ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4541 HHES HB 265 - HB 277 (FILE 1) 113

HB

265

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

House Hess:

April 15, 1988

April 19, 1988

April 20, 1988

5-0789B
Hein
4/14/88

Original sponsor: Hudson

IN THE HOUSE

CS FOR HOUSE BILL NO. 265 (H.E.S.S.)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to community service by, and drug and alcohol abuse treatment for, delinquent minors who violate criminal laws relating to drugs and alcohol."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS. The legislature finds that

(1) an alarming number of minors try drugs or alcohol, or both, at an early age;

(2) many juvenile arrests are drug related or alcohol related;

(3) chemical dependency is a disease characterized by the loss of control over drug or alcohol use, and that related problems, such as suicide and motor vehicle accidents, have become the major health problems of teenagers;

(4) chemical dependency among minors causes serious legal, health, and social problems for the entire state;

(5) the 15 to 20 percent of minors who drop out of school may be in need of preventive education and treatment for chemical dependency;

(6) drug or alcohol use by minors frequently results in truancy, poor scholastic performance, and impairment of short-term memory and attention abilities, and retards the social and emotional development of minors;

(7) the health and welfare of many minors in the state can be improved if the problem of chemical dependency is properly addressed in the disposition of delinquent minors in cases involving violation of criminal laws relating to drugs and alcohol.

* Sec. 2. AS 09.65.070(d) is amended to read:

(d) No action for damages may be brought against a municipali
or any of its agents, officers, or employees if the claim

(1) is based on a failure of the municipality, or i
agents, officers, or employees, when the municipality is neither own
nor lessee of the property involved,

(A) to inspect property for a violation of a
statute, regulation or ordinance, or a hazard to hea th or saf
ty;

(B) to discover a violation of any statute, regul
tion, or ordinance, or a hazard to health or safety if an i
spection of property is made; or

(C) to abate a violation of any statute, regulation
ordinance, or a hazard to health or safety discovered on propert
inspected;

(2) is based upon the exercise or performance or th
failure to exercise or perform a discretionary function or duty by
municipality or its agents, officers, or employees, whether or not th
discretion involved is abused;

(3) is based upon the grant, issuance, refusal, suspensio
delay or denial of a license, permit, appeal, approval, exceptio
variance, or other entitlement, or a rezoning;

(4) is based on the exercise or performance during th
course of gratuitous extension of municipal services on an extra
territorial basis; [OR]

(5) is based upon the exercise or performance of a duty
function upon the request of, or by the terms of an agreement
contract with, the state to meet emergency public safety requirements

(6) is for injury to a minor that occurred while the mino

was performing community service under AS 47.10.080.

* Sec. 3. AS 47.10.080 is amended by adding new subsections to read:

(l) If the court finds that a minor is delinquent as a result of violating a criminal law relating to the possession, use, or sale of a controlled substance or an alcoholic beverage, the court may, in addition to an order issued under (b) of this section, issue an order

(1) that a drug and alcohol screening and evaluation be administered to the minor by a program approved by the office of alcoholism and drug abuse, Department of Health and Social Services; and

(2) specifying community service to be performed by the minor.

(m) In this section,

(1) "alcoholic beverage" has the meaning given in AS 04.-21.080;

(2) "controlled substance" has the meaning given in AS 11.-71.900.

5-0789B
Hein
4/20/88

Original sponsor: Hudson

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 265 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to restitution and community service by, and drug and alcohol abuse treatment for, delinquent minors who violate criminal laws."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS. The legislature finds that

(1) an alarming number of minors try drugs or alcohol, or both, at an early age;

(2) many juvenile arrests are drug related or alcohol related;

(3) chemical dependency is a disease characterized by the loss of control over drug or alcohol use, and that related problems, such as suicide and motor vehicle accidents, have become the major health problems of teenagers;

(4) chemical dependency among minors causes serious legal, health, and social problems for the entire state;

(5) the 15 to 20 percent of minors who drop out of school may be in need of preventive education and treatment for chemical dependency;

(6) drug or alcohol use by minors frequently results in truancy, poor scholastic performance, and impairment of short-term memory and attention abilities, and retards the social and emotional development of minors;

(7) the health and welfare of many minors in the state can be improved if the problem of chemical dependency is properly addressed in the disposition of delinquent minors in cases involving violation of criminal laws relating to drugs and alcohol.

* Sec. 2. AS 09.65.070(d) is amended to read:

(d) No actio for damages may be brought against a municipality or any of its agent , officers, or employees if the claim

(1) is based on a failure of the municipality, or its agents, officers, or employees, when the municipality is neither owner nor lessee of the property involved,

(A) to inspect property for a violation of any statute, regulation or ordinance, or a hazard to health or safety;

(B) to discover a violation of any statute, regulation, or ordinance, or a hazard to health or safety if an inspection of property is made; or

(C) to abate a violation of any statute, regulation or ordinance, or a hazard to health or safety discovered on property inspected;

(2) is based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty by a municipality or its agents, officers, or employees, whether or not the discretion involved is abused;

(3) is based upon the grant, issuance, refusal, suspension, delay or denial of a license, permit, appeal, approval, exception, variance, or other entitlement, or a rezoning;

(4) is based on the exercise or performance during the course of gratuitous extension of municipal services on an extra-territorial basis; [OR]

(5) is based upon the exercise or performance of a duty or function upon the request of, or by the terms of an agreement or contract with, the state to meet emergency public safety requirements;

(6) is for injury to a minor that occurred while the minor was performing community service under AS 47.10.080.

* Sec. 3. AS 47.10.080 is amended by adding new subsections to read:

(l) If the court finds that a minor is delinquent as a result of violating a criminal law, the court may, in addition to an order issued under (b) of this section, issue an order

(1) specifying restitution to be made, and community service to be performed, by the minor; and

(2) that a drug and alcohol screening and evaluation be administered to the minor by a program approved by the office of alcoholism and drug abuse, Department of Health and Social Services, if the law that was violated relates to the possession, use, or sale of a controlled substance or an alcoholic beverage.

(m) In this section,

(1) "alcoholic beverage" has the meaning given in AS 04.-21.080;

(2) "controlled substance" has the meaning given in AS 11.-71.900.

STATE OF ALASKA 1988 LEGISLATIVE SESSION
FISCAL NOTE

REQUEST:

Bill Version: CS HB 265
Publish Date: 04/20/88

Revision Date:
Title: An act relating to community service of minors
Sponsor: Hudson
Requestor: House HESS

Agency Affected: Alaska Court System
BRU: Trial Courts

Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)						
OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
Personal Services	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Travel	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Contractual	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Supplies	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Equipment	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Land & Structures	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Grants & Claims	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
REVENUE	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
FUNDING: (Thousands of Dollars)						
General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Other	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0
POSITIONS:						
Full-time	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Part-time	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .
Temporary	. . . .	. . . .	. . . .	. . . .	. . . .	. . . .

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact. Fiscal note assumes the Alaska Court System will not be responsible for monitoring minor's compliance with community service.

Prepared by: Jan Strandberg, General Counsel
Division: Alaska Court System
Phone: 264-8228
Date: 04/20/88

Approved by: Arthur H. Snowden, II, Administrative Director
Agency: Alaska Court System
Date: 04/20/88

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management & Budget
Impacted Agency(ies)
Senate Secretary

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

MEMORANDUM April 13, 1988

SUBJECT: Municipal liability for minor injured while performing court-ordered community service (HB 265)

TO: Representative Bill Hudson

FROM: Edward H. Hein EHH
Legislative Counsel

You have asked whether a municipality can be held liable for injury to a minor who is performing court-ordered community service in the municipality, as provided under Sec. 2 of HB 265.

A civil action may be brought against a municipality regarding activities or conditions within the scope of the municipality's authority, unless an action is barred under AS 09.65.070. That section does not bar an action against a municipality for injury to a person who is performing a service for the municipality. A minor who is injured while performing court-ordered community service conceivably could successfully sue a municipality if the municipality was under a duty to supervise the minor's service activities and the injury was caused by the municipality's failure to adequately supervise or by some dangerous condition that was allowed to exist because of the municipality's negligence, except as provided in AS 09.65.070.

If you wish to ensure that municipalities will not be held liable for such a minor's injuries, I suggest that you amend AS 09.65.070(d) by adding a new paragraph to read: "(6) is for injury to a minor that occurred while the minor was performing community service under AS 47.10.080;"

If you have further questions about this matter, feel free to contact me at your convenience.

EHH:bb
b4/130

Municipality of Anchorage

P.O. BOX 196650
ANCHORAGE, ALASKA 99519-6650
(907) 343-4674

Tom Fink
MAYOR

MUNICIPAL HEALTH & HUMAN SERVICES COMMISSION

March 9, 1988

Representative Johnny Ellis
House Health Education and
Social Services Committee, Chair
Alaska State Legislature
POB V
Juneau, Alaska 99811

Dear Representative Ellis,

The Municipal Health and Human Services Commission would like to lend their full support to the passage of HB265. Substance abuse is ranked as the second highest behavioral and mental health problem priority in the Anchorage Health and Human Services Plan (January 1988).

The provision of clear consequences for youth who break laws related to the acquisition, possession, and use of alcohol and controlled substances is essential to successful long-term prevention efforts. It is also appropriate that youth in need are provided the opportunity to elect treatment in lieu of community service if a first time offender. HB265 is consistent with Objective #2, Substance Abuse in Volume 3 of the Anchorage Health and Human Services Plan, Policy Recommendations and Objectives (page 4-98) which recommends altering public opinion about the acceptability of social and recreational use of drugs in the community-at-large.

If you have any questions, I would be happy to answer them. You can reach me at 562-2828, or our staff at 343-4674.

Sincerely,

Gari B. Andreini, Chair
Municipal Health and Human Services Commission

cc: House HESS Committee
Representative Bill Hudson, Sponsor
Anchorage Municipal Assembly
Tom Fink, Mayor, Municipality of Anchorage
Ron Garzini, Manager, Municipality of Anchorage
Robert A. (Bert) Hall, Director, Health and Human Services,
Municipality of Anchorage

SJ20/dPD20

DRUG USE
among Alaska youth

Percentage of Alaska, U.S youth who have tried drugs

Drug	Alaska youth ages 12-17	U.S. youth ages 12-17
Marijuana	47 4	26.7
Hallucinogens	7.9	5.2
Cocaine	16 6	6.5
Heroin	2 3	0.1
Stimulants	25 9	6.7
Depressants	14.0	5.8
Tranquilizers	11.1	4 9
Alcchol	71 7	65.2
Tobacco	55 0	49.5

Source Alaska Medicine, January-March 1987 Issue

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CS HB 265
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: "..relating to community service by, and drug and alcohol abuse treatment for delinquent minors."
Sponsor: Hudson
Requestor: _____

Agency Affected: Health & Social Services
BRU: _____
_____
Components: _____
_____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Russell Webb for
Prepared by: Yvonne M. Chase, ACSW, Director — Phone: 465-3170
Division: Family & Youth Services — Date: 4-14-88

Myra M. Munson
Approved by Commissioner: Myra M. Munson — Date: 4-15-88
Agency: Dept. of Health & Social Services

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

(7)

HOUSE COMMITTEE REPORT

Date referred: 4/10/87 FURTHER REFERRALS: Judiciary

DATE: 4-20-88

The Health, Education and Social Services Committee has considered HB 265

"An Act relating to community service by, and drug and alcohol abuse treatment for, delinquent minors who violate criminal laws relating to drugs and alcohol."

RECOMMENDS:

[✓] replace with CSHB 265 (HESS) [ ] the same title

[ ] attached amendment(s) [X] a new title

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the ______ Committee

ADOPTS: [ ] ______ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact

[ ] zero fiscal note

[X] zero with analysis

[ ] same as previous fiscal note published ______

[ ] same as previous zero fiscal note published ______

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

Co-Chairman's signature

HB

269

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907·465·3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

House Hess:

February 4, 1988

HOUSE COMMITTEE REPORT

(7)

Date referred: 5/16/87 FURTHER REFERRALS: Finance

DATE: 2/4/88

The Health, Education and Social Services Committee has considered HB 269

"An Act relating to eligibility for veterans' interest rates for housing mortgage loans."

RECOMMENDS:

[ ] replace with ______________ [ ] the same title

[ ] attached amendment(s) [ ] a new title

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the ______________ Committee

ADOPTS: [ ] __________ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact

[ ] zero fiscal note

[✓] zero with analysis

[ ] same as previous fiscal note published ______________

[ ] same as previous zero fiscal note published ______________

SIGNING DO PASS:

Joyce Munson

Ellis

Bill Hudson

Max F. Gruenberg

Niilo Koponen

SIGNING OTHER RECOMMENDATIONS:

Bette E. Cato No Rec.

Dave Donley No Rec

Ellis

Chairman's signature

Niilo Koponen

HOUSE COMMITTEE REPORT

(7)

Date referred: 5/16/87 FURTHER REFERRALS: Finance

DATE: 2/4/88

The Health, Education and Social Services Committee has considered HB 269

"An Act relating to eligibility for veterans' interest rates for housing mortgage loans."

RECOMMENDS:

[ ] replace with _____ [ ] the same title

[ ] attached amendment(s) [ ] a new title

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: [ ] _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact

[ ] zero fiscal note

[✓] zero with analysis

[ ] same as previous fiscal note published _____ _____

[ ] same as previous zero fiscal note published _____

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

N. Rec.

No Rec

Chairman's signature

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: _____
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: HB 369: An Act Relating to Veterans
Sponsor: _____
Requestor: _____

Agency Affected: Revenue
BRU: Alaska Housing Finance Corporation
Components: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES	0					
TRAVEL	0					
CONTRACTUAL	0					
SUPPLIES	0					
EQUIPMENT	0					
LAND & STRUCTURES	0					
GRANTS, CLAIMS	0					
MISCELLANEOUS	0					
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

Please see Bill Analysis as previously prepared.

Prepared by: Dr. Ronald D. Lehr — Phone: 907-276-5599
Division: Alaska Housing Finance Corporation — Date: 2/8/88

Approved by Executive Director: Ronald D. Lehr — Date: 2/8/88
Agency: _____

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

ALASKA HOUSING FINANCE CORPORATION
Fiscal Note - HB 269

It is difficult to determine how much this measure would cost AHFC since it is difficult to estimate how many former and current Public Health Service (PHS) employees will take advantage of this program. Currently there are 250 PHS commissioned officers working in Anchorage. (Statewide figures were not immediately available.) If all took advantage of the program and qualified, at an average loan amount of $110,000, a 1 percent subsidy would cost AHFC $1.5 million.

If the bill was amended to extend the 1 percent preference interest rate to all active military with at least five years of service, again AHFC finds it difficult to determine just how much it would cost. However, the following is an estimate.

As of September 1986, there were 25,906 active military personnel -including Navy, Army, Air Force, Marines and Coast Guard - serving in Alaska. If one-third of those personnel, applied for, were qualified and received the subsidy, based on an average loan of $116,000, the 1 percent subsidy would cost AHFC $64 million.

It should be noted that the Fiscal Note columns all show zeros. The impact of this proposal would be on AHFC's Revolving Loan Fund.

Additional background and historical information is contained in the attached letter to the bill's sponsor, Representative Barnes.

(7)

HOUSE COMMITTEE REPORT

Date referred: 4/13/87

FURTHER REFERRALS: HESS
Finance

DATE: 5-16-87

The State Affairs Committee has considered HB 269

"An Act relating to eligibility for veterans' interest rates for housing mortgage loans."

RECOMMENDS:

[ ] replace with _____ [ ] the same title
[ ] a new title

[ ] attached amendment(s)
- [ ] do pass
- [ ] do not pass
- [X] no recommendation
- [ ] individual recommendations
- [ ] additional referral to the _____ Committee

ADOPTS: [ ] _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact
[ ] zero fiscal note
[X] zero with analysis

[ ] same as previous fiscal note published _____
[ ] same as previous zero fiscal note published _____

SIGNING DO PASS:

D.A. Bowles

SIGNING OTHER RECOMMENDATIONS:

Terry Martin - No Rec.
NIRFC
Cliff Davidson no rec

Chairman's signature

Alaska State Legislature

House of Representatives

REPRESENTATIVE
RAMONA L. BARNES
DISTRICT 14

Official Business

ANCHORAGE
2230 PAXSON
ANCHORAGE, ALASKA 99504
(907) 337-7904

BOX V
JUNEAU, ALASKA 99811
(907) 465-3438

5

THE INTENT OF HB 269

The intent of HB 269 is to allow Public Health Service Officers to become eligible as veterans for the purpose of the Alaska Housing Finance Corp. State Veterans Interest Rate Preference program.

Public Health Service Officers are eligible for federal VA housing loans, and Alaska's Veteran Mortgage Program (VMP). They are eligible for most VA benefits under federal law, therefore, to exclude these "Veterans" from this interest preference program offered by the state is inconsistent with other aspects of veterans benefits.

The AHFC/ Fed VA program can be combined with the State Veterans Interest Rate Preference program to produce an extremely attractive interest rate for those purchasing or refinancing a home. Under the current statute (AS.56.101), Public Health Service Officers are not eligible for this combination. It is the intent of this bill to add these "Veterans" to this statute.

The foreclosure rate of AHFC has increased significantly over the past year. It is the intent of this legislation that this group of veterans should be eligible for the benefit this preference provides. In Alaska's current poor economy, anything that will help people keep their homes or buy a home helps our state.

Public Health Service Officers currently number 250 in the Anchorage area. The number living outside of this area is not available at this time. It is difficult to say how many people will make use of this program, therefore, the cost is not known. (See fiscal note and letter).

Favorable consideration of this bill would be apprectiated by its sponsors.

Thank you for your time.

1972, Act Oct. 24, 1972, P. L. 92-540, Title IV, § 409, 86 Stat. 1092, substituted new item 102 for one which read: "102. Dependent parents and husbands.".

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§ 101. Definitions

For the purposes of this title [38 USCS §§ 101 et seq.]—

(1) The term "Administrator" means the Administrator of Veterans' Affairs.

(2) The term "veteran" means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

(3) The term "surviving spouse" means (except for purposes of chapter 19 of this title [38 USCS §§ 701 et seq.]) a person of the opposite sex who was the spouse of a veteran at the time of the veteran's death, and who lived with the veteran continuously from the date of marriage to the date of the veteran's death (except where there was a separation which was due to the misconduct of, or procured by, the veteran without the fault of the spouse) and who has not remarried or (in cases not involving remarriage) has not since the death of the veteran, and after September 19, 1962, lived with another person and held himself or herself out openly to the public to be the spouse of such other person.

