

Immunisation: Communication and Perception of Risk

Summary of a workshop held in Melbourne, Australia
15 May 2002

Alison Williams and Jill Forrest, Editors

Immunisation has vastly reduced the burden of infectious diseases but, as with any medical intervention, it carries a small risk of side effects. This workshop, a joint initiative of the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases (NCIRS) and the Department of Health and Ageing, was convened to discuss how best to communicate information about risks and benefits. It was attended by public health professionals, providers, consumers, journalists and government representatives.



**NCIRS National Centre for Immunisation Research and
Surveillance of Vaccine Preventable Diseases**
Locked Bag 4001, Westmead NSW 2145
www.ncirs.usyd.edu.au

© NCIRS 2003

ISBN 1 86487 575 5

Speakers

Lyndal Bond

Centre for Adolescent Health, Royal Children's Hospital, Melbourne

Margaret Burgess

NCIRS

Bruce Gellin

National Network for Immunisation Information, USA

Julie Leask

NCIRS

Peter McIntyre

NCIRS

Kay McNiece

Media Unit, Department of Health and Ageing

Sue Page

Northern Rivers Division of General Practice

Sophie Scott

ABC Television

Meredith Ward

Parent

Jacqui Worsley

Research and Marketing Group, Department of Health and Ageing

Attitudes toward immunisation: perspectives from the USA

Dr **Bruce Gellin**, a public health physician, Executive Director of the National Network for Immunization Information (www.immunizationinfo.org), and currently Director of the US National Vaccine Program Office, discussed perspectives and current attitudes towards vaccination in North America, and their implications for risk communication.

Media influences in the new age of consumerism

A photograph of a ward of children in ‘iron lungs’ following an epidemic of polio, taken earlier last century, is a visual reminder of a disease long-forgotten in developed countries. But recent cover stories in popular magazines such as *Newsweek* question the safety of childhood immunisation. Although many people value vaccines, and coverage is at an all-time high in the USA, the perceived risk of a child acquiring such a disease is now so low that people worry more about possible side effects of the vaccine, rather than the disease it prevents. In the new Age of Consumerism we can no longer say: “We are the experts, we know what is good for you, do it”.

Providers and public health workers face the challenge of conveying the importance of vaccination programs to a population in developed countries which is healthy (partly as a result of the vaccination-induced decline of vaccine preventable diseases) in a social climate where risks are less tolerated than in the past.

The ‘science’ of decision-making

Visual Media images are often emotive, and people generally remember what they see. Such powerful images can magnify even minute risks out of proportion. People tend not to remember declining epidemiological curves of vaccine-preventable diseases; rather, they form value judgements about immunisation risks, and their decisions about vaccinating their children are not usually based on facts alone. “The art of practical decision-making comes from intuitions that are more unconscious than analytical and in great emergencies, the man of affairs feels his conclusions first and understands them later.”¹ So challenging beliefs about vaccination purely with ‘science’ (by quantifying the large benefits and small risks of vaccination) is often not enough. Trust and credibility of the source are important — who delivers the message, and in what manner.

Effective risk communication involves understanding what people need to know, what they currently know, and what their perspective is, then working backwards and ‘filling in the gaps’. Many people have never thought about immunisation until confronted by a Media story that raises a question about vaccines. We need to understand who our audiences are, and their sources of information on immunisation. Health carers must be informed about vaccination issues, otherwise patients may seek other (possibly less accurate) sources of information.

Risk communication strategies

At a population level the process of risk communication includes: (a) identifying the audience and their concerns; (b) assessing key messages the audience seek; (c) performing formative research; and (d) testing some of these messages and seeing what works best. Once established, key messages should be distributed and evaluated. In vaccine risk communication the process is essentially the same, except that new issues frequently arise (such as the suggested links between MMR vaccine and autism, Hib vaccine and diabetes, etc). We need to be tuned-in to emerging concerns, and prepared to respond in an open and honest fashion.

