

Sharp and to the Point

Quarterly newsletter produced by the Immunisation Section, SA Health

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This newsletter is produced quarterly by the Immunisation Section. If you have any feedback or comments on what you would like to see in future editions; or would like to receive further copies or have your name removed from our mailing list, please contact Sara Almond on phone 1300 232 272, fax (08) 8226 7197 or email sara.almond@health.sa.gov.au.

Introducing Prevenar 13®

As of 1 July 2011 South Australia will replace the use of 7-valent pneumococcal conjugate vaccine (7vPCV) Prevenar® with 13-valent pneumococcal conjugate vaccine (13vPCV) Prevenar 13® in line with changes to the National Immunisation Program.

Prevenar-13® – will be offered in the same dose schedule at 2 months (recommended from 6-8 weeks of age), 4 months and 6 months of age and will offer greater protection against pneumococcal disease as it contains 6 additional serotypes (1, 3, 5, 6A, 7F and 19A).

Streptococcus pneumoniae is the bacterial pathogen responsible for invasive pneumococcal disease (IPD) such as bacteraemia, meningitis and pneumonia. It is also responsible for non invasive disease such as acute otitis media and sinusitis. IPD is a major cause of morbidity and mortality particularly in children less than 2 years of age. Cases of IPD caused by serotypes not currently covered by Prevenar 7®, predominantly 19A, have been increasing.

In children the highest rate of pneumococcal disease is seen in those less than 2 years of age. A single dose of Prevenar 13® will be offered to all children aged between 12-35 months of age and who have completed their course of Prevenar 7®. This program will commence on 1 October 2011. Prevenar 13® will be available as 0.5 ml in a pre-filled syringe.

Further information can be found at

<http://www.health.gov.au/internet/main/publishing.nsf/Content/pbac-psd-Pneumococcal-july10>

Reminder!

The Communicable Disease Control Branch (CDCB) has changed its telephone number from (08) 8226 7177 to 1300 232 272 (1300 CDCB SA).



Increasing coverage rates in 4 year olds

Although South Australia has high vaccination coverage rates in the 1 and 2 year old groups, there have been declining rates of immunisation coverage in the 4 year-olds over the past two years. During the same period there has been an increase in the notification rate of vaccine preventable diseases, such as pertussis.

In December 2010 only 87% of children in South Australia had received their 4 year old booster vaccines (Infanrix IPV and MMR). When looking specifically at Aboriginal children the figure is even less, at 77%. This is below the level required for effective community protection.

SA Health will be launching a state-wide awareness campaign to remind parents about the importance of the booster vaccinations required before their child goes to Kindy. The campaign will focus on preparing for big adventures prior to commencing Kindy and will inform parents that these immunisations can be safely given from 3 and a half years of age.

Promotional materials will assist in conveying the messages, aimed at both parents and children. The main concept of the strategy is a storybook focusing on a young child going to receive his booster immunisations. The storybook will be mailed out to all children turning 3 and a half years of age and will also include an information brochure for parents. A follow up reminder card/fridge magnet will also be sent to children prior to their 4th birthday.

Providers will receive some promotional materials to assist in promoting the key messages throughout their community.

Look out for some fun materials to share with four year olds.



Rubella serology and vaccination in women of child bearing age

Dr Katina D'Onise, Public Health Physician, Specialist Services Section, CDCB

As a result of feedback from readers on the recent article "Vaccine recommendations for HCWs – what is accepted as demonstrated immunity" the following information provides clarification of the recommendations for rubella screening and vaccination in women of child bearing age.

The Australian Immunisation Handbook 9th Edition recommends screening for rubella antibodies before or early on in every pregnancy. This recommendation is based on the very rare risk of infection with rubella following previous immunity (from wild infection or vaccination) and the risk of errors from the laboratory. Despite this recommendation, there is evidence that although the measurable antibody level following rubella vaccination may wane over time, there is likely to be ongoing immunity as there is a significant 'memory' component to the response to a subsequent challenge with the virus.

