

To: ISMTP@B11WDC-OV08B@Servers["Kay Golan" <ksg0@cdc.gov>], Bill Hall@ASPA, Campbell Gardett@ASPA, John West@ASPA, MARTHA HENNEGHAN@ASPA

From: "Hoskins, Sharon (K.D.)" <sdh4@cdc.gov>

Cc:

Bcc:

Subject: MMWR SUMMARIES 11/27/98

Attachment: Headers.822

Date: 11/20/98 4:24 PM

> Reports scheduled for publication in MMWR 47 (46) dated November 27, 1998,
> are listed below.

>
> 1. LOW MEDIA INTEREST. Hib vaccines were licensed in 1988.
> Since that time, cases of Hib among children <5 years has declined by 99%.
> The small numbers of Hib cases reported --- among children who have been
> vaccinated --- indicates that vaccine failure is rare. Includes
> state-by-state table.

>
> "Progress Toward Eliminating Haemophilus influenzae Type b
Disease Among Infants and Children---United States, 1987--1997"

Haemophilus influenzae type b (Hib) causes serious invasive diseases among previously healthy children aged <5 years in the United States. Before the availability of conjugate vaccines, Hib was the most common cause of bacterial meningitis among preschool-aged children. Since 1993, the incidence of Hib invasive diseases has declined >95% among U.S. children aged <5 years. This report describes the continued decline of reported Hib invasive disease and underscores the need for complete investigation and reporting of H. influenzae invasive disease cases (2 tables, 2 figures).

> 2. LOW MEDIA INTEREST. Review conducted in 28 countries (with
> a national training program) found that an average of only 16 cases were
> correctly assessed for diarrheal diseases; only 20% of children were
> correctly rehydrated. Health-care workers performed at high level when
> assessing moderate disease, but performed poorly when classifying and
> treating severe disease. Further investigation is needed to correct the
> problem.

>
> "Health Worker Performance After Training in the WHO/UNICEF
Guidelines for Integrated Management of Childhood Illness---Western
Province, Kenya, 1994"

> Each year, an estimated 12 million children aged <5 years
> die in developing countries, and >70% of these deaths result from
> respiratory infections, diarrhea, malaria, measles, and/or malnutrition.
> The World Health Organization and the United Nations Children's Fund have
> developed the Integrated Management of Childhood Illness (IMCI) guidelines
> that provide for evaluation by nonphysician health workers (HWs) of every
> sick child presenting to a first-level health facility for each of these
> conditions. However, little is known about HW performance after IMCI

**FAX Transmission**

U.S. Department of Health and Human Services
Office of the Secretary

DATE:

11/10

TO:

Sen Klein

FAX:**PHONE:****FROM:**

Ellen Dahl

Office of the Assistant Secretary for Public Affairs

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TOTAL NUMBER OF PAGES TRANSMITTED:

3

COMMENTS:

Thursday's MMWR rates, per
Melissa.

- Ellen

Table 1. Vaccination coverage levels among children aged 19-35 months, by selected vaccines--National Immunization Survey, United States, 1994 - 1997

Vaccine/Dose	April-December 1994 ¹	January-December 1995 ²	January-December 1996 ³	January-December 1997 ⁴
	% (95% CI) ⁵	% (95% CI)	% (95% CI)	% (95% CI)
DTP/DT ⁶				
≥3 Doses	94(± 0.6)	95(± 0.6)	95(± 0.4)	95(± 0.4)
≥4 Doses	76(± 1.1)	79(± 1.0)	81(± 0.7)	81(± 0.7)
Poliovirus				
≥3 Doses	83(± 1.0)	88(± 0.8)	91(± 0.5)	91(± 0.5)
<i>Haemophilus influenzae</i> type b (Hib)				
≥3 Doses	86(± 0.8)	92(± 0.6)	92(± 0.5)	93(± 0.5)
Measles-containing vaccine (MCV) ⁷				
≥1 Doses	88(± 0.8)	90(± 0.7)	91(± 0.5)	91(± 0.5)
Hepatitis B				
≥3 Doses	37(± 1.2)	68(± 1.0)	82(± 0.7)	84(± 0.6)
Varicella vaccine				
1 Dose	NA ⁸	NA ⁸	16(± 0.7) ⁹	26(± 0.7)
Combined Series				
4DTP/3Polio/1MCV ¹⁰	74(± 1.1)	76(± 1.0)	78(± 0.8)	78(± 0.7)
4DTP/3Polio/1MCV/3Hib ¹¹	69(± 1.2)	74(± 1.0)	77(± 0.8)	78(± 0.8)

1 Children in this survey period were born between May 1991 and May 1993.

2 Children in this survey period were born between February 1992 and May 1994.

3 Children in this survey period were born between February 1993 and May 1995.

4 Children in this survey period were born between February 1994 and May 1996.

5 Confidence interval.

6 Diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids (DTP/DT).

7 Includes any measles containing vaccine administered at any age.

8 Data not available in this reporting period. Data collection for varicella vaccine began in July 1996.

9 Estimate based on data collected during July-December 1996; children born between August 1993 and May 1995.

10 Four or more doses of DTP/DT, three or more doses of poliovirus vaccine, and one or more doses of MCV.

11 Four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of MCV, and three or more doses of Hib.

Q: Are immunization rates continuing to increase for children aged 19-35 months?

A: As with overall coverage for all children aged 19-35 months, vaccination levels remain the highest ever recorded. In part, because of these high levels, increases in coverage have leveled off more recently. To overcome this apparent leveling in coverage, vaccination providers must become even more efficient and effective in ensuring full protection of children.

Q: Why have the rates for children living below poverty level increased?

A: Efforts that may have contributed to improvements in children living below poverty level include the Vaccines for Children Program; federal support of state assessment and provider feedback of coverage levels in public clinics and community and migrant health centers; and strong linkages with the Special Supplemental Nutrition Program for Women, Infants, and Children.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

February 10, 1997

NOTE FOR RAHM EMANUEL

FROM: NANCY-ANN MIN *NAM*

SUBJECT: IDEA FOR ANNOUNCEMENT OF IMMUNIZATION RATES

This note will explain the message I left for you last week about my idea for a possible Presidential event concerning the success of the Childhood Immunization Initiative, which was launched in 1993. I have just learned that the Centers for Disease Control and Prevention (CDC) plans to announce new childhood immunization rates which show that the Nation has met the President's immunization goals in 1995 -- ahead of the scheduled date of 1996.

CDC Plans to Publish Good News

CDC plans to publish updated children's immunization rates in the February 28 issue of the *Morbidity and Mortality Weekly Report* (MMWR), a weekly CDC publication containing articles on public health information and disease surveillance. The updated figures will contain estimated immunization rates for the full 1995 calendar year, and will show continued improvement in immunization rates.

At this point, you are undoubtedly wondering (1) why would CDC announce news like this in something called the *Morbidity and Mortality Weekly Report*? (Good question, and the answer is, they always do it that way); and (2) why are we just now getting information about what happened in 1995? (Another good question; the answer is a long, annoying story that has to do with unavoidable lags in data gathering).

The good news is that estimates for the fourth quarter of 1995 will show immunization rates met the Administration's goals for 1996. (The goals came from a report called Healthy People 2000 that I believe was developed during the Bush Administration; specifically, they call for achieving a 90% immunization rate among two year-olds for most vaccinations against diseases like diphtheria, tetanus, pertussis, measles, polio, and others, and 70% for Hepatitis B).

Some Caveats Apply

Let me note two points in the "bad news" category just so you're aware of them. First, these data reflect immunization rates among children born from February 1992 to March 1994 -- all before implementation of the Vaccines For Children program began in October, 1994. Therefore, some might say that the new rates show the program was never necessary in the first place; however,

we can respond that the high immunization rates reflect the President's focus on immunizing children since he took office. No one can disagree that this has been a particular focus of the Administration; indeed, we have been criticized for it. Second, the annual rate for immunization with the full series of all recommended immunizations (i.e., the percentage of two year-olds who have had all the immunizations, as opposed to the percentage who have had each individual immunization), remains steady at 75%, rather than rising. My response to that would be that immunization with the full series was not one of the 1996 goals; rather, HHS' goal is to raise this "series" immunization rate to 90% among two-year olds in 2000, and we are on track to do just that..

We Should Consider a White House Announcement

I think we should consider an event that will underscore the leadership of the President and the First Lady in this area.

cc: Bruce Reed
Don Baer
Ann Lewis



DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield

Assistant Secretary for Public Affairs

Phone: (202) 690-7850

Fax: (202) 690-5673

To: Pauline AbernathySteve CohenFax: 456-2878
456-7805 Phone: _____Date: 2/26 Total number of pages sent: 3

Comments:

Here is the draft press release on immunization -- without a quote from the First Lady. I just wanted you to see it before you decide you definitely want to include a quote since it is not as big and as good news as you might have been led to believe earlier. Please let me know how you want to proceed, as soon as possible.

Thanks very much,
Sally Gaff
690-7854

HHS NEWS

DRAFT

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

EMBARGOED FOR RELEASE 12:30 p.m.
Thursday, February 27, 1997Contact: CDC Press Office
(404) 639-3286

Record

NATIONAL INTERIM IMMUNIZATION GOALS MET, BUT COMMITMENT STILL NEEDED TO REACH YEAR 2000 GOALS

A record percentage of U.S. toddlers have received their recommended baby shots on schedule, according to year-end National Immunization Survey data for 1995, reported in this week's *Morbidity and Mortality Weekly Report*.

The survey data show that the nation exceeded interim immunization goals for 1995, and for most vaccines, goals for 1996 were already being achieved a year early. In addition, the number of reported cases of diphtheria, mumps, tetanus, measles, rubella, polio and *Haemophilus influenzae* type b, the most common cause of meningitis in young children, continue to be at or near record-low levels.

"We have a firm national commitment to increase the number of American children who are protected from vaccine-preventable diseases, and we are meeting our interim goals," said Health and Human Services Secretary Donna E. Shalala. "Now we must keep working to finish the job and achieve the high levels of full immunization that we have set for the year 2000."

National goals for most of the vaccinations required by 2-year-olds were set as interim steps to reaching the nation's year 2000 immunization goal of vaccinating 90 percent of 2-year-olds with all recommended vaccinations. The 1995 goals were 87 percent for DTP, 85 percent for Hib, 90 percent for MMR, 85 percent for polio, and 50 percent for hep B.

In 1995, 95 percent of children 19 to 35 months of age had received three doses of diphtheria, tetanus, pertussis (DTP) vaccine; 92 percent had received three doses of *Haemophilus influenzae* type b vaccine (Hib); 90 percent had received the required dose of measles, mumps, rubella vaccine (MMR); 88 percent had received three doses of polio vaccine; and 68 percent received three doses of hepatitis B vaccine (hep B). The hepatitis B vaccination data show a 17 percentage increase in vaccination since the last reporting period, July 1994 to June 1995.

The 1996 immunization goals are 90 percent for DTP, polio, MMR, and Hib, and 70 percent for hepatitis B.

- MORE -

-2-

★ Although interim immunization goals have been met, the NIS data estimates that more than one million children in the United States have not been fully vaccinated with the full series of recommended vaccines. According to the CDC report, 76 percent of two-year olds received the full recommended series of immunizations in 1995. The percentage remains at a record-high, up from 75 percent in 1994, but still 14 percentage points below the year 2000 goal of 90 percent for the full series.

In addition, the NIS data showed considerable variation between states and urban areas indicating children are not equally well protected in all parts of the United States. Twenty-eight states met either all of the 1995 immunization coverage goals, or all of the goals except hepatitis B.

"Vaccines work – they are superb, cost-effective tools to prevent disease. However, there is still work to be done to ensure every child in this country gets an equal chance at a healthy life," said CDC Director David Satcher, M.D., Ph.D. "While no single factor accounts for under-immunization, achieving and sustaining high coverage clearly requires coordinated and comprehensive action by health-care providers, parents, and communities."

X [series The goal of the Administration's Childhood Immunization Initiative is to increase vaccination levels to at least 90 percent among preschoolers by the year 2000. This initiative's five strategies include: improving immunization services for needy families, especially in public health clinics; reducing vaccine costs for lower-income and uninsured families; building community networks to reach out to families and ensure that young children are vaccinated as needed; improving systems for monitoring diseases and vaccinations; and improving vaccines and vaccine use.

