



The Older Australian and Aboriginal and Torres Strait Islander Influenza and Pneumococcal programs

The distribution of influenza vaccine for these programs commenced in February 2000. A total of 205 835 doses of influenza vaccine has been distributed to the end of June for both programs compared with 183 428 doses for the same period in 1999.

Demand for vaccine by immunisation providers has now reduced.

The 4th influenza stocktake, July 2000, indicated that there were approximately 15 000 doses of influenza vaccine remaining in providers' vaccine refrigerators. Consequently, the Communicable Disease Control Branch notified all immunisation providers to implement *The use of excess influenza vaccine policy*. For further information contact the SA Immunisation Coordination Unit on 8226-7177.

Nine thousand doses of influenza vaccine were distributed to hospitals and health centres by the Department of Human Services for staff, to reduce risk to patients.

The Aboriginal and Torres Strait Islander pneumococcal program has distributed 1316 doses of pneumococcal vaccine from February to the end of June this year compared with 3589 doses for the same period in 1999. Pneumococcal vaccine can be administered all year round for Aboriginal people who meet the following criteria:

- Over 50 years of age
- Aged between 15 and 50 years and at increased risk because of chronic illness
- Immunocompromised people

Free pneumococcal vaccine for these groups can be obtained by contacting the Vaccine Distribution Centre on 8226-7032 or fax your order to 8226-6453.

Laboratory and clinical diagnoses of influenza are markedly fewer than for the same period in the previous two years and the seasonal increase has occurred later than in 1998 or 1999.

National Influenza Coverage Survey

For the first time influenza coverage is being assessed on a national basis by the Department of Health and Aged Care. A telephone survey will commence mid August and the final report will be available in early December.

Hepatitis C Treatments and Trials seminar

In August the Communicable Disease Control Branch (CDCB) and the Hepatitis C Council of South Australia co-hosted a public seminar on Hepatitis C Treatments and Trials. Updates on the current treatment options available for people with hepatitis C, and a forecast of future drug trials was provided by a range of speakers.

These included Professor Chris Burrell, Head of Microbiology at the IMVS and member of the Australian National Council on AIDS, Hepatitis C and Related Diseases; Dr David Gordon from the Flinders Medical Centre; Dr Hugh Harley, Consultant Gastroenterologist, Royal Adelaide Hospital; and the Hepatitis C Council of South Australia. CDCB chaired the evening.

The seminar was informed of new thinking about targeted therapy and continuing gaps in treatment for cirrhotic patients and those in early stage disease. The value of interferon monotherapy as the first choice in hepatitis C treatment, given promising early results of combination therapy trials, was discussed. Improved histology was noted as a valid outcome of intervention in addition to sustained virological response. Access to combination therapy (which is not widely available in South Australia) was also discussed. The overwhelming interest shown by GPs and the public in this first seminar has meant that more events of this nature will be hosted by DHS, in partnership with the Hepatitis C affected community in South Australia.

Research Activities

The value of notification goes beyond the immediate public health importance of individual cases. These data also form a valuable resource for research studies. The CDCB in conjunction with the Rheumatology Department of The Queen Elizabeth Hospital has recently completed a survey of post-salmonella arthritis. The branch is also working with the Department of Public Health, Adelaide University and CSIRO Division of Human Nutrition to study the general nature of the diets of children under 5 years of age who have been notified with *Campylobacter* infection. The aim is to determine if there are differences in the diets of children who become cases compared with the diets of a sample of well children.

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GOVERNMENT OF SOUTH AUSTRALIA

Cryptosporidiosis

There were 55 cases of cryptosporidiosis notified. Thirty six percent of cases occurred in children less than four years and 11 percent in persons aged between 35 and 40 years. Overall there were 22 males and 33 females.

During April a cluster of 5 cases of cryptosporidiosis was observed. The director of a childcare centre noticed an increased number of children with diarrhoeal illness and alerted the Communicable Diseases Control Branch (CDCB). Four of the five cases that were notified attended the centre.

