

NOTICE

Materials in our digital Oral History collections are the products of research projects by several individuals. USF Libraries assume no responsibility for the views expressed by interviewers or interviewees. Some interviews include material that may be viewed as offensive or objectionable. Parents of minors are encouraged to supervise use of USF Libraries Oral Histories and Digital Collections. Additional oral histories may be available in Special Collections for use in the reading room. See individual collection descriptions for more information.

This oral history is provided for research and education within the bounds of U.S. Copyright Law (Title 17, U.S.C.). Copyright over Oral Histories hosted by the USF Libraries rests with the interviewee unless transferred to the interviewer in the course of the project. Interviewee views and information may also be protected by privacy and publicity laws. All patrons making use of it and other library content are individually accountable for their responsible and legal use of copyrighted material.

USF College of Public Health Oral History Project
Oral History Program
Florida Studies Center
University of South Florida, Tampa Library

Digital Object Identifier: C53-00017
Interviewee: Henry T. Janowski (HJ) Interviewer: E.
Charlton Prather (CP)
Interview date: August 7, 1999
Interview location: Unknown
Transcribed by: Will Clark
Transcription date: October 1, 2014 to October 31, 2014
Audit Edit by: Jodi L. Harman
Audit Edit date: November 17, 2014 to November 18, 2014
Final Edit by: Peter Cannon
Final Edit date: April 20, 2015

E. Charlton Prather: We are very happy to have with us this morning Mr. Henry Janowski, who is currently the bureau chief of the Bureau of Immunization with the state Department of Health. He's been in public health virtually all of his professional career, which exceeds 30 years. I don't think he wants me to speak to how far beyond 30, because if I do that, that would age me too.

But he's been in the Florida public health system a long time and has seen a lot of development and a lot of progress in the state's efforts for disease control. He's a graduate of Florida State University and joined the public health system immediately after graduation in our venereal disease program, where he stayed for a number of years, but took some time off for a master's degree at the University of Tennessee, a Master's in Public Health.

And went to the central office of venereal disease control, but during the course of his progress was assistant state epidemiologist for a good while. Served as a state epidemiologist for a while, and has been now—as head of the state's immunization efforts for a good while. I'm a little uncertain as to what moved him in that direction.

But Mr. Janowski, it's truly a pleasure that you would take the time to come, and on behalf of the University of South Florida and the College of Public Health there, we're grateful that you would come and talk to us about immunization and disease control, and the relationships of those things in Florida.

But how did you happen to come to immunization from a background in venereal disease and epidemiology?

Henry T. Janowski: Well, first, thank you, Dr. Prather; I appreciate being here. It's a great opportunity. I have spent, as you indicated, a number of years in epidemiology, and had been around the protection program. And after seven or eight years in epidemiology, I had observed what was going on with the immunization program, and had rather distinct goals and objectives to reach in the immunization program—which I was interested in—and it was something that I felt like was really a worthy challenge and something that was worthwhile to do, and, at the time, thought it would be fairly easy to accomplish, insofar as meeting those skills; that turned out to be a real challenge.

But I saw that as my next step in my career, and a fun step, and, actually, it has been. It's been a real challenge and it's been a lot of fun.

CP: Good, good, good, good, good. And when did you come? Is that a fair question?

HJ: Started in immunization in January of '83.

CP: I'm not sure I can remember that far back.

HJ: After spending seven or eight years in the epidemiology program prior to that.

CP: Yes, yes. What was your major—your first and major challenge when you arrived? Was it in the doldrums? Were you doing good? Were there immunizable [sic] epidemics afoot?

HJ: Stepped right into the middle of measles epidemics.

CP: Oh.

HJ: Yeah. And they had—there had been some recent changes. To go back to a little bit of the history of the program—although the first Vaccination Assistance Act I think occurred in 1962 or '63, where we got federal dollars for immunization programming. And I think the first laws were in 1972 that required immunizations for school entrance in kindergarten and first grade.

And then that was amended in '82. And in '82, they said all grades, kindergarten through 12 had to be immunized for measles and rubella and DTP and polio. Well, at that time, we were having a lot of problems, both in the preschool population as well as in the school population.

So, one of the first challenges I had was—because we were right in the middle of a large outbreak of measles, particularly in the Miami-Dade County area, but other outbreaks around the state—was to get into the school system and clean up what was in there.

And unfortunately it was not being well controlled insofar as documentation is concerned, and the requirements for getting into school and for those that were coming in at a grade level beyond either the kindergarten or first grade. We had a lot in the school system that were unimmunized.

So, we had to get into the school system and, first of all, clean up the documentation—and there was every kind of documentation in there, from standard documentation of appropriate dates and times signed by physicians, to literally notes on scrap paper to—I even saw some documentation that was written on napkins. That had—

CP: But school—

HJ: Completely immunized and signed by somebody.

CP: School entrance immunization was a requirement at the time. Still, was it not?

HJ: It was just a requirement to get into school. So, you could have come into—at higher grade levels, which was the case. So, then the law would change to include everybody that was K through 12.

CP: Okay. Yeah, I'm just surprised at the poor documentation, poor record keeping, because your birth certificate immunization program had been going on, as you said, since '61, '62-ish. Was this a common pattern over the state?

HJ: Yes, it was. They had—apparently, there was not—and again, this a little before my time—but prior to the '80s, there was not a lot of enforcement. I think there was a lot

more disease control going on than there was enforcement and compliance with the rules. Although they were off to a good start.

So what we had to do was to get in and clean up the documentation and use one form of documentation and not 15 different kinds of documentation; and teach the system, whether it was the folks in the school system that actually reviewed the documentation as the kids came into school to say, "Here's the standard."

There is a standard form with standard requirements on there. It has to be signed by certain people or they can't get into school. So, we really started enforcing those requirements. No shots, no school.

CP: How did that impact the epidemic?

HJ: It made a difference in the '80s. When it was going on, it had a significant impact, particularly in the school kids. But we're still having problems that we were having to deal with in the preschool kids. That continued, unfortunately.

CP: Since that is—even today?

HJ: Not today.

CP: All right.

HJ: Not today.

CP: All right.

HJ: It diminished, actually, with the stricter enforcement and compliance with the school laws. The measles, as well as the other vaccine-preventable diseases, diminished rather significantly. And, even today—this year for example, and it's almost unbelievable that we live in a state of fifteen million people and we've had one case of measles.

CP: Congratulations.

HJ: And that one case of measles came from Germany, in fact; it wasn't even a case that was indigenous to Florida.

CP: That's marvelous.

HJ: It is. It's incredible. It's really incredible.

CP: When was the last case of in-state transmission of measles? How long ago has that been?

HJ: Well, we've had some—only a few cases in the last couple of years, but each of those came from an imported case. The last time we've actually had an outbreak has been five or six years since we've had cases that were—that did not come from an outside source; that transmission took place here.

CP: You trust your surveillance? You have good surveillance?

HJ: I think we have very good surveillance, and that we've heightened the awareness over the years, and the medical community is aware that we're very interested in any kind of rash illness that might have to do with measles. So I feel like the surveillance is fairly good. I think we'd hear about it.

CP: Good.

HJ: I think we'd hear about it.

CP: When did measles become a required immunization for school entrance or school attendance?

HJ: That was probably in '72. That's probably in '72 for school entrance. And then again, later in '82, it was for all school attendees. And then, because—again, the epidemiology pointed us to an older generation—

CP: Yes?

HJ: Older generation—for the college students who are looking at this, the college population. Then we started having outbreaks in the college population. And we managed to work with the council of presidents, and the head of the university system—and, at that time, Dr. Reed—in getting them to pass some regulations for requiring immunization for measles and rubella in the university system. And that was in 1986, and we've had some fairly significant outbreaks in the college population.

CP: Really?

HJ: Really.

CP: Yeah. How did Florida react to the recent death of a meningitis case in one of the northern schools? TV announcer allowed that the colleges were now playing with the idea of required immunization for meningitis for college entrances. Have you got involved with that?

HJ: I really haven't, but there have been a number of calls that have come in. There is—it's heightened the awareness again around the state, and we have a lot of concerned parents, as well as concerned students, that are seeking information on that. And some, in fact, want to be immunized. And if they want to be immunized, they can get immunized.

