Exploring communication strategies to use with parents on childhood immunisation

Parents are often uncertain about the risks and benefits of immunisation. Effective delivery of information can help encourage uptake in children and young people.

BACKGROUND
Childhood immunisation uptake is generally high in the UK. The majority (92%) of babies have received a primary course of the “five in one” DTap/IPV/Hib vaccine by 12 months (The NHS Information Centre for Health and Social Care, 2008). This protects against five diseases: diphtheria – D; tetanus – T; pertussis – P; polio (IPV – inactivated polio vaccine) and Hib (Haemophilus influenzae type b).

However, rates in some primary care trusts are low, with variation within districts reflecting inequalities in uptake (Cummins et al, 2004).

MAIN ISSUES
Improving access to immunisation services

The National Institute for Health and Clinical Excellence (2009) guidance suggested that some groups have poor access to immunisation services and children remain under vaccinated. It recommended ways in which access to these services could be improved. These include:

- Extending clinic times;
- Ensuring clinics are child and family friendly;
- Extending the availability of appointments for immunisation;
- Offering home visits where appropriate.

PRACTICE POINTS

- Primary care trusts seeking to improve access to immunisation services need to ensure frontline staff undertaking targeted home visiting have the necessary knowledge and skills to communicate with parents.
- Healthcare professionals carrying out immunisation consultations with parents need to continue to improve their understanding of the evidence base behind recommended vaccinations.
- They also need to reflect on how they deliver immunisation information in their practice. Is it done in a paternalistic way or does it encourage uptake? Is it done in a paternalistic way or does it encourage uptake?


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While childhood immunisations are voluntary in the UK, healthcare staff strongly encourage uptake; this is endorsed by the Department of Health. While a few parents refuse immunisation outright, many more are uncertain about the risks and benefits.

This uncertainty was exacerbated during the controversy over the mumps, measles and rubella vaccine. This prompted many studies exploring parents’ views, which reported considerable criticism of the approach of healthcare professionals.

The National Institute for Health and Clinical Excellence (2009) published guidance on reducing differences in uptake. Six key areas were identified for improvement: immunisation programmes; information systems; training; the contribution of nurseries, schools and colleges; targeting groups at risk of not being fully immunised; and hepatitis B immunisation for babies.

This article examines the literature on healthcare professionals’ views about the universal childhood immunisation programme and information for parents. It also highlights issues around improving access and information delivery.
The limited research on home visits suggests that other factors need to be considered when introducing or evaluating the effectiveness of this service.

An international systematic review evaluating the effectiveness of home visiting programmes on the uptake of childhood immunisations identified several papers detailing various home visiting programmes by health visitors, community mothers (that is, non-professionals), public health nurses and other professionals (Kendrick et al, 2000). The combined results found that these programmes had no effect on the uptake of immunisation.

However, the programmes were likely to have been conducted in the wake of the MMR controversy, when concern about vaccination was high and parental confidence in healthcare professionals’ intervention may have been low. Furthermore, offering targeted home visiting conflicts with some healthcare professionals’ beliefs so may not always have been delivered with conviction.

A recent UK qualitative study among 22 health visitors explored their perceptions of their role regarding immunisation (Redsell et al, 2010). The results revealed that, while some administered vaccines to children on their caseloads and supported the view that they were helping families to access services by immunising at home, others felt that parents failed to attend immunisation appointments because of other priorities. In this case, immunising at home took the responsibility of attendance away from parents, thereby giving them permission to miss appointments.

A few health visitors felt that if families did not attend repeated immunisation appointments, this indicated they did not want their child to have them, a view which should be respected. Some parents who were uncertain about immunisation did not accept the risks posed by either accepting or explicitly refusing; rather they decide to opt for a kind of indeterminate state where they were fully committed to neither vaccination nor non-vaccination.

Serpell and Green (2006) suggested that, in making this compromise, parents aim to reduce the risks involved in either decision. However, they also pointed out that, in reality, these parents are making a decision not to have immunisations by omission. Non-attendance for appointments may be a way in which these parents covertly refuse immunisation without entering into the debate. Home visiting to discuss the issue may be effective for such parents who feel more comfortable at home territory.

