

How a Health Authority achieved 91% uptake in one year

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The rubella vaccination campaign in Sheffield

The previous issue of *Education and Health* contained a report by John Balding on *What do immunisation enquiries tell us?* In this report, mention was made of the No/Don't know/Yes responses by 4th-year pupils in four Sheffield schools to the question "Have you been vaccinated against rubella?" This led us to contact the Sheffield Health Authority to find out the true take-up rate for the area, and the Information Officer, Dr Gordon Reid, sent us his report on the 1979 rubella vaccination campaign in Sheffield schools. Many aspects of this campaign, covering births in the school year 1966-67, will be of interest to teachers and health-education personnel.

It is worth adding that the take-up rate for girls under 16 at schools in Sheffield has been as follows: 1966 births—88%; 1967 births—95%; 1968 births—99%; 1969 births—not yet completed, but standing at 67% at the end of 1982. —Ed.

In May 1979, the Department of Health circularised Area Health Authorities, asking them to give greater emphasis to the organisation and co-ordination of their programmes against congenital rubella. It was recognised that in the long term an improved schoolgirl vaccination programme could lead to the elimination of congenital rubella, and to achieve this objective it was stressed that the uptake of rubella vaccination amongst school-

girls aged 11-13 should be increased to at least 90% in each Area.

The first task of the Sheffield working party was to assess past levels of uptake, and to estimate the potential workload involved in increasing uptake amongst schoolgirls and women of child-bearing age. It was not easy to calculate the precise vaccination uptake amongst schoolgirls in the 11-13/14 age range, as vaccination programmes for the relevant age group spanned two calendar years within the single school year. However, by totalling all vaccinations between 1971 (the commencement of the programme) and 1978, and using the total number of girls reaching the age of 14 as a base, it was estimated that just under 70% were being vaccinated under the current programme—20% below the DHSS target.

In addition, there was little standardisation in the system adopted by each school for its vaccination programme. This gave rise to a number of problems, if the target of 90% were to be achieved. For example, the rates in different schools could be much higher and much lower than the mean; there was little information on the reasons for the 30% defaulters; and there was poor coverage of the follow-up (if any) in these cases. The working party decided that a standardised and systematic method of carrying out the vaccination programme was essential for an improved uptake rate—and good communication and publicity were important.

The programme and the results

The target population was estimated, from OPCS statistics, at 4,300, so that a 90% uptake would correspond to 3,870 vaccinations. Record sheets from the registers of each of the 50 schools were compiled during the first and second weeks of September. These listed the names of all girls due for vaccination, and consent forms were issued to all these girls, a total of 4,281, after they had heard a talk from the school nursing sister. The record sheet was used to indicate the parental response for each girl. Girls not returning consent forms could then be followed up, as could those whose parents declined consent, this being done at the discretion of the nurse.

The majority of girls consenting to vaccination were treated in November and December 1979. Follow-up of absentees continued through to May 1980. The treatment for girls whose parents opted for vaccination by their own GP was more difficult to confirm, as it was dependent upon the GP making a notification for payment purposes. Since some may not have done this, they will not appear in the totals.

The results of the campaign may be summarised as follows:

1. The total number of girls vaccinated by the end of May 1980 was 3,898 — 91% of the total listed number of 4,281. The target uptake rate was therefore achieved in the first year.

2. The vast majority of parents opted for vaccination in school, and 97% of this group had been treated by the end of May 1980. The 3% included a number of persistent absentees, as well as a few transfers to other schools and possibly some failures to record a vaccination.

3. Just under 400 parents (9%) opted for vaccination by their own GP. By the end of May 1980 the confirmed uptake in this group was only 63%, and the claim by parents that their daughter had already been vaccinated was often not supported by the records. In some instances it was clear that GPs had undertaken active

vaccination campaigns within their own practice, and in these cases GP uptake rates were high. A relatively small number of practices accounted for the majority of the GP vaccinations.

4. Only 134 girls (3%) failed to return the consent form within the specified period, or returned it with a refusal. The majority of these were followed up by the school nursing sister, either by sending a second form or a letter, or by visiting the home. This secured a further 47 consents, leaving 87 non-consents. It is worth noting that written follow-up proved to be most valuable in obtaining further consents, while home visits produced only 20 successes out of 62 attempts. It must be asked whether the resources being used on home visits are cost-effective, and further feedback on this issue, from school nurses, would be of interest.

Health/social education and the whole person

If one is organising a health and social education programme, the obvious and conventional strategy is to identify such components as diet, exercise, smoking, alcohol consumption, and — dare I say it? — use of the road. I believe, however, that time should also be given to exploring the significance of these behaviours in the whole life of the young person.

The arena provided by Michael Rodd for his young drivers was obviously helpful to them, and it was not focussed on "good practice" but on relationships with one another, with parents, and with the law; and also on social behaviour.

TACADE, the Health Education Project at Southampton University, and Life-skills Associates at Leeds University, are three current sources of teaching materials for use in the secondary school which use this health education/social behaviour perspective. These materials are used in core courses for all students, and, being attractive to teachers, are becoming more popular; but to what extent do they focus on being a road user? Ken Jolly, at Reading University, is currently developing materials specific to road safety, but will it find its way into health and social education courses, or will it be restricted to specialist areas?

One of the problems I see here is a political one. Development of educational materials depends upon funding, and the funding body (whether it be a bank, insurance company, or cosmetics manufacturer) naturally wants recognition and publicity. It may strongly influence the scope of the material being prepared, and it may want a separate slice of labelled curriculum in order to be satisfied, which could result in an isolated "package" seemingly unrelated to other aspects of personal development. Those fostering any aspect of safety education should, however, try to see it more as an important contributory ingredient of a larger section of the curriculum.