Provider attitudes

The ‘audience’ is not restricted to consumers and parents, it also includes health professionals.

A recent survey indicated a degree of concern about vaccine safety among providers, as well as some differences in beliefs between provider types. A 1999 Canadian study² showed that 88% of paediatricians and family physicians and 57% of nurses agreed that: “in general, the vaccines that are recommended for

use in infants are safe". When asked whether vaccines were effective, 88% of doctors but only 52% of nurses said yes. It is important to understand how such beliefs might affect how providers communicate the risks of vaccination to parents.

What do parents do when their doctor cannot resolve their questions and concerns? Do they opt out, find a new doctor, or delay vaccination? What other sources of information do they seek out? An unpublished CDC study showed they most often looked first to the family doctor for information, second to a family member, and third to a friend with medical or nursing training. The Internet and magazines/ books were next on the list.

How can we empower parents to ask providers about issues which concern them, and encourage open dialogue in a time-efficient manner, taking into account pre-existing ethnic, cultural and racial differences in knowledge and attitudes?

Optimising time

Tools to help maximise information-giving during a consultation may include a waiting room poster listing questions parents might wish to ask the doctor about vaccination, to prompt discussion with the provider. Another memory aid (CURES) (*see below*) is designed to facilitate dialogue, encompassing questions a provider might ask a parent.

- Do you have any **C**ultural, religious, or personal beliefs that affect your view of immunisation?
- Has your child or any child you know ever had a serious **R**Eaction to a vaccine?
- Do you have any specific concerns about the **S**afety of any vaccine?



References

1. Walter Lipman, 1889-1974.
2. Dionne M, Bouilanne N, Duval B, et al. Manque de conviction face a la vaccination chez certains vacinateurs quebecois. *Revue Canadienne de Sante Publique* 2001; 92: 100-104.

Perceptions of risk

Julie Leask, a social researcher at NCIRS, spoke about risk communication.

Ms Leask gave a brief background of the evolution of risk communication, an area which has developed over the past 20 years through a need to improve how the government and industries respond to mass public outrage about environmental health risks. For example, the Three Mile Island nuclear accident in 1979 in Pennsylvania was a major event that triggered interest in risk communication, and its principles are now being applied to other areas such as immunisation.

Next, she highlighted the need to understand how people perceive risks, quoting from the *Sydney Morning Herald*: “the risks that kill you aren’t necessarily the ones that frighten you”. That is, people’s responses to health risks violate expectations based on probability. Another example was an anecdote about people’s behaviour when the movie *Jaws* was showing in the USA. People swimming at the beach would hear the shark alarm, and because of a greater sensitivity to sharks at the time, would run out of the water, jump in their cars and speed away without any seat belts on. Such contradictions in responses to health risk are of interest in understanding risk perception.

Risks are tolerated to a different degree, depending on a number of factors.

- First, risks are in general less tolerated if they are imposed on people. When people feel they have no choice, they are less likely to accept a risk. For example, some parents have expressed anger that they do not have the choice to give their child MMR vaccine as separate antigens.
- Second, risks might not be equally distributed. For example, rubella vaccine carries very small risks for all the children who receive it, yet the benefits are largely for unborn children. In other words, those who bear the risk don’t necessarily benefit most from the vaccination.
- Third, risks are less well tolerated if the agent posing them is man-made, rather than natural. So when people talk about vaccines as toxic chemical cocktails which interfere with the body’s natural defence systems, this appeals to that fear.
- Finally, people are less likely to accept risk if the outcome is particularly dreaded (eg, intellectual handicap).

Risk communication is the exchange of information about health or environmental risks between interested parties, and it links to risk perception in that we need to understand where other people are coming from in order to communicate with them. It takes us from a top-down approach, where experts impart information to the public, to an exchange of information and perspectives. The stakeholders here include not only the Government and the public, but also providers, parents, journalists, public health workers, epidemiologists, those from the pharmaceutical industry and those from the Anti-Vaccination Lobby. Involving stakeholders means more than just having a consumer representative on your committee: it also means researching the needs and values of parents, and there is an ongoing need for this in the Australian context.

