

Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

November 1998

Immunization Issue

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OFFICE OF PUBLIC HEALTH AND SCIENCE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Adult Immunizations Save Lives

By Kevin Thurm, Deputy Secretary, U.S. Department of Health and Human Services

I am delighted that the Office of Minority Health has chosen to focus this issue on adult immunization, and appreciate the opportunity to share with you the U.S. Department of Health and Human Services' (HHS) message about the critical importance of protecting adults as well as children against vaccine-preventable diseases.

As health workers, educators, and community leaders, you play a vital role in adult immunization, whether you are providing routine care for a patient, treating individuals who are at high risk of vaccine-preventable diseases such as influenza (flu) or pneumonia, or educating your neighbors or your community about important health issues. I invite you to join us and our partners in our coordinated efforts to prevent illness and to save the lives of as many as 50,000 to 70,000 adults each year in the United States who die from vaccine-preventable diseases or their complications.

We've made great strides in protecting children against such deadly infectious diseases as polio. Because of the efforts of individuals like you, childhood immunization rates are at an all-time high and infant mortality is at an all-time low.

But tragically, adults, particularly seniors and racial and ethnic minorities, are not enjoying the same protection against vaccine-preventable diseases as our children. In fact, each year in the U.S. alone, at least 45,000 adults die of complications of influenza, pneumonia, or hepatitis B despite the availability of safe and effective vaccines to prevent these illnesses. And about 90 percent of the deaths from flu-related illnesses occur in people aged 65 and above.

The Clinton Administration has fought to reach the same level of success getting adults

immunized as we have in ensuring our children's safety from disease and sickness. Medicare coverage of flu shots for seniors began in 1993, providing a boost to adult immunization rates. In 1997, 65 percent of the nation's elderly—nearly all of them Medicare beneficiaries—received their annual flu shots, a 15 percent jump from 1993. Medicare also covers pneumococcal shots.

Nevertheless, we still have a long way to go. Adults remain 100 times more likely than children to die each year from vaccine-preventable diseases. People with diabetes are about three times more likely to die from flu and pneumonia than those without diabetes, yet more than half of those with diabetes did not get a flu shot in 1995. In addition, African-Americans and other minorities continue to fall short of the immunization levels of the general population.

That's why last year we began implementing a comprehensive Adult Immunization Action Plan—a blueprint for future action by HHS and our partners. To reach our goals, we are working with our partners to determine which immunization strategies work best and why, and to share that information as broadly as possible. We are continuing to build on sound, scientific research at all levels. We are finding new ways to effectively deliver vaccines to adults, not only in the hospital, clinic, or nursing home, but also in non-traditional sites like pharmacies and churches. And we are getting the message to doctors and health care professionals, to families and communities, that vaccination is not just the smart thing to do, it's the right thing to do.

Meanwhile, we are strengthening our efforts to overcome the disproportionate

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The Office of Minority Health Resource Center provides free information on various health issues affecting U.S. minorities including cancer, heart disease, violence, HIV/AIDS and diabetes. Call us to learn about funding sources for minority health programs.

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The editors of Closing the Gap would like to thank Jane Zanca, health communications fellow at the Centers for Disease Control and Prevention, for her valuable writing and editorial contributions to this issue.

HCFA Kicks Off 3rd Year of Community Flu Projects

By Jackie Harley and Diane Wade, RD, LD

In 1912, when the great ship Titanic sank, taking over 1,500 lives, Rachel Hollis was 9 years old. Six years later, when she was 15, the 1918 Spanish Flu pandemic swept around the world, taking more than 22 million lives, many of them young people like herself. Ms. Hollis was taken ill with that flu, but she survived. Now, at 95, the Baltimore, Maryland, senior wants to know if it's okay to get her annual flu shot, since she has diabetes and angina. So she asked her doctor, Elijah Saunders, MD.

Dr. Saunders, a cardiologist at University Hospital in Baltimore, said that Ms. Hollis is exactly the kind of patient who *should* get the flu shot. And thanks to Medicare's preventive benefits available to the aged and disabled, Ms. Hollis will be able to afford her shot.

Berena Reed, another survivor of the 1918 flu epidemic and Baltimore resident, takes her flu shot religiously every year because, as she says, it keeps her healthy. But getting to the clinic has become increasingly more difficult.

Because of people like Ms. Hollis and Ms. Reed, the Health Care Financing Administration (HCFA)—the agency responsible for Medicare, Medicaid, and the Child Health Insurance Program—started the Horizons Program to address issues subsequently identified in the President's initiative to reduce racial and ethnic disparities in health. Established in 1996, the Horizons Program forms partnerships to meet the needs of special populations.

One project within the Horizons Program is the Good Neighbor Flu Project. It joins the resources of HCFA's Central Office with Baltimore City's Action for Community Enrichment and Maryland Partnership for Prevention's annual flu-shot campaigns.

HCFA's first neighborly challenge strives to increase the rate of flu shots among the 40,000 African American Medicare beneficiaries residing in Baltimore. The Good Neighbor Flu Project began when HCFA staff, many of whom had parents and grandparents living in Baltimore, realized they should be "good neighbors" by starting in their own backyards to increase the rate of flu shots.

A specific intervention developed by HCFA staff is a video, "Standing in the Safety Zone," which focuses on survivors of the 1918 influenza pandemic. That pandemic killed over 700,000 people in the U.S., and 4,000 people in Baltimore over a three-month period. Featured in the video are Baltimore Mayor Kurt Schmoke and Emmy award-winning actor André Braugher, along with Ms. Hollis and Dr. Saunders.

HCFA knows that racial and ethnic minorities tend to use preventive services at much lower rates than the majority of the community and has committed itself to meeting the Healthy People 2000 goal of 60 percent flu immunizations for Americans aged 65 and older. According to Ms. Reed, the reasons for not getting the shot may be as simple as transportation. She suggested taking the flu shot to her family. When the Good Neighbor Project made that possible, the whole family got the shot.

The importance of the flu shot increases for people like Ms. Hollis, who are at high risk for complications such as heart disease, diabetes, and other chronic conditions. The flu shot should be given to such patients in early Fall.

The Good Neighbor Flu Project allows HCFA headquarters staff to put their knowledge and skills on health issues

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to work within Baltimore. For the past two years, HCFA staff have fostered a unique collaboration between the Baltimore City Health Department, the Delmarva Foundation, and HCFA's Boston Regional Office, Morgan State University, UniversityCARE, and the Maryland Partnership for Prevention, to help Medicare beneficiaries fight the flu.

Through the Good Neighbor Flu Project partnership and coalition-building efforts, the additional multi-focused interventions include reaching out to beneficiaries and physicians, and working in acute and ambulatory care facilities.

Adult Immunizations...from page one

burden of vaccine-preventable diseases in racial and ethnic communities. The HHS Initiative to Eliminate Racial and Ethnic Disparities in Health, announced earlier this year by President Clinton and HHS Secretary Donna E. Shalala, and led by Surgeon General Dr. David Satcher, plans to eliminate health disparities in six critical areas, including adult immunizations, by the year 2010.

With the flu season now upon us, there is no better time for you to be involved. Take every opportunity to remind seniors that flu and pneumococcal shots are important and are covered by Medicare. Encourage others at high risk to get vaccinated, including individuals with diabetes. Join or form a coalition in your community to spread the word about adult immunization.