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Note: HHS press releases are available on the World Wide Web at:
<http://www.dhhs.gov>.



CENTERS FOR DISEASE CONTROL AND PREVENTION
"The Nation's Prevention Agency"

CENTERS FOR DISEASE CONTROL
AND PREVENTION
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DATE 2/ 25/ 97 PAGES 6 + Cover

TO Pauline Abernathy
White House / Domestic
Policy Council

Phone: _____

Fax: 456-2878

FROM Robert Green

Phone: _____

COMMENTS/NOTES

The National Immunization Survey Briefing Summary

Introduction

On February 28, 1997, CDC will announce the 1995 immunization coverage levels obtained from the National Immunization Survey (NIS) conducted from January 1995 to December 1995. This report includes 19-35 month old children born between February 1992 and March 1994. This briefing describes the recent refinements made to the NIS, provides a summary of the key findings of the survey, describes implications of the reported coverage on incentive funding and describes the plans for future releases of NIS survey data.

Summary of key issues

- ▶ Release of the data was delayed due to refinements to the coding of the data. These were corrected and procedures were adopted to prevent such occurrences in the future. There was no effect on immunization coverage estimates at the national level when we compared the data before and after the enhancements.
- ▶ Three main findings from the 1995 survey include 1) a 76% coverage rate for the series of four doses of DTP, three doses of polio vaccine, and 1 dose of measles-containing vaccine (4:3:1 series), indicating no real change as compared to the previous report from July 1994 to June 1995, 2) all States were at or over 66% coverage, and 3) hepatitis B coverage increased 17 points compared to the previous survey period of July 1994 to June 1995.
- ▶ All the national Childhood Immunization Initiative goals for 1995 were met and three of the five goals for 1996 were also met. Twenty-four States and 14 of 28 urban areas met the 1995 immunization goals.
- ▶ More States and local areas had increases than decreases in coverage for the 4:3:1 series; one State and two local areas had statistically significant decreases compared to the previous report from July 1994 - June 1995.
- ▶ Some States will receive lower incentive funds in 1997 than in 1996, and for some States the difference is substantial. Reasons for this include; a larger pool of States eligible to divide the limited funds, higher coverage rates at the State level, and declining birth cohorts in some States.
- ▶ In past surveys, we have included measles vaccine given at any time as acceptable for immunization status. The new provider record check study includes reliable data on the date of vaccination which allows inclusion of measles doses given only on or after the first birthday. We plan to include the date of measles vaccination in the algorithm used to assess

immunization status in the future. This will lead to lower coverage rate estimates for some States and may also have implications for incentive funding.

Data Refinements

In August 1996, a preliminary review of immunization coverage estimates from the NIS showed unexpected changes from previous results and established trends. NIP staff worked in collaboration with NCHS and the contractor to evaluate the unexpected findings and searched for possible reasons for the changes. A detailed and rigorous review of the methods were conducted and three types of data coding inconsistencies were found.

- ▶ Some new vaccines were not appropriately coded (e.g. Engerix B was not coded as hepatitis B vaccine), leading to an underestimation of vaccine coverage.
- ▶ Transcription errors were found in the provider data entry form and could either underestimate or overestimate coverage.
- ▶ Monovalent vaccines were sometimes entered as multivalent (e.g., measles only vaccine entered as MMR), possibly leading to overestimation of coverage.

These inconsistencies were corrected and survey procedures have been implemented to avoid these types of inconsistencies in the future. Overall, the data refinements had little or no impact on the national estimates for specific antigens (Table 1). There was a one percentage point increase for the 4 DTP/3 Polio/1 Measles-containing vaccine series. At the State and local area level, the changes were minor (range -1% to +2%); for hepatitis B, the largest increase was 3% (no decreases).

Summary of new findings: 1995 vaccination coverage estimates

- ▶ 76% of all 19 to 35 month old children have received four doses of DTP, three doses of polio vaccine, and one dose of measles-containing vaccine (4:3:1 series) and 74% have received the 4:3:1 series, plus 3 *Hemophilus influenzae* Type b vaccine (Hib) (4:3:1:3 series). The coverage level for the 4:3:1 series was sustained as compared to July 1994 - June 1995.
- ▶ For the first time all States have coverage rates higher than 65% for the 4:3:1 series, making them eligible for incentive funds. Only one State is at 64% for the 4:3:1:3 series.
- ▶ All the immunization coverage goals for 1995 were met or exceeded at the national level (Table 2).
- ▶ 24 States and 14 of 28 urban areas met all the 1995 interim goals, four States met all the goals except for hepatitis B vaccine (Figure 1).
- ▶ 10 States met all the 1996 goals, and seven met all but hepatitis B vaccine (Figure 2).

- ▶ More States and IAP areas showed significant increases rather than decreases in coverage for the 4:3:1 series (Table 3).
 - For the 4:3:1 series, 11 States had significant increases and three had significant decreases.
 - For hepatitis B, every State had a significant increase in coverage (range 6% to 28%).
 - For MCV, nine States and local areas had significant increases and four had significant decreases.
- ▶ The 1996 goals for DTP, MCV, *Hemophilus influenzae* Type b vaccine, were also met and we are within two percentage points of meeting the 1996 goals for polio vaccine and hepatitis B vaccine.
- ▶ Individual antigen coverage rates are at an all time high at the national level (Table 4).
- ▶ The greatest change in vaccination coverage at the national level was a 17 percentage point increase for hepatitis B vaccine when compared to the time period from July 1994 to June 1995.
- ▶ There has been in a sharp increase in hepatitis B vaccine coverage, from 51% for the period of July 1994 to June 1995 to the current calendar year of 1995, to 68%. In addition, the difference in hepatitis B coverage between older and younger children in NIS has also narrowed. For the period July 1994 to June 1995, children age 19-24 months had a hepatitis B coverage level of 65% compared to 34% for children age 31-35 months; for the period January 1995 to December 1995, the coverage in similar age children increased to 75% and 57% respectively.
- ▶ At the State level, individual antigen coverage rates vary as follows (Table 5):
 - DTP 3+ ranged from 99% to 87%, with a median of 95%
 - DTP 4+ ranged from 90% to 67%, with a median of 79%
 - Measles-containing vaccine (MCV) ranged from 98% to 83%, with a median of 90%
 - Polio 3 ranged from 94% to 78%, with a median of 89%
 - Hib 3+ ranged from 97% to 84%, with a median of 92%
 - Hep B 3+ ranged from 89% to 24%, with a median of 66%
 (Table 6 shows the range for individual antigens at the urban area level)

Financial Implication of Findings

Congress earmarked 33 million dollars a year for incentive funding, based on a formula as follows:

- \$50 per child from >65% - ≤75%
- \$75 per child from >75% - ≤85%
- \$100 per child for >85% or higher

NIP elected to use 4:3:1 coverage as the basis of the incentive award.

- ▶ In FY97, all States, the District of Columbia and four territories will receive incentive funds. Last year, in FY96, one State and two local areas had 4:3:1 coverage below 65% and were not eligible to receive funds.
- ▶ Some States will have a decrease in incentive funding due to small drops in 4:3:1 coverage, smaller birth cohorts, and an increase in areas eligible to divide the total funds available.
- ▶ Small statistically insignificant changes can lead to major reductions in incentive funds. For example, California's coverage went from 73% to 71%, a two percentage point decrease. Since coverage below 65% does not count, the real change is 8% eligible (73% minus 65%) versus 6% eligible (71% minus 65%), a relative decrease of 25%.
- ▶ Examples of changes in incentive funding between FY96 and FY97 (Table 7):
 - California -- reduction of \$1.2 million, 4:3:1 coverage declined from 73% to 71%, birth cohort decreased from 601,730 to 585,324.
 - Ohio -- reduction of \$135,000, 4:3:1 coverage remained at 74%, birth cohort decreased from 162,247 to 158,793.
 - Florida -- reduction of \$792,000, 4:3:1 coverage decreased from 79% to 76%, birth cohort slightly increased from 191,713 to 192,537.
 - Illinois (not including Chicago) -- increase of \$1.45 million, 4:3:1 coverage increased from 74% to 85%, birth cohort slightly decreased from 131,902 to 131,751.
 - Michigan -- received no funds in 1996, will receive 451,352, 4:3:1 coverage increased from 63% to 70%, birth cohort decreased from 144,089 to 139,855.

Future Plans

Measles Coverage

Traditionally we have accepted measles vaccination at any time in estimating coverage. Now, for the first time we can reliably determine if the date of measles vaccination was on or after the first birthday. This is a more precise method but may decrease the national coverage estimates for 4:3:1 by about 1 percentage point. We anticipate that for most States there will be no significant change, but for some States and urban areas the drop may be as high as 4 percentage points.

These suggested changes were discussed with ASTHO and CSTE and they agreed the changes should be made in the future. Although the current NIS report does not include this change, an MMWR that is planned for May 1997 will use the new algorithm that will report the data with and without considering vaccination on or after the first birthday as well as MMR instead of any measles-containing vaccine. All future reports will include this method. It is expected that this change will have a slight impact on incentive funding, decreasing the amounts for some States and local areas since 4:3:1 coverage and 4:3:1:3 coverage (the likely standard for FY98 incentive funds) may decrease.

Future Publication of NIS data

The NIS data on national coverage rates will be published twice a year. Additional quarterly publications will include information on specific antigens or issues such as hepatitis B coverage, and coverage by race and ethnicity. Quarterly reports of individual vaccine and combined series coverage from the NIS will be sent to each State and local area.

NIP is working with NCHS and the contractor to assure that NIS data are published within 6 months after data collection. We expect to meet this objective with the data for 1996 and we expect to publish the report in July 1997. Following that publication, we will resume publication every two quarters.

B. 2/92 - 5/94

Table 4. Vaccination coverage levels among children aged 19-35 months, by selected vaccines—National Immunization Survey, United States, January–December 1995

Vaccine/Dose	1996 Goal	1995 Goal	NIS ¹ 12-Month Estimate 7/94-6/95	NIS Refined 12-Month Estimate 7/94-6/95	NIS 12-Month Estimate 1/95-12/95	NIS Quarter IV 1995 Estimate 10/95-12/95
	%	%	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
DTP/DT²						
≥3 Doses	87%	90%	94± 0.5	94± 0.5	95± 0.6	95± 0.7
≥4 Doses	—	—	78± 1.0	78± 1.0	79± 1.0	80± 1.2
Poliovirus						
≥3 Doses	85%	90%	86± 0.8	86± 0.8	86± 0.8	90± 1.0
<i>Haemophilus influenzae</i> type b (Hib)						
≥3 Doses	85%	90%	91± 0.7	91± 0.7	92± 0.6	92± 0.8
Measles-Mumps-Rubella (MMR)⁴						
≥1 Dose	90%	90%	89± 0.7	89± 0.7	90± 0.7	91± 0.9
Hepatitis B						
≥3 Doses	50%	70%	51± 1.1	51± 1.1	68± 1.0	78± 1.3
19-24 months	—	—	64± 1.3	65± 1.3	75± 1.1	80± 2.1
25-30 months	—	—	51± 1.3	52± 1.3	70± 1.2	77± 2.1
31-35 months	—	—	34± 1.3	34± 1.3	57± 1.3	75± 2.4
Combined Series						
4DTP/3Polio/1MMR ⁵	—	—	75± 1.0	76± 1.0	76± 1.0	79± 1.3
4DTP/3Polio/1MMR/3Hib ⁶	—	—	73± 1.0	74± 1.0	74± 1.0	76± 1.3

- 1 National Immunization Survey
- 2 Confidence Interval
- 3 Diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids (DTP/DT).
- 4 Goals are for MMR; estimates are for Measles containing vaccine (MCV).
- 5 ≥4 doses of DTP/DT, ≥3 doses of poliovirus vaccine, and ≥1 dose of MCV.
- 6 ≥4 doses of DTP/DT, ≥3 doses of poliovirus vaccine, ≥1 dose of MCV, and ≥3 doses of Hib.

Note. One of the objectives for the Year 2000 is to achieve series-complete coverage for the recommended vaccines among at least 90% of children aged 2 years.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

FEB 21 1997

Dear Colleague:

On behalf of the Centers for Disease Control and Prevention (CDC), thank you for your State's contributions toward ensuring that the Nation's children are protected against vaccine-preventable diseases.