So far, the college health association nor the CDC has changed the recommendations, but I understand there's some discussions about doing that, in fact; make that a recommendation.

CP: Okay. Speaking of college kids, it reminds me of that, the—back to measles, though. And the measles vaccine itself and the early days of a complication with the measles vaccine. Was there? There was not? Your look in your eyes tell me there was never a particular problem with the vaccine.

HJ: Well, I can't say that there wasn't. I can't remember one myself. But the vaccine was introduced before my time. And there might very well have been, but I'm not familiar with it.

CP: All right.

HJ: But before I leave the college in 1986, one thing that I did want to show you, you probably haven't seen this in a while.

CP: I would appreciate that.

HJ: But this—I'd like for you to see this. The handwriting should be familiar.

CP: (laughs) Mr. Janowski has just handed me a piece of paper, and it says, "To Mr. Hank Janowski, a gold star award for excellence in vaccinizing the state universities." And that had to do with measles. Do I have to say who signed this?

HJ: You have to say who signed that.

CP: This was signed by the then-Florida State Health Officer, it says here, and I'm having difficulty with that signature, Mr. Janowski.

HJ: But it says E. Charlton Prather, MD.

CP: Now that you say that, you're—I think that's correct. (CP and HJ laugh)

HJ: You just need to see the gold star, please? (CP laughs)

CP: Thank you, Mr. Janowski.

HJ: Well, I appreciate the recognition there. But actually, that really was a—that was a significant adventure in convincing the folks that that needed to be done. But they were—the university system's been very cooperative, and it's made a significant change. We haven't had outbreaks in the university system for many years. And making that change brought about that.

CP: Yeah. In the historical sense of universities, I'm reminded a case of tetanus in an athlete at one of the universities. Long before your time, Mr. Janowski. But it got the university system really upset and concerned—and this was post-World War II. All returning veterans had been adequately immunized against tetanus, but a death in a

prominent athlete, secondary to tetanus, really created an opportunity for those interested in the prevention of tetanus.

But I'm recalling a very similar incident in which tetanus became a required immunization for entrance into our universities, as a direct result of that. The state board of health provided—we did a lot of immunizing of university students. It was frightful, but it worked out very well. I'm anxious to know what the current statuses are. Are there immunizations required for university entrance?

HJ: Yes.

CP: Nowadays?

HJ: Yes. The—again, they still have the measles and rubella requirement. There are some recommendations even for hepatitis B. And to make sure that you're up-to-date on your DTP and your polio. But there are no requirements; the only actual requirements are for measles and rubella.

CP: Well, there's enough fear. It worries me we have to require it for an educated group, you know? It just makes so much sense to protect yourself. So you were initiated with fire into the immunization program.

HJ: Indeed.

CP: Right in the middle of a measles epidemic.

HJ: Indeed.

CP: Where were you in the heydays of the rubella concerns and the congenital deformations secondary to rubella?

HJ: Well, that was a little bit earlier in my time. I was in the epi [epidemiology] program, but not involved in—so much in immunization.

CP: Yes.

HJ: The—I was trying to come up with the date. I can recall—remember something when they got their first shipment of rubella vaccine in the state.

CP: Oh, really?

HJ: I guess it was in the late '60s. Does that sound right?

CP: It would been—

HJ: Late '60s.

CP: Yes. (affirmative murmurs) What happened?

HJ: No, it was just I had read they were anxious that they had received this and the first shipment come in, and they were delighted to get it out and get it dispersed to the counties to get started with the immunizations for rubella. A lot of folks don't remember rubella. It was a tragedy just like the polio was.

CP: Yes, it was. And that vaccine really got a boost because there was a little epidemic of rubella congenital abnormalities just prior to the vaccine's availability, and it got the attention of the United States. And the vaccine was welcomed. I'm constrained to remark upon the first two people in Florida immunized with the new rubella vaccine were my kids.

HJ: Is that right?

CP: (laughs) Yeah, and one of my kids was the first one to get a—first person to be immunized in Florida with measles, too. That was fun. (laughs)

HJ: You know, you—in saying that, reminds me that, in fact, one of these—I brought a book along that had to do with the acceptance. This was a monograph that was done on the epidemiology of polio vaccine acceptance, and this was done down in the Miami area. And I was surprised at some of the conclusions that they reached in this study, and this was done back in the late '50s, early '60s.

And that they were dealing—we're still dealing with some of the same problems that they were dealing with even back then; when even as a child—a very young child, you understand—

CP: Of course.

HJ: That I can remember the polio—

CP: Your mother told you a lot about it.

HJ: Yes. Mother told me a lot about it. But I can remember being frightened, really frightened, as a child about polio. Because they had—I can remember in the '50s that they were shutting down schools and shutting down swimming pools and the movie theaters. They wouldn't let you congregate anywhere. And then, they come [sic] out with the vaccine—the injectable vaccine, first of all, in the mid '50s

And I can remember people—and I was one of them—that got immunized. And they had these polio Sundays where they lined up and immunized all these kids. Well, I was amazed to see that, as frightening as it was back then, when they first—and then—you know, this was before the vaccine, when they had the iron lungs and you had the children in braces. Oh, it was just frightening. It was terrible.

CP: Every community had children in braces.

HJ: Yeah. What surprised me was, and they pointed out here, that—even then, you would think people would flock, just absolutely everybody, would flock to get their children immunized. But that didn't happen. I mean, there was a big interest, there was a lot of people; but there was also a lot of people that didn't.

And in this day and time, it hasn't changed any. You still have that segment of the population, for whatever reason, that doesn't seem to feel like it concerns them. And it still takes a lot of information and a lot of education; and unfortunately, in a lot of cases, it takes legislative requirements for schools and—

CP: What's your theory as to how come the people ignore the obvious facts?

HJ: I don't know. I wished I had the answer to that. It'd make our lives a whole lot easier in trying to—

CP: And you'd probably get a mobile—a Nobel Prize.

HJ: I probably would. I probably would.

CP: If you could explain that.

HJ: They seem to think one of the things that led people to being immunized was, one, they either knew somebody that had polio, for example, or they were well-informed, well-educated about it. Those—or they were in—within a social group that found it acceptable and were educated about it. And that tended to get them more immunized than those that were less or less socially involved in it.

CP: So that kind of guides your programming, does it not? Recognizing those sociological truisms?

HJ: It does. And we seek out of those pockets of need, if you will, and we also—one thing that we changed back in the early '90s—we came out with what we call a missed opportunity policy to avoid missed opportunities that we always try to—anytime a healthcare provider sees a child—that they screen them for the immunizations, regardless of the reason that they're there. And that has helped close that gap, to make sure that every opportunity is given.

CP: I like that. That's rediscovered. I remember some campaigning about that long before you arrived.

HJ: I bet.

CP: Yeah. And that's fascinating. And you're seeing it, and you're feeling that it's working now among staff. I include doctor's offices, privately practicing physicians of all persuasions; not only the pediatricians, but all the physicians should be on that same bandwagon. The cost benefit and the human benefit is just overwhelming.

HJ: It is.

CP: From your reading, though, let me move backwards to Florida's beginning in immunization. From your reading, do you have knowledge of when did Florida get involved with doing vaccines? Which one was it, and what did they do?

HJ: You know, back in—actually, in the turn of the century, when we got into the 20th century—the cholera, smallpox, tuberculosis, and measles. I think those were the major diseases and the major killers. And, you know—I know you've already covered our state health department, State Board of Health, started back in 1889.

And around the turn of the century, that was some of their largest problems that they had to deal with. And what even made it worse was when we moved more from a rural population to an urban population, it brought us closer together and it created problems with the diseases.

To the best of my memory, it was about—even though we had a bureau of preventable disease, and then later—that was in the early—1901, 1905, something like that—then they, I think, they had the first bureau of epidemiology around 1916, I believe.

CP: Yes.

HJ: You—

CP: I was not there.

HJ: You were not? Okay.

CP: I was not there.

HJ: I think the first actual effort, and I don't know what the delivery system was, but it was about 1926 was for diphtheria. And diphtheria was a real killer here, as elsewhere. But I don't know what their delivery system was, unless it was through their private practitioners, because the health departments hadn't even been organized yet.

CP: No. No. And there were the—can I fill in for you?

HJ: Please.

