

SAĞLIK ÇALIŞANLARI AŞIDAN NEDEN KORKUYOR ?

Firdevs Aktaş

Gazi Üniversitesi Tıp fakültesi
Enfeksiyon Hastalıkları ve Klinik
Mikrobiyoloji Anabilim Dalı

Sağlık çalışanları kimler?

- Doktor ve diş hekimleri
- Hemşire
- Hastabakıcı
- Tıp, hemşirelik ve diş hekimliği öğrencileri
- Laboratuvar çalışanları
- Sağlık kurumu destek personeli
- Gönüllü hastane çalışanları

REVIEW ARTICLES

Healthcare workers' role in keeping MMR vaccination uptake high in Europe: a review of evidence

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Measles is a highly contagious and potentially fatal disease. Europe is far from the 95% coverage rates necessary for elimination of the disease, although a safe and cost-effective vaccine is available. We reviewed the literature on studies carried out in European countries from January 1991 to September 2011 on knowledge, attitudes and practices of health professionals towards measles vaccination and on how health professionals have an impact on parental vaccination choices. Both quantitative and qualitative studies were considered: a total of 28 eligible articles were retrieved. Healthcare workers are considered by parents as a primary and trustworthy source of information on childhood vaccination. Gaps in knowledge and poor communication from healthcare workers are detrimental to high immunisation rates. Correct and transparent information for parents plays a key role in parental decisions on whether to have their children vaccinated. Healthcare workers' knowledge of and positive attitudes towards measles-mumps-rubella (MMR) vaccination are crucial to meeting the measles elimination goal. An effort should be made to overcome potential communication barriers and to strengthen vaccine education among healthcare professionals.

Introduction

Measles is a highly contagious disease and a leading cause of death among children below five years-old worldwide, although a safe and cost-effective vaccine is available [1]. Although measles usually runs a simple course, serious complications can occur: the most common in industrialised countries are otitis media (in 7–9% of cases), pneumonia (1–6%), diarrhoea (8%), post-infectious encephalitis (1 per 1,000–2,000 cases), subacute sclerosing panencephalitis (SSPE) (1 per 100,000 cases) and death (1–3 per 1,000 cases) [2]. Women who are infected during pregnancy are at greater risk of miscarriage and premature delivery [2].

The most common way of administration of the measles vaccine is in combination with the mumps and rubella vaccines (the trivalent mumps-measles-rubella (MMR) vaccine). In Europe, MMR uptake has been an issue for many years. In 2000, a survey of MMR uptake in Europe showed that uptake was low in many countries [3].

Sağlık çalışanlarında bilgi ve pozitif yönlendirme eksikliği

Before the introduction of the MMR vaccine, people were vaccinated against measles, mumps and rubella separately. However, the introduction of the MMR vaccine led to a significant increase in vaccine uptake. In many countries, the uptake of the MMR vaccine has been low. It is necessary to reach and maintain measles vaccination coverage at 95% [1,7]. Currently, however, the vaccination coverage is still far from this level. In fact, a drop in vaccine coverage rates to suboptimal levels has been reported in Europe in recent years [8,9].

In the first eight months of 2011 alone, more than 29,000 cases of measles were reported in Europe. About one third of them required hospitalisation and in the first six months of the year, measles was responsible for eight deaths and 24 cases of acute encephalitis [9].

Currently there is no standard European policy of administration of the MMR vaccine: of 30 European countries, vaccines are administered at the paediatrician's office in 7, in healthcare centres in 12, and in multiple locations in 11 [10, and data from European Centre for Disease Prevention and Control (ECDC) experts for Malta and Romania]. There are also consid-

Doktorlar kilit personel

- Çocuk aşılamalarında çocuk hekimleri aileleri ikna etmede kilit rol oynuyor
- Erişkin bağışıklamasında tüm hekimler
- Hekimler erişkin bağışıklamasının yönlendiricisi
- Doktorların kendi bağışıklamalarına verdikleri önem hastalarına tavsiye etmeleri demek



Review

Factors influencing pandemic influenza vaccination of healthcare workers—A systematic review

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Health Belief Model

ABSTRACT

Introduction: Maintaining high vaccination rates among healthcare workers (HCW) is an essential component of pandemic preparedness. Numerous studies have examined factors influencing vaccination in various HCW groups, but no systematic review has been conducted to identify factors that are consistently associated with vaccination research.

Methods: We conducted a systematic review of the literature using CINAHL, AMED, Cochrane, and PubMed from January 2005 and December 2011, focusing on vaccine status was the most common outcome.

Results: 20 publications were included in this review. HCW were more likely to accept the H1N1 vaccine if they perceived (1) the H1N1 vaccine to be safe, (2) H1N1 vaccination to be effective in preventing infection to self and others (i.e. loved ones, co-workers and patients), and (3) H1N1 was a serious and severe infection. Positive cues to action, such as the access of scientific literature, trust in public health communications and messaging, and encouragement from loved ones, physicians and co-workers were also found to influence HCW H1N1 uptake. Previous seasonal influenza vaccination was found to be an important socio-demographic predictor of vaccine uptake. Factors unique to HCW pandemic vaccine behaviour are (1) lack of time and vaccine access related barriers to vaccination, (2) perceptions of novel and rapid pandemic vaccine formulation, and (3) the strong role of mass media on vaccine uptake.

Conclusions: Many of the factors that influenced HCW pandemic vaccination decisions have previously been reported in seasonal influenza vaccination literature, but some factors were unique to pandemic vaccination. Future influenza vaccine campaigns should emphasize the benefits of vaccination and highlight positive cues to vaccination, while addressing barriers to vaccine uptake in order to improve vaccine coverage.

20 yayın irdelenmiş
Üçü Türkiye'den
Aşılama oranları :% 9-92
Türkiye: %13-23

Aşılama başarısını belirleyen faktörler

20 araştırmanın metaanalizi

Aşıyı reddetme nedenleri

- Güvenli bulmama (6)
- Yan etki (11)
- Etkililiğinden şüphe etme (7)
- Aşının çabuk hazırlanması (7)

} AŞI KORKUSU

Aşıyı yararlı bulma

- Aşı kendisini korur (9)
- Sevdiklerini korur (7)
- Hastaları korur(7)

Aşılama başarısını belirleyen faktörler

20 araştırmanın metaanalizi

Hastalık algısı

- Hastalığı geçirerek bağışıklık kazandığını düşünme (2)
- Daha önce aşılandığı için bağışık olduğunu düşünme (9)
- Hastalığın ciddi olduğu algısı (11)

Diğer etkenler

- Media (6)
- Bilimsel kaynaklar (3)
- Sağlık otoriteleri (6)
- Doktorlar (2)
- İş arkadaşı, patron(3)
- Politik kişilikler (2)
- Sevdiği biri(2)

Pandemik aşırı kabul edenlerin çoğu düzenli mevsimsel influenza aşısı olanlar



Review

Nosocomial transmission of measles: An updated review

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ABSTRACT

Despite a decrease in global incidence, measles remains a major cause of morbidity and mortality. Nosocomial transmission of measles has been reported in several countries. This review of the literature by search engines and colleagues. Here, we explain ways from cases of community-acquired measles.

