On behalf of the Immunisation Section we wish you all a Merry Christmas and Happy New Year

Did you know?

The dTpa (diphtheria-tetanus-pertussis) Boostrix® vaccine will transition from Year 10 to Year 7 of secondary school in 2015. To achieve the transition, in 2015 the Boostrix® vaccine will be offered to all secondary school students in Years 7, 8, 9 and 10. In a community setting these children are aged 12 to 16 years. From 2016 only Year 7 students (12 to 13 years of age) will be offered the Boostrix® vaccine.

Year 9 secondary school boys (aged 14 to 15 years) have until 31 December 2014 to have free human papillomavirus (HPV) vaccine (Gardasil®) doses. From 1 January 2015, doses of HPV vaccine will need to be purchased by prescription for boys aged 14 to 15 years. Promote the importance of a complete course of three HPV vaccine doses with your adolescents and their parent or guardian.

MMR vaccine should still be used at four years of age for children who previously had Priorix® at 12 months of age and Varilrix® at 18 months of age. MMR vaccine will continue on the schedule at four years of age until 31 December 2015. The four-year-old MMR scheduled dose will remain until all children who were aged over 18 months at 1 July 2013 reach the age of four years. After this time four-year-old children will only need one injection, Infanrix IPV® (DTPa IPV) vaccine. Vaccines for four-year-olds can be administered from three years and six months of age.

All vaccines administered to children younger than seven years of age must be reported to the Australian Childhood Immunisation Register (ACIR). At a minimum, reporting should be undertaken weekly. Children who are assessed by the ACIR as ‘not fully immunised’ are either overdue for one or more vaccines or are up-to-date but the vaccine provider has not notified the ACIR. Don’t forget to report influenza vaccine doses administered to children.

An updated Victorian vaccine schedule will be introduced from January 2015. Note the vaccine schedule changes for adolescents (aged 12 to 16 years). Read inside for more information about the schedule changes. Be sure to download the latest version of the vaccination schedule at the start of the year to display for a quick reference. You can download the schedule at <www.health.vic.gov.au/immunisation>.
National Immunisation Strategy 2013–2018

Australia’s National Immunisation Program (NIP) is a strong and internationally recognised program that has achieved a national average of over 90 per cent coverage for most childhood vaccines. Australia’s achievements in immunisation meet international goals set by the World Health Organization under the Global Immunisation Vision and Strategy.

There have been many changes to the NIP in recent years. Vaccines have been added, cohorts have expanded, new vaccine purchasing arrangements have been implemented and there is a greater focus on improving monitoring to ensure vaccine safety. It is now time to build on the strengths of the NIP and identify areas for further improvement.

The National Immunisation Strategy articulates action areas to maintain the successful delivery of the NIP, including addressing current issues to further improve national immunisation and vaccine delivery.

The strategy is consistent with Commonwealth, state and territory government efforts to reform the health system and encourage a greater focus on health rather than illness, as well as contributing to a better preventive health system. Its aim is to prevent disease and severe outcomes by maximising immunisation coverage in people of all ages.

The National Immunisation Strategy comprises eight strategic priority areas with key actions to complement and strengthen the NIP:

- improve immunisation coverage
- ensure effective governance
- ensure secure vaccine supply and efficient use of vaccines
- continue to enhance vaccine safety monitoring systems
- maintain and ensure community confidence in the NIP through effective communication strategies
- strengthen monitoring and evaluation of the NIP through assessment and analysis of immunisation register data and vaccine-preventable disease surveillance
- ensure an adequately skilled immunisation workforce through promoting effective training for immunisation providers
- maintain Australia’s strong contribution to the region.

Vaccine schedule changes from 2015

Gardasil® vaccine catch-up program for Year 9 boys ends

Year 9 secondary school boys (aged 14 to 15 years) have until 31 December 2014 to have the human papillomavirus (HPV) vaccine (Gardasil®) doses for free. You can still order the Gardasil® vaccine for boys aged 14 to 15 years or in Year 9 of secondary school. Promote the importance of a complete course of three HPV vaccines with your adolescents and their parent or guardian.

From January 2015 an incomplete HPV course needs to be completed by the family purchasing the Gardasil® vaccine by prescription. A vaccine course does not need to be restarted if the spacing between doses is longer than recommended. An adolescent with an incomplete vaccine course in 2015 should be recalled and encouraged to complete all three doses.