CP: I didn't go through that, but I've read that piece of history. That acceptable? Yeah, and we were stimulated. The diphtheria vaccine—diphtheria toxoid—became available about 1922, '23. It was new. People were not used to immunizations; the only one they were really used to was smallpox.

The United States had been smallpox immunizing ever since the smallpox became available. Some of Jenner's own smallpox vaccine was used in Boston to stem an outbreak of smallpox in the mid-1700s, before we became a nation, which I think is fascinating.

Dr. Porter used smallpox vaccine in Florida very early in his tenure, and recommended the immunization against smallpox for school children as early as 1902, which was a universal thing. And I'm carrying in my memory that somewhere in the late thirties, smallpox immunization became a requirement for school entrance in Florida.

You need to check me out on that. I'm pulling my brain kind of hard. But I've carried that as the first, quote, "required immunization for Florida" was smallpox. And even then, even then, not Dr. Porter--but in my time at the state board of health provided smallpox vaccine.

Two practicing physicians, who gave most of the smallpox immunizations, were done by the practicing physicians, even in this—as late as the late '40s and early '50s. Health departments, of course, did too. But the state board of health provided the vaccine to anybody who'd use it, free of charge.

We would ship it to them, and they would use it. Largely, private physicians; they gave more immunizations than did the health departments in the very early 1950s, in terms of pure numbers.

HJ: Can you recall what the price of vaccine used to be back then?

CP: For smallpox vaccine? When I became fiscally responsible for it—it would have been in the late '50s—I think we were paying about three-quarters of a cent a dose. Three-quarters of a cent per dose per smallpox vaccine.

HJ: Times have changed significantly. (CP and HJ laugh)

CP: Yeah. But I got onto that for diphtheria. If you've read your history, too, there was a significant amount of diphtheria in the mid-1920s. Death rate was running about 60 percent to diphtheria. The state leadership was concerned, the state physicians were concerned; but there was a great hesitancy with this toxoid, this toxoid, that was the diphtheria vaccine. And the written record shows there was a significant resistance, even on the part of physicians, to use that stuff.

But the health officer of the time made it available and did some education. There was a whole *Florida Health Notes* given to trying to motivate physicians first to use the vaccine. And, if you remember, the *Florida Health Notes* were distributed rather widely to the public and anybody who would read them.

And that particular health notes was given—as I read it now, I can read it as being focused on physicians to use the vaccine. But in the same one was appropriate writing to stimulate [the] public to begin to ask for the diphtheria vaccine that you know to be a toxilate.

And the state board of health would provide it, again, to any physician who would use it. It would be provided free. You're reminded that there was only three or four operating organized health departments at that time, and they were all city, a city function. There was one in Pensacola that stands out. One in Orlando stands out. The one in Jacksonville stands out.

And the city health department in Tampa was active, but it—the concerns of these were not the public's health. The concerns of these were the medical care of the indigent. It's what the city health departments were focused on, largely. But they did some good public health stuff, too.

But with the beginning of—I don't know remember who the health officer was at that time—but there was a significant public education effort, and this being significant because this was the second publically distributed-vaccine in Florida—smallpox being the first, diphtheria being the second—and was stimulated by a large outbreak.

And most of the cities of Florida during the period from about 1922 that went on, continued on into the early thirties that diphtheria was a very significant problem with very high mortality rates associated with it. The gamma globulins, the hyper immune vaccines, hyper immune sera, were also available then; few physicians had experience with it, and it was made in horses. And there was a lot of reaction; a lot of anaphylactic reaction secondary to the use of the horse serum, the antitoxin for diphtheria.

I don't know the numbers—you've stimulated me—those numbers are available to us; and I haven't had them in my hand in years. But that's a piece of the beginning of Florida's attention to the immunizable diseases: first smallpox, and then secondly diphtheria. And it came, at that time, as a single toxoid. It did not have the pertussis, the whooping cough, which you have today, and it did not have the tetanus that you have today.

Those three were combined, if my memory serves me correct, only in the mid-thirties. Those three—two toxoids and one cellular vaccine—get put together into one dose that we now call DPT. So, that's a late—late arriving on the scene. And it shocks me that you still have diphtheria. As you said, how come do you still have diphtheria?

HJ: Well, not much. We haven't had a case in Florida in a number of years. We had one case a few years ago, but there's not much diphtheria at all.

CP: Congratulations.

HJ: Yeah.

CP: Now, the vaccine is almost 100 percent preventable. And it works so well.

HJ: You know, as you were particularly talking about smallpox—it's hard for me, even being involved in immunizations, to realize it hadn't been that many years ago that they used to have major outbreaks of smallpox in this state.

CP: In Florida.

HJ: In Florida.

CP: That's correct.

HJ: I mean, thousands of cases. I mean, it's amazing.

CP: Up through the forties.

HJ: Yeah.

CP: Up through the 1940s. Yeah, these modern folk—smallpox and things—we don't even have any in the world.

HJ: That's right. You know, back in—well, I think it was—the last case was in Somalia, I believe, in '77.

CP: That's pretty good.

HJ: And I think it was declared eradicated from the face of the earth in '79. Officially declared. And—but it's really difficult, and a lot of folks don't realize that there were major outbreaks of that disease, smallpox, with people dying—lots of people dying here in Florida. And back in the turn of the century, and what, like you said, on later into the—almost to the mid-century, people of dying diphtheria and smallpox not that far back. It's amazing.

CP: A lot of us lived through that. Even you were young enough to remember some of that.

HJ: I can. I can. Especially, again, the polio.

CP: Yes. Let's go to polio a little and address Florida's history of attention to polio. You mentioned the vaccine trials in Miami, and that was one of the oral vaccines, was it not?

HJ: (affirmative murmurs) The trials took place in Hillsborough County, in Tampa, on the three—

CP: On the three, on the three. The one in Miami was single valent, they called it.

HJ: They did some studies in Miami in—but the ones I was making reference to had to do with vaccine acceptance of the injectable, the IPV vaccine.

CP: Okay. I'm sorry.

HJ: But the trials, the ones—I know there were other trials because this one makes reference to some that took place in the Dade County area. But this was in Hillsborough [County] in the late '50s, early '60s. And they found it was quite effective, and—I didn't realize, but apparently there were a number of trials that went on with Sabin vaccine around Florida. I know they wrote this monograph on this one, but apparently, it makes reference that there were others.

CP: Yes. There were a number; and the ones in Miami using a Russian-prepared vaccine, by the way. Was—there are three types of Polio? You know, when you have to be immunized against all three types, because all of 'em cause paralytic disease? Did the technology of combining those three viruses into one injection—there were some problems with the technology, that they couldn't get them all into one bottle with equal potency.

So, the earliest trials, you had to have three shots, one of each of the three vaccines. In the University of Miami—I want to mention a name, Dr. Eugene Flipsy, who was director of—professor of preventive medicine at the University of Miami School of Medicine, was the main investigator; he was the boss in charge of that process.

And it was German vaccine. It was—I'm sorry, Russian vaccine that was used in license through an American company. I don't remember which one. And those trials, in an effort as the first—that was the first large trial of an oral—I'm sorry, of an injectable polio vaccine.

It had too many slip-throughs, the vaccine did, and was not acceptable for licensure in the United States. That was the first, and was very notable as the first polio vaccine trial in the United States, was done in Miami at that time. And the vaccine was not acceptable; the data were not acceptable, neither for immunization nor for safety too.

And then, in Hillsborough was another very large trial. You need to remind me, I'm thinking that was oral vaccine.

HJ: It was oral vaccine.

CP: Yeah. A major in that—concomitantly were trials going on in California with the first rounds of the letter—of the injected vaccines, the killed [inactive] vaccines were in California. And the licensure of the vaccine came out of those California studies. Subsequent was that there was no further Florida studies done on the injectable vaccine.

But the first and major and conclusive studies of the oral vaccine both for analogic efficacy and for safety were done in Hillsborough County. And it was those data that caused a fully licensure of our oral vaccine, and the sugar cube—the sugar cube vaccine.

So, yes. There were—Florida was significant in the—in our having the polio vaccine. And you noted from the studies in Hillsborough that folks were—folks were excited about it, but there were significant pockets of people who don't take vaccines and why. And from your epidemiology point of view, that causes you pause and worry. Don't you?

HJ: Yes, it does.