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1. Introduction

Despite the proven strategies of the World Health Organization (WHO) for improving measles vaccine coverage, the disease is still one of the leading causes of vaccine-preventable death worldwide [1]. Although a marked global reduction in measles mortality and incidence have been observed in the past decade, measles continues to circulate, affecting susceptible individuals worldwide, leading to its reintroduction in areas where the disease has been eliminated

and to the occurrence of outbreaks in countries where its incidence is low.

WHO regional elimination targets for measles in Africa and southeast Asia, such as reaching 90% national coverage with the first dose of measles-containing vaccine (MCV1), have not yet been met [2,3]. In Europe, despite a decline of measles incidence in the past decade, the incidence has increased recently in Western Europe with the occurrence of outbreaks due to suboptimal vaccination coverage. Transmission settings include the community, antivaccination groups, schools and health-care facilities [4]. Internally displaced population groups (mainly the Roma ethnic group), with limited health-care access, moving from Eastern to Western Europe have reportedly been associated with measles outbreaks

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1997-1998
 Nozokomiyal salgınlar % 22.1
 310 nozokomiyal vaka
 64 ü sağlık çalışanı

Health Care Workers as Source of Hepatitis B and C Virus Transmission

Abigail L. Carlson, BA^a, Trish M. Perl, MD, MSc^{a,b,c,*}

KEYWORDS

- Hepatitis B • Hepatitis C • Nosocomial transmission
- Health care worker

Hepatitis B virus (HBV) and hepatitis C virus (HCV) are major causes of liver disease with prevalence varying geographically of morbidity and mortality. Malaria,¹ whereas HCV has infected

The prevalence of HBV varies depending on the vaccination strategy. In the United States, the prevalence varies from less than 1% to 10% in North America and

Health care-associated transmission of HBV and HCV is well documented in the literature.⁵⁻⁹ Among these cases, the most common route is from infected providers to their chronic phase, infected

infected secretions, with implications for infection control and for the management of infected providers. In 2000, the World Health Organization estimated that 60,000 occupationally acquired HBV and 16,000 occupationally acquired HCV infections occurred among health care workers (HCWs).¹⁰ Although patient-to-provider and patient-to-patient transmission are most often described, an important subset of cases involves the transmission of infection from ill providers to their patients. This article reviews known cases of HCW-to-patient transmission of HBV and HCV, appropriate infection

with prevalence varying geographically of morbidity and mortality. Malaria,¹ whereas HCV has infected

depend on the vaccination strategy. In the United States, the prevalence varies from less than 1% to 10% in North America and

1992-2001 11 makale
Hepatit B li sağlık çalışanından geçiş
%0.2-13,
500 den çok vaka