Report all HPV vaccine doses administered to the National HPV Vaccination Program Register at <www.hpvregister.org.au/>.

Boys and girls aged 12 to 13 years or in Year 7 of secondary school are eligible for the free Gardasil® vaccine in the ongoing secondary school-based vaccine program or in a community setting such as a GP clinic or a local council community session.

Boostrix® transitioning to Year 7 of secondary school

The diphtheria-tetanus-pertussis (dTpa), Boostrix® vaccine will transition from Year 10 to Year 7 of secondary school in 2015. To achieve the transition, in 2015 the Boostrix® vaccine will be offered to all secondary school students in Years 7, 8, 9 and 10. In a community setting these children must be aged 12 to 16 years to be eligible for the free Boostrix®. From 2016, only Year 7 students (children aged 12 to 13 years) will be offered the Boostrix® vaccine.

There are several benefits to moving the Boostrix® vaccine to Year 7:

- earlier boosting protection for adolescents against diphtheria, tetanus and pertussis
- optimising control of pertussis infection to reduce transmission to vulnerable family and community members
- a simpler school-based vaccine program targeting a single year level from 2016
- better Boostrix® vaccine uptake in the school-based program
Childhood vaccine coverage data

The Australian Childhood Immunisation Register (ACIR) provides quarterly vaccination coverage data for Victorian children aged between 12 to less than 15 months (cohort one), 24 to less than 27 months (cohort two) and 60 to less than 63 months (cohort three). The ACIR report measures antigen coverage for diphtheria, tetanus, pertussis, pneumococcal, poliomyelitis, hepatitis B, Haemophilus influenzae type b (Hib), measles, mumps, and rubella.

**Cohort one children** have received their third vaccination for diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B, Hib and pneumococcal, all prior to the age of one year. It is assumed that all previous vaccine doses were received.

**Cohort two children** have received their third vaccination for diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B and their fourth dose of Hib and their first vaccination for measles, mumps and rubella, all prior to the age of two years. It is assumed that all previous vaccine doses were received.

**Cohort three children** have received their fourth vaccination for diphtheria, tetanus, pertussis, poliomyelitis and their second vaccination for measles, mumps and rubella, all prior to the age of five years. It is assumed that all previous vaccine doses were received.

The ACIR does not measure vaccine coverage for:
- hepatitis B vaccine scheduled at birth
- rotavirus vaccine scheduled at two, four and six months of age
- meningococcal C vaccine scheduled at 12 months of age
- varicella vaccine scheduled at 18 months of age.

### Table 1. Vaccine coverage for the three cohorts identified as Aboriginal and/or Torres Strait Islander, Victoria, 30 September 2014.

<table>
<thead>
<tr>
<th>Age cohort in months</th>
<th>State Indigenous coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-&lt;15</td>
<td>88.6%</td>
</tr>
<tr>
<td>24-&lt;27</td>
<td>93.9%</td>
</tr>
<tr>
<td>60-&lt;63</td>
<td>92.2%</td>
</tr>
</tbody>
</table>

Local government area vaccine coverage report

Table 2 presents ACIR quarterly immunisation coverage at 30 June 2014 for children aged 12–<15 months (cohort one), 24–<27 months (cohort two) and 60–<63 months (cohort three). These data were processed at 30 September 2014. Only those immunisation services a child has received up to 12 months, 24 months and 63 months of age are included in this table. The local government area (LGA) is defined by the child’s residential address.

**In cohort one**, 14 per cent (11 of 79) of LGAs achieved immunisation coverage greater than or equal to 95 per cent. Victoria achieved 91.70 per cent coverage in cohort one compared to the Australian coverage of 91.50 per cent. Ararat, Strathbogie and Towong LGAs reported a coverage rate between 80 to less than 85 per cent in age cohort one. Gannawarra, Mansfield, Moyne, Queenscliffe and West Wimmera LGAs reported 100 per cent coverage.

**In cohort two**, 34 per cent (27 of 79) of LGAs achieved immunisation coverage greater than or equal to 95 per cent. State coverage for cohort two was 93.30 per cent compared to the Australian coverage of 92.80 per cent. Indigo, Melbourne and Queenscliffe LGAs reported a coverage rate between 80 to less than 85 per cent in age cohort two. Buloke, Central Goldfields, Hindmarsh, Murrindindi, Pyrenees, Towong and West Wimmera reported 100 per cent coverage.