CP: If you've got a pocket of live polio vaccine out there somewhere, it's kind of hard to fits [sic] them in with immunized folks around them. How do you overcome that?

HJ: We're still fighting it.

CP: Oh, you still have 'em? You still have folks that don't see the need?

HJ: Still have 'em. Still have 'em. They go back to earlier when I mentioned these pockets of needs that we look for out in the communities. And, you know, actually we are—even now, we're getting into what they call the GIS system, the Geographic—

CP: Global—

HJ: The—

CP: I don't know.

HJ: (laughs) Are we both too old for the—? GPS, Global Positioning System.

CP: Okay, thanks.

HJ: That's it. GPS.

CP: I knew that's what you were trying at.

HJ: We're even getting into that, yes.

CP: You are?

HJ: Yeah. We were—what we were doing was mapping out, in fact, where our immunization levels were by GPS identification; and then, where our resources were, and trying to tie the resources with where these pockets of needs are that we still have in the communities. So, we're trying to move forward a little bit.

CP: With GPS?

HJ: Yes, with GPS.

CP: I can't even fathom that. In the old days, you sent somebody out there with a map and a pencil.

HJ: That's exactly right.

CP: You marked 'em down.

HJ: Now we can sit at the computers and do that. We certainly can.

CP: Fascinating.

HJ: But, you know, you mentioned these trials with the polio vaccine; we've gone full circle now from our injectable polio to our trivalent oral polio, and now we've gone all the way back to where—in fact, come January 1, the oral polio will no longer even—I don't even think it'll be available—but it's not recommended at all. We're going to a full injectable—

CP: The complication rate has become too unacceptable, based—

HJ: They found you're at greater risk from getting polio from the vaccine than you were from a wild virus.

CP: And that risk is what?

HJ: It was miniscule. And it was something like one in every eight to ten million doses. It was fairly small.

CP: But, when we have no polio, that's an unacceptable risk.

HJ: That's correct, and that's why they changed it. It was an unacceptable risk. We had—it's been—gosh, it must have been 12 to 15 years ago since we've had our last wild virus polio in Florida.

CP: Was it imported? Or local?

HJ: I don't recall the epidemiology of it.

CP: Okay.

HJ: It's been a long time, thank goodness.

CP: Okay, our polio—and I'm young enough to remember the polio wards at St. Luke's Hospital in Jacksonville, where the state provided support. And I have a mental picture of a ward with about 20 iron lungs lined up against a wall with a patient in each one of those.

And those were still there. That ward was still active in the mid-to-late '50s—1958, I think—with a massive outbreak of polio in Jacksonville. And the injected vaccine had just become available. It was brand spankin' new, but licensed.

And the response to that—I mentioned it's Jacksonville, 'cause I think it's the last outbreak Florida's had; a real polio outbreak where there were multiple cases was in Jacksonville.

HJ: You recall the year that was?

CP: Fifty-eight, '59, in there. And the response was a massive community-wide immunization program. But the community surrounding Jacksonville is—I don't remember Tallahassee, but I'm remembering as far away as Suwannee County and Hamilton County; those who went to Jacksonville viewed Jacksonville as their injection center.

There was a demand, demand for the vaccine for their children, and the state board of health mounted a rather significant injected polio vaccine that was by—our first use of the jet injector guns was used to get that vaccine in, in those days. Do you still use the jet injectors?

HJ: We don't use them. They had—I hate to even mention that, back when they had the swine flu scare, back in '76 I believe it was, they used the jet injectors, and as far as I know, they haven't used them since then.

CP: Really? The public reaction to 'em?

HJ: Yeah. They—also, I think, they—you know, as we became more concerned with blood borne pathogens and the possibility of a potential for transmission because they touched the skin and that sort of stuff.

CP: And they drew blood in many instances.

HJ: Yeah. So—although they're working on new apparatuses now, and have some out on the market but we don't have any available.

CP: Fascinating. I remember that, and I'm constrained to remark that the first dose of swine flu vaccine in Florida was given in a jet injector guess to whom? State Health Officer.

HJ: Is that right?

CP: Yep. Before all the TV cameras and the presence of the secretary and the governor, both of whom got their swine flu [vaccine] too. (laughs) Well, I'm glad to hear this story on polio. What role did the state health department play in polio prior to vaccine? Do you know?

HJ: No, you're—

CP: Oh, you're the immunization person.

HJ: Yeah, and you're going before my time.

CP: All right.

HJ: We're getting' back in your time.

CP: Distribution of gamma globulin—I just want for the record—is a part of Florida's interest and concern through the American Red Cross, who produced gamma globulins, which was the beginning.

But our only—only thing we could for polio—it was used therapeutically in the early stage. But the most of it was used prophylactically; those who have been exposed to polio were given a calculated dose of immune globulin of gamma globulin as a preventive for polio.

It worked pretty good. It was profoundly expensive, but the state board of health procured it, the American Red Cross developed it, as I told you, and with help of the polio foundation, naturally; the Foundation for Infantile Paralysis.

And it was a major, major business of the epidemiology office, by the way, during—largely during the '50s—was the maintenance keeping and distribution of the gamma globulin as a polio preventive.

We could just plan at the beginning of mid-summer the demand would begin to go up, because there was cases, there was polio cases in Florida. No significant outbreaks during those days, but cases, and I'd like to think that the gamma globulin probably was influential in prevention of significant outbreaks.

It was a piece of the history on polio, but it pleases me in that it is a disease of the past.

HJ: For sure.

CP: But the risk is still here, is it not? Don't you still have it on our borders? Isn't it still present on our borders? Doesn't every airplane have a risk of bringing some in?

HJ: I started to say, we've done pretty good with our borders, but the fact that Florida—and a lot of people don't really pay much attention to this—but just through the gates of Miami, we have something like four million international visitors coming through there, and the same way with—in Orlando, about an equal number.

In fact, we have something like forty million people that are visitors that come into the state of Florida. All those have a potential risk, and with our airline travel in this day and time, someone can be infected in another country and be here in a few hours. So, yeah, there's always a potential.

And you need to—you know, it's part of the problem with—in selling our product, if you will, in selling the idea of immunizations, if we remove the threat, and we've done a very good job of that, that people don't see the need for it. Or they see the need for, "You can get your children immunized, but I don't really need necessarily need mine immunized."

CP: "And since mine play with yours, if yours is immunized, mine's protected."

HJ: That's right.

CP: You hear any of that?

HJ: Yeah.

CP: We used to hear that a lot in the old days. Let me hark back, though, and stimulate your brain for the progression of organized effort in Florida for immunization. And you mentioned earlier the infant immunization follow-up program. You said something like that?

HJ: You know, it goes back—again, I mentioned, in '60—1962, the Vaccination Assistance Act from the federal government gave us some additional dollars; and they had—from birth records, they would follow up on new births in the state to try to get them into an immunization program, whether it's in the public or the private sector, but to get them into the health department and get them into the doctor and get them started.

And that has—actually, that still goes on today. It's changed a little bit. We have a—we follow up on the new births, still through the county health departments; we have an electronic mailer, if you will, that we mail them a package of information and a—along with their immunization registry card—and it still goes on to this day. So, it's been going on since the '60s up until now, and all new births in this state—

CP: Get a greeting?

HJ: Get a greeting. And then we also have—Hallmark greeting cards has been very generous to us the last couple of years. They have provided us with a Hallmark greeting card that we send out at the child's first birthday to remind them to continue on with their immunizations.

CP: Really?

HJ: Yeah. Nice cards, signed by the governor.

CP: Marvelous!

HJ: It is. It was a good program, and we're appreciative of Hallmark cards doing that for us. It's a very attractive card. But, you know, it moved in from the '60s and this—the new mother follow-up program into passing some laws; again, back in '72, I think the first law passed, and then it was amended in the '82.

And then, it has—we got some new laws that started in the '90s, as a matter of fact; most recently—well, we changed when the new vaccine for *Haemophilus influenzae* came out. We have a requirement in childcare centers.

I might add, after schools, we had, I think it was 1974, they changed—they passed laws requiring immunization requirements for childcare centers. Although, that wasn't readily enforced either; in fact, again, until the early '80s, we really started pushing that.