To accomplish this, we need your commitment, leadership, and energy. I hope this issue will provide you with a better understanding of adult immunization and more determination than ever to work together to ensure that adults receive the life-saving vaccines they need.❖

Provider-focused interventions include providing doctors and other health care workers with tool kits that contained information on flu shots, such as an information page on ordering the flu vaccine, and a flu fact sheet. It also contains information on how to respond to patients' fears about flu shots, provides lists of pharmaceutical companies which supply vaccines, and provides letters to be sent to patients reminding them to get a flu shot.

Beneficiary-focused interventions include working with church ministers and nurses to provide education and accurate information about flu immunizations to their communities. Together, they conduct face-to-face presentations, and use radio, television and local newspaper public service announcements to promote vaccinations. Other activities include participating in wellness and health clinics and other community fairs, conducting focus groups to identify barriers which prevent seniors from getting immunized, and providing beneficiaries with information about flu and reminders to get the flu shot.

The overall success of the project was attributed to partnerships between the various agencies, the recruiting of volunteers from organizations and nursing schools, and the combination of various interventions. Medicare claims data show immunization rates in Baltimore City increased between 1996 and 1997 from 36.7 to 38.5 percent for Whites, and 17.6 to 18.9 percent for Blacks. In addition, the rates of flu shots administered to African American Medicare beneficiaries in Baltimore increased 2.2 percent during the 1997 flu season, compared to the national rate of .7 percent.

Good Neighbor Flu Project activities for 1998 included a major media kickoff, provider and beneficiary education, and the administering of flu shots in 26 flu clinics in Baltimore City's predominately African American neighborhoods.

The Horizons Pilot Project introduced the first interventions focused solely on African Americans since the beginning of the Peer Review Organizations (PRO) Program. The project also established the first, and so far only, contractual arrangements between HCFA and Historically Black Colleges and Universities (HBCUs). The pilot project for the Horizons program formed partnerships between eight PROs and twelve HBCUs. PROs are groups of physicians who work with HCFA to protect Medicare beneficiaries and improve the quality of care.

The PROs and HBCUs implemented intervention strategies during the 1996 flu season, targeting 96,090 African American Medicare beneficiaries in their states. During the 1997 flu season, 566,245 African American Medicare beneficiaries in those states were targeted—80 percent of the African American Medicare population in the eight Horizons states.

Various types of provider interventions were developed for physicians, pharmacists, nurses, hospitals, home health agencies, health centers, and rural health clinics. They also worked with churches to provide information on flu shots, and they educated school-aged children about the importance of grandparents being protected against the flu.

Both the Good Neighbor Flu Project and the Horizons Pilot Project will use lessons learned from the previous two years to increase the rates of flu shots among African American Medicare beneficiaries for the 1998 flu season. In addition, the lessons learned from these projects will undoubtedly contribute to quality improvement efforts focused on the African American population for other clinical conditions.

See page 15 for a list of Horizons contacts. Jackie Harley is a health insurance specialist for HCFA. Diane Wade is Horizons project manager at HCFA's Dallas Regional Office.❖

Lifesaving Vaccines Under-Used by Minority Adults

By Steve Sepe, MPH

Despite the staggering morbidity and mortality and associated costs of influenza, pneumococcal disease, hepatitis B infection, and other vaccine-preventable diseases of adults, the vaccines available to prevent these diseases are underused.

The use of influenza vaccine has been improving over the last decade, and coverage levels in adults have increased overall. However, certain racial and ethnic minority groups are missing the lifesaving benefits of these vaccines because they receive them at disproportionately lower rates than other groups.

Influenza and pneumococcal vaccines save lives

Approximately 90 percent of U.S. deaths associated with influenza and pneumococcal disease occur among adults aged 65 years and older. Consequently, the vaccines for these diseases are especially important for elders.

In 1995, the death rates for pneumonia and influenza among Whites was 12.4 per 100,000 population. Asian Americans and Pacific Islanders and Hispanics fared better, with rates at 10.8 and 9.9, respectively. But for African Americans the rate was much higher, at 17.8. Among Native Americans and Alaskan Natives, the rate was 14.2.

Hepatitis B vaccine spares suffering

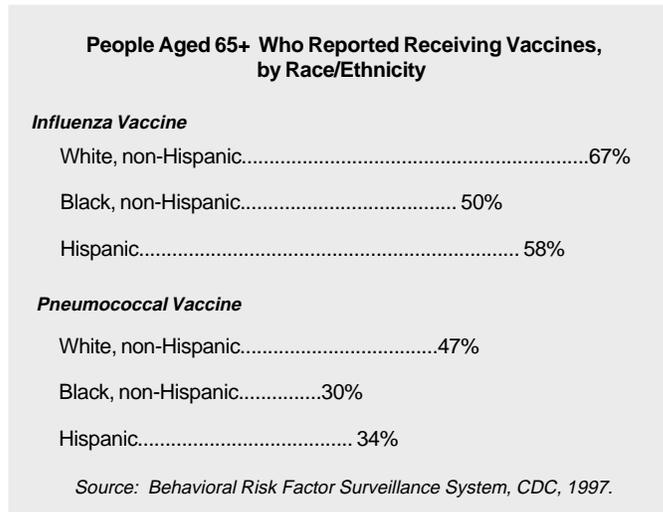
Hepatitis B infection is possible at any age, from birth well into the elder years. The infection spreads easily, especially if a family or household member is infected.

Chronic infection leads to liver failure, cirrhosis, and liver cancer. As discussed on page 10, hepatitis B infection rates are devastatingly high among first-generation Asian Americans and their offspring, and among Pacific Islanders. A simple series of three injections with hepatitis B vaccine can spare enormous suffering and save lives.

Vaccination rates are lower among certain groups

The most recent data from the 1995 National Health Interview Survey and 1997 Behavioral Risk Factor Surveillance System, show the disparities between racial and ethnic groups. These data document the highest coverage levels recorded for influenza and pneumococcal vaccines among people age 65 and older, but clearly indicate a need to focus activities on racial/ethnic minorities.

While it is unclear why vaccination rates vary among racial and ethnic groups, we know it is probably not an access to care issue. Even though minorities go to see their physicians at around the same rates as Whites, their vaccination rates are significantly lower. Currently, the national Adult Immunization Action Plan is calling for specific studies to look at reasons for these trends.



What your organization can do

The Adult Immunization Action Plan—formulated after more than a year of cooperative effort among HHS agencies—specifies that to decrease racial and ethnic health disparities, we must use the best available science to develop high quality health care at a reasonable cost. And we must ensure that the care purchased protects and improves

beneficiary health and satisfaction.

In general, agencies and community groups should:

- increase the demand for adult vaccination by improving provider and public awareness;
- increase the capacity of health care delivery system to effectively deliver vaccines to adults;
- expand financing mechanisms to support the increased delivery of vaccines to adults; and
- monitor and improve the performance of the nation's immunization program.

Specific action steps to achieve these objectives are contained with the Adult Immunization Action Plan.

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How Are We Doing?

By James A. Singleton, MS

Pneumonia and influenza are the fifth leading cause of death in the United States among people aged 65 years and older, according to the National Center for Health Statistics (NCHS).