There are two other important factors in risk communication: first, **trust**; a very precious commodity which is easy to lose and very hard to win back, as we have seen in the United Kingdom after the BSE (‘mad cow’) affair; second, **openness**. There is a real fear that if you tell the public about risk they will avoid it altogether. Sometimes that may be the case, but generally being open is an investment in trust. People do not like a ‘cover-up’. It is very important that people feel they are being told everything.

Finally, the risk messages themselves need to relate to the needs and values of your audience. The information itself must be clear, brief and couched in plain language. Acknowledging uncertainty again maintains trust and credibility. When you compare risks, use caution. A risk comparison is something like saying: “your child has a smaller chance of having a serious vaccine reaction than of being hit by a bus”. Although such comparisons can be helpful, they can appear to trivialise peoples’ concerns. So it may be better to try to compare like with like. For example, “Immunisation is like putting your children in car seats. You might not be able to get them out quickly in a car fire, but that protection is worth the risk”.

How to communicate risk

- Allow parents to feel empowered to ask questions.
- Identify the nature and depth of individuals' concerns about vaccination.
- Establish their current beliefs and identify what further information they need.
- Tailor the amount of information to the individual's needs, try not to overload.
- Be tuned-in to emerging concerns about vaccination, and be prepared to respond to each of them as they arise, in an open and honest fashion.
- Remember that 'science' (facts alone) may not be enough, source credibility is also important.
- Remember, the family doctor remains the most frequently sought source of information on immunisation.

A parent's perspectives and 'choice'

Meredith Ward spoke of her experiences as a mother of two sons aged 6 and 4. The older son was diagnosed with autism at the age of 2 years and also has an intellectual disability; the younger has borderline language disorder with challenging behaviours. She is a full-time mother and works as a volunteer committee member and media liaison officer for various organisations. She also works as an advocate for improving the availability of early childhood intervention services, school support and other issues for families living with autism.

Meredith had her first son vaccinated because she herself had been vaccinated, and she had grown up in a culture which believed that immunisation was important and necessary to protect her own children's health, as well as being an important step in the prevention of the spread of diseases. She has heard most of the stories that blame vaccines: the possible link between MMR and autism; the preservative in the vaccines causing developmental problems; claims that vaccines are 'dirty', and that they overload the immune system. As a parent within the autism community, she has been exposed to these concerns as well.

However, she does not think that vaccines have affected her sons' abilities to develop. Her earliest recollection of any Media discussion of the possible link between autism and vaccinations came about a year after her first son was diagnosed. In her opinion, her son's developmental abilities were there when he was born and not something that happened later. She does not believe that MMR caused his autism. She believes that he was different from birth, that there were signs from the very beginning. Recently, Meredith rang her paediatrician's office to check the onset of one of the symptoms she first noticed (when she held her older son he would go very stiff and straight, hold his arms straight out and throw his head back and begin to cry). This first occurred when he was 4 months old.

Meredith and her husband then had to decide whether or not to vaccinate their second son, who was approaching the age when a booster MMR vaccination was indicated. In spite of the fact that they had one child who was autistic, they decided to go ahead and vaccinate him. This decision was not made easily. Her husband, in particular, wasn't quite sure about it because of all the Media attention in recent years, so they considered their options carefully. When it came to giving the MMR booster to their older autistic son they learned through the clinic at the Royal Children's Hospital Melbourne that they could have a blood test to see if he was adequately immune to MMR as a result of the first MMR vaccine he had had at 12 months of age. This showed that he only required rubella to be given, hence he did not need the booster.

Meredith indicated that most parents she knows are pro-immunisation, but some are suspicious about the link between MMR and autism. On the other hand she knows of some families who are convinced that their child was normal before receiving the MMR vaccine. She thinks that often such parents are grieving and looking for an answer and somebody to blame. There are many other theories ‘out there’. She has heard various speakers, and listened to all sorts of other theories, about “it could be diet” or “it’s immunisation” or it’s all of these things, and thinks that unfortunately parents of children with disabilities can become victims of people who have some theory in mind. She acknowledged that it can be very difficult to sort through all this information when you are a grieving parent.

