Response

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Dr. Hinman has presented an excellent, succinct, and condensed paper on the professional perspectives regarding concerns surrounding childhood immunizations, particularly from the perspective of the clinical immunologist. My response is not from this same perspective but rather from the perspective of the community health nurse, one of the professionals experienced in delivering the vaccines to the public. From this perspective, I would like to make some comments I feel need more emphasis or were overlooked by Dr. Hinman's presentation.

Regarding vaccine effectiveness and safety, I would like to state that there is a growing concern among community health nurses in Maryland and other immunization professionals about the increasing difference between the safest vaccine for an individual vs. the vaccine which is best for the community. Currently, as Dr. Hinman points out, we have more vaccine-related polio than polio caused by the wild virus. It would be desirable to have levels of polio immunization so high that we could safely switch to killed virus. I realize there is lively debate on this issue that must continue so that we all have more facts on which to base our decisions. But, in Maryland, where polio immunization levels are high, we are greatly concerned about this difference of individual vs. community safety. Dr. Hinman points out that rubella vaccine is only 9 years old and we cannot be sure at this time that protection will be life-long. Community health nurses are concerned that vaccine effectiveness be adequate throughout the childbearing years of our female children. We hope someone is planning for the contingency that protection will not last and an effective booster may be needed.

Dr. Hinman also speaks of the "duty to warn." Professionals involved in immunization programs have taken on this responsibility and are carrying it out admirably. However, this responsibility has increased the burden of providers considerably. Consent forms are lengthy, technical, and are too negative. While we accept the responsibility to warn the public of potential risk, we sincerely hope the forms will be rewritten in more understandable language for the general public.

On the issue of willingness vs. true compliance, there is whole-hearted agreement with Dr. Hinman that the gap is too large. Without our state laws, immunization levels would be an even more critical problem. Last year with a renewed effort, Maryland volunteers, together with education and health officials, successfully halted a predicted measles epidemic of over 400 cases. We had 51 sporadic cases, only 3 of which were in the Baltimore City school system.

The entire delivery system needs a critical analysis. Some examples: 1) The urban poor frequently use out-patient departments of hospitals for child health care and there is little if any prevention in these busy out-patient departments. 2) Is a monetary charge for vaccines a barrier in the private sector? 3) Are clinic locations, their organization, and the hours they are offered a barrier in the public sector? Many feel this is so. Why can we not

have mobile van immunization clinics in low compliance neighborhoods in the early summer evening hours? Parents could bring all the children, even preschoolers, to receive needed vaccines right in front of their door. Public attitudes towards immunization is an area Dr. Hinman states is generally positive, but the truth is that these attitudes are still not strong enough to produce the much needed and vital change in behavior. We need to find ways to change the prevailing noncompliance behavior. Then we will reach our 90% goals.

To strengthen future general public attitudes, we should begin parenting classes in all junior high schools. Here we could teach the importance of immunization as well as total child health care to our future parents.

The commitment of the military toward immunization can be questioned also. In 1977, the Naval Academy in Maryland had a rubella outbreak. An immunization prevention program was never initiated, thus, the community at large was needlessly exposed to an increased risk.

Provider attitudes need strengthening. Checking vaccination records should be part of routine assessment by doctors and nurses when caring for children and in talking with their parents. One case in point among community health nurses that comes to my mind is the home health visit. While it is often true we are in the home caring for elderly or disabled adults, the fact remains that children are also present in many homes. This could provide the opportunity to examine the immunization record and do some health education. Providers need to form a lasting alliance with concerned volunteers to change public attitudes sufficiently to alter behavior. The current volunteer effort spearheaded by the National League for Nursing needs some permanence.

School health records need improvement also. It is often the case that not only is the immunization record difficult to find, but complete health status information is spread all over. There is a great need to assemble the health record in a single more orderly fashion. This record also must follow the child whenever the child moves to another school.

Parents need to be informed that it is their responsibility to keep an immunization record on each child. Parents should have these records like international travelers have their passports.

Educators need to appreciate more fully the importance of a strong school health program managed by qualified personnel. The trend to replace school health nurses with aides is a questionable trend at best.

Lastly, our Federal leaders need to strengthen their commitment. Money should not vary so much from year to year. A campaign every 5-10 years is not sufficient. Children are born every year and sporadic immunization campaigns take scarce health manpower away from other needed school health projects. Ninety percent immunization level should be an annual health goal for the entire nation.