But I've got to add that, at this point in time, in schools, immunization levels are about 98 percent of our school children are immunized, and about 96 or 97 percent of our children in childcare centers are immunized.

CP: Marvelous!

HJ: It is. It's been—

CP: And that's happened under—during your watch?

HJ: Yes, it has, a matter of fact!

CP: I might have to send you another gold star!

HJ: Okay. (CP and HJ laugh)

Pause in Recording

HJ: It really has been a goal that we've tried to reach, and it's been one that we feel like we've accomplished, and it's made a very, very big difference in the morbidity of vaccine preventable diseases in that age group.

Now, I'm gonna' have to go back and say, when we thought we had been doing such a marvelous job in the preschool population, that, lo and behold, in 1989, 1990, and 1991, we had a resurgence of measles.

CP: Whoops.

HJ: About 55,000 cases occurred in the United States with about a 135 deaths, I believe. Florida had somewhere around 1,400 cases and a death; and it occurred, for the most part, in the preschool population.

And that stirred great interest, not only in the state but at the national level. They had an immunization initiative that started back in '89 and '90 that they started putting special attention into immunizations and started funneling some more money there.

In 1991 and '92, they came up with an immunization action plan—I say “they,” this came out of the federal government—that if the states wanted some monies, they had to come up with an immunization action plan for the state of Florida, for example, which we did.

And what we did was to ask each of the 67 county health departments to provide us with a plan themselves: what it is that they needed, that they wanted to do to increase immunization levels in their community. So, we gathered those plans, and then made a state plan; and what it all boiled down to, for the most part, is we needed more people.

We needed more nurses to provide more immunizations; and to have extended hour clinics, outreach clinics; and make immunizations more accessible and more convenient to our clients. Well, that happened.

And another significant thing happened also. We asked the Kiwanis Club to join us in this effort, and in 1992, the Kiwanis International in the state of Florida joined us, and actually obligated themselves for an eight-year period, until the year 2000, to work with us, to help reach the goal of 90-percent immunization levels of our two-year-old population.

So, that started in '92, and we got—and it was to go for five years; the funding was to go for five years. The funding actually lasted longer than that, and in fact, we're still getting some funding. Not as much, but some.

But during that period of time from 1992—was when it was passed, I think the monies got here by 1993—so since that time, we've gotten about thirty-five million dollars that was poured into the state for increased services and the counties were able to get more nurses, have more clinics, have extended hour clinics, to have more outreach.

The Kiwanis Club helped us put on special programs. They even helped purchase some outreach vans. There have been several vans purchased around the state; I know there's one in Jacksonville, and in Miami, and Fort Lauderdale, and Pensacola, and I think some other areas. But they helped purchase these vans for outreach services to kids that don't have access to the clinics.

So, it's been a—indeed, a worthwhile effort. At that time, in the early '60s, our immunization levels in our two-year-old population was running around 62 percent, and it's now right at a little over 86 percent. So we've made some significant progress in that preschool population.

And that all came out of the fact that we were, I guess we were a little bit smug in our feelings that we had the battles won back in the 1989, and '90, and '91, when we had this rather significant outbreak of measles, but that did bring about some significant changes: not only in the way that we do business or that we had more staff, but there were a number of other things that—

For example, I've mentioned already this pocket of needs, that we've gone out and tried to seek out where the under-immunized are in the community, and where the resources are, and tried to make sure that where the pockets of need were, that we had the resources to match that.

We also tried to join forces with some of our other agencies. The WIC program—the women, infant, and children—we tried to coordinate with them so that every child that comes in for WIC services, and there are literally hundreds of thousands of them to participate in that program, that they get screened for immunization as part of their services.

CP: Excellent.

HJ: Another thing that I'm right proud of that we were able to do was to work with the department of children and—families and children—children and families. With the aid

to family with dependent childrens [sic] or the WAGES® program, I should say at this point I guess it's called. But for the children that participate in those programs, immunization was made a requirement for participation in that.

So, if you get—if you get those services, then you're screened and immunization—appropriate immunizations are provided. So, working with—one, having those extended clinics, extended hours, more accessible clinics, working with these organizations such as Kiwanis, approaching it a little bit differently with this missed opportunities policy and screening everybody that comes in, working with social services and WAGES® program and the WIC program, has made a significant difference. A significant difference.

In 1994, a program that came out that's—again, it was a federally funded program; it's actually a Medicaid program that is administered by the department of health is the Vaccine[s] For Children program. Now, you mentioned earlier, back in the early days, when the state board of health was handing out vaccines to physicians. With this Vaccine[s] For Children program—by the way, like everything else, the price has changed it a little bit.

CP: Oh, it has?

HJ: Yeah. It's a little over a penny a dose now, (CP laughs) significantly so, in a lot of cases. For example, I don't remember what the first measles used to—the first measles vaccine sold for, but I can remember when it was just a couple of dollars a dose. And it's—even on our contracts—it's about 16 dollars a dose.

CP: Yeah, the first that we bought, as I'm recalling, was we had pay a 1.35 dollar per dose.

HJ: Per dose.

CP: (affirmative murmurs)

HJ: Well, even on our federal contracts, it's about 16 dollars a dose, and if you buy it on the market, for the private physicians, it's about 25 or 26 dollars a dose. Just to give you an idea of the difference in prices.

But this Vaccine[s] For Children program came out of the fact that they were—a lot of the children were being unimmunized because of prices: because prices of services and prices of vaccine.

That, and the fact—again, we thought we were creating some missed opportunities because children would go in to their private physician's office and they were unable to pay, so they were then referred from the private physicians down to the county health department. Well, a lot of mommas and a lot of kids didn't show up down at the health department when they left the doctor's office.

CP: Naturally.

HJ: Right. So, there was—what we were doing was creating a missed opportunity there. So this Vaccine[s] For Children program was to help there. It was supposed to help with the cost. It was supposed to put the vaccine in the hands of the private physicians, so that they would no longer have to refer kids at that and create a missed opportunity. They could, in fact, immunize right there on the spot. That began in October of 1994, and it has been a rousing success.

CP: Really?

HJ: It's just been wonderful. We have—we started off with about—I'm gonna' say, about 700 physicians that joined us in this program when it first started. And we now have somewhat over 2,000 sites with about over 5,000 physicians in the state that work with us, that we provide vaccine to and then they administer it to those eligible for this program; which is those that are uninsured or underinsured or in Medicaid or American Indians, those four categories. But it's been an absolute—probably has done more for immunization programming in—certainly in the last ten years, than anything else we've done.

CP: Really?

HJ: It is really, really (inaudible).

CP: That is phenomenal.

HJ: But not only just the fact that we've—they're assisting us in providing the vaccines to these kids, but it's also done a lot to bring us together, the public and the private sector. But we've always tried to work towards, and this has brought us together. I mean, we work very closely with them; they're very appreciative of this, and we literally house the vaccine here.

We ship it out of the state health department here. We have our own shipping containers and dry ice and wet ice and the vaccine, and we can literally get the vaccine to them quicker than what the companies can do it. So, they're very appreciative of the fact that we have those kinds of services.

CP: What—for my curiosity, and you're being state government, how ominous are the reporting requirements you put on the physicians?

HJ: You know, when they first started this program—it tickles me that you bring that up; that being an old bureaucrat as you have been in the past (CP laughs)—the federal government was very sensitive to the fact that they didn't want any undue hardships on the private community that was participating in this. So, the requirements were small.

CP: I think that speaks to the success.

HJ: Well, it's changed a little bit (HJ and CP laugh) but not to the demise of the program. But we knew how government works, and even though they said, to start with, we didn't want a whole lot of accountability. Or we didn't want—I shouldn't say it that way—we didn't want to put a lot of paperwork and a lot of bureaucracy attached to this program.

But, at the same time, I knew, the way the government works, they're gonna' want accountability. (CP laughs) So, we tried to slip a little bit in there, along with signing up for the program, although not much. They had to sign an agreement that they would follow the recommendations of the—

CP: Immunization practices.

HJ: ACIP immunization practices, and a few things like that; and other than that, there wasn't a whole lot of documentation, other than they had to agree to who to provide it to. We've gone a little bit further than that; but it's been helpful to 'em too that we've asked now for a little bit more of who you give it to, and—and, of course, they've always had to identify on their records, eligibility of the client that they were giving it to.