She also described anger in the community, because of issues of ‘choice’, which has been removed in relation to giving individual components of the MMR vaccine separately. Some people say they do it in the United Kingdom, so why can’t we have separate immunisations in Australia? Some parents think that the drug companies are protecting their own interests, that nobody really has the child’s best interests at heart, or that it is a conspiracy.

In spite of her experiences as a mother of an autistic child, Meredith concluded that the decision to immunise her children was easy to make, and that it was an informed decision based on knowledge of the risks. She believes it was the right thing to do.

Providers at the coal face

The next speaker was Dr **Sue Page**, a general practitioner based in the Northern Rivers region of New South Wales, a part of the country which has a large alternative lifestyle community. She is actively involved in the Northern Rivers Division of General Practice and is NSW President of the Rural Doctors Association.

Dr Page opened her presentation with an anecdote about a patient who had delayed cardiac investigations because of a sticky note on her request form. The note had a Viagra logo in the bottom corner, which stated “warning, talk to your doctor”. The patient did not have her cardiac investigation, because she thought that warning meant she needed to return to talk to her GP first. This illustrated the idea that things which we as health-care professionals assume everyone understands, because they are so common to us, may be completely misinterpreted by patients.

She also told of a mother who chose not to have her children vaccinated and was coming in to sign the conscientious objector form. It transpired that this was because the mother had had tetanus as a child and “nearly died of it” — so there was “no way she was going to give a tetanus needle to her kids” in case they got tetanus from it too.

In spite of such misunderstandings, the main reason that people are not immunised in Australia is limited access. Conscientious objectors make up only about 3% of the Australian population. National and international research shows that very often the leaders of anti-vaccination organisations have had a child with an adverse reaction to immunisation. They have a basic distrust of conventional medical sources, usually as a result of a bad experience with them, and as a consequence seek alternative health care. They are also quite against any form of infringement of civil liberties; they make emotional appeals, and are very effective at influencing the communities in which they live.

It is important to recognise that the vast majority of parents who refuse immunisation of their child are not conscientious objectors. The first step is to understand the reason for their concerns, and not to take a defensive stance. Always ask “What particularly worries you?” Sometimes these worries are easy to address, at other times they require an explanation of how data can be misinterpreted.

To help explain how an association may not necessarily be a causal one, Dr Page gave an example of a study at a primary school which looked at what makes it easier for children to spell. This study found that children with bigger feet could spell better than those with smaller feet — an interesting finding which was reproduced in other primary schools and which held true in all primary schools in Australia. Indeed, children with bigger feet did spell better — because they were older. Understanding that statistics on their own are not trustworthy helps parents become more critical of anti-vaccination literature.

Finally, Dr Page discussed the role of written material on immunisation, and the importance of having it available when a parent requests it. She also emphasised the importance of being prepared to answer issues as they arise in the Media, and discussed some of the myths related to immunisation. These are also covered in the publication *Myths and Realities* (http://immunise.health.gov.au/myths_2.pdf). Additional information on immunisation is available on the web site for Northern Rivers Division of GP (available at <http://www.nrdgp.org.au>) and the new web site <http://www.vaccination.org.au>.

What doesn't take time but works in the patient-provider encounter?

- “Our records show...as not being vaccinated, is that correct?”
- “I agree it’s your choice, but do you mind me asking why you decided that?”
- “What particularly worries you?”
- “Yes, that would worry me too, and that’s why it is so reassuring the research shows the opposite...”

Communication in the public arena

Sophie Scott, a medical journalist, presented some of her experiences with Media stories on immunisation.