Hepatitis A virus

There were 15 cases of hepatitis A virus (HA) reported, 10 females and 5 males. The highest proportion of disease occurred in persons aged between 35 and 40 years (3 cases). There have been fewer cases of HA notified this quarter compared to the previous period (15 *versus* 74).

During 2000 an increase in cases has been observed in residents living on the West Coast of South Australia (SA). Six further cases have been reported from this region in the current period. An age-specific vaccination program was implemented within an Aboriginal community in response to an increase of symptomatic HA infection in children aged less than 5 years.

Legionella pneumophila infection

During this quarter there were three cases of *Legionella pneumophila* type 1 notified to CDCB. Ages of the cases ranged from 41 years to 57 years (1 female, 2 males). All cases were interviewed and environmental exposure risk factor histories obtained. Each of the cases proved to be epidemiologically linked to a recent outbreak of Legionnaires disease at an aquarium in Victoria.

Malaria

There were 12 cases of malaria reported, six more than for the same period in 1999. Infection occurred only in males, the highest proportion occurring in males aged between 20 and 35 years. All cases of infection were acquired overseas. *Plasmodium vivax* was detected in 9 (75 %) cases. In this group, a greater proportion of infection (77%) was acquired in South East Asia (predominantly Indonesia). The remaining 3 cases of disease were identified as *Plasmodium falciparum*; the Pacific Islands and Africa were nominated as sources of infection.

Measles

Eight cases of measles were notified in the last three months. No cases were notified in the previous quarter. Cases ranged in age from 1 to 41

years, the highest proportion occurring among cases aged 11 years or greater.

A cluster of seven cases of measles occurred during April and May 2000. This cluster was the first notified in SA since April 1999. All cases were confirmed serologically. Six of the seven cases were aged between 20 and 41 years and one case was 3 years old.

Close contacts received normal immunoglobulin (human) and MMR vaccination was administered if exposure to a case occurred within 72 hours. Enhanced surveillance was established via local general practitioners and pathology collection centres. Three of the cases were employed as health care workers.

Invasive meningococcal infection

Eight confirmed cases of invasive meningococcal infection were notified during this quarter, five more than in the corresponding period in 1999. Of the eight cases, disease occurred in five females and three males. Ages of cases ranged from four weeks to 86 years with a large proportion (63%) of cases occurring in children less than 5 years. Two cases have died. Four hundred and seventy five contacts were identified and of these, 217 received chemoprophylaxis at a local hospital. The remaining contacts received health advice on meningococcal disease. Five cases were serologically characterised as serogroup B disease, two as serogroup C, and one as serogroup Y. Further subtyping did not reveal an epidemiological link between cases.

Pertussis

There were 68 cases of pertussis. Forty four cases of infection occurred in males, 23 in females and one was unknown. Fifty-eight cases of disease (58, 85%) occurred in 11 year olds or greater. During this quarter a cluster of 18 cases has occurred on the south coast of SA. From January to June of this year 126 cases have been notified. An upward trend in the number of cases occurring in NSW has not been observed in SA.

Salmonella

During this quarter there were 116 cases of *Salmonella* infection, accounting for ten percent of overall notifications. Infection occurred equally among males and females. Thirty five percent occurred in children under 5 years. Several common phage types identified included, *Salmonella* Typhimurium phage type 185 (9 cases), *Salmonella* Typhimurium phage type 135A (9 cases), *Salmonella* Typhimurium phage type 44 (8 cases) and 16 cases with *Salmonella* Typhimurium untypeable.