But for inventory purposes, and to help us and help them at the same time, we've asked them to keep, in fact, records of who they give it to. Because we ask them, when they send us an order, we ask them to give us how much vaccine they have on hand, and then their order. And then, we take a look at how much we've shipped, how much they have on hand, and how much they need.

So we can keep up with their inventory and give them what they need, according to what their usage is. But they have not had any difficulty whatsoever with the kind of demands that we've made on 'em. It's just, it's just—it's been an incredible success. It really has. Now those kids that were at one time being referred to being immunized in their medical home, which is what we would like for them to do. So, it's made a big difference; a very big difference.

CP: That is super!

HJ: It is.

CP: Super. I would hark back to our early days: a physician could call the office of the epidemiologist and say, "I want 25 doses of small vaccine—smallpox vaccine." And they shipped out. It was shipped out. All we needed was his address.

But the vaccines were even relatively cheap at that time; all cost was significantly less than they are now; but at 16 bucks a whop, you know? Yeah, as a taxpaying public, I want you to have some sort of security, that that vaccine's being used prudently.

HJ: Not only that; another thing that we do, that we've used as an opportunity with the Vaccine[s] For Children program is—and we started this not long after the program started—is that I send people out into the field, into the private physician's office to monitor this program and how they're using the vaccine.

A lot of good has come out of that. First of all, we've been able to provide a lot of education to the physician and to his staff on the vaccine handling and storage practices. Believe it or not, there's a lot of problems with, you know, at what temperature to store vaccine and how to store it.

And with the new varicella vaccine and the polio vaccine having to be frozen and the others being maintained at a certain temperature, that gave us an opportunity to get out in the private physician's office that we really hadn't had before.

So we do that, we cover all the, you know: "This is how you do it, this is how you store it, this is how you handle it." In addition to that, we have a computer program that we take with us, with little laptop computers. It's changed from the abacus they used to use in a slide rule.

CP: Do you all know how to use an abacus?

HJ: No, no, no.

CP: I don't know what's gone and happened to you. (laughs)

HJ: But we take—we go out there and we pull a—depending on the size of the practice, we either pull a sample of his two-year-old children or we take the full population of his two-year-old children; and there's a computer program, it's called CASA, which is a clinic application for analyzing the data on the two-year-olds and the immunization levels of them.

Most private physicians, if you ask them, "Doctor, what are the immunization levels like on your preschool population? Did you immunize them?" "They're great. They're absolutely great. They're all immunized. All my clients are immunized."

CP: "Every one I've stuck a needle to are immunized."

HJ: That's right. What we ended up finding out was, to their surprise—to their genuine surprise—that the immunization levels weren't so good in their practice. And we're able to point that out through that computer analysis. And what makes you really feel good is, because they're genuinely interested in providing good preventive healthcare to their clients—

CP: I think they are.

HJ: They are. Once that was pointed out to 'em, then they started doing more follow up. They're doing tickler recall systems to get these clients back in. We go back in a year later and reevaluate their program again, and you would see the increase, a significant increase, in most; in most, a significant increase in the immunization levels.

CP: Marvelous!

HJ: So, that VFC program, the Vaccine[s] For Children program, not only did it provide them with the vaccine and the resources, but it provide[d] us with an avenue to develop some good relationships with the private medical community to get into their practices, to work with them, to help increase their immunization levels. And it's just been great; just been great.

CP: Have you—are you in a position where you could publish on some of this? *Florida Medical Journal* now is kind of defunct, though, isn't it?

HJ: Actually, I didn't know that.

CP: Yeah, I haven't seen one. Because of money—

HJ: Come think of it, I haven't seen one lately either.

CP: Yeah. I was wanting to encourage you to get permission to write up a lot of this and stimulate the rest of them.

HJ: Well, it's just been great. It really has. They knew what they were doing when they put that program out there.

CP: That's marvelous. And the feds are funding it?

HJ: Yes, yes.

CP: All right. Good, good. All of this just pleases me so much. Let me flip your page to the other side. What's the morbidity rates for your immunizable [sic] diseases? We got good immunization coverage, we got some hold—

HJ: What morbidity rates?

CP: That's the right answer.

HJ: That's the right answer.

CP: That's the right answer for I'm asking how many cases of smallpox you had in the last three years? Or how many cases of measles? How many cases of whooping cough?

HJ: It's been, since vaccines have come out; we've talked a little bit about the history of when they came out. In the state of Florida, the morbidity is down right at 99 percent from what it was in the pre-vaccine era. And, of course, we don't have any smallpox, of course. We have—we haven't had but one case of diphtheria that I can even remember in the last ten years or so.

We haven't had a case of polio in, I guess, in 15, 16, 18 years. We still have a little whooping cough; we usually have 40 or 50 cases of whooping cough a year. Again, we've had only one case of measles this year, and only a case or two in the last three or four years. Rubella, we still have a few cases, but not many, just a handful. So, it's working.

One preventive health measure that does work—I might point out that another thing that just came out in publication from the CDC, the MMWR—that's the *Morbidity and Mortality Weekly Report*—it's talking about the control of infectious diseases, and they were just pointing out some of the events that have taken place, and public health—the significance of public health over the 19th century. Or the 20th century, I should say.

CP: Good point.

HJ: Nineteenth century we're talking about; yes, 20th century we're talking about.

CP: You're talking about your time, not my time. Okay.

HJ: But there were—you know, they mention in here, and I don't know that you can see this, but the morbidity going down; but it's just been absolutely incredible. And they pointed out, for example, that the deaths in the turn of the century were, something like, 30.4 percent of those deaths were in children less than five years of age. And that's dropped to just a little over one percent. Now, I think that statistic was back in '96 or '97.

CP: And you public healthers [sic] can take the most of the credit for that.

HJ: You can indeed. I don't think most people understand the significance that public health has made in that, with, not only just vaccines, which has been a very large contributor to that, but just clean drinking water and the sanitary improvements that we've made in public health.

Pause in Recording

CP: That's impressive. I'm sure that you could speak to just the clean water supplies having a significant impact on a whole lot of other stuff. I'm recalling that infantile diarrhea, for example, was a significant cause of death for young children, according to death certificates.

Knowing so much of that was related to contaminated water. That has just been phenomenal on the decrease of sickness in the human population. But I'm thinking, Mr. Janowski, didn't—was there not some sort of environmental impact on the variations in polio morbidity over time, particularly the resurgence of the outbreaks in the '50s?

HJ: Well, it did.

CP: How do you analyze that?

HJ: Well, the—just the fact that we've moved from a more rural society to bringing in populations into the urban areas, and bringing more people closer together, is not only with polio but many of our infectious diseases; it had a significant impact. We've been fighting that ever since. (HJ and CP laugh)

CP: I think the TB people could say something to that, too. The variations in TB morbidity is related to population movement, you know, coming together.

HJ: Well, I just don't think that the population in general understands, you know—first of all, the significance of being able to walk into your kitchen, and turn a faucet, and get clean water; they just expect it to be there, and it's always there. It wasn't always there. And I think the fact that public health has done a lot, not only with clean drinking water, but food services too, and make sure the food supply is clean.

But you take a—clean water and a good, clean food supply, and immunizations during the early part of this century, and it's increased the lifespan close to, I think, 30 years. So we have a lot to be thankful for, insofar as public health in general is concerned.

CP: Public health has been the driving rod, the driving force back of this, has it not? Organized community effort for its common good is what public health is, is it not?

HJ: It is indeed.

CP: Fascinating. You know, I'm very impressed with all of this, Mr. Janowski, the immunization program. You know, it probably could have done more good in the early days, if we'd have been more assertive and more assertive even in the early days with pushing the vaccines that we had. But I think there was a lot of reluctance, even on the part of physicians. Insecure because this was new. You know, immunization was new, kind of, in our attitudes.

HJ: You know, even today, we still have—there's that segment of population out there that still gives us a lot of trouble when we feel like we're doing the right thing. And we're making some—even some recent changes that we've made with, you know, hepatitis B, for example. And just two years ago—three years ago, I think we're in the third year now—we had some new requirements for our seventh grade population to require hepatitis B, a second dose of MMR, and a TB booster.

And this was done for several reasons. One was, of course, to get this segment of the population protected and immunized, especially against the hepatitis B. But also to get them back into—the adolescents, to get them back into their medical home.

