National Immunisation Program Implementation Seminar

The first Immunisation Program Implementation in Australia seminar was held in Sydney on the 7th - 8th March 2013. It was a great opportunity to have this seminar back-to-back with the National Immunisation Committee (NIC) meeting, which enabled members of NIC to actively participate and provide their insights on program implementation in Australia.

The day started with a welcoming address by Julianne Quaine from the Australian Department of Health and Ageing. Michael Batchelor from Victoria chaired the first session on program implementation by states and territories. Topics included HPV vaccine coverage issues from Victoria and the Northern Territory; showcasing of the smart phone reminder application from NSW; changes to school-based immunisation in Tasmania; follow-up of overdue children in the ACT; antenatal influenza vaccinations and post-natal pertussis from WA; and a presentation on areas of low coverage from SA.

Ms Heather O’Donnell: Victorian HPV Vaccine Program low coverage project

The presentation by Heather O’Donnell on HPV vaccine coverage in Victoria stressed the importance of appropriate ‘systems’ and ‘processes’ for implementation of successful school-based immunisation programs. These included forging and maintaining good relationships between local providers and the education sector; increasing knowledge and awareness of HPV and its links to cervical cancer amongst parents and girls; well-resourced pre and post-immunisation strategies; and availability of accurate and timely HPV immunisation coverage data.

Dr Helena White: Gaining ground – Immunisations in remote locations

Dr Helena White from the NT provided insights on implementation issues in remote areas and Indigenous populations. Experience has shown that the NT Immunisation Register recall system allows clinics to actively locate patients and administer vaccines, with clinic lists being a useful adjunct to increase timeliness. Provider reminders are also effective and lead to increased vaccination coverage. This approach could be useful and applied in populations with similar demographics, cultural values and health status but would simultaneously...
require accurate immunisation records as currently available in the NT.

Ms Sue Campbell-Lloyd: NSW Immunisation Campaign

From NSW, Sue Campbell-Lloyd provided an overview of the development, implementation and evaluation of the NSW Immunisation Campaign including the creative strategy used in the campaign. The creative strategy involved using nursery rhymes, storytelling and rhyming couplets as a way of spreading information. She also provided a ‘sneak peak’ of the smart phone application (‘app’). This app, which is compatible with iPhone and Android platforms, would help parents keep their children’s vaccinations on time. Sue provided a snapshot of the functionality features that include setting up of personalised schedules for individual children; management of due date reminders; ability to print schedules; and options of listening to lullabies. Data that could be extracted and analysed using this app include Google analytics, number of downloads by postcode and Aboriginal and Torres Strait Islander status.

Ms Simone Duncombe: Improving adolescent immunisation coverage

Simone Duncombe presented Tasmania’s strategies for improving adolescent immunisation coverage. She started her presentation by providing Tasmania’s performance in their school-based immunisation program; the current challenges; and an overview of the school-based immunisation improvement project and targets. The current challenges include budget; diverse attitudes held by local governments; evolving changes in the immunisation sector; and access to quality targeted information by parents, adolescents, providers, schools and program management staff. The goals of the school-based immunisation improvement project are to increase knowledge of key stakeholder groups; streamline processes to increase efficiency and support providers and associated support staff; and develop contemporary resources and tools to increase coverage. This collaborative project would be monitored using an interactive approach and evaluation of processes and outcomes. The target for school-based HPV and adolescent pertussis coverage is 75–80%.

Ms Carolyn Banks: Follow up of overdue children

Carolyn Banks presented a case study on follow-up of overdue children in the ACT. She started her presentation with an overview of the ACT Health system and coverage rates. The pilot follow-up study commenced in 2003 and was continued in 2005 for all children overdue for immunisation at 7–10 months, 19–22 months and 55–59 months. This follow up was conducted quarterly. An ACIR 11A report was generated to identify overdue children. Letters were sent to all parents/guardians of children who were overdue and approximately 700–900 letters were sent each quarter. The response rate was relatively consistent throughout the life of this program. The data showed that close to 24% replied to the letter by returning a phone call. Three per cent of letters were returned as the people had moved and three quarters of the people did not respond. A repeat ACIR 11A report was generated one month after the original report.