As you know, CDC implemented the National Immunization Survey (NIS) to: (1) provide continuing data on current vaccination coverage levels as one element of President Clinton's Childhood Immunization Initiative (CII), a national strategy to ensure high immunization coverage of children during the first two years of life, and (2) enable each State and local immunization program to evaluate its progress toward achieving the goals of the CII and the Healthy People 2000: National Health Promotion Disease Prevention Objectives.

Enclosed is an advance copy of the NIS results of the 1995 survey that included 19- to 35-month-old children who were born between February 1992 and May 1994. Overall, these data reflect the highest immunization coverage levels achieved nationally. The Nation has met all of the 1995 CII objectives, including the objective for hepatitis B vaccine. Specifically, 24 States and 13 urban areas met all the 1995 objectives, and 4 States met all objectives except the one for hepatitis B vaccine. Data from the last quarter of 1995 show that all five of the 1996 CII goals were reached during that quarter. Especially noteworthy is that the 1995 data reflects an increase in hepatitis B coverage relative to the prior reporting period--from 51 percent to 68 percent--and up to 78 percent during the last 1995 quarter.

Results of the NIS are expected to be officially released at the end of February in the *Morbidity and Mortality Weekly Report (MMWR)*. The new, refined data for 1995 are presented in the enclosed tables. The enclosed data include information on all antigens by State and urban areas; however, the *MMWR* article will cover only: (1) national estimates for individual vaccines including hepatitis B; and (2) national, State, and urban area coverage for the 4DTP/3OPV/1MMR (4:3:1) and the 4DTP/3OPV/1MMR/3Hib (4:3:1:3) series. In interpreting the information, particular attention should be paid to the 95 percent confidence intervals around the coverage estimates. These are measures of precision. Coverage estimates, which vary over time or between different areas, but for which 95 percent confidence intervals overlap may be due to chance rather than real differences.

Page 2 - Dear Colleague

Although it has taken more time than originally anticipated to implement enhancements and publish the latest data, we expect to publish future NIS data within 6 months of completing data collection. We will publish the 1996 calendar year NIS data in the summer of 1997. Subsequently, 12 months of NIS data will be published every 6 months, instead of quarterly. Two new quarters will be added and two quarters dropped from the prior release. Although we will only publish NIS data every 6 months, we will continue to provide States with quarterly data. During the intervening quarters, we will publish special reports using NIS data, such as summaries of hepatitis B coverage and coverage by race and ethnicity.

Because the NIS is a new survey, we continue to explore ways to enhance and improve the analysis of the data. For example, past immunization surveys included measles vaccinations administered at any time; however, the provider record check portion of the NIS now allows us to reliably determine if measles vaccine was given on or around the first birthday. In addition, receipt of single antigen measles vaccine can now be distinguished from receipt of measles, mumps, rubella (MMR) vaccine. In publishing the 1995 data, we included measles vaccinations administered at any time, but in the future, we plan to include only MMR administered on or around the first birthday. This process may slightly lower the coverage both for MMR and for combined series estimates.

The enclosed information is embargoed until the official release of the MMWR. The National Immunization Program will notify you of the release date shortly. Please do not release this information to the public until after that date. Dr. Walter Orenstein, Director, and Dr. José Cordero, Deputy Director, National Immunization Program, CDC, telephone (404) 639-8200, are available if you have questions.

We appreciate your continuing efforts to improve the immunization status of America's children.

Sincerely,



David Satcher, M.D., Ph.D.
Director

Enclosures

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

01-Aug-1996 07:05pm

TO: (See Below)

FROM: Gordon P. Agress
Office of Mgmt and Budget, HD

SUBJECT: Did Immunization Funding Double?

Earlier this afternoon you asked us to verify an HHS statement that funding for immunizations has doubled under the Clinton Administration. The table below answers your question.

Total Immunization Fund (mandatory -- VFC and Medicaid -- and discretionary; dollars in millions)

	FY93	FY94	FY95	FY96 (estimate)	FY97 (President's Budget)
BA	511	813	921	681	957
OL	442	639	630	866	941

Note that immunization outlays have doubled from FY93 to the estimate in the President's FY97 Budget. These figures are consistent with the presentation in the President's FY97 Budget.

We understand that HHS told you that immunization BA is \$1077 million in 1997. While we cannot confirm this number, we note that HHS sometimes presents VFC funding on a calendar rather than fiscal year basis -- and the Budget uses fiscal year numbers. We expect that if HHS recalculated those numbers to show VFC on a fiscal year basis for 1997, HHS would probably agree with our numbers, which are derived from HHS numbers in OMB's MAX budget system.

Distribution:

TO: Diana M. Fortuna

CC: Nancy-Ann E. Min
CC: Barry T. Clendenin
CC: Richard J. Turman
CC: Mark E. Miller
CC: Barbara E. Washington
CC: Sarah A. Bianchi

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

02-Aug-1996 10:09am

TO: Elizabeth Berman

FROM: Diana M. Fortuna
 Domestic Policy Council

CC: Jeremy D. Benami
CC: Jennifer L. Klein

SUBJECT: Back up for statement on immunization funding

Attached from OMB is the backup on how immunization funding has doubled. The relevant figures are the outlays rather than the budget authority. Note that this is as of the President's FY97 budget request, so the proper language is that we have proposed to double it -- although the FY96 numbers are very close to doubled.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

01-Aug-1996 05:16pm

TO: Gordon P. Agress

FROM: Diana M. Fortuna
 Domestic Policy Council

CC: Nancy-Ann E. Min
CC: Barry T. Clendenin
CC: Richard J. Turman

SUBJECT: immuniz. funding

FYI: According to Orenstein and CDC's director of financial management, here are the numbers on total immunization funding:

FY93: \$341 million (includes only CDC discretionary money)
FY94: \$609 million (includes \$528 in CDC discret. plus VFC)
FY95: \$921 million (includes \$464 in CDC discret. plus VFC)
FY96: \$845 million (includes \$468 in CDC discret. plus VFC)

All the CDC discretionary numbers match what was in your chart.

Not clear if/how it backs out any Medicaid.

Janice Klink of ASMB is supposedly an expert.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

01-Aug-1996 06:28pm

TO: Nancy-Ann E. Min
TO: Jennifer L. Klein
TO: Jeremy D. Benami

FROM: Diana M. Fortuna
 Domestic Policy Council

SUBJECT: Immunization funding

I am examining the contention that HHS has doubled immunization funding, and have identified some real issues with CDC's analysis. I leave it to Nancy-Ann, of course, to make the final call on this. Numbers are from HHS's ASMB.

CDC got its "doubled" statistic by comparing CDC's discretionary funding in FY93 to CDC discretionary funds plus the VFC program for FY96. However, this ignores the fact that much of VFC's costs were formerly reflected as Medicaid costs.

When you add to FY93 our best estimate of how much Federal Medicaid funds were spent on immunization that year, you get an increase from \$511 million in FY93 to \$938 million in FY96, or an 84% increase.

The "doubled" statement works IF you use outlays from 93 to the President's 97 budget -- but outlays may be dicey. It also works if you accept HHS's estimate of what FY97 BA would be, but this is apparently somewhat suspicious -- for some reason it reflects a 15% increase over FY96.

Nancy-Ann, what do you think? Jeremy says we have to figure this out tonight.

Since taking office, spending on immunization has doubled.

**CDC Childhood Immunization Funding: Presidential Request and Actual Appropriation,
FY94-97**

(dollars in millions)

		FY 1993		FY 1994		FY 1995			FY 1996		FY 1997	
		<u>Actual</u>	<u>President's Budget</u>	<u>Actual</u>	<u>% Delta</u>	<u>President's Budget</u>	<u>Actual</u>	<u>% Delta</u>	<u>President's Budget</u>	<u>Actual</u>	<u>% Delta</u>	<u>President's Budget</u>
CDC Discretionary	BA	341	668	528	-21%	464	464	0%	478	468	-2%	488

+400 M for VFC

April 25, 1996

**Health Division**

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to:

Richard Turman
Barry Clendenin
Nancy-Ann Min
Diana Fortuna

Decision needed
Please sign
Per your request
Please comment
For your information

—
Z
—
—

With information: al copies for:

Subject: Table of Immunization Rates, Provider
Verified and Not Verified

IID Chron, IPS Chron

From: Gordon Agrcss

Phone: 202/395-4926
Fax: 202/395-3910
Room: #7026

Per your request, we have developed the attached table of immunization rates from various CDC surveys and estimated according to a variety of methodologies. The table includes:

- Immunization rates for "all children" from the National Health Interview Survey (NHIS) from 1992 through 1994. Prior to August 1995 this was "the" immunization rate.
- Immunization rates for children whose parents answered NHIS question using an immunization record or who denied their children were immunized. CDC staff say that this estimate is slightly more accurate than the "all children" estimate, since parents used records rather than relying on their memory, but state that it cannot be generalized to the whole population.
- Immunization rates for all children from NHIS data verified by consultation with the child's health care provider. CDC staff regard these estimates as the most accurate, but they are not available for years prior to 1994.
- Immunization rates from the National Immunization Survey (NIS). These data were first published in August 1994. They are also provider-verified.

CDC staff say that they cannot back out the effects of provider verification on immunization rates in years prior to 1994.

We have also attached copies of the August 24, 1995 and February 23, 1996 *Morbidity and Mortality Weekly Report* articles publishing the NIS figures.

Attachments

Comparison of Immunization Rates from Various Survey Methodologies (Immunization rates among children 19 to 35 months for 4 DTP, 3 Polio, 1 Measles containing vaccine.)					
	1992	1993	1994	April 1994 - December 1994	April 1994 - March 1995
National Health Interview Survey (NHIS)					
all children	55%	67%	68%	<i>provider verif. NHIS - many more kids included</i>	
children with record	57%	60%	64%		
provider verified			73%		
National Immunization Survey (NIS)					75%
NHIS "all children" was the only CDC published estimate of immunization rates prior to August, 1994.					
NHIS "children with record" is the immunization rate among children whose parents said they answered the survey questions referring to the child's immunization record, or who denied the child was immunized.					
NHIS "provider verified" is NHIS with verification of children's records with their providers.					
NIS rates are "provider verified."					

Born Jan 195 - Surveyed Aug '96
 Reported Aug '97

Recent edition = 75% - Measures kids →
 May '91 - Aug '93

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

19-Apr-1996 10:39am

TO: Gordon P. Agress

FROM: Diana M. Fortuna
 Domestic Policy Council

SUBJECT: numbers

We're cancelled today, but here's what I was picturing:

	Combined Series -- quarter by quarter					
	Q1	Q2	Q3	Q4		current Q
NHIS	x	x	x	x'		x'
NIS	-	-	y	y'		y'

Q1 would be however far back we think we need to go, probably FY92-ish. In my example, Q4 is the first quarter where both systems had provider verification, so we would draw a vertical line to show where that started.

All of this assumes they can't back out the effect of provider verification.

To me, this would really lay it out clearly. What do you think?

Disabilities Among Children — Continued

6. Verbrugge LM. The disability supplement to the 1994-95 National Health Interview Survey (NHIS-Disability). Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, NCHS, 1993.
7. Badley EM. An introduction to the concepts and classifications of the *International Classification of Impairments, Disabilities, and Handicaps*. *Disabil Rehabil* 1993;15:161-8.

Disabilities Among Children — Continued

State and National Vaccination Coverage Levels Among Children Aged 19-35 Months — United States, April-December 1994

Vaccination Coverage Levels — Continued single survey providing state and national estimates of vaccination coverage levels among children aged 19-35 months. CDC implemented the NIS in April 1994 as one element of the five-part Childhood Immunization Initiative (CII) (1), a national strategy to achieve and maintain high vaccination levels among children during the first 2 years of life. NIS collects quarterly data from the 50 states, the District of Columbia, and 27 urban areas considered to have populations at high risk for undervaccination. This report of initial NIS findings provides the results of both national and state vaccination coverage levels for April-December 1994.

The NIS uses a two-phase sample design. For the first phase, a quarterly random sample of telephone numbers for each survey area is called, and a screening questionnaire is administered to locate households with one or more children aged 19-35 months. Vaccination information is collected for age-eligible children. All respondents are requested to refer to written records. During April-December 1994, approximately 1.2 million telephone numbers were called, and 25,247 interviews were completed (an average of 110 interviews per area per quarter). The overall response rate for eligible households was 71% (range: 60%-88% among the individual states).