**In cohort three**, 29 per cent (23 of 79) of LGAs achieved immunisation coverage greater than or equal to 95 per cent. State coverage for cohort three was 92.60 per cent compared to the Australian coverage of 92.20 per cent. Hepburn and Mount Alexander LGAs reported a coverage rate of 80 to less than 85 per cent in age cohort three. Benalla, Buloke, Queenscliffe, Towong and West Wimmera LGAs reported 100 per cent coverage.
Table 2. Local government area vaccine coverage data at 30 June 2014

<table>
<thead>
<tr>
<th>Age group</th>
<th>% fully immunised</th>
<th>Local Government Area (LGA)</th>
<th>Total LGAs</th>
<th>% LGAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohort 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(12–&lt;15 months)</td>
<td>100</td>
<td>Gannawarra, Mansfield, Moyne, Queenscliffe, West Wimmera</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>95+</td>
<td>Benalla, Corangamite, Golden Plains, Horsham, Loddon, Northern Grampians</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>85-&lt;90</td>
<td>Bayside, Cardinia, East Gippsland, Glenelg, Greater Dandenong, Hepburn, Hindmarsh, Manningham, Melbourne, Mildura, Port Phillip, Swan Hill, Wellington</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>80-&lt;85</td>
<td>Ararat, Strathbogie, Towong</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Cohort 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(24–&lt;27 months)</td>
<td>100</td>
<td>Buloke, Central Goldfields, Hindmarsh, Murrindindi, Pyrenees, Towong, West Wimmera</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>95+</td>
<td>Ballarat, Bass Coast, Baw Baw, Benalla, Campaspe, Colac-Otway, Corangamite, East Gippsland, Golden Plains, Greater Bendigo, Horsham, Loddon, Manningham, Mildura, Moira, Moorabool, Moyne, Strathbogie, Wangaratta, Wodonga</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>85-&lt;90</td>
<td>Alpine, Ararat, Greater Dandenong, Hepburn, Mansfield, Port Phillip, South Gippsland</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>80-&lt;85</td>
<td>Indigo, Melbourne, Queenscliffe</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Cohort 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(60–&lt;63 months)</td>
<td>100</td>
<td>Benalla, Buloke, Queenscliffe, Towong, West Wimmera</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>95+</td>
<td>Ararat, Campaspe, Central Goldfields, Gannawarra, Golden Plains, Greater Bendigo, Hindmarsh, Horsham, Latrobe, Mitchell, Moonee Valley, Moorabool, Moyne, Northern Grampians, Strathbogie, Warrnambool, Wodonga, Yarriambiack</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>85-&lt;90</td>
<td>Alpine, Bass Coast, Glenelg, Greater Dandenong, Indigo, Melbourne, Port Phillip, Pyrenees, Swan Hill, Wangaratta</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>80-&lt;85</td>
<td>Hepburn, Mount Alexander.</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Vaccines administered to children younger than seven years of age must be reported to ACIR. At a minimum, this reporting should be undertaken weekly. Children who are assessed by the ACIR as ‘not fully immunised’ are either overdue for one or more vaccines or the child is up-to-date with their vaccines but the vaccine has not been notified to the ACIR.

You can implement systematic processes in your practice to improve reporting, for example by:

• recording childhood vaccine encounters to ACIR online at <www1.medicareaustralia.gov.au/ssl/acircirgseco>
• making sure your practice management software is enabled to report vaccines to the ACIR
• accessing the ACIR 11B – Due/Overdue report for each GP provider; recalling the overdue children and reminding the due children of a vaccine appointment using information technology
• reviewing the monthly ACIR statement to check payment has been made and if any amendment is required for the data notified to ACIR.

**The benefits of reporting to ACIR electronically**

**Timely reporting**

ACIR ‘purple forms’ can remain in the clinic for longer than a week before being posted to ACIR. There can also be a delay in data entry once the notification is received by ACIR thereby delaying a timely update to the child’s vaccine history. Online reporting avoids delays.

**Timely access to immunisation incentive and notification payments for parents and GPs**

Delaying the notification report means that a child’s vaccine history may appear overdue. Until the data is transmitted, parents will be unable to claim immunisation incentive payments. In addition, GPs will not receive their notification payment until the data is received to complete the child’s vaccine schedule.

