

Influenza Vaccinations: A Leadership Approach

Christine Ann Meister, BS

ABSTRACT

Each year thousands of individuals in the United States are diagnosed with cases of seasonal influenza (flu) and the recent pandemic strain of H1N1 influenza. Complications of the flu can lead to serious health issues resulting in hospitalization and even death. Vaccination for seasonal flu and H1N1 can decrease the number of cases of the flu, thus decreasing the number of complications resulting from infection. Unfortunately, a large percentage of the population chooses not to get vaccinated every year for the seasonal flu because they do not trust vaccine safety and effectiveness. To gain the public's trust and increase the number of influenza inoculations, the Centers for Disease Control and Prevention (CDC) and state health departments should incorporate John Kotter's eight-stage plan for leadership change. Kotter's plan helps groups create goals that eventually lead to a cultural change. Goals of educating both the general population and individuals at risk of complications from the flu will lead to an increase in trust and eventual reduction of influenza complications and deaths.

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Background

Every year tens of thousands of people get sick from the flu. The Centers for Disease Control and Prevention (CDC) estimate that from 1976 to 2006, between 3,000 and 49,000 deaths were caused by flu related illnesses (CDC, 2011a). The incidence of flu and incidence of complications from the virus can be reduced and even prevented by increasing the number of people who are vaccinated each year against seasonal and H1N1 influenza. Unfortunately, a large portion of the population does not get vaccinated. This paper addresses the main reasons why at-risk populations choose not to get vaccinated for the flu and provides an action plan for increasing the number of people who are vaccinated each year.

Significance of Problem

The CDC (2011b) estimates that between April 2009 and April 2010, during the pandemic H1N1 flu season, between 43 million and 89 million cases of H1N1 were reported in the United States, resulting in 8,870-18,300 deaths. Between October 3, 2010 and May 21, 2011, the World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) recorded 40,282 cases of influenza A (including both H3N2 and H1N1 viruses) and 13,944 cases of influenza B viruses. These numbers may be underestimated, however, because not all cases during the flu season were reported and tested. Although that season was less severe than the 2009-2010 season, it was more severe than the 2008-2009 flu season (CDC, 2011b).

Everyone aged six months and older should get vaccinated, especially those who are at risk for severe complications for the flu and those who work or live in close proximity to those at risk (CDC, 2011c). Vaccine campaigns are run by both the CDC

and state health departments; however vaccination turnouts for the seasonal flu are not high. In the June 10, 2011 *Morbidity and Mortality Weekly Report (MMWR)*, the CDC estimated that nationwide about 49% of children between six months and 17 years of age were vaccinated during the 2010-2011 flu season, about 6.7% higher than the previous flu season. About 30.2% of adults between 18 and 49 years of age, 45.6% of adults between 50 and 64 years of age, and 68.6% of adults aged 65 and older were vaccinated during the 2010-2011 season. According to the CDC (2011c) 48.4% of at-risk adults with a medical condition that increases their chance for complications caused by influenza were inoculated for the seasonal flu last year.

If we are to increase the number of flu vaccine inoculations each season, an action plan needs to be put in place. A movement structured around a strong leadership process may help gain the public's trust in the CDC, state health departments and the safety of vaccination techniques.

Factors Related to or Affecting the Problem

Many of the reasons why the general population does not get vaccinated revolve around the idea that people cannot trust the CDC or that vaccinations are a money-making ploy for the drug companies that create them (Swine Flu Information, 2011). Ramsey and Marczinski (2011) found that college students who chose not to get vaccinated for H1N1, did so because they believed that the vaccine would not work, that the vaccine had not been tested enough, and because they were worried about both serious and minor side effects. Pregnant women are also identified as an at-risk group for complications due to H1N1 influenza. The most common reasons for pregnant women to choose not to get vaccinated for

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the H1N1 and seasonal influenza was because they had not been vaccinated in the past, because they were afraid for the health of their babies and because they were concerned about their own health (Ahluwalia, Singleton, Jamieson, Rasmussen and Harrison, 2011).