She began by showing video clips of a sample of immunisation stories she had covered in the past. These stories were aired because they satisfied a number of different criteria that journalists need to consider — they contained:

- topics of interest to the audience (because vaccination involves children, parents are always going to want to hear about it);
- something new (a new vaccine);
- a ‘good news’ message.

Sophie believes that medical reporting is an area where people look for good news, for stories that are uplifting and offer some hope about the future.

Presentation of stories relating to possible side effects of immunisation is more complex. This issue, as well as the issue of public interest and immunisation, was discussed in the context of research on MMR vaccine and autism, first published in *The Lancet* several years ago. Broadcasters in Australia had to weigh up the public’s right to know about the research against the potential damage in running the story — whether parents might see the story and decide not to get their children immunised.

Journalists need to be aware of the potential impact of the message they give, particularly if the story involves possible adverse effects of immunisation. Presenting a balanced message can be very challenging, as people often do not hear the full message of the story — they often come away with only the negative message. In the end, the broadcaster decided not to run the story, because it was only one piece of research which had not been replicated anywhere else in the world and which was not supported by doctors in Australia. The story has been aired on other channels in Australia since.

Finally, Sophie presented ‘tips’ for those who may be interviewed by the Media on immunisation-related issues. She recognised the fact that sometimes medical people find it difficult to summarise issues and to express themselves in a non-scientific and succinct way. Journalists, on the other hand, are looking for a short sharp sound bite, summing up the issues. It is important, when being asked for an interview, to ask:

“What program is it for?” That will make a big difference in how you respond. An in-depth interview for *The 7.30 Report* or *Four Corners* will be very different to a five-minute interview with a TV or radio news reporter. Also ask if it is live or taped. With the latter, it is always possible to do the take again to get your message across.

Media liaison

Ms **Kay McNiece**, from the Media Unit of the Commonwealth Department of Health and Ageing, presented the Media’s view.

“In 1996 Health Minister Michael Wooldridge implemented the 7-point plan “*Immunise Australia*”. This incorporated the States and Territories and included: old and new vaccination programs; new vaccines; incentives to doctors, immunisation providers and parents; and huge public awareness campaigns. Australia’s ambitious mass Measles Control Campaign was also included.”

“In terms of Media, we were originally running with the fact that young mothers hadn’t seen the old diseases; mainstream and health Media were keen to run the story. We always had a child or parent who would say how sick their child had been, and if only that child had been immunised. There was huge response. Research done before the public awareness campaigns told us that about 98% of parents agreed with immunisation, they just didn’t get around to doing it.”

“However, very soon the anti-immunisation lobby came along, mainly in the name of the Australian Vaccination Network, which sounded very like an immunisation group. Its main spokesperson then was a doctor (of micropaleontology). The Network claimed that putting viruses into a child to induce an immune reaction was dangerous, life-threatening, unnatural. They claimed that measles had been dying out in Europe and had only started coming back when vaccination became popular, and in fact measles had been cured in Britain because of good nutrition programs; and other things like “it took us 3 years of research before we looked at each other and said Vaccines are what are killing our children”. Initially these claims were extreme and pretty easy to refute in the Media, but there were more enduring accusations, like MMR vaccination at 18 months being responsible for autism, which is often diagnosed at 18 months. Andrew Wakefield’s research was unsubstantiated, he even said himself he could not establish a causal link. But if you run the story, even if you give both sides of it, people are going to be really frightened.”

“We found that you needed a balance in responding to the anti-immunisation lobby. They were in local areas, newspapers and radio stations, spread throughout Australia. If we replied to a very small Letter to the Editor in a local newspaper, was that giving an unfounded accusation more publicity? Sometimes we absolutely had to engage them. You might remember the *Quantum* series. The stories got worse every week, so we needed a coordinated national response in the States and Territories, Media units and myself, with people like Margaret Burgess as National spokesperson. We had to organise to counteract the accusations and quite wild stories that we saw in that program. We actually rang the producer and complained about that program.”