Importantly, there is good evidence that two doses of MMR vaccine are sufficient to ensure immunity to rubella. While there may be rare individuals who do not adequately respond to two doses of MMR, further vaccination is unlikely to change this. As such, while serology continues to be officially recommended for each pregnancy in Australia, once there is documented evidence of receipt of two MMR doses, no further doses of MMR are necessary regardless of the serological results.

References:

Australian Immunisation Handbook, 9th edition, 2008. National Health and Medical Research Council, Australia. Canberra: Australian Government, 2008.
Plotkin SA, Reef S. Rubella vaccine. In: Plotkin SA, Orenstein WA, eds. Vaccines. 4th ed. Philadelphia, PA: Saunders, 2004.

No link between Flu vaccine and Guillain-Barré Syndrome (GBS)

A massive study in China has shown no connection between the 2009 H1N1 influenza vaccine and GBS.

From 21 September 2009 to 21 March 2010 a total of 89.6 million people were vaccinated against H1N1 influenza.

Following the mass vaccination program in China, Dr Yu Wang from the Chinese Centres for Disease Control and Prevention in Beijing, collected data on all adverse events reported. The study concluded an exceptionally low rate of GBS was discovered, less than the background rate observed in the Chinese population.

Penina Haber, epidemiologist at the US Centers for Disease Control stated that the study results were similar to those from the US analysis of adverse events, providing further evidence of the safety of the H1N1 influenza vaccine.

These findings suggest there is no evidence that the vaccine is associated with an increased risk of the Guillain-Barré syndrome.

References:

http://www.sciencenews.org/view/generic/id/69491/title/No_flu_vaccine_link
<http://www.nejm.org/doi/full/10.1056/NEJMoa1008553>

TB in Australia and the role of BCG vaccination

Dr Rick Stapledon, TB Consultant, SA TB Services, Department of Thoracic Medicine, RAH.

Tuberculosis (TB) remains a global public health challenge with approximately 90% of the morbidity and mortality borne by low income countries. Two thirds of cases occur in countries regional to Australia with rates in excess of 100 per 100,000 population. Major driving forces are socio-economic and health disparities and population growth further amplified by HIV co-infection. The emergence of drug resistant TB is another major issue hampering TB control efforts and reflects deficiencies in TB programs.

In Australia the TB picture is markedly different. The ongoing annual rates of TB remain amongst the lowest in the world at between 5-6 per 100,000 population. Most cases (80-90%) occur in migrants from high burden countries. In Australian born individuals the rate remains very low, particularly in children less than 5 years who are an important marker of good TB control. Importantly, severe forms such as TB meningitis in young children are very rare, with an annual average of only one case Australia wide in the past 10 years.

The rate of TB is higher in some Aboriginal and Torres Strait Islander communities than for the non-Aboriginal Australian born but actual case numbers are small. The rate for drug resistant TB remains low with most cases "imported" and the impact from HIV infection has been minimal. The number of cases reported in Australians who have travelled or lived in high prevalence countries is also small.

The control of TB in any community is largely reliant on early detection and treatment of infectious cases to minimize transmission. In Australia, as in other low

prevalence settings, targeting those most at risk from latent TB infection for preventive therapy (e.g. close contacts, immune-suppressed) is considered an important secondary strategy.

The role of BCG vaccination in the control and prevention of TB in low prevalence settings is very limited. Its use in the general Australian population was discontinued in 1986 because of the low incidence of TB and risk benefit concerns. The most important benefit from BCG vaccine is in minimising the risk of severe forms of TB in neonates and young children, for which it is about 90% protective. However the protective benefit against pulmonary disease is only an average 50%. The benefit from BCG vaccine in older age groups is less clear and is no longer recommended in most Australian health care workers.