The CDC's Advisory Committee on Immunization Practices (ACIP) reports that the typical influenza epidemic causes more than 20,000 excess deaths and up to 200,000 excess hospitalizations. *Streptococcus pneumoniae*, a bacterial pathogen, causes 500,000 cases of pneumonia and 30,000 cases of pneumococcal bacteremia annually.

Older adults are at increased risk of complications from influenza and pneumococcal infections. Approximately 30 to 40 percent of older adults with pneumococcal bacteremia die, according to ACIP.

Community-based studies indicate that Blacks and selected American Indian groups have a higher incidence of pneumococcal bacteremia than Whites.

Healthy People 2000 Objectives

According to ACIP, safe and effective vaccines are available to prevent the complications of influenza and pneumococcal bacteremia. National Healthy People 2000 objectives—set by Federal, State and local health officials, and members of the private sector—call for at least 80 percent immunization against influenza each year and pneumococcal infection over a lifetime for institutionalized, chronically ill, or older people; and at least 60 percent for noninstitutionalized people aged 65 years or more, and other people at increased risk for complications.

How are we doing?

A national nursing home survey conducted by NCHS in 1995 estimated that 1.4 million Americans, or 4 percent of persons aged 65 and older, resided in nursing homes.

According to the survey:

- Influenza vaccination levels of residents were at or near the year 2000 objective in all racial/ethnic groups (78 to 80 percent) among the 80 percent of residents for whom vaccination status was known.

Among non-institutionalized persons age 65 and older:

- Self-reported rates of influenza vaccination (during past 12 months) and pneumococcal vaccination (ever) rose at each of five measurements between 1989 and 1995.
- In 1997, the most recent year for which national data are available from the National Health Interview Survey (NHIS), vaccination levels reached 58 percent for influenza and 32 percent for pneumococcal vaccine.
- 1995 data from CDC's Behavioral Risk Factor Surveillance System indicated that 45 states achieved influenza vaccination levels of 60 percent or higher, but pneumococcal vaccination rates were less than 60 percent in all states.
- In 1995, the influenza vaccination rate estimated from the NHIS for Whites aged 65 and over reached 60 percent; rates for Blacks (40 percent) and Hispanics (50 percent) were significantly lower.
- Pneumococcal vaccination rates were approximately half of influenza rates for each racial/ethnic group. The rate for Whites was significantly higher than for Blacks, Hispanics, and Asian Americans

and Pacific Islanders.

Access to care issues do not explain the lower pneumococcal vaccination rates or the lower influenza and pneumococcal vaccination rates in racial/ethnic minorities.

- In the 1995 NHIS, 46 percent of Whites aged 65 years and older reported at least four contacts with physicians in the preceeding 12 months, compared with over 50 percent for other minority groups.
- Even among persons reporting at least four contacts with physicians in the preceeding 12 months, the influenza vaccination rate of Blacks remained lower than that of Whites.

Call to action

To prevent unnecessary deaths and disease, significant improvement is needed for pneumococcal immunization of all target groups.

The role of physicians' and patients' attitudes in racial and ethnic disparities in influenza and pneumococcal vaccination rates needs further exploration. In some cases, members of minority communities may be less likely to receive vaccination recommendations from physicians.

Timely collection and reporting of data on vaccination coverage and disease incidence are necessary to assess the effectiveness of vaccination programs. Public, private and community partners must work together to implement culturally appropriate and scientifically-based interventions to improve vaccination use in all persons at risk.

James A. Singleton is an epidemiologist for the National Immunization Program, Centers for Disease Control and Prevention. ❖

Workshop Explores Creative Methods of Encouraging Adults to Get Shots

By Alicia Postema

The Visiting Nurses Association in Denver, Colorado, found a way to get adult American Indians to pony up for their shots. Offering pony rides for the children, families were drawn from as far as 40 miles. While their kids rode the ponies, the adults were provided education on immunizations and, if they so desired, were vaccinated.

In another program to alleviate the need for transportation to an immunization clinic or physician's office, the visiting nurses attended a number of pow-wows where they provided education on the importance of immunization, and administered vaccines.

These are two of an increasing number of creative solutions to convincing adults to get their health protected with vaccines. With adult immunization rates sub-optimal, and a large portion of minority adults not receiving immunizations, it is becoming increasingly common to see large banners in local grocery stores and pharmacies encouraging people to get their influenza and pneumococcal vaccine. In many instances, beneath those banners are tables where people can sit down, between picking up the bread and milk, to receive immunizations.

Yet another creative program sponsored by the Visiting Nurses Association made use of time spent in line waiting to vote. Election day, the first Tuesday of November, falls within the recommended time for administering flu vaccine. Members of the Visiting Nurses Association provided informative materials, obtained signed consent, and administered vaccine, while individuals were waiting in line. The need for an extra trip to an immunization clinic was alleviated.

Recognizing that these immunization programs in "non-traditional" settings are becoming increasingly common, the National Vaccine Advisory Committee (NVAC) and the National Vaccine Program Office (NVPO) sponsored a public workshop on December 1 and 2, 1997, to explore the use of non-traditional settings for adult immunizations.

Workshop participants included members of NVAC and representatives from more than 50 organizations including federal and state agencies, community and professional organizations, and private companies. In addition to learning about creative immunization programs in non-traditional settings around the nation, the benefits and challenges associated with the programs were discussed.

Have site? Will travel

Pharmacies across the country are now becoming more actively involved in immunization activities. Pharmacists are acting as vaccine promoters, vaccine facilitators, and vaccine administrators by educating their clients about the importance of immunizations, hosting vaccine clinics and giving vaccine themselves. Twenty-five states now have statutes that allow pharmacists to administer vaccine.

The Horizons program, a collaborative effort of HCFA's Professional Review Organizations and 12 Historically Black Colleges and Universities in eight southern states, has shown that wherever people go, immunizations can go too. Under the project, immunizations have been offered to adults in more than 14 non-traditional settings including shopping malls, senior centers, voting sites, parks, and public housing projects. The goal is to identify successful interventions for increasing immunization rates among African Americans by focusing on community-based activities.

A few creative spins on the concept of the home as a non-traditional setting for immunization have also been explored. Immunization clinics have been established within public housing complexes. Available medical personnel from nearby hospitals were brought in to administer the vaccine.

This new version of the "house call" was particularly important to the elders living in these complexes, since transportation is often difficult for them. They were able to receive their shots without traveling beyond the complex.

In Allentown, Pennsylvania, the Meals on Wheels program helped identify homebound elderly who might be in need of vaccine. Flyers about the flu vaccine were given to the Meals on Wheels office to be delivered to the elders along with their meals. Individuals expressing an interest in receiving vaccine were contacted by phone to verify eligibility and to set up a convenient time for a home visit in which they would receive vaccine.

Anne Duerst of the Allentown Health Bureau explained their program to reach the homeless—a seldom-recognized, vastly underserved group that is at increased risk for vaccine-preventable diseases. She emphasized the importance of going to the population you are trying to reach, rather than having them come to you.

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They learned that the homeless often will not go to senior centers or other preexisting immunization sites for various reasons:

- They don't know where the sites are located.
- They feel the shots are only for the elderly.

The Allentown Health Bureau overcame this problem by going to soup kitchens, a site routinely visited by many homeless, to provide education on immunization and administer vaccine.