“Ever since then we have been organised before a program, with fact sheets, literature, and information handouts for spokespeople, Media members and the public. We have to be organised, while balancing whether or not we over-react. When there is a damaging story, immunisation rates are at risk of going down again. It’s hard enough to take your child to be immunised at the best of times, but if you have at the back of your mind there may be some risk, it’s often easier not to take the action.”

“The other challenges for public relations people are new drugs and vaccines. A newly licensed vaccine is obviously effective, so why isn’t it on the free list or the immunisation schedule. It’s hard to explain to journalists that this is an independent process that has to be gone through. The meningococcal C vaccine is a good example; we spend quite a lot of time explaining to journalists that meningitis C is not the main strain of meningococcal infection in Australia, as in Britain.”

“When Wooldridge left, immunisation coverage had risen from 53% to 90%. The whole Australian community is touched by the immunisation message — grandparents, sisters, aunts, uncles understand the need to keep immunisation rates up. There is no room for complacency, the anti-immunisation lobby is still

there and we will always have to decide how to balance over-reacting with letting a story run. Parents need factual information, they need to understand that vaccines are not 100% safe. We must be as open as possible, and remember that the first place the public will go for information is their GPs. We must give them proper resources and keep them informed.”

Campaign planning

Ms **Jacqui Worsley** is head of the Research and Marketing Unit of the Commonwealth Department of Health and Ageing. She discussed campaign planning in the context of the Measles Control Campaign (MCC) of 1998.

The MCC was initiated as the first phase of the commitment to the eradication of measles, with the aim of increasing to at least 95% the proportion of 5-12 year old children who had received their second dose of MMR (measles-mumps-rubella) vaccine. This was to be achieved by raising awareness of the second dose of MMR vaccine, by making parents aware of the proposed Campaign for the school-based immunisation program (which required consent), and by increasing and reinforcing positive attitudes to school-based immunisation.

Research conducted before the Campaign confirmed that parents of 5-12 year olds were receptive to school-based programs, and that they accepted the seriousness of measles. However, they had little awareness and some confusion about the second dose of MMR vaccine. This research also identified the need for further information about the reason for the change in the schedule, and the needs of immunisation providers. Parents wished to know more about the logistics of the program and about alternatives, such as taking their child to the family doctor if they did not wish their child to be immunised at school.

Creative development research was then undertaken with a total of 14 groups of parents of primary school aged children, to confirm that the correct messages were being taken away from the TV advertising, information packs and booklets. This research also confirmed that the revised consent form was easily understood by parents. The information pack and booklet were revised in line with feedback from this qualitative research.

The National Campaign was launched in July 1998, with a full-page newspaper advertisement in metropolitan and non-metropolitan newspapers. There was also an Internet site, a telephone information line and a strategy for those of non-English speaking background. This stage of the Campaign was to increase parents' awareness about it, and to alert them to the fact that the information pack would be coming home.

The second stage was a reminder TV commercial which ran for the third week and finished with another newspaper advertisement. This was intended to alert parents that they needed to sign the consent form and return it to school.

The vaccination programs took place between August and November 1998 and were followed with a final TV commercial called 'Catch-up'. This signalled that, if your children had missed out on their vaccination, they could visit their GP or health clinic. In addition, immunisation providers and schools were provided with relevant information.

Daily continuous tracking was conducted over the five weeks of the Campaign. This involved 70 telephone interviews per night over four weeks and a final week of 210 interviews, resulting in 2184 interviews. The main role of the daily continuous tracking was to act as a risk management strategy: to identify negative reactions after the launch, and to react to them quickly. The daily tracking showed that there was increased knowledge about the Campaign over time. For example, the proportion of parents who reported that the age for the measles vaccination was changing rose from 14% at benchmark to 80%. The proportion who said that the second measles vaccine was being offered to all primary school students rose from 15% to 91%, and the proportion who acknowledged that the consent form needed to be signed for children to participate rose from 33% to 97% by week 4.