The use of BCG vaccine is limited to neonates and infants considered at high risk of exposure to TB. For example children 5 years and under who will be living or staying for extended periods in high prevalence countries should be considered for BCG vaccination (and given 2 to 3 months prior to departure). Vaccination is not considered necessary in those undertaking brief holidays. Each individual's situation needs to be carefully assessed.

The preferred approach (when BCG is not given and there is access to TB advice) is to recommend a tuberculin skin test if household exposure, while overseas, is suspected or known and offer preventive treatment in healthy positive reactors. A drawback of BCG vaccination apart from its partial and variable protective effect is the subsequent imprecision of tuberculin testing to detect recent infection. Although shown to be more specific, Interferon gamma release assays (IGRAs) have not been validated in those less than 5 years of age. Therefore, in the event of a high risk exposure, irrespective of BCG status, preventive therapy would still need to be considered at this age.

Pertussis serology is not recommended to assess immunity

Dr Doug Shaw, Medical Consultant, Public Health, CDCB

The last issue of Sharp and to the Point (Issue 33 – February 2011) discussed vaccine recommendations for Health Care Workers and presented a table of acceptable evidence for immunity to measles, mumps, rubella and pertussis infection. The presence of measles IgG, mumps IgG and rubella IgG on serology provide acceptable evidence of immunity for measles, mumps and rubella respectively.

However, for pertussis, serology is unreliable and not recommended to demonstrate immunity, either prior to, or following pertussis vaccination. Instead, acceptable evidence of immunity for health care workers is documented evidence of pertussis booster vaccination in the previous 10 years. This would also be acceptable evidence for child care workers and people in similar occupations. Medical practitioners are encouraged to follow this recommendation and not request pertussis serology to assess immunity.

Did you know?

A new US study of 1,159 men has shown that 50% experienced at least one HPV infection during the 28 month study period. The men ranged in age from 18-70 years of age and were recruited from cities across North and South America. Researchers concluded that men remain at risk of HPV infection throughout their lives, with the risk increasing with multiple sexual partners.

Researchers also noted that there was no association between the age and incidence of any type of HPV infection, but did find that the ability of the immune system to clear HPV infections increased with age.

<http://www.haiboss.com/health/study-shows-hpv-risk-in-men/>
<http://www.doctorslounge.com/index.php/news/hd/18203>

(Ref NCIRS Newsbriefs-March 2011)

Focus on...

Indigenous immunisation

How identification and timeliness of vaccination can impact on burden of disease in the Indigenous population

It is a well established fact that the Indigenous population in general experiences a greater burden of disease when compared to the non-Indigenous population, and this is especially true for vaccine preventable diseases. For example, rates of hepatitis A infection in Indigenous children less than 4 years of age are approximately 35 times greater than those for non indigenous children in the same cohort (Menzies et al 2008).

Over the past 2 years the reported vaccine coverage rates in Indigenous children in South Australia has been declining. According to the most recent reports from the Australian Childhood Immunisation Register (ACIR), only 78% of Indigenous children aged 12-15 mths are fully vaccinated for their age, compared to 92% for non Indigenous children in the same age cohort. Coverage rates are lowest in metropolitan areas of Adelaide.

Low immunisation coverage coupled with high notification rates of disease, for example pertussis, places very young infants at risk of contracting disease. Nationally, in the 4 years from 2003 to 2006, hospitalisation and notification rates for pertussis in Indigenous children 0-4 years of age were 66% and 35% greater respectively when compared to non-Indigenous children in the same age group (Menzies et al 2008).

A number of strategies are currently in place aimed at improving immunisation coverage in 4 year olds, including a component of the Maternity Immunisation Allowance (MIA) payment and the SA Health 4 year old promotional campaign. Within the context of the Indigenous community it is important that providers further enable greater access to childhood immunisation through accurate identification and timely delivery of vaccination.

Indigenous Identification

Accurate identification of an individual's Indigenous status is critical to ensuring access to appropriate care. This is of particular relevance when considering immunisation as there are distinct differences in immunisation recommendations between Indigenous and non-Indigenous populations.