**Reduce data entry error**

The ACIR ‘purple form’ must be entered manually which sometimes leads to data entry error. Reporting online reduces the number of people involved in processing a report thereby decreasing the likelihood of an error with the data entry.
Simultaneous injections by two immunisation providers – a case report

A four-year-old girl presented to her healthcare facility for routine diphtheria, tetanus, pertussis, polio (DTPa-IPV) and measles, mumps, rubella (MMR) vaccines. Her sibling also presented for routine 18-month-old measles, mumps, rubella, varicella (MMRV) vaccine. The required vaccines were prepared for both children. The four-year-old child was vaccinated first with two nurses administering the vaccines simultaneously. The MMR and MMRV vaccines were administered instead of the MMR and DTPa–IPV vaccines.

The error was immediately detected and acknowledged to the family. The mother was upset but agreed to have the DTPa–IPV administered to her four-year-old at the time of the appointment. The error was reported to SAEFVIC, the Victorian vaccine safety service. SAEFVIC initially contacted the family and again on day seven after vaccination. SAEFVIC discussed with the family the increased risk of fever and febrile seizure when MMRV vaccine is administered as the first dose of MMR containing vaccine. No adverse event following her vaccinations was reported.

Discussion – Simultaneous injections

When two injections are required, some immunisation providers choose to give both injections simultaneously into each limb by two people rather than sequential administration. This case study highlights the need for a systematic approach and clear communication between immunisation providers to avoid a vaccine error. Strategies that may assist in preventing these types of errors could be to prepare the vaccines for one child at a time. Another approach could be that both vaccinators ensure they have verbalised which vaccine they have prior to administration.

Vaccine errors involving the wrong patient commonly involve family members presenting for vaccination at the same visit. This highlights the need for additional precautions when providing vaccines to more than one family member at the same visit. A strategy to consider for this scenario includes preparing a workflow system for clinical staff to routinely follow procedure when preparing and administering the vaccines. The procedure should include failsafe measures for checking the correct vaccine and dose is given to the correct person, via the correct route, at the correct time.

Currently there is insufficient evidence for or against having two immunisation providers administer vaccines at the same time rather than one vaccine after the other. Two studies were unable to demonstrate a difference in pain response in the child between simultaneous administration and sequential administration.

As a passive surveillance system, SAEFVIC relies on adverse event reporting by healthcare practitioners and consumers. While SAEFVIC may only capture a proportion of vaccine administration errors in Victoria, they are provided with an overview of the types of errors that do occur. SAEFVIC offers expert advice for individual management. Through education SAEFVIC aims to help reduce the incidence of preventable vaccine errors.

If you experience a vaccine error or adverse event following vaccination, please call SAEFVIC on 1300 882 924 (option 1) between 9.00 am – 4.00 pm or report online at <www.saefvic.org.au> or fax on (03) 9345 4163.

Further reading

Measles – a case study

Key messages

• Confirm or encourage measles vaccination for any person born since 1966 - apply this rule to yourself and colleagues – don’t assume you are immune!
• Be alert for measles in patients presenting with a febrile rash.
• Minimise the risk of transmission within your department/practice through immediate isolation of suspected cases.
• Measles virus is very infectious and can remain in the environment for 30 minutes.
• Notify Communicable Disease Prevention and Control at the Department of Health of suspected and confirmed cases immediately on 1300 651 160.
• Take blood for serological confirmation and nose and throat swab for PCR diagnosis.

The shopping centre: In early July 2014, a seven-year-old boy unwell with measles saw a movie at Highpoint shopping centre. He had recently returned from Taiwan. That same day, five-year-old twin girls, also visited Highpoint. Somewhere at the centre the children crossed paths and transmission occurred, simply by breathing, coughing or sneezing in close proximity. The twins contracted measles two weeks apart. The seven-year-old boy also infected his nine-year-old sister, who flew to Tasmania while infectious. None of the children had received measles vaccination.

The medical centres: The first twin visited two GPs and was seen by four physicians at a large metropolitan hospital presenting with the classic symptoms of measles including the febrile rash but she was not tested for measles. One GP suspected measles but did not notify the department of their suspicion.

The primary school: Both girls attended primary school while infectious with measles. They also attended a school photo session, after school care, and various public spaces including playgrounds. The primary school was asked to review the school enrolment immunisation status certificates to identify unvaccinated children.