Post-implementation data has shown that there has been a significant reduction in children who were overdue. The ACT immunisation coverage rates are now consistently above the national average and it is thought that the parental reminders have had a positive effect on these rates.
Professor Paul Effler: Influenza vaccination among pregnant women in WA, 2012

Paul presented findings from a study undertaken in WA to determine uptake of influenza vaccination in pregnant women. This presentation started with a background on pregnant women and children being at increased risk of poor outcomes from influenza infection and the recommendation for vaccination for pregnant women and children by the World Health Organization (WHO). In the Australian context, free influenza vaccination has been offered to pregnant women since 2009 and been recommended by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) since 2011.

In WA, an operational directive dated 21 March 2012 states that all pregnant women should be offered influenza vaccination as part of routine antenatal care. Several sources of information were distributed including; letters to maternity hospital directors; patient consent forms for antenatal clinics; reminder stickers for patient records; letters to GPs and immunisation providers; pre-printed obstetrician’s referral for influenza vaccination letters. The aims of the study were to determine the uptake of influenza vaccination in pregnant women in WA; determine the extent influenza to which vaccination was offered to pregnant women; assess women’s knowledge and attitudes to influenza vaccination in pregnancy; and identify barriers or enablers to influenza vaccinations in pregnant women. The study used data from the Midwives’ Notification Database of mothers who gave birth to a live infant between 08/04/2012 and 07/10/2012. Five hundred and seventy women were randomly selected (285 metro and 285 country) and interviewed by phone. Vaccination status was verified using Department of Health database or records from the vaccination provider. The study found that approximately 25% of pregnant women were vaccinated against influenza in 2012 and that 38% of women were advised by their antenatal healthcare provider to be vaccinated. About 50% of women believed that influenza vaccination is safe and effective to use in pregnancy. Finally, the majority (70%) of women would agree to be vaccinated against influenza if their antenatal care provider recommends this.

Ms Maureen Watson: Tackling low coverage with innovative promotional strategies

Maureen presented outcomes of a study on different strategies used in SA for increasing coverage. The aims of the study were to raise awareness that the 4-year vaccinations could be given as early as 3½ years of age and to encourage attendance for 4-year vaccinations before children started kindergarten. Primary targets were parents and caregivers of children between 3½ and 5 years of age and secondary targets were children between 3½ and 5 years of age. The key message of the study was that all children should receive their 4-year booster vaccinations before they started kindergarten, which could be any time after 3½ years of age. In the campaign, they used a storybook, stickers and masks as an appealing introduction to the need for the 4-year booster vaccinations. The campaign also acted as a reminder for parents to have their children booked in for vaccination. The key message was that vaccinations were a necessary step on the path to ‘Big Adventures’ at kindergarten.

The ACIR was the distributor of the campaign resources. Coverage data from ACIR reported for the 4-year vaccines for children born between January to June 2007 and turning 4 years in January 2011 were examined. Providers were encouraged to start vaccinating early and this led to a slight increase in those vaccinated before 4 years of age, pushing the percentage of those vaccinated at 49 months up to 51%. Following the introduction of the campaign, there was a significant increase in the percentage vaccinated before 47 months and most children were immunised by 52 months.

Mr Scott Brown: Data cleaning for overdue Indigenous children

Scott presented his findings from a data cleaning exercise to identify overdue Indigenous children in Queensland. This data cleaning exercise commenced in December 2010. Quarterly ACIR reports (11A) were generated to identify all overdue Indigenous children in February, May, August and November of the year. Agreement was sought from State NACCHO affiliate (QAIHC) to use data and reports that were provided to Public Health
Units. The key finding of this exercise was that vaccination data cleaning identified more than 50% of children not overdue. This allowed focused efforts on catching-up the smaller cohort of children actually overdue, which proved to be a worthwhile exercise. Even after this data cleaning exercise, the gap between Indigenous and non-Indigenous children persisted for the 12-month old cohort. Future work in the area would be to identify the reasons for the existing gap and the strategies to reduce this gap.

**Friday 8th March**

Day two of the seminar commenced with a Welcome to Country by Mr Michael West. In addition to the speakers in Session 1 outlined below, a special address was made by Federal Minister for Health, Tanya Plibersek (pictured below). Minister Plibersek announced her ongoing support of Australia’s National Immunisation Program and the work done by those who are involved in program implementation. She also acknowledged the work that has gone into updating the 10th edition of *The Australian Immunisation Handbook*, and its value as a resource for those in the immunisation field.