In the second phase, vaccination information is requested from health care providers of children in surveyed households because parents tend to underestimate the number of doses received for multiple-dose vaccines and to overestimate coverage for single-dose vaccines (2,3). Households excluded from phase two include those that use records indicating their children received all of the recommended doses for at least four vaccines* because such recorded histories are highly accurate (CDC, unpublished data, 1995). Based on these exclusions, 18,479 (73%) households were eligible for phase two. Of these, vaccination information was obtained from providers for 7594 (41%) children. The demographic characteristics and the reported vaccination histories were similar for children in households with provider information and households with parental reports only.

Overall, 57% of the children in the survey had either written records of having received all of the required doses for at least four vaccines, or had vaccination information based on provider records. The data obtained from provider records were used to improve the accuracy of the vaccination coverage estimates for the

(Continued on page 619)

*Vaccines in this series include four doses of diphtheria and tetanus toxoids and pertussis vaccine (DTP), three doses of poliovirus vaccine, one dose of measles-mumps-rubella vaccine (MMR), and three doses of *Haemophilus influenzae* type B vaccine (Hib). Children may or may not have received three doses of hepatitis B vaccine.

Vaccination Coverage Levels — Continued

entire sample. Standard two-phase estimation procedures (4) were used to estimate vaccination coverage for each surveyed area. The estimates were adjusted using natality data to create a weighted sample representative of children aged 19–35 months in the United States; in addition, adjustments were made for nonresponse and for exclusion of households without a telephone to account for the finding that children in households without telephones are less likely to be vaccinated than children in households with a telephone (CDC, unpublished data, 1995) (5).

Based on the NIS, among children who were born during May 1991–May 1993 and who were aged 19–35 months (median: 27 months) when surveyed, estimated vaccination coverage was 75% (confidence interval [CI]=±1.2%) for receipt of at least four doses of diphtheria and tetanus toxoids and pertussis vaccine (DTP), three doses of poliovirus vaccine, and one dose of measles-mumps-rubella vaccine (MMR) (4:3:1 series) (Table 1). However, except for hepatitis B, coverage levels for each of the vaccines individually were substantially higher: coverage with three or more doses of DTP was >90%; coverage for one dose of MMR, three or more doses of polio, and three or more doses of *Haemophilus influenzae* type B vaccine (Hib) ranged from 83% to 89%. The lower overall coverage for the 4:3:1 series was accounted for primarily by low coverage for the fourth dose of DTP (77%).

State-specific estimated coverage levels for the 4:3:1 series ranged from 61% (CI=±6.2%) to 88% (CI=±4.6%) (Table 2). Coverage levels were <65% in three states,

TABLE 1. Vaccination coverage levels among children aged 19–35 months, by selected vaccines — United States, 1994

Vaccine/Dose	1996 Goal	NHIS*		NHIS provider†		NIS‡	
		%	(95% CI)	%	(95% CI)	%	(95% CI)
DTP/DT**							
≥3 Doses	90%	89	(±2.4)	93	(±2.2)	93	(±0.7)
≥4 Doses	—	69	(±3.0)	76	(±3.4)	77	(±1.1)
Poliovirus							
≥3 Doses	90%	78	(±2.7)	83	(±3.0)	83	(±1.0)
<i>Haemophilus influenzae</i> type b							
≥3 Doses	90%	73	(±3.1)	89	(±2.6)	88	(±0.9)
Measles-containing (MCV)							
≥3 Doses	90%	91	(±1.8)	88	(±3.8)	89	(±0.9)
Hepatitis B††							
≥3 Doses	70%	27	(±3.5)	17	(±2.8)	37	(±1.2)
Combined series							
4 DTP/3 Polio/1 MCV§§	—	67	(±3.1)	72	(±3.4)	75	(±1.2)

* 1994 National Health Interview Survey, January–June.

† 1994 National Health Interview Survey, January–June, with provider data.

‡ 1994 National Immunization Survey, April–December.

§ Confidence interval.

** Diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids.

†† The difference between the NIS and NHIS provider estimates for hepatitis B is primarily because of different time periods for the surveys and the rapid improvement in hepatitis B coverage during 1994.

§§ Four doses of DTP/DT, three doses of poliovirus vaccine, and one dose of MCV.

*Vaccination Coverage Levels — Continued***TABLE 2. Estimated vaccination coverage with the 4:3:1 series,* by state — National Immunization Survey, United States, April–December 1994**

State	Sample size	4:3:1 Series coverage	
		%	(95% CI) [†]
Alabama	622	75	(±6.1)
Alaska	318	73	(±6.9)
Arizona	649	77	(±4.8)
Arkansas	345	71	(±6.9)
California	1,304	74	(±4.9)
Colorado	331	75	(±7.2)
Connecticut	329	86	(±5.6)
Delaware	309	81	(±6.6)
District of Columbia	277	73	(±8.8)
Florida	915	76	(±6.2)
Georgia	620	79	(±5.7)
Hawaii	340	86	(±5.7)
Idaho	313	64	(±7.4)
Illinois	644	68	(±6.0)
Indiana	642	74	(±5.7)
Iowa	309	81	(±6.0)
Kansas	309	82	(±5.6)
Kentucky	342	80	(±6.1)
Louisiana	636	71	(±6.6)
Maine	302	82	(±6.0)
Maryland	633	79	(±5.4)
Massachusetts	633	82	(±5.3)
Michigan	624	61	(±6.2)
Minnesota	318	81	(±5.6)
Mississippi	331	83	(±6.1)
Missouri	317	64	(±7.5)
Montana	321	75	(±6.3)
Nebraska	325	72	(±6.6)
Nevada	322	69	(±8.0)
New Hampshire	295	83	(±6.0)
New Jersey	603	71	(±7.2)
New Mexico	326	73	(±7.4)
New York	639	77	(±5.1)
North Carolina	355	84	(±5.8)
North Dakota	328	81	(±5.0)
Ohio	970	73	(±5.2)
Oklahoma	319	76	(±7.2)
Oregon	321	71	(±6.9)
Pennsylvania	640	77	(±5.1)
Rhode Island	316	82	(±5.9)
South Carolina	328	84	(±5.7)
South Dakota	329	74	(±6.7)
Tennessee	972	74	(±4.6)
Texas	1,733	71	(±4.3)
Utah	472	70	(±5.6)
Vermont	312	88	(±4.6)
Virginia	327	81	(±6.4)
Washington	712	74	(±4.9)
West Virginia	312	66	(±8.3)
Wisconsin	647	76	(±5.1)
Wyoming	313	78	(±5.7)
Total	25,247	75	(±1.2)

* Four doses of diphtheria and tetanus toxoids and pertussis vaccine, three doses of poliovirus vaccine, and one dose of measles-mumps-rubella vaccine.

[†] Confidence interval.

Vaccination Coverage Levels — Continued

≥85% in three states, and were higher in the northeastern and southern regions (Figure 1).

To assess the validity of estimates from the NIS, findings were compared with previously reported data from the National Health Interview Survey (NHIS) (6,7), a national household survey of the U.S. civilian, noninstitutionalized population. For January–June 1994, NHIS data had been supplemented with provider information in the same manner as in the NIS survey. The estimated coverage level of 71% in the NIS survey was similar to the 72% estimate obtained from the NHIS, and vaccine coverage levels for each individual vaccine (except for hepatitis B) were nearly identical (Table 1). In addition, estimates of vaccination coverage derived independently by selected states for 1994 were similar to those reported in the NIS (CDC, unpublished data, 1995).

Reported by: National Center for Health Statistics; Assessment Br, Data Management Div, National Immunization Program, CDC.

Editorial Note: The NIS data provide the first current, population-based, state-specific estimates of vaccination coverage produced by a standard methodology for the United States. These findings enable valid comparisons of state efforts to deliver vaccination services. The NIS has obtained the most reliable estimates of vaccination coverage through the use of health-care provider records and the use of data from the NHIS to adjust for households without telephones. The estimate of the coverage for the 4:3:1 series based on NIS (75%) was substantially higher than that previously reported through the NHIS (67%), probably reflecting improvements in the accuracy of both NIS and NHIS data with the inclusion of information from providers rather than a true increase in coverage. CDC will continue to assess and improve the quality of national vaccination data.

The vaccination coverage rates reported in the NIS and in recent reports from the NHIS are the highest ever recorded in the United States. In particular, the findings in the NIS indicate that the CII goal for 90% coverage with three doses of DTP was

FIGURE 1. Estimated vaccination coverage with the 4:3:1 series,* by state — National Immunization Survey, United States, April–December 1994



Vaccination Coverage Levels — Continued

exceeded, and that the 90% coverage goals for polio, measles, and Hib were nearly attained (1). Coverage for hepatitis B, the vaccine most recently added to the pediatric schedule, was the lowest because many children were born before the recommendations for vaccination were made.

Coverage for four doses of DTP is the lowest of the three vaccines included in the combined series. The Advisory Committee on Immunization Practices recently reaffirmed its recommendation for a fourth dose of DTP for all children aged 12–18 months (8). Efforts to ensure timely administration of the fourth dose of DTP vaccine must be intensified to further reduce the incidence of pertussis and should include simultaneous administration with other vaccines recommended for children aged 12–18 months.

The substantial variation in state-specific coverage levels for the 4:3:1 series underscores the need for vaccination efforts targeted at children aged <2 years; in addition, more than one million children still lack one or more doses of the recommended vaccines. One of the national health objectives for the year 2000 is to achieve series-complete coverage for at least 90% of 2-year-old children for all recommended vaccines[†] (objective 20.11) (9). Implementation of the five-part CII strategy will be essential to meet this goal and to build a national system that maintains high coverage levels.

Potential limitations of NIS include the possible biases associated with exclusion of households without telephones, household nonresponse, and inaccurate reporting from households and small sample sizes for some states. An adjustment for exclusion of households without telephones was made to account for findings in the 1992–1993 NHIS that coverage levels for the 4:3:1 series are approximately 10 percentage points lower among children in households without telephones (CDC, unpublished data, 1995). Although provider information was not available for all children, those children whose providers were not included in the survey were similar to children whose provider was included, suggesting that use of provider data did not introduce a bias. In addition, estimates based on small sample sizes have a larger variance; future analyses will include data for four quarters, thereby reducing the size of the sampling error.

CDC will use the NIS, with data from the NHIS, to evaluate progress toward national vaccination goals and, because of the comparability of the information in the NIS, to identify states with the highest rates (whose programs may be models for other states) and states with lower rates (which may need special attention). These coverage estimates are being used to distribute \$33 million in incentive funds, with the greatest funding per fully vaccinated child to states that achieve the highest levels of coverage.

References

1. CDC. Reported vaccine-preventable diseases—United States, 1993, and the Childhood Immunization Initiative. *MMWR* 1994;43:57–60.
2. Goldstein KP, Kviz FJ, Daum RS. Accuracy of immunization histories provided by adults accompanying preschool children to a pediatric emergency department. *JAMA* 1993;270:2190–4.
3. Valadez JJ, Weld LH. Maternal recall error of child vaccination status in a developing nation. *Am J Public Health* 1992;82:120–2.
4. Cochran WG. Double sampling. In: Cochran WG. *Sampling techniques*. 3rd ed. New York: John Wiley & Sons, Inc, 1977:327–58.

[†]Series-complete coverage of all currently recommended vaccines include four doses of DTP, three doses of polio, one dose of MMR, and three doses each of Hib and hepatitis B vaccine.

Vaccination Coverage Levels — Continued

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7. CDC. Vaccination coverage levels among children aged 19–35 months—United States, April–June 1994. MMWR 1995;44:396-8.
8. CDC. Recommended childhood immunization schedule—United States, 1995. MMWR 1995; 44(no. RR-6).
9. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.