The choice not to get vaccinated is an important decision in personal autonomy. However, the public's mistrust of the safety of vaccines is unfounded. Vaccines are rigorously tested by drug companies before the FDA can approve of them. The CDC and U.S. Vaccine Adverse Event Reporting System (VEARS) reported that during the 2010-11 flu season, an estimated 163 million doses of influenza vaccine were administered in the U.S. As of December 14, 2010, VAERS received 6845 reports of adverse affects to the vaccine. Of those reports, 415 were considered serious side effects. Included among those 415 reports were 18 reports of deaths and 51 reports of Guillian Barré Syndrome (GBS). It had not been confirmed, however, that those 18 deaths and GBS reports were a direct result of the influenza vaccine (VEARS, 2011).

It is important that vaccine safety concerns are not misrepresented in the media. The CDC, state health departments and the media need to trust that the public will recognize safety concerns and still and will be able to make the appropriate decision regarding their health and the safety of others. The risks should be discussed in a clear and informative manner to protect personal autonomy. At the same time, the public needs to be educated about the overall benefits vaccinations can have for both individuals and the nation as a whole.

Implications for Leadership

John Kotter outlines an eight-stage process of leadership in his book *Leading Change*. His outline begins with establishing a need for change and ends with ensuring that the change is ingrained into the culture of the population. Incorporating Kotter's leadership action plan into vaccine campaigns may help to increase the number of influenza vaccine inoculations and thus decrease the number of flu-related illnesses and deaths each year.

Step 1: Establish a Sense of Urgency

The first step in Kotter's leadership action plan is to emphasize the need for change. Sources of complacency must be identified and eliminated for the change to begin.

"With complacency high, transformations usually go nowhere because few people are even interested in working on the change problem. With urgency low, it's difficult to put together a group with enough power and credibility to guide the effort or to convince key

individuals to spend the time necessary to create and communicate a change vision" (Kotter, 1996).

Kotter explains that sources of complacency include the absence of a major visible crisis, low performance standards by individuals, human nature, and capacity for denial.

Applying these ideas to the influenza vaccine issue, the sources of complacency are the mistrust of vaccine safety, belief that vaccines are ineffective and thus will not help the issue, and the belief that the individual cannot make a difference in increasing the number of vaccine inoculations.

To remove and/or minimize the sources of complacency, the public needs to be made aware of the positive and negative sides of receiving a vaccine. Campaigns need to respect the intelligence of the individual while emphasizing the importance of vaccination for society as a whole, the family unit, and the individual.

Step 2: Create the Guiding Coalition

The second step in the Kotter's leadership action plan is to select a group to lead the campaign for change. This group must be able to adapt to the ever-changing market, must be large enough to have political power, must be experts in the field while still representing various points of view, and must have enough credibility to be taken seriously (Kotter, 1996).

State health departments may be the best option to lead the influenza vaccine campaign. The CDC would have the most political clout, but state health organizations have the ability to design their programs for the needs of their own state. State health departments can create educational programs within schools, as well as within insurance companies and other health-related groups. State departments may be able to reach the public using local media in ways that may be difficult for a federal organization like the CDC.

Step 3: Develop a Vision and Strategy

After designating a leadership group to guide the change, goals and visions for the future must be established. "Vision refers to a picture of the future with some implicit or explicit commentary on why people should strive to create that future" (Kotter, 1996). Kotter explains that these goals should not be authoritarian in nature and that they should not micromanage the groups and individuals within the overall corporation/population. Instead, the strategy should work to clarify the goals of the campaign and should motivate those affected by the change. Visions should be imaginable, desirable, feasible, focused, flexible, and easily communicable (Kotter, 1996).

The visions for an influenza vaccine campaign should be geared towards those at greatest risk for complications from the flu and then should expand

to include the general population. Those at greater risk for complications are young children, adults 65 and older, pregnant women as well as people with certain chronic illnesses such as asthma, heart disease and weakened immune systems (CDC, 2011a). The goals should include not only increasing the number of vaccinations, but also educating the population and encouraging trust in the state health departments, the CDC, and vaccine companies.

Steps 4 and 5: Communicating the Change Vision and Empowering Broad-based Action

The next steps in the leadership process are advertising and carrying out the campaign's visions. Kotter (1996) is clear that when trying to achieve the group's vision, the leadership coalition should not limit the capabilities of the population and should not underestimate the power of the individual. The campaign should communicate its goals in a simple but effective way using multiple techniques. The leaders should teach by example. Also, like any good persuasive argument, the campaign should acknowledge counter arguments and should respectfully refute their statements.