Those are just some examples of creative programs being developed to reach underserved, at-risk adult populations. The point from these examples is that it is important to think about the particular characteristics of the population you are trying to reach. Where do they like to go? What do they like to do? In what type of situation would they feel most comfortable receiving vaccine, and from whom would they feel comfortable receiving it? Then you must tailor the program accordingly.

Benefits

Several benefits of using non-traditional sites for immunizations were identified. They include:

- Accessibility and convenience. Going to those in need of vaccine, instead of making them come to you, saves them the hassle of scheduling an appointment and removes transportation limitations as a barrier.
- Reduced cost. Influenza vaccine administered in a non-traditional setting ranges from \$10-\$15 and pneumococcal vaccine ranges from \$15-\$20.
- Increase in overall awareness of the importance of adult immunizations.

Challenges

There are associated challenges as well. Challenges include assuring that 1) post-vaccination observation, which is crucial to identifying and treating

anaphylactic (shock) reactions, occurs routinely and is of long enough duration; 2) appropriately trained and skilled personnel are on-site to respond to any adverse reaction; 3) primary care providers, the health department, and the vaccine recipient are provided with a record of vaccine received; 4) lack of liability protection for providers is not a barrier to promoting or administering vaccine; 5) state legal regulations do not restrict the operation of safe and effective immunization programs; 6) immunization programs in non-traditional settings are integrated with patients' "medical homes", to minimize fragmentation of care and maximize utilization of other preventive health measures; and 7) mission and motivation of those operating the program does not affect the quality of services provided.

The NVAC and the NVPO recognized that although no formalized, coordinated effort to provide immunizations in non-traditional settings currently exists, many adults are already receiving vaccine in such settings. To determine the capacity of immunization programs in non-traditional settings for improving immunization rates in underimmunized adults, and to better ensure the safety of individuals choosing to be immunized in such settings, the NVAC is developing a set of recommendations for further research and a set of quality standards for immunization programs in non-traditional settings.

In many ways, standards for immunization programs in non-traditional settings are congruent with those developed for programs in traditional settings; therefore, the standards NVAC is developing will consist of existing adult immunization standards with additional caveats unique to non-traditional settings.

The power of immunization to save lives and spare suffering does not cease at childhood. As with childhood immunizations, adult immunizations

are a cost-effective means of preventing disease. Creative programs, like those described above, could help to increase levels of immunization among adults, but many, including a large proportion of minorities, are still not receiving appropriate vaccinations.

To realize these benefits, vaccines must be made readily available to the public. As the workshop demonstrated, several approaches are needed. Health-care workers must be educated to the severity of vaccine-preventable disease and the safety and effectiveness of vaccination so they consistently offer vaccine to their patients.

Enhanced educational efforts are needed to effectively empower adults to seek out preventive services such as vaccination. Also, the number and type of programs safely administering vaccine to adults need to be increased so that more individuals will be able to receive vaccine and avoid the consequences of contracting a vaccine-preventable disease.

Alicia Postema is a policy fellow for the National Vaccine Program Office, Centers for Disease Control and Prevention. ❖

Lifesaving vaccines...from page 4

Groups working to increase access to better health care among minorities should consider the Adult Immunization Action Plan as a core document for their efforts.

The complete document can be viewed on the National Vaccine Program Office's Web site at <http://www.cdc.gov/od/nvpo>. For further information, call the NVPO at 404-639-4450.

Steve Sepe is associate director for policy, National Vaccine Program Office, Centers for Disease Control and Prevention. ❖

Pharmacists Provide Immunizations, Education to Minorities

By Wendy J. Friedig

Each year, as many as 70,000 Americans die of vaccine-preventable diseases. The majority of these people visited a physician, but failed to receive an immunization. As the number of deaths from vaccine-preventable diseases continues to rise each year, we are faced with the challenge of trying to find a way to reverse this trend. So, what options are available for patients to receive the education and immunizations they need? They can turn to their pharmacist.

Pharmacists in 26 states currently have the legal authority to administer immunizations. As widely accessible health professionals, pharmacists have a significant role in the prevention of this nationwide public health care need.

Immunization rates among minorities are substantially lower than their Caucasian counterparts. The 1993 National Health Interview Survey reported that for African American and Hispanic women over age 65, immunization rates for influenza vaccine were 29 percent and 38 percent, respectively; pneumococcal vaccine were 14 percent and 14 percent; and tetanus toxoid were 22 percent and 25 percent. These rates compare with 54 percent, 29 percent, and 28 percent, respectively, for White women 65 years of age or older.

Immunization rates are lower in African Americans and Hispanics due to a combination of factors which include both less likelihood of being offered immunizations and less likelihood of accepting an offer to be immunized. However, because pharmacists are the most trusted health care professionals, 50 to 94 percent of patients accept pharmacists' recommendations for vaccinations.

Access to health care is a great concern within the American population. Pharmacists are the only contact many people have with a health professional, not only in

rural areas, but also in many urban areas.

In October 1997, the American Pharmaceutical Association Academy of Students of Pharmacy (APhA-ASP) and the Student National Pharmacy Association (SNPhA), who represent the students of the national professional society of pharmacists and minority pharmacy students, respectively, launched "Operation Immunization: The Nation's Pharmacy Students Protecting the Public Health."

During this campaign, pharmacy students teamed up with pharmacists and other health care professionals to administer immunizations to over 25,000 individuals and educated thousands more.

Due to its great success in 1997, APhA is continuing Operation Immunization in 1998 in conjunction with the APhA Academy of Pharmacy Practice and Management (APhA-APPM), who represents individual pharmacy practitioners.

APhA and HHS's Office of Minority Health (OMH) have signed a Memorandum of Understanding to address the complex issues that affect low childhood and adult immunization rates among U.S. minorities. Future APhA activities are expected to focus on programs and policies aimed at improving immunization rates within minority populations in order to eliminate health disparities that exist between minorities and the

Access to health care is a great concern within the American population. Pharmacists are the only contact many people have with a health professional, not only in rural areas, but also in many urban areas.

general population.

Immunizations provide an immediate, preventative health outcome that can be promoted and provided by pharmacists and pharmacy students. By increasing immunization awareness, pharmacists can help increase immunization rates and decrease deaths from vaccine-preventable diseases.

Wendy J. Friedig is an experiential extern at the American Pharmaceutical Association. For more information on APhA immunization activities, call Jann Hinkle at 1-800-237-2742. ❖

Black Doctors Raise Immunization Awareness, Give Minorities New Shot at Life

To the National Medical Association (NMA), “Immunization is more than a shot in the arm...it's a shot at life.” According to Yvonné Fuller, national director of the National Immunization Outreach Efforts (NIOES), Immunization rates among adults are too low, especially among minorities. “Everyone has a role to play in increasing and maintaining high immunization rates among African American adults and children,” she said.

In 1995, the NMA initially developed the NIOES to ensure that 19- to 35-month-old children were adequately immunized against vaccine-preventable diseases. However in 1997, after reviewing the data and seeing the increased disparity in African American adult immunization rates, the program was expanded to address adult immunization issues.

Part of a cooperative agreement with HHS's Centers for Disease

Control and Prevention, NIOES's goals are to:

- increase awareness of vaccine-preventable diseases and immunization rates among African Americans and other minority adults;
- promote the adult immunization message to African Americans and other minority adults;
- decrease missed opportunities among providers; and
- encourage community and private sector organizations to support providers in adult immunization outreach efforts.