Vaccination Coverage Levels — Continued



February 23, 1996 / Vol. 45 / No. 7

MNWR

MORBIDITY AND MORTALITY WEEKLY REPORT

- 145 National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19–35 Months — United States, April 1994–March 1995
- 161 Continued Sexual Risk Behavior Among HIV-Seropositive, Drug-Using Men — Atlanta; Washington, D.C.; and San Juan, Puerto Rico, 1993

National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19–35 Months — United States, April 1994–March 1995

Vaccination Coverage Levels — Continued An ongoing survey to provide national, state, and selected urban area estimates of vaccination coverage levels among children aged 19–35 months. CDC implemented NIS in April 1994 as one element of the five-part Childhood Immunization Initiative (CII) (1), a national strategy to achieve and maintain high vaccination levels among children during the first 2 years of life; CII contains interim goals to the year 2000 national objectives (2). NIS collects quarterly data from all 50 states, the District of Columbia, and 27 urban areas considered to be at high risk for undervaccination. This report provides the results of national, state, and urban area vaccination coverage levels for April 1994–March 1995, which document the highest overall vaccination levels ever achieved for preschool-aged children in the United States, but a wide range (41 percentage points) between areas with the highest and lowest vaccination coverage levels.

NIS uses a two-phase sample design: the first phase employs a quarterly random sample of telephone numbers for each survey area and includes administration of a screening questionnaire to respondents aged ≥18 years to locate households with one or more children aged 19–35 months. Vaccination information is collected for age-eligible children. All respondents are asked to refer to written records; however, reports from recall also are accepted. During April 1994–March 1995, approximately 1.6 million telephone numbers were called, and 33,876 interviews were completed (an average of 434 interviews per area). The overall response rate for eligible households was 70% (range: 60%–85% among the 78 survey sites).

In the second phase, vaccination information is requested from health care providers of children in surveyed households. During 1994, households were excluded that used records indicating their children received all recommended doses of four specific vaccines.* All households identified in the first quarter of 1995 were included in the second phase. Based on exclusions, 27,108 (80%) children were eligible for the second phase; of these, vaccination information was obtained from providers for 11,609 (43%)

*These vaccines were four doses of diphtheria and tetanus toxoids and pertussis vaccine, three doses of poliovirus vaccine, one dose of measles-mumps-rubella vaccine, and three doses of *Haemophilus influenzae* type b vaccine.

Vaccination Coverage Levels — Continued

children. The demographic characteristics and the reported vaccination histories were similar for children in households with and without provider information.

Overall, for 54% of the children in the survey, either written records of having received all of the required doses for the four vaccines were available, or vaccination information based on provider records was available. The data obtained from provider records enabled improvements in the accuracy of the vaccination coverage estimates for the entire sample. Standard two-phase estimation procedures (3) were used to estimate vaccination coverage for each surveyed area. Estimates were adjusted using natality data to create a weighted sample representative of children aged 19–35 months in the United States; in addition, adjustments were made for non-response and for exclusion of households without a telephone because children in households without telephones are less likely to be vaccinated than children in households with a telephone (4; CDC, unpublished data, 1995).

Based on NIS, among children born during May 1991–August 1993 and who were aged 19–35 months (median age: 27 months) at the time of the survey, estimated vaccination coverage was >90% for three or more doses of diphtheria and tetanus toxoids and pertussis vaccine (DTP); coverage for three or more doses of poliovirus vaccine, one dose of measles-mumps-rubella vaccine (MMR), and three or more doses of

TABLE 1. Vaccination coverage levels among children aged 19–35 months by selected vaccines — National Immunization Survey (NIS), United States, April 1994–March 1995

Vaccine/Dose	1996 Goal	Year 2000 objective	NHIS*		NIS	
			%	(95% CI) [†]	%	(95% CI)
DTP/DT[‡]						
≥3 Doses	90%	90%	93	(±1.4%)	94	(±0.6%)
≥4 Doses	—	90%	75	(±2.4%)	77	(±1.0%)
Poliovirus						
≥3 Doses	90%	90%	83	(±2.2%)	84	(±0.9%)
<i>Haemophilus influenzae</i> type b (Hib)						
≥3 Doses	90%	90%	89	(±1.8%)	90	(±0.7%)
MMR[§]						
≥1 Dose	90%	90%	87	(±1.8%)	89	(±0.8%)
Hepatitis B						
≥3 Doses	70%	90%	26	(±2.2%)	42	(±1.2%)
19–24 Months			41	(±4.1%)	58	(±1.4%)
25–30 Months			23	(±3.5%)	41	(±1.4%)
31–35 Months			10	(±2.9%)	24	(±1.3%)
Combined series						
4 DTP/3 Polio/1 MMR**	—	90%	73	(±2.4%)	75	(±1.0%)
4 DTP/3 Polio/1 MMR/ 3 Hib ^{††}	—	90%	71	(±2.4%)	72	(±1.1%)

* 1994 National Health Interview Survey.

[†] Confidence interval.

[‡] Diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids.

[§] Measles-mumps-rubella vaccine.

** Four doses of DTP/DT, three doses of poliovirus vaccine, and one dose of MMR.

^{††} Four doses of DTP/DT, three doses of poliovirus vaccine, one dose of MMR, and three doses of Hib.

Vaccination Coverage Levels — Continued

Haemophilus influenzae type b vaccine (Hib) ranged from 84% to 90% (Table 1). Hepatitis B vaccine coverage was 42% and ranged from 24% for children aged 25–35 months to 58% for children aged 19–24 months.

Estimated vaccination coverage was 75% (95% confidence interval [CI]=±1.0%) for receipt of at least four doses of DTP, three doses of poliovirus vaccine, and one dose of MMR (4:3:1 series). When the series was expanded to include three doses of Hib (4:3:1:3 series), estimated coverage levels were 72% (95% CI=±1.1%). The lower overall coverage for the 4:3:1 and 4:3:1:3 series compared with coverage for the individual vaccines was accounted for primarily by low coverage for the fourth dose of DTP (77%).

State-specific estimated coverage levels for the 4:3:1 series ranged from 63% (95% CI=±5.3%) to 87% (95% CI=±4.1%), and for the 4:3:1:3 series from 59% (95% CI=±5.3%) to 86% (95% CI=±4.2%) (Table 2). Estimated coverage levels among selected large urban areas ranged from 52% (95% CI=±8.2%) to 87% (95% CI=±5.1%) for the 4:3:1 series, and from 46% (95% CI=±8.0%) to 87% (95% CI=±5.2%) for the 4:3:1:3 series (Table 3).

To assess the validity of estimates from NIS, findings were compared with coverage estimates from the National Health Interview Survey (NHIS) (CDC, unpublished data, 1995), a national household survey of the U.S. civilian, noninstitutionalized population. During 1994, NHIS data had been supplemented with provider information in the same manner as in NIS. The estimated coverage levels in NIS of 75% for the 4:3:1 series and 72% for the 4:3:1:3 series were similar to those in NHIS (73% and 71%, respectively). Vaccine coverage levels for each vaccine (except for hepatitis B) were nearly identical (Table 1).

Reported by: National Center for Health Statistics; Assessment Br, Data Management Div, National Immunization Program, CDC.

Editorial Note: The NIS data provide the first population-based state and urban area-specific estimates of vaccination coverage produced by a standard methodology for the United States. NIS permits monitoring of coverage levels of existing vaccines and tracking of the implementation of vaccination with new vaccines. Vaccination coverage estimates from the April 1994–March 1995 NIS and the 1994 NHIS are the highest ever recorded in the United States. In particular, findings from NIS indicate achievement of the 1996 CII goal for 90% coverage with three doses each of DTP and Hib, and the 90% coverage goals for polio and measles were nearly attained (5). Estimated coverage for hepatitis B, the vaccine most recently added to the pediatric schedule, was the lowest because, within the 19–35-month age group, many children were born before this vaccine was recommended (6). Estimated coverage increased with successive age cohorts born after the recommendation for hepatitis B was widely disseminated (Table 1). In addition, the NIS-based estimate of coverage for hepatitis B vaccine probably exceeds that from NHIS because NHIS assessed coverage from January through December 1994, when a higher proportion of children were born before promulgation of the recommendation for universal hepatitis B vaccination. In addition, NIS assessed coverage from April 1994 through March 1995, when all children surveyed were born after the recommendation went into effect.

The Advisory Committee on Immunization Practices recently reaffirmed its recommendation for a fourth dose of DTP for all children aged 12–18 months (7). Recently completed field trials suggest that the efficacy of whole-cell vaccine can decrease

Vaccination Coverage Levels — Continued

TABLE 2. Estimated vaccination coverage with the 4:3:1 series* and 4:3:1:3 series†, by coverage level and state — National Immunization Survey, United States, April 1994–March 1995

Coverage level/ State	4:3:1 Series coverage		Coverage level/ State	4:3:1:3 Series coverage	
	%	(95% CI) [‡]		%	(95% CI)
≥85%			≥85%		
Connecticut	86	(±4.8%)	Vermont	86	(±4.2%)
Massachusetts	85	(±4.2%)			
Vermont	87	(±4.1%)	75%–84%		
75%–84%			Connecticut	84	(±5.2%)
Arizona	77	(±4.3%)	Delaware	79	(±5.8%)
Colorado	76	(±5.8%)	Florida	78	(±4.9%)
Delaware	81	(±5.7%)	Georgia	75	(±5.4%)
Florida	79	(±4.8%)	Hawaii	80	(±5.6%)
Georgia	78	(±5.3%)	Iowa	82	(±4.8%)
Hawaii	84	(±5.1%)	Kansas	79	(±5.1%)
Iowa	83	(±4.5%)	Kentucky	80	(±5.3%)
Kansas	82	(±4.8%)	Maine	80	(±5.1%)
Kentucky	81	(±5.2%)	Maryland	77	(±4.8%)
Maine	83	(±4.9%)	Massachusetts	83	(±4.5%)
Maryland	79	(±4.6%)	Minnesota	77	(±5.3%)
Minnesota	78	(±5.2%)	Mississippi	80	(±5.5%)
Mississippi	80	(±5.5%)	New Hampshire	82	(±5.2%)
New Hampshire	84	(±5.0%)	New York	75	(±4.6%)
New York	76	(±4.5%)	North Carolina	78	(±5.6%)
North Carolina	83	(±5.3%)	North Dakota	80	(±4.5%)
North Dakota	82	(±4.4%)	Pennsylvania	76	(±4.6%)
Pennsylvania	78	(±4.4%)	Rhode Island	81	(±5.2%)
Rhode Island	83	(±5.0%)	South Carolina	79	(±5.3%)
South Carolina	81	(±5.3%)	Virginia	77	(±5.8%)
South Dakota	76	(±5.6%)	Wyoming	76	(±5.4%)
Virginia	78	(±5.8%)			
Washington	75	(±4.2%)	65%–74%		
Wisconsin	76	(±4.4%)	Alabama	73	(±5.3%)
Wyoming	79	(±5.2%)	Alaska	68	(±6.2%)
65%–74%			Arizona	74	(±4.5%)
Alabama	74	(±5.2%)	Arkansas	66	(±6.1%)
Alaska	72	(±6.1%)	California	70	(±4.6%)
Arkansas	69	(±6.0%)	Colorado	73	(±6.1%)
California	73	(±4.5%)	Idaho	65	(±6.3%)
Idaho	66	(±6.3%)	Indiana	70	(±5.1%)
Illinois	69	(±5.1%)	Louisiana	72	(±5.4%)
Indiana	72	(±5.0%)	Missouri	66	(±6.5%)
Louisiana	74	(±5.3%)	Montana	71	(±5.7%)
Missouri	67	(±6.5%)	Nebraska	67	(±5.9%)
Montana	72	(±5.7%)	Nevada	65	(±6.6%)
Nebraska	72	(±5.7%)	New Jersey	69	(±6.0%)
Nevada	68	(±6.5%)	New Mexico	70	(±6.5%)
New Jersey	70	(±5.9%)	Ohio	73	(±4.6%)
New Mexico	73	(±6.2%)	Oklahoma	70	(±6.7%)
Ohio	74	(±4.6%)	Oregon	65	(±6.3%)
Oklahoma	73	(±6.6%)	South Dakota	74	(±5.7%)
Oregon	67	(±6.2%)	Tennessee	70	(±4.3%)
Tennessee	73	(±4.2%)	Texas	68	(±3.9%)
Texas	71	(±3.8%)	Utah	67	(±4.8%)
Utah	70	(±4.8%)	Washington	73	(±4.3%)
West Virginia	69	(±6.3%)	West Virginia	68	(±6.3%)
			Wisconsin	74	(±4.4%)
<65%			<65%		
Michigan	63	(±5.3%)	Illinois	64	(±5.2%)
			Michigan	59	(±5.3%)
Total	75	(±1.0%)	Total	72	(±1.1%)

* Four doses of diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids (DTP/DT), three doses of poliovirus vaccine, and one dose of measles-mumps-rubella vaccine (MMR).