(4)(A) The term "child" means (except for purposes of chapter 19 of this title [38 USCS §§ 701 et seq.] and section 5202(b) of this title [38 USCS § 5202(b)]) a person who is unmarried and—

(i) who is under the age of eighteen years;

(ii) who, before attaining the age of eighteen years, became permanently incapable of self-support; or

(iii) who, after attaining the age of eighteen years and until completion of education or training (but not after attaining the age of twenty-three years), is pursuing a course of instruction at an approved educational institution;

and who is a legitimate child, a legally adopted child, a stepchild who is a member of a veteran's household or was a member at the time of the veteran's death, or an illegitimate child but, as to the alleged father, only if acknowledged in writing signed by him, or if he has been judicially ordered to contribute to the child's support or has been, before his death, judicially decreed to be the father of such child, or if he is otherwise shown by evidence satisfactory to the Administrator to be the father of such child. A person shall be deemed, as of the date of death of a veteran, to be the legally adopted child of such veteran if such person was at the time of the veterans' death living in the veterans' household and was legally adopted by the veteran's surviving spouse within two years after the veteran's death or the date of enactment of

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creased by the amount set forth in 38 U.S.C. 411(b) for each child.

(4) If the surviving spouse is determined to be in need of regular aid and attendance under the criteria in § 3.352 or is a patient in a nursing home, the total amount payable shall be increased by the amount set forth in 38 U.S.C. 411(c). If the surviving spouse does not qualify for the regular aid and attendance allowance but is housebound under the criteria in § 3.351(f), the total amount payable shall be increased by the amount set forth in 38 U.S.C. 411(d).

[29 FR 10396, July 25, 1964, as amended at 35 FR 18661, Dec. 9, 1970; 37 FR 6676, Apr. 1, 1972; 39 FR 34529, Sept. 26, 1974; 44 FR 22717, Apr. 17, 1979]

§ 3.6 Duty periods.

(a) *"Active military, naval, and air service".* This includes active duty, and period of active duty for training during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in line of duty, and any period of inactive duty training during which the individual concerned was disabled or died from an injury incurred or aggravated in line of duty.

(b) *"Active duty".* This means:

(1) Full-time duty in the Armed Forces, other than active duty for training;

(2) Full-time duty (other than for training purposes) as a commissioned officer of the Regular or Reserve Corps of the Public Health Service:

(i) On or after July 29, 1945, or

(ii) Before that date under circumstances affording entitlement to "full military benefits," or

(iii) At any time, for the purposes of dependency and indemnity compensation.

(3) Full-time duty as a commissioned officer of the Coast and Geodetic Survey or of its successor agencies the Environmental Science Services Administration and the National Oceanic and Atmospheric Administration:

(i) On or after July 29, 1945, or

(ii) Before that date:

(a) While on transfer to one of the Armed Forces, or

(b) While, in time of war or national emergency declared by the President, assigned to duty on a project for one of the Armed Forces in an area determined by the Secretary of Defense to be of immediate military hazard, or

(c) In the Philippine Islands on December 7, 1941, and continuously in such islands thereafter, or

(iii) At any time, for the purposes of dependency and indemnity compensation.

(4) Service at any time as a cadet at the United States Military, Air Force, or Coast Guard Academy, or as a midshipman at the United States Naval Academy;

(5) Authorized travel to or from such duty or service; and

(6) A person discharged or released from a period of active duty, shall be deemed to have continued on active duty during the period of time immediately following the date of such discharge or release from such duty determined by the Secretary concerned to have been required for him or her to proceed to his or her home by the most direct route, and, in all instances, until midnight of the date of such discharge or release. (38 U.S.C. 106(c))

(i) January 1, 1957, for service-connected death benefits where the discharge or release occurred on or after that date.

(ii) January 1, 1959, for service-connected disability compensation where the discharge or release occurred on or after January 1, 1957.

(iii) July 21, 1961, for compensation or pension, where the discharge or release occurred prior to January 1, 1957.

(c) *Active duty for training.* (1) Full-time duty in the Armed Forces performed by Reserves for training purposes;

(2) Full-time duty for training purposes performed as a commissioned officer of the Reserve Corps of the Public Health Service:

(i) On or after July 29, 1945, or

(ii) Before that date under circumstances affording entitlement to "full military benefits," or

(iii) At any time, for the purposes of dependency and indemnity compensation;

(3) Full-time duty performed by members of the National Guard of any State, under 32 U.S.C. 316, 502, 503, 504, or 505, or the prior corresponding provisions of law or full-time duty by such members while participating in the reenactment of the Battle of First Manassas in July 1961;

(4) Duty performed by a member of a Senior Reserve Officers' Training Corps program when ordered to such duty for the purpose of field training or a practice cruise under chapter 103 of title 10, United States Code (this subparagraph is effective October 1, 1982, with respect to deaths and disabilities resulting from diseases or injuries incurred or aggravated after September 30, 1982, and it is effective October 1, 1983, with respect to deaths and disabilities resulting from diseases or injuries incurred or aggravated before October 1, 1982) (Pub. L. 97-306, as amended by sec. 210, Pub. L. 98-223); and

(5) Authorized travel to or from such duty.

The term does not include duty performed as a temporary member of the Coast Guard Reserve.

(d) *Inactive duty training.* This means: (1) Duty (other than full-time duty) prescribed for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by the Secretary concerned under 37 U.S.C. 206 or any other provision of law;

(2) Special additional duties authorized for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by an authority designated by the Secretary concerned and performed by them on a voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned; and

(3) Duty (other than full-time duty) performed by a member of the National Guard of any State, under 32 U.S.C. 316, 502, 503, 504, or 505, or the prior corresponding provisions of law. The term "inactive duty training" does not include:

(i) Work or study performed in connection with correspondence courses,

the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, or air service.

(17) The term "non-service-connected" means, with respect to disability or death, that such disability was not incurred or aggravated, or that the death did not result from a disability incurred or aggravated, in line of duty in the active military, naval, or air service.

(18) The term "discharge or release" includes (A) retirement from the active military, naval, or air service, and (B) the satisfactory completion of the period of active military, naval, or air service for which a person was obligated at the time of entry into such service in the case of a person who, due to enlistment or reenlistment, was not awarded a discharge or release from such period of service at the time of such completion thereof and who, at such time, would otherwise have been eligible for the award of a discharge or release under conditions other than dishonorable.

(19) The term "State home" means a home established by a State (other than a possession) for veterans disabled by age, disease, or otherwise who by reason of such disability are incapable of earning a living. Such term also includes such a home which furnishes nursing home care for veterans.

(20) The term "State" means each of the several States, Territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico. For the purpose of section 903 and chapters 34 and 35 of this title, such term also includes the Canal Zone.

(21) The term "active duty" means—

(A) full-time duty in the Armed Forces, other than active duty for training;

(B) full-time duty (other than for training purposes) as a commissioned officer of the Regular or Reserve Corps of the Public Health Service (i) on or after July 29, 1945, or (ii) before that date under circumstances affording entitlement to "full military benefits" or (iii) at any time, for the purposes of chapter 13 of this title;

(C) full-time duty as a commissioned officer of the National Oceanic and Atmospheric Administration or its predecessor organization the Coast and Geodetic Survey (i) on or after July 29, 1945, or (ii) before that date (a) while on transfer to one of the Armed Forces, or (b) while, in time of war or national emergency declared by the President, assigned to duty on a project for one of the Armed Forces in an area determined by the Secretary of Defense to be of immediate military hazard, or (c) in the Philippine Islands on December 7, 1941, and continuously in such islands thereafter, or (iii) at any time, for the purposes of chapter 13 of this title;

(D) service as a cadet at the United States Military, Air Force, or Coast Guard Academy, or as a midshipman at the United States Naval Academy; and

(E) authorized travel to or from such duty or service.

(22) The term "active duty for training" means—

(A) full-time duty in the Armed Forces performed by Reserves for training purposes;

(B) full-time duty for training purposes performed as a commissioned officer of the Reserve Corps of the Public Health Service (i) on or after July 29, 1945, or (ii) before that date under circumstances affording entitlement to "full military benefits", or (iii) at any time, for the purposes of chapter 13 of this title;

(C) in the case of members of the National Guard or Air National Guard of any State, full-time duty under section 316, 502, 503, 504, or 505 of title 32, or the prior corresponding provisions of law; and

(D) authorized travel to or from such duty.

The term does not include duty performed as a temporary member of the Coast Guard Reserve.

(23) The term "inactive duty training" means—

(A) duty (other than full-time duty) prescribed for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by the Secretary concerned under section 206 of title 37 or any other provision of law; and

(B) special additional duties authorized for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by an authority designated by the Secretary concerned and performed by them on a voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned.

In the case of a member of the National Guard or Air National Guard of any State, such term means duty (other than full-time duty) under sections 316, 502, 503, 504, or 505 of title 32, or the prior corresponding provisions of law. Such term does not include (i) work or study performed in connection with correspondence courses, (ii) attendance at an educational institution in an inactive status, or (iii) duty performed as a temporary member of the Coast Guard Reserve.

(24) The term "active military, naval, or air service" includes active duty, any period of active duty for training during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in line of duty, and any period of inactive duty training during which the individual concerned was disabled or died from an injury incurred or aggravated in line of duty.

Official Business

Alaska State Legislature

House of Representatives

REPRESENTATIVE
RAMONA L. BARNES
DISTRICT 14

ANCHORAGE
2230 PAXSON
ANCHORAGE, ALASKA 99504
(907) 337-7904

BOX V
JUNEAU, ALASKA 99811
(907) 465-3438

MEMORANDUM

1-15-88

TO: HESS COMMITTEE

FROM: REPRESENTATIVE RAMONA BARNES

RE. PUBLIC HEALTH SERVICE OFFICERS

Your attention is directed to 42 # 213 (d) which clarifies the status of commissioned officers of the Public Health Service with regard to veteran's status as covered under the Veteran's Admin istration.

Your attention is further drawn to page 160, the purpose paragraph wherein the intent of Congress is expressly stated. Please note that the rights herein granted are in no way diminished or impaired, thereby including but not limited to home loans, etc,.

Official Business

Alaska State Legislature

House of Representatives

REPRESENTATIVE
RAMONA L. BARNES
DISTRICT 14

ANCHORAGE
2230 PAXSON
ANCHORAGE, ALASKA 99504
(907) 337-7904

BOX V
JUNEAU, ALASKA 99811
(907) 465-3438

MEMORANDUM

TO: Representative Fran Ulmer, Chairperson House State Affairs Committee

FROM: Representative Ramona L. Barnes

DATE: April 28, 1987

SUBJECT: HB 269

HB 269," An Act relating to eligibility for veterans' interest rates for housing mortgage loans", would amend AS 18.56.101. by adding Public Health Service Officers to the current definition of veteran.

The addition of Public Health Service Officers to this definition would allow a large block of people to take advantage of the veterans interest rate offered by AHFC. It is my feeling that this may help many people refinance their homes at a favorable interest rate and avoid future housing problems.

Public Health Service officers are considered veterans under federal law and are eligible for federal Veterans Housing loans. Therefore, this amendment would bring the definition of veteran under AS.18.56.101 into line with the federal definition.

This bill is currently in your committee awaiting action. I would appreciate a scheduled hearing in the near future. If there are any questions I can answer for you please do not hesitate to contact me.

Thank you for your prompt consideration of this matter.

ode Cong.Service, p. 1211. See, also, Act 28, 1948, 1948 U.S.Code Cong.Service, 103; Act Oct. 12, 1949, 1949 U.S.Code g.Service, p. 2089; Act Apr. 27, 1956, U.S.Code Cong. and Adm.News, p. ; Act Aug. 10, 1956, 1956 U.S.Code g. and Adm.News, p. 4613; Pub.L. 15, 1960 U.S.Code Cong. and Adm. s, p. 1834; Pub.L. 91-253, 1970 U.S. Cong. and Adm.News, p. 3041; Pub.L. 6, 1979 U.S.Code Cong. and Adm.News, 254; Pub.L. 96-342, 1980 U.S.Code and Adm.News, p. 2612; Pub.L. 97-25 U.S.Code Cong. and Adm.News, p. 74; 97-35, 1981 U.S.Code Cong. and News, p. 396.

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o government agencies, see section 801 ied Services.

io are retired under subsec. (a) of this rces.

es

United States § 44.

ns

mpensable periods

tiff was entitled to include the period by him as Assistant to the Surgeon l as well as the three years and two served as Deputy Surgeon General in ing the four years required by former (b)(2) of this section. Draper v. U. , 121 Ct.Cl. 625.

ount of recovery allowed

e plaintiff sued for the difference be- ie retirement pay he received for the rom Sept. 1, 1947, to Oct. 1, 1949, the rank of brigadier general and the nt pay he should have received for od based on the rank of major gener- plaintiff was entitled to recover. . U. S., 1952, 121 Ct.Cl. 625.

§ 7(b), Dec. 29, 1973, 87

e X, § 1012, by Pub.L. 89-239, § 3 6, 1965, 79 Stat. 931, renumbered § 1112 by Pub.L. 91-572, § 6(b), 970, 84 Stat. 1506, renumbered Ti- 1212, by Pub.L. 92-294, § 3(b), 972, 86 Stat. 137, renumbered Title 312, by Pub.L. 93-154, § 2(b)(2),

Nov. 16, 1973, 87 Stat. 604, provided for the retirement of certain officers of the Reserve Corps of the Public Health Service for disability.

§ 212b. Repealed. Apr. 27, 1956, c. 211, § 5(d), 70 Stat. 117

Historical Note

Section, Act July 31, 1953, c. 296, Title II, § 201, 67 Stat. 254, authorized the recall of retired officers of the Service, and is now covered by section 212(c) of this title.

§ 213. Military benefits

Rights, privileges, immunities, and benefits accorded to commissioned officers or their survivors

(a) Except as provided in subsection (b) of this section, commissioned officers of the Service and their surviving beneficiaries shall, with respect to active service performed by such officers—

(1) in time of war;

(2) on detail for duty with the Army, Navy, Air Force, Marine Corps, or Coast Guard; or

(3) while the Service is part of the military forces of the United States pursuant to Executive order of the President;

be entitled to all rights, privileges, immunities, and benefits now or hereafter provided under any law of the United States in the case of commissioned officers of the Army or their surviving beneficiaries on account of active military service, except retired pay and uniform allowances.

Award of decorations

(b) The President may prescribe the conditions under which commissioned officers of the Service may be awarded military ribbons, medals, and decorations.

Authority of Surgeon General

(c) The authority vested by law in the Department of the Army the Secretary of the Army, or other officers of the Department of the Army with respect to rights, privileges, immunities, and benefits referred to in subsection (a) of this section shall be exercised, with respect to commissioned officers of the Service, by the Surgeon General.

Active service deemed active military service with respect to laws administered by Veterans' Administration

(d) Active service of commissioned officers of the Service shall be deemed to be active military service in the Armed Forces of the United States for the purposes of all laws administered by the Veterans' Administration (except the Servicemen's Indemnity Act of 1951) and section 417 of this title.

Active service deemed active military service with respect to Soldiers' and Sailors' Civil Relief Act of 1940

(e) Active service of commissioned officers of the Service shall be deemed to be active military service in the Armed Forces of the United States for the purposes of all rights, privileges, immunities, and benefits now or hereafter provided under the Soldiers' and Sailors' Civil Relief Act of 1940.

(July 1, 1944, c. 373, Title II, § 212, 58 Stat. 689; July 15, 1954, c. 507, § 14(a), 68 Stat. 481; Aug. 1, 1956, c. 837, Title V, § 501(b)(1), 70 Stat. 881; Apr. 22, 1976, Pub.L. 94–278, Title XI, § 1101, 90 Stat. 415.)

Historical Note

References in Text. The Servicemen's Indemnity Act of 1951, referred to in subsec. (d), is Act Apr. 25, 1951, c. 39, Pt. I, 65 Stat. 33, which was classified generally to subchapter II (section 851 et seq.) of chapter 13 of former Title 38, Pensions, Bonuses, and Veterans' Relief, and was repealed by Act Aug. 1, 1956, c. 873, Title V, § 502(9), 70 Stat. 886.

The Soldiers' and Sailors' Civil Relief Act of 1940, referred to in subsec. (e), is Act Oct. 17, 1940, c. 888, 54 Stat. 1178, which is classified to section 501 et seq. of the Appendix to Title 50, War and National Defense. For complete classification of this Act to the Code, see section 501 of the Appendix to Title 50 and Tables volume.

1976 Amendment. Subsec. (e). Pub.L. 94–278 added subsec. (e).

1956 Amendment. Act Aug. 1, 1956 amended section generally to extend all rights, privileges, immunities, and benefits provided for commissioned officers of the Army or their surviving beneficiaries to commissioned officers of the Service, with the exception of retired pay and uniform allowances, when performing duty under certain circumstances, and to provide that active service of commissioned officers shall be deemed to be active military service in the Armed Forces for the purposes of all laws administered by the Veterans' Administration (except the Servicemen's Indemnity Act of 1951) and section 417 of this title.

1954 Amendment. Subsec. (a)(1). Act July 15, 1954 struck out "burial payments in the event of death," following "limited to,".

Change of Name. The Department of War was designated the Department of the Army and the title of the Secretary of War was changed to Secretary of the Army by Act July 26, 1947, c. 343, Title II, § 205(a), 61 Stat. 501. Section 205(a) of Act July 26, 1947 was repealed by Act Aug. 10, 1956, c. 1041, § 53, 70A Stat. 641. Section 1 of Act Aug. 10, 1956 enacted "Title 10, Armed Forces", which in sections 3011 to 3013 continued the military Department of the Army under the administrative supervision of a Secretary of the Army.

Effective Date of 1956 Amendment; Applicability. Section 501(b)(2) of Act Aug. 1, 1956, provided that: "The amendment made by this subsection [to this section] (A) shall apply only with respect to service performed on or after July 4, 1952, (B) shall not be construed to affect the entitlement of any person to benefits under the Veterans' Readjustment Assistance Act of 1952 [Act July 16, 1952, c. 875, 66 Stat. 663], (C) shall not be construed to authorize any payment under section 202 (i) of the Social Security Act [section 402(i) of this title], or under Veterans Regulation Numbered 9(a), for any death occurring prior to January 1, 1957, and (D) shall not be construed to authorize payment of any benefits for any period prior to January 1, 1957."

