

Lisa: Hi, I am Lisa Hernandez.

Avigail: And I'm Avigail Oren.

Lisa: And we are your hosts for Scholar Strategy Network's No Jargon. Every other week, we will discuss an American policy problem with one of the nation's top researchers—without jargon.

Avigail: So Lisa, you know, but the listeners probably don't, that I have a 10 month old son. I've been talking to his pediatric practice recently about vaccine schedules because it seems like there are going to be some changes to the recommended timeline for receiving vaccines and even what is and is not recommended. And with summer travel coming up and rising measles cases, I feel like myself and a lot of other parents are having some confusion and stress around vaccination these days.

Lisa: I mean, the stress seems to be echoed among a lot of people when it comes to all the different vaccines and public health messaging that can get a little bit confusing and all the decisions that are gonna be coming in the next couple of weeks. So, I'm really glad that I got the opportunity to talk with an expert who really emphasizes the importance of having conversations around health and vaccines with one another.

So I'm excited for our listeners to join us in this conversation because for this week's episode, I spoke to Professor Lindsey Haynes-Maslow, whose research focuses on policies that lead to healthy behavior. She is an associate professor of health policy and management at the University of North Carolina at Chapel Hill.

Here's our conversation.

Lisa: Professor Haynes-Maslow, thank you so much for coming on No Jargon.

Lindsey: Thank you so much for having me.

Lisa: Well, today we're gonna be talking about vaccines. It's been a popular topic for at least the last five years. We're going to talk about who we trust, who we don't trust, and why this matters in today's public health landscape.

And to start, I want to ask you something about news making the headlines nowadays, and for context, for the listeners, we are recording this on Monday, June 23rd, and we need to make sure to say that because news and events change all the time. But earlier this month, President Trump's top health official, Robert F. Kennedy Jr. abruptly dismissed every member of the advisory committee on immunization practices—a 17-member panel. And that group usually helps shape national vaccine recommendations—everything from childhood immunizations to seasonal flu shots that we're all familiar with. And he has since appointed eight replacements, including several anti-vaccine voices. And this is obviously a very dramatic shift and we want to know, what are your reactions to these moves?

Lindsey: First off, I think Secretary Kennedy's decision to let go all 17 members of the panel is actually pretty untraditional. Normally, this is actually discussed with more than just the Secretary of Health and Human Services. So, one, I think, individuals on that committee were actually even surprised themselves. I think some just received an email. We actually have a professor at our school at the University of North Carolina, Chapel Hill, that was actually serving on that committee, and was let go.

And I'm still waiting to see what's gonna happen. You said it's June 23rd. They're actually gonna be meeting this week, this new committee. So it's a committee of eight members now, which you did highlight that several individuals on that committee do have interesting perspectives on vaccines. And have had mixed comments, mixed reviews on whether or not they trust

vaccines, if they think they're safe, if they think they're effective. So I'll be really curious to see what's gonna happen at these upcoming meetings. But I think what is probably the most concerning is they've got very important votes to vote on this week. You already just mentioned the flu shot. We have two flu shots that they need to vote on to see if we can have that out in the flu. Fall. So that's something that is going to be discussed.

Another issue that they may or may not discuss is, Secretary Kennedy decided to change the recommendations on the COVID-19 vaccine. Again, that is normally not done without consulting with that committee on immunization practices. So, they don't know if they're going to start making recommendations on the COVID-19 vaccine. They were also supposed to make decisions on the HPV vaccine and the meningitis vaccine as well. So I think it's gonna be very interesting at the end of the week. I'll be curious what they come up with or what decisions they decide to make in terms of, "do we implement these vaccines? Do we cover these vaccines?"

I think what's probably most concerning to me right now is what the health insurance industry is going to do. Because if they start not recommending vaccines, then you get into a conversation of, "is my health insurance, assuming I have health insurance, will they cover this or am I going to pay out of pocket?" And we already are in a fairly heightened state of our economy right now where people are very aware of money. So it's almost like a perfect storm is brewing in terms of losing a lot of experts in this field that have experience on top of people not really knowing or trusting where they're getting their information. These are new people. It's a new committee. Again, we don't really know what their views are, comprehensively. If you ask people to literally pay out of pocket, that's a financial burden and it's, I think, one step farther from making it harder to have access to healthcare.