Provider education and advocacy activities take place in target areas such as Detroit, Michigan; Los Angeles, California; the District of Columbia; St. Croix, VI; Houston, Texas; and Miami, Florida. Educational information is also distributed to NMA providers nationwide.

NIOES educational activities include an immunization workshop,

“Immunizing the Urban and Minority Child/Adult,” that serves as an update for physicians, nurses, and other allied health professionals who work with urban and minority children and adults. Regional and local updates are tailored to individual needs. Workshops also address changes, updates and emerging concerns in the immunization arena.

Meetings outside the target areas are scheduled in conjunction with other national, state, local organizations and health departments.

In addition to the workshops, NIOES:

- provides technical support in the development and implementation of local immunization initiatives; and
- creates and distributes educational immunization information geared toward African Americans and other minorities.

The NMA is the oldest professional membership association representing more than 22,000 Black physicians and other minority physicians in the United States, Puerto Rico, and the U.S. Virgin Islands. Established in 1895, throughout its history the NMA has focused on improving the health status and outcomes of minority and disadvantaged people. The NMA calls upon its own network of member physicians, as well as NMA state and local societies, to implement NIOES within specific geographic areas.

For more information, contact Yvonné Fuller, director of NMA's National Immunization Outreach Efforts at (202) 347-1895; write NMA NIOES 1012 Tenth Street, NW, Washington, DC 20001; or e-mail at yfuller@oncon.com. Visit the NMA Web site at NMAnet.org. ❖

If you have diabetes, a flu shot could save your life!

For people with diabetes, the flu can be more than aches and pains. It can mean longer illness, hospitalization, even death. Because diabetes can make the immune system more vulnerable to severe cases of the flu, people with diabetes are almost three times more likely to die from influenza or pneumonia. This message is especially important for African Americans who are disproportionately affected by diabetes and are less likely to get a flu shot.

The Centers for Disease Control and Prevention (CDC) recommends that diabetics talk to their doctors about getting vaccinated against the flu and pneumococcal disease, the cause of the most common form of pneumonia. According to the CDC, it is safe to have these vaccines together.

Contact your doctor, health care provider or local health department for dates, times and places where flu vaccines are given. Both flu and pneumococcal vaccines are covered by Medicare, Part B.

Hepatitis B Vaccine Saves Lives, Spares Suffering Among Asian Americans and Pacific Islanders

By Jane A. Zanca

United States Representative Joe Moakley of South Boston, Massachusetts, knows first-hand the devastating effects of hepatitis B infection. Desperately ill with the infection, which he contracted in 1995, the then 69-year-old congressman was just months from death. A liver transplant saved his life. Moakley was fortunate. He lived to tell his story.

Each year, between 4,000 and 5,000 deaths are related to hepatitis B, a viral infection that attacks the liver and causes liver failure, cirrhosis (scarring), and liver cancer. Most, if not all, of these deaths and an enormous amount of suffering—often lifelong—might be spared by just three injections of hepatitis B vaccine, before infection is acquired.

That's a message that the Hepatitis B Task Force, a group of professionals from the public health community, is working hard to spread. But they're racing against a disease that Task Force director Moon Chen, PhD, MPH, says is "100 times more infectious than HIV or AIDS." It spreads easily, even to infants and children—a population that many mistakenly believe to be safe from infection. If a family member becomes infected, the remainder of the family, including children, are at high risk of infection.

These factors have health implications for immigrant families, which is why public health professionals from around the nation have joined together to promote hepatitis B vaccinations among Asian American and Pacific Islander (AAPI) populations. Among the 70 public health volunteers are Dr. Chen, professor of Public Health at Ohio State University; Gary Euler, DrPH, chief of hepatitis activity in the Adult Vaccine Preventable Diseases Branch of the Centers for Disease Control and Prevention (CDC); and Chris Jenkins, MPH, director of a Vietnamese community project in San Francisco.

The CDC estimates that overall, 1 to 1.25 million Americans are chronically infected with the virus and can

pass it to others. Many have no symptoms and don't appear to be ill. Indeed, individuals infected in the first five years of life may not have any complaints until their fourth or fifth decade, when they present with a devastating diagnosis of liver failure, cirrhosis, or liver cancer. "Then they have a short clinical course and die," said Dr. Euler.

The risk of hepatitis B infection to children may be greatly underappreciated. In the U.S., more than one-third of those who are chronically infected with hepatitis B acquired the virus during childhood or adolescence. Before 1991, the year the vaccine was recommended for all infants in the U.S., approximately 30,000 infants became infected with hepatitis B each year.

In the AAPI population, toddlers acquire the virus at birth from the infected mother, or through inadvertent and often, indirect, exposure to body fluids or substances of an infected family member.

Infection in childhood inflicts a greater disadvantage than on those who are infected later in life. People infected at birth suffer a 70 percent to 90 percent risk of developing chronic hepatitis B virus infection, versus 30 percent risk for those infected at 6 years or younger, and 5 percent to 10 percent risk for those infected in adulthood. Persons with chronic infection are at substantially increased risk of the devastating complications of the infection.

Consequently, early vaccination is a vital intervention. "Hepatitis B vaccine has been recommended for children of Asian descent in the United States since 1982," said Dr. Euler. "Coverage of other infants began in 1991."

Unfortunately, the lapse of time between implementation of these recommendations left out a group of children who are now age 5 to 15. These children comprise the "catch-up group," the ones the Task Force wants to reach.

"Survey results in 1997 showed that 90 percent of Asian children age 2 to 3 are vaccinated," Dr. Euler noted. "Among those over age 5 in surveyed areas—Philadelphia,

Are you at risk for Hepatitis B?

One in 20 people in the U.S. will get hepatitis B some time during their lives. Your risk is higher if you:

- have sex with a person who is infected with hepatitis B virus;
- have sex with more than one partner;
- are a man and have sex with a man;
- live in the same house with someone who has lifelong hepatitis B infection;
- have a job that involves contact with human blood;
- shoot drugs;
- are a patient or work in a home for the developmentally disabled;
- have hemophilia; or
- travel to areas where hepatitis B is common.

San Diego, and Honolulu—only 2 to 30 percent are vaccinated. We have a million [AAPI] children who need to be vaccinated.”

According to Dr. Chen, “the goal is to increase to 90 percent the percentage of all AAPI children in the United States vaccinated against hepatitis B virus by the end of the year 2000. We know this can be done,” he said. “We can reach this goal.”

Among the challenges before the Task Force is increasing awareness in the AAPI population. “The Task Force’s knowledge, attitudes, and beliefs surveys say these communities are not aware of new recommendations,” said Dr. Euler. “Knowledge in general about hepatitis B and the Vaccines for Children program is low,” he said. “Parents and even providers on the front line are not fully aware of recommendations, the availability of vaccine, and the need to vaccinate.”

How do you reach the community with potentially lifesaving information? Chris Jenkins has taken this question to Texas, which has the second largest population of Vietnamese in the nation. Jenkins is leading a controlled trial, initiated in October 1997, of two interventions in Dallas and Houston, where all Vietnamese-Americans are first-generation immigrants.

“The parents are all foreign-born, and English is not their native language,” Jenkins said. Between the two cities, 35 to 48 percent have less than high-school education, 26 to 28 percent have no health insurance, and 25 to 34 percent live below the poverty line.