Transfer of Functions. All functions of Public Health Service, of the Surgeon General of the Public Health Service, and of all other officers and employees of the Public Health Service, and all functions of all agencies of or in the Public Health Service transferred to Secretary of Health, Education, and Welfare [now Secretary of Health and Human Services] by 1966 Reorg.Plan No. 3, 31 F.R. 8855, 80 Stat. 1610, effective June 25, 1966, set out under section 202 of this title.

For transfer of functions of other officers, employees, and agencies of the Department of the Treasury, with certain exceptions, to the Secretary of the Treasury with power to delegate, see Reorg.Plan No. 26 of 1950, §§ 1, 2, eff. July 31, 1950, 15 F.R. 4935, 64 Stat. 1280, 1281, set out in the Appendix to Title 5, Government Organization and Employees. Functions of the Coast Guard, and the Commandant of the Coast Guard, were excepted from transfer when the Coast Guard is oper-

ating as part of the Navy under
and 3 of Title 14, Coast Guard.

Recomputation of Social Secur
for Officers Entitled to Old-age
Benefits Prior to January 1, 1957
vivors of Officers who Died Prior
1, 1957. Section 501(b)(3) of A
1956, as amended Oct. 17, 19
96–88, Title V, § 509(b), 93 Stat.
) that:

"In the case of any individual—

"(A) who performed active s
a commissioned officer of
Health Service at any time dur
od beginning July 4, 1952, and
cember 31, 1956, or (ii) as a co
officer of the Coast and Geodet
any time during the period beg
29, 1945, and ending Decembe
and

"(B)(i) who became entitled
insurance benefits under sectio
the Social Security Act [sectio
this title] prior to January 1, 1

"(II) who died prior to Janu
and whose widow, child, or pa
tled for the month of January 1
basis of his wages and self-emp
come, to a monthly survivor's b
section 202 of such Act [section
title]; and

"(C) any part of whose servic
in subparagraph (A) was not
the computation of his primar
amount under section 215 of su
tion 413 of this title] but woul
included in such computation if
ment made by paragraph (1) of
tion or paragraph (1) of subsect
been effective prior to the da
computation, the Secretary of
Human Services shall, notwiths
provisions of section 215(f)(1) c
curity Act [section 415(f)(1) c
recompute the primary insura
of such individual upon the filir
plication, after December 1956.
(if he dies without filing such
tion) by any person entitled
survivor's benefits under secti
such Act [section 402 of this t
basis of his wages and self-emp

Armed Services ⇨7.

service with respect
ief Act of 1940

of the Service shall be deemed
orces of the United States for
s, and benefits now or hereaf-
Civil Relief Act of 1940.

July 15, 1954, c. 507, § 14(a), 68
1), 70 Stat. 881; Apr. 22, 1976,

53, 70A Stat. 641. Section 1 of Act
. 1956 enacted "Title 10, Armed
which in sections 3011 to 3013 con-
e military Department of the Army
administrative supervision of a Sec-
the Army.

ve Date of 1956 Amendment; Appli-
Section 501(b)(2) of Act Aug. 1,
vided that: "The amendment made
ubsection [to this section] (A) shall
y with respect to service performed
r July 4, 1952, (B) shall not be con-
affect the entitlement of any person
s under the Veterans' Readjustment
Act of 1952 [Act July 16, 1952, c.
tat. 663], (C) shall not be construed
ize any payment under section 202
Social Security Act [section 402(i) of
, or under Veterans Regulation
1 9(a), for any death occurring prior
1, 1957, and (D) shall not be con-
authorize payment of any benefits
riod prior to January 1, 1957."

r of Functions. All functions of
alth Service, of the Surgeon General
lic Health Service, and of all other
d emoloyees of the Public Health
d all functions of all agencies of or
blic Health Service transferred to
of Health, Education, and Welfare
etary of Health and Human Ser-
1966 Reorg.Plan No. 3, 31 F.R.
tat. 1610, effective June 25, 1966,
der section 202 of this title.

nsfer of functions of other officers,
and agencies of the Department of
ry, with certain exceptions, to the
f the Treasury with power to dele-
eorg.Plan No. 26 of 1950, §§ 1, 2,
1, 1950, 15 F.R. 4935, 64 Stat.
. set out in the Appendix to Title
nent Organization and Employees.
of the Coast Guard, and the Com-
f the Coast Guard, were excepted
er when the Coast Guard is oper-

ating as part of the Navy under sections 1 and 3 of Title 14, Coast Guard.

Recomputation of Social Security Benefits for Officers Entitled to Old-age Insurance Benefits Prior to January 1, 1957 or for Survivors of Officers who Died Prior to January 1, 1957. Section 501(b)(3) of Act Aug. 1, 1956, as amended Oct. 17, 1979, Pub.L. 96–88, Title V, § 509(b), 93 Stat. 695, provided that:

"In the case of any individual—

"(A) who performed active service (i) as a commissioned officer of the Public Health Service at any time during the period beginning July 4, 1952, and ending December 31, 1956, or (ii) as a commissioned officer of the Coast and Geodetic Survey at any time during the period beginning July 29, 1945, and ending December 31, 1956; and

"(B)(i) who became entitled to old-age insurance benefits under section 202(a) of the Social Security Act [section 402(a) of this title] prior to January 1, 1957, or

"(ii) who died prior to January 1, 1957, and whose widow, child, or parent is entitled for the month of January 1957, on the basis of his wages and self-employment income, to a monthly survivor's benefit under section 202 of such Act [section 402 of this title]; and

"(C) any part of whose service described in subparagraph (A) was not included in the computation of his primary insurance amount under section 215 of such Act [section 415 of this title] but would have been included in such computation if the amendment made by paragraph (1) of this subsection or paragraph (1) of subsection (d) had been effective prior to the date of such computation, the Secretary of Health and Human Services shall, notwithstanding the provisions of section 215(f)(1) of the Social Security Act [section 415(f)(1) of this title], recompute the primary insurance amount of such individual upon the filing of an application, after December 1956, by him or (if he dies without filing such an application) by any person entitled to monthly survivor's benefits under section 202 of such Act [section 402 of this title] on the basis of his wages and self-employment income. Such recomputation shall be made only in the manner provided in title II of the Social Security Act [sections 401 to 425 of this title] as in effect at the time of the last previous computation or recomputation of such individual's primary insurance amount, and as though application therefor was filed in the month in which application for such last previous computation or recomputation was filed. No recomputation made under this paragraph shall be regarded as a recomputation under section 215(f) of the Social Security Act [section 415(f) of this title]. Any such recomputation shall be effective for and after the twelfth month before the month in which the application was filed, but in no case for any month before January 1957."

Disposition of Remains of Deceased Personnel. Recovery, care, and disposition of the remains of deceased members of the uniformed services and other deceased personnel, see section 1481 et seq. of Title 10, Armed Forces.

Burial of Certain Commissioned Officers. Act Apr. 30, 1956, c. 227, 70 Stat. 124, provided: "That burial in national cemeteries of the remains of commissioned officers of the United States Public Health Service who were detailed for duty with the Army or Navy during World War I pursuant to the Act of July 1, 1902 (32 Stat. 712, 713), as amended, and Executive Order Numbered 2571 dated April 3, 1917, and of the wife, widow, minor child and, in the discretion of the Secretary of the Army, unmarried adult child of these officers is authorized: Provided, That the remains of the wife, widow, and children may, in the discretion of the Secretary of the Army, be removed from a national cemetery proper and interred in the post section of a national cemetery if, upon death, the related officer is not buried in the same or an adjoining gravesite."

Legislative History. For legislative history and purpose of Act July 1, 1944, see 1944 U.S.Code Cong.Service, p. 1211. See, also, Act July 15, 1954, 1954 U.S.Code Cong. and Adm.News, p. 2546; Act Aug. 1, 1956, 1956 U.S.Code Cong. and Adm.News, p. 3976; Pub.L. 94–278, 1976 U.S.Code Cong. and Adm.News, p. 709.

Library References

Armed Services ⇨7.

C.J.S. Armed Services § 27.

Notes of Decisions

Personal injury claims 2
Purpose 1

1. Purpose

Intent of Congress in amending this section was to grant Public Health Service officers on detail with armed forces the identical federal rights available to commissioned army officers. Wanner v. Glen Ellen Corp., D.C.Vt. 1974, 373 F.Supp. 983.

2. Personal injury claims

This section which grants Public Health Service officers on detail with the armed forces the identical federal rights available to commissioned army officers had no application to claim for loss of husband's services and consortium and medical expenses asserted by wife of lieutenant commander in the United States Public Health Service who was injured in skiing accident. Wanner v. Glen Ellen Corp., D.C.Vt.1974, 373 F.Supp. 983.

§ 213a. Rights, benefits, privileges, and immunities for commissioned officers or beneficiaries; exercise of authority by Secretary or designee

(a) Commissioned officers of the Service or their surviving beneficiaries are entitled to all the rights, benefits, privileges, and immunities now or hereafter provided for commissioned officers of the Army or their surviving beneficiaries under the following provisions of Title 10:

(1) Section 1036, Escorts for dependents of members: transportation and travel allowances.

(2) Chapter 61, Retirement or Separation for Physical Disability, except that sections 1201, 1202, and 1203 do not apply to commissioned officers of the Public Health Service who have been ordered to active duty for training for a period of more than 30 days.

(3) Chapter 69, Retired Grade, except sections 1370, 1374, 1375 and 1376(a).

(4) Chapter 71, Computation of Retired Pay, except formula No. 3 of section 1401.

(5) Chapter 73, Retired Serviceman's Family Protection Plan; Survivor Benefit Plan.

(6) Chapter 75, Death Benefits.

(7) Section 2771, Final settlement of accounts: deceased members.

(8) Chapter 163, Military Claims, but only when commissioned officers of the Service are entitled to military benefits under section 213 of this title.

(9) Section 2603, Acceptance of fellowships, scholarships, or grants.

(10) Section 2634, Motor vehicles: for members on permanent change of station.

(11) Section 1035, Deposits of Savings.

(12) Section 1552, Correction of military records: claims incident thereto.

(13) Section 1553, Review of discharge or dismissal.

What's Available To The Veteran

Alaska HOUSING FINANCE CORPORATION

There are three basic options available to the veteran through AHFC:

1. ***An AHFC Loan combined with a Federal Veterans Administration Loan;***
2. ***The Veterans Mortgage Program; and***
3. ***The State Veterans Interest Rate Preference.***

1. AHFC/Federal VA

Benefit:
The major benefit of combining an AHFC loan with a Federal VA guaranteed loan is the lower down payment.

Maximum Loan Amount: $135,000

Minimum Down Payment:

Up to $110,000	Zero down
$110,000-$135,000	25% on the amount over $110,000

***Qualification:**
Eligibility for the Veteran benefit is determined by the Federal Veterans Administration. This program may be combined with AHFC's Regular Program, the Veterans Mortgage Program, Tax-Exempt Program, HOF Program and Mobile Home Program.

2. Veteran's Mortgage Program (VMP)

Benefit:
A lower interest rate than under AHFC's other programs, on the entire loan amount.

Maximum Loan Amount:
Single Family

Residence	$199,850
Duplex	$255,650
Triplex	$308,900
Four-plex	$384,000

If the residence is a multi-family dwelling (duplex - four-plex) then all units must have been occupied as such for at least 5 years.

Minimum Down:
Single-Family and Duplex [redacted]
Triplex and Four-plex

***Qualification:**
Federal restrictions require that individuals applying under this program be "qualified veterans" as defined under Title 38, United States Code 101(2) and have been on active duty prior to January 1, 1977, and cannot have been out of the service for more than 30 years.

Documentation that is accepted by AHFC as evidence of meeting the code is the Veterans Certificate of Eligibility, or a letter from the Federal Veterans Administration and a DD-214, or, for Commissioned Officers, a letter from Personnel stating the entry date of service. Basically, an individual must have served in the Armed Forces and have been discharged other than dishonorably. In addition, active military who have completed their initial period of duty may qualify. The code also includes certain individuals in the Public Health Service but severely limits National Guard and Reservist. You may combine this program with Number 1 to receive the benefit of both the lower interest rate and the down payment.

3. State Veterans Interest Rate Preference

Benefit:
The State Veteran receives a 1 percent lower interest rate on the first $90,000 of the loan. The important thing to remember is that this is not a program but an interest rate differential that must be applied to a program. It may be applied to all of the programs offered by AHFC but it may not be combined with Number 2, the Veterans Mortgage Program.

***Qualification:**
Determination for the State Veterans Interest Rate preference is made by AHFC. To qualify for the lower rate, the borrower may not currently be on active duty. An individual must have served in the Armed Forces for 90 days or more (unless discharged due to a service connected injury) and have been discharged other than dishonorably. Active duty for the purpose of training will not be counted toward the 90 day requirement. Members of

3

Alaska HOUSING FINANCE CORPORATION

May 13, 1987

The Honorable Ramona Barnes
Representative, State of Alaska
Post Office Box V
Juneau, Alaska 99811
ATTENTION: PATTY SWENSON

SUBJECT: PROPOSED LEGISLATION HB 269

Dear Representative Barnes:

You have asked AHFC to provide information regarding the possible fiscal impact to the Corporation should HB 269 be enacted.

As HB 269 was introduced and currently reads, AHFC's State Veterans Interest Rate Preference would be expanded to include Public Health Service commissioned officers. All PHS officers regardless of the amount of time they served, would be eligible under this proposal.

It is difficult to determine how much this would cost AHFC since we have no historical data which tells us how many PHS borrowers we have. However, according to the Anchorage PHS office, there are currently 250 PHS commissioned officers living in Anchorage.

The number of PHS officers located in Alaska, outside of Anchorage, was not immediately available. However most PHS employees working in rural areas live in federal government-provided housing.

AHFC estimates that on an average loan of $110,000, a one-percent interest rate subsidy costs AHFC approximately $6,000. Therefore, if 250 PHS officers were qualified to buy homes and sought financing through AHFC, the one-percent subsidy would cost approximately $1.5 million.

Also, AHFC has no way of predicting how much it would cost AHFC if HB 269 should be amended to allow active military with at least 5 years of service to participate in the State Veterans Interest Program. However, from 1982 to present, AHFC has loaned to 3,605 active duty military borrowers. About half, or 1,874, have loans made under the federal Veteran's Mortgage Program (tax-exempt).

If we assume that the remaining borrowers would have been eligible for the State Veterans Interest Rate, which would have cost AHFC $12 million.

Telephone (907) 278-5599
235 East 8th Avenue
Third Floor
P.O. Box 101020
Anchorage, Alaska 99510

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

What's Available To The Veteran

Alaska HOUSING FINANCE CORPORATION

There are three basic options available to the veteran through AHFC:

1. ***An AHFC Loan combined with a Federal Veterans Administration Loan;***
2. ***The Veterans Mortgage Program; and***
3. ***The State Veterans Interest Rate Preference.***

1. AHFC/Federal VA

Benefit:
The major benefit of combining an AHFC loan with a Federal VA guaranteed loan is the lower down payment.

Maximum Loan Amount: $135,000

Minimum Down Payment:

Up to $110,000	Zero down
$110,000-$135,000	25% on the amount over $110,000

***Qualification:**
Eligibility for the Veteran benefit is determined by the Federal Veterans Administration. This program may be combined with AHFC's Regular Program, the Veterans Mortgage Program, Tax-Exempt Program, HOF Program and Mobile Home Program.

2. Veteran's Mortgage Program (VMP)

Benefit:
A lower interest rate than under AHFC's other programs, on the entire loan amount.

Maximum Loan Amount:
Single Family

Residence	$199,850
Duplex	$255,650
Triplex	$308,900
Four-plex	$384,000

If the residence is a multi-family dwelling (duplex - four-plex) then all units must have been occupied as such for at least 5 years.

Minimum Down:
Single-Family and Duplex [redacted]
Triplex and Four-plex

***Qualification:**
Federal restrictions require that individuals applying under this program be "qualified veterans" as defined under Title 38, United States Code 101(2) and have been on active duty prior to January 1, 1977, and cannot have been out of the service for more than 30 years.

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the Reserve (if the unit is a troop program unit) and Alaska National Guard with a minimum of 5 years service may also qualify. In addition, a widow or widower may qualify if the Veteran was inducted from Alaska.

Type of Loan

AHFC utilizes an Alaska Building Equity (ABE) mortgage which is assumable by a qualified buyer. Under this type of mortgage, the interest rate is fixed, however, there are moderate increases to the monthly payments in years four through nine. These increases are applied directly to the outstanding principal balance on the loan. Therefore, the loan is repaid in approximately 18 years. A detailed description of the ABE mortgages is available in AHFC's pamplet "Buying a Home in the Future."

Interest Rates

Mortgage interest rates are based on the interest rate for AHFC bonds plus the Corporation's operating costs and will vary from time to time. INTEREST RATES ARE SUBJECT TO CHANGE WITHOUT PRIOR NOTICE. Consult your lender for the current AHFC rate.

**The qualifications given for the three options are not intended to be inclusive but to provide only the basic guidelines.*

3

Alaska HOUSING FINANCE CORPORATION

May 13, 1987

The Honorable Ramona Barnes
Representative, State of Alaska
Post Office Box V
Juneau, Alaska 99811
ATTENTION: PATTY SWENSON

SUBJECT: PROPOSED LEGISLATION HB 269

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235 East 8th Avenue
Third Floor
P.O. Box 101020
Anchorage, Alaska 99510

For your information, in FY 1987, through February 28, 1987, AHFC has made 1589 loans under the State Veterans Interest Rate Program and 356 loans under the federal Veterans Mortgage Program. The average loan was $116,000.

If you need more information, don't hesitate to contact me.

Sincerely,

Margaret Nelson

Margaret Nelson
Special Assistant/Public Information Officer

MN:de


HB
275

HB 275 An Act continuing the correctional industries program; and providing for an effective date.