The certificates showed that six students were unvaccinated including the twins. Seven children were excluded from attending the school until the risk of infection had passed, including a student who was immunocompromised. A total of five out of six unvaccinated children at the school contracted measles. These children attended extra community activities (sporting and music events) and multiple GP waiting rooms while infectious.

The sports field: One student attended his football grand final, even managed to score a goal while infectious! All team members and parents were advised about a case of measles in the team. Fourteen days later, the team’s two adult trainers (both born between 1966–1980), developed symptoms consistent with measles, saw their GPs but were not tested for measles even though they presented letters explaining their measles exposure. Both men were hospitalised with measles. Their vaccine history was unknown and blood results confirmed they were unimmunised.

The workplace: One football trainer, a truck driver by profession, had been driving around Melbourne making deliveries while infectious.

The personal life: One man’s wife was 39 weeks pregnant. Serology showed she had measles immunity. While infectious, the husband had attended several prenatal classes with his wife. Extensive contact tracing of the maternity hospital was carried out to ensure that all pregnant women who had contact with the case were immune. Unfortunately, the husband was in isolation when his wife went into labour, and missed the birth of his first child.

A measles outbreak can touch hundreds of lives and highlights near misses and system failure. This case study demonstrates the far reaching and unexpected consequences of having no immunity to measles. Exclusion, isolation and vaccination kept the vulnerable protected such as the immunocompromised, pregnant and newborns.

As part of the Health Department’s response, 41 exposure sites were actively followed up, involving hundreds of people. The total number of cases linked to the seven-year-old unvaccinated boy who contracted measles on his trip to Taiwan currently stands at 10.
Measles – clinical predictors

The most important clinical predictors for measles are:

- generalised maculopapular rash (usually starting on the face), lasting three or more days
- fever (at least 38 °C, if measured) present at the time of rash onset
- cough or coryza or conjunctivitis.

Measles is transmitted by airborne droplets and direct contact with discharges from respiratory mucous membranes of infected persons and, less commonly, by articles freshly soiled with nose and throat secretions.

The incubation period is variable and averages 10 days (range: 7–18 days) from exposure to the onset of fever, with an average of 14 days from exposure to the onset of rash.

The infectious period of patients with measles is five days before to four days after the appearance of the rash.

Catch-up vaccine quiz

Siblings aged five and eight years attend your health service, they have not been vaccinated. Neither child has a high-risk medical condition or a contra-indication to vaccination. The family wish the children to be up-to-date with their vaccines now. The family are Medicare card holders. As the children are younger than 10 years of age, they are eligible for free government supplied vaccine. (Visit Free vaccine Victoria – Criteria for eligibility at <www.health.vic.gov.au/immunisation/free-vaccine.htm>).

Plan the vaccine catch-up program you would propose for each child.

Visit the Australian immunisation handbook, p. 50, Table 2.1.7 Minimal acceptable dose intervals for children <10 years of age at <immunise.health.gov.au/internet/immunise/publishing.nsf/Content/handbook10-2-1#table2.1.7>. Answer on the back page.

Correction: Issue 71, October 2014, Immunisation catch-up quiz: test your skills, Case 1 and Issue 65, October 2013, A case study for catch-up. Following the administration of Infanrix hexa® at 15 months, Menitorix® should be administered two months later as the Haemophilus influenza type b booster dose.

Cold chain preparation while on holiday

Before closing your clinic

• Reduce orders to minimise the vaccine stock levels held in the fridge over the holiday period.
• Check that the door is closed firmly and lock the fridge if possible.
• Check that the power supply at the facility remains on.
• Record the minimum and maximum temperatures at the end of the last working day.

Reopening your clinic

• Record the minimum and maximum temperatures at the start of the first working day.
• Check and download the data logger if available.
• Report a breach to the Immunisation Section as soon as practicable.
• Reorder stock for use over the coming one-month period if the fridge is in order.

Report a cold chain breach (a temperature recording of less than 2°C or greater than 8°C for longer than 15 minutes)

• Download and complete the cold chain breach form at <www.health.vic.gov.au/immunisation>.
• Fax the form to 1300 768 088 or email it to <immunisation@health.vic.gov.au>.
• Put a sign on the fridge ‘Do not use or discard vaccines until further notice’.
• Vaccine advice will be provided, or call the Immunisation Section on 1300 882 008.