For example, Indigenous children are due to receive hepatitis A (VAQTA) at 18 and 24 months of age and pneumococcal (Pneumovax 23) vaccination at 24 months of age in addition to the usual vaccines. If these children have not been accurately identified at provider level they are less likely to be offered these specific vaccines. This is of particular importance when considering the greater incidence of these diseases in the Indigenous population.

Identification: some key facts

- Within SA, a recent study by Rank et al (2007) found that completeness of Indigenous status reporting to ACIR for children aged 12-14 months of age stood at 72%.
- There are significant incentives available for practices that enrol/correctly identify and treat Aboriginal or Torres Strait Islander patients. For further details refer to the Medicare Australia 'Practice Incentive Payments – Indigenous Health Incentive Guidelines May 2011'.

Component	Payment	Activity required for payment
Sign-on Payment	\$1000 per practice	One-off payment to practices that agree to undertake specified activities to improve the provision of care to their Aboriginal and Torres Strait Islander patients with a chronic disease.
Patient Registration Payment	\$250 per eligible patient per calendar year	A payment to practices for each Aboriginal and Torres Strait Islander patient aged 15 years and over, registered with the practice for chronic disease management.
Outcomes Payment	Tier 1: \$100 per eligible patient per calendar year	Payment to practices for each registered patient for whom a target level of care is provided by the practice in a calendar year.
Total: up to \$250	Tier 2: \$150 per eligible patient per calendar year	Payment to practices for providing the majority of care for a registered patient in a calendar year.

Above – Payments and Requirements of the Practice Incentive Program Indigenous Health Incentive

- It is important to remember to identify Indigenous status on the ACIR at EVERY encounter, or the ACIR will assume non-Indigenous status and coverage assessment of the Aboriginal population will continue to be underestimated.

Timeliness

Timeliness of immunisation is important in achieving a protective effect for both the individual and the wider population. When children are not vaccinated according to the recommended schedule, they not only fail to receive timely protection against preventable diseases at a time when they are most vulnerable, but also increase their risk of never fully completing the vaccination course. Numerous reports have shown that failure to adhere to the recommended schedule of primary and follow up booster immunisations results in resurgence of disease (Guera 2007).