Any change in immunization level after the interventions in the two Texas groups will be compared with levels in a population in the Washington, DC, metropolitan area, matched by education, health insurance status, and income, but receiving no intervention.

The intervention at the East Dallas Counseling Center involves a coalition of churches, pagodas, physicians, police, newspaper editors, and any other concerned group that might get the word out. “The mission of the coalition is to mobilize the community and tell them there’s an epidemic and children are going to die needlessly,” said Jenkins.

In Houston, the intervention is a media campaign. Articles about hepatitis B and advertisements are published in Vietnamese newspapers, billboards are posted, commercials are broadcast on Vietnamese-language radio, and a brochure in Vietnamese is being distributed. Jenkins is most excited about the apparent popularity of a calendar reminding people to take their children to get shots. “We hope this will be an enduring educational tool,” he said.

Who should get vaccinated for Hepatitis B virus?

- ✓ All babies at birth, infants, children, and adolescents
- ✓ Persons of any age whose behavior puts them at high risk for hepatitis B infection
- ✓ Persons whose jobs expose them to human blood

Jenkins, who speaks Vietnamese, has both friends and family in the Vietnamese community. His stakes in the studies are personal as well as scientific. “It’s estimated that 15 percent of Vietnamese adults are chronically infected with hepatitis B virus,” he said. “Vietnamese men have the highest rate of liver cancer in the U.S. Chances [of developing liver cancer] are 200 times greater than if you don’t carry the virus.”

The Task Force has worked closely with the CDC’s Advisory Committee on Immunization Prac-

tices (ACIP), and was instrumental in ACIP’s decision to change the recommended age groups for hepatitis B vaccination. Recommending universal childhood vaccination, beginning with infants, was done for a number of reasons. As the ACIP noted in its 1991 recommendations, the strategy of selectively vaccinating only those with known risk factors had not lowered the incidence of hepatitis B. Also, 5 percent to 10 percent of individuals with hepatitis B have no known risk factors, and 30 percent of individuals diagnosed with the infection don’t acknowledge their risk factors.

The Task Force also works with various AAPI organizations, such as the Vietnamese Medical Association in the United States. With the Vaccines for Children program, the Task Force is developing a mailing list of all providers in high-risk areas, to be used for future efforts.

Cities with highest number of AAPIs in residence (in descending order)

- Los Angeles-Long Beach, CA
- New York City, NY
- Honolulu, HI
- San Francisco, CA
- Oakland, CA
- San Jose, CA
- Anaheim-Santa Ana, CA
- Chicago, IL
- Washington DC-MD-VA
- San Diego, CA
- Seattle, WA
- Houston, TX
- Sacramento, CA
- Philadelphia, PA
- Riverside-San Bernardino, CA

Jane A. Zanca is health communications fellow for the National Vaccine Program Office, Centers for Disease Control and Prevention. ❖

CDC Closes Gap on Hispanic Childhood Immunizations

By Victor G. Coronado, MD, MPH

Disparities in vaccination coverage have been documented previously among different racial/ethnic groups. The October 17, 1997 *Morbidity and Mortality Weekly Report (MMWR)* presents findings from CDC's National Immunization Survey, which documents progress toward achieving the 1996 Childhood Immunization Initiative (CII) by racial/ethnic group and by level of poverty.

The findings indicate that two of the five CII vaccination coverage goals were met for Hispanic children; the other three were within two percentage points of meeting the goals. Results for two of the five racial/ethnic categories—Hispanic, and White, non-Hispanic—are listed below compared with the national estimates.

Based on data from earlier surveys, these differences represent a narrowing of the gap in coverage between non-Hispanic white children and Hispanic children. This narrowing may reflect nationwide efforts to increase vaccination levels in Hispanic populations.

State and local health departments and community and professional organizations have implemented multifaceted efforts in some major urban areas to improve vaccination levels among minority populations.

Since 1994, the National Immunization Project has released nine public service announcements (PSA) in Spanish for use on television and radio and in print. These PSAs target Hispanic parents and caregivers of children

younger than 2 years of age. More than one-half of all calls placed to the toll-free hotline numbers are a result of these PSA messages reaching the public.

National PSAs complement or support the mission of the CII and immunization activities at the state and local levels. Ongoing research indicates that Hispanic audiences respond well to strong, dramatic messages. The ability to transfer this knowledge to practice has allowed the PSAs to

win gold and bronze medals and other awards of excellence at the Worldfest International Film and Video Festival in both the health services subcategory and the Hispanic market subcategory.

Further efforts to increase vaccination coverage in Hispanic and other minority groups are ongoing. Achievement of the national Healthy People 2000 objective of 90 percent coverage of all American children with the vaccines in the basic series will require a fully functional vaccine-delivery system and sustained participation of communities, health care providers, government officials, and private-sector partners.

Further information on the survey can be found in the *MMWR Volume 46,*

Number 41 pages 963-969. (Web: <http://www.cdc.gov/epo/mmw/mmw.html>). To reach the CDC's Spanish hotline number, call 1-800-232-0233.

Dr. Victor G. Coronado is medical epidemiologist at the Data Management Division of the National Immunization Program, Centers for Disease Control and Prevention. ♦

U.S. National Immunization Survey, 1996*

Vaccination coverage levels among all children aged 19-35 months, by vaccines and race/ethnicity

Vaccine/ Dose	1996 Goal	Natl. Estimate	White, non-Hisp.	Hispanic
DTP/DT				
≥3 Doses	90%	95%	96%	93%
≥4 Doses	—	81%	83%	77%
Poliovirus				
≥3 Doses	90%	91%	92%	89%
Measles-containing vaccine				
≥1 Dose	90%	91%	92%	88%
Haemophilus influenzae type b (Hib)				
≥3 Doses	90%	92%	93%	89%
Hepatitis B				
≥3 Doses	70%	82%	82%	80%

*Children in this survey were born during February 1993-May 1995.

Adult Vaccines: Who Should Get What, and When?

By Jane A. Zanca

It's a fact! As many as 50,000 to 70,000 adults in the United States each year die needlessly from vaccine-preventable diseases or their complications. According to the Centers for Disease Control and Prevention (CDC), about 45,000 adults die of complications of influenza, pneumococcal infections, or hepatitis B. The Advisory Committee on Immunization Practices for Immunization of Adolescents and Adults has made recommendations on who should or should not receive common immunizations.*

Tetanus and diphtheria toxoids (Td) vaccine

Tetanus (lockjaw) is caused by *Clostridium tetani*, an organism that grows in soil and produces a highly virulent toxin. A tiny break in your skin is all *C. tetani* needs to enter your bloodstream. Tetanus is always devastating. It can cause lasting damage to speech, memory, and mental function. Up to half of all Americans over age 50 are inadequately immunized against tetanus and diphtheria. Who should get Td vaccine?:

- ✓ all adults;
- ✓ all adolescents who at age 11-12 or 14-16 years of age have not received a dose in the previous 5 years.

The schedule for receiving the vaccine is every 10 years for adults. If you are younger than 17 years and think it has been more than five years since your last tetanus shot, or if you are older than 17 years and think it has been more than 10 years since your last booster, tell your physician. You should not have Td vaccine if:

- ✗ you have had any allergic reactions to previous inoculations with Td vaccine.