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SAĞLIK ÇALIŞANI

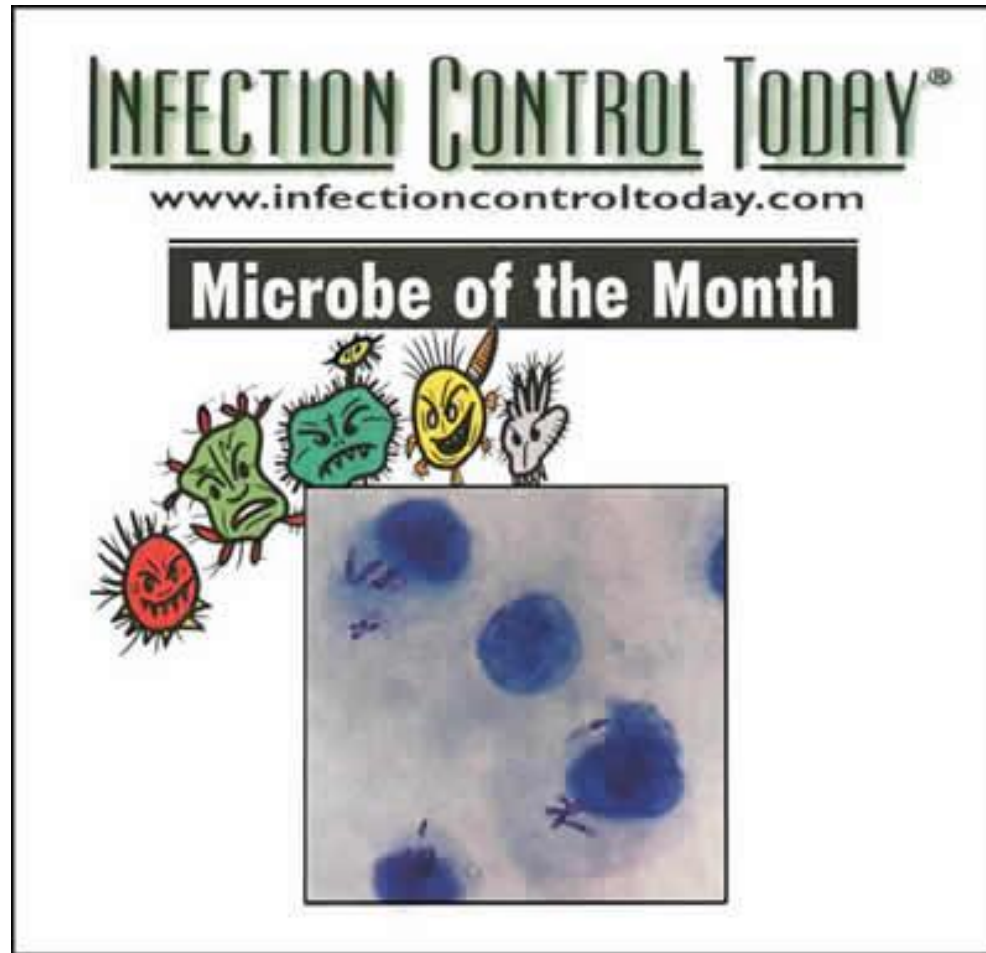


Ailesini seviyor ve
düşünüyor

İşine Aşık
Hastayken de çalışıyor



Enfeksiyon kontrolünü ihmal ediyor



- Yeni aşılar  g vensiz
- Aşı markalarını  nemsiyor
- Enjeksiyondan korkabiliyor





Clinicians' opinions on new vaccination programs implementation

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ABSTRACT

In Canada, several new vaccines were recently added to the national immunization schedule. Decision-makers are faced with the choice whether to implement new vaccination programs. The aim of this study was to assess physicians' opinions regarding 7 new vaccines, and perceptions of self-administered, anonymous, mail-based questionnaire. A total of 1182 family physicians and to all 1852 Canadian physicians. The frequency and severity of the diseases, efficacy of immunization programs were used to calculate a score for each vaccine. Scores ranging from 0 to 100. Of respondents perceived the health and economic impact of new vaccines as important and considered new vaccines strongly agreed or agreed that the new vaccines were important to the public and by the health professionals who recommended them. The vaccines (respectively 30% and 29% strongly agreed) of 100 for the measles, mumps, rubella and varicella (MMRV) vaccine; 73.1 for the meningococcal ACYW135; 68.9 for the combined dTAP-IPV-Hib-HBV vaccine and 56.9 for the rotavirus vaccine. Health professionals consider in the decision-making process regarding new vaccines. Without health professional support, the introduction of new vaccines is less successful. In this study, the MMRV and the hexavalent (DTaP-IPV-Hib-HBV) vaccines received the highest ratings.

Yeni aşılar karşı
ihtiyatlı

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1. Introduction

In the context where resources are limited and where the number and cost of available vaccines increases, public health authorities have to prioritize which vaccines should be included in publicly funded vaccination programs [1–5]. In Canada, the integration of a new vaccine into a publicly funded vaccination program is the responsibility of provinces and territories [6]. Although several existing frameworks and evaluation criteria can facilitate the

decision-making process regarding a new potential immunization program [7,8], to our knowledge, a criterion for prioritization of concurrent vaccination programs is included in only one of these frameworks [9].

Clinicians' knowledge, attitudes and beliefs toward new vaccines are known to influence their intention to recommend a new vaccine and it is commonly recognized that their recommendation is a major factor in vaccine uptake [6,10–12]. However, few empirical studies have assessed the attitudes of health professionals on vaccination programs prioritization [13–15]. In recent studies among Canadian officers of public health and Quebec nurses, a high heterogeneity of perceived usefulness, safety, protectiveness, and acceptability of new candidate vaccines has been reported [14,15].

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Sağlık Çalışanlarını
Nasıl Aşılatalım?

Bağışıklama Gerekçesi

- Sağlık çalışanının kendisini, ailesini ve hastaları korumak
- Sağlık personeline uygulanacak başarılı bir bağışıklama programının maliyeti
- Salgın kontrolü ve tek olgu temelinde tedavi maliyetinden daha ekonomik

Immunization of Health-Care Personnel

Recommendations of the Advisory Committee on Immunization Practices (ACIP)

Güncelleme



Continuing Education Examination available at <http://www.cdc.gov/mmwr/cme/conted.html>.



kendinizi koruyun, hastanızı koruyun, aşılarınızı yaptırmayı unutmayın!

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önce kendi aşılarınızı yaptırmayı unutmayınız.

Unutmayın, sizden sağlık bekleyenler,
sağlıklı olmanızı da bekliyor.

Teşvik ve
hatırlatma



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SAĞLIK
SAĞLIĞIN BAŞI
AŞI



aşı çalışma grubu
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HEALTH CARE WORKERS VACCINATIONS

The art of medicine

Time to mandate influenza vaccination in health-care workers

Earlier this year, I had the opportunity to chat with David Salisbury, National Director for Immunisation at the UK's Department of Health. He told me how proud he was of the success that had been achieved in getting people living in the UK to get their influenza shots. I mentioned that one group that had proven very tough to vaccinate in the USA was health-care workers. He rolled his eyes and confided that doctors in the UK were a hard lot to get vaccinated as well.

Why is it that health-care workers around the world prove so hard to vaccinate against influenza or other communicable diseases? Rates of influenza vaccination in health-care workers have averaged well under 50% for the past decade in many hospitals and long-term care facilities in the USA and in other nations. What should be done about this dismal state of affairs? Will redoubling efforts at voluntary vaccination work? That seems unlikely. This low uptake of vaccination in health-care workers does not seem to be the result of a failure to push from administrators and government authorities. Nor are the culprits a lack of vaccines or money to pay for them. The call for those who care for others to get vaccinated both for their own protection and that of their patients has been issued year after year. All manner of efforts have been made to make vaccination in the workplace easy to do, ranging from bringing carts with vaccine directly on to hospital floors, posters, webcasts, jamborees, and various incentive schemes. None of these approaches have succeeded in getting rates up to where they need to be to protect the workforce and patients.

The evidence that vaccinating doctors and nurses protects patients from infection, morbidity, and death is well established. Nevertheless, health-care workers invoke a litany of excuses for avoiding the jab. Some say they don't get sick. Others insist that they avoid contact with patients if they are sick, while others maintain that they stay at home if they do get sick. All of this is absolute and utter malarkey. Health-care workers get influenza just like everyone else. Even if they don't get debilitating symptoms, they are still infectious. In fact, those infected with influenza are highly contagious 24 hours before symptoms appear. Nor does it take direct contact with patients to be a powerful disease vector in a hospital, nursing home, or clinic. And, seriously, when was the last time someone stayed away from work at a hospital short of being confined to a bed as a result of near terminal illness? The number of sick days afforded many health-care workers is often not sufficient to encourage time off from work when influenza occurs.

Decades of relying on voluntary efforts to overcome such oft-espoused claptrap as to why influenza vaccination is not needed by health professionals have failed. Given the failure of voluntary vaccination strategies and the dangers low vaccination rates present to vulnerable patients, shouldn't all health-care workers be required to be vaccinated against influenza and other communicable diseases as a condition of their employment? Of course they should. The fact that influenza vaccination is safe and efficacious does not seem to be sufficient as a motivator to achieve high rates of compliance. It is time to make clear what the ethical reasons are for requiring vaccination and then to get a mandate in place in all health-care institutions and clinics.

First, every code of ethics adopted by physicians, nurses, nurses aides, social workers, pharmacists, and other health-care professionals states very clearly, succinctly, and loftily that the interests of patients must come ahead of anyone else's. Since it is clear that newborn babies, the elderly, and the immunocompromised have a powerful interest in not being killed by those caring for them and in having a healthy workforce available to treat them, these self-proclaimed professional ethical codes that extol patients' interests fully support requiring vaccination as a condition of employment. Whatever one's views about personal rights to choose, unless a valid medical reason exists to not vaccinate, the best interests of the patient trumps personal choice in the hierarchy of self-imposed professional values.