† Four doses of DTP/DT, three doses of poliovirus vaccine, one dose of MMR, and three doses of *Haemophilus influenzae* type b vaccine.

‡ Confidence interval.

Vaccination Coverage Levels — Continued

substantially >6 months after the third dose and underscore the need for boosting immunity with a fourth dose of DTP (7,8). Findings in this report indicate that coverage with four doses of DTP was the lowest of the four vaccines included in the combined series, emphasizing the importance of intensifying efforts to ensure timely administration of the fourth dose of DTP and the need for simultaneous administration with other vaccines recommended for children aged 12–18 months.

TABLE 3. Estimated vaccination coverage with the 4:3:1 series* and the 4:3:1:3 series†, by coverage level and selected urban area — National Immunization Survey, United States, April 1994–March 1995

Coverage level/ Area	4:3:1 Series coverage		Coverage level/ Area	4:3:1:3 Series coverage	
	%	(95% CI) [‡]		%	(95% CI)
≥85%			≥85%		
Boston	87	(± 5.2%)	Boston	87	(± 5.2%)
Santa Clara Co., Calif.	85	(± 4.9%)	75%–84%		
75%–84%			Baltimore	77	(± 6.1%)
Baltimore	80	(± 5.8%)	Cuyahoga Co., Ohio	82	(± 5.5%)
Cuyahoga Co., Ohio	84	(± 5.3%)	El Paso Co., Tex.	79	(± 5.4%)
Dade Co., Fla.	77	(± 6.4%)	Fulton/DeKalb cos., Ga.	75	(± 6.9%)
El Paso Co., Tex.	82	(± 5.1%)	Jefferson Co., Ala.	75	(± 6.3%)
Fulton/DeKalb cos., Ga.	77	(± 6.7%)	Marion Co., Ind.	78	(± 6.1%)
Jefferson Co., Ala.	78	(± 6.0%)	Milwaukee Co., Wis.	77	(± 6.0%)
Kings Co., Wash.	78	(± 5.3%)	New York City	75	(± 6.5%)
Maricopa Co., Ariz.	77	(± 6.1%)	Santa Clara Co., Calif.	80	(± 5.6%)
Marion Co., Ind.	81	(± 5.8%)	65%–74%		
Milwaukee Co., Wis.	80	(± 5.7%)	Dade Co., Fla.	74	(± 6.6%)
New York City	76	(± 6.5%)	Dallas Co., Tex.	66	(± 7.0%)
65%–74%			Davidson Co., Tenn.	67	(± 6.4%)
Bexar Co., Tex.	67	(± 6.5%)	District of Columbia	67	(± 7.3%)
Dallas Co., Tex.	71	(± 6.6%)	Duval Co., Fla.	71	(± 6.2%)
Davidson Co., Tenn.	69	(± 6.3%)	Franklin Co., Ohio	70	(± 6.8%)
District of Columbia	72	(± 7.0%)	Kings Co., Wash.	74	(± 5.6%)
Duval Co., Fla.	74	(± 6.0%)	Los Angeles Co., Calif.	68	(± 7.7%)
Franklin Co., Ohio	71	(± 6.8%)	Maricopa Co., Ariz.	74	(± 6.3%)
Los Angeles Co., Calif.	73	(± 7.5%)	Orleans Parish, La.	66	(± 7.8%)
Orleans Parish, La.	67	(± 7.8%)	Philadelphia Co., Pa.	69	(± 7.4%)
Philadelphia Co., Pa.	71	(± 7.3%)	San Diego Co., Calif.	72	(± 5.8%)
San Diego Co., Calif.	74	(± 5.8%)	Shelby Co., Tenn.	71	(± 7.0%)
Shelby Co., Tenn.	73	(± 6.9%)	<65%		
<65%			Bexar Co., Tex.	64	(± 6.6%)
Chicago	61	(± 8.7%)	Chicago	61	(± 8.7%)
Detroit	52	(± 8.2%)	Detroit	46	(± 8.0%)
Houston	62	(± 8.1%)	Houston	58	(± 8.0%)
Newark, N.J.	62	(± 10.0%)	Newark, N.J.	55	(± 10.1%)

* Four doses of diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids (DTP/DT), three doses of poliovirus vaccine, and one dose of measles-mumps-rubella vaccine (MMR).

† Four doses of DTP, three doses of poliovirus vaccine, one dose of MMR, and three doses of *Haemophilus influenzae* type b vaccine.

‡ Confidence interval.

Vaccination Coverage Levels — Continued

One of the national health objectives for the year 2000 is to achieve series-complete coverage for the recommended vaccines among at least 90% of children aged 2 years (objective 20.11) (2). Series-specific coverage levels that include Hib (i.e., 4:3:1:3 series) are reported here. All children included in the survey were born after October 1990, when recommendations for universal Hib vaccination of infants became effective.

Coverage levels varied substantially by state and large urban areas (e.g., a difference of 27 percentage points in 4:3:1:3 coverage between the states and 41 percentage points between the urban areas with the highest and lowest reported coverage levels). Although reasons for these differences have not been determined, these findings suggest that the national goals are achievable and that effective approaches should be adapted from the most successful areas. Efforts must be intensified to increase coverage among children in those areas with the lowest coverage.

Publication of the state NIS data in August 1995 assisted in strengthening vaccination program activities at the state level in some areas with the lowest coverage (9). For example, in Michigan, related efforts have included creation of a new plan to address undervaccination; organization of meetings with health-care providers, community groups, and business leaders to discuss undervaccination; and conducting an immunization summit at which the Michigan Department of Public Health initiated a new statewide vaccination information campaign. In Missouri, the governor established as a priority the need to increase vaccination levels of children aged <2 years and established goals of increasing levels to 75% by 1996 and to 90% by 1997. CDC will continue to use data from NIS and NHIS to evaluate progress toward national vaccination goals and to stimulate further efforts to improve vaccination coverage.

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Vaccination Coverage Levels — Continued

Immunization Levels of 19-35 Month Old Children United States, 1994 and 1994/95 Goals for 1994, 1996 and 2000

Vaccine	<u>P e r c e n t a g e s</u>				
	<u>Year</u>		<u>Goals by Year</u>		
	<u>1994</u>	<u>1994/95</u>	<u>1994</u>	<u>1996</u>	<u>2000</u>
	(Apr-Dec) (Apr 94-Mar 95)				
DTP 3+	93	94	85	90	90
OPV 3	83	84	75	90	90
MMR	89	89	85	90	90
Hib 3+	86	90	75	90	90
Hep B3	37	42	30	70	90
DTP 4	77	77	---	---	90
4DTP/3OPV/1MMR	75	75	---	---	90

Source:

National Immunization Survey (NIS), 1994 and 1995.



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Recommended Childhood Immunization Schedule United States, January - June 1996

Vaccines are listed under the routinely recommended ages. **Bars** indicate range of acceptable ages for vaccination. **Shaded bars** indicate catch-up vaccination: at 11-12 years of age, hepatitis B vaccine should be administered to children not previously vaccinated, and Varicella Zoster Virus vaccine should be administered to children not previously vaccinated who lack a reliable history of chickenpox.

Age ► Vaccine ▼	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	4-6 yrs	11-12 yrs	14-16 yrs
Hepatitis B ^{1,2}	Hep B-1										
			Hep B-2		Hep B-3					Hep B ²	
Diphtheria, Tetanus, Pertussis ³			DTP	DTP	DTP		DTP ³ (DTaP at 15+ m)		DTP or DTaP	Td	
<i>H. influenzae</i> type b ⁴			Hib	Hib	Hib ⁴		Hib ⁴				
Polio ⁵			OPV ⁵	OPV	OPV				OPV		
Measles, Mumps, Rubella ⁶						MMR			MMR ⁶ or	MMR ⁶	
Varicella Zoster Virus Vaccine ⁷						Var				Var ⁷	

Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

- ¹ Infants born to HBsAg-negative mothers should receive 2.5 µg of Merck vaccine (Recombivax HB) or 10 µg of SmithKline Beecham (SB) vaccine (Engerix-B). The 2nd dose should be administered ≥ 1 mo after the 1st dose.
Infants born to HBsAg-positive mothers should receive 0.5 mL hepatitis B immune globulin (HBIG) within 12 hrs of birth, and either 5 µg of Merck vaccine (Recombivax HB) or 10 µg of SB vaccine (Engerix-B) at a separate site. The 2nd dose is recommended at 1-2 mos of age and the 3rd dose at 6 mos of age.
Infants born to mothers whose HBsAg status is unknown should receive either 5 µg of Merck vaccine (Recombivax HB) or 10 µg of SB vaccine (Engerix-B) within 12 hrs of birth. The 2nd dose of vaccine is recommended at 1 mo of age and the 3rd dose at 6 mos of age.
- ² Adolescents who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series at the 11-12 year-old visit. The 2nd dose should be administered at least 1 mo after the 1st dose, and the 3rd dose should be administered at least 4 mos after the 1st dose and at least 2 mos after the 2nd dose.
- ³ DTP4 may be administered at 12 mos of age, if at least 6 mos have elapsed since DTP3. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is licensed for the 4th and/or 5th vaccine dose(s) for children aged ≥ 15 mos and may be preferred for these doses in this age group. Td (tetanus and diphtheria toxoids, adsorbed, for adult use) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT.
- ⁴ Three *H. influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB [Merck]) is administered at 2 and 4 mos of age, a dose at 6 mos is not required. After completing the primary series, any Hib conjugate vaccine may be used as a booster.
- ⁵ Oral poliovirus vaccine (OPV) is recommended for routine infant vaccination. Inactivated poliovirus vaccine (IPV) is recommended for persons with a congenital or acquired immune deficiency disease or an altered immune status as a result of disease or immunosuppressive therapy, as well as their household contacts, and is an acceptable alternative for other persons. The primary 3-dose series for IPV should be given with a minimum interval of 4 wks between the 1st and 2nd doses and 6 mos between the 2nd and 3rd doses.
- ⁶ The 2nd dose of MMR is routinely recommended at 4-6 yrs of age or at 11-12 yrs of age, but may be administered at any visit, provided at least 1 mo has elapsed since receipt of the 1st dose.
- ⁷ Varicella zoster virus vaccine (Var) can be administered to susceptible children any time after 12 months of age. Unvaccinated children who lack a reliable history of chickenpox should be vaccinated at the 11-12 year-old visit.

Birth Cohorts to be Surveyed and the RDD Release Date

Year	Survey Month	19 Months	35 Months	MMWR Release									
1994	April	Sept 1992	May 1991			A	F						
	May	Oct 1992	June 1991			u	e						
	June	Nov 1992	July 1991			g	r						
	July	Dec 1992	August 1991			s	a			J			
	August	Jan 1993	Sept 1991			t	r			u			
	September	Feb 1993	Oct 1991			5	y			n			
	October	March 1993	Nov 1991							e			
	November	April 1993	Dec 1991										
	December	May 1993	Jan 1992							9			
1995	January	June 1993	Feb 1992							6			
	February	July 1993	March 1992										
	March	August 1993	April 1992										
	April	Sept 1993	May 1992										
	May	Oct 1993	June 1992										
	June	Nov 1993	July 1992										
	July	Dec 1993	August 1992										
	August	Jan 1994	Sept 1992										
	September	Feb 1994	Oct 1992										
	October	March 1994	Nov 1992										
	November	April 1994	Dec 1992										
	December	May 1994	Jan 1993										
1996	January	June 1994	Feb 1993										
	February	July 1994	March 1993										
	March	August 1994	April 1993										
	April	Sept 1994	May 1993										
	May	Oct 1994	June 1993										
	June	Nov 1994	July 1993										

Comparison of Maximum and Minimum Cases (by Year), and Current Morbidity of Selected Vaccine Preventable Diseases

	Maximum cases	Minimum cases	1995* (Prov.)
Measles	894,134 (1941)	312 (1993)	288
Mumps	152,209 (1968)	1,537 (1994)	840
Polio (paralytic) **	21,269 (1952)	0	0
Rubella	57,686 (1969)	160 (1992)	146
Diphtheria	206,939 (1921)	0 (1993)	0
Tetanus	1,560 (1923) ***	45 (1992)	34
Pertussis	265,269 (1934)	1,010 (1976)	4,315
<i>H. influenzae</i> **** invasive disease (<5 years)	1,563 (1991)	329 (1994)	276

*Subject to change due to late reporting

**Caused by wild virus

***Mortality

****Reporting began in 1991. Estimates in pre-vaccine era up to 20,000.



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Comparison of Maximum and Minimum Cases for 1980-1994, and 1995 Provisional Cases of Selected Vaccine Preventable Diseases

	Maximum cases (1980-1994)	Minimum cases (1980-1994)	1995* cases (Prov.)
Measles	27,786 (1990)	312 (1993)	288
Mumps	12,848 (1987)	1,537 (1994)	840
Polio (paralytic)**	0	0	0
Rubella	3,904 (1980)	160 (1992)	146
Diphtheria	5 (1991)	0 (1993)	0
Tetanus	95 (1980)	45 (1992)	34
Pertussis	6,586 (1993)	1,248 (1981)	4,315
<i>H. influenzae</i> *** invasive disease (<5 years)	1,563 (1991)	329 (1994)	276

*Subject to change due to late reporting

**Caused by wild virus

***Reporting began in 1991. Estimates in pre-vaccine era up to 20,000.



National Immunization Program

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HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Thursday, Apr. 18, 1996

Contact: CDC Press Office
(404) 639-3286

U.S. MARKS "IMMUNIZATION WEEK" WITH RECORD-HIGH IMMUNIZATION LEVELS

Americans have two new records to celebrate--one high, one low--during this year's National Infant Immunization Week (NIIW), April 21-27. In the United States, the national infant immunization rate is at an all-time high and vaccine-preventable childhood diseases are at historic all-time lows.