Improving healthcare professionals’ knowledge and skills

A paper by Andrew Wakefield and colleagues, published in 1998 and interpreted as suggesting a causative link between the MMR vaccine and autism, sparked concern over vaccine safety and escalated into a major public controversy. Uptake of the vaccine fell to a record low, sparked concern over vaccine safety and escalated into a major public controversy.

Uptake of the vaccine fell to a record low, demonstrating the negative impact that media reporting can have on parental decision making. Parents of both unvaccinated children (Sporon and Francis, 2001) and vaccinated children expressed concerns about vaccine safety (Salmon et al, 2005; Raithatha et al, 2003; Evans et al, 2001). They criticised the information they received about the vaccination from healthcare staff, suggesting it was of poor quality and biased in favour of immunisation (Smalibegovic et al, 2003; Evans et al, 2001, 2001). They criticised the information they received about the vaccination from healthcare staff, suggesting it was of poor quality and biased in favour of immunisation (Smalibegovic et al, 2003; Evans et al, 2001).

In a more recent investigation, health visitors thought the MMR situation was recovering (Redsell et al, 2010). Smith et al (2007) also reported an increase in the proportion of parents who considered MMR to be completely safe or to carry only a slight risk. However, the current MMR immunisation rate of 85% remains lower than the peak coverage of 92% achieved in 1995-96 (The NHS Information Centre for Health and Social Care, 2008; 2005).

Much of the research on healthcare professionals’ knowledge and skills around immunisation information delivery emerged in the years after the MMR crisis. Petrovic et al (2001) conducted a survey on the second dose of the MMR vaccine among healthcare staff (health visitors n=148, practice nurses n=239 and GPs n=206) working in North Wales. The results showed that 48% (220/460) had reservations and 11% (15/460) disagreed with the policy of giving the second dose. Although health visitors were nominated as the best source of advice on the vaccine, only 61% of this group reported feeling very confident about explaining the two dose schedule to a parent. The authors concluded that healthcare professionals’ knowledge and practice about MMR vaccine varied considerably.

Henderson et al (2004) undertook a survey to ascertain the views of GPs working in Scotland about immunisation. The survey had a good response rate (73%), of whom 28% had concerns about the MMR vaccination.

A Department of Health (2004) survey reported at that time 20% of GPs, 12% of health visitors and 11% of practice nurses were concerned about some aspect of the immunisation programme. The main concerns were related to MMR, including high levels of parental anxiety, the introduction of the new five in one vaccine and parents’ lack of choice. Although nine out of 10 of those interviewed claimed they were confident about explaining immunisation issues to parents, inconsistencies in knowledge were apparent both within and between all groups of healthcare professionals (DH, 2004).

Clearly, the findings of these papers need to be set in the context of the MMR crisis, which is now subsiding. However, they...
highlight how poor healthcare professionals' understanding of the evidence base on immunisations can make them susceptible to public crises of confidence (Hilton et al, 2009).

Such misunderstandings are not unique neither to the UK nor to MMR. A survey of 150 practice nurses in New Zealand in 2004 found that 20% believed that six week old babies were too young to be immunised because of misconceptions about the infant immune system (Petrosis-Harris et al, 2005). This study also reported that additional support and training was needed to improve knowledge about vaccination and its side effects, together with specific strategies to deal with controversial information obtained by parents from the internet.

NICE (2009) recommended that all staff involved in immunisation services are appropriately trained and regularly updated. Training should be tailored to individual needs to ensure that staff have the necessary skills and knowledge, such as communication skills and the ability to answer questions about different vaccinations (NICE, 2009).

In the UK, increasing access to training for all healthcare professionals and support staff involved in immunisation using the national minimum standards for immunisation training (Health Protection Agency et al, 2005) should help improve practitioners' knowledge.

NICE (2009) acknowledged the need to ensure healthcare professionals' knowledge is up to date. It also underlined the importance of access to resources such as the Green Book (DH, 2010) and training to ensure staff have the necessary skills and knowledge to answer parental questions on vaccinations.

Providing tailored information, advice and support

NICE (2009) recommended that parents and young people should be provided with tailored information, advice and support to ensure they know about the recommended routine childhood vaccinations and the benefits and risks.