Lisa: Yeah, it sounds like this is a pretty dramatic shift from the usual way that vaccine decisions are made. And for those listeners that maybe are not

familiar with the usual process, what does it look like for a committee to make decisions on vaccines in the U.S.

Lindsey: I'm new to this area in terms of the actual committee, but most of those individuals are professors, they're researchers, they're scientists. They're actively working in this field. They normally have peer reviewed studies or what we call studies or published studies in journals that have been vetted. They basically have their data reviewed, their study design reviewed. When I was reading up on the current committee, there are individuals on that committee that have no publications around vaccines. There's no data that they, it looks like they've worked with. I'm hoping that maybe they understand or have more experience than what is shown on their background or on their studies or lack of studies that have been published.

But I think that's one area of one, and also just reducing the amount of voices in the room. If we think about, just a kitchen table, right? I know this is vaccines, but let's pretend we're at the kitchen table and it's dinner time. Maybe it's a holiday meal. The more people you have, the more voices you have, the more perspectives you're going to get and you're going to get questions of, "is this the right thing to do? Is there an alternative way to do? Is there a better way to think about this?" I worry that going from 17 members down to eight diminishes a lot of voices and a lot of perspectives. And you miss out on maybe that one person who has the moment of, "let's just pause for a second and think, how does this actually play out in the real world? If we make this recommendation, how are we gonna implement this?"

And I think that's where a lot of mistrust or questions around the COVID-19 vaccine and this kind of vaccine hesitancy movement has come. We're not great at communicating directly to people on the ground. What concerns me is we put more questions in front of people because we're changing processes and when we don't explain the steps that we're taking and which is

I think again, what we probably should have done a better job during the pandemic of each additional step of explaining “why are we doing this?” You know, science is an iterative process. We do something, we try something, we learn something, and then we continue to move on and, and just reiterate that. But again, I think just if we continue putting more questions out there, I just don't think that the public is going to be confident in what our government is providing us in terms of information.

Lisa: Well, speaking of the pandemic, I definitely want to get into the COVID-19 vaccines and the confusion around who should get them, when. What were the things that, in your opinion, looking back, what did we get right during the pandemic when it comes to that public health messaging, when it came to vaccines? And what are some areas that maybe we missed the mark on?

Lindsey: I always kind of laugh at, I hate to say a laugh, but when I was going through school, I think in graduate school we were planning for the next pandemic flu. So we had the playbook for an outbreak—what happens if you have a pandemic, you know, flu outbreak or you know, something really large happens. If we have an epidemic, what do we do? So we knew that we needed to communicate immediately, which I think our country and other countries did fairly well about raising alarm and concerns that there is a—they didn't know at the time— “there's a virus, we're not sure how it's transmitted, but we're trying to figure it out.” I'm sure we can all remember the stories of people on the cruise ship and just staying there for months and not knowing how they're getting this virus. And it's, you know, airborne. That's really how they kind of learn that once it's airborne, I think we realize that, okay, now we need to update and, and let people know that this is how you can actually get COVID-19 if it's airborne.

So we were giving regular updates and communicating, but what I don't think we did well was go back and start from the beginning and go back and start

from the basics of this is how we do science. This is how vaccines are made. One concern, I remember when I was talking to my own primary care provider during the pandemic, when the vaccine was not out, we didn't know what technology they'd be using. And I said, "you know, I'd be really concerned if they get something out within a year." And my provider actually said, "yeah, I would too, because I have seen, you know, it takes a decade to get a drug or a medication from research and development all the way to being able to sell it or put it on the market."

What I then realized was they had already been working on this technology and this type of vaccine for years. So I don't think we did a great job of explaining that we didn't start in the halfway, we were already halfway there, and we were really just completing and refining part of that vaccine and how that works. I think we forgot to learn how to tell the story and say, "here's chapter one, and here's an introduction and this is how it works. We're probably gonna give you information today. That may change tomorrow. You know, whatever I say right now, it may be inaccurate three hours from now. I don't know, someone might make a discovery on that," but I think we should have been more transparent about what we know, what we don't know, and this is how we're going to try to communicate.

