Immunisation Issues

Coming Events

Vaccinator Training Course:	16/17 November 2010	Cost $70
Update for Vaccinators:	12 October 2010	Cost $45

Seize the Moments: missed opportunities to immunise at the family practice level. Turner N, Grant C, Goodyear-Smith F, Petousis-Harris H. Family Practice; 28 May 2009.

Missed opportunities (MOs) were defined by these Auckland researchers as health care visits where children do not receive an immunisation when they are age eligible for the vaccine with no contraindications present. The records of 616 children in 62 randomly selected practices were audited. These infants made 10,094 visits to primary care practices with many opportunities lost to vaccinate due or overdue children. MOs occurred at 97% of practices, in 5.5% of visits. 31% of the children had one or more visits that were an MO. 80% of MOs were acute care visits, mostly for respiratory tract illness, otitis media, viral illnesses, skin infections, gastroenteritis and eczema. True contraindications were present at only 5% of visits. 1.5% of 3297 of nurse visits resulted in MOs, compared with 6% of 6797 physician visits. MOs were a strong predictor for incomplete immunisation.

MO visits are more common with acute illness visits. The main focus of an acute illness visit is on the presenting complaint. Parents and physicians may not wish to vaccinate an acutely unwell child, regardless of the lack of contraindication. However follow-up visits are scheduled after many acute care consultations and provide opportunities to consider and offer immunisations.

A well organised practice has an electronic practice management system to flag to all members of the practice team, at all encounters, that a child is due/overdue for an immunisation event. With a systematic approach and good teamwork, at each encounter the provider can offer brief advice and immediate referral of the child for vaccination at the time if desired. Improving focus on opportunistic immunisation with visits at the provider level may have greater gains than relying on a multiple stepped recall system.

The paper can be viewed in Family Practice Advance Access May 28 2009 or a full copy of this research is available from the Immunisation Team.

Yellow fever vaccination - *Yellow fever vaccination in Hawke's Bay are:*

The Hastings Health Centre	The Doctors Hastings
The Doctors, Greenmeadows	City Medical, Napier

HBDHB has published "Moving Immunisation Coverage Forward " on its website. http://www.hawkesbaydhb.govt.nz/web_content2.asp?ID=100000306 under a heading in red *Public Information.*

Below is a link to a cartoon presentation covering a summary of events from the MMR/Wakefield escapade. More information has been included in this presentation than in other documents and it is worth a read.
http://darryl-cunningham.blogspot.com/2010/05/facts-in-case-of-dr-andrew-wakefield.html

Medical Officer of Health
Public Health
ADVICE

Inside

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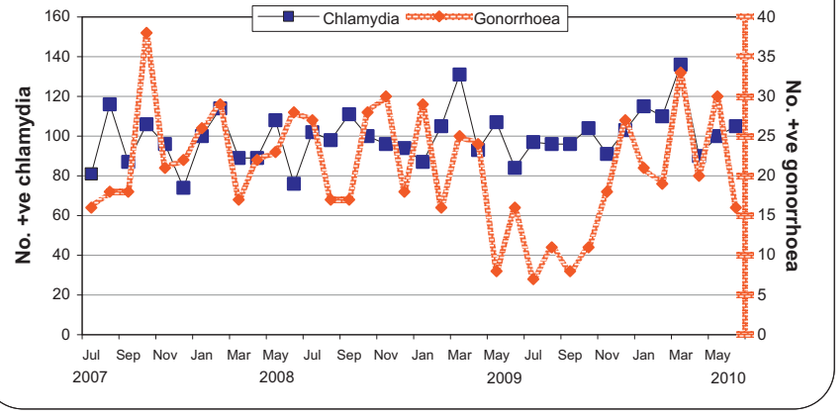
CHLAMYDIA AND GONORRHOEA IN HAWKE'S BAY

Genital infection with chlamydia is endemic in New Zealand among 15-24 year olds. Rates and numbers of positive chlamydia tests in Hawke's Bay are shown in figure 1 and table 1. Rates in 2007-2010 were 421/100,000 in males and 1117/100,000 in females. This shows no change from 2003-5 and equates to approximately three infections every day. The majority of positive chlamydia tests are among females, because they are more likely to be tested for a variety of reasons.

Figure 1: Number of positive chlamydia & gonorrhoea tests in Hawke's Bay by month, July 2007 to June 2010



Males and females have similar rates of positive gonorrhoea tests (181/100,000 and 147/100,000 respectively). Again the 15-24-year-olds are the most heavily affected.

We will now regularly include the number and rate of positive chlamydia (DNA amplification) and gonorrhoea (culture) tests in our Table Of Selected Notifications. Elimination of duplicate tests from the data has not been attempted. Unique identifiers cannot be supplied with laboratory datasets owing to Privacy Act constraints.