Second, all health-care workers are obligated to honour the core medical ethics requirement of "First Do No



- Salgınlarda ve toplu aşılama kampanyalarında medya gibi dış etkenler aşılama programlarını olumsuz etkileyebiliyor
- Normalde bağışıklama karşıtı hareketler az medya ilgisi önemsiz
- Sağlık personeli aşılaması bu koşullarda korku faktörü içermiyor

HASTALIK KORKUSU VE AŐI KORKUSU



Toplumsal tepkiler

Aőılama oranları, hastalık epidemiyolojisini etkilemektedir.
Bu da aőı oranlarını etkilemektedir.

Hastalıđa yakalanma korkusu	Çok fazla	Yok	Yok
Aőılarla ilgili korku	Yok	Yok	Güvensizlik ve korku
Aőılamaya	Yoğun istek	İstek yoktur İlgisizlik vardır.	Red



Changes in influenza vaccination rates among healthcare workers following a pandemic influenza year at a Japanese tertiary care centre

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SUMMARY

Background: Although influenza vaccination, which is a key part of a control plan to prevent nosocomial influenza transmission, is recommended for all healthcare workers (HCWs), the achievement of a high influenza vaccination rate among HCWs is a challenge. In Japan, there are limited data on influenza vaccination rates among HCWs. Moreover, the effect of pandemic influenza on influenza vaccination rates among HCWs following a pandemic year remains unclear.

Aim: To determine influenza vaccination rates among HCWs in a tertiary care centre in Japan, and to evaluate the need for further interventions among HCWs.

Methods: The 2005–2010 influenza vaccination rates among HCWs in a tertiary care centre in Sapporo, Japan were reviewed retrospectively using a national health service database.

Findings: There was a gradual increase in the seasonal influenza vaccination rate among HCWs from 2005 to 2010, and a high vaccination rate in the 2010 pandemic H1N1 influenza season. However, the vaccination rate in 2010–2011 was significantly lower than that for the pandemic vaccine in 2009–2010, with doctors having the lowest vaccination rate among all HCWs.

Conclusion: Pandemic influenza may not have a sustained effect on the uptake of influenza vaccination in subsequent years. Thus, vaccination rates among HCWs after a pandemic year still need to be monitored, and the implementation of interventions such as a mandatory vaccination programme should be considered to maintain consistently adequate vaccination rates.

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Hastalık korkusu aşılama oranının artırılabilir

Introduction

Influenza vaccination is recommended for all healthcare workers (HCWs) by the US Centers for Disease Control and Prevention and the World Health Organization as a key part of a control plan to prevent nosocomial influenza transmission.^{1,2}

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HASTALIK KORKUSU



If vaccine rates continue to drop, signs like this one may again become a common sight. Before polio vaccine was available, 13,000 - 20,000 cases of paralytic polio were reported each year in the United States. These annual epidemics of polio often left thousands of victims - mostly children - in braces, crutches, wheelchairs, and iron lungs. The effects were life-long. (Photograph property of MOD archives).

Polio virus causes acute paralysis that can lead to permanent physical disability and even death. (Photograph: World Health Organization)



AŞI PROPAGANDASI



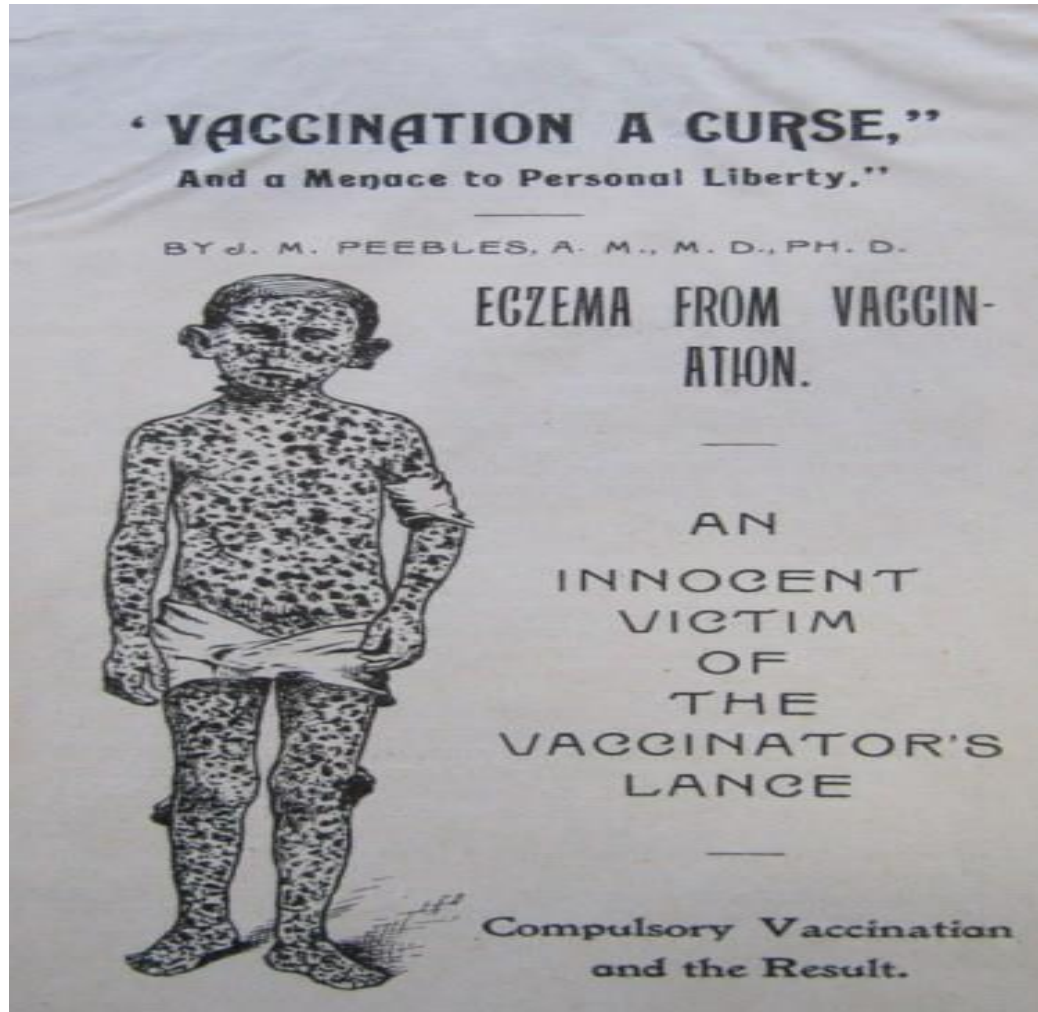
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AŞI KORKUSU