Influenza vaccine

Between 1972 and 1991, four influenza epidemics took more than 40,000 lives each, and more than 90 percent of the deaths attributed to pneumonia that resulted from influenza occurred in people 65 years of age or older, according to the CDC. People should receive the vaccine if:

- ✓ they are 65 years of age and older, particularly residents of nursing homes or other facilities for patients with

chronic medical conditions;

- ✓ they are six months of age or older and have chronic heart, vascular, or lung disorders, including asthma;
- ✓ they are six months of age or older and have needed regular medical follow-up or hospitalization during the preceding year for any of these conditions: chronic metabolic diseases; kidney disorder; anemia; immune suppression (e.g., people undergoing chemotherapy); and immunodeficiency disorders (such as AIDS).
- ✓ People with other diseases, such as diabetes, emphysema, or heart disease, are at greatest risk of influenza complications.
- ✓ Women in their second or third trimester of pregnancy during influenza season should also be immunized.
- ✓ And anyone, including household members and caregivers, who can transmit influenza to persons at high risk should get the flu shot.

People should receive influenza vaccine every year in the Fall. Medicare part B will pay for this immunization.

- ✗ You should not have influenza vaccine if you are allergic to eggs, or you are acutely ill and have a fever.

Pneumococcal (PPV; pneumonia vaccine)

This disease accounts for some 500,000 cases of pneumonia, and 50,000 cases of bacteremia (blood infection), and claims 25,000 lives each year. Streptococcus pneumoniae is the leading cause of bacterial meningitis. The older the patient, the higher the risk of death from pneumonia. Who should receive the vaccine?:

- ✓ adults 65 years of age and older;
- ✓ persons with two or more years of diabetes mellitus, chronic heart disease, vascular disease, or lung disorder, including: congestive heart failure, cardiomyopathy, chronic obstructive lung disease, or emphysema;
- ✓ persons 2 years of age or older with any of the following conditions: spleen dysfunction, removal, or destruction; certain cancers (e.g., cancer of the blood, such as leukemia); chronic liver disease; alcoholism; kidney failure; cerebrospinal fluid leaks; organ transplant; and immune suppression, including HIV infection;
- ✓ Alaskan Natives and certain Native American populations.

Most people should receive one dose. People vaccinated prior to age 65 should receive this vaccine when they turn 65, if 5 years or more have passed since the first dose. A second dose should be given, at least five years after the first dose, to:

- ✓ people who have had their spleen removed or whose spleen no longer functions;
- ✓ people with organ transplants, chronic kidney disease, immune suppression, or immune deficiency; and
- ✓ others at high risk of fatal infection.

If you are pregnant or think you may be pregnant, advise your health care provider. There are special instructions for having pneumococcal vaccine, especially in the first trimester. Medicare part B will pay for this immunization.

Measles and mumps vaccines

People of any age can get measles, but those born after 1956 who have no proof of immunity are particularly at risk. Although mumps rarely leads to death, adults are at greater risk than children of dying from it. Who should get vaccinated?:

- ✓ adults born after 1956 and who are without written documentation of immunization on or before their first birthday;
- ✓ health care personnel born after 1956 who are at risk of exposure to measles, particularly if the health-care worker does not have documentation of two doses of vaccine on or after the first birthday. These workers can first have a blood test to see if they have already been exposed to measles and had an immune response to it;
- ✓ people infected with HIV but who don't have severe immune suppression;
- ✓ Travelers to certain foreign countries where measles is still prevalent;
- ✓ persons entering college who have not had measles and have not received two doses of the measles vaccine.

Everyone should receive at least one dose, but people in college, in health care professions, or traveling to a foreign country should have two doses. The second dose must be at least one month after the first dose. Who shouldn't get these vaccines?:

- ✗ people taking chemotherapy;
- ✗ people who have immune deficiency;
- ✗ people who have had an anaphylactic (shock) reaction to neomycin.
- ✗ pregnant women. Women who receive this vaccine should avoid pregnancy for

...continued on next page

*Adapted by the National Vaccine Program Office.

three months after the immunization.

- ✗ people who have received an immune globulin preparation or blood product in the preceding 3 to 11 months.

Rubella (German measles) vaccine

As many as 12 million women of childbearing age are susceptible to rubella. If rubella occurs during pregnancy, it can result in severe birth defects, miscarriages, and stillbirths. Who should get the vaccine:

- ✓ persons (especially women) who do not have written documentation of immunization on or after the first birthday, or who have had a blood test that shows no previous infection with rubella; and
- ✓ health care workers who are at risk of exposure to people with rubella and may have contact with pregnant women.

The schedule for this vaccine is one dose for group 1, and at least one dose for group 2.

- ✗ People who shouldn't get this vaccine are the same as for measles and mumps.

Polio vaccine

This vaccine comes in two forms: inactivated vaccine (IPV), which is administered as a shot; and the live vaccine (OPV), which is given orally. The following adults should receive the vaccine:

- ✓ travelers to areas or countries where an epidemic of polio is occurring or where polio is common;
- ✓ members of communities or specific population groups with disease caused by wild polio viruses;
- ✓ lab workers who handle specimens that may contain polio viruses;
- ✓ health care workers who have close contact with patients who may be excreting wild polio viruses; and
- ✓ unvaccinated adults whose children will be receiving the OPV vaccine.

An adult who has no prior polio vaccination should receive 3 doses of IPV, unless excluded by the conditions listed in the next column. Also, an adult who has previously been partially immunized against polio should have 3 doses of IPV or OPV. If you need the polio vaccine for travel, plan ahead. It will take at least two full months to get the complete series on an accelerated schedule. The normal schedule spaces the doses by 6 to 8 weeks.

- ✗ Teenagers residing in the U.S. do not need routine polio vaccination.

You should not have the IPV form of polio vaccine if:

- ✗ you have had a reaction to streptomycin, polymyxin B, or neomycin.

And, you should not have the OPV form of polio vaccine if:

- ✗ you have had an anaphylactic reaction to a

previous OPV dose; or

- ✗ you have an immunodeficiency disorder, or an altered immune state due to cancer.

Varicella (chicken pox) vaccine

Approximately 5 percent to 10 percent of adults are susceptible to chicken pox.

They are 25 times more likely to die of the disease than are children. Adolescents and adults who develop chicken pox are 10 times more likely than children to develop pneumonia, bacterial infections, or brain inflammation. Who should get the vaccine:

- ✓ anyone who isn't certain whether they have had chicken pox;
- ✓ all health care workers who have never had chicken pox;
- ✓ any family contact who has never had chicken pox and has contact with persons with compromised immunity;
- ✓ people who haven't had chicken pox and haven't been vaccinated, and are at high risk of exposure, for example:
 - ✓ persons who live or work in environments where catching chicken pox is likely (teachers, day-care workers, etc.);
 - ✓ persons who live or work in environments where catching chicken pox is possible (college students, prison staff, etc.);
 - ✓ women of childbearing age who are not pregnant; and
 - ✓ international travelers.