**Session 1**

**Dr Nikki Turner: Immunisation program implementation in New Zealand**

Nikki summarised the similarities and differences in the New Zealand (NZ) immunisation schedule and delivery to that in Australia. She also described the NZ National Immunisation Register, introduced in 2005, which contains entire population birth cohorts, hence having the advantage of capturing denominator data. However, she highlighted that the register still has room for improvement, i.e. does not capture flu vaccinations. Nikki talked through New Zealand vaccine coverage data, which is high overall, but still with some ethnic and socioeconomic disparities. Nikki highlighted that high coverage is achieved, and aspired to, with minimal financial incentives for GPs (none for parents), but instead through quality incentives and positive feedback loops.

Nikki also highlighted the importance of getting the ‘systems’ right before high vaccine coverage can be achieved and maintained. Some of the important factors which influenced coverage were discussed including those at provider, parental and environmental level. Some of the challenges that NZ still faces with respect to immunisation implementation include reducing equity gaps, identifying and engaging with vaccine decliners, and improving data quality.

**Professor Peter McIntyre: Immunisation program implementation in Australia**

Peter provided an overview of the current status of the immunisation program in Australia, highlighting the large growth it has undergone over the last decade, the diversity of the program and its delivery. He talked through examples of three vaccines available in Australia to highlight some of the strengths and weaknesses in immunisation implementation. These were the introduction of rotavirus vaccination to the National Immunisation Program (NIP) in 2007; introduction of varicella vaccination to the NIP in 2005; and measles
vaccination programs. Some of the challenges identified included those that are specific to the vaccine preventable disease, (e.g. the availability of multiple vaccines and their interchangeability) those specific to general challenges such as pockets of low vaccine coverage, and data limitations.

Peter also described the school-based immunisation programs in Australia which achieve high vaccine uptake and also provide a mechanisms for monitoring and reporting adverse events. Future improvements summarised by Peter were to see greater collaboration between health and education sectors in Australia, particularly with respects to immunisation; to better capture immunisation records; and to improve communication around vaccines and vaccine preventable diseases to the diverse stakeholders.

**Associate Professor Julie Leask: Communicating with parents about immunisation**

Julie explained how the explosion of digital communication in recent years has changed the way that parents access information on immunisation and how this impacts their decision making processes. Strategies to counteract misinformation on immunisation were also described. In addition Julie highlighted that good communication on its own is not enough to maintain high vaccine uptake, but supportive systems are also needed to foster public trust and also provider support. She described some of the most common parental concerns around immunisation which mainly stemmed from concerns of vaccine safety and testing. Although Julie noted that there was some early evidence that there may be an increase in vaccine hesitancy among the population, better mechanisms are needed to monitor trends in vaccine support. She summarised that it is important for immunisation providers to engage with their patients and start a dialogue to understand their needs and concerns, quoting the need to “localise, personalise, and harmonise” information.

She also stressed the importance of prioritising special risk groups in immunisation communication strategies such as those targeted to Australian Aboriginal and Torres Strait Islander communities.

**Session 2 – Enhancing immunisation program delivery in Australian primary care**

**Dr Jenny Royle: Developing a plan for those hesitant about vaccination**

Jenny highlighted that ‘not immunising’ is a temporary state for an individual and that many triggers may prompt them to revisit their decision again. When communicating with a vaccine refuser it is important to consider the person, not the process. Jenny described the “Winnable” communication plan which focuses on making discussions specific for the family and their issues, highlighting local disease epidemiology, and being upfront about potential adverse events, as well as about disease treatment limitations (which may be an alternative scenario if vaccine is not administered and a disease is contracted).

**Ms Melinda Hassall: Implementation of immunisation programs for the Indigenous community**

Melinda described her role as a member of the Queensland Aboriginal and Islander Health Council (QAIHC), and the challenges and opportunities for delivering vaccines to Indigenous Australians in Queensland. Some of the challenges included access and quality of immunisation coverage data as well as staff mobility and knowledge loss. The opportunities for improvement were in data-linkage particularly with eHealth (PCEHR), diversifying and legislating training for immunisation administration, and utilising contemporary media such as twitter and Facebook to delivery simple messages on immunisation.