FILE CONTENTS

1) Copy of HB 275

2) Zero Fiscal Note, Dept. of Corrections

3) History of Alaska Correctional Industries, 3/2/87

4) Budget and Audit Committee Report, 3/17/87

5) House HESS Minutes, 5/6/87

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version: HB 275
Publish Date: 4-17-87

REQUESTS:

Revision Date:
Title: "An Act confirming the correctional industries program"
Sponsor: Representative Swackhammer
Requestor:

Agency Affected: Dept. of Corrections
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	Ø	Ø	Ø	Ø	Ø	Ø
CAPITAL	Ø	Ø	Ø	Ø	Ø	Ø
REVENUE	Ø	Ø	Ø	Ø	Ø	Ø

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	Ø	Ø	Ø	Ø	Ø	Ø

POSITIONS:

FULL-TIME	Ø	Ø	Ø	Ø	Ø	Ø
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Susan E. Knighton, Research Analyst IV
Phone: 465-3376
Division: Statewide Programs
Date: 4-21-87

Approved by Commissioner: Susan Humphrey-Barnett
Date: 4-21-87
Agency: Department of Corrections

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)
- Senate Secretary

3/2/87

BRIEF HISTORY OF ALASKA CORRECTIONAL INDUSTRIES

GENERAL: 1979 - State of Alaska financed "Alaska Corrections Master Plan" by Moyer and Associates, who recommend implementation of an Industries program. An Industries Manager, Wally Roman was hired October 16, 1981. In the spring of 1982, the Hammond Administration introduced and the Legislature passed HB 194 (enacted as AS 33.32.) which establishes the Alaska Correctional Industries program. In October of 1982, the Governor appointed the Correctional Industries Commission. In July, 1985, a Marketing and Sales Manager was added to the staff, and in September, 1985 the management of the Industries program (three individuals) was relocated from Juneau to Anchorage. Staff which did not transfer was replaced at the new location.

AGRICULTURAL OPERATIONS: Farming operations began as a camp work project at the Palmer Correctional Center over twenty years ago. In March, 1983, the Correctional Industries Commission approved the expansion of the operation as a correctional industry to provide produce for state institutions. Mechanized field and potato processing equipment was purchased for a sum in excess of $100,000 including many surplus pieces of equipment which were rebuilt at the institution. Acreage under cultivation was increased to approximately 27 acres, and is yielding in excess of 200 tons of potatoes. FLowers are also grown for State projects, including the Anchorage International Airport. 8 to 15 inmates are employed based upon seasonal needs.

AUTO BODY REPAIR: This business also began in prior years sometime in the 1970's, at the Palmer Correctional Center. In March, 1983, upgrading and modernization of the existing auto body shop program was approved by the Correctional Industries Commission. Conversion of an existing shop building yielded a 2900 square foot shop which contains a paint booth, mixing room, tool room, welding facilities, and a state of the art frame straightening rack. The quality control was brought up to rigid commercial standards, and the shop now repairs virtually all State of Alaska vehicles in the southcentral region. This shop employs from 5 to 8 inmates.

COMMERCIAL LAUNDRY: In March, 1983, the Correctional Industries Commission approved the building of a commercial laundry facility at the Lemon Creek Correctional Center to provide service to the State of Alaska Marine Highway system's southeast runs, and all other state institutions in the Juneau area. At that time, the laundry needs of the Marine Highway system were being met in Seattle, Washington, and Prince Rupert, B.C., Canada. Laundry operators in the Juneau area declined this business due to high seasonal nature. Construction of the new facility was begun in the fall of 1983 and completed in December, 1984. Operations have been excellent with almost 3/4 of a million pounds of laundry processed annually, employing 18 to 35 inmates.

COMMERCIAL BAKERY: In October, 1983, the Correctional Industries Commission approved the establishment of a commercial bakery at Lemon Creek Correctional Center to provide baked goods to the Marine Highway system and other state agencies throughout Alaska. This operation was designed to share the same building as the laundry operation, and went into operation in January, 1985. It has continued from that time to supply top quality baked goods to the Marine Highway system at prices at or less than previous suppliers in Seattle, Washington, and Prince Rupert, B.C., Canada. This operation has commission approval for commercial sales which are being developed. The bakery employs 5 to 8 inmates.

FURNITURE ASSEMBLY: July, 1983, the Correctional Industries Commission approved the establishment of a furniture and upholstery production and repair facility. A first consideration was to utilize a quonset hut at the Lemon Creek Correctional Center, but this idea was discarded and the proposed operation was moved to the Wildwood Correctional Center in Kenai, Alaska. The decision was based upon the availability of a building that could be renovated at a relatively low cost, an institutional work force of medium custody inmates, and proximity to the large southcentral market for furniture. In the spring of 1985, a contract was awarded to CPSI, a Boulder, Colorado consulting firm which gives assistance to correctional systems for furniture manufacturing. An agreement with four large national furniture companies provided pre-made components of standard furniture items for assembly at the new plant. Furniture manufacturing began in the Wildwood plant in January, 1986. A substantial dollar volume has been produced since start up of the plant, but further review is necessary due to much lower margins than originally expected, and a major collapse of the furniture market due to budget restrictions. The plant employs 15 to 25 inmates. After careful review of the current product lines, which are quite broad, this operation will probably be reduced to labor intensive oak/upholstered furniture an a few other complimentary lines which have proven very acceptable in our market place, and provide a more adequate profit margin.

METAL FABRICATION PLANT: In October, 1983, the Correctional Industries Commission approved the establishment of a metal fabrication plant to be located at the Wildwood Correctional Center. Plant operations began in January, 1986 and with the receipt of the large Spring Creek Correctional Center production order for bunks and desks, the plant has been running at full production level for the past 8 months with 20 to 30 inmates working full time. This plant produces a variety of products beyond cell furniture, including fish carriers for the Department of Fish and Game, barbeque pits for the Division of Parks, and several communities in Alaska, as well as custom fabricated "one off" specialities.

MT. MCKINLEY MEAT AND SAUSAGE PLANT: In May, 1986, the Division of Agriculture approached the Department of Corrections with the idea of using inmate labor to operate the failed meat plant in Palmer until the private sector was able to operate it again. The Agricultural Revolving Loan Fund purchased the plant and has signed an agreement with the Department of Corrections to operate the facility. Initial public hearings were held on February 6, 1987 and the Industries Commission decided to table the operational proposal until the next meeting, March 16, 1987, when the commission will hear additional public testimony regarding operation of the plant. At the present time the Department of Corrections plans to provide meat for its own consumption only. This facility will employ 20 inmates.

STATE OF ALASKA

AUDIT DIVISION
POUCH W
JUNEAU, ALASKA 99811

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

March 17, 1987

SUMMARY OF: A Special Report on the Department of Corrections, Alaska Correctional Industries, March 17, 1987.

PURPOSE OF THE REPORT

In accordance with a Legislative Budget and Audit Committee request and Title 24 of the Alaska Statutes, this special report has been prepared to document our review of the Alaska Correctional Industries program. Our review was conducted to determine if the program should be allowed to terminate on July 1, 1987, as provided by the enabling legislation.

OVERVIEW OF ALASKA CORRECTIONAL INDUSTRIES

Alaska Correctional Industries (ACI) was established to develop and operate agricultural, industrial, and service enterprises to provide realistic work experience for prisoners, to direct their efforts toward financial responsibility, to improve their effective work habits and occupational skills, and to increase the probability of opportunities for employment after release. The program currently employs 86 inmates with metal and furniture shops in Kenai, agriculture and auto body businesses in Palmer, and laundry and bakery operations in Juneau.

AUDITOR'S CONCLUSIONS

In our opinion, the Alaska Correctional Industries program generally provides realistic work experience and this experience is more realistic than that available through the institutional jobs. We further believe the work experience provided by ACI will improve the likelihood of successful employment after the inmate is released.

We recommend that the ACI program be extended. However, we suggest the extension be for a definite period (perhaps four years). This would allow the Legislature an opportunity to further review the progress of the program and require ACI to demonstrate their success with the program.

FINDINGS AND RECOMMENDATIONS

1. ACI should develop and utilize program cost guidelines for analyzing all existing and proposed industries.

The decision to continue or develop an industry within ACI should be based, in part, upon its financial viability. At present, ACI does not explicitly consider the full cost of an industry in its decision process. Financial statements, by industry, are prepared each month; however, these statements exclude the costs associated with the program's production managers and administrative personnel and the costs of the program's property, plant, and equipment. We estimate the net cost (revenue less expenses) in FY 86 to have been $600,000, or approximately $45 per inmate employee per day. The calculated or forecast net cost per day should be compared to a guideline cost established by the Correctional Industries Commission. This guideline should be equal to, or slightly above if justified, the incremental cost to the institution of providing alternative workweek daytime activities for the inmates. ACI should not enter into or continue industries which are not likely to approach this guideline.

2. The Correctional Industries Fund (CIF) financial statements should be presented in the State's Annual Financial Report in accordance with generally accepted accounting principles (GAAP).

CIF is an intragovernmental service fund and should be accounted for on an accrual basis. GAAP requires all the activities and the resources used by ACI to be reflected in their financial statements. The most significant items to be included are property, plant, and equipment and the related depreciation, implicit lease expense, inventory, and accounts receivable.

Alaska Statute 33.32.020 should be modified to require CIF to account for the entire industries program, including approximately $500,000 of annual personnel costs presently excluded from CIF by statute.

Who We Are

We are a program of the State of Alaska's Department of Corrections. Our agricultural, industrial, and service enterprises employ individuals incarcerated within the State's Correctional system. Each business is supervised by a skilled and experienced production manager. Our quality products and services are available for sale to all local, state and federal government agencies as well as school districts and non-profit organizations. Our catalog is available to all potential customers.

Quality Products

We offer the type of quality products your organization needs. Every product is fully guaranteed.

Competitive Prices

All prices are maintained at or below market levels, helping reduce your costs of doing business.

Ease of Purchasing

Our Eagle River Sales Office is set up to make ordering easy. No bidding is necessary—our products are included in the State of Alaska Contract Award Manual.

Rehabilitation

Inmates are offered an opportunity to use their time productively by learning marketable skills.

Call Us!

Sales Office

P.O. Box 600 Eagle River, AK 99577
694-6000

Central Office

2200 E. 42nd Ave. Anchorage, AK. 99508
561-4426

Production Facilities

1. Furniture Manufacturing Plant — 283-7296
   Kenai
2. Agricultural Operations — 745-5054
   Palmer
3. Auto Body/Fender Repair Shop — 745-5054
   Palmer
4. Metal Products — 283-7296
   Kenai
5. Commercial Bakery — 780-6105
   Juneau
6. Commercial Laundry — 780-6106
   Juneau

ALASKA
CORRECTIONAL
INDUSTRIES

QUALITY PRODUCTS FOR ALASKA
MARKETABLE SKILLS FOR THE FUTURE

What We Make

Furniture Manufacturing

1. Our complete line of top quality, contemporary office and institutional furniture includes durable oak-framed tables, chairs, and sofas as well as metal-framed desks, chairs, tables, file cabinets, book cases, and computer furniture. We wholesale our furniture products to private entities as well as retail to our more traditional government and non-profit markets. Financing is available through third-party leasing companies. Located at the Wildwood Correctional Center in Kenai.

Agricultural Operations

2. Situated in the rich Matanuska Valley, our farm operates two greenhouses and has over twenty-five acres of land under cultivation. We currently focus on providing potatoes and fresh vegetables to insititutional users. Located at the Palmer Correctional Center.

Auto Body Shop

3. Offering all the capabilities of any commercial facility, our auto body and fender repair business can restore the frame and body of any vehicle. Commercial painting services are provided on the premises. Current customers include the Matanuska-Susitna Borough and the State of Alaska, Department of Transporations and Public Facilities. Prompt turn-around is assured. Located at the Palmer Correctional Center.

Metal Products

4. Capable of fabricating hundreds of different metal products, our metal fabrication business is a fully equipped job shop. We specialize in working with your custom design to create exactly the product you need. Our current contracts include the fabrication of the institutional cell furniture for the Spring Creek Correctional Center now under construction in Seward. Located in the Wildwood Correctional Center in Kenai.

Commercial Bakery

5. Our bakery business provides a full range of bakery products comparable to any privately-owned commercial bake shop. The bakery takes orders for both standard and custom baked products as well as providing all the baked goods used by the Alaska Marine Highway System. Located at the Lemon Creek Correctional Center in Juneau.

Commercial Laundry

6. Offering a full range of services, our laundry business has the capability to process over four thousand pounds of laundry per day. The 6,500 square foot facility is primarily dedicated to providing the services required by the Alaska Marine Highway System and other state agencies in Southeast. Located at the Lemon Creek Correctional Center in Juneau.

More Industries Planned

7. Help us work for you. Tell us what products and services you need and how we can improve our current offerings. Your input is essential.

HB

277

file 1

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STA 3 database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

House Hess:

February 11, 1988

March 10, 1988

April 21, 1988

My Name is Ellen Ramlett
Member of Alaska Dissatisfied Parents Together
& a health
I'm A parent, A
concious person. I think
House Bill 277 should be
passed.
I challenge you to vote
based on fact, not fear.
By fear I mean that some
groups fear that ALASKANS
WON'T VACCINATE their children,
given A choice. You have
heard testimony that
many children HAVE been harmed
by VACCINATIONS, Parents know their
able to make an informed choice for their children
children best & should be
The CONCLUSION that AK
immunization program has
prevented disease is
false.

I think the MAIN REASON
I feel so STRONGLY About
Choice in ANY mandatory
giving of medicine is that
I'm 32 years old &
I myself was drugged
most of my childhood.
In the last 10 years I've
learned A lot About myself
AND gained A lot of my health
back thru NATURAL methods.
I'm sure I was VACCINATED
fully. My mother told me. I had
measles AS AN INFANT. I had
ASTHMA age 2 thru 12, IN
retrospect I think I would have
been better off without the
VACCINATIONS given that my
CONSTITUTION was ready to begin
living. Had my parents been
informed they may have chosen NOT to VACCINATE

Giving A child A VACCination does NOT make sure they won't get that disease. I got measles after being VACCINATED for them. I have heard of other children who got mumps after being VACCINATED for them while their UNVACCINATED sibling remained well.

ONE MAN kept saying why take A chance? Parents need TO know that they are taking A chance when they choose TO VACCINATE. And in my opinion A child's immune system can better able to resist disease W/O VACCINATIONS.

If all Dr.s were held accountable for the effects of VACCINATIONS ON their patients there would be

If you believe the immunizations work why are you afraid of my child not being immunized?

I believe it is my right and responsibility as a parent to ~~learn~~ be educated on the effects of immunizations. It is on the ~~education~~ basis of learning that I can make the decision for my child.

I might also state that I have 2 sons. My older son was immunized for mumps. He had them twice once on each side

My youngest son was exposed to the mumps and ~~has~~ did not come down with the mumps.

Connie Conaway
Anchorage

ATTACHMENT II

REFUSAL OF IMMUNIZATION

As the parent/guardian of _____

Name Age Birthdate

_____

School Grade

I do not wish to have my child receive the following immunizations:

(Check Disease)

Rubeola (Measles) . . . . . ☐

Rubella (German Measles). . . . . ☐

Mumps . . . . . ☐

Poliomyelitis . . . . . ☐

Diphtheria. . . . . ☐

Tetanus (Lockjaw) . . . . . ☐

Pertussis (Whooping Cough). . . . . ☐

Comments . . . . . .

. . . . . .

_____

Signature of Parent/Guardian Date

Nebraska

LEGISLATIVE BILL 59

Approved by the Governor April 20, 1979

Introduced by Koch, 12

AN ACT to amend Sections 79-404 and 79-440.01, Reissue Revised Statutes of Nebraska, 1943, relating to schools; to require examination and immunization of certain students as prescribed; to provide exceptions; to provide procedures; and to repeal the original sections.

Be it enacted by the people of the State of Nebraska,

Section 1. That section 79-404, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

79-404. (1) The district board or the board of education, in all classes of school districts, shall not admit any child to the first grade of any school of such district unless such child has reached the age of six years or will reach such age on or before October 15 of the current year; Provided, that in the event any child has successfully completed the kindergarten or beginner grade such child may enter the first grade of any such school regardless of age.

(2) The board in all classes of school districts shall not admit any child into the kindergarten or beginner grade of any school of such school district unless (a) such child has reached the age of five years or will reach such age on or before October 15 of the current year or (b) such child has demonstrated through recognized testing procedures approved by the State Board of Education that he is capable of carrying the work of those grades.

(3) The school board or board of education may require a birth certificate prior to entrance of a child into the beginner grade and shall require evidence of a physical examination by a qualified physician and ~~such immunization as required by the board~~ within six months prior to the entrance of a child into the beginner grade and the seventh grade, or in the case of a transfer from out-of-state to any other grade of the local school; Provided, no such physical examination or ~~immunization~~ shall be required of any child whose parent or guardian shall object thereto in writing, ~~on the grounds that such physical examination or immunization is contrary to the religious tenets of an established church of which he is a member or adherent~~. The cost of such physical

examination shall be borne by the parent or guardian of each child who is examined.

This section shall not be construed to prohibit any district board or board of education in its discretion, from establishing and supporting financially, programs to which attendance shall be voluntary which they deem beneficial to the education of prekindergarten children, nor shall this section be construed to allow any school district to fail to meet its responsibilities under Chapter 43, article 6.

Sec. 2. That section 79-444.01, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

79-444.01. Each board of education and the governing authority of each private school in this state shall require each child--under--twelve--years--of--age student to be protected against measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, and tetanus by immunization before-being-permitted-to-attend-any--school under-its-jurisdiction, prior to November 1 of each school year for original enrollees or, in the case of a student transferring from another school, within sixty days after the enrollment date, unless a parent or guardian of such child student presents a written statement that he or she does not wish to have such child student so immunized. In-the-case-of-any-child--enrolled in-school-on-September-2,-1973,-the-immunization-required by-sections-79-444.04-and-79-444.02-shall-be-effected--no later-than-September-1,--1973. Such written statement shall be kept in the student's file. Any student who does not comply with this section shall not be permitted to continue in school until he or she shall so comply.

The cost of such immunization shall be borne by the parent or guardian of each child student who is immunized; Provided, that such cost shall be borne by the Department of Health for those children students whose parents or guardian are financially unable to meet such cost, for such service, to-the--extent--that--funds--are specifically-available-for-such-purposes.

Sec. 3. The Department of Health shall adopt and promulgate rules and regulations relating to the required levels of protection, the evidence necessary to prove that the required examination or immunization has been received, and the reporting of each student's immunization status. The Department of Health shall furnish local school authorities with copies of such rules and regulations and any other material which will assist in the carrying out of this act.

Sec. 4. At the time the parent or guardian of any child is notified that such child must have a physical examination pursuant to section 79-444, or immunizations pursuant to section 79-444.01, he or she shall also be notified in writing of his or her right to submit a written statement refusing a physical examination or immunization for his or her child.

Sec. 5. Any person violating the provisions of this act shall be guilty of a Class V misdemeanor.

Sec. 6. That original sections 79-444 and 79-444.01, Reissue Revised Statutes of Nebraska, 1943, are repealed.

DPT MODEL STATE VACCINE REFORM LEGISLATION
(November 1984)

I. Introduction

In May 1984, Maryland became the first state in the Nation to enact vaccine reform legislation, which had been supported by Dissatisfied Parents Together (DPT). The attached article from the October 1984 edition of State Legislatures Magazine, entitled "Maryland Controls Vaccine", describes the background and provisions of the new Maryland law.