RotaTeq® vaccine administration has strict cut-off dates

RotaTeq® vaccine administration has strict cut-off dates for the commencement of the first oral dose and for the completion of the third dose.

If the first dose is not given by 12 weeks of age, RotaTeq® should not be administered to the child at any stage after this time.

You must commence the RotaTeq® vaccine before the infant is older than 12 weeks, that is, no later than 12 weeks and six days (less than three months old). The last dose of RotaTeq® vaccine for an infant must be given by 32 weeks of age, that is, no later than 32 weeks and six days (less than seven and a half months old). The minimum interval between doses is four weeks.

The RotaTeq® wheel provides accurate guidance to ensure the vaccine is administered within the safe cut-off times. Order the wheel by emailing <Leanne.Whitlock@biocsl.com.au>. 
Hepatitis B vaccine birth dose coverage data

The hepatitis B vaccine birth dose has been scheduled on the National Immunisation Program since May 2000 and is recommended for all newborn infants. The rationale for every infant to be offered the birth dose is not only to prevent vertical transmission from a carrier mother (recognising that there may be errors or delays in maternal testing, reporting, communication or appropriate response), but also to prevent horizontal transmission in the first months of life from a carrier among household or other close contacts.

The hepatitis B vaccine dose should be administered within 24 hours of birth, and definitely within seven days. Every effort should be made to administer the dose before discharge from the obstetric hospital or delivery unit.

Perinatal data is submitted by the healthcare provider for every birth in Victoria. The Victorian Perinatal Data Collection (VPDC) captures the number of hepatitis B vaccine doses administered within seven days of birth, for all live births in Victoria. The graph depicts percentage of newborns in Victoria, from 2009 to 2012, who have either received hepatitis B vaccine before or at seven days of age; after seven days of age; not received the vaccine; or not stated if they had received the vaccine.

Administration of the birth dose of hepatitis B vaccine in Victoria

All newborns of mothers known to have chronic hepatitis B infection must be given a birth dose of hepatitis B vaccine and hepatitis B immunoglobulin (HBIG).


Hepatitis B vaccine is a very safe and effective vaccine to protect against the inadvertent transmission of the hepatitis B virus to the infant. An unnecessary delay in the administration of the birth dose of hepatitis B vaccine may have long-term health implications for the infant if they are at risk of exposure to the hepatitis B virus.

Order the free Infant hepatitis B brochure for families so they can understand the importance of the birth dose of the hepatitis B vaccine. Order at <ideas.health.vic.gov.au/resources-immunisation.asp>. The brochure has been translated in a range of community languages from Arabic to Vietnamese. Download the translated resource from the department’s immunisation website at <www.health.vic.gov.au/immunisation/factsheets/language.htm>. 
Catch-up vaccine answer

Unimmunised siblings aged five and eight years of age have presented for vaccine catch-up. According to the Australian childhood immunisation handbook, 10th edition, 2013 (updated January 2014), page 49 and page 50; both children would be eligible for the proposed catch-up vaccine schedule.

Alternative catch-up vaccine plans can also be formulated for this scenario.

<table>
<thead>
<tr>
<th>Minimum interval for further doses</th>
<th>Infanrix IPV®</th>
<th>HB-Vax-II® Paediatric</th>
<th>Menitorix®</th>
<th>Priorix-Tetra®</th>
<th>Priorix® or M-M-R11®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose due now</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4 weeks</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>4 weeks</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8 weeks</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4 months</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Comments: 4th dose spaced 6 months after 3rd dose. Minimum 4 months space between dose 1 and dose 3. Aged over 4 years therefore a reduced incidence of febrile seizure.

Further reading

Missed opportunities for HPV vaccination in adolescent girls: A qualitative study

Research indicates that provider recommendation is the key to improving HPV vaccination rates and that most adolescents who are unvaccinated received other vaccines, indicating missed opportunities for HPV vaccination. This study explores in-depth the content of provider–patient conversations that either create or prevent opportunities for HPV vaccination. Effective and ineffective conversations are presented with the goal of providing practical tools to improve communication regarding HPV vaccines.


Contact

For further information on the Immunisation Section please contact:

Immunisation Section, Department of Health
50 Lonsdale Street, Melbourne 3000

Phone: 1300 882 008
Fax: 1300 768 088
Email: immunisation@health.vic.gov.au

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