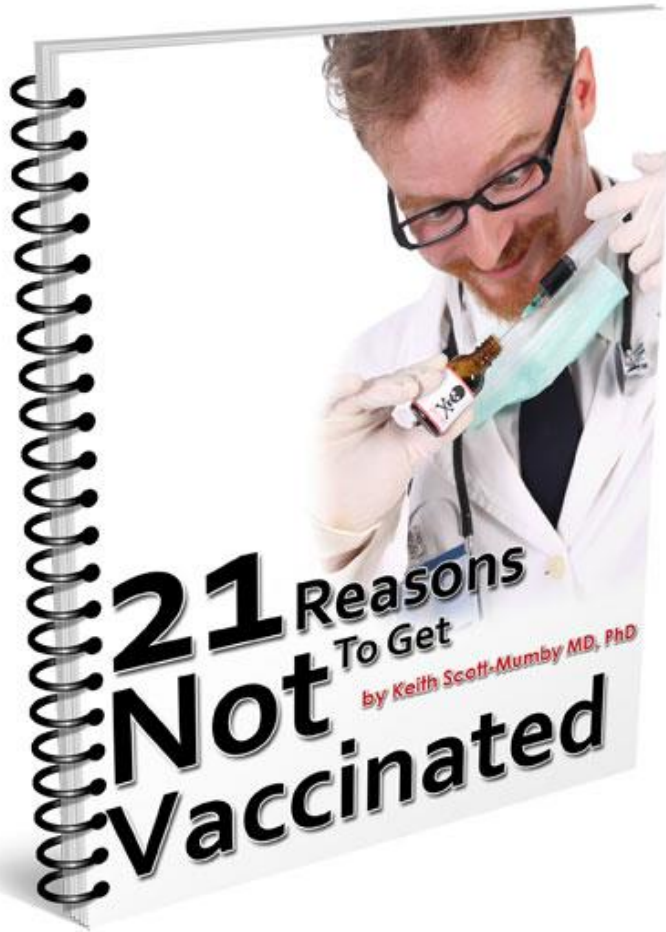
AŞI KARŞITI PROPAGANDA



SAĞLIK ÇALIŞANLARI AŞIDAN NEDEN KORKUYOR ?



AŐI KARŐITI DOKTORLAR



Aőılama: Kitlesel
sahtekarlık



UNIVERSITY OF GLASGOW

MECHAN PROFESSOR
GORDON T. STEWART, M.D.



RECHILL HOSPITAL
GLASGOW G20 9NB
TEL 041-946 7120

13th February, 1980

GTS/LS

DEPARTMENT OF COMMUNITY MEDICINE

Mr. P. Allen,
Secretary,
Committee on Safety of Medicines,
Finsbury Square House,
33/37A Finsbury Square,
LONDON, EC2A 1PP

Dear Mr. Allen,

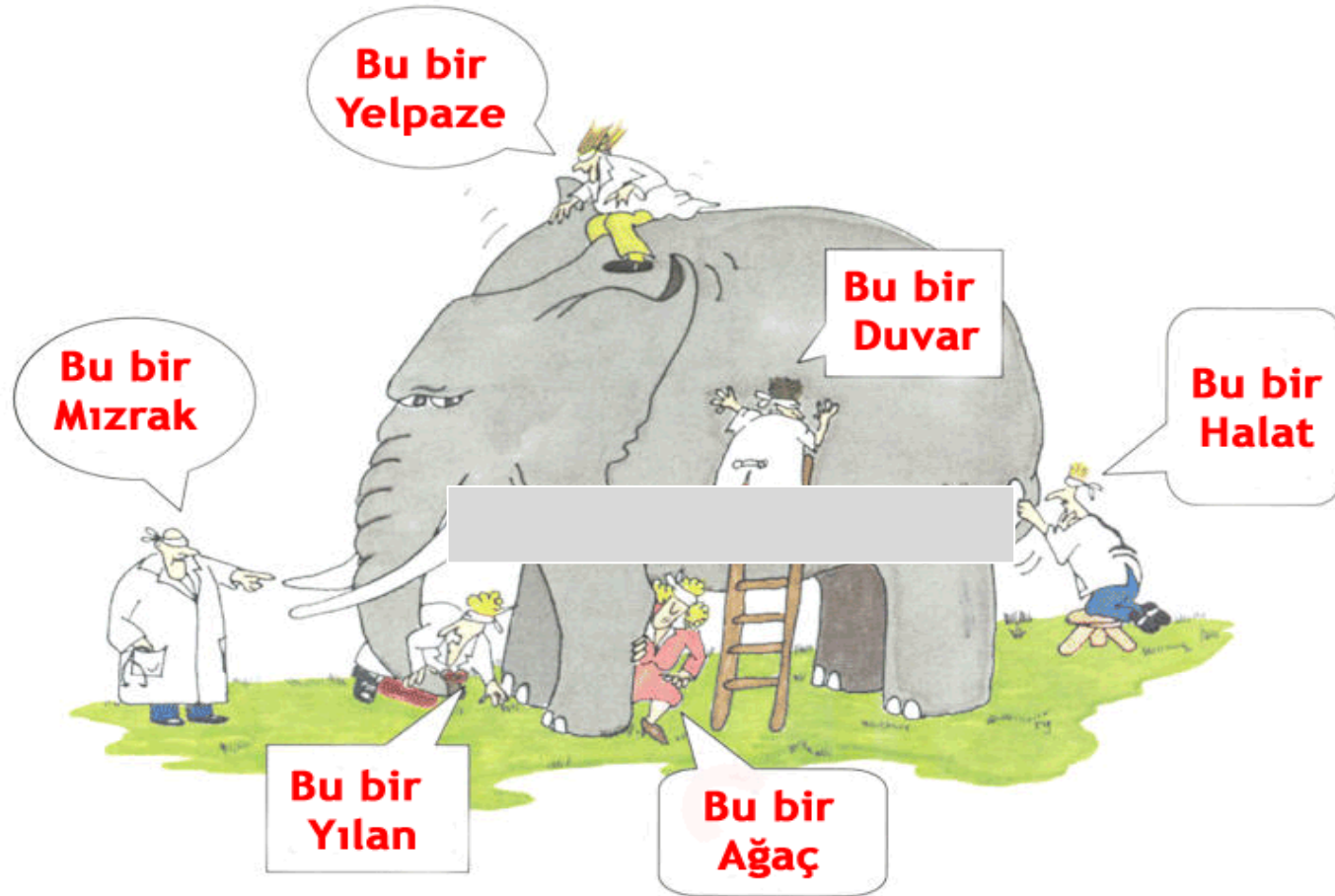
264499
In reply to yours of 11th February, I am sorry to say that I do not agree with you that there is nothing more that can or should be done. Let me say again that the important matter confronting us is the safety of the vaccine. It is not in the public interest to withhold additional information relating to the safety of the vaccine, which has come to our attention as a result of a collaborative programme and which is highly germane to our report. I would not for a moment question Dr. Pollock's right to report independently on the PHLS study and we should certainly make it clear in our report that we are quoting their results. Without these results, however, our report will be not only incomplete but open to serious criticism. Had it been stated at the beginning that the PHLS results would not be available for quoting in our report, I for one would not have agreed that collaboration with them held any benefits for us and would have insisted upon a separate exercise as an extension of that agreed with Professor Butler and indeed with myself. All of my results have been made available to you from the start and will continue to be available, whether or not our Panel meets again. Professor Butler has expressed the same view about the rest of the collaborative study.