Briefly stated, the primary goals of the Maryland law were:

(1) Parent Information: to mandate that parents be given written information on the risks, as well as the benefits, of vaccines before children are vaccinated (including identification of possible severe reactions, contraindications to the vaccines, reasons for delaying vaccination, etc.);

(2) Record Keeping and Reporting: to require doctors and clinics to record and report serious vaccine reactions to health authorities, and to keep records on vaccine manufacturer and lot number for each shot given;

(3) Follow-Up: to require state health departments to compile information on serious reactions, to send that information to the federal Health and Human Services Department and to the State legislature, and to follow-up on the long term effects to children who suffer vaccine reactions;

(4) Greater Doctor Discretion: to make clear the general vaccine contraindications, i.e. the circumstances under which vaccine should not be given to a child, or should be delayed, and to give doctors discretion to decide on a case-by-case basis when the vaccine should not be given to a specific child; and

(5) Making School Entry Requirements Consistent with These Changes: to assure that children with medical exemptions cannot be excluded from school or punished in any other way.

Since enactment of the new Maryland law, Dissatisfied Parents Together (DPT) has received numerous inquiries and letters about the new law. State chapters of DPT, State legislators, and other interested persons have contacted DPT and asked, "How can we get the vaccine laws in our state changed?"

In order to respond to this question, Dissatisfied Parents Together (DPT) has put together this paper on Model State Vaccine Reform Legislation.

DPT recognizes that the laws and politics of each state are different. Thus, the model bill presented here is intended only as a guide; the model will have to be adapted to the particular form of the laws in each state and to the particular conditions existing in each state. Nonetheless, it is hoped that the model bill language will be a useful starting point for parents and State legislators who are considering State vaccine-reform legislation.

This paper begins by setting forth the exact language of the new Maryland vaccine reform law in Part II. (The numbers along the left side of the law are included to enable the reader to see where the Maryland law's approach might be amended to deal with other concerns and issues. See Parts III and IV of this paper for further discussion of these other issues and concerns.

The Maryland law deals primarily with the pertussis (whooping cough) or "P" part of the DPT vaccine. Part III of this paper identifies how the model presented by the Maryland law could be changed to apply to all man dated vaccines.

The Maryland law gives physicians greater discretion to make case-by-case judgments as to which children should not receive the vaccine. It did not address the question of whether (and under what circumstances) parents should be permitted by law to object to their children's vaccination. As of December 1983, twenty-two states permitted parents to object to mandated vaccines on the basis of "personal conviction or philosophic objection." Part IV of this paper identifies how the model presented by the Maryland law could be changed to assure a parent's right to object to vaccination on personal, philosophic, or other grounds.

Dissatisfied Parents Together (DPT), as a national organization, neither recommends, nor opposes the language contained in Parts III and IV of this paper. Whether any of these changes or additions should be made is a matter for state-by-state determination. The language that is provided is offered simply as an option that state chapters of DPT and state legislators may consider. In deciding whether to pursue any of these options state chapters of DPT should take into account the pre-existing law in each state, the political feasibility of various changes in each state, the administrative requirements in each state, and the status of infectious disease control in the state.

Finally, Part V of this paper is a copy of the testimony given by DPT President, Jeff Schwartz, in support of the Maryland legislation. This testimony is presented not only to explain the bases for DPT's support of the bill, it is also presented as a possible model for other parents to present their testimony in their states, talking about their particular experiences and difficulties.

Finally, if any state legislator or DPT state chapter wishes to get further information or advice, please call DPT National Headquarters at (703) 938-DPT3 and we will respond as soon as we are able.

II. The Maryland Law: A Base Model

The following legislation was enacted by the General Assembly of the State of Maryland and signed into law by the Governor on May 29, 1984:

AN ACT concerning

State Mandated Immunizations - Pertussis

FOR the purpose of defining certain terms; providing for the development and dissemination of information concerning pertussis and the pertussis vaccine; requiring parents to be informed about State mandated immunizations including the risk of pertussis and pertussis vaccines; requiring record keeping and reporting by health care providers and the collection of data by the Department of Health and Mental Hygiene with respect to pertussis and major adverse reactions to pertussis vaccines; requiring the Department to issue certain guidelines; establishing criteria under which pertussis vaccines should not be administered; and generally relating to pertussis and the administration of pertussis vaccines.

BY adding to

Article - Health - General
Section 4-204(c); and 18-328 to be under the new part 19 "Part V. Pertussis"
Annotated Code of Maryland
(1982 Volume and 1983 Supplement)

BY adding to

Article - Education
Section 7-402(a)(3)
Annotated Code of Maryland
(1978 Volume and 1983 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health - General

4-204

(c) Whenever a resident birth occurs, the Secretary shall promptly provide parents of the newborn child with information on immunizations mandated by this state or required for admission to a public school in this state.

PART V. PERTUSSIS

18-328

(A) in Part V. of this Subtitle, the following words have the meanings indicated.

(B) "Health Care Provider" means any licensed health care professional, organization, or institution, whether public or private, under whose authority pertussis vaccine is administered.

(C) "Pertussis Vaccine" means any vaccine that contains materials intended to prevent the occurrence of pertussis, whether or not the materials are administered separately or in conjunction with other materials intended to prevent the occurrence of other diseases.

(D) "Major Adverse Reaction: means:

(1) Any serious illness, disability, or impairment of mental, emotional, behavioral, or physical functioning or development, the first manifestation of which appears within 7 days after the date of administration of pertussis vaccine and for which there is reasonable scientific or medical evidence that pertussis vaccine causes, or significantly contributes to, such effect; and

(2) Any other reaction, which the Department, after consultation with the medical and Chirurgical faculty of Maryland, determines by guideline is a basis for not continuing with pertussis vaccine administration.

18-329

(A)(1) Prior to the administration of pertussis vaccine, the health care provider shall provide to the individual's parent or guardian written information satisfying the requirement of this subsection, and appropriate inquiries attempt to elicit the information necessary to make the determinations required by § 18-332(B) of this subtitle.

(2) the information required under § 4-204(C) of this article, as to pertussis vaccine, and under paragraph (1) of this subsection shall include:

(I) the frequency, severity, and potential long-term effects of pertussis;

(II) possible adverse reactions to pertussis vaccine which, if they occur, should be brought to the immediate attention of the health care provider;

(III) a form listing symptoms to be monitored and containing places where information can be recorded to assist in reporting to the health care provider, local health officer, and the Department;

(IV) measures parents should take to reduce the risk of, or to respond to, any major adverse reaction;

(V) early warning signs or symptoms to which parents should be alert as possible precursors to a major adverse reaction;

(VI) when and to whom parents should report any major adverse reaction;

(VII) a summary of the immunization requirements adopted under § 7-402(A) of the Education Article -- including those related to pertussis vaccine; and

(VIII) the information required under Section 18-322(A)(1) through (3) of this subtitle.

(B) The Department by guideline and consistent with § 18-331(B) of this subtitle shall prescribe the form and content of the information provided to parents in accordance with this section.

18-330

(A) At the time of administration of pertussis vaccine to an individual, the health care provider shall record in a permanent record to which the patient or the patient's guardian shall have access on request:

(1) the date of each vaccination;

(2) the manufacturer and lot number of the vaccine used for each;

(3) any other identifying information on the vaccine used; and

(4) the name and title of the health care provider.

(B) Within 24 hours any health care provider who has administered pertussis vaccine to an individual and has reason to believe that the individual has had a major adverse reaction of the vaccine shall:

(1) record all relevant information in the individual's permanent medical record; and

(2) report the information, including the manufacturer's name and lot number to the local health officer who shall immediately forward the information to the Department. On receipt of the information, the Department shall immediately notify the vaccine manufacturer.

18-331

(A) By guideline, the Department shall establish a system, sufficient for the purposes of subsections (B) and (C) of this section, to collect data from the local health officers, from public and private health care providers, and from parents on the incidence of pertussis and major adverse reactions to pertussis vaccine.

(B) On the basis of information collected under this subsection and of other information available, the Department shall periodically revise and update the information required by § 18-329 and the guidelines adopted under § 18-332 of this subtitle.

(C) (1) The Department shall report to the United States Centers for Disease Control all information collected under § 18-331(A), including that received under § 18-330(B) of this subtitle.

(2) Subject to § 2-1312 of the State Government Article, the Department shall report annually to the General Assembly the incidence of pertussis and of major adverse reactions to pertussis vaccine.

18-332.

(A) The Department shall adopt guidelines, after notice and public hearing in accordance with the Administrative Procedures Act, setting forth:

(1) The circumstances under which pertussis vaccine should not be administered;

(2) The circumstances under which administration of the vaccine should be delayed;

(3) Any categories of potential recipients who are significantly more vulnerable to major adverse reactions than is the general population; and

(4) Procedures to notify all physicians of the content of the final guidelines and all updates issued thereafter.

(B) The administration of pertussis vaccine to an individual may not be required by any provision of law if, in the physician's medical judgment:

(1) The circumstances specified under subsection (A)(1) or (2) of this Section are present; or

(2) Taking into account the information specified under Subsection (A)(3) of this Section as well as all other relevant information, and the risk to the potential recipient outweighs the benefits both to the potential recipient and to the public in administering the vaccine.

(C) Nothing in this Section shall be construed to affect any emergency authority of the Secretary under any other provision of law to protect the public health.

Article - Education

7-402

(a)(3) Any requirement for the administration of pertussis vaccine shall be consistent with § 18-332(B) of the Health - General Article.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 1985, and that all guidelines authorized or required to be promulgated under Sections 18-328 through 18-332 of the Health - General Article, as enacted by this Act, shall be promulgated no later than January 1, 1985.

Notes on the Maryland Law

Two particularly unique aspects of Maryland law need to be noted.

RE[illegible]T: SERIOUS ADVERSE REACTION FOLLOWING RECEIPT OF PERTUSSIS VACCINE.

Patient's Name and _____ Sex _____ Age _____

Address _____ Phone _____

Describe Reaction. (Include date vaccine was administered and type of vaccine)

_____

_____

_____

Hospitalized?_____ Name of hospital _____

CUT ALONG THIS LINE

If your child has a serious reaction following pertussis vaccine, this information must be reported to the health authorities. Normally, this will be done by your doctor or clinic once they have knowledge of the event. You also may file a report, by completing the form above and submitting it to your respective local health department listed below.

NAMES, ADDRESSES AND PHONE NUMBERS OF MARYLAND'S LOCAL HEALTH DEPARTMENTS

Allegany, Box 1745, Willowbrook Road, Cumberland, 21502	777-5600
Anne Arundel, Health Services Bldg., J Harry S. Truman Pkwy., Annap., 21401	224-7095
Baltimore, New Courts Bldg., 401 Bosley Ave., Towson, 21204	494-2724
Calvert, P.O. Box 980, Prince Frederick, 20678	535-5400
Caroline, Box 10, 411 Franklin St., Denton, 21629	479-0556
Carroll, Box 845, 540 Washington Rd., Westminster, 21157	857-5000
Cecil, Court House Annex, 2nd Floor, Elkton, 21921	398-5100
Charles, Box 640, LaPlata, 20646	934-9577
Dor[illegible], Rt. 50 & Woods Rd., Box 319, Cambridge, 21613	228-3223
Frederick, 12 E. Church St., Frederick, 21701	694-1700
Garrett, Garrett Co. Medical Center, Oakland, 21550	334-8111
Harford, 119 Hays St., Box 191, Bel Air, 21014-0191	838-3047
Howard, 3450 Court House Dr., Box 476, Ellicott City, 21043	992-2333
Kent, College Ave., Ext., Box 359, Chestertown, 21620	778-1150
Montgomery, 100 Maryland Ave., Rockville, 20850	681-5000
Prince George's, Hospital Rd., Cheverly, 20785	386-[illegible]300
Queen Anne's, 206 N. Commerce St., Centreville, 21617	758-0720
St. Mary's, Tudor Hall Dr., P.O. Box 316, Leonardtown, 20650	475-8921
Somerset, Box 129, Dr. Robert Johnson Health Center, Westover, 21871	651-0822
Talbot, 100 S. Hanson St., Box 480, Easton, 21601	822-2292
Washington, 1302 Pennsylvania Ave., P.O. Box 2067, Hagerstown, 21740	791-3200
Wicomico, 300 W. Carroll St., Salisbury, 21801	749-1244
Worcester, P.O. Box 249, Snow Hill, 21863	632-1100
Baltimore City, 111 N. Calvert St., Baltimore, 21202	396-4387
State Health Dept., 201 W. Preston St., Baltimore, 21201	225-0677

Turn page for more →

IMPORTANT INFORMATION AVAILABLE TO YOU

Each time your child is given a DTP shot, the following information is recorded in a permanent record and is available to you from your doctor or clinic upon request:

- the date and time of day the vaccine was given,
- the DTP dose number,
- the name and title of the person who gave the shot,
- the vaccine manufacturer name, and
- the vaccine lot number.

You should keep information concerning the dates of any vaccine given to your child in a permanent immunization record plus the details of any reactions that may occur until your child enters school. The Maryland Department of Health and Mental Hygiene, Division of Immunization, 201 W. Preston Street, Baltimore, MD 21201, provides a personal Maryland Immunization Record for this purpose.

IMMUNIZATION REQUIREMENTS FOR ENTRY TO SCHOOL

There is a law in Maryland that requires children to have certain immunizations in order to enroll in a public or private school. Before a child is allowed to attend school, proof of immunization must be shown. Proof of immunization consists of a written record showing the month, day and year of each immunization, along with the signature of the person or clinic which administered each dose.

The following immunizations are currently required in Maryland:

- DTP — 4 doses for pupils less than 7 years of age,
- DT/Td — 3 doses for pupils 7 years of age and older,
- Polio — 3 doses for pupils less than 18 years of age,
- Measles — 1 dose of live virus vaccine on or after the first birthday, or a blood titer of at least 1:4, and
- Rubella — 1 dose of live virus vaccine on or after the first birthday, or a blood titer of at least 1:8.

As with pertussis, there are medical reasons that could exempt some children from mandated immunizations, the law allows a religious exemption, also.

SUMMARY

You have the right to receive and understand the information contained in this booklet. If you don't understand any part of it, ask to discuss it before your child receives pertussis vaccine.

Maryland law requires that most children receive, among other vaccines, pertussis vaccine in order to attend school. However, your child could be exempted temporarily or permanently from this mandate if he or she meets the appropriate conditions for such exemptions that are outlined in this booklet.

Under Maryland law, if your doctor decides that your child should not get the vaccine, his judgment is final. It cannot be reversed by the State or Local Health Department or by school officials. Except in an emergency, your child cannot be kept out of school because of the doctor's decision not to give your child the vaccine.

DHMH PRAMP
[illegible]

IMPORTANT INFORMATION ABOUT PERTUSSIS AND PERTUSSIS VACCINE

Prepared for you by:

The Maryland Department of Health and Mental Hygiene
The Medical and Chirurgical Faculty of the State of Maryland
The Maryland Chapter of the American Academy of Pediatrics

INTRODUCTION

This booklet is intended to answer some of the questions you may have about pertussis (whooping cough) and pertussis vaccine. You should read this information before your child receives the DTP vaccine.

Pertussis or whooping cough can be a serious disease. In some persons, especially very young children, it can cause permanent brain damage or even death. In order to protect persons from whooping cough, Maryland law requires most children to get four DTP shots before they go to school.

However, not all children have to get pertussis vaccine. In some cases, the "P" part of the DTP vaccine can cause serious reactions, including permanent brain damage or even death. So some children should not get the "P" part of the DTP vaccine at all. Also, for some children the series of pertussis vaccine should be delayed.

So it is very important to read and to understand this information about the disease and the pertussis vaccine to protect your child's health. If there is something in this booklet you don't understand, ask the person who gave you the booklet to explain it.

WHAT IS PERTUSSIS (WHOOPING COUGH)?

Pertussis, also known as whooping cough, is a highly contagious disease caused by the bacteria, *Bordetella pertussis*, and is spread through the air to others. The disease starts with cold symptoms and progresses to repeated, violent coughing spells which can interfere with eating, drinking and breathing. The coughing spells may be accompanied at the end by a "whooping" sound while the victim struggles to inhale. The disease will normally last for one-to-two months.

WHAT ARE THE RISKS OF GETTING WHOOPING COUGH?

According to the Centers for Disease Control (CDC), in the past ten years an average of 1,800 cases of pertussis have been reported each year in the U.S. Since many cases go unrecognized or unreported, the real numbers could be much higher.

Over half of the reported cases occur in children under 1 year of age. Most reported cases of whooping cough involve children under 5 years of age. This is why vaccination in early life is so important. Older children and adults, even those who have been vaccinated, can also contract the disease and are believed in many cases to be the source of infection in the younger children.

Although there is some disagreement about how effective the vaccine is, most children who receive the series of pertussis vaccine are protected from whooping cough. The disease is often milder in vaccinated children who do become ill with the disease.

WHAT ARE THE POSSIBLE DANGERS OF WHOOPING COUGH?

In the U.S. over the last ten years, an annual average of 8 deaths has occurred following the disease. While fatality is low, almost all deaths are among children under 1 year of age, most in those under 6 months.

While there is no specific treatment for pertussis, prompt medical attention and supportive care can be successful in reducing the severity and complications of the disease.

WHAT ARE THE POSSIBLE DANGERS OF THE PERTUSSIS PART OF DTP VACCINE?

Most U S doctors and public health officials believe that the benefits of pertussis vaccine outweigh the risk of reactions to the vaccine for most children. Most children have only a low fever, some crying and/or soreness after a DTP shot. Some have no reaction at all.

Some children, however, have serious reactions to the "P" part of the DTP vaccine. These reactions may include convulsions, seizures, shock-collapse (turning blue or pale, limp, non-responsive), a fever of 105 degrees F. or more, high-pitched unusual cries, unusually long sleeping with great difficulty waking the child, or crying which lasts more than 3 hours and cannot be stopped. Any of these signs should be reported to your doctor or clinic at once.

In some cases serious reactions to the vaccine can involve long-term uncontrolled seizure disorders, brain damage, and even death.

There is a great deal of disagreement over how often these serious reactions happen. The pertussis vaccine is known to cause serious reactions more often than other vaccines. An effective test to screen the pertussis vaccine for its potential to cause reactions is not available. It is not known how many children die or get long lasting disabilities after the DTP shot is given, yet clearly children who get DTP shots are at somewhat greater risk of serious reactions than those who get DT shots, without the "P".