A recent joint initiative between Family Planning Assocation, the Healthy Populations team of the HBDHB and the Eastern Institute of Technology has seen the development of systems and competencies for nurses (predominantly primary health care nurses) to provide and supply *repeat* contraception and treatment for genital chlamydia infection

under standing orders. To date over 50 primary health care nurses have completed and passed this three-day course covering contraception, clinical assessment and standing orders. They are working in various settings, including general practice, school-based clinics, Māori provider settings and nurse-led clinics in high-deprivation and rural areas.

Further FPA training is planned to enable nurses who reach an advanced level of practice to *initiate* contraception under standing orders.

HBDHB is also fostering workforce development for youth by encouraging the development of a youth-oriented workforce. These workers are developing skills in the HEADSS assessment (housing, education, alcohol and drugs, sexual health, smoke-free).

Table 1: Chlamydia & Gonorrhoea numbers and rates by age group between 1 July 2007 to 30 June 2010

Age Group (years)	Chlamydia		Gonorrhoea	
	No.	Rate*	No.	Rate*
0-14	118	115.7	15	14.7
15-19	1578	4696.4	308	916.7
20-24	1098	4285.7	232	905.5
25-29	396	1716.5	91	394.5
30-34	190	759.4	55	219.8
35-39	105	347.6	26	86.1
40-44	42	134.5	16	51.2
45+	60	31.7	11	5.8

* Annualised Age specific rate per 100,000 population, calculated using 2009 mid-year population estimates

Typhoid in Fiji

Fiji has had occasional outbreaks of typhoid over the last 3 years. It is estimated that rates in some parts of the country are 1-10 per thousand, similar to India and China. The latest outbreak of typhoid fever is in Navosa area in Western division, on the biggest island of Viti-Levu. To date there have been total of 224 cases, only 27 of which have been microbiologically confirmed. Food and drink at public events are suspected as vehicles.

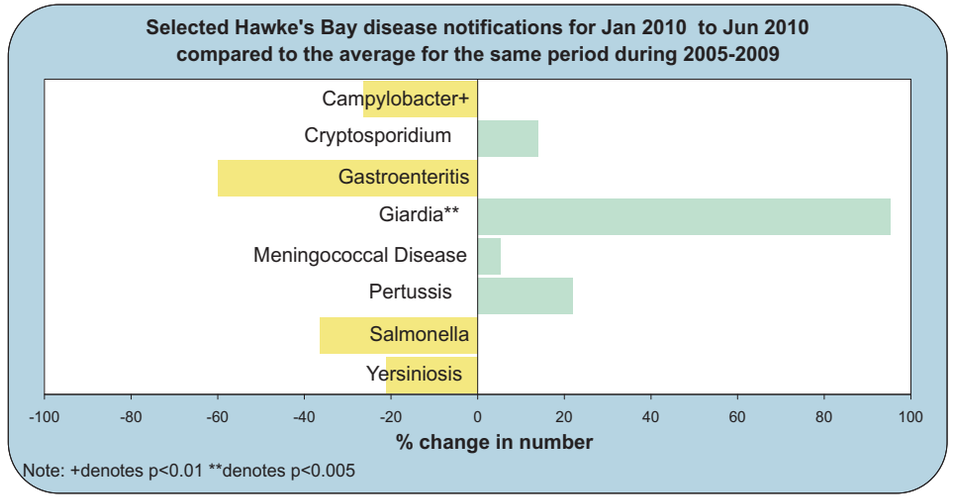
Most of the cases have been amongst the indigenous Fijians. However New Zealanders visiting Fiji are advised to pay particular attention to personal hygiene and food safety, and should consider getting a typhoid vaccination prior to travel. The Fiji Ministry of Health is advising visitors to villages and settlements to exercise caution with local water supplies and recommends that tourists carry their own drinking water on such excursions. Tourists should avoid taking part in kava drinking ceremonies in rural areas unless tour operators can provide assurances that Fiji Ministry of Health guidelines are being observed.

Commentary on *Disease Surveillance Summaries*

The increase in Giardia is largely due to an outbreak at a Hastings daycare. However an increase nationally has been noted lately.