The Healthy Child Programme (DH, 2009) also suggested that "parents or carers should be provided with good quality, evidence based information and advice on immunisations including the benefits and possible adverse reactions". McMurray et al (2004) conducted 69 interviews with parents and 12 with primary care practitioners, managers and immunisation coordinators to explore decision making and education needs in relation to the MMR controversy. Parents and practitioners identified a need for new approaches to support decisions. The authors suggested that immunisation information might be better received if provision of support is integrated into parents' pre-existing experiences and understanding.

A longitudinal survey in Australia (n=195) revealed that some mothers want healthcare professionals to provide them with balanced information on the risks and benefits of immunisation as well as the risks and consequences of the disease to support their decision making (Wroe et al, 2004).

A systematic review exploring the support needs of parents making decisions about their child’s health identified three overarching themes (Jackson et al, 2008). These were needs for:
- Timely, consistent, up to date, evidence based information tailored to the individual, delivered in a variety of formats from trustworthy sources;
- The opportunity to talk with others in the same situation to share information, experiences and ideas;
- The ability to be in control of one’s level of preferred involvement in the decision making process (Jackson et al, 2008).

There is little evidence base to date examining whether healthcare professionals in the UK provide balanced information for parents to help them with immunisation related decisions.

In Redsell et al’s (2010) study, health visitors reported that they worked in partnership with parents; however, they went on to describe how they provided parents with information about immunisation and then withdrew from the decision making process altogether.

This way of communicating has been described as an "information giving model" where information is shared (from professional to patient) but the informed patient is left to make their own decision and the healthcare professional has no further input in the process (Charles et al, 1997). This model of information provision appears to be common place among nursing professionals (Redsell and Buck, 2009).

DISCUSSION

The NICE (2009) guidance is welcome as it highlights areas of practice in relation to immunisation that need improvement that is underpinned by research evidence. This article has focused on two main areas: problems with access that might lead to under-vaccination; and problems with poor understanding of the risks and benefits of immunisation that might lead to non-vaccination.

PCTs considering expanding services to include home visiting need to have a greater understanding about why parents do not bring their children to immunisation appointments. They may be covertly refusing and there may be issues around home visiting with the intention of vaccinating their child. Furthermore, health visitors hold a wide variety of views about home visiting (Redsell et al, 2010) so PCTs might also wish to identify an appropriate person to take on this role.

Clearly, some healthcare professionals deliver immunisation information to parents using a knowledge deficit approach. This assumes that parents who are uncertain or refuse immunisation lack knowledge and the healthcare professional’s role is simply to communicate information. However, Serpell and Green (2006) stated that providing parents with all the facts about complex health issues and assuming they will take the optimal decision by default is not effective. This approach is also considered outdated in most other areas of healthcare (DH, 2003).

There is a public health argument that providing balanced information about the risks and benefits of immunisation might reduce uptake as those who misunderstand risk may subsequently refuse vaccination for their child. However, in other areas of healthcare, informed choice and shared decision making are being incorporated (DH, 2003) and immunisation cannot be the exception.

The shared decision making model (Charles et al, 1997) supports the view that patients – or parents in this case – should have an active role in health related decisions. Clearly, true “shared decision making” is difficult to achieve during immunisation consultations, because of the overriding public health need for immunisation levels to be high enough to achieve herd immunity.

However, healthcare professionals could provide additional support to parents with their decision making. Staff may need further guidance to help them understand and value the views of parents. They may also require extra skills to facilitate partnership with parents in the decision making process.

Parents need guidance on how to assess the validity of information from different sources. One way healthcare professionals could suggest they do this is to access a recommended website, such as www.healthtalkonline.org.

In terms of delivering immunisation information, it is important that healthcare professionals listen to parents' concerns and questions, openly discuss both the risks and benefits of immunisation and reach a
CONCLUSION
Healthcare professionals have a difficult role in balancing parents’ right to choose with the need to achieve universal childhood immunisation. However, there is considerable scope for improving immunisation information delivery. Central to this is the need to improve evidence based knowledge and the skill to communicate this effectively among healthcare professionals. This can and is being done locally by training and implementation of national standards. However, this knowledge needs to be delivered to parents in a way that supports their decision making.

Some parents may be happy with an information giving approach, but others need information tailored to their needs. Healthcare professionals responsible for delivering immunisation information need a greater awareness of the approaches available and how to adapt their advice accordingly.

REFERENCES