"Today, more American children than ever before are properly immunized -- and fewer children than ever before are suffering from vaccine-preventable disease. Just today, for example, it was reported that the number of measles cases last year was the lowest ever," President Clinton said. "Still, we need to do more. All of us can help in this effort -- by educating parents, volunteering in local health programs, and supporting efforts in our communities. Together, we can ensure that every child in this country gets an equal chance at a healthy life."

HHS' Centers for Disease Control and Prevention provisionally reports that seven vaccine-preventable diseases were at record lows in the United States in 1995. Fewer children than ever before suffered from measles, mumps, rubella, diphtheria, tetanus, polio and a form of bacterial meningitis. Compared to the pre-vaccine era, these life-threatening diseases have declined 95 percent or more.

State health departments, for 1995, have reported the lowest number of measles cases since reporting began in 1912. The provisional total for 1995 is 301 cases, down 69 percent from the 963 reported cases in 1994. This is a significant decline from the number of cases reported when a measles epidemic swept the nation at the start of this decade. From 1989 to 1991, 55,000 cases of measles were reported, which killed more than 130 children and adults.

According to CDC's most recent National Immunization Survey, which surveys parents of preschoolers nationwide, 75 percent of two-year-olds in the United States received their full series of shots as recommended. Yet, despite this record high, more than one

million American children remain vulnerable to disease because they need one or more doses of vaccine.

In 1994, President Clinton officially proclaimed "National Infant Immunization Week" as the last week in April every year, to focus attention on the target population of the Childhood Immunization Initiative--infants and toddlers. This year, communities across the nation will be participating in outreach activities during the week.

State and local health departments and community immunization coalitions have planned special activities during NIIW. On April 22, in Atlanta, the 1996 Olympic Game mascot, Izzy, is going to check his immunization record. On April 23, Health and Human Services Secretary Donna E. Shalala will visit the East Valley clinic in San Jose, and on April 25, Secretary Shalala will participate in immunization outreach activities at the Maria de los Santos clinic in Philadelphia's Empowerment Zone. On April 24, Boston's Commonwealth Housing is holding a health fair that will provide free on-site immunizations; Boston's preschooler immunization rate, at 87 percent, is the highest in the nation among sites surveyed.

"Our message during National Infant Immunization Week is one of hope and concern," said Secretary Shalala. "Vaccines work--they are superb, cost-effective tools to prevent disease. However, with one of every four infants in the United States missing a needed shot, parents can't be sure their child is fully protected until they check. We encourage parents and health care providers to stop and check preschoolers' shot records during National Infant Immunization Week -- and at every health care visit throughout the year."

National Infant Immunization Week is an annual special observance that highlights the importance of public and private partnerships in increasing infant immunization. During the past two years, successful immunization partnerships have been launched with organizations such as Gerber, K-Mart, MacDonalds, and the Kiwanis and Rotary clubs. "Deadly viruses do not respect state or community borders; the problem of under immunization of infants affects every community in this nation," said CDC Director, Dr. David Satcher. "While no single factor accounts for under immunization, achieving and sustaining high coverage requires action by health-care providers, parents and communities."

The National Infant Immunization Week is an important part of the broader outreach effort within the Administration's Childhood Immunization Initiative. The initiative, launched by CDC in 1994, aims to further increase infant immunization levels and reduce diseases, like measles, while building a system to sustain high rates and deliver new vaccines to generations of children to come. "To truly succeed, we must break down all of the barriers that

prevent our children from being immunized on time," said Secretary Shalala. "That is why this Administration has doubled funding for childhood immunization, helped states and communities reduce immunization barriers, and built a national outreach effort the likes of which this country has never seen."

The goal of the Administration's Childhood Immunization Initiative is to increase vaccination levels to at least 90 percent among preschoolers by the year 2000. The initiative's five strategies include: improving immunization services for needy families, especially in public health clinics; reducing vaccine costs for lower-income and uninsured families; building community networks to reach out to families and ensure that young children are vaccinated as needed; improving systems for monitoring diseases and vaccinations; and improving vaccines and vaccine use.

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NOTE: Information on NIIW and childhood immunization is now available on the Internet. Visit CDC's home page at <http://www.cdc.gov/> for the most current information on childhood immunization. For information on local NIIW activities in your state, contact the CDC press office at (404) 639-3286.

National Infant Immunization Week Activities (April 21-27)

Events:

On April 22, Secretary Shalala visited T.H.E. (To Help Everyone) Clinic for Women in Los Angeles, California. She toured the clinic and participated in the clinic's weekly childhood immunization activities.

On April 22, Dr. Satcher of CDC did an event with the 1996 Olympic Game mascot, Izzy, in Atlanta.

On April 23, Secretary Shalala visited the East Valley clinic in San Jose, California. She toured the clinic and held a brief press availability, highlighting a new public/private immunization partnership in Santa Clara County.

On April 25, Secretary Shalala participated in immunization outreach activities at the Maria de los Santos clinic in Philadelphia's Empowerment Zone.

AmeriCorps is canvassing low-income neighborhoods in Alexandria, Virginia throughout the week. AmeriCorps has created an immunization outreach partnership with the Alexandria hospital and the local Rotary Club. Volunteers will be distributing immunization information and checking children's immunization records throughout the week. On Saturday, April 27, the Cora Kelly Recreation Center will hold a Family Immunization Awareness Fair.

Local events, sponsored by elected officials, public health clinics, and community groups, are taking place across the country.

Press:

CDC has distributed a Video News Release on NIIW 1996. In addition to immunization outreach activities, the VNR shows the President signing the National Infant Immunization Week proclamation in 1994.

Secretary Shalala sent letters to the editors of 20 major papers across the country. To date, eight papers plan to print the letter or quote the Secretary in their own editorials.

In addition, HHS Regional Directors are submitting letters to the editors of local papers in their regions.

HHS and CDC have distributed NIIW press releases and fact sheets to reporters.

Congress:

A letter from the Secretary and a fact sheet on NIIW were sent to all members of Congress. The letter encourages members to participate in local childhood immunization events throughout the week.

Tampa Trib.; 4-22-96

Immunization Week

Do you know if your child is properly immunized? Many parents don't — and that's a big danger for their children. In Florida, 21 percent of 2-year-olds have not received the full series of vaccines they need to protect them from life-threatening diseases, such as measles and pertussis.

The good news is that we've made real progress in the last few years. Today, infant immunization rates are at their highest levels in history, and vaccine-preventable childhood diseases are at an all-time low. But our work is far from done. There are still more than 1 million preschoolers in this country who don't have all their shots; your child could be one of them.

This week is National Infant Immunization Week. Parents need to check their children's immunization records to make sure they're up to date — and bring them in for their shots if they're not. Doctors need to take every opportunity to vaccinate children during office visits.

For information on where to go for shots, call 1 (800) 232-2522.

DONNA E. SHALALA
Washington, D.C.

The writer is the U.S. secretary of health and human services.

Well done on immunization levels

Hartford Courant 4/18/96

For those who get tired hearing about what's going wrong in Connecticut, here's an antidote:

This state is among the five national leaders in the immunization of children.

In fact, Connecticut is a close second only to top-ranked Vermont in the percentage of preschoolers receiving the principal vaccines against 10 dreaded diseases. The immunization levels in these two New England states are 87 and 86 percent respectively.

Nationally, the level has improved significantly. According to figures released last week by the federal Department of Health and Human Services, only 55 percent of America's young children were immunized four years ago. Today, that number is 75 percent — the highest level in history, said HHS Secretary Donna E. Shalala. As a result, childhood infectious diseases are at an all-time low, she reported.

Widespread immunization isn't cost-free. Over four years, the federal government has nearly doubled — to \$938 million today — the budget for vaccine purchases and immunizations. The Clinton administration has requested \$1 billion

for the next fiscal year.

But the benefits outweigh the costs. Society will pay a far higher price if children are unprotected from infectious diseases such as polio, measles, diphtheria, whooping cough, mumps, tetanus, rubella and chicken pox.

Although the improvement in immunization levels is cause for cheer, the loudest hurrahs will come when America reaches its goal by the year 2000. That goal is to have 90 percent of 2-year-olds immunized.

To get there, attention must focus on urban and rural poverty areas, where motivating parents to bring their children for rounds of disease-preventing shots is a problem.

Thirteen states plan to require parents to immunize their children as a condition of receiving welfare. Massachusetts is the only New England state among the 13.

Connecticut should be part of this list. If the national goal is 90 percent immunization by 2000, we ought to set our sights at 100 percent coverage by then. We can get there. Connecticut has already shown that it can be a leader.

THE OREGONIAN 4/19/96

Smart parents, safe kids

Parents wouldn't think of putting their babies in the streets to play where cars might strike them.

Yet many Oregon parents think nothing of putting their unvaccinated babies in settings where disease might strike them.

Oregon ranks a shameful 47th in the nation for adequately immunizing infants and toddlers, according to a federal survey. Only 67 percent of Oregon's 2-year-olds are fully protected from 10 serious and preventable illnesses.

Kids who are vaccinated can avoid measles, diphtheria, tetanus, whooping cough, polio, mumps, rubella, hepatitis-B, a flu that's the most common cause of spinal meningitis, and chickenpox.

It's a no-brainer, but it's not a no-strainer, which is part of the problem. To help, a health, business and government partnership is offering free shots in every Oregon county next week.

People who want to take their kids, or know others who might, can call 1-800-723-3638 from 8 a.m. to 8:45 p.m. weekdays to find out about clinics in their areas. Information is also available at more than 150 McDonald's — a good place to find lots of parents and kids.

The huge health and cost benefits of immunization eclipse the small risks. Parents shouldn't hesitate to protect their children this way — it's like putting them to play in sandboxes instead of streets.

A shot in the arm

At last the state of Florida surpasses most of the nation in something other than crime and poverty. Immunizations of children by their second year have soared to 75 percent nationwide. However, 80 percent of Florida's children are now immunized against a range of preventable disabling diseases. That's great news reflecting fantastic strides.

It is a result of the sorts of partnerships that could be a balm to a host of social problems, if applied as thoughtfully and purposefully.

Indeed, a host of Florida players preceded — by a number of years — the Clinton administration's push to immunize 90 percent of U.S. kids by age 2.

Education and access barriers are falling, especially in poor urban areas. Public and private health-care providers are armed with a new awareness of the need to ensure that children do not fall through the cracks and become vulnerable to measles, mumps, diphtheria, spinal meningitis, and other ailments.