Table 1. Number of notified cases by disease and onset date.*

Disease	1999		2000	
	April-June	Jan-June	April-June	Jan-June
Vector-borne				
Arboviral infection, RRv and non-RRv	3	41	81	264
Malaria	6	11	12	19
Faecal-oral, food and water borne				
<i>Campylobacter</i> infection	586	1270	387	837
Cryptosporidiosis	16	62	55	117
Suspected food poisoning	36	74	1	2
Hepatitis A	40	74	15	39
HUS/TTP/SLTEC (non-HUS)	6	16	5	18
<i>Listeria</i> infection	1	1	1	4
Paratyphoid fever	1	3	1	1
<i>Salmonella</i> infection	118	767	116	286
<i>Shigella</i> infection	17	41	12	19
Typhoid fever (<i>S. Typhi</i>)	0	4	2	2
<i>Yersinia</i> infection	2	9	0	6
Respiratory and other				
Atypical mycobacterial infection	9	19	3	6
<i>Legionella</i> infection	20	38	21	34
Meningococcal infection	3	8	8	9
Ornithosis	2	4	0	2
Tuberculosis	22	44	6	27
Zoonoses				
Hydatid disease	1	2	2	3
Leptospirosis	1	3	0	0
Q fever	2	2	1	1
Vaccine-preventable				
<i>H. influenzae</i> type b	1	2	0	0
Measles	2	3	8	8
Mumps	2	3	2	7
Pertussis	58	102	68	126
Rubella	1	4	1	3
Other				
Tetanus	0	0	0	1

* as at 2 August 2000

Communicable Disease Summary, by onset date. 1 April to 30 June 2000 cont

An outbreak of *Salmonella* Typhimurium phage type 185 occurred in March this year. During this quarter 11 further cases were identified bringing the total number of cases to 37. Further hypothesis generating interviews were conducted. An epidemiological and environmental investigation was conducted but a common food source responsible for the outbreak was not identified.

In the previous period an outbreak of *Salmonella* Typhimurium phage type 44 was identified. Eleven cases of infection were linked to the consumption of unpasteurised milk from a dairy in a rural community in SA. The sale of milk to the public from this dairy was ceased in July

1999. This quarter a further case occurred with epidemiological links to the previous cases. The consumption of raw cream purchased from the same dairy was identified as the source of illness.

Shigella

There were 12 cases notified during this quarter, eight males and four females. Twenty five percent of infection occurred in children aged less than five years. Further subtyping revealed six cases of *Shigella flexneri* biotype 2A and of these three cases occurred in Aboriginal people. A further four cases of *Shigella sonnei* biotype G and one case each of *Shigella sonnei* biotype A and *Shigella flexneri* biotype 4A were also identified.

Guidelines for the Control of Meningococcal Disease in Australia

In 1999 the Communicable Diseases Network Australia and New Zealand (CDNANZ) agreed to a proposal made by the National Centre for Disease Control (NCDC) to convene a working party to revise the guidelines for the control of meningococcal disease in Australia. The working party members include Dr Robert Hall (Chair), Professor Rosemary Munro, Professor Peter Collignon, Dr Tony Capon, Dr Jeffrey Hanna, Dr John Carnie and Dr Angela Merianos. Committee membership has also been extended to New Zealand. It is anticipated that the committee will have an ongoing role in the surveillance and management of meningococcal disease.

The new guidelines will be specifically targeted towards public health physicians, whose primary responsibility is to initiate meningococcal disease control responses, including contact tracing, and to general practitioners, hospital emergency department personnel and hospital clinicians/microbiologists whose responsibility remains with disease management. Several new sections have been included in the guidelines with a particular focus on appropriate chemoprophylaxis, the recognition of outbreaks of disease, vaccination, and laboratory diagnosis.

Recently there have been considerable advances in laboratory diagnostic techniques. Nucleic acid amplification assays such as polymerase chain reaction (PCR) tests are now conducted in many centres around Australia. A variety of phenotypic and genotypic techniques are now also available and will significantly contribute to the surveillance of clusters of cases of disease.

The new guidelines will provide a succinct and practical, evidence-based document for public health practitioners, essential for the management of meningococcal disease. It is anticipated that the document will be released later in the year.

Infection Control in the Health Care Setting. Guidelines for the prevention of transmission of infectious diseases

The Commonwealth Department of Health and Aged Care is currently revising the National Health and Medical Research Council (NHMRC) document *Infection control in the health care setting - guidelines for the prevention of transmission of infectious diseases*.

The draft document is available for consultation from 22 July 2000 to 1 September 2000.

