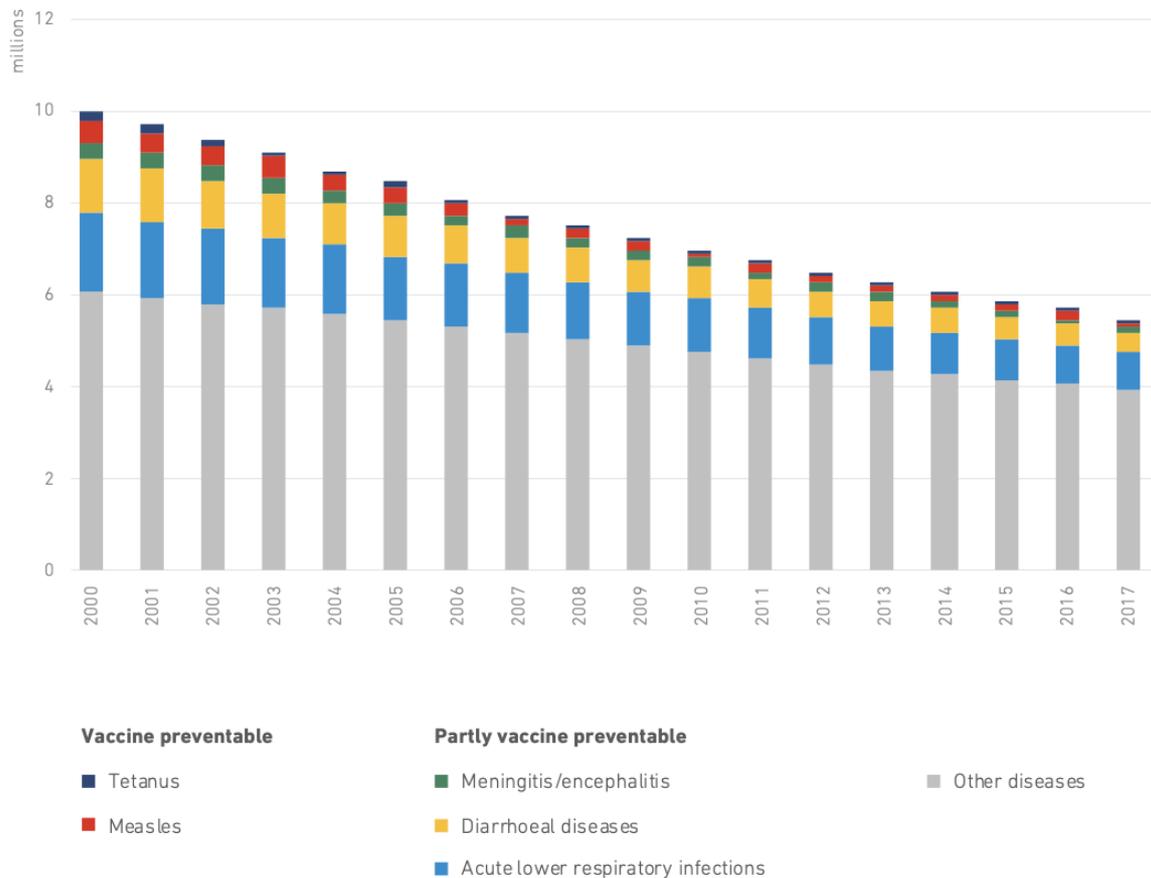
Number of regions and countries verified for measles elimination



Global coverage for selected vaccines (percent)



Global number of child deaths per year - by cause of death preventable or partly preventable by vaccines between 1990 and 2017



Useful links and references

<https://apps.who.int/iris/bitstream/handle/10665/329097/WHO-IVB-19.07-eng.pdf?ua=1>

https://www.who.int/immunization/global_vaccine_action_plan/sage_assessment_reports/en/

https://www.who.int/immunization/programmes_systems/vaccine_hesitancy/en/

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6607742/>

<https://www.vaccinestoday.eu/stories/mandatory-vaccination-work-europe/>

https://www.who.int/immunization/sage/meetings/2014/october/SAGE_working_group_revised_report_vaccine_hesitancy.pdf?ua=1