Farklı uzmanlık dalları ile ilgili olumsuz yorumlar

- Aşı kansere yol açabilir
- Aşı ile ilgili çalışmalar uzun vadeli etkilerini göstermez
- Otoimmün hastalıklara yol açabilir
- Allerjik hastalıkları tetikleyebilir
- Ani bebek ölümüne yol açabilir



Uzman gözlükleri ile saptanan yan etkiler aşılamanın başarısını (büyük fili) görmemize engel mi?



Dr. Andrew Wakefield'in etkilediği kitleler aşı olmayıp kızamık oldular

CMAJ

NEWS

Lancet retracts 12-year-old article linking autism to MMR vaccines

Published at www.cmaj.ca on Feb. 4

Twelve years after publishing a landmark study that turned tens of thousands of parents around the world against the measles, mumps and rubella (MMR) vaccine because of an implied link between vaccinations and autism, *The Lancet* has retracted the paper.

In a statement published on Feb. 2, the British medical journal said that it is now clear that “several elements” of a 1998 paper it published by Dr. Andrew Wakefield and his colleagues (*Lancet* 1998;351[9103]:637-41) “are incorrect, contrary to the findings of an earlier investigation.”

Dr. Richard Horton, editor of *The Lancet*, declined through a spokesperson to speak to *CMAJ* about this issue.

In the original paper, Wakefield and 12 coauthors claimed to have investigated “a consecutive series” of 12 children referred to the Royal Free Hospital and School of Medicine with chronic enterocolitis and regressive developmental disorder. The authors reported that the parents of eight of the 12 children associated their loss of acquired skills, including language, with the MMR vaccination. The authors concluded that “possible environmental triggers” (i.e. the vaccine) were associated with the onset of both the gastrointestinal disease and developmental regression.

In fact, as Britain’s General Medical Council ruled in January, the children that Wakefield studied were carefully selected and some of Wakefield’s research was funded by lawyers acting for parents who were involved in lawsuits against vaccine manufacturers. The council found Wakefield had acted unethically and had shown “callous disregard” for the children in his study, upon whom invasive tests were performed.

When the original article was picked up by the general media, the findings



Reuters/Luke MacGregor

Dr. Andrew Wakefield speaks to media in London, England on Jan. 28 after the General Medical Council ruled that he acted unethically in doing his research into a link between Measles Mumps Rubella vaccinations and autism.

were fuelled by speeches and public appearances in which Wakefield recommended single vaccines rather than the combined MMR. Many parents seeking a cause for their children’s illness seized upon the apparent link between the routine vaccination and autism, say Canadian researchers who laud the retraction.

“I think a lot of families were looking for a reason, so they were extremely vulnerable (to this explanation),” says Jeanette Holden, a geneticist at Queen’s University in Kingston, Ontario. Holden, whose brother is autistic, heads the Autism Spectrum Disorders — Canadian–American Research Consortium.

“The problem is that this had dramatic health consequences, which was that people just didn’t vaccinate their children,” she adds.

In the United Kingdom, the Health Protection Agency attributed a large

measles outbreak in 2008 and 2009 to a concurrent drop in the number of children receiving the MMR vaccine. Pockets of measles — which can be fatal — have also cropped up in Canada and the United States as a result of parents’ refusal to vaccinate.

“In the course of my discussions with families it’s almost invariable that the measles question comes into play,” says Dr. Suzanne Lewis, a pediatrician and clinical professor of medical genetics at the University of British Columbia in Vancouver.

“I was quite thankful to see the retraction — it’s long overdue,” she adds.

Both Holden and Lewis, who is also a member of the Autism Spectrum Disorders — Canadian–American Research Consortium, questioned the article’s original heft, given its small sample size.

“Why *The Lancet* published it is completely beyond me,” Lewis says.

Early report

Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children

A J Wakefield, S H Murch, A Anthony, J Linnell, D M Casson, M Malik, M Berelowitz, A P Dhillon, M A Thomson, P Harvey, A Valentine, S E Davies, J A Walker-Smith

Summary

Background We investigated a consecutive series of children with chronic enterocolitis and regressive developmental disorder.

Methods 12 children (mean age 6 years [range 3–10], 11 boys) were referred to a paediatric gastroenterology unit with a history of normal development followed by loss of acquired skills, including language, together with diarrhoea and abdominal pain. Children underwent gastroenterological, neurological, and developmental assessment and review of developmental records. Ileocolonoscopy and biopsy sampling, magnetic-resonance imaging (MRI), electroencephalography (EEG), and lumbar puncture were done under sedation. Barium follow-through radiography was done where possible. Biochemical, haematological, and immunological profiles were examined.

Findings Onset of behavioural symptoms was associated by the parents, with measles, mumps, and rubella vaccination in eight of the 12 children, with measles infection in one child, and otitis media in another. All 12 children had intestinal abnormalities ranging from lymphoid nodular hyperplasia to granuloid ulceration. Histology showed patchy chronic inflammation in 11 children and reactive ileal lymphoid hyperplasia in seven, but no granulomas. Behavioural disorders included autism (nine), disintegrative psychosis (one), and possible postviral or vaccinal encephalitis (two). There were no focal neurological abnormalities and MRI and EEG tests were normal. Abnormal laboratory results were significantly raised urinary methylmalonic acid compared with age-matched controls ($p=0.03$), low haemoglobin in four children, and a low serum IgA in four children.

Interpretation We identified associated gastrointestinal disease and developmental regression in a group of previously normal children, which was generally associated in time with possible environmental triggers.

Lancet 1998; **351**: 637–41

See Commentary page

Inflammatory Bowel Disease Study Group, University Departments of Medicine and Histopathology (A J Wakefield FRCS, A Anthony MB, J Linnell PhD, A P Dhillon MRCP, S E Davies MRCP) and **the University Departments of Paediatric Gastroenterology** (S H Murch MB, D M Casson MRCP, M Malik MRCP, M A Thomson FRCP, J A Walker-Smith FRCP), **Child and Adolescent Psychiatry** (M Berelowitz FRCP), **Neurology** (P Harvey FRCP), and **Radiology** (A Valentine FRCP), **Royal Free Hospital and School of Medicine, London NW3 2QG, UK**

Correspondence to: Dr A J Wakefield

Introduction

We saw several children who, after a period of apparent normality, lost acquired skills, including communication. They all had gastrointestinal symptoms, including abdominal pain, diarrhoea, and bloating and, in some cases, food intolerance. We describe the clinical findings, and gastrointestinal features of these children.