This document contains amalgamated amendments and revisions of two documents:

- *Infection control in the health care setting - guidelines for the prevention of transmission of infectious disease*, NHMRC, 1996; and,
- *Creutzfeldt-Jakob disease and other Human Transmissible Spongiform Encephalopathies: Guidelines on patient management and infection control*, NHMRC, 1995.

The outcome of the process will be a revised version of these guidelines which is intended to be applicable in a broad range of health care settings. They will be evidence-based best practice guidelines, which encompasses principles of risk communication and management.

The web address for a copy of the draft and details for submissions is:

<http://www.health.gov.au/pubhlth/strateg/communic/review/>

The telephone number for enquiries will be available on the web site.

Implementation of the 2000-2002 Australian Standard Vaccination Schedule (ASVS)

The 2000–2002 ASVS commenced for infants born from May 1 2000. The SA Immunisation Coordination Unit supplied all community based immunisation providers with ‘starter doses’ of Infanrix-Hep B vaccine and PedvaxHib vaccine. Vaccination with these two vaccines commenced July 1 (when the infants born May 1 would be 2 months of age). These two vaccines are administered at 2 months and 4 months.

The 3rd dose of Infanrix-Hep B is administered at 6 months.

The 3rd dose of PedvaxHib is administered at 12 months.

Ordering patterns of these vaccines from the Vaccine Distribution Centre appear to show that PedvaxHib is NOT always being given with the Infanrix-Hep B. SAICU has also received a number of phone calls from immunisation providers where HibTiter has been given instead of PedvaxHib.

The recommendation is:

If HibTiter is being administered at 2 months of age rather than PedvaxHib then these infants need to stay with the HibTiter schedule at 4 months, 6 months and 18 months and NOT revert to the PedvaxHib schedule.

Public health website

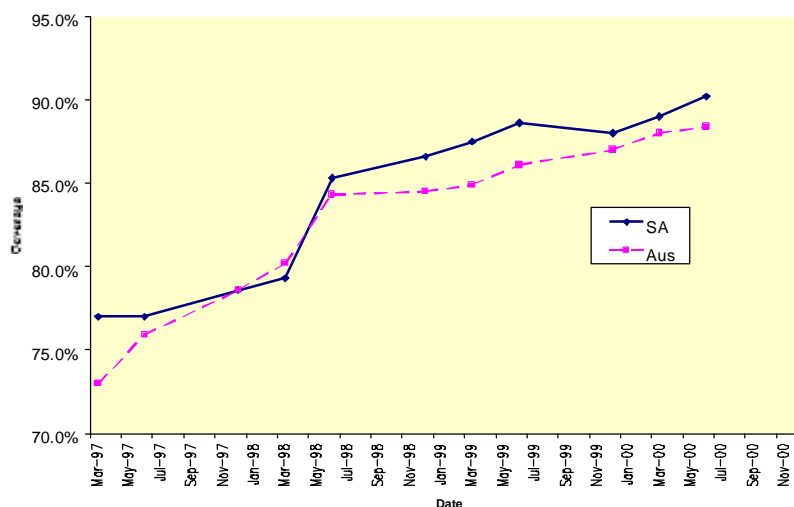
A weekly report of notifiable diseases in SA is published every Wednesday afternoon. The address is <http://www.dhs.sa.gov.au/PEHS/> Click on ‘disease summary’.

The quarterly *CDC Bulletin* is published on the website in ‘pdf’ format. Previous issues are also available.

Vaccination levels in SA compared with the Australia (March 2000)

In March 2000, 90% of South Australian children fully immunised aged 12<15 months while 88% of Australian children in this age group were fully immunised. Chart 1 compares South Australia with Australia. Table 2 compares South Australia with other states, territories and Australia.

Chart 1. Immunisation coverage, Australian Childhood Immunisation Register data, SA and Australia, ages 12<15 months. March 1997 to June 2000.



In the same period, 92% of South Australian children were fully immunised with the first dose MMR, due at 12 months. For Australia, 91% of children were fully immunised for the first dose MMR.

