Immunizations and AAPIs

Infectious diseases are still major causes of illness, disability, and death. Moreover, new infectious agents and diseases are being detected, and some diseases that were once considered under control have reemerged in recent years. In addition, antimicrobial resistance is evolving rapidly in a variety of hospital- and community-acquired infections.

Vaccines can prevent the debilitating and in some cases fatal effects of infectious disease. Although vaccines have helped eliminate the illness and disability of polio, measles, and rubella, for example, the organisms that cause these diseases have not disappeared. They have only receded and have the potential to reemerge if vaccination coverage drops. Vaccines protect more than the vaccinated individual—they also protect society.

Historically, childhood vaccination rates have been lower in certain minority populations compared with the majority population. Immunization efforts need to be intensified, particularly to increase vaccination coverage for children living in poverty. Substantial numbers of undervaccinated children remain, particularly in large urban areas with traditionally underserved populations, causing concern about potential outbreaks of disease.

Many adults are also at increased risk for vaccine-preventable diseases. Vaccination coverage against pneumococcal infections and influenza among African Americans and Hispanics, for example, remains substantially below that of the general population. (US DHHS, 2000).

CHILDHOOD IMMUNIZATIONS

Each year, 1.7 million children worldwide die from diseases that could have been prevented with vaccines that are readily available in developed countries. Children who are immunized are protected from these dangerous diseases, which can lead to disability or death. Every girl and boy needs to be immunized.

It is essential that all parents know why, when, where, and how many times children should be immunized. Parents also need to know that it is safe to immunize children even if they have an illness or a disability or are suffering from malnutrition. (UNICEF, n.d.).

Recommended Childhood and Adolescent Immunization Schedule
The Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) has provided a schedule and guidelines for immunizing children and adolescents against hepatitis B; diphtheria, tetanus, and pertussis (DTP); *Haemophilus influenzae* type b (Hib); polio; measles, mumps, and rubella (MMR); varicella (chickenpox); pneumococcal disease; hepatitis A; and influenza. You can access the Recommended Childhood and Adolescent Immunization Schedule, United States, 2003, at http://www.cdc.gov/nip/recs/child-schedule.pdf. (CDC, 2002c).

Incidence of Preventable Diseases

- **Measles mortality.** In the US, the majority of deaths due to measles occur in children. **In California, from 1989 to 1990, one-third of the measles deaths occurred in the Southeast Asian and Pacific Islander communities, specifically Cambodian, Hmong, Laotian, and Samoan.** (APIAHF, no date).
- **High measles rates among Hmong.** In 1990, half the cases of measles contracted in Minnesota were among children of Hmong immigrants, even though Hmong account for less than 1% (15,000) of the entire state population. (APIAHF, n.d.).

Immunization Rates

- **High immunization rates.** According to the CDC, in 2002, AAPI populations had childhood immunization rates that exceeded those of all other groups. However, the data have not been disaggregated by cultural groups within the AAPI category. (CDC, 2002a).

- **Rising immunization rates among AAPI children.** In 1996 and 2002, the vaccination rates for AAPI children 19 to 35 months of age in the US were as follows:

	1996	2002
Combined series	78%	NA
Polio	90%	95%
Haemophilus influenzae type b (Hib)	92%	93%
Diphtheria, tetanus, pertussis (DTP)	84%	98%
Measles	94%	NA
Hepatitis B	84%	94%
Measles, mumps, rubella (MMR)	NA	94%

NA, not available.
(Sources: 1996 data, APIAHF, n.d.; 2002 data, CDC, 2002a)

Pertinent Facts

- **Vaccine-preventable diseases can be very serious or, in some cases, fatal.** Despite the many interventions aimed at boosting immunization rates, one-third of California children younger than two years of age lacked the full required immunizations in 1996. That year, two infants died from pertussis (whooping cough) in California. In some areas of the state, half the toddlers are vulnerable to whooping cough because they have not completed their immunization series. The 1989–1991 outbreak of measles in California resulted in 17,000 cases, 3,400 hospitalizations, and 70 deaths. (California Department of Health Services, 1997).

- **Babies and children infected with HBV are more likely to develop chronic infections.** Chronic hepatitis B occurs when someone has had HBV in his or her blood for at least six months. People who get hepatitis B in childhood have a 30% to 90% chance of becoming chronically infected. They may carry the virus in their blood for the rest of their lives; it rarely goes away on its own. Those with chronic HBV infection have a significant risk of developing liver failure or liver cancer, usually in adulthood. (NANAY, 2003b).

- **HBV symptoms in babies and children are not obvious.** Most babies or children who get hepatitis B do not look or feel sick. (NANAY, 2003b).

Recommendations for Reducing Chronic Hepatitis B Virus Infection in Infants and Young Children (Perinatal Infection)

Each year, 16,000 to 18,000 children in the US are born to mothers infected with HBV. Without prevention programs, about 8,000 of these infants would become infected with HBV. However, 95% of these infections are preventable through appropriate maternal screening and infant care.

Screening pregnant women during an early prenatal visit is essential to identify those who are infected. Women at high risk should be retested late in pregnancy. In 1997, 14 states had laws or regulations to ensure such screening.

To be maximally effective, steps to prevent the transmission of HBV to infants born to infected mothers must begin as soon as the child is born. Such infants should receive a first

dose of hepatitis B vaccine within 12 hours of birth, followed by hepatitis B immune globulin between the ages of 12 and 15 months to ensure that they are not infected and have developed immunity to the virus. (US DHHS, 2000).

Recommendations: Hepatitis B Vaccine

- **Hepatitis B vaccine is recommended for all children 0 to 18 years of age in the US.** AAPI babies should receive the first dose of vaccine in the hospital. If the mother is infected with HBV, her **newborn infant must get the first dose of hepatitis B vaccine within 12 hours of birth, along with another injection of hepatitis B immune globulin (HBIG).** This will protect the newborn from getting hepatitis B. All babies need another dose of hepatitis B vaccine at 1 to 2 months and a third dose at 6 months of age. Babies whose mothers are infected with hepatitis B should have a blood test at 9 to 15 months of age to be sure that they are protected.

- **All toddlers, older children, and adolescents should also receive the hepatitis B vaccine.** This is especially important for AAPI children because of the high incidence of the disease in these communities. However, many have never been offered the hepatitis B vaccine. These children should be vaccinated as soon as possible. (NANAY, 2003b).

Risk Factors and Challenges

- **Record keeping.** According to Denise Lau, the Massachusetts Department of Public Health has a standard-issue "blue book" immunization record. But parents sometimes forget to bring it with them to get it updated, which is especially important when families switch providers or move often.
- **Lack of awareness.** One of the main reasons why parents do not bring children for immunization is that they have a fever, cough, cold, diarrhea, or some other illness on the day of the scheduled immunization. (UNICEF, n.d.).

Recommendation
Make sure that new mothers and close relatives understand that it is safe to immunize a child who has a minor illness. (UNICEF, n.d.).

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