**Ms Kate Russo: Talking resources for CALD communities**

Kate outlined the demographic uniqueness of the Shepparton area in Victoria and how it shapes immunisation implementation approaches in the area. In particular, it is a highly diverse population with respect to culture and language with 15% of the population culturally and linguistically diverse (CALD). She highlighted the importance of taking the time to know your community when tackling
immunisation delivery in such settings, for example engaging with local council, stakeholders and community to ensure the appropriate systems are in place and followed. Kate then demonstrated talking poster boards and talking books which were developed for the community. These talking resources provide short messages in multiple languages on the press of a button and were utilised by the council and also by GPs to engage with members of the CALD community.

Ms Kerry Finlay: Implementing the immunisation program across state borders

Kerry clarified the role of medical locals, and the challenges faced by the Hume Medicare Local of Albury/Wodonga which must deliver vaccines to those on the border of NSW and Victoria. The main challenges discussed were dealing with different vaccines, and different schedules, particularly with respect to short-term programs. She gave rotavirus vaccination as an example which was provided as a 3-dose course in Victoria but as a 2-dose course in NSW. Kerry also described the strategies that they have utilised to meet these challenges, particularly the importance of communication and developing strong relationships with all stakeholders. This has resulted in very high coverage over the years; however, Kerry highlighted that changes to availability of published local coverage reports means that utilising coverage data to congratulate high achievers and motivate those with low coverage will no longer be possible.

Dr Vicky Sheppeard: Measles outbreak: Shining the spotlight on pockets of under-immunisation

Vicky described in detail the epidemiology of the three most recent measles outbreaks in NSW; the first and largest in 1993, followed by two smaller outbreaks in 2006 and 2011–12. She highlighted that, in all of the outbreaks, measles was introduced by travellers and transmission was facilitated by pockets of the population who had less the optimum vaccine coverage, particularly within the CALD youth population. She suggested that, in response to this, it may be appropriate to target measles pre-travel vaccinations particularly to young adults and also catch-up vaccinations for CALD youths and young adults. Vicky also highlighted that resources should be developed for community and healthcare workers to help them identify and isolate measles cases to prevent further transmission in outbreak situations.

Session 3 – Monitoring and reporting of AEFI in practice

Associate Professor Kristine Macartney: Overview of Horvath review work

Kristine summarised the major findings of the Horvath review and focused on the recommendations stemming from the review, highlighting work completed to date in response to these recommendations. The recommendations and responses listed were

1. The governance of the vaccine safety system: to consider current arrangements, and make recommendations for an improved system of governance for safety monitoring – a new statutory Advisory Committee on the Safety of Vaccines (ACSOV) has been established to this effect.
2. Defining surveillance objectives and establishing protocols and procedures for managing AEFI – a Working Party of experts is developing standardised case definitions, and signal detection and investigation mechanisms.
3. Improving the national system for timely reporting of AEFI – a Working Group (incl. members from NIC and TGA) has been established, and agreed templates (a single form) for nationally consistent reporting of AEFI has been developed.
4. Raising community and health professional awareness of vaccine safety monitoring to ensure more complete reporting of AEFI – a communication plan is being developed, and examples of enhanced communication were given.
5. Nationally agreed protocols for program action and communication – a plan developed by DoHA aims to ensure a nationally consistent program response to a possible or confirmed vaccine safety signal arising from an unexpected or unwanted (adverse) event.
6. Transparency and the functions of the TGA to ensure better access to vaccine safety information for consumers and health professionals – resulting in the establishment of the DAEN (Database of Adverse Event Notifications).
7. Improved vaccine usage and safety monitoring data – for which a number of
initiatives to enhance current vaccine registries, data linkage projects and other solutions were highlighted.

Dr Richard Hill: Reporting and monitoring from a regulator perspective

Richard began his presentation highlighting the roles of the TGA, with specific reference to the systems in place for monitoring of AEFI. He noted that the majority of AEFI reports are provided by the pharmaceutical industry, whereas the majority of vaccine-related AEFI reports are provided by state/territory authorities. An apparent gap in the system is reporting by GPs.

By giving an overview of the data generated by the monitoring system, he noted that the rate of vaccine-related adverse events were comparable to other vaccines, but not all medicines (for which there are generally less AEFI reports), prohibiting their direct comparability. Richard added to Kristine’s presentation, highlighting the positive changes that have occurred following the Horvath review, such as improved information flow/reporting and improved transparency and communication – noting the TGA’s online report system. However there continues to be challenges (e.g. increasing number of vaccines, and AEFI following concomitant administration of multiple vaccines).