To measure behaviour in relation to the MCC, respondents were asked whether they had read the information pack, signed the consent form and returned the form to school. By the final week of tracking, 82% of parents reported that they had read the information pack, 73% had signed the consent form and 70% had returned the form to school. Of those who read the information pack, 92% rated it as informative and 60% as very informative.

The final outcome survey, conducted in November 1998, found that 4.5% of children had received their second dose before the Campaign, 79% of children had been immunised at school, and 11% had been immunised elsewhere during the Campaign, giving an overall coverage rate of 94%. A subsequent national serological study, conducted by the National Centre for Immunisation Research and Surveillance, confirmed these results. Further, 96% of parents who had had their child or children immunised as part of the Measles Control Campaign reported that they were satisfied with the Campaign (64% were very satisfied), and 94% of school principals said they would be very likely to support future school-based vaccination programs.

The Report of Australia's Measles Control Campaign is available at:
<http://immunise.health.gov.au/beatmeasles.pdf>

Responding to anti-vaccination lobbyists

The final speaker was Associate Professor **Peter McIntyre**, Deputy Director of the NCIRS.

Professor McIntyre has taken an interest over the years in several vocal opponents of immunisation, and distilled some of his experiences with them. He showed a video of one presenting arguments against vaccination. This person was billed as having taken a very careful and comprehensive look at the medical literature about childhood vaccination (with the implication that those who are pro-immunisation, particularly doctors, haven't taken the trouble to do this). The arguments focussed on convincing the audience that vaccination has had nothing to do with the decreased rates of infections such as diphtheria and *Haemophilus influenzae* disease. Professor McIntyre highlighted some of the problems with these arguments.

He also discussed the role of some health professionals who occasionally feel they have 'seen the light' and believe that their colleagues have been concealing important facts about the risks of immunisation for years and then feel compelled to draw attention to them.

In public fora, there is often an over-representation of people who have alternative views of health, who are unfavourably disposed to pro-vaccination arguments. Such people might be quite receptive to assertions such as those mentioned above, and might see their protagonist as something of a champion. The attitude of a 'conventional' health professional in this kind of public forum ("Well, I know more facts than you") can seem rather arrogant and out of touch with what the real issues are.

With lay audiences, the arguments of anti-vaccination proponents appeal to universal themes, and they seem very concerned about the overall well-being of children — in contrast, medical professionals may appear to be scientifically arrogant. However, a potential Achilles' heel of opponents to vaccination is that some never actually acknowledge that immunisation has ever done any good for anybody.

Summary

Dr **Lyndal Bond** summarised some of the points of interest arising during the day's discussions.

- First, it is important not to see parents with concerns about immunisation as enemies and anti-immunisers.
- Second, having a trusting open relationship with your clients is a crucial factor in risk communication, as is the importance of asking parents: "What particularly worries you?"
- Third, immunisation providers need to be updated on the changes occurring in the schedule and immunisation recommendations. Health providers are not always as pro-immunisation as we think they are. They are often asked to defend their point of view as an immuniser, and when they are threatened by the unfamiliar, they may feel on 'shaky ground'.

Key points from the workshop

1. Vaccine-preventable diseases are now "out of sight, out of mind" in developed countries such as the USA and Australia. Thus the small risks associated with vaccination are seen by many to outweigh the benefits.
2. Responding to concerns about vaccine safety with pure scientific evidence may not be enough, as the information from which such concerns arise is often very emotive and powerful and can overwhelm the facts.
3. Parents may be reluctant to immunise their child for various reasons; however, most are not true conscientious objectors. Providers should try to address parents' concerns in an open non-defensive manner. It is important to foster trust in the provider-parent relationship.
4. Keep providers informed of changes to vaccination schedules and of current issues about immunisation.
5. At a public health level, be prepared to respond to controversies as they arise in the Media. Be organised and have networks in place so that information can be rapidly disseminated to providers and public health workers.
6. Recognise that there will be a small percentage of the population (about 3% in Australia) who will choose not to immunise their children, in spite of the scientific evidence about the benefits of immunisation.