This is why parents, doctors, and clinics need to give careful consideration before giving this vaccine and need to be alert to possible serious reactions which may occur.

DOES THE LAW REQUIRE ME TO GET PERTUSSIS VACCINE FOR MY CHILD?

Maryland law requires most children to receive several different immunizations before they can enter school – pertussis vaccine is one of them. In order to enter school, a minimum of 4 doses of DTP is required, 5 are recommended.

Not all children are required to get DTP shots. Maryland law allows some children not to have the "P" part of these shots if:

- the child has any condition listed in the following section ("Which Children Should Not Receive Pertussis Vaccine?").
- the parents object due to their good faith religious beliefs and practices (in which case the objections must be universal and not for pertussis vaccine alone), or
- the doctor decides that because of your child's particular situation, the risks of the vaccine outweigh the benefits to the child and the public. For instance, if a parent, brother, or sister of the child to be given the vaccine has epilepsy, seizures, or other diseases of the central nervous system, or has had a severe reaction to a DTP shot, the doctor may choose not to give the vaccine.

WHEN SHOULD A CHILD'S DTP SHOTS BE DELAYED?

A child's DTP shots should be delayed if he or she:

- has a fever or ear or chest infection or is sick at the proposed time for vaccination, or has not completely recovered from a past illness;
- has had a previous convulsion, seizure, or nervous system illness, until it can be determined that no more seizures are happening and the condition is stable and under control, or
- is receiving chemotherapy or radiation treatments which may reduce the immune response of the child to vaccines.

A child's shots can be continued after he or she is well.

WHICH CHILDREN SHOULD NOT RECEIVE PERTUSSIS VACCINE?

It is generally agreed that some children should not get the "P" part of the DTP vaccine. The pertussis vaccine should not be given to your child if:

- he or she has an underlying neurologic or seizure disorder which is getting worse or is uncontrolled;
- he or she is seven years of age or older; or
- he or she has already had an earlier DTP shot and had any of the following reactions after the shot:
  - a measured fever of 105 degrees F. or greater (some manufacturers believe a temperature of 103 degrees F. or greater is a contraindication, therefore, this also should be reported to your doctor),
  - a severe allergic reaction,
  - collapse or shock-like state,
  - persisting, inconsolable crying lasting 3 hours or more, or an unusual high-pitched cry;
  - convulsion(s) with or without fever occurring within 7 days, or
  - other severe problems of the brain occurring within 7 days, this includes prolonged sleeping and inability to wake child, unusual twitching of the body or unusual staring.

Some vaccine manufacturers state that a family history of central nervous system disorders is an absolute reason not to get whooping cough vaccine (the P part of the DTP vaccine). However, the Centers for Disease Control and the American Academy of Pediatrics disagree with the manufacturers on this issue. Therefore, any family history of central nervous system problems should be considered carefully with your doctor before vaccination.

Your child should not need further pertussis shots if he or she has had laboratory confirmed whooping cough. This also should be considered with your doctor.

If a child should not receive pertussis vaccine, he or she can still be protected against diphtheria and tetanus by receiving DT vaccine rather than DTP.

ARE CERTAIN CHILDREN MORE LIKELY TO HAVE A SERIOUS REACTION TO DTP VACCINE THAN OTHERS?

The medical experts do not agree on the reasons why reactions following vaccination happen, nor can they predict in which children serious reactions will occur. But there are some factors which may make children more likely to have serious reactions.

A child may be at higher risk of a serious reaction to the "P " part of the DTP vaccine if he or she:

- has had a serious reaction to a previous DTP shot;
- has a neurologic illness, including seizures or convulsions, the severity of which is changing or uncontrolled, or
- has a fever or infection or is sick when the shot is given.

HOW TO REDUCE THE RISK OF A SERIOUS REACTION TO PERTUSSIS VACCINE

It is important that a child's medical history be provided to the doctor or clinic before he or she receives the pertussis vaccine. Such a history should include, but not necessarily be limited to, the following information:

- major birth problems;
- your child's and family's history of convulsion (seizure) or neurological illness;
- any allergy;

- recent or present illness;
- medicines or treatment currently taking; and
- your child's and family's history of previous vaccine reactions.

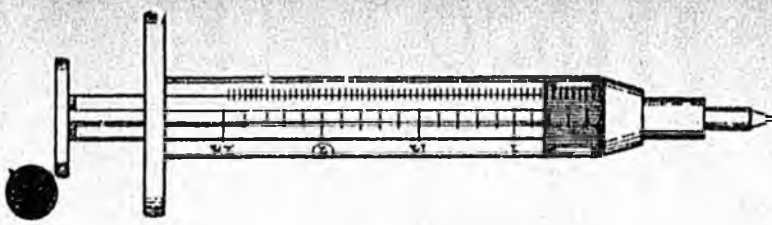
Besides providing your doctor with your child's medical history, there are other things which can be done to reduce the risk of a serious vaccine reaction. One thing you can do is take your child's temperature before he or she is vaccinated to make sure he or she has no fever. Another is to make sure your child has no obvious signs of infection at the time vaccine is given. If your child's throat is red or the child has been pulling his or her ears, this may be a sign of infection and should be discussed with your doctor.

WHAT SIGNS TO LOOK FOR IN A SERIOUS REACTION TO VACCINE

It is important to observe your child carefully at periodic intervals after vaccination, particularly during the first 72 hours. If your child has any of the following symptoms after a DTP shot, write down the details on this form to help you report the correct information to your doctor or clinic:

SYMPTOM	DATE	TIME	DURATION	DESCRIPTION
Measured fever nearing 105 degrees F				
High-pitched, unusual crying				
Persistent, inconsolable crying (3 or more hours)				
Inability to wake child, unusually prolonged sleeping				
Shock or collapse; loss of muscle control, turning white, blue or gray; limpness				
Convulsion, seizure, unusual repeated twitching, jerking, startling, or staring spells				
Loss of sensory or muscle control, paralysis, limping, loss of speech, hearing or sight				
Difficulty or stoppage of breathing				
Severe local reaction, large red, blue or purple coloring with extended swelling near where the shot was given				

If any of these events happen after your child gets a DTP shot, call your doctor or clinic at once. Tell them about the shot, when it was given, and about your child's reaction. *Arrange for a prompt examination at the doctor's office, clinic, or emergency room.* When things settle down, write down in detail exactly what happened.



Dissatisfied Parents Together (DPT)
128 Branch Road, Vienna, VA 22180
(703) 938-DPT3

May 22, 1987

Mrs. Shannon Kohler
President, Alaska DPT
Box 1746
Soldotna, AK 99669

Dear Shannon,

Enclosed are the new regulations issued by the Maryland State Health Department in regards to the vaccine safety legislation that was passed in Maryland.

As you can see by the Mar 1987 date, this information is just now reaching the health care providers in Maryland. This law was not implemented at the date it was given. Since health care providers are only now receiving this information on giving information to parents, recording manufacturer, date, batch number and recording and reporting adverse reactions to the state, it would be difficult for anyone in the state health department to analyze data collected by this new law that has not previously been available. The data will only now be available to analyze because prior to Mar 1987, the data does not exist.

Sincerely,

Kathi Williams

Kathi Williams, Director
Dissatisfied Parents Together (DPT)

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 52 PREVENTIVE MEDICINE

10.52.05 Pertussis and Pertussis Vaccine

Authority: Health-General Article, §4-204(c)
Annotated Code of Maryland

Notice of Final Action

On April 17, 1986, new Regulations .01 — .05 under a new chapter COMAR 10.52.05 Pertussis and Pertussis Vaccine, were adopted by the Secretary of Health and Mental Hygiene. These new regulations, which were proposed for adoption in 12:26 Md. R. 2558 — 2560 (December 20, 1985), have been adopted as proposed.

Effective Date: May 19, 1986.

ADELE WILZACK
Secretary of Health and Mental Hygiene

[Md. R. Doc. No. 85-R-473-F. Filed at Div. of St. Doc. April 23, 1986.]

.01 Definitions.

A. "Department" means the Maryland Department of Health and Mental Hygiene.

B. "Health care provider" means any licensed health care professional, organization, or institution, whether public or private, under whose authority pertussis vaccine is administered.

C. "Major adverse reaction" means any:

(1) Serious illness, disability, or impairment of mental, emotional, behavioral, or physical functioning or development, the first manifestation of which appears within 7 days after the date of administration of pertussis vaccine and for which there is reasonable scientific or medical evidence that pertussis vaccine causes, or significantly contributes to, the effect; and

(2) Other reaction, which the Department, after consultation with the Medical and Chirurgical Faculty of Maryland, determines is a basis for not continuing with pertussis vaccine administration.

D. "Patient" means the individual to whom pertussis vaccine is being administered.

E. "Pertussis vaccine" means any vaccine that contains materials intended to prevent the occurrence of pertussis, whether the materials are administered separately or in conjunction with other materials intended to prevent the occurrence of other diseases.

.02 Requirements for Health Care Providers.

A. Before the administration of pertussis vaccine, the health care provider shall provide to the patient's parent or guardian written information addressing:

(1) The frequency, severity, and potential long-term effects of pertussis;

(2) Possible adverse reactions to pertussis vaccine, which, if they occur, should be brought to the immediate attention of the health care provider;

(3) A form that lists symptoms of possible pertussis vaccine adverse reactions to be monitored and which contains places where information can be recorded to assist in reporting to the health care provider, local health officer, and the Department;

(4) Measures parents should take to reduce the risk of, or to respond to, any major adverse reaction to pertussis vaccine;

(5) Early warning signs or symptoms to which parents should be alert as possible precursors to a major adverse reaction to pertussis vaccine;

(6) When and to whom parents should report any major adverse reactions to pertussis vaccine;

(7) A summary of the immunization requirements adopted under Education Article, §7-402(a), Annotated Code of Maryland, including those related to pertussis vaccine;

(8) The circumstances under which pertussis vaccine may not be administered;

(9) The circumstances under which administration of pertussis vaccine shall be delayed; and

(10) Categories of potential recipients who are significantly more vulnerable to major adverse reactions to pertussis vaccine than is the general population.

B. Before the administration of pertussis vaccine, the health care provider shall, by appropriate inquiries, attempt to elicit the information necessary to determine, based on a physician's medical judgement, whether:

(1) Pertussis vaccine should not be administered to the patient;

(2) Administration of pertussis vaccine should be delayed; or

(3) The risk to the potential recipient of the vaccine outweighs the benefits both to the potential recipient and to the public in administering the vaccine.

C. The circumstances under which the administration of pertussis vaccine shall be delayed or may not occur are established by the Immunization Practices Advisory Committee (ACIP) to the Public Health Service. The Department will notify all health care providers of these circumstances.

D. A physician who determines, pursuant to §B, that the administration of the pertussis vaccine to a patient shall be delayed or may not occur shall submit to the local health officer the name, address, date of birth, and the basis for the determination for each patient.

E. Pertussis vaccine should not be given if in the physician's medical judgement, taking into account any categories of potential recipients who are significantly more vulnerable to major adverse reactions than is the general population, as well as all other relevant information, the risk to the potential recipient outweighs the benefits both to the potential recipient and the public in administering the vaccine.

F. At the time of administration of pertussis vaccine to a patient, the health care provider shall record, in a permanent record to which the patient's parent or guardian shall have access upon request:

(1) The date each dose of pertussis vaccine is administered;

(2) The manufacturer and lot number of the vaccine used for each;

(3) Other identifying information on the vaccine used; and

(4) The name and title of the health care provider who authorized the vaccine to be administered and the one who administered it.

G. A health care provider who has administered the pertussis vaccine to a patient and who has been informed by the parent or guardian of the patient, or has reason to believe that the patient has had a major adverse reaction to pertussis vaccine, shall within 24 hours of receipt of that knowledge:

(1) Record to the extent of his knowledge all relevant information in the patient's permanent medical record; and

(2) Report information, including the manufacturer's name, date of administration, type and lot number of the vaccine, a brief description of the reaction, and other specified information on a morbidity report card, to the local health officer. These reports can also be made by telephone.

.03 Requirements of Local Health Officers.

A. Upon receipt of notification of a major adverse reaction to a pertussis vaccine, the local health officer shall:

(1) Notify and forward the morbidity report card to the Department within 24 hours; and

(2) Assure that the necessary information to fill out a "Report of Adverse Event Following Immunization" is obtained.

B. At the time of completion, the Report shall be submitted to the Department.

.04 Requirements of the Department.

A. Whenever a resident birth occurs, the Department shall promptly provide parents of the newborn child with information included in Regulation .02A(1)—(10) of this chapter.

B. The Department shall prescribe the form and content of the information about immunizations provided to parents at times of birth and of administration of pertussis vaccine, according to Regulation .02A(1)—(10) of this chapter.

C. Upon receipt of information regarding a major adverse reaction to a pertussis vaccine, the Department shall immediately notify the vaccine manufacturer of the following:

(1) Date of immunization;

(2) Lot number of vaccine; and

(3) Type of reaction.

D. The Department shall establish a system to collect data from local health officers, from public and private health care providers, and from parents, on the incidence of pertussis and major adverse reactions to pertussis vaccine. This system shall be organized so that periodic revisions and updates of information and guidelines may be made. In addition, the information collected shall be sufficient for any reports required by the Department on pertussis and major adverse reactions to pertussis vaccine.

E. On the basis of the data collected and of any other information available, the Department shall periodically revise and update:

(1) The information provided to parents at the times of birth and of administration of pertussis vaccine;

(2) The information provided to health care providers regarding pertussis immunization deferral or exemption, and all other information otherwise regarding risks and benefits to the patient and to the public; and

(3) Other pertinent information on pertussis and pertussis vaccine.

F. The Department shall report to the centers for disease control (CDC) the incidence of pertussis and major adverse reactions to pertussis vaccine.

G. The Department shall report annually to the General Assembly on the incidence of pertussis and of major adverse reactions to pertussis vaccine.

H. The Department shall notify by mail or other means, or both, all health care providers of their responsibilities relevant to these regulations as well as other appropriate materials (for example, ACIP recommendations, parent information pamphlets, and morbidity report cards). Revisions of these and new materials shall also be distributed in the same manner.

.05 General.

Nothing in these regulations shall be construed to affect any emergency authority of the Secretary of Health and Mental Hygiene under any other provision of law to protect the public health.

State of Maryland

PREVENTIVE MEDICINE ADMINISTRATION

Address Replies to P.O. Box 13528
Baltimore, Maryland 21203

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • (301) 225-6677

ADELE WILZACK, R.N., M.S., SECRETARY

ERIC M. FINE, M.D., M.P.H., DIRECTOR

March, 1987

Dear Doctor:

Enclosed are the materials you requested concerning the new Pertussis and Pertussis Vaccine regulation (COMAR 10.52.05) that became effective in Maryland on May 19, 1986. These materials will assist you in complying with the regulation; they are:

- o Pertussis Regulation
- o July 12, 1985 ACIP Recommendations for DTP Vaccine
- o Guidelines for Implementing the Pertussis Regulation
- o Reporting Card for Adverse Reactions to Pertussis Vaccine
- o Pertussis Patient Information

It is important that you review all the enclosed material. Section .02, Items A through G, in the regulation outlines your particular responsibilities. The Guidelines further delineate those responsibilities. Within the ACIP Recommendations for DTP, you will find detailed information on vaccine use, precautions and contraindications, side effects and adverse reactions, and other vital information on Pertussis and Pertussis Vaccine.

As specified in Section .02, G (2) of the regulation, you are <u>required</u> to report any "major" (as defined in Section .01, C) adverse reaction associated with the administration of pertussis vaccine to your respective local health department. This can be accomplished by mailing a standard morbidity report card to the local health department or by telephoning the information to them. After they receive your initial report, someone from the health department will contact you to get more details about the reaction.

Section .02, A of the regulation, describes in detail the type of information that must be given to the parent or guardian of a patient before pertussis vaccine is administered. To assist you in complying with this provision of the regulation, the Department, in conjunction with the Medical and Chirurgical Faculty of Maryland and the State chapter of the American Academy of Pediatrics, has prepared the pamphlet, "Important Information About Pertussis and Pertussis Vaccine." Feel free to reproduce the number of copies you will need for your practice.

If there is any way we may assist you further in carrying out your part of this regulation, please contact either of us.

Sincerely,

Feng-Ying C. Lin, M.D., M.P.H., Chief
Center for Clinical Epidemiology

Robert E. Longenecker, Chief
Division of Immunization

FYCL/REL/mw
Enclosures

The New Epidemiology of Measles & Rubella by James D. Cherry University of California, Los Angeles. Dr. Cherry is a Professor of Pediatrics at the Univ. of Calif., L. A. School of Medicine and an attending physician at UCLA Hospital and Clinics. 1980 ARTICLE, Hospital Practice, July 80 Pp 49-57

This is the lead in to article

"Both diseases have been effectively controlled in the pediatric population that, in the prevaccine era, harbored them. However, with the shift in prevalence to adolescents and young adults, it is possible the diseases may be "time bombs"."

The Prevaccine era: Clinical studies showed: 95% of Americans had had measles by age 15. Serologic studies of young adults entering military service show 99% had measles/rubella antibodies. Highest incidence in the prevaccine era was in children 5 to 9, next highest under 5, only 10 % occured in children over 10 and 3% in persons over 15.

possible because "real" immunity was established?

A.W. Hedrich in 1933 published a landmark study on epidemiologic patterns of measles in Baltimore from 1900 to 1931. He reported that when 68% of the children less than 15 years of age were immune to measles epidemics did not develop.

1976 & 1977 Los Angeles County 67 children were studied for measles hemagglutination inhibiting antibody (HIA) titers after "booster" shots.

Direct Quote

The results: "In short, the data suggested that a booster dose might not have any lasting effect on waning immunity."

Spring 1977 - outbreak UCLA campus. 34 cases [18 thought they were immune (11 by vaccination, 6 by natural disease, one by both)]
506 students underwent serologic screening, 9% had HIA titers of less than 5 and thus, presumably , were susceptible to measles: *in other words, the outbreak had developed in a population that appeared to be 91% immune.* Some were reimmunized with same result as above (i.e. the

Direct Quote

booster did not foster increased immunity): "In short, there was extremely poor correlation between histories of immunization and either susceptibility to or protection against measles. Antibody responses in vaccinees cast doubt once again on the efficacy of revaccination (but not, it should be emphasized, on the efficacy of belated *primary* vaccination)"

Of 212 students and campus employees who were vaccinated during the study and who could be followed, 58 complained of vaccine associated reactions.