Professor Paul Effer: Reporting and monitoring from a state and territory perspective

Paul provided the audience with a background and overview to the Western Australia Vaccine Safety Surveillance (WAVSS) system. Utilising 290 AEFI reports received by the system in 2012, he outlined that dedicated staff follow-up on every report, and for serious events a follow-up clinic has been established. Data are routinely published online. A key pay-off of the system has been to provide evidence for vaccine safety, and the value of documenting a negative association is invaluable. Paul promoted the need for a national system (highlighting the successes of the US based system, VAERS), and that WA was willing to take this on when it comes in.
10th Edition of The Australian Immunisation Handbook now available

Recently, the Minister for Health, The Honorable Tanya Plibersek, launched the 10th edition of The Australian Immunisation Handbook. The 10th edition of the Handbook includes new recommendations on who should receive vaccines and when, as well as recommendations on the use of new vaccines available in Australia. *

Some of the new recommendations outlined in the 10th edition of the Handbook include those for protecting against pertussis (whooping cough) in very young babies and the elderly, immunising pregnant women against influenza and pertussis, providing HPV vaccines to males as well as females, and new guidelines on the management of exposures to rabies and bat lyssaviruses. The Handbook also contains the current and new (from July 1, 2013) National Immunisation Program Schedule.

The new Handbook is over 500 pages long and is the pre-eminent guideline on the use of immunisation in Australia. It is considered the ‘Immunisation Bible’ for all healthcare professionals who are involved in delivering important vaccines to protect the health of all Australians. The Handbook, which has been available online and has been sent to all healthcare professionals, has the stamp of approval of the National Health and Medical Research Council. More than 20 staff of the National Centre for Immunisation Research and Surveillance, worked tirelessly on preparing the 10th edition of the Handbook over the last 3 years, working closely with members of the Australian Technical Advisory Group on Immunisation (ATAGI), Australia’s key advisory group on immunisation. Chair of the ATAGI, Professor Terry Nolan of the University of Melbourne, School of Population Health, thanked the staff of NCIRS at the Handbook launch, as well as members of other important groups who advise on Immunisation, such as the National Immunisation Committee.

To help providers navigate through the new Handbook, NCIRS has provided a valuable “What’s new in the 10th edition Handbook” educational slide set on its website (http://www.ncirs.edu.au/index.php) A video highlighting what’s new on the Handbook will also be freely available on the website in late April.

RECENT PUBLICATIONS


McIntyre PB, Sintchenko V. The “how” of polymerase chain reaction testing for Bordetella pertussis depends on the “why” [editorial]. Clinical Infectious Diseases 2013;56:332-4.


RECENT MEETINGS HELD

Communicable Disease Control Conference 2013

This year the Communicable Diseases Network Australia’s 2-day Communicable Disease Control Conference occurred as a back-to-back meeting with the Australian Society for Infectious Diseases (ASID) Annual Scientific Meeting in Canberra. The co-located conferences shared a 1-day overlap, bringing together infectious disease specialists and public health practitioners to discuss communicable diseases, from the community to the hospital bedside.

A number of NCIRS staff presented at the CDC conference. Professor Peter McIntyre, NCIRS Director, was invited to give a plenary presentation on pertussis and to chair a session on vaccine preventable diseases. Other presentations by NCIRS staff included:

- Dr Clayton Chiu - Influenza hospitalisations in young Australian children during seasonal and pandemic periods
- Dr Aditi Dey - General practice encounters following seasonal influenza vaccination as a proxy measure of early-onset adverse reactions
- Dr Deepika Mahajan - Post-licensure surveillance of the human papillomavirus (HPV) vaccine in Australia, January 2007 – June 2012
- Dr Robert Menzies - Has the pneumococcal polysaccharide vaccine worked in elderly Australians?
- Mr Brett Archer - Meningococcal B disease in Australia: epidemiological review to inform vaccine policy
- Ms Alexis Pilsbury - The clinical setting is important for measles transmission: lessons from the 2012 outbreak in New South Wales
- Dr Helen Quinn - Effectiveness of preventing infant pertussis by ‘cocooning’ strategy: a NSW case-control study

Australian Immunisation Professionals Network

There are now around 650 Australian immunisation professionals subscribed to the NCIRS-AIP email discussion group. NCIRS-AIP is designed to facilitate communication between professionals involved in immunisation in Australia, whether at the level of research, policy development, or as immunisation providers.