Part of empowering broad-based action is to identify other sources of complacency and barriers that may have not been evident while organizing the leadership change (Kotter, 1996). By providing training to individuals outside of the guiding coalition while still maintaining the essential structure of the campaign, individuals within the target population can take actions on their own to help achieve the organization's goals.

Communicating the vision for increasing the number of influenza vaccinations should be respectful of individual autonomy and should effectively communicate both the benefits and risks of receiving a flu shot. Flu shot campaigns should include all types of media and there should be opportunities for the public to discuss their concerns and provide feedback. Effective communication between the guiding coalition and the target population will lead to an increase in autonomy, allowing individuals to make their own informed and educated decisions. Individuals within the target population will become the informants, possibly leading to a snowball effect of encouraging others to get vaccines.

Steps 6 and 7: Generate Short-term Wins and Consolidate Gains to Produce More Change

Short-term wins are necessary to evaluate the effectiveness of the leadership change. According to Kotter (1996), a good short term win is visible, unambiguous and clearly related to the change effort, meaning that the result is clear, easily distinguished and is a natural step towards achieving the overall vision. It is also important that the guiding coalition does not lose motivation after the first few goals are achieved. "Whenever you let up

before the job is done, critical momentum can be lost and regression may follow" (Kotter, 1996). Short-term gains should be recognized and the group needs to be immediately motivated to work towards the next goal.

Part of reducing momentum-loss is to recognize interdependencies within the guiding coalition and to eliminate those that are unnecessary (Kotter, 1996). Codependency can hold groups back by attempting to serve more than one agenda. By eliminating extraneous and outside factors, campaigns can continue to grow to their full potential.

Short-term goals in vaccine campaigns can be measured by the increase in numbers of vaccinated individuals and by cross-sectional studies on beliefs about vaccine importance, effectiveness and safety, as well as the trust in government vaccine campaigns. Once goals are achieved, their results should be distributed to the public, encouraging more people to take action.

By breaking up interdependencies within influenza vaccine campaigns, individual groups may be able to gain more ground and reach separate populations. For example, health insurance companies working with multiple doctors' offices to campaign for increasing vaccine inoculations could work with each doctors' office separately to begin campaigning on their own. Each doctors' office would be better able to target their campaign towards the individuals they are serving rather than the larger population of multiple offices.

Step 8: Anchor New Approaches in Culture

The final step in Kotter's approach to leadership change is to ingrain the goals of the organization into the goals of the culture. "Until changed practices attain a new equilibrium and have been driven into the culture, they can be very fragile" (Kotter, 1996). Inconsistencies between the modern culture and the goals of the campaign should be confronted and addressed; otherwise the changes made by the organization will be defaulted back to attitudes present before the campaign began.

There is an inconsistency between goals of vaccine campaigns and the values of society. This inconsistency mainly revolves around the trust/mistrust of government safety tests for influenza vaccines and the necessity of getting a vaccine in the first place. To gain the public's trust, the vaccine campaigns need to be educational. The guiding coalitions need to trust the public to make informed decisions regarding their autonomy based on the education the coalition provides to them. Vaccine campaigns need to explain the effectiveness of safety tests and vaccine statistics to gain the public's trust. If the goals of the campaign are going to be ingrained in society, society has to trust that the goals are both reasonable and honest.

Conclusion

To increase the amount of influenza vaccinations amongst populations in the U.S., the CDC and state health departments should incorporate John Kotter's eight-step process of leadership change. By developing short-term and long-term goals, health departments can continue to gain momentum in educating the public about the effectiveness and necessity of influenza inoculation. Eventually the goals of the health department will be incorporated into the mainstream goals of society, leading to a permanent health change.

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Christine Meister (cmeister@mail.usf.edu) is a master of public health student in the Department of Community and Family Health, University of South Florida College of Public Health, Tampa, FL. This paper was submitted to the *FPHR* on November 27, 2011, and accepted for publication on January 30, 2012. Copyright 2012 by the *Florida Public Health Review*.