Federal initiatives are providing huge quantities of vaccine to the states, which in turn funnel it to health-care providers. Doctors are not allowed to charge for the vaccines, other than a small

IMMUNIZING CHILDREN

Florida, surpassing the national rate, continues to make strides in quelling diseases in children.

administrative fee. Additionally, federal funds are helping communities obtain the resources that they deem most useful, be it a mobile van or another clinic staffer.

At the state level, Florida's comprehen-

sive Healthy Start program plays a major role in making sure that children are born healthy and stay that way. Immunizations clearly are vital to that.

The third component of Florida's success remains the private, volunteer efforts of civic organizations, most specifically in this case the Kiwanis Clubs of Florida. Nine years ago, under the leadership of Dr. Wil Blechman of North Miami Beach, the clubs forged a partnership with the state and provided equipment and volunteers with commitments to clinics. Dr. Blechman last year was appointed state health officer.

The measurable progress in Florida, and around the nation, is all the evidence needed to keep these efforts funded. As recently as last year, Congress attempted to disable the vaccine-purchase program, but common sense ultimately prevailed. If the quality of children's lives is to mean anything at all, then this most basic of life-enhancing aid will continue unimpeded.

MILWAUKEE JOURNAL SENTINEL (WI)

APRIL 22, 1996



A good week to immunize

This is National Infant Immunization Week. Unfortunately, many parents simply do not know whether their children are properly immunized against a wide range of childhood illnesses.

The U.S. Department of Health and Human Services reports that in Wisconsin, 24% of 2-year-olds have not received all of the vaccinations they need to avoid life-threatening diseases such as measles and whooping cough.

The challenge is clear: Parents need to examine their children's immunization records. Make certain they are up to date. Then make arrangements to get any vaccinations that have not been administered.

The message will be publicized in a number of ways this week. But for instant information on where to go for shots, there's a number to call: It's (800) 232-2522.

Significant progress has been made in recent years in infant immunization rates. There can be no justification for retreat.

LETTERS TO THE EDITOR

Need for immunizations in children often ignored

Do you know if your child is properly immunized? Many parents don't — and that's a big danger for their children.

In Arkansas, 31 percent of 2-year-olds have not received the full series of vaccines they need to protect them from life-threatening diseases like measles and pertussis.

The good news is that we've made real progress in the last few years. Today, infant immunization rates are at their highest levels in history, and vaccine-preventable childhood diseases are at an all-time low.

But our work is far from done.

There are still more than one million pre-schoolers in this country who don't have all their shots — and your child could be one of them.

This week — National infant Immunization Week — communities across the country are joining hands to ensure that all children get the shots they need, when they need them.

But we need your help. Parents need to check their children's immunization records to make sure they're up to date — and bring them in for their shots if they're not.

Doctors need to take every opportunity to vaccinate children during office visits. It's up to all of us to ensure that every child gets an equal shot at a

healthy life.

For information on where you can go to get shots, call 1-800-232-2522.

Donna E. Shalala
Secretary of Health and
Human Services

The Times (Arkansas), April 25, 1996

Parenting Magazine Questions and Answers

Question:

Where and when was the rise in infant immunization rates reported?

Answer:

The most recent data is from the National Immunization Survey, which surveys parents of preschoolers nationwide. According to this data, which covers the 12-month period ending in March 1995, infant immunization rates have reached a record high: seventy-five percent of the nation's two-year-olds received the full series of recommended shots (four doses of diphtheria/tetanus/pertussis vaccine, three doses of polio vaccine, and one dose of measles/mumps/rubella vaccine). We also have the highest rates ever recorded for vaccination against certain specific diseases, such as measles and polio. The other good news is that fewer children than ever before suffered from vaccine-preventable diseases -- last year, for example, the number of measles cases was the lowest ever reported.

Question:

Why has the immunization rate risen?

Answer:

The rise in rates partially results from increased awareness about the importance of proper childhood immunization, in the wake of the 1989-1991 measles epidemic that killed over 130 people, many of them children. A major cause of that epidemic was the failure to vaccinate infants on time, and we've been working to increase immunization rates by keeping clinics open longer, developing state-specific action plans, creating partnerships with the private sector, and educating parents. We've made substantial progress, but we still have work to do, since more than one million preschoolers in this country are still missing a needed shot.

Question:

Why hasn't the childhood immunization rate gone up even further?

Answer:

Several barriers stand between our children and protection from disease. Some parents are unaware that their children should get 80 percent of their vaccinations by age two. Some providers miss opportunities for immunizing children. Some clinics aren't open in the evenings, when working parents are available. Finally, cost also contributes to under-immunization; the private cost of a full series of vaccinations has increased from about \$27 in 1983, to more than \$300 today.

The Clinton Administration's comprehensive Childhood Immunization Initiative is working on all fronts to break down these barriers and ensure that all children get the shots they need -- when they need them.

Question:

What would it take to reach the Clinton Administration's goal of ensuring that at least 90 percent of the nation's preschoolers are properly immunized by the year 2000?

Answer:

The Administration has launched a comprehensive Childhood Immunization Initiative to ensure that at least 90 percent of the nation's preschoolers are properly immunized by the year 2000. The initiative's five strategies are: improving immunization services for needy families, especially in public health clinics; reducing vaccine costs for lower-income and uninsured families; building community networks to reach out to families and ensure that young children are vaccinated as needed; improving systems for monitoring diseases and vaccinations; and improving vaccines and vaccine use.

While we've made real progress, reaching our goal will require more work from all of us -- parents, relatives, health care providers, businesses, and community groups all need to join hands to ensure that every child gets an equal chance at a healthy life. For more information on childhood immunization and where to go for shots, parents can call 1-800-232-2522.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

16-Apr-1996 12:10pm

TO: (See Below)

FROM: Diana M. Fortuna
 Domestic Policy Council

SUBJECT: RE: Comparing Immunization Rates from 1992 and 1995

Thanks for the info. While I understand that it is not possible to go back and backcast the 1992 number WITH provider verification, it would be interesting to know how many percentage points provider verification added to the rate at the time it was introduced, just to give us a sense of what kind of difference it made.

My understanding is that there are 3 other questions to address in thinking how to describe our progress since 1992:

1. The switch from NHIS to NIS: aren't the NIS figures higher than NHIS by a few points? (Since we are maintaining both systems at present, I assume we can examine the spread between the two for a few quarters.)
2. The question of what a "1995" number means. HHS told me that the 75% figure for 1995 is for 4 quarters ending March 31, 1995 (so it is actually 3 quarters from 1994). And since it measures 19-35 month olds, some of the shots counted in this 1995 number occurred in 1992 or 1991. Does that make sense to you?
3. How much of the progress from 92 to 95 took place in 1993 as opposed to 1994 or 1995.

I think these are the questions to pursue. Let me know of any mistakes in my thinking.

Distribution:

TO: Gordon P. Agress

CC: Nancy-Ann E. Min
CC: Jennifer L. Klein
CC: James I. Blount
CC: Barry T. Clendenin
CC: Richard J. Turman

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

15-Apr-1996 06:20pm

TO: (See Below)

FROM: Gordon P. Agress
 Office of Mgmt and Budget, HD

SUBJECT: Comparing Immunization Rates from 1992 and 1995

Last week you noted that Secretary Shalala was quoted as saying that immunization rates have risen from 55% in 1992 to 75% in 1995, and asked if there were any methodological concerns regarding this comparison.

CDC staff tell us that the 1995 figures came from the National Immunization Survey, which used "provider verification" to adjust its estimates of immunization rates. The 1992 figures came from the National Health Interview Survey, which did not use provider verification at that time. Since provider verification tends to increase estimates of immunization rates, the 1992 figures are probably lower than they would have been had provider verification been used. CDC staff said they could not say what the 1992 rates would have been had provider verification been used.

Thus, it is possible that critics of the program could say that some of the improvement in the rates is attributable to changes in methodology rather than in immunization status -- if they are aware of the provider verification distinction in the first place.

Distribution:

TO: Diana M. Fortuna

CC: Nancy-Ann E. Min
CC: Jennifer L. Klein
CC: James I. Blount
CC: Barry T. Clendenin
CC: Richard J. Turman
CC: Jim R. Esquea
CC: Barbara E. Washington

February 14, 1996



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

CC:
Jennifer
Klein

Please route to:

Richard Turman
Barry Clendenin
Nancy-Ann Min
Alice Rivlin

BC
NKM

Decision needed _____
Please sign _____
Per your request _____
Please comment _____
For your information X

With informational copies for:

Subject: FYI -- Update on Immunization Rate Data

HD Chron, HPS Chron

From: Gordon Agress

Phone: 202/395-4926
Fax: 202/395-3910
Room: #7026

HHS called Nancy-Ann last Thursday to brief her on immunization rates that they plan to publish in the *Mortality and Morbidity Weekly Report* on February 23. Participating in the call were Bill Corr, HHS, Dr. Walter Orenstein, Director of CDC's National Immunization Program, Jennifer Klein of the Domestic Policy Council, and other staff.

Rates Show Progress towards Meeting the Goals

As the table below shows, the new data compares immunization rates for April 1994 to March 1995 with previous estimates for April 1994 to December 1994. The update shows continued progress towards the Administration's goals. Rates for three or more doses of vaccine for *Haemophilus influenzae* type b (Hib) have achieved the 1996 goal of 90%, rates for three doses or more of Hepatitis B (Hep B) improved by 5 percentage points to 42% (the goal is 70%), and rates for three doses or more of polio vaccine inched from 83% to 84% towards the goal of 90%. The figures are estimates of national immunization rates among children aged from 19 to 35 months and are based on data from the National Immunization Survey (also known as the Random Digit Dialing survey, or RDD).

While the Hep B rates are generally low, Dr. Orenstein notes that these rates are much higher for younger children in the sample -- for example, the rate among children 19-24 months old is 58% while that among children 31-35 months old is 24%. He says that the overall rate will rise quickly as the survey picks up more of these younger children.

Latest Immunization Rates Show Progress Towards President's Goals (national immunization rates among children 19 to 35 months; based on data from the Random Digit Dialing Survey)			
Vaccine/Dose	1996 Goal	April 94 to December 94	April 94 to March 95*
Diphtheria/Tetanus/Pertussis (DTP)			
3+ Doses	90%	93%	94%
4+ Doses		77%	77%
3+ Poliovirus (OPV)	90%	83%	84%
3+ <i>Haemophilus influenzae</i> type b (Hib)	90%	86%	90%
1+ Measles Mumps Rubella (MMR)	90%	89%	89%
3+ Hepatitis B (Hep B)	70%	37%	42%
Combined series			
4 DTP/3 OPV/1 MMR (4:3:1)	--	75%	75%
4 DTP/3 OPV/1 MMR/3 Hib (4:3:1:3)	--		72%
* CDC plans to publish these figures in an MMWR article on February 23.			

HHS said that in addition to these national data, the article will also include rates for each State and some cities. Some cities have low immunization rates (below 65% for the 4:3:1 series); Nancy-Ann asked Bill Corr to work with John Hart in the White House to ensure that these cities (Chicago, Detroit, Houston and Newark; also Bexar County, Texas) are not surprised by the publication of these rates.

CDC also plans to publish national immunization rates from the National Health Interview Survey (NHIS) for all of 1994. Language in the conference report on the Senate Labor/HHS appropriations bill may force CDC to discontinue the RDD, and HHS wants to ensure that everyone is aware that the NHIS numbers are generally very close to the RDD numbers so that HHS is not accused of playing with the numbers.

CDC Doubts Rates Will Reach Goals By October

Immunization rates will be updated again in June to show rates for July 1994 through June 1995, and again in October to show rates for October 1994 through September 1995. Dr. Orenstein said that he doubts that the Hep B rates will rise quickly enough to meet the goal of 70% in the October numbers.¹ Bill Corr suggested that you could announce in October that figures for the incidence of vaccine-preventable disease are at record low levels.

CDC To Brief Senator Bumpers on Rates

Nancy-Ann suggested to Dr. Orenstein that he meet with Senator Bumpers before the article is published to show him these rates and to discuss with him the continuation of the RDD. Senator

¹ Dr. Orenstein also noted that we will not know whether we have reached the goal for 1996 until some time in 1997, since data for 1996 will not be available until then. While technically correct, this may not be how the goals are generally understood.

Bumpers is particularly interested in childhood immunizations, and it was his office that included the conference report language suggesting that CDC discontinue the RDD.

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Name	Date
Eric Morse	6/16/2000

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