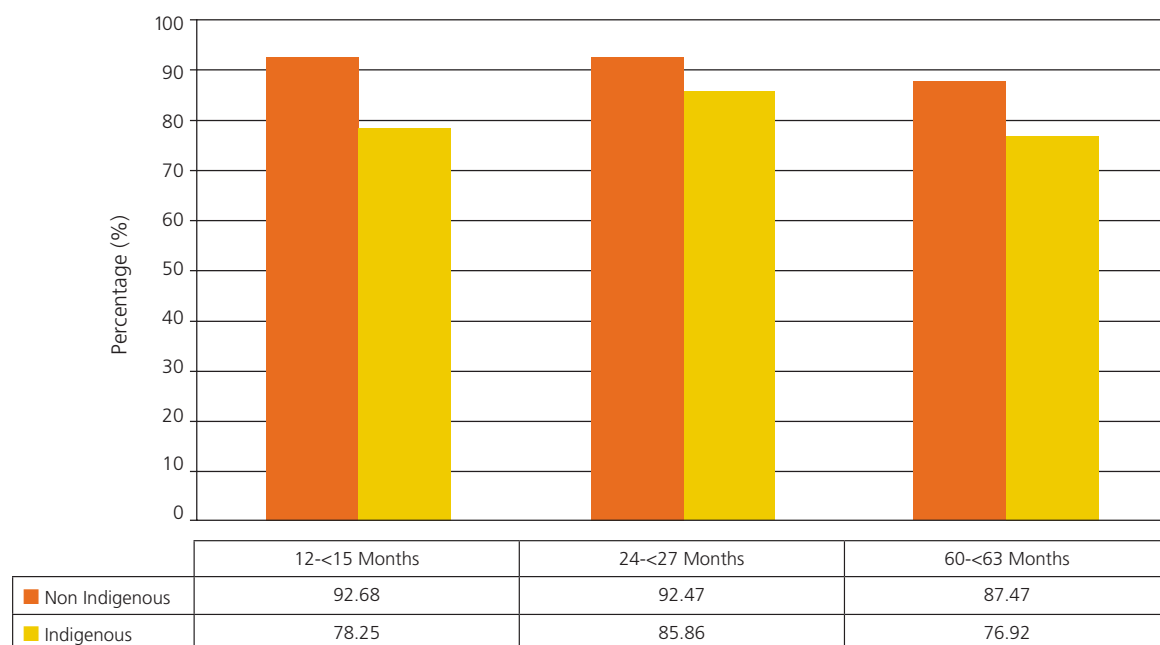
Timeliness: some key facts

- A recent study by Bailie et al (2009) has shown that, in remote areas, only 64% of Indigenous children aged up to 12 months receive their full immunisation course as per the schedule. This figure drops to 34% for 4 year olds.
- Delayed immunisation has been linked to higher pertussis hospitalisation rates in Indigenous infants (Kolos et al 2007)
- 38% of pertussis cases in Indigenous infants (< 1yr) occur in the 3-6 months of age cohort, highlighting the need for effective and timely immunisation against pertussis in very early childhood (Kolos et al 2007).
- Maternity Immunisation Allowance (M.I.A) has been split into 2 payments to encourage timely and complete vaccination at 18 months of age and 4 years of age.

General Facts and Information

- ACIR coverage estimates for Indigenous children (and non Indigenous children) does not assess vaccination status inclusive of Pneumovax 23 and hepatitis A (VAQTA), hence coverage for Indigenous children is likely to be lower.
- The graph below demonstrates some of the key points relating to Indigenous immunisation coverage in SA:
 - Immunisation coverage in all cohorts of Indigenous children is below the National Immunisation Program (NIP) benchmark of 92.5% and is below that of non Indigenous children in the same cohort.
 - The lower coverage in the Indigenous 12-15 month cohort means children in this most vulnerable group are not receiving timely protection against diseases like pertussis and rotavirus.
 - The comparatively lower coverage in the 60-63 month cohort means a lot of children are not receiving their boosters against diseases like pertussis, further hampering efforts to control the current epidemic of this disease.

South Australia Immunisation Coverage rates by Age Group and Indigenous Status as at 31st March 2011



References

- Menzies R, Turnour C, Chiu C, McIntyre P (2008) 'Vaccine preventable diseases and vaccination coverage in Aboriginal and Torres Strait Islander people, Australia, 2003 to 2006', Canberra: Department of Health and Ageing.
- Rank, C, Menzies, R. (2007) 'How reliable are Australian Childhood Immunisation Register coverage estimates for indigenous children? An assessment of data quality and coverage', Communicable Diseases Intelligence, <http://www.health.gov.au/internet/main/publishing.nsf/content/cda-cdi3103c.htm>
- Guera, A. (2007), 'Delays in Immunisation have potentially serious health consequences', Paediatric Drugs, Vol. 9, No. 3, pp. 143 – 148.
- Baillie, R.S, Si, D, Dowden, M.C, Selvey, C.E, Kennedy, C, Cox, R, O'Donoghue, L, Liddle, H, Connors, C.M, Thompson, S, Burke, H, Brown, A, (2009), 'A Systems Approach to Improving Timeliness of Immunisation', Vaccine, Vol. 27, pp. 3669 – 3674.
- Kolos, V, Menxies, R, McIntyre, P, (2007), 'Higher Pertussis Hospitalisation Rates in Indigenous Australian Infants and Delayed Vaccination, Vaccine, Vol. 25, pp. 588 590.