CP: Oh, good side benefit!

HJ: Well, actually, that was one of the main reasons, was to get them back in for other preventive health services besides the immunization. And we're, I think, we're

accomplishing that now. The first year it was just get 'em immunized, unfortunately, and not get them back into their medical home, which is actually what we were trying to do.

But it hasn't been easy. There's been a lot of—well, there's been a lot of support, but then there's a lot of factions out there that, one, for the hepatitis B, for example, they see that as a sexually transmitted disease and, “My child doesn't need hepatitis B vaccine 'cause he's not sexually active. Everybody else's child is sexually active.” But it's amazing that hepatitis B vaccine is the only vaccine that we have right now that prevents cancer. And people don't realize that.

CP: Fascinating.

HJ: And they also think that hepatitis B is only passed through sexual contact, and they don't understand that there's, clearly, a third of the cases that we don't where it comes from; we don't know what the source of it is. So, indeed, it's a good thing to do. We've also just started with varicella—with the chicken pox vaccine—and requirements to both in our school system for—that's coming up in the year 2001, 2002. And this past year, we started with hepatitis B in our school entrance. So, two new approaches. But when you mentioned—you know, even in the past, I think we should've been a little bit more forceful; we could've prevented more illness, more deaths.

CP: Yes, that's my point.

HJ: But we're still having to push. You know, you'd like to just say, “Here is a good thing. Let's take advantage of it.” But it doesn't work that way.

CP: It doesn't. List off for me the required immunizations today.

HJ: Diphtheria, tetanus, and polio, measles, mumps, and rubella; varicella is coming up in 2001 and 2002; hepatitis B; and *Haemophilus influenzae* B.

CP: Those are the required immunizations? You didn't—did you mention pertussis?

HJ: Yes. Diphtheria, tetanus, and pertussis: DTP; measles, mumps, rubella.

CP: And to your costs for those vaccines—I forgot to count 'em—what's a base cost just for the vaccines for those?

HJ: You're probably, if you're talking about on the private sector, I'm gonna' say close to 300 dollars.

CP: Just for the vaccines?

HJ: Just for the vaccines. To give you some idea: in '82 or '83, when I started in the immunization program itself, our complete budget for vaccine, for staff, for everything was about six hundred thousand dollars; this year, it's about thirty million. So, it's changed just a little.

CP: Oh, gracious!

HJ: Even just the vaccine budget itself is about twenty-five million dollars.

CP: Really?

HJ: Yeah.

CP: This is expensive. You provide all your vaccines to the public without charge. If I go to the health department, do they charge me anything?

HJ: They do not. That is correct.

CP: Wow.

HJ: That—there's been some changes there in the delivery system over the years. The county health departments that have been the primary point of delivery, and that has changed, particularly most recently. In the past, it's been pretty much a 50-50 deal: about 50 percent in the private sector and 50 percent in the public sector; and a little bit, a percent or two, from the military.

But recently, with the change that we've had in our healthcare delivery system, in managed care, there has been a lot of change now from the public sector into the private sector. And, of course, all the more reason for the Vaccine[s] For Children program to get the vaccine out there, where it's needed, for those that are eligible. But now, it's running about 70 percent in the private sector and 30 percent in the public sector; so a very, very significant change.

CP: That is marvelous. And that's education of your physicians.

HJ: Yes. Well, all the more important for us to out there working with physicians also, and doing the same kind of monitoring and evaluation in their offices that we used to do in the public sector, and encouraging them to do the follow-up with the tickler recall systems.

CP: Did you have any resistance physicians letting you get into their records?

HJ: You know, it's—I anticipated that. I just anticipated some problems, and I was joyously surprised; there just hasn't been any. It's just been a great experience there, you know. And not only that; once we get in there and we provide some education and do some evaluations, they graciously invite us back. It's just a great relationship. It's the best —

CP: I want this message to get to the medical community at large some way.

HJ: I hope they're talking to each other. And, actually, they are. That's one reason that the program has grown as much as it has; even though we've done a lot of education, a lot of mailings out there, I think physicians tend to get, you know, stacks and stacks, and they don't read it all. But we've grown from that 700 to over 5,000, and I think most of that is by word of mouth, that, "Hey, did you hear about to VFC program? It really works. It works good. We get vaccine—"

CP: "Here, call this number."

HJ: "Call this number," yeah. So, the word's out there, but it's really a—I'm just truly impressed with it. I'm impressed with the relationships that we have out there, and how well it's working; and, obviously, the kids are getting immunized. We're up to over 80 percent now of our two-year-olds.

CP: Great. How's your relationship to the county health departments?

HJ: Good. We—

CP: The physician health officers advertising for you with the medical community?

HJ: They—you know, that varies from place to place, to just how closely they work with the local communities, and I think that's always been that way. There're some that are very active with the local medical societies, and some less so.

I think it's an extremely important relationship, probably one of the most important things that they can do; and it helps all of our programs, not only immunizations, but to establish and maintain those kind of working relationships. But I think it varies from county to county just how much they do. I'd like to say it's—there are a lot of good relationships out there. It's done a lot of good.

CP: Good. Good, good, good, good, good, good, good. But they're—now I'm doing 30 percent of the now immunizations for the state at large. They've suddenly acquired a goodly amount of time that could be devoted to something else.

HJ: To other things, that's right.

CP: Yeah.

HJ: And we're sort of doing the same thing. We're shifting our responsibilities, again, more from one of where we have spent a lot of time in the school system and in childcare centers, assessing records and making sure that they're in compliance with the immunization requirements.

And we've been doing that for—gosh, I guess it's almost 30 years; and we're still doing that because we still want them to know that we're interested, so we're still knocking on doors and checking records, probably something to the tune of, you know, a 100,000 a year that we're looking at.

But we're not looking at 'em all, obviously: there's probably about two million kids in the school system: but we do random samples in all counties in order to make sure that they are in compliance. And they are.

CP: Good. Is this immunization program dedicated staff? Or county health department staff? Immunization dedicated staff—full-time immunization staff?

HJ: It is. That's changed around over the years from—you know, we went through this period of time with HRS when we had the districts, and then the districts took the staff. We had the staff before, then the districts took the staff; now the staff is back with the immunization program.

The bureau of immunization has about 50 staff members, 20—about 22, 23 of them—about half of them are out in the field, located in the 12 major metropolitan areas of the state. And they do the majority of the assessments and the surveys that go on in the school systems and in childcare centers, and working with various organizations out there. And then we have staff that's in headquartered here, that goes out and works with the private physicians, as well as the staff out in the field.

CP: Quality control. You're doing evaluation. You're putting it out there—you must've been an epidemiologist or something.

HJ: Yeah, yeah.

CP: Yeah, that's very good, Mr. Janowski.

HJ: We actually do a lot of quality control, and the VFC program that I explained, and those visits to the private physicians. We also do the same thing, and with this CASA evaluation, that we go into the clinics, both in the public clinics, the community health centers also—I haven't mentioned them—that we work with as well as the private physicians. So we do a lot of monitoring and feedback to let them know exactly what it is we find and what our recommendations are.

CP: I'm sure every one of 'em know[s] the advantage: they need to sit down and do this, but they don't have time. And I would welcome you in my office to do that grunt work for me. I'd like to know that.

HJ: Well, you know, to my surprise, they welcome us too, and I'm pleased with that. It's been a very good relationship, and we continue that.

CP: Yeah. Give me a paragraph on where you are headed. Where are you going from now, immunization program wise?

HJ: Well, we're still trying to reach that 90 percent by next year.

CP: All right.

HJ: We don't have too far to go, but I dare say that last six or seven percent is going to be the toughest.

CP: Yeah, they always are.

HJ: Yeah, they are. But I still think we're gonna' get there. And, actually, if you look at the individual antigens rather than the combinations of four DTP or three polio and three hepatitis and two MMRs; if you look at the individual antigens, for the most part, we've already reached that 90 percent. If you looked at the immunization levels of two-year-olds for measles, you would probably find it, probably, about 92 or 93 percent.

And in the same way, if you looked individually for polio and DTP, you would find it 90 percent. Collectively, though, if you look at the two-year-old population: have they all had all of them at the right time? And that's where we're at about 96 or 86.3 percent or so. So if you looked at individual antigens, we're really already at that 90 percent. We've made it, and we're proud of that.