Maintaining the current gains for infants will be our challenge while at the same time improving vaccine uptake for older children, adolescents, adults and the elderly.

Table 2. Coverage for children 12<15 months for Australia (June 2000)

State/Territory	Percent fully immunised *
ACT	91
Tasmania	91
South Australia	90
Victoria	90
Queensland	90
WA	87
NSW	87
NT	83
Australia	88

* Fully immunised is defined as completion of 3 doses DTP, Hib and OPV

Vaccination coverage levels in each SLA for children 12<15 months and 24<27 months as of June 2000

Table 3 (refer to inserted council coverage table) describes the vaccination levels for SA children aged 12<15 months and 24<27 months in local council areas for the reporting period March 2000.

The data have been obtained from the Australian Childhood Immunisation Register. Note that the ACIR continue to analyse the SA council data using the old council boundaries and this remains a problem for interpretation. The data should be interpreted with caution, particularly if the number of children in the age group is less than 40.

The notes at the bottom of the table define what vaccine doses have been included in the formula for calculation of coverage for each age group. The data for children aged under 27

months are minimum estimates only as the ACIR may still have incomplete records for these children. Each coverage figure can be compared with the SA and Australian data for those age groups, see page 4. Local councils with coverage lower than 90% for the 12<15 month age group are below the SA benchmark. Local councils lower than 70% may have these results for a number of reasons, not necessarily because the children are incompletely immunised (although this may be true). In some cases the immunisation service providers in the council area may not be sending the children's immunisation data to the ACIR or they are sending the data in too late for inclusion into the analysis for the report period.

Local councils immunisation service providers who have an ACIR provider number can access

this data from the ACIR secure website at www.hic.gov.au (click on the ACIR logo and logon if you are a registered provider).

The ACIR Internet Help Desk can be contacted on 1300 650 039 if you want to discuss accessing the secure website. You can e-mail the ACIR for more information: acir@hic.gov.au

Parents and registered ACIR vaccination providers can check a child's immunisation history by phoning: 1800 653 809 (free call).

School immunisation programs

2000, Year 8 Hepatitis B Immunisation Program

Thank you to all immunisation service providers for their support in implementing this year's program. Data received in SAICU indicate that the majority of schools have received two visits so far this year. However, it is impossible for SAICU to determine a progress vaccine coverage rate until all ImPs data for schools visited this year are received from Councils.

2000, Year 10 Adult Diphtheria and Tetanus and Oral Poliomyelitis Immunisation Program
Thank you to all immunisation service providers for supporting the Year 10 immunisation program. The school immunisation data will be analysed shortly and progress vaccination rates will be made available for this year's program.

For more information about the school programs contact Charyn White on 8226-7177.

1999, Year 8 Hepatitis B Immunisation Program

The Evaluation of the Year 8 Hepatitis B Immunisation Program report is available. All immunisation service providers currently involved in the school based program will automatically receive a copy. For more copies or information about the program please contact SAICU on 8226-7177.

Year 10 diphtheria and tetanus (ADT) and polio (OPV) program coverage data

Table 4 provides a breakdown of vaccination coverage for the two vaccines from 1996–1999 inclusive. Vaccination coverage is declining in this program although local councils are adopting many of the initiatives in the Year 8 hepatitis B program for the Year 10 program. These strategies may result in an increase in coverage in 2000. The provider data enrolments are used as the denominator not the statewide school enrolments as previously reported. For more information about the school programs contact Charyn White on 8226-7177.

Revised Understanding Childhood Immunisation Booklet

This booklet for parents has been rewritten to show the changes to the Australian Standard Vaccination Schedule (ASVS) and other parent advice.

SAICU has again arranged with Child and Youth Health to have the booklet inserted in to the Personal Health Record. This will be done on the next print run.

Local Immunisation Coordinators have been sent a supply of the booklets to distribute to general practitioners.

Public providers can request copies from SAICU (tel 8226-7177 or fax 8226-7197).