Invasive pneumococcal disease and the Pneumovax 23 recall

Dr Katina D'Onise, Public Health Physician, Specialist Services Section, CDCB

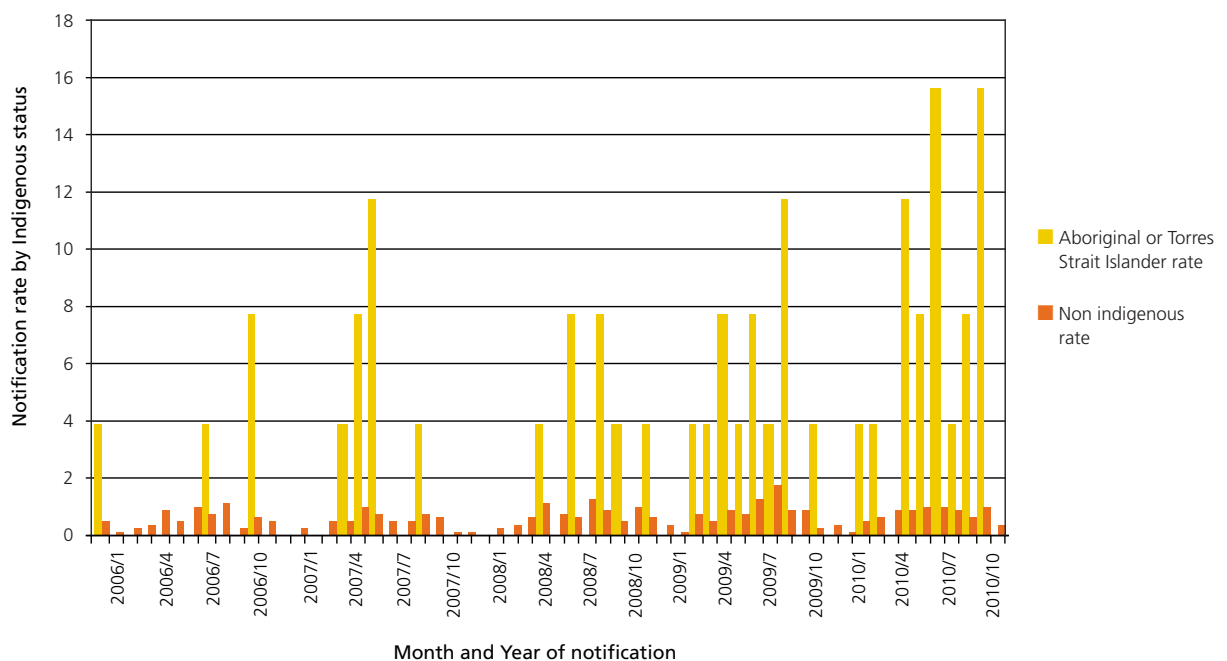
Invasive pneumococcal disease is a serious but vaccine preventable infectious disease. The most common clinical syndromes of invasive pneumococcal disease include pneumonia, meningitis and bacteraemia without a focus.

The graph displays the notification rate of invasive pneumococcal disease by Indigenous status in South Australia. The rate of notification of infection has been consistently higher in Aboriginal and Torres Strait Islanders compared with non-Indigenous Australians. This trend is similar in the rest of Australia with the national incidence of invasive pneumococcal disease in Aboriginal and Torres Strait Islanders being 3.2 times that of non-Indigenous Australians. This increased risk for Aboriginal and Torres Strait Islanders has led to the recommendation that all Aboriginal and Torres Strait Islanders over 50 years receive Pneumovax 23 (in addition to smokers, other adults over 65 years and those who are at risk of invasive pneumococcal disease from 10 years of age).