Patients and methods

12 children, consecutively referred to the department of paediatric gastroenterology with a history of a pervasive developmental disorder with loss of acquired skills and intestinal symptoms (abdominal pain, bloating and food intolerance), were investigated. All children were admitted to the ward for one week, accompanied by their parents.

Clinical investigations

We took histories including details of immunisations and exposure to infectious diseases, and assessed the children. In 11 cases the history was obtained by the senior clinician (JW-S). Neurological and psychiatric assessments were done by consultant staff (PH, MB) with HMS-4 criteria.¹ Developmental records were reviewed, including a review of prospective developmental records from parents, health visitors, and general practitioners. Four children did not undergo psychiatric assessment in hospital; all had been assessed professionally elsewhere, so these assessments were used as the basis for their behavioural diagnosis.

After bowel preparation, ileocolonoscopy was performed by SHM or MAT under sedation with midazolam and pethidine. Paired frozen and formalin-fixed mucosal biopsy samples were taken from the terminal ileum; ascending, transverse, descending, and sigmoid colons, and from the rectum. The procedure was recorded by video or still images, and were compared with images of the previous seven consecutive paediatric colonoscopies (four normal colonoscopies and three on children with ulcerative colitis), in which the physician reported normal appearances in the terminal ileum. Barium follow-through radiography was possible in some cases.

Also under sedation, cerebral magnetic-resonance imaging (MRI), electroencephalography (EEG) including visual, brain stem auditory, and sensory evoked potentials (where compliance made these possible), and lumbar puncture were done.

Laboratory investigations

Thyroid function, serum long-chain fatty acids, and cerebrospinal-fluid lactate were measured to exclude known causes of childhood neurodegenerative disease. Urinary methylmalonic acid was measured in random urine samples from eight of the 12 children and 14 age-matched and sex-matched normal controls, by a modification of a technique described previously.² Chromatograms were scanned digitally on computer, to analyse the methylmalonic-acid zones from cases and controls. Urinary methylmalonic-acid concentrations in patients and controls were compared by a two-sample *t* test. Urinary creatinine was estimated by routine spectrophotometric assay.

Children were screened for antiendomysial antibodies and boys were screened for fragile-X if this had not been done

Aşılama konusunda 6 yanlış

- Aşı uygulamasından önce görülen hastalıklar hijyen ve sanitasyonun daha iyi olması nedeniyle artık az görülüyor
- Aşılananlar da hasta oluyor
- Aşıların bazı serileri daha çok yan etkiye hatta ölüme neden oluyor. Bu aşı lot numaralarını içeren aşıları olmamalıyız

Aşılama konusunda 6 yanlış

- Aşılar pek çok yan etkiye yol açıyor(ani bebek ölümü, otizm, Guillain Barre sendromu) Uzun vadede ne gibi etkileri olacağı bilinmiyor
- Aşı ile önlenebilir hastalıklar artık ülkemizde görülüyor bu nedenle aşılarmaya gerek yok
- Farklı hastalıklara karşı uygulanan karma aşılar yan etkileri arttırıyor ve immün sistemi aşırı zorluyor

Korku nedeni başlıklar

- Bebeklikte birçok aşı yapılması çocuğun immün sistemini aşırı bir yük oluşturarak işlevini bozar mı?
- İnfluenza aşısı/Guillain Barré Sendromu
- Dörtlü konjuge meningokok aşısı/GBSHepatit B aşısı / nörolojik hastalıklar
- Aşılanma sonrası bayılma /MCV4,HPV ve Tdap
- Aşılar-Adjuvan maddeler/otizm

Aşı yan etkisi mi/rastlantı mı?

- Aşılama sonrası görülen bir tıbbi olay aşı yan etkisi olabileceği gibi; rastlantısal olarak ortaya çıkan başka bir nedene de bağlı olabilir
- Ancak, bu durum genellikle aşıya atfedilir ve yanlış olarak aşı suçlanabilir.
- Bu olayların özellikle fazla sayıda kişinin aşılandığı kampanyalarda ortaya çıkma ihtimali yüksektir.

- **Bebeklikte birçok aşı yapılması çocuğun immün sistemini aşırı bir yük oluşturarak işlevini bozar mı?**
- Bu savı destekleyen hiçbir kanıt yoktur
- Bebekler her gün pek çok virüs ve bakteri ile karşılaşır
- Soğuk algınlığında 4-10 antijenle, streptokoksik farenjitte 25-50 antijenle tanışır
- İmmünsistemin çok antijenle karşılaşması immünbaskılamaya yol açmaz

İnfluenza aşısı/Guillain Barré Sendromu

- 1976 da ABD de uygulanan domuz influenza aşısının GBS ile ilişkisi “The Instituted of Medicine Immunization Safety Review Committee”yeniden incelenmiş
- Mevcut verilerin ilişkiyi kabul veya reddedecek nitelikte olmadığına karar vermiştir

Dörtlü konjuge meningokok aşısı/GBS

- Guillain-Barré sendromu aşı yapılan birkaç kişide bildirilmiştir
- Bu hastaların hepsi iyileşmiş veya iyileşmektedir
- Aşı ilişkisi gösteren yeterli kanıt bulunmamaktadır

Hepatit B aşısı / nörolojik hastalıklar

- 2002'de , ABD Institute of Medicine (IOM) mevcut verileri inceleyerek hepatit B aşısı ile MS ve diğer demiyelinizan nörolojik hastalıklar arasında herhangi bir ilişki olmadığı sonucuna vardı

Aşılanma sonrası bayılma /MCV4,HPV ve Tdap

- Tüm aşılarla bu etki bildirilmiştir
- Vaccine Advers Event Reporting System(VAERS) 1 Ocak 2005-31 Haziran 2007 kayıtlarına göre adolesan aşılama sırasında bu üç aşı ile en sık görüldüğü saptanmıştır
- Ancak bayılmanın aşılarla mı, adolesan çağda olmakla mı ilişkili olduğu bilinmemektedir

Timerosal/civa /otizm

- İlişki gösterilmemekle birlikte 2001 de çocukluk aşılarından bu madde çıkarıldı
- Timerosalden bağımsız olarak otizm vakaları artmaya devam ediyor



Adjuvan içeren aşılar

En sık kullanılan adjuvan alüminyum

- Hepatit A
- Hepatit B
- DTaP, Tdap
- *Haemophilus influenzae* type b (Hib)
- Human papillomavirus (HPV)
- Pnömonokok