NCIRS-AIP provides:
- A forum for questions and feedback
- Regular international updates on immunisation news, notifications of news items, publications and meetings of interest, and summaries and commentaries on recent papers presented and discussed at the NCIRS Immunisation Journal Club.
- An avenue for rapid information about media controversies.

NCIRS-AIP is intended to be an interactive forum for debate as well as serving as a source of reliable information. Posts and responses are encouraged from all members and, in the interests of open and rapid communication, discussion content is not screened before distribution to the group. Senior NCIRS staff keep a watching brief on messages posted to the group and provide additional information where it is thought to be useful.

If you are interested in subscribing to this group, please go to http://ncirs.edu.au/immunisation/professionals-network/index.php

NCIRS | 10
NEW STUDY

Trial to assess effectiveness of using face-masks among Hajj pilgrims

AN EXCITING NEW TRIAL ASSESSING THE EFFECTIVENESS OF FACE-MASKS TO PREVENT RESPIRATORY INFECTIONS AMONG HAJJ PILGRIMS IN MECCA, SAUDI ARABIA IS UNDERWAY.

Prepared by Dr Harunor Rashid

This year Professor Robert Booy and colleagues including Dr Elizabeth Haworth (of Oxford University), Dr Harunor Rashid and Dr Osamah Barasheed are planning to conduct a trial to assess the effectiveness of using face-masks in the prevention of syndromic and of laboratory-proven respiratory infections among Hajj pilgrims in Mecca, Saudi Arabia. In October 2013, about 2,500 Hajj pilgrims participating from 10 countries will be recruited in this trial. In preparation for this study, Professor Booy and colleagues recently met the Grand Mufti (Imam) of Australia Dr Ibrahim Abu Muhammed at his Sydney office, and subsequently visited Saudi Arabia to discuss the practical protocols with Professor Ziad Memish, Assistant Deputy Health Minister (preventive medicine) of Saudi Arabia.

The Grand Mufti expressed his full support to facilitate this study through his contacts with various community centres and GPs who look after the Hajj pilgrims.

Professor Booy and team were invited by the Ministry of Health, Saudi Arabia, to discuss the practical aspects of the trial at a panel discussion that took place in Riyadh on 10th and 11th March. Prof Booy and Osamah Barasheed presented the practical protocol and the recent Hajj data at the discussion. The Saudi Ministry of Health found this study to be ‘a very high priority research’ of their country and promised considerable support for this trial.

Professor Booy is going again to meet the senior officials of the Saudi Ministry of Health in Riyadh at the end of April to continue and broaden discussions.
This paper describes a Phase III, double-blind, multicentre randomised controlled trial which aims to assess the immunogenicity and safety of a quadrivalent inactivated influenza vaccine (QIV) in children. Presented by Dr Melina Georgousakis, Senior Research Officer, NCIRS

Although historically seasonal influenza vaccines contain three influenza strains (Influenza A/H1N1, Influenza A/H3N2 and Influenza B), in 2012 the World Health Organization recommended that an additional B strain be included so that both influenza B lineages are represented in seasonal vaccines. This is in response to the fact that in recent decades two influenza B lineages have been circulating (Yamagata and Victoria) and the lineage included in trivalent seasonal vaccines (TIV) is often mismatched to the lineage circulating that season. In this trial, children 3–17 years of age were randomised to receive either TIV containing a Yamagata influenza B strain; the same TIV containing a Victoria Influenza B strain or QIV containing the same influenza A strains as in the TIVs as well as influenza B strains representing both influenza B lineages.

There was also an open label group included in the study of young children 6–35 months who only received QIV. Blood was collected on day 0 (prior to vaccine administration) and 28 days after the last dose of vaccines. The antibody response to each influenza strain was measured using the haemagglutination-inhibition assay (HI). QIV was highly immunogenic with seroconversion rates of 91.4%, 72.3%, 70.0% and 72.5% against A/H1N1, A/H3N2, B/Victoria and B/Yamagata, respectively.

The immunogenicity of the QIV was non-inferior for the influenza strains shared between the TIV and QIV, and was superior for the alternative-lineage B strains only included in QIV. Review of solicited injection site and general adverse events 7 days post vaccination, and serious adverse events out to 6 months following vaccination, concluded that the reactogenicity and safety of QIV was consistent with TIV.