But we still want to get everybody immunized completely by two years of age. But that's also a big task. (CP laughs) A big task. Where else are we going? You know, again, I've already mentioned some of the new requirements, for example, the varicella, starting in 2001, 2002. And the hepatitis [B] that we just started this year in the school entrance.

You know, I think the thing for us down the road is, first of all, there's all kinds of new vaccines on the horizons that they're working on. In addition to that, I think the thing that's probably gonna' help us most is to get some of these vaccines into multi-doses or into multi-antigens, I'd say, in a dose. And, you know, for example, I know that there is one on the horizon that's a penta-valent: it's a five-valent vaccine.

That, I think, one thing that makes it difficult for us, and difficult for parents to accept is their—those little babies getting stuck as much as they do. And I feel for 'em also. It is a lot of sticking. And so, the more that we can combine those vaccines, I think the better it's gonna' be for us. I think we're gonna'—it's gonna' help us with increased levels and it's gonna' help us to get kids immunized at an earlier age.

That—along with, you know—we're finally catching up with the technology age; we are in the process of building a statewide registry—computerized registry that should've been done many years ago, and we've never had the resources to do that.

CP: Oh, the technology, though, to have done it. You talked about typing the individual pages when we first came in; that would've taken an army of clerical staff to keep a statewide registry longhand.

HJ: Yeah. Yeah, it would. We've actually, uh, are in the developmental stages—well, we're a little bit further down the road than that. We have an immunization module that's available to the county health departments that they can register their clients and then manipulate the information; it will print documentation for them, it will forecast what the vaccine immunizations needed are for the client when they're there.

It will do all kinds of assessments for them. Just to simply download the information. In fact, you can download that information into this CASA that I was talking about, and evaluate your levels right there.

CP: Are the data centralized on a mainframe or are these their local computers?

HJ: These are local right now.

CP: Okay, okay.

HJ: But it's the regist—that was the module I'm talking about—the registry that we're currently building, which is being, by the way, piloted in five counties right now in Florida. So we've gone far enough that we've developed the software; we're debugging it right now, if you will.

Hopefully we'll have it into most of the counties by early next year, and into the private sector, hopefully, maybe by the end of the following year. And what we're trying to do is to download the vital statistics births right into the registry, so that we have all one 192,000 births into the registry.

And then, as children come in, whether it's a private physician or a county health department, they can access the registry, and then the person and the demographic information and all that is already there. You can input the immunizations and then, as the mobile society that we have, if the child turns up again, first one is in Miami and the next one is in Pensacola, all they're gonna' have to do access the computer registry and then pop up and it will show just exactly what they have.

In the past, it's been a real problem because we've actually wasted, unfortunately, a lot of vaccine and over-immunized a lot of the population because we have such a mobile population that they don't maintain their records.

CP: Inadequate records, yeah.

HJ: Yeah, and they don't know where they got immunized last.

CP: "And I don't know what he got."

HJ: I don't—right.

CP: Yeah, "I don't know what he got."

HJ: So this will solve a lot of problems. So, we're going to take advantage of the technology as it becomes available to us, and it's been a long way from that slide rule, right, that we used to use?

CP: Yeah. (laughs)

HJ: Calculating *t* test and chi-squares and two-by-two tables and—and you know now, you can put that in a little machine and it'll do all that for you.

CP: I've heard that. I'm told I'd have to go back to college, though, to learn how to use it. (HJ and CP laugh) Mr. Janowski, this is just so great. What have we left out that we need to have on the record?

HJ: Well, I mentioned the monies that have been put into it; it's a little bit different than it used to be. It's expensive, but, I have to say, it is still one of the best preventive health dollars available anywhere.

CP: Under any circumstances.

HJ: Under any circumstances. You still get the best bang for your bucks with immunizations, there's no question about it, even though it sounds like a lot of money.

CP: Oh, yeah. Now, just compare the measles, case of measles pneumonia in a hospitalization for five days.

HJ: Yeah, true.

CP: You know?

HJ: True.

CP: That's kind of hard to sell to us politicians, but the reality of what you're saying is recognized.

HJ: Another thing that I failed to mention that's important that we had a lot of controversy about folks being hurt by immunizations, and I would not ever want to hurt a single living soul ever and not be the cause of that.

But immunizations—and I think for a large part—have been unfairly blamed for some children being hurt, simply because it's temporally associated with when you give the vaccines, there's a lot of other developmental things going on with infants that create all kinds of problems; and then you give them an immunization, and all of a sudden, it becomes the fault of the immunization.

But at any rate, we got—for the last ten years or so, it's really gotten to be a problem and it's really gotten to be a controversy; and about in the early '90s, they come [sic] out with a registry, if you will; it's a vaccine registry for adverse events. It's called the VAERS system.

CP: National in scope.

HJ: It's national in scope to where anyone that even thinks that they've been hurt by a vaccine can register with this, and there's a compensation program for those that have truly been hurt by the vaccine.

But it also has given them an opportunity for more research into the vaccine as to what is or is not caused from the vaccines. And I think they've helped to dispel a lot of fears that—for example, sudden infant death syndrome was, for a while there, blamed on vaccines.

CP: I remember.

HJ: And they've proved over and over again that that, in fact, is not. So anyway, they're collecting a lot of data. But at the same time, for people that feel like they have been hurt, there is a compensation program. I just think that needed to be said.

CP: All right. Agreed. Agreed, agreed, agreed now.

HJ: Positive things over the horizon. Again, I think with the combination of vaccines, with a good delivery system, with the Vaccine[s] For Children program, with people utilizing the missed opportunities policy and screening at every opportunity, with working with social service agencies, working with civil organizations to give us assistance; we're gonna' make that 90 percent, and I think we're gonna' be able to maintain that.

CP: All right!

HJ: Particularly with the relationship between our private medical community and our public health system. It's working real well.

CP: Great, great, great.

HJ: Dr. Prather, I brought this along just to show you; I'm sure you probably don't remember this, but this actually came out of your old, old bureau of preventive health services back in—when you were in the state board of health over in Jacksonville.

CP: Did you steal it?

HJ: You know, actually, I got that out of a garbage can. When we were moving, back in '76, and they were moving the state board of health and then—the division of health, I guess I should say; a part of HRS—and they were cleaning things out. I looked and I took that out of a garbage can. What I wanted to point at, we mentioned earlier about the cost of things? This little scale here, which, you know, we used to measure—

CP: Our mail.

HJ: You had to weigh your mail before you sent it out. You had to weigh it, put stamps on it—

CP: Each individual office did that.

HJ: Each individual one. And I was noticing down here that a stamp—the mail for a letter was three cents. Is that going to tell how old you were now?

CP: No, that was born long before I was.

HJ: Was it?

CP: Yeah.

HJ: I just wanted to point that out, now that takes you back a little while; all the way back to three cents.

CP: You know, I would point (up?) too: that was official US mail. I have to tell the story. I call—I was called by a secretary of a prominent office in the department of health

sometime, not too long ago, wanting to know my fax number. I do not have a fax, and I told the little lady, “I don’t have a fax.” “Well, boss wants me to get something to you, and he told me to call you to get your fax number.” “Well, I don’t have a fax.”

And she was silent a long time. And then she, “Well, how can I get it to you?” And I said, “Well, I can think of two ways immediately: one, send a courier over or use the US mail.” And she was still—another long pause, and she says, “I’ve only been here three months and I don’t know how to use the mail.” (HJ laughs)

That is a fact. But this scale reminds me of how the technology has moved. You rarely use “US Mail” anymore. You know, and your faxes and your email, you know, has just superseded all of that.

HJ: It really is.

CP: It really is. That’s an interesting piece of history, Hank. And I appreciate your having it.

HJ: (laughs) You’re welcome.

CP: Well, let me say, Mr. Janowski, this has been just tremendous and great, and I want you to know that the University of South Florida and the College of Public Health just thank you so much for sharing with us.

This has been an exciting moment for me to, one, be brought up to date on immunization programming; and two, to hear all this put together into a logical package that you’ve done, a very valuable chapter of our oral history collection and program. And I just thank you so much for participating with us. And I am Skeeter Prather.

HJ: Thank you, Dr. Prather. A pleasure.

End of Interview