PH ADVICE

Disease Surveillance Summaries



Selected notifications July 2009 to June 2010

Disease	Hawke's Bay Cases	Hawke's Bay rate*	New Zealand Cases	New Zealand rate*
Campylobacter	357	232.7	7570	175.4
Chlamydia	1243	810.3	*Not available*	
Cryptosporidium	35	22.8	978	22.7
Giardia	88	57.4	1847	42.8
Gonorrhoea	221	144.1	*Not available*	
Hepatitis A	2	1.3	58	1.3
Invasive pneumococcal disease	28	18.3	635	14.7
Lead absorption	5	3.3	216	5.0
Legionella	4	2.6	106	2.5
Leptospirosis	5	3.3	88	2.0
Meningococcal disease	9	5.9	136	3.2
Non seasonal influenza A (H1N1)	140	91.3	2508	58.1
Pertussis	19	12.4	1220	28.3
Rheumatic fever	7	4.6	143	3.3
Salmonellosis	46	30.0	1022	23.7
Tuberculosis disease	10	6.5	323	7.5
VTEC / STEC infection	5	3.3	132	3.1
Yersinia	17	11.1	386	8.9

* Annualised crude rate per 100,000 population calculated from 2009 mid-year population estimates.

Brief and Early Intervention for Alcohol, Tobacco and Other Drugs

Brief and early interventions (BI) for alcohol, tobacco and other drugs (ATOD) aim to screen, detect and intervene with clients before substance dependence develops.

There is good evidence that BI can be very effective with drinkers and tobacco smokers, and some evidence to support its relevance for cannabis and other drug use. BI is best used at critical moments, such as injury admission to hospital, family crisis, employment problems or police intervention.

BI is early, short (approx 30 mins) and can be applied in a variety of settings by a range of health professionals. BI includes strategies to inform and educate the client and follow-up on progress. It is unlikely to be effective for those who experience chronic relapse and dependence or psychiatric co-morbidity. They are more likely to require referral for supportive care and long term expert treatment.

FRAMES

FEEDBACK**:** providing relevant feedback to the client regarding the personal risks associated with ATOD consumption;
RESPONSIBILITY: an emphasis on the client's personal responsibility and choice to reduce ATOD use;
ADVICE: the provision of explicit advice to the client about changing hazardous ATOD behaviour;

MENU OF OPTIONS: providing the client with a range of alternative treatment strategies and self-help options so that they are able to find an approach that is appropriate to their own situation.
EMPATHY: an empathetic, warm and reflective approach

SELF-EFFICACY: reinforcement and enhancement of the client's self-efficacy.

Motivational Interviewing

Many clients who might benefit from a BI are likely to be in a pre-contemplation stage or ambivalent about changing their ATOD use. Therefore the strategies of motivational interviewing are important for intervening effectively.

Five Principles of Motivational Interviewing

Expression of empathy

- Use active and reflective listening
- Be aware that ambivalence is a usual presentation; accepting this may help bring about change
- Avoid labels eg: “alcoholic”, “drug addict”

Deployment of discrepancy

- Build awareness of the consequences of their ATOD use. Give factual information in response to their concerns e.g. physical injury, family arguments, financial difficulties, ill health, loss of work.
- Establish goals that encourage willingness to change. Highlight the conflict between their aspirations and their continued ATOD use.
- Give advice in a way that expresses concern for their wishes and well-being to encourage their desire for change.

Avoid argument

- Arguments are counterproductive and will not help
- Focus on their own concerns and perceptions
- If they express resistance, change your interview strategies.
- They (not the counsellor) should make their own suggestions for change and identify the actions needed.

Rolling with resistance

- Momentum: go with the conversation, it can be used to good advantage
- People's perspectives can be shifted
- New perceptions should be invited but not imposed
- Avoid "correcting" the person's views
- The most valuable resource in finding solutions to their problems is the person themselves

Support self-efficacy

- A person's hope and belief in the possibility of change is important in developing and maintaining the motivation to change
- Self-efficacy is not the same as self-esteem. It impacts on their beliefs about their ability and potential to change
- The person is responsible for setting their own goals and carrying out their personal change
- There is hope for people with ATOD problems; they can be helped through a range of options

Follow up, monitoring and referral

The offer of follow-up indicates your concern for the person and will provide them with further opportunities for support and skill development. There is evidence that regular medical checkups and feedback improve the efficacy of brief interventions.

Assist and encourage the person to self-refer to services for follow up. Provide resources and practical help if needed, including information regarding telephone support.

An excellent WHO manual on brief interventions is available at http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf. See the ALAC website for more information www.alcohol.org.nz for information on safe drinking levels.

For more information and references contact Bob Pearce, clinical leader, Community Mental Health. Phone 06 834 1815 ext. 4218.

How safe is your waiting room?

Waiting rooms are an excellent setting for transmission of repiratory illness. People with respiratory tract symptoms or rash may have influenza, pertussis, measles or other diseases of public health importance. Please ensure they are isolated on arrival. An infectious patient with a prolonged wait in a busy waiting room can spread their infection and make the job of contact-tracing more difficult. Early triage reduces this risk.