Pneumovax 23 provides immunity for 23 common serotypes of Streptococcus pneumoniae, thereby reducing the risk of invasive pneumococcal disease. Vaccine providers will be aware that the Therapeutic Goods Administration has temporarily suspended the revaccination (a second dose) of Pneumovax 23 following reports of an increased number of adverse events following the second dose including severe injection site reactions, such as cellulitis and abscess. It is however important to note that it is still recommended that those who are eligible to receive the vaccine continue to do so for the first dose. This will continue to reduce the risk of invasive pneumococcal disease in the community while awaiting the final determination of the Therapeutic Goods Administration on the safety of the second dose into the future.

For more information please go to: www.tga.gov.au/hp/index.htm

Invasive pneumococcal disease notification by Indigenous status in South Australia, 2006-2010



The internet and Immunisation

Several organisations over the world collaborate in the functioning and development of the internet. No one body owns this mass source of information and there is no control over the information that is posted on the internet.

Many households and workplaces have access to the internet and this means young parents and families have greater access to information about health issues than previous generations.

This generation of parents are much more likely to research immunisation information on the internet than discuss it with their doctor or immunisation provider. Information from the Centers for Disease Control in the USA shows that people are also more likely to believe something they find on the internet than what their doctor or health provider advises.

www.cdc.gov/vaccines/vac-gen/6mishome.htm

When looking for immunisation information on the internet people enter a minefield of best practice guidelines mixed with unproven theories and outdated information. Parents are bombarded with misleading information along with evidence based science.

For example, currently the first 10 sites listed following a Google search for "Immunisation", will provide reputable evidence based sites such as those referenced for this article. However, in a Google search for "Vaccination" the first 10 sites are a mixture of evidenced based articles and the views and opinions of organisations opposed to vaccination. Furthermore, videos found through a "vaccination" search include anti-vaccination videos

featuring celebrities alerting parents that vaccines cause autism.

Parents can view a range of conflicting information on the internet, and consequently can become overwhelmed and disillusioned. Who should they believe? What will be the consequences of their decision?

Immunisation providers can help parents who present to their clinics with questions or concerns about immunisation by discussing evidence based information, supported by resources such as immunisation pamphlets from SA Health or the Myths and Realities booklet developed by the Australian Government. Providers can also direct parents to credible sources of information on the internet.

Recommended websites:

Chain of Protection: <http://www.chainofprotection.org>

Department of Health & Ageing: <http://www.health.gov.au/>

SA Health: <http://www.health.sa.gov.au/pehs/>

Immunisation Myths & Realities-Responding to Parents Arguments Against Immunisation: <http://www.health.gov.au/>

Immunisation Action Coalition: <http://www.immunize.org/>

National Centre for Immunisation Research & Surveillance: <http://www.ncirs.usyd.edu.au/>

NCIRS Immunisation Myths & Realities-Responding to Parents Arguments Against Immunisation – online format: <http://www.ncirs.edu.au/immunisation/education/tools/myths-and-realities/player.html>

WHO Communicable Disease and Immunisation: <http://www.who.int/wer/en/>

Narcolepsy and H1N1 Vaccination

Narcolepsy is a rare sleep disorder that causes a person to fall asleep suddenly and unexpectedly. Since August 2010, following the widespread use of H1N1 (2009) influenza vaccine, 12 countries have reported cases of narcolepsy, particularly in children and adolescents, raising some concern. The highest rates of reporting have occurred in Finland, Sweden and Iceland.

In a systematic review, Finnish researchers found that individuals aged 4-19 years of age who had received the H1N1 (2009) vaccine were at higher risk of developing narcolepsy than those who had not. This increase was not seen in younger or older age groups in Finland. Researchers consider the vaccine may contribute to developing narcolepsy in combination with some additional environmental factor and/or in people genetically predisposed to developing the condition, which has a strong genetic linkage and is seen almost exclusively in people with a particular genotype. All of the cases of narcolepsy reported in Finland in 2009-2010 had this particular genotype. The pandemic vaccine used in Finland was Pandemrix H1N1 (2009) influenza vaccine, manufactured by GlaxoSmithKline.

Studies are continuing in Sweden to determine if the apparent increase in people experiencing narcolepsy is higher in vaccinated persons.