For persons 13 years of age and older, two doses are given, 4 to 8 weeks apart. If more than 8 weeks elapse following the first dose, the second dose can be administered without restarting the schedule. You shouldn't have the vaccine if:

- ✗ you have had an anaphylactic reaction to gelatin or neomycin;
- ✗ you have untreated, active tuberculosis;
- ✗ you are receiving therapy that is suppressing your immune system, or you have immunodeficiency (including HIV);
- ✗ you have a family history of congenital or hereditary immunodeficiency in first-degree relatives, unless your immune competence has been substantiated by your health care provider or laboratory tests;
- ✗ you have received an immune globulin preparation, blood, or a blood product within the preceding 5 months; or
- ✗ you are pregnant. Pregnancy should be avoided for one month following each dose of the vaccine.

Hepatitis A vaccine

Hepatitis A is now recognized as the most common vaccine-preventable disease in travelers. Who should get the vaccine?:

- ✓ those traveling to or working in countries that have an intermediate or high level of infection in the population;

- ✓ men who have sex with men;
- ✓ people who use drugs illegally, whether the drugs are injected or not injected;
- ✓ persons who work around or handle hepatitis A virus-infected primates, or who work with HAV in a laboratory;
- ✓ persons with chronic liver disease;
- ✓ persons with clotting factor disorders;
- ✓ certain food handlers.

Depending on the type of vaccine, adults need two doses, separated by the period of time recommended by the vaccine manufacturer.

You should not have this vaccine if:

- ✗ you have a history of hypersensitivity to alum; or
- ✗ you are hypersensitive to 2-phenoxyethanol.

The safety of hepatitis A vaccine during pregnancy has not been determined, although it is expected to be low. You should discuss this with your doctor.

Hepatitis B vaccine

The hepatitis B virus is 100 times more infectious than the virus that causes AIDS. It infects 100,000 to 140,000 Americans annually. In the U.S., there are between 1 to 1.25 million people with chronic hepatitis B virus infections who can infect other household members and sexual contacts. Who should get the vaccine?:

- ✓ people whose job exposes them to blood or blood-contaminated body fluids;
- ✓ clients and staff of institutions for developmentally disabled persons;
- ✓ people receiving hemodialysis treatments;
- ✓ recipients of clotting-factor concentrates;
- ✓ household contacts and sex partners of those chronically infected with hepatitis B;
- ✓ adoptees from countries where hepatitis B is common;
- ✓ certain international travelers.
- ✓ people who inject illicit drugs;
- ✓ men who have sex with men;
- ✓ heterosexual men and women with multiple sex partners or a recent episode of a sexually transmitted disease.
- ✓ long-term prison inmates;
- ✓ all unvaccinated adolescents.

If you have not been immunized and think you may have been exposed to hepatitis B, notify your health-care provider. Three doses are needed, on the following schedule: (1) initial dose; (2) dose 2 at 1-2 months after the initial dose; (3) third dose at 4-6 months after the initial dose. A greater dose may be used for people with immune deficiency or immune suppression.

- ✗ People who have had a reaction to yeast should not get the vaccine.

- ✗ If a blood test shows prior or continuing infection with hepatitis B, the immunization is not needed.

Your health care provider has special instructions if you are on hemodialysis, immunodeficient, or immune suppressed. ❖

Resources: Immunizations

Internet:

- The Web site of the CDC Hepatitis Branch contains full text of ACIP recommendations, data on disease burden, information on vaccine safety, and fact sheets on hepatitis B, as well as other types of hepatitis. **Address:** <http://www.cdc.gov/ncidod/diseases/hepatitis/b>.
- Visit the Web site of the Immunization Action Coalition/Hepatitis B Coalition. This site offers information that can be downloaded and printed in Cambodian, Chinese, Farsi, Hmong, Korean, Laotian, Russian, Tagalog, and Vietnamese. **Address:** <http://www.immunize.org>.
- Visit the Web site of the National Coalition for Adult Immunization at <http://www.medscape.com/Affiliates/NCAI>.
- Providers who wish to enroll on the mailing list for providers in high-risk areas should contact their local Vaccines for Children Coordinator. Coordinators are listed in the CDC home page at <http://www.cdc.gov/nip/vfc/coord.htm>.
- The Every Child by Two Web site, <http://www.ecbt.org>. The All Kids Count Web site, <http://www.allkidscount.org>.

Videos:

- **Change the Legacy: Catching Up with Hep B**, is a 10-minute video that outlines the problem and the need to vaccinate. This video is designed for physicians, health administrators, and program planners. Also, **The Healthy Asian-Pacific Islander (HAPI) Kids Manual**, which comes with the video, explains how to implement a catch-up program of hepatitis B vaccinations. Both are available from the Hepatitis B Coalition, 1573 Selby Avenue, #234, St. Paul, MN 55104; call (651) 647-9009; fax (651) 647-9131.
- **Family Album**, a video for parents in several Asian languages. For more information, browse IAC's Web site at <http://www.immunize.org>.

Hotlines:

- CDC National Immunization Hotline, 1-800-232-2522 (English), or 1-800-232-0233 (Spanish). Information specialists answer questions from callers throughout the United States, Puerto Rico, and the U.S. Virgin Islands. The hotline offers information on vaccine-preventable diseases, immunization schedules, adverse reactions, and immunization-related issues. Mon.-Fri., 8:00am-11:00 pm.

Publications:

- Consumer Education Materials on Adult Immunization, developed and published by the National Coalition for Adult Immunization, provides information on the safe and effective vaccines that help prevent influenza, pneumococcal disease, hepatitis A and B, measles, mumps, rubella, tetanus, diphtheria, and chickenpox. Contact: the National Coalition for Adult Immunization, 4733 Bethesda Ave., Ste. 750, Bethesda, MD 20814, (301) 656-0003.
- **Las vacunas de mi bebé (My Baby's Immunization)**. Produced by COSSMHO, this bilingual book includes immunization information and provides space for parents to maintain children's developmental and health information. Contact: COSSMHO, 1501 16th Street NW, Washington, DC 20036, (202) 387-5000.
- **Immunization Action News**. This newsletter, published by the Centers for Disease Control and Prevention, covers new immunization recommendations, immunization highlights from around the country, and other topics on immunization. Copies can be ordered through the CDC's Information/Distribution Center, M/S E-34, 1600 Clifton Road, Atlanta, GA 30333; or by fax at (404) 639-8828.

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Closing the Gap

Conferences/Meetings: 1998

Nov. 13-15: 11th Annual East Coast Migrant Stream Forum in Springfield, MA, sponsored by the North Carolina Primary Health Care Association. Contact: (919) 461-0150.

Dec. 5-9: 10th Annual Conference of the National Association for Native American Children of Alcoholics, "The Healing Journey: A Return to the Circle," held in Tulsa, OK. Contact: 1-800-322-5601.

Dec. 6-9: 1998 National STD Prevention Conference, "New Vision, New Partners, New Approaches," held in Dallas, TX, sponsored by the Centers for Disease Control and Prevention. Contact: 1-888-280-8645.

Dec. 9-11: Sixth Minority Health Conference, "Are We Closing the Gap? A Community Perspective," held in San Antonio, TX, sponsored by the Texas Department of Health. Contact: (512) 458-7629.

Dec. 9-10: Healthy People 2010 Regional Meeting in Sacramento, CA, sponsored by the U.S. Department of Health and Human Services. Contact: 1-800-367-4725.

Dec. 17-20: Fourth Annual Conference of the World Foundation for Medical Studies in Female Health, held in New York, NY. Contact: (516) 944-3192.