Adjuvan içermeyen aşılar

Canlı atenüe aşılar

- Kızamık
- Kızamıkçık
- Kabakulak
- Suçiçeği
- Rota virus

İnaktif polio

Mevsimsel influenza

TABLE: Summary of Causality Conclusions

Vaccine	Adverse Event	Causality Conclusion
Varicella	Disseminated varicella infection (widespread chickenpox rash shortly after vaccination)	Convincingly Supports
Varicella	Disseminated varicella infection with subsequent infection resulting in pneumonia, meningitis, or hepatitis	Convincingly Supports ^a
Varicella	Vaccine strain viral reactivation (appearance of chickenpox rash months to years after vaccination)	Convincingly Supports
Varicella	Vaccine strain viral reactivation with subsequent infection resulting in meningitis or encephalitis (inflammation of the brain)	Convincingly Supports
MMR	Measles inclusion body encephalitis	Convincingly Supports ^{a,b}
MMR	Febrile seizures (a type of seizure that occurs in association with fever and is generally regarded as benign)	Convincingly Supports
MMR	Anaphylaxis (a very rare but sudden allergic reaction)	Convincingly Supports
Varicella	Anaphylaxis	Convincingly Supports
Influenza	Anaphylaxis	Convincingly Supports
Hepatitis B	Anaphylaxis	Convincingly Supports ^c
Tetanus Toxoid	Anaphylaxis	Convincingly Supports
Meningococcal	Anaphylaxis	Convincingly Supports
Injection-Related Event	Deltoid bursitis (frozen shoulder, characterized by shoulder pain and loss of motion)	Convincingly Supports
Injection-Related Event	Syncope (fainting)	Convincingly Supports
HPV	Anaphylaxis	Favors Acceptance
MMR	Transient arthralgia (temporary joint pain) in women	Favors Acceptance ^d
MMR	Transient arthralgia in children	Favors Acceptance
Influenza	Oculorespiratory syndrome (a mild and temporary syndrome characterized by conjunctivitis, facial swelling, and upper respiratory symptoms)	Favors Acceptance ^e
MMR	Autism	Favors Rejection
Influenza	Inactivated influenza vaccine and Bell's palsy (weakness or paralysis of the facial nerve)	Favors Rejection
Influenza	Inactivated influenza vaccine and asthma exacerbation or reactive airway disease episodes in children and adults	Favors Rejection
MMR	Type 1 diabetes	Favors Rejection
DT, TT, or aP containing	Type 1 diabetes	Favors Rejection

^a The committee attributes causation to individuals with demonstrated immunodeficiencies.

^b The committee attributes causation to the measles component of the vaccine.

^c The committee attributes causation to yeast-sensitive individuals.

^d The committee attributes causation to the rubella component of the vaccine.

^e The committee attributes causation to two particular vaccines used in three particular years in Canada.

All other causality conclusions are the evidence is inadequate to accept or reject a causal relationship.

SOURCE: Adverse Effects of Vaccines: Evidence and Causality

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Gazi Üniversitesi Gazi Hastanesi

2001-2013 Yılı Personel Sağlığı Verileri

Meslek	Sayı
DOKTOR	493
HEMŞİRE	1429
HASTABAKICI	465
HEMŞİRE ÖĞRENCİ	827
TIP FAKÜLTESİ ÖĞRENCİSİ	1943
TEMİZLİK ELEMANI	483
DİĞER	71
TOPLAM	5569

Gazi Üniversitesi Gazi Hastanesi

2012 Yılı Sağlık Çalışanı Aşılamaları

AŞI	SAYI
HEPATİT B	160
HEPATİT A	76
KKK	47
SUÇİÇEĞİ	6
İNFLUENZA	119
TOPLAM	408

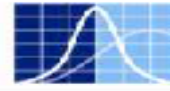
Sağlık Çalışanlarını
Nasıl Aşılayalım?

HASTALIK KORKUSUNUN AŞI KORKUSUNU AŞMASI

Hastalığa yakalanma korkusu	Çok fazla	Yok	Yok
Aşılarla ilgili korku	Yok	Yok	Güvensizlik ve korku
Aşılamaya	Yoğun istek	İstek yoktur İlgisizlik vardır.	Red



IDSA



SHEA
The Society for Healthcare
Epidemiology of America

Infectious Diseases Experts Call for Mandatory Immunization of Health Care Personnel

*Three Leading Infectious Diseases Societies Say Immunization
Should be Condition of Employment in Healthcare Facilities*

(Arlington, Va.)—In a joint policy statement released today, the Infectious Diseases Society of America (IDSA), the Society for Healthcare Epidemiology of America (SHEA), and the Pediatric Infectious Diseases Society (PIDS) call for mandatory, universal immunization of health care personnel as recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).

ACIP recommendations for health care personnel currently include vaccination against influenza, measles, pertussis (whooping cough), hepatitis B, and varicella (chicken pox). A complete list of ACIP-recommended vaccines for health care personnel can be found [here](#). ([link](#))

Some voluntary health care personnel vaccination programs have been effective when combined with strong institutional leadership and robust educational campaigns, say the Societies. However, for the vast majority of facilities, mandatory immunization programs are necessary to achieve target immunization rates. The policy calls for documentation of immunity or receipt of recommended vaccinations as a condition of employment, unpaid service, or receipt of professional privileges.

"Immunization rates for ACIP-recommended vaccines remain low among health care personnel," said Barbara Murray, MD, president of IDSA. "When voluntary programs fall short, we think vaccination should be a condition of employment for the protection of both patients and health care workers from illness and death associated with these diseases."

Those who cannot be vaccinated due to medical contraindications or because of vaccine supply shortages may need to be reassigned away from direct patient care or take other infection control measures. "ACIP-recommended vaccines are proven to be safe, effective and cost-saving," said Daniel Diekema, MD, president-elect of SHEA. "Although there may be exceptions made for individuals for whom vaccination is not appropriate or in circumstances when the vaccine is not available, these exceptions should be extremely rare." Notably, the policy does not provide for exemptions based on personal belief or religion.

The Societies have previously called for mandatory influenza vaccination for health care personnel. "This new statement adds to this by recognizing the significant threat that other pathogens pose for the health of patients and health care workers in the healthcare setting," said David Kimberlin, MD, president of PIDS. The Societies also support requiring health care employers to engage in comprehensive educational efforts to inform health care personnel about the benefits of immunization and the risks of not maintaining immunization.

See the full policy statement on mandatory vaccination of health care personnel ([link](#)).

- Related IDSA policy statement on mandatory immunization of health care personnel against seasonal and pandemic influenza ([link](#)).
- Related SHEA position paper on influenza vaccination of health care personnel ([link](#)).

###

ZORUNLU
AŞILAMA



iyi yıllar