In Australia, Panvax was the pandemic influenza vaccine used and does not appear to be implicated in any of these reports.

At this stage, it does not appear that narcolepsy following vaccination against pandemic influenza is being experienced world wide, and this complicates the findings out of Finland. However, the WHO Global Advisory Committee on Vaccine Safety (GACVS) believes that investigation concerning narcolepsy and vaccination against H1N1 (2009) with Pandemrix and other pandemic H1N1 (2009) vaccines is warranted.

GACVS will continue to monitor the situation as further investigations are conducted and will update information as it becomes available.

Reference:

WHO Global Advisory Committee on Vaccine Safety, 8 Feb 2011, Statement on Narcolepsy and Vaccination

New Resources from the Immunise Australia Program

Seasonal Influenza vaccine brochures are now available on the Immunise Australia Program website in 16 other languages. For further details visit the website and access the Publications and Resources section. <http://www.immunise.health.gov.au/>

Problems encountered with vaccine deliveries in rural areas risking vaccine losses.

Although vaccine orders in the metropolitan region are delivered via refrigerated trucks this is not possible for all of our rural providers. Vaccine orders for rural customers are transported in eskies carefully packed with icepacks. The temperature is monitored through Heat Sensitive and Freeze Watch monitors placed in the esky. There is always the risk that the packing does not maintain the required temperature range throughout transportation. Therefore, it is important that rural providers check both monitor cards before unpacking the vaccines. It is also important that the vaccines are unpacked immediately to ensure the cold chain is maintained. Once the cards are checked and have not indicated any problem the vaccines must be unpacked and placed in the fridge immediately.

Problems are encountered when staff fail to immediately attend to delivered vaccines. The eskies are packed to provide a suitable temperature range during transport only. If the vaccines are not attended to immediately on arrival at the site, the temperature in the esky will increase and risk damage to the vaccines.

Any staff involved in receiving and handling vaccine deliveries must be aware of their responsibilities under the National Cold Chain Guidelines and SA Health Policies.

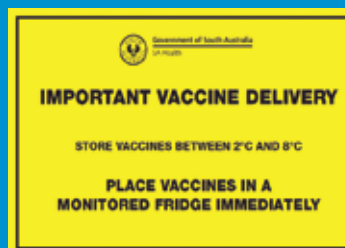
<http://www.health.gov.au/internet/immunise/publishing.nsf/content/provider-store>

<http://www.health.sa.gov.au/pehs/immunisation-index.htm>

If it is discovered that the vaccines have been compromised it should be reported to the Immunisation Section immediately. Any report will require details on how the vaccines were packed i.e. size of esky, how many icepacks were used, condition of icepacks (partially thawed, completely thawed), as all this information assists in improving transportation and reducing losses.

A yellow sticker accompanies each vaccine delivery highlighting the importance of this message.

Providers receive program funded vaccine from the government at significant cost and as such have a responsibility to ensure appropriately trained staff manage the receipt of vaccine deliveries.



Questions and Answers

Q When was Boostrix, Hepatitis B and Varicella introduced into the school program?

A The following vaccines were introduced to the SA School Based Immunisation Program (SBIP) in the following years:

- Hepatitis B – 1999
- Varicella – 2006
- Boostrix – 2004

Q What vaccine is used for Japanese Encephalitis Virus?

A Jespect® is the only available vaccine for Japanese Encephalitis, as Je-Vax vaccine is currently not available in Australia.

Jespect® vaccine is administered as a 2 dose course by intramuscular injection at 0 and 28 days.

Information on potential booster doses is currently still awaiting results of clinical trials.

Indicated for use in persons 18 years of age and older, travelling to endemic areas.

For more information please contact Immunisation Section on 1300 232 272 or by emailing Sara.Almond@health.sa.gov.au www.health.sa.gov.au/pehs/immunisation-index.htm



<http://www.gilf.gov.au/>

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