Table 4. SA school vaccination program for Year 10: ADT and Oral Polio (1996–1999)

Year	ADT vaccination rates			Oral polio vaccination rates		
	<i>Students enrolled</i>	<i>Number</i>	<i>%</i>	<i>Students enrolled</i>	<i>Number</i>	<i>%</i>
	<i>Provider data</i>	<i>vaccinated</i>	<i>vaccinated</i>	<i>Provider data</i>	<i>vaccinated</i>	
1996	15 431	10 800	70	15 262	10 787	71
1997	17 250	11 789	68	16 881	11 719	69
1998	18 225	12 442	68	18 208	12 539	69
1999	18 992	12 465	66	18 992	12 492	66

Vaccine Safety

From 1 January to 30 June 2000 SAICU received 61 reports of an Adverse Event Following Immunisation (AEFI) of which 15 fulfilled the criteria for notification to the National Adverse Event Reporting Scheme. During the same period 204 048 vaccine doses were distributed (excluding adult vaccines). The rates of reportable AEFIs are recorded in Table 5.

The surveillance information demonstrates an extremely low rate of serious AEFIs and reflects the safety of childhood vaccines. However, it also demonstrates the inherent problem of under reporting using a passive surveillance system.

An increase in the reporting of severe local reactions for the 4th and 5th dose of DTPa has been detected (Chart 2). Local adverse reactions after booster immunisation with acellular pertussis vaccine is more common in children primed with acellular vaccine compared with those primed with whole cell vaccine (Halperin SA et al. *Pediatric Infectious Disease Journal* 14(9):792-7,1995). The mechanism of this has not been well defined.

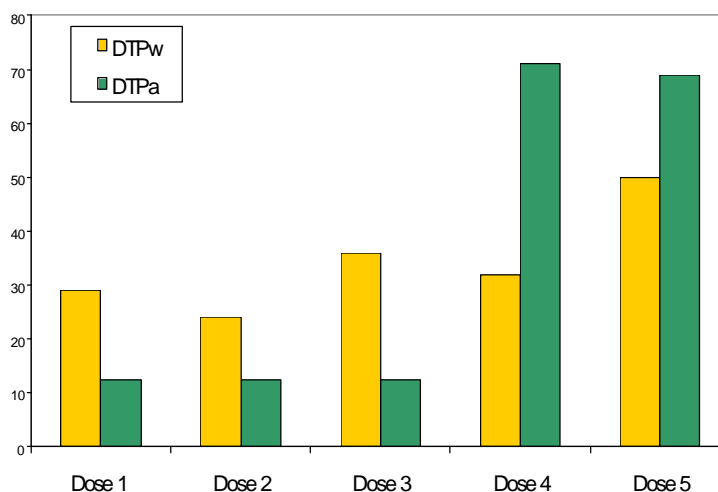
We encourage immunisation providers to continue to report moderate/severe local reactions (see below) as well as any other AEFI they may be concerned about. If you wish to discuss or clarify any AEFI please contact SAICU. The notification form for reporting AEFI can be downloaded from the Public Health SA website at www.health.sa.gov.au/pehs/ Click on 'Immunisation' on the home page.

Contact details: Tel 8226-7177 or fax 8226-7197 or email maggi.osbourn@dhs.sa.gov.au

Definition of a severe local reaction includes redness and/or swelling centred at the site of injection and one or more of the following:

- Swelling beyond the nearest joint
- Pain, redness, or swelling of more than 3 days duration
- Loss of function of the affected limb of more than 1 days duration
- Any requirement for hospitalisation or hospital review.

Chart 2. Percentage of AEFI reports due to a local reaction according to dose number and use of DTPw vs DTPa 1 January 1997 to 30 June 2000



Criterion*	DTPa		Hib		Hep B		MMR		BCG	
	1999	2000	1999	2000	1999	2000	1999	2000	1999	2000
Hypotensive-Hyporesponsive episode	2.1	2.0	-	-	0.0	2.6	-	-	-	-
Convulsions	4.3	0.0	-	-	-	-	-	-	-	-
Skin rash	6.3	2.0	2.6	0.0	5.1	2.6	0.0	4.5	-	-
Lymphadenitis	-	-	-	-	-	-	-	-	124	0.0
Severe local reaction	2.0	8.0	-	-	-	-	-	-	-	-
Distributed doses	47 258	49 153	36 950	35 954	38 600	37 867	30 376	22 143	2419	2370

* NHMRC *The Australian Immunisation Handbook*, 7th edition, p271-75.