Proportions of study participants reporting adverse events were greater for youngest study participants (6–35 months) than for older participants (3–17 years).
5 minutes with Hal Willaby

Hal recently joined NCIRS and is working in the Social Research Unit with Associate Professor Julie Leask. He has spent the last few years completing a PhD in psychology at the University of Sydney, and working with doctors and nurses to improve healthcare provider–patient decision making.

1. WHAT DOES YOUR ROLE AT NCIRS ENTAIL?
Generally speaking, I investigate the psychosocial barriers to vaccine uptake, and then think about the best ways to reduce those barriers. Right now, I’m working hard with Julie Leask to get a comprehensive overview of the many factors that impact on parents’ vaccination decisions, so that we can measure those to determine which – or which set – are the most influential. These will then inform the ‘Vaccination Communication Framework’ which is being developed to help GPs more effectively speak to reluctant parents about their concerns and fears relating to vaccination.

2. WHAT ISSUES IN IMMUNISATION CONCERN YOU THE MOST?
As a cognitive psychologist, I think a lot about how people make decisions involving risk and probability, and in particular how people get decisions wrong, and what can be done to help them make better decisions. It’s an oversimplification, but I see the world as being full of people that could improve their lives by improving their decisions. The thought that parents’ misinformed decisions can lead to sick kids (and worse) really motivates.

3. WHAT IS THE MOST ENJOYABLE PART OF YOUR ROLE AT NCIRS?
I work with a lot of really clever people, who are really well trained, and who have a lot of responsibility (and drive) to make a real difference in Australia.

4. DESCRIBE YOURSELF IN THREE WORDS…

5. WHAT WOULD YOU SPEND YOUR LAST $5 ON...
A really cold Coopers.

6. YOUR IDEA OF HAPPINESS IS…
Listening to my 3-year-old daughter laugh.

7. IF YOU COULD INVITE THREE PEOPLE OVER FOR DINNER, WHO WOULD THEY BE?
David Attenborough, John Stewart, Neil Armstrong

8. IF YOU COULD HAVE ANY SUPERPOWER, WHAT WOULD IT BE AND WHY?
Batman. Such cool toys.

9. DO YOU HAVE ANY HIDDEN TALENTS?
Yes!

10. IF YOU WEREN’T WORKING AT NCIRS YOU WOULD BE…
Doing something else that applies cognitive psychology to health/public policy. Or maybe travelling...

DATES FOR YOUR DIARY
COMING SOON

Vaccines in Public Health Workshop to be held on 21st and 22nd August 2013 at The Children’s Hospital at Westmead. This course is an elective within the Master of Public Health and Master of International Public Health programs at The University of Sydney. It is also available to any health professional interested in vaccines and public health. For more information on the content of the workshop please contact Dr Aditi Dey (aditi.dey@health.nsw.gov.au) or for administrative enquiries contact (nicole.jacobs@health.nsw.gov.au) or on 02 9845 1401.
World Immunisation Week

World Immunization Week, was recently held on the week beginning 20 April. This important event aimed to promote one of the world’s most powerful tools for health – the use of vaccines to protect, or “immunise”, people of all ages against disease.

Prepared by Danielle Grant

Under the global slogan “Protect your world – get vaccinated”, WHO encourages individuals and organisations (like the National Centre for Immunisation Research) to coordinate and engage in activities during World Immunisation Week.

As many of our staff were dedicated to other crucial projects and being the flu season, we decided as a Centre to focus our efforts on promoting World Immunisation Week on one day - Wednesday 24 April, 2013 at The Children’s Hospital at Westmead.

With the dedicated help of the local Public Health Unit, we were fortunate for them to bring along valuable resources in educating and informing parents about vaccines. NCIRS were able to promote the new campaign by NSW Health “Don’t be late, vaccinate” and brochures were available in over five various languages.

Staff were also able to assist parents with checking if their children were up to date and the team were able to provide advice to parents who had questions relating to the flu vaccines for children.

Flu vaccinations at Bondi!

Our very own Immunisation Nurse Ms Kath Cannings recently featured in the MX Newspaper when she travelled all the way to Bondi Beach to give a group of Bondi Surf Life Savers their flu vaccinations.

From left to right: Alexa Connors, Jean Paul Buhagiar, Robert Cunningham, Julia Jansen and Jimmie Lindstrom with our nurse Kath Cannings pictured in the centre.

Picture courtesy of Chris Pavlich.