I think the biggest thing that no one predicted was how political it would get so quickly. And I think as soon as politics and political agendas got in front of science, education, and medicine, I think that's when we really started to see not great outcomes. And that's when you started having the much more, "well, I'm not going listen to the government. I don't wanna listen to the CDC, I am going to go and look on this social media group, or actually, I'm going to ask my, provider, what do they think?"

And I also think the providers were also caught off guard as well. I had a colleague, we were working on a grant for vaccine-hesitant individuals, and a

patient literally asked a doctor, when they were about to get the vaccine, they said, “if I receive this, does this mean I'm a Democrat?”

And I remember asking my colleague, I said, “how did you even respond to that?” Because I would, again, as someone who's in health policy, I'd say, “well, you're only a Democrat if you register to be a Democrat.” But this person, this patient really did think that if they took a vaccine, it would label them some type of political party. That was early on when the vaccine was first available. And I think that was the first real sign of “this is getting scary.” If people are now associating medicine with political parties and agendas, that should not happen. And how do we start to change that narrative in that conversation?

Lisa: And you mentioned the term “vaccine hesitant.” And want to—this is a No Jargon podcast, so we wanna make sure to know exactly what we are talking about here—could you define vaccine hesitancy? And also is there a difference between being vaccine-hesitant and just anti-vaccine?

Lindsey: Thank you so much. I mean, yeah, the word “vaccine hesitancy,” I probably didn't use before the pandemic. So this is even new to, I think, some academics and some that work in this area, but I do like to use the World Health Organization's definition and it really just says vaccine hesitancy is talking about when people delay acceptance of a vaccine or they refuse a safe vaccine even though it's available.

But I do think it's really important that we don't equate someone who's vaccine hesitant with the anti-vax movement. It's not your pro-vaccine or your anti-vaccine. Vaccine-hesitant folks are normally those that might have questions, they might have concerns. There are certain groups in our country that have had not great experiences with the medical field in the past. So again, there are reasons behind their hesitancy and sometimes they are different. But I'm glad you asked that because yeah, we don't want to label

folks that are vaccine hesitant as anti-vaxxers. We learned in the field that labels, people don't like them. They don't like to be just put into a box and just told, "this is what you are." So I think that's a really good distinction to make.

Lisa: I wanna dive a little bit into maybe some of the myths that contributed to a lot of the information that people were receiving during the pandemic, especially as online platforms came into play, and I think a huge one was the myth that vaccines cause autism or that they are linked in some way, which is totally debunked. And yet it's still out there. So I want to ask you, what keeps these beliefs alive? Is it just about bad information? Does this tap into something deeper? And what has been an effective way of cutting through these myths and making sure that actual facts get out there for folks?

Lindsey: Yeah. The autism is linked to vaccines. You're right, that has been debunked for decades. The original study was published by an individual that falsified data. That has been proven time and time again.

One thing that I think is really important, and again, this is us going back to the basics. We also have to remember that autism, we've gotten a lot better in the medical field at detecting autism earlier on and actually diagnosing it. So, unless you diagnose something, you're not going to see numbers go up. So I think that there's also this just—I mean, I look at graphs. I see, "okay, wow, our autism rates are increasing," like that is a question. But then if you recognize that within the medical field, we're really trying to make sure that newborns, infants, toddlers, are getting those well-being checks, they're seeing a pediatrician on a regular basis, and that's really how we're catching individuals within the healthcare setting. Even schools, where they have school nurses or maybe a counselor. So we've just gotten a lot better at that. But I think that the basic and the root issue is once something gets out there, it's really hard to stop that myth. I mean, it takes one voice, and also depending on how confident you sound. If you talk to someone who sounds,

probably sound a lot smarter than me or more confident than me, maybe I could convince you of anything. But it's that conversation where I think that people see numbers and they only see numbers and they hear one narrative and they forget that there's a lot of other discussions going around.

And I think that's also really important 'cause I hear even my family or friends will say, "well, I read a study" and I said, "did you read a study? Or did you read an article that referenced a study?" Because I think as researchers and, and those in academia, I think we need to be better at explaining our own studies to the media. I think some people are concerned to speak to the media, but I've always said, if you're not talking about your own research and explaining your results to the public, then you can't fault the media if they get something wrong about your study. Like you need to get out in front and you need to communicate. But I think the fact that you continue to have that narrative and just that idea and behind people's thoughts and feelings, and especially maybe if you have a child with autism, maybe you, question, "was it environmental? Was it linked to something else Was it because I had a child later in life?" I mean, there are a lot of different reasons for this rise.