Rubella Since 1969 Rubella activity has declined about 70% (aprox administration of 83 million doses). But as with measles there has been a shift in age groups susceptible to rubella. Before rubella immunization less than 25% of reported rubella involved patients 15 or older. BY 1975

62% was in the 15 or older. By 1976 & 1977 70 % in 15 and older (Highest in the 15-19 yr group)

"The decline in congenital rubella is curious because the number of infections in women of child bearing age has remained the same. Anyway, it is clear that the apparent stability in the control of congenital rubella is precarious."

Atypical Measles - Usually occurs in recipients of killed vaccine. Atypical measles was first noted in 1965. It is a serious illness with fever, headache, abdominal pain, myalgia, yellowish red, maculopapular, frequently vesicular and petechial skin rash, and pneumonia. It lasts one to three weeks, recent reports suggest increasing duration and severity.

"Since "only" about 1.8 million doses of killed vaccine were distributed between 1963 and 1967 and since "only" an estimated 600,000 to 900,000 children received two or three doses of killed vaccine in those years, it was expected in the early 1970's that the problem would disappear quickly."
"It is a disease of significant morbidity in young adults and adolescents: It also presents a diagnostic challenge for primary care physicians unfamiliar with exanthematous diseases, particularly those illnesses normally confined to the pediatric population.

CLINICAL STRATEGY

The 'New' Epidemiology of Measles and Rubella

JAMES D. CHERRY *University of California, Los Angeles*

Both diseases have been effectively controlled in the pediatric population that, in the prevaccine era, harbored them. However, with the shift in prevalence to adolescents and young adults, it is possible the diseases may be "time bombs."

This is the first of five articles on the current concepts and problems of immunoprophylaxis. The second, "The Problems of Poliovirus Immunization" by Vincent A. Fulginiti, will appear in the August issue. "Live, Attenuated Varicella Vaccine—Where Do We Go From Here?" by Philip Brunell and "Pertussis Immunization: Prospects, Problems, and Perspectives" by Edward A. Mortimer Jr. will follow in September and October, respectively. The series will conclude in November with a discussion of "Rabies Prophylaxis in the 1980s" by Stanley A. Plotkin.

Dr. Cherry is Professor of Pediatrics at the University of California, Los Angeles, School of Medicine and Attending Physician at the UCLA Hospital and Clinics.

After more than 16 years of routine measles immunization and more than 10 years of routine rubella immunization in the United States, it is clear that we have done well in controlling both diseases; it is also clear, I think, that we can and should do better. In both instances, the need for improvement centers on a better understanding of herd immunity; in measles, however, there is also a continuing need for us to redress past mistakes whose consequences are still with us. Consequently, a major focus of this article will be the view that greater control of measles and rubella demands that we make an effort to identify and immunize susceptible adolescents and young adults.

Let us begin with measles. In the early 1960s, about 400,000 cases of measles were reported in the United States each year, with about 400 deaths annually. Measles vaccines were introduced in 1963, and by the years 1974–76, the incidence of the disease had dropped to about 30,000 cases per year, with about 30 deaths annually. Thus, the efficacy of measles immunization in the nation is impressive. Equally impressive is the safety of the vaccines used during the past 10 years. Severe reactions to the vaccines occur at a rate of approximately one per million children immunized, and severe illness or death is over a thousand times more likely to occur in a person who acquires the disease naturally than in one who becomes ill as a result of vaccination.

In 1978, the federal government announced that its aim was to eradicate indigenous measles from the country by 1982. What are the prospects for attaining this goal, given our current measles immunization strategy—namely, immunization of 90% or more of the U.S. population between the ages of one and four years?

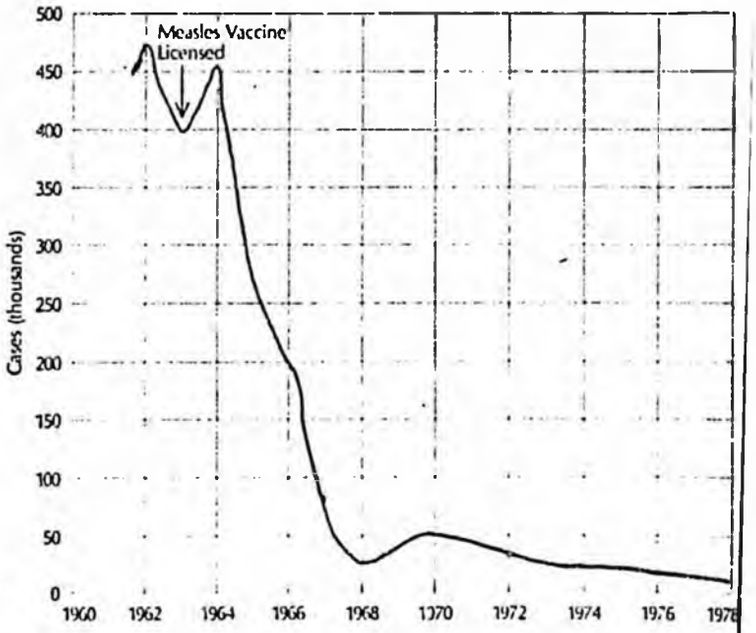
To a great extent, the answer can be found by considering the history of measles epidemiology in the United States before and after vaccine introduction. Prior to immunization programs, clinical surveys showed that at least 95% of Americans had had measles by age 15; serologic studies of young adults entering military service showed that 99% had previously had measles. The highest incidence in the prevaccine era was in children of five to nine years, the next highest in those under five; only 10% of cases occurred in children over age 10, and only 3% in persons over age 15.

The prevaccine era, of course, was also a time when we began to formulate concepts of herd immunity. In 1933 A. W. Hedrich published a landmark study on epidemiologic patterns of measles in Baltimore from 1900 to 1931. He reported that when 68% of the children less than 15 years of age were immune to measles, epidemics did not develop. Today we would regard that proportion of immunes to susceptibles as too low, but we still retain the basic concept—that there exists a threshold of herd immunity that will prevent epidemics.

As for the postvaccine era, 1963 saw the licensure of two types of measles vaccine for use in the United States: the Edmonston B strain vaccine (using live, attenuated virus) and a formalin-inactivated killed-virus vaccine. Difficulties were associated with both. The Edmonston B vaccine frequently produced high fevers, and to prevent this, gamma globulin was often administered concomitantly. Febrile reactions were not seen with the killed vaccine, but its major problem (which was quickly realized) was that it did not produce lasting protection by itself. Accordingly, as a sort of compromise solution, a common practice in early measles immunization programs was to give multiple doses of the killed vaccine followed by a single dose of the live vaccine. Another common practice at the outset was to begin immunization in infants by nine months of age, often as early as six months.

By 1964, it was clear that nine months of age (or younger) was too early to begin immunization. By 1965, another live vaccine (Schwarz strain), further attenuated to prevent febrile reactions, was licensed, but many physicians continued concomitant administration of gamma globulin. In 1968, the vaccine currently in use in the United States (the more attenuated Enders' line) was licensed.

The immediate impact of immunization on the incidence of measles was



Since the introduction of measles vaccines in 1963, the overall prevalence of the disease in the United States has dropped by more than 90%, from about 400,000 cases per year in the early 1960s to about 30,000 in recent years (left). At the same time, however

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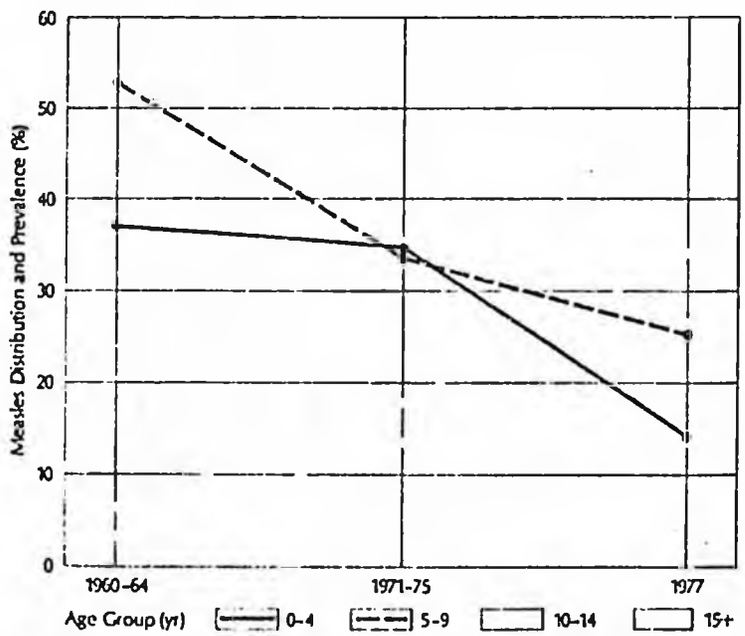
less than dramatic, mainly because vaccine distribution did not reach all segments of the pediatric population. Beginning in 1966, however, federal assistance for vaccine purchases by state public health departments was made available. From that point until about 1970, the incidence of measles in the United States fell dramatically. In 1964, for example, there were 458,083 cases of measles reported; in 1968, there were only 22,231. Interestingly, the United States Immunization Survey for 1968 estimated that about 59% of children between one and four years of age and 50% of those between five and nine years of age had received measles vaccine.

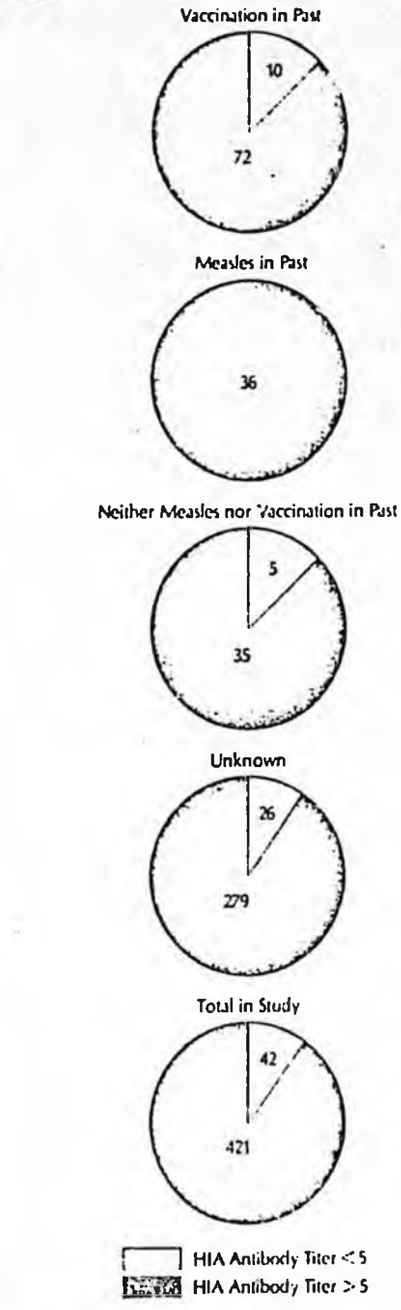
In 1969, rubella vaccine was licensed, and at the same time we experienced the beginning of a short-lived period of complacency about measles. From then until 1971, federal funds for measles control were restricted, the number of doses administered was allowed to lag below the birthrate, and there were instances in which the measles vaccine that was used was carelessly stored (too much heat or light), overdiluted, or otherwise improperly handled. Predictably, measles case reports increased sharply in 1970 and 1971. After 1971, however, federal funding for measles control was resumed, adherence to proper storage and handling procedures was emphasized, and immunization after one year of age was widely performed.

The next few years were relatively quiet on the measles front, but in 1976 and 1977, another surge in case reports occurred. What was unusual about this upswing was that as many as 60% of the cases (in which age was known) occurred in individuals over age 10 and 26% in those over age 15. In other words, the epidemiology of measles had changed dramatically, shifting from the younger to the older age groups.

Why? One factor was the large number of susceptibles who had never been vaccinated against or infected by measles. For example, the United States Immunization Survey noted that only about 67% of children who



there has been a dramatic shift in age-specific attack rates, with relative measles prevalence in older age groups rising; in the early 1960s, less than 10% of cases involved patients aged 10 or older, compared with over 60% in 1977 (right).



When antibody data were correlated with history in 463 UCLA students, 12% of those reporting prior measles vaccination and 8.5% of those who did not know their immune status had HIA titers below 5, conversely only 12.5% of those reporting an acquired immunity had the same evidence of apparent susceptibility

were 10 to 13 years old between 1973 and 1976 were immunized against the disease. Also contributing were the same mistakes that were made in early immunization programs. The incidence of true primary vaccine failure—that is, lack of antibody response in patients given the right vaccine under the right conditions—was probably negligible, occurring in no more than an estimated 5% of vaccinees.

What about the possibility of waning immunity in those who *had been* vaccinated? In the 1970-71 epidemic, studies in the St. Louis area indicated that about one half of 10,000 cases of measles occurred in vaccinees, and about half of these vaccinees had been less than one year old at the time of immunization. Some of the affected children in St. Louis had mild, apparently modified, disease. About one third of the vaccine failures showed only secondary specific antibody (IgG) response, that is, evidence of prior immunologic stimulation to measles without subsequent protection. Similar data for Cincinnati were reported by C. C. Linnemann Jr. et al and for New Haven by A. Schluederberg et al, both of whom noted a large number of "vaccine failures" in patients whose IgG was responsive but whose IgM was not. The attack rate in St. Louis was significantly higher in those vaccinated four years or more before the epidemic than in those vaccinated within the subsequent three years. This finding was recently echoed by J. S. Marks et al in their study of a 1976 outbreak in the Newark, Ohio, area; there the attack rate was significantly greater in patients vaccinated 10 years or more before the outbreak than in those vaccinated within the subsequent nine years. In short, since these studies indicated that vaccine failure rates increase with time, one could make a case for evidence of waning immunity; however, the influence of improper immunization in these "failures" could not be discounted.

One practical question raised by these findings was whether booster doses might correct the problem of waning immunity—if, that is, waning immunity existed and was in fact a problem. Unexpectedly, some answers were provided during 1976 and 1977 in a Los Angeles County program designed to provide primary immunization to children who had slipped through previous immunization programs.

The data were clearest in 67 of the children studied. All of them had initial measles hemagglutination-inhibiting antibody (HIA) titers of less than 5. It turned out that 27 of these children responded to immunization with a primary IgM response indicative of primary immunization. But there were 26 other patients whose response to vaccination consisted solely of a rise in IgG measles antibody. We postulated that most of the latter group probably had been vaccinated previously; later we were able to confirm that. Indeed, half of them had. The contrast in antibody response between these children (given booster doses) and those vaccinated for the first time was dramatic. In the primary vaccinees, the initial mean postimmunization titer was 73, and a year later it was 30. In the booster vaccinees, there was only a modest initial rise in titer, and after a year the level was almost back to where it had been before the booster. In addition, we noted a lack of "take" in 14 other children, most of whom probably had been immunologically stimulated previously. In short, the data suggested that a booster dose might not have any lasting effect on waning immunity.

In the spring of 1977, an outbreak of measles on the campus of UCLA provided an opportunity to study the epidemiologic and serologic characteristics of the disease in young adults of the vaccine era. A number of interesting points emerged. First, a total of 34 cases of measles were documented, the most important finding being that 18 involved patients thought they were immune (11 by reported vaccination, six by reported

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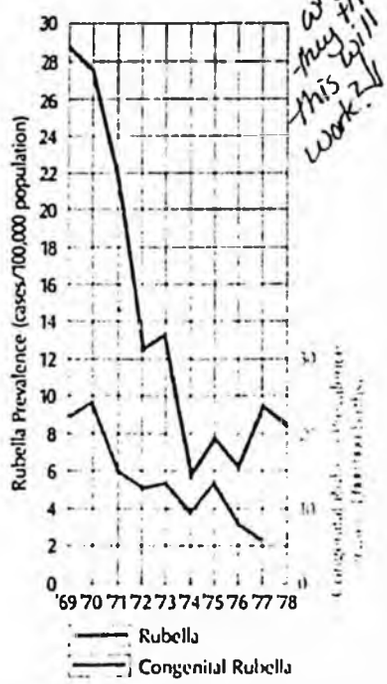
One further note: Of 212 students and campus employees who were vaccinated during the study and who could be followed, 58% complained of vaccine-associated reactions. During a three-week reporting period, fever (16%), eye pain (15%), bed confinement (17%), and skin rash (7%) were the most notable complaints; three vaccine recipients experienced especially severe reactions, including high fever, persistent eye pain, and prolonged bed confinement (only one of the three reported having been vaccinated previously). Thus, the impression was that measles vaccine may be more reactogenic in adults than in children; however, because serologic screening had not been done prior to immunization, the nature of the reactions (aberrant immunologic vs vaccine viral infection in the susceptible host) could not be determined. Recently, two studies, one at a military base and the other on a college campus, have revealed no severe reactions in more than 600 vaccinees; these findings are encouraging. but why the other reactions at UCLA?

Before turning to my recommendations, there is one other point to be addressed: atypical measles. This syndrome was first noted in 1965 but did not receive much attention until 1967, when V. A. Fulginiti et al reported a number of cases. It is characterized at first by acute onset of fever, headache, abdominal pain, and myalgia; two to three days later, a yellowish red, maculopapular, and frequently vesicular and petechial skin rash appears, beginning distally and then spreading centrally. In many patients, the extremities are edematous, and pneumonia occurs in almost all (but may not be detected by x-ray). The illness has been described as lasting one to three weeks, but recent reports suggest increasing duration and severity: in 1979, for example, D. B. Martin et al reported persistent residual nodular densities in chest x-rays of patients up to six months after the acute episode of atypical measles.

Although atypical measles has been reported very rarely in patients inoculated with live vaccine only, it usually occurs in recipients of killed vaccine. Since "only" about 1.8 million doses of killed vaccine were distributed between 1963 and 1967, and since "only" an estimated 600,000 to 900,000 children received two or three doses of killed vaccine in those years, it was expected in the early 1970s that the problem would disappear quickly. Eventually (if its pathogenesis involves killed vaccine) it will, but in the meantime, atypical measles is still very much with us. It is a disease of significant morbidity in young adults and some adolescents; it also presents a diagnostic challenge for primary care physicians unfamiliar

with exanthematous diseases, particularly those illnesses normally confined to the pediatric population. Moreover, the possibility of misdiagnosis is heightened when the syndrome is incompletely expressed and the patient's vaccination history is fragmentary, unelicited, or not considered. In the years to come, still more cases undoubtedly will occur, and in many the etiology will go unrecognized.

