

Letter to the Editor

RE: RACIAL AND ETHNIC DISPARITIES IN MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN

We read with interest the article “Socioeconomic and Racial and/or Ethnic Disparities in Multisystem Inflammatory Syndrome” by Javalkar et al.¹ Multisystem inflammatory syndrome in children (MIS-C) is a potentially fatal complication of severe acute respiratory syndrome coronavirus 2 infection (coronavirus disease 2019 [COVID-19]) because patients can develop myocarditis, coronary artery abnormalities, arrhythmias, myocardial ischemia, cardiogenic shock, and death.² Javalkar et al demonstrated that children in Massachusetts with lower socioeconomic status and higher social vulnerability index (SVI) had higher odds of developing MIS-C and that, of the children with lower socioeconomic status and higher SVI, those with Hispanic ethnicity and Black race had between 8.7 and 49.8 times higher odds of developing MIS-C than their non-Hispanic white counterparts.¹

This is in line with a recent study by Payne et al revealing that from April to June 2020, the incidence of MIS-C was 9.26, 8.92, and 2.94 times higher in Black, Hispanic or Latino, and Asian American or Pacific Islander persons, respectively, than white persons.³ These findings are of great importance because the Black (24%) and Hispanic (27%) populations have the lowest vaccination rates thus far, and there is still significant hesitancy among parents to vaccinate their children against COVID-19, with only 21% of those aged 12 to 15 years and 32% of those 16 to 17 years being fully vaccinated to date.^{4,5} Furthermore, the vaccine is still not available to children <12 years of age.

There needs to be increased vaccine access to all populations but in particular to ethnic and racial minority children of all ages. In addition, all parents should be informed about the serious complications of COVID-19 in children, such as MIS-C. With misinformation on COVID-19 vaccines emerging on Internet sites and social media, vaccination hesitancy has become more pronounced. Addressing vaccine hesitancy is important because the success of preventing COVID-19 and its serious complications will depend on high vaccine acceptance. Parents should be encouraged to openly express their fears about COVID-19 and the vaccine itself. As providers, we need to listen engaged, provide support, and continue to seek to understand and address such fears while building parental trust.

As the vaccine becomes available to children of all ages, we cannot leave the ethnic and racial minority groups without adequate information and protection against a potentially fatal disease and its associated complications. It is important to start conversing with parents now about COVID-19 and the risk of MIS-C. Every effort should be made to make the vaccine accessible to all ethnic and racial minority children to prevent fatal outcomes when prevention is finally available and to, once and for all, end the prolonged pandemic that has shaken the entire world in multiple and personal ways.

Amarilis A. Martin
Division of Pediatric Critical Care Medicine,
Department of Pediatrics, Children's Hospital of
Michigan

Courtney E. Harris
Division of Infectious Diseases, Department of
Internal Medicine, Brigham and Women's
Hospital, Boston, MA

Jocelyn Y. Ang
Division of Infectious Diseases, Department of

*Pediatrics, Children's Hospital of Michigan,
Detroit, MI*

E-mail: aamartin@dmc.org

CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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doi:10.1542/peds.2021-053907

AUTHOR'S RESPONSE

We thank Martin et al for their insightful comment. We agree that it is imperative that we ensure equity in vaccine uptake for children by facilitating access to providers and accurate information. The Centers for Disease Control and Prevention currently stratifies vaccination rates on the basis of the SVI, which is 1 of the indices used in our study. The average vaccination rate of the population aged ≥12 years is

inversely correlated with social vulnerability, with a vaccination rate of 35.8% in high social vulnerability areas compared with 46.1% in low social vulnerability areas as of July 14, 2021. With regards to race and ethnicity, Centers for Disease Control and Prevention data reveal vaccination rates of 23.7% of Black and 29.1% of Hispanic individuals, as compared with 32.6% of white individuals as of July 12, 2021.¹ Thus, socioeconomic and racial and/or ethnic inequities in rates of COVID-19 and MIS-C are similarly present in vaccination rates across the United States.

Ensuring vaccine access, as Martin et al have noted, is a key element. Programs, such as the Health Center COVID-19 Vaccine Program, provide support for vaccination in federally qualified health centers: >91% of individuals served by these health centers live at or below the Federal Poverty Guideline, and the majority are racial and/or ethnic minorities.² In our state of Massachusetts, the COVID-19 Vaccine Equity Initiative has identified 20 vulnerable communities to be prioritized for vaccine allocation.³ Such efforts should continue to be supported and expanded to ensure that we do not leave vulnerable groups behind and at risk for this disease.

Another important element is working to provide accurate information to those expressing

vaccine hesitancy or, perhaps more aptly named, vaccine deliberation. It is important to note that the United States has a long history of exploitative practices against minority groups that has led to justifiable distrust of the health system. Daily injustices, such as experiencing racism and bias in health care further lead to distrust of the medical system.⁴ Moreover, the pandemic has had a more devastating effect on minority populations: Black Americans are twice as likely to personally know someone who was hospitalized or who died of COVID-19 than white Americans.⁵ As providers, we must mitigate justifiable medical distrust and reduce bias and discrimination in our medical system with an open-minded and trauma-informed approach to vaccine counseling.

We appreciate this thoughtful comment on our study and share the view that vaccination efforts are a key element in eliminating the health disparities we have seen among children during this pandemic. We must support ongoing efforts to ensuring equitable access to vaccination and an empathetic approach to vaccine counseling. With these efforts, we can continue to work toward eliminating disparities in COVID-19 and MIS-C.

Karina Javalkar
Resident Physician, Boston Children's Hospital

Victoria K. Robson
Attending Physician, Chief Resident, Boston
Children's Hospital

Audrey Dionne
Attending Physician, Boston Children's Hospital
E-mail: karina.javalkar@childrens.harvard.edu

CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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doi:10.1542/peds.2021-053907