Getting back to your question of how do we roll back that tape a little bit and have a conversation of "why do you think this and help me understand?" I think those words "help me understand" is really important. Especially if you're coming from a point of—I'm a professor at a university. I don't go out and introduce myself that way. I normally just say, I'm Lindsay, I'm from UNC. You know, try to be personable. And then you have a conversation and say, "oh, I've never heard that. Can you tell me more about that?" Or, "I'm trying to understand" or, "have you ever looked into this resource?" But I think the most important thing is trying to listen and hear the full story of why someone believes something has happened or why they believe in a myth.

Listen and then offer information. But I think what we learned during the pandemic and then through my work with vaccine hesitancy communities is

that your end goal is not to convince them to get the vaccine. Your end goal is to make sure that they have access to new information where they can use that to make another decision and hopefully a more informed decision, that's based off of evidence and, and maybe not non-evidence.

Lisa: You've mentioned having conversations with folks about vaccines and information around them. I'm wondering if there are moments in which you have found that a lot of folks are really just concerned about health overall, more so than the political matters.

Obviously there's a lot of anti-vaccine rhetoric that is directly connected to a lot of wellness narratives. What do you think about those two sides of health sort of merging together in a way that seems like it's a juxtaposition, but for a lot of people, wellness and anti-vaccine go hand in hand.

Lindsey: Yeah, I think that's a very interesting question and, and even from a viewpoint of, I think some people are really drawn to Secretary Kennedy because of his views on food and nutrition, and I have focused a lot on nutrition and food policy throughout my career in addition to health policy. And so when he talks about certain aspects, he actually is referencing the evidence, within, what we have. That's on more of the food and nutrition side. Then, when you come to the vaccine side, that's where I start to see some gaps in information of where you start mixing evidence and non-evidence and then that becomes very confusing. That's almost like you're playing a game of, "okay, that sentence was correct, that one was inaccurate. that one may be mixed."

So I think what we're seeing is two groups of populations, those that are, you know, very much into health and wellness and making sure we're eliminating certain ingredients or chemicals from our food. That's one area. And then you have the group that is completely "vaccines, they're not making us healthy, they're actually harming us." So you are getting these two groups

where I think that they don't actually have similar interest on one or the other, but they're overlapping because of Secretary Kennedy.

So that is something where I think researchers will be definitely looking at in terms of social movements and social beliefs, and how do different movements join, how do they become allies? And then sometimes, how do they become opponents?

Lisa: Absolutely, and definitely I think what we are talking about here essentially is all around this campaign around "Make America Health Again" as RFK Jr. would put it. It's that framing of personal health responsibility. There's definitely more messaging on the left side that is more about community wellness. What about individual responsibilities versus community-oriented messaging, do you think is maybe appealing to people or not?

Lindsey: I have mostly focused on policies that impact low-income communities and populations, vulnerable populations. So I very much don't like the focus on it's an individual's responsibility, because you make a lot of assumptions there. You assume that maybe they have transportation to actually get somewhere to get a vaccine. Or you make the assumption that they have actual health insurance. You make the assumption that they could have those out-of-pocket costs, basically money, to pay for their own healthcare. So I do not like the focus on its purely individual responsibility.

I think the idea of community is a lot easier in terms of "we are a community together and you define your community." And some of the strongest strategies that we've seen in terms of trying to promote vaccines is working with communities and working with community leaders, working with trusted leaders. And depending on which communities you're working with, they might have very different values or different viewpoints.

When we were back in 2021, 2022, we were working with migrant farm workers and we found out that, I think this is well known, but, they were family-oriented. So a lot of our messaging was around, you know, vaccines are safe, it'll protect you, and so you can take care of your family and take care of your kids. And as we were having those conversations, there was a woman who said, "I don't want to get the vaccine until my children can get it." And she was very adamant that—and it's interesting because we're in a vaccine hesitancy focus group and she's not really technically vaccine hesitant. She really is actually focused on "I want to protect my kids first" and then we have to go back to "Yes, that is absolutely important. That's what we want to do. And they're trying to do studies right now to see if we can do that, but you can also protect your family by getting vaccinated if you want to."