- No report.

Video Library

The CDC branch has a small collection of videos that are available for loan.

To request loans of videos send a fax to Ms Helen Masterman, and include video title, number of copies and length of time required.

Video loans will generally be for up to one month, unless specifically requested.

Fax 8226-7197.

Title	date	time: minutes	Producer	Comments
Rubella: German measles. Health protection for you	1999	5.5	The Deafness Association of NT	Promotion of childhood vaccination. Cambodian, Cantonese, English, Indonesian, Mandarin, Portuguese, Thai and Vietnamese.
Rubella: German measles		4.5	Deafness Foundation Vic	Vietnamese version with English subtitles for use by health workers
Protect your baby for life	1997	8.5	SKB, CSL	Childhood immunisation: pertussis, tetanus, diphtheria, Hib, polio, hepatitis B, measles, mumps and rubella. NHMRC Immunisation schedule of 1994 has been replaced on 1 May 2000.
Calling the shots. Where do you stand on immunisation in child care?	1998	15	Centre for Community Child Health, Victoria	Target group: Child Care workers. This video is in the kit distributed to long-term child care centres: <i>Improving infection control in child care centres</i> .
You've got what?	1992	90	SAHC	Seven chapters on common infectious diseases. Target group: Adolescents.
Immunise Australia			Dept of Health and Family Services	Community Education Program, TV advertisements, plus scenarios of Children play group with child coughing, infant patients with pertussis, mother with convalescing child, preparation for an immunisation (oral and injection) session at health centre, series of immunisation (oral and injection) sequences infants and children. May be useful as discussion starters.
Clinical aspects of vaccine-preventable infectious diseases	circa 1997	14	SKB, CSL	Childhood immunisation: pertussis, tetanus, diphtheria, Hib, polio, hepatitis B, measles, mumps and rubella. NHMRC Immunisation schedule of 1994 has been replaced on 1 May 2000. Similar in content to <i>Protect your baby for life</i> , with more detail on the organisms.
Zoonosis: More than a dose of the flu	1991	15-20	AQIS	Target groups: slaughterers, people who work with animals. Note: Q fever vaccine is now licensed and the support group ZAAG no longer exists in Adelaide.
Q fever: testing procedures	N/A	9	CSL	Immunisation providers' training video for giving Q fever vaccination.
Ross River virus. Prevention is the only cure	1992	20	EHB, Health Dept WA	General viewing. Provides an overview of the incidence, impact and control of Ross River virus in WA.
The female of the species	1994		Riverland Local Government Association, SA.	General viewing. Provides an overview of the biology, habits and threats of the mosquito and some tips on how to deal with the nuisance.
Malaria. Epidemiology of malaria	Circa 1993-94	23.5	Roche Products Pty Ltd	Prof. Robert Steffen, Zurich (18 mins) and Dr Robert Kass, Australia (5.5 mins) discuss epidemiology and treatment of malaria.
Immunisation techniques in Australia			Wyeth Lederte Vaccines	Current techniques for injections. For immunisation providers and medical practitioners.
The vaccine cold chain			Wyeth Lederte Vaccines	Target group: Personnel along the way, from the beginning to the end, of the cold chain.
Alien invasion. Prevent hepatitis B. Get the shots	Circa 1998	10	Human Services, Vic	Target group: Year 8 students. Distributed to all high schools.
Medical response to biological warfare and terrorism	1998 6 in series	variable	Food and Drug Administration, Public Health Training Network and US Army Medical Research Institute of Infectious Disease.	Target groups: Management and medical personnel of hospitals. Trainers of medical students. Proceedings of a 3-day course.