Where, as we try to make our way toward elimination of indigenous measles by 1982, does all of this lead us? The most clear-cut finding is the shift in the incidence of measles from younger to older age groups. Unfortunately, many of the other points we have reviewed, in an attempt to explain and come to terms with this shift, are clouded by uncertainties. For example, waning immunity in vaccinees does appear to exist, but its occurrence in properly immunized individuals has not been determined, and its epidemiologic significance is unknown. There is also, I think, good evidence indicating that booster doses to counteract waning immunity will be ineffective, with present vaccines at least. It is clear, too, that we cannot reasonably expect to identify susceptible adolescents or adults simply on the basis of history. On the other hand, it appears that if we elect to immunize *everybody* in the older age groups, a high percentage (perhaps as much as 80% to 90%) of such vaccinations will be unnecessary because of previously acquired immunity. In addition, the prospect of multiple doses of live vaccine entailed by such a shotgun approach raises the possibility of abnormal sensitization to the virus and consequent vaccine reactions. Then again, in the epidemics of 1970–71 and, especially, of 1976–77, we are faced with evidence that measles can spread despite high levels of herd immunity; in particular, the UCLA outbreak, in the face of 91% immunity, does not bode well for a national policy whose goal is 90% immunity. Finally, there is the persisting problem of atypical measles, the prevention of which would seem to call for reimmunization with live vaccine; here, too, there exists a risk of untoward reactions (in one study of 75 former recipients of killed vaccine, 13% had severe local reactions to live vaccine), but generally, the reactions of revaccination are considerably less severe than the alternative: atypical measles at some unspecified future date.



Since vaccine licensure in 1969, rubella cases in the United States have dropped 70%, the prevalence of congenital cases has dropped more modestly. Data for recent years may be incomplete.

The conclusion, I think, is that if we are truly going to eliminate measles in the United States, we must make a greater effort to track down and immunize susceptible adolescents and young adults; to do so requires serologic screening—in colleges, the military, industry, various institutions (including hospitals), and physicians' offices. If we settle for 90% immunity in children and ignore older age groups, we will continue, for the most part, to block major epidemics, but we will also continue to develop an expanding cohort of adolescents and adults in whom there are many susceptibles. As long as they stay in this country, these susceptibles will be relatively safe—probably increasingly so as more and more children are immunized. But once susceptibles travel to the many parts of the world where the virus is more prevalent or endemic, they will run the risk of getting measles and exposing others upon their return; thus, if such disease is not prevalent at the outset, it could become so on occasion.

Admittedly, screening programs in adolescents and adults would be expensive, but so, too, would be a program of mass, unscreened immunization or programs of emergency immunization in developing outbreaks. We must also acknowledge that questions remain about measles serology—for example, what titer shall we agree upon as the cutoff indicator of immunity? The risk of morbidity in older patients either vaccinated for the first time or revaccinated (i.e., killed-vaccine recipients) must also be

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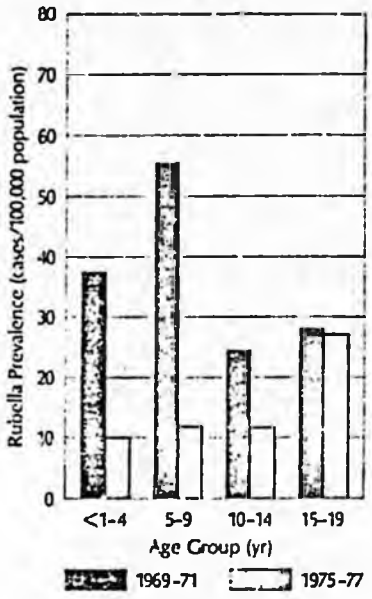
Another "selling point" for this ambitious undertaking is that measles screening could be combined with rubella screening for the same age groups. Why also rubella? With the distribution of over 83 million doses of rubella vaccine since 1969, rubella activity in the United States has dropped about 70%, despite periodic upswings in incidence. But as with measles, this drop has been accompanied by a shift in the age groups susceptible to rubella. Essentially, we have controlled the disease in persons 14 years of age or younger but have given it a free hand in those 15 or older. Before the advent of rubella immunization, less than 25% of reported rubella cases in this country involved patients 15 or older. By 1975, however, 62% of rubella cases in patients of known age occurred in the 15-or-older group; in 1976 and again in 1977, the figure was slightly more than 70%, and the attack rate has been highest in those between 15 and 19 years of age.

Of course, the point of rubella immunization is not prevention of rubella but prevention of the congenital rubella syndrome. Since 1969 and 1970, when the CDC's National Congenital Rubella Registry listed 78 and 90 cases, respectively, the number of reported cases has declined and *apparently* has remained relatively stable at about 30 to 40 per year (data for the last three years or so must be regarded as incomplete because of a common lag in recognition of the syndrome). This decline in congenital rubella is curious because the number of infections in women of childbearing age has remained the same. It is perhaps artifactual and explained by the fall in the fertility rate in the United States and also the more frequent use of therapeutic abortion. Anyway, it is clear that the apparent stability in the control of congenital rubella is precarious.

First, whatever herd immunity goal may have been envisioned at the outset, the level reached in the pediatric population has been no greater than 70% (some of the reasons for this will be discussed later). Second, prior to vaccine licensure, approximately 15% to 20% of women of childbearing age were susceptible to rubella; recent serologic surveys indicate that a similar percentage of women of that age group are still susceptible. Third, in the last couple of years, outbreaks of rubella have occurred in junior and senior high schools, colleges, military bases, and such noteworthy places of employment as hospitals.

As is well known, rubella control to date has been attempted by two different strategies: the so-called U.S. approach (immunizing one-year-olds, other preschoolers, and children between five and nine years) and the so-called U.K. approach (immunizing 11- to 14-year-old girls). Unfortunately, data on the efficacy of the British approach are generally lacking, but at a 1976 meeting on the subject it was stated that in the face of a 72% vaccination rate in the target population, the incidences of rubella and congenital rubella remained unchanged. However, in a recent serologic survey 93% to 96% of women born after 1956 (who would have been offered rubella vaccine in school) were found to have antibody. On the other hand, it is clear that the U.S. approach, whatever its own shortcomings, has not only dramatically reduced the incidence of rubella but also has significantly impeded the epidemic potential of the disease: since 1969, there have been no epidemics in U.S. children. A major concern with the U.S. approach was whether immunity would wane over the years; thus far, rubella vaccine apparently has remained effective, although the possibility that natural challenge has boosted immunity in vaccinees cannot be ruled out.



Data from Massachusetts, New York City, and Illinois indicate that rubella vaccination has controlled the disease in patients aged 14 and younger but not in those in the 15-to-19 age group.

In the United States, one potential problem that militated against immunizing girls 11 to 14 years or older was the possibility that pregnant or soon-to-be-pregnant subjects (and their fetuses) might be inadvertently exposed to the virus. Concern about this was (and probably still is) so great that many physicians were discouraged from vaccinating older susceptible female patients; too often, the prudent recommendation that serologic testing be performed before vaccination of any female adolescent or adult became, rather than a tool to promote appropriate rubella immunization, a deterrent to any immunization at all—whether serologic testing was available or not.

In this regard, it has turned out that more than 300 pregnant women *were vaccinated* inadvertently in the United States during the past 10 years or so. In most cases, pertinent serologic data are absent, but we do know of about 70 infants born to previously seronegative women who had been immunized during or shortly before pregnancy. No infant had any obvious congenital malformations, but there were two with evidence of subclinical in utero infection (elevated rubella-specific IgM in one and elevated IgG at age 24 months in the other). Moreover (echoing studies performed prior to widespread rubella immunization), rubella virus has also been found in the products of some aborted pregnancies in previously susceptible women vaccinated during pregnancy. Thus far, the overall observed risk of malformation has been zero, but the actual risk is probably greater; it has been estimated at no more than 5.4%, which contrasts with a risk of at least 30% from natural infection.

In considering the reasons for rubella susceptibility in older U.S. age groups, another point that needs to be recalled is that four different rubella vaccines have been used in this country. At present, the only one currently licensed is the RA27/3 (available since January 1979), which is derived from human tissue culture—a reason for initial reluctance to use it. Field trials and four- to seven-year follow-ups of this vaccine have indicated a failure rate of about 3%. Of the other vaccines, the HPV77 DK12 strain (used from 1969 to about 1973) and the Cendehill strain (used from about 1970 to 1976) have had similar or perhaps slightly higher failure rates. But neither of these vaccines was very widely used in this country. Through 1978, most U.S. vaccinees received the HPV77 DE5 strain, and for this vaccine the failure rate was similar to the other vaccines. Of the four vaccines, geometric mean antibody titers have been the highest with the currently licensed (RA27/3) vaccine.

Does low or undetectable rubella antibody after vaccination mean susceptibility to reinfection? First of all, reinfection has been noted in patients with vaccine-induced or natural antibody, and the lower the titer, in general, the greater the likelihood of reinfection. But no study to date has documented illness or viremia in reinfected patients, nor is there evidence that an asymptomatically and aviremically infected mother can transmit infection to her fetus, although the possibility remains that such a patient might transmit infection, through pharyngeal excretion of virus, to another susceptible individual and thereby jeopardize herd immunity. IgM and IgG characterization of antibody response in vaccinees with low or absent titers might indicate whether they have partial immunity to natural disease, but in this regard H. H. Balfour Jr. and D. P. Amren have reported that RA27/3 revaccination in a small group of former HPV77 DE5 recipients resulted in boosterlike rises in rubella HIA titers from low or undetectable levels and that high titers were maintained for at least 10 weeks thereafter.

What about adverse reactions to rubella vaccine? In children, skin rash and lymphadenopathy occasionally occur, and transient pain in peripheral

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small joints has been common in some studies. Joint symptoms (arthralgia and transient arthritis) appear to be more frequent and more severe in susceptible female adults than in children, but they are generally short-lived (beginning two to 10 weeks after immunization and lasting one to three days) and rarely recur. Aside from pregnancy, the major contraindications to rubella vaccination (which are similar to those for measles immunization) include immune-deficiency diseases or suppressed immune response occurring in leukemia, lymphoma, and generalized malignancy or when steroids, alkylating agents, antimetabolites, or radiation are being used; patients with febrile illnesses should not be vaccinated until they have recovered.

Where does all of this lead us? The first point is that we should continue to improve rubella immunization rates in children, extending protection to well over 90% of that population and as close to 100% as possible. The second point is simply that the same goal should apply to susceptibles in older age groups.

Since more than two thirds of reported rubella cases in the United States involve patients in their mid-teens or older, since almost one third of the pediatric population was never covered by rubella immunization programs, since a history of rubella immunization (without documentation) is likely to be an unreliable index of immunity in older persons, and since many older individuals are already immune to rubella, comprehensive serologic screening programs to identify susceptibles would seem to be in order—all the more so as time passes and the "herd" of adolescent and adult susceptibles grows. It may be argued that screening for older female susceptibles should be emphasized (as a mandatory part of school entrance requirements and in premarital screening programs, prenatal clinics, or family planning centers, for example); older male susceptibles should not be ignored, however, and will probably require equal attention in schools and colleges, the military, and places of employment if the epidemic potential of the disease in older age groups is to be blocked. Perhaps nowhere is the need for identifying susceptibles more pronounced than in hospitals (staff and patients), but the risk of rubella (and, ultimately, congenital rubella syndrome) exists wherever older seronegative individuals congregate.

If recent U.S. experience with rubella (and measles) has taught us anything about immunoprophylaxis and herd immunity, it is that our national population is not one herd, monolithic and static, but several herds, each responsive to its own epidemiologic dynamics. Levels of immunity achieved in one herd—no matter how high—may not be protective for another herd; rather, they may simply reveal how unprotected some herds are (adolescents and young adults), as compared with others (preschoolers and most prepubertal children). Clearly, herd immunity in the United States today is not strictly comparable to that in Baltimore during the first 30 years of this century.

A conservative, watch-and-wait approach to recent shifts in the age-specific incidences of rubella and measles may arguably be advocated, especially when one considers that surveillance programs for each disease are poor and need to be improved in order to provide better data, identify developing outbreaks, and facilitate their management. Certainly, the dollar commitment that would be necessary to control these diseases more fully is awesome—and so, too, the logistics of implementation and enforcement. On the other hand, the available evidence suggests that these diseases may be time bombs. And the costs of an explosion could far exceed those of defusing them now. □

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Rubella Susceptibility in Sixth Graders: Effectiveness of Current Immunization Practice

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ABSTRACT. Rubella hemagglutination inhibition antibody titer was determined for 702 sixth grade students from nine randomly chosen schools in a community served well medically. Rubella immunization had been given by private physicians, the health department, hospital clinics, and through a mass immunization effort in 1970. The overall susceptibility rate, as defined by a rubella hemagglutination inhibition titer of less than 1:8, was 15%. Susceptibility did not differ significantly in regard to sex, race, or source of vaccine. Of 469 children with a documented rubella immunization, 13.2% were susceptible or vaccine failures. Menarche was reported by 30% of the girls. To increase the level of protection against rubella during the childbearing years, continued emphasis on early childhood immunization combined with consideration of a booster rubella immunization for preadolescents is recommended. *Pediatrics* 65:1086–1089, 1980; *rubella, rubella vaccine, immunization policy, vaccine failure, serologic survey.*

The major clinical sequelae of rubella are the fetal wastage and anomalies of the congenital rubella syndrome that occur with rubella infection in early pregnancy. Thus, prevention of infection in the fetus is the principal goal of the rubella immunization effort.[1] As a means of ensuring this protection, Krugman[2] suggested that the feasibility of administering rubella vaccine to all girls entering the sixth grade be considered.

In previous serologic surveys of rubella vaccinees, protective antibody response has been reported in more than 95% of susceptible children who are immunized after 12 months of age.[3] In these studies, vaccine was administered to the recipients by the investigators under well-controlled circumstances. Less well studied is the effectiveness of the vaccine when administered by a variety of providers under variable conditions.

Knowledge of the level of rubella susceptibility among sixth grade students is necessary to determine the feasibility of recommending rubella vaccine for all girls at the sixth grade level. It also serves as a measure of the effectiveness of immunization practice in a community when carried out by a variety of health providers. To provide this data, a serologic survey of public school sixth grade children was done.

METHODS

In Winston-Salem, NC, an urban community of 140,000 population that is well served medically, children have received rubella vaccine since 1969 from several providers: various private physicians, health department clinics, and a mass rubella immunization effort in 1970. Serologic screening by rubella hemagglutination inhibition (HI) antibody titer was offered to all sixth grade students in nine schools selected randomly from the 18 schools with sixth grades. Parents who granted permission for their child's participation in the study reported by questionnaire the age, sex, and race of their child, history of clinical rubella, type of immunization received, date and source of the immunization, and for girls, history of menarche.

School immunization records of participants and nonparticipants were reviewed for documentation of rubella immunization. Participation of the student in the school free lunch program was used as an identifier of lower income families. In the Win-

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A team consisting of two or more physicians, school health nurse, and school health assistant visited each of the nine schools for blood collection. A specimen of 10 ml of whole blood was collected, spun down, and the separated serum was frozen. Rubella HI titer was determined by the Virology Laboratory of the North Carolina Division of Health Services. This laboratory regularly participates in Communicable Disease Center proficiency testing and performs 50,000 HI antibody titers annually. An HI antibody titer of less than 1:8 was considered indicative of susceptibility to rubella.[15] Parents and physicians of susceptible children were informed of the test results. Parents of susceptible children were urged to contact their child's physician or clinic for advice about rubella immunization. Statistical analysis was done by χ^2 test.

RESULTS

Of 1,400 sixth grade students in the nine schools, 702 (50%) received parental permission for participation. In only two of the nine schools was participation less than 50%. Analysis of the data from the schools with less participation did not differ significantly from the schools with higher participation. Therefore, the results were combined. Of the participants, 47.4% were boys and 52.6% girls; 69.5% were white and 30.5% nonwhite; 24.6% were from low-income families as defined by enrollment in the free lunch program. The demographic characteristics of participants compared to the entire sixth grade of 2,990 students are shown in Table 1. Participants did not differ significantly from the entire sixth grade population in regard to sex or race. The study population had significantly fewer low-income students ($P < .01$), than did the entire sixth grade. The mean age of participants was 11.4 years. A history of menarche was given by 30% of the girls in the study.

Overall susceptibility rate to rubella was 15%. As shown in Table 2, male students, white students, and higher income students showed a greater serologic susceptibility to rubella than did the female,

TABLE 1. Demographic Characteristics of Participants Compared to Entire Sixth Grade

	Participants	Total 6th Grade
No.	702	2,990
Boys	47.4%	51.5%
Girls	52.6%	48.5%
White	69.5%	66.5%
Nonwhite	30.5%	33.5%
Free lunch (low income)*	24.6%	30.0%

* $P < .01$ by χ^2.

TABLE 2. Susceptibility Rate by Sex, Race, and Income

	Susceptible (%)
Boys	16.5
Girls	13.6
White	16.0
Nonwhite	12.6
Free lunch (low income)*	10.2
Nonfree lunch	16.5
Overall susceptibility	15.0

* $P < .05$ by χ^2.

TABLE 3. Susceptibility Rate by Source of Vaccine

Source	Susceptible (%)
Private physician	12.5
Health department	12.1
Mass immunization	16.6
Unspecified clinic	16.7

nonwhite, and low-income students. By χ^2 analysis, there was no significant difference in susceptibility rate by sex or race. The difference between free lunch and non-free-lunch participants was statistically significant ($P < .05$).

It was possible to identify the source of rubella vaccine for 58.0% of the participants. The susceptibility rate did not differ significantly among the various sources of the vaccine as shown in Table 3. A history of rubella immunization was given by 78.5% of participants. The susceptibility rate was significantly lower (13.4%) in those with a history of immunization, whether it was documented or not, than in those without a history of immunization (20.5%).

Rubella immunization was documented by home or school record in 469 (66.8%) of the participants. Of these, 62 were susceptible, giving a vaccine failure rate of 13.2%. These 62 students made up 59.0% of the total number of susceptible students. For students in whom rubella immunization could not be documented, the susceptibility rate was 18.5%. The 85% of students with protective titers consisted of 7.1% with an HI titer of 1:8, 21.4% with 1:16, and 56.5% with 1:32 or greater.

DISCUSSION

Prior to rubella vaccine, rubella occurred with a pattern of epidemic spikes every six to nine years with peaks of 100 to 500 cases per 100,000 population.[4] Since the introduction in 1969 of rubella vaccine, the number of reported rubella cases in the United States has declined dramatically to less than ten cases per 100,000 population annually. There has been a parallel decrease in the reported cases of congenital rubella syndrome.[5]