So I think that it's very interesting when we go back to community and just trying to understand how people work together as a community, how do they support each other as a community? Sometimes I am not the right person to go into the community. Normally, I will be working with a community partner where people actually know that individual, they know their name, they know their background, they know their family members. So I think that focus on community, it also takes the onus off that individual of feeling pressured. Whereas it's just a community conversation. It's a little bit more informal, and you don't feel like you have to make a decision right then and there.

Lisa: Absolutely. And this program that you mentioned here, it's, and you can correct me if I'm wrong, but it is the EXCITE program, which is short for the Extension Collaboration on Immunization Teaching and Education at North Carolina State. And this project focused on vaccine education, you mentioned, around farm workers and rural communities. One of the things that I'm wondering is throughout this experience, rural and medically underserved areas face pretty unique challenges. So what are the barriers

that you learned that these folks are up against when it comes to vaccines and how is it different from urban areas?

Lindsey: Yeah, I mean, to be honest, in terms of the rural communities, what we again have focused on very much is that you cannot have an outsider come in and say, “this is what you need to be doing. This is when you need to do it.” It has to be from—so we're in the south, so normally that's going to be maybe a faith-based leader. Maybe it's someone that's a teacher at a local high school that a lot of people trust and respect. You never know who that trusted messenger is. But I do find it's really important, especially in rural communities, that they tend to know each other. I've lived in really small towns myself, and I understand that people talk. I lived in a small town when I was probably a teenager, and I did not like that people talk because then my parents knew when I was out of curfew but the good thing is people do talk and they talk to people that they trust. So, again, an outsider coming in, it's not going to be that effective.

What I do think is interesting, again with rural communities is you have to remember that they also might not have access to the same information because social media has taken over so much and because the media landscape has changed so much, we can self-select into what we actually read and what we choose to read or don't choose to read. I mean, I'm sure you get ads all the time thrown at you on your phone and you didn't choose to read it, but it's there and you see a headline.

So I think that one, trying to figure out what is a good source? And that whole conversation of “do we trust our federal government to give us health information?” Once that is gone, you have to ask the question: “who's next in line? “And normally you're going say, that's probably gonna be their healthcare provider, and hoping that that rural community has a healthcare provider there, or multiple healthcare providers that they trust. But rural communities do face lower rates of physicians and clinicians living there.

So they might not have access to that. They might have to drive an hour or two. That was actually a big issue for those that wanted to get vaccinated in the beginning was just the fact that they would need to drive at least two to anywhere to four hours to get to a vaccine clinic, when it was just released and when certain individuals were eligible.

I don't think we see similar issues to that level in urban communities. But, I will say with just kind of the vaccine hesitancy movement, I'm starting to, as you, I think we mentioned earlier on, it's no longer just based on income or education. You find people that are high income, have a high education and they're still very skeptical or they're hesitant about vaccines.

I feel like we're seeing maybe a little bit more similarities between rural and urban communities and I think it comes back down to "do we trust our public health?" and "do we trust what the government is saying about what we should be doing?" And those are valid questions from both communities.

Lisa: I'm also thinking about looking ahead towards the next outbreak or the next thing that we have to worry about as far as the health emergency. And we have heard a lot about measles outbreaks popping up in the U.S. and several states. This disease we thought was long gone. Actually in our previous episode of No Jargon, we talked to a doctor working in Sudan and treating patients in measles outbreaks there. If you could share a little bit about how and why is measles making a comeback here in the United States, and is this an urgent situation that we should be worried about?

Lindsey: Yeah, I mean, I would say it's absolutely urgent. It is much more contagious than COVID-19. So that's the first thing to know. Is that it's easily spread. Also if you are not vaccinated, you have a very high chance if you're exposed to measles, of actually catching it. In 2025 alone, I think it's about a thousand people have been diagnosed with measles in the United States,

and 95% of them are unvaccinated. So that right there shows you how quickly something can spread.

And we have to remember at the end of the day, and you've mentioned you were talking to a doctor in Sudan, viruses and these diseases do not respect borders. What is concerning to me is while we think about, right now, a measles outbreak in the United States, we could actually be spreading that to other countries. And what happens if we do that to other countries that may not have the same health infrastructure that we do?

I think it's also concerning that when the measles outbreak is currently still going on, we're getting mixed messages from Secretary Kennedy. There are messages of, "yes, you should be vaccinated or, but it's your personal choice." So there's always a, "you should do this, but..." and then something else. And then there were, I think, recommended other options for protecting yourself, improving your immunity, and your health and wellness. And those are the aspects where, again, that's the mixed messaging of "get the vaccine, but you can also take vitamin A" or you know, "it's your decision at the end of the day." And I think that is where you need a leader and you need someone to say, "here's what the science says." If you get vaccinated, you will not get measles. Your chances of getting measles is, you know, less than 1%.

The one thing that I also have not seen a lot is—we're not showing photos of what measles actually looks like. I really don't see those pictures in the news and I don't always know if people really understand how painful, how uncomfortable, how horrible it is to actually sit there and deal with those symptoms.

COVID-19, you really couldn't see. It was an airborne respiratory illness, and unless you saw someone in a hospital on a ventilator—I think images really resonate with people. And if we don't see the suffering, and I hate to say that, I sometimes don't think people take it seriously. We have mixed messages on

what we do to control it. We're getting into a very concerning territory of we need guidance and we need clear guidance.

Lisa: Given that there's a lack of federal guidance—messages are not really landing well with people, they're not understanding the sort of emergency around this issue, why we should take it very seriously—what is the role of local leaders, organizations, folks that are more on the ground, that they can play in order to make sure that people feel prepared in order to face this measles outbreak?

Lindsey: That's a great question. And I, I think right now we have a lot of local universities, local hospitals, local health departments, federally qualified health centers that are trying to partner with community-based organizations, faith-based organizations—those that are trusted partners and again, on the ground. And it gets really again, about having that conversation of, “have you vaccinated your children yet? If, not, can you help me understand why?” Or, you know, “what are some of the hesitations? let me hear some of your questions and, can we talk to, can we have a healthcare provider come out and talk to us or can we have our local provider come out and talk to you?”

I think the power of a conversation with a provider— so that's a physician, it could be a nurse practitioner, could be a physician assistant—and if you have trust within your provider, I think that's probably going to be the most important aspect because they are looking— granted, they're also looking for guidance on federal policy—but they also have their connections to the medical field, which I think is so important. So we can still have evidence-based information and share good information. And again, we need to, I think, not be so adamant on pushing and say “this is what you have to do.”

Again, it's a conversation and you basically give someone more information and you let them know that you're starting the conversation not to convince them. You are literally starting the conversation to share information and let them ask questions, and then let them speak about, how they're feeling, why they're feeling that. Did they have a bad experience? Did they hear about somebody else having a bad experience?

Lisa: Absolutely. And you know, I am so appreciative of the fact that we've been able to have a conversation ourselves here and ask questions and I think it's really important to keep having conversations around this, especially when we definitely hear a lot of bits and pieces of information online, but maybe not a full conversation. And I want to maybe wrap up our conversation here for our listeners and see if you have one big takeaway that you want people to walk away with

Lindsey: If you are in public health today, if you are in higher education or in medicine, I hope you are getting out into the community. I hope you are talking to your friends, your neighbors, the community members. We need to be out more. We need to be talking with people more, and we need to understand perspective.

So that is my takeaway—we don't need to be hidden in our offices. We need to be out talking with people so that people also know that we're also people that have our own feelings. We have our own questions as well, but we might go about answering them a different way. So I think just going back to the basics of being a human and just recognizing that we're all humans in this together.

Lisa: Well, thank you so much for sharing that, Lindsay. I appreciate you coming on No Jargon.

Lindsey: Thank you so much for having me again.

Lisa: And thanks for listening. For more on Professor Haynes-Maslow's work, check out our show notes at scholars.org/nojargon. No Jargon is the podcast of the Scholars Strategy Network, a nationwide organization that connects journalists, policymakers, and civic leaders with America's top researchers to improve policy and strengthen democracy. The producers of our show are Wendy Chow and Dominik Doemer. Our audio engineer is Peter Linnane. If you liked the show, please subscribe and rate us on Apple Podcasts or wherever you get your shows. You can give us feedback on X, formerly known as Twitter, @NoJargonPodcast or at our email address nojargon@scholars.org.