

**Hepatitis A for Aboriginal Persons
Information for Health Care Providers
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Background & Rationale:

1. Why is this program being offered?

There has been an outbreak of hepatitis A in several First Nations communities on Vancouver Island, beginning in the fall of 2010. Four of the five hepatitis A outbreaks in BC in the past 15 years have been in First Nations Communities.

Higher rates of hepatitis A are common in First Nations communities due to a variety of socioeconomic factors, including crowded housing, family structures, cultural gatherings and mobility. Due to the evidence of ongoing transmission of hepatitis A and the importance of social gatherings and mobility between First Nation communities, hepatitis A vaccine will be introduced into the routine schedule for Aboriginal infants and pre-school children in an attempt to reduce transmission, as First Nations individuals constitute approximately 98% of Aboriginal persons in BC.

2. Why are we only offering vaccine to Aboriginal children?

The main targets for this program are infants, toddlers and young children since hepatitis A infections in the young are often asymptomatic, going undetected and hence are more likely to spread the illness. Most Aboriginal people over the age of 35 years are likely already exposed and immune to hepatitis A.

3. When are these program changes taking effect?

Starting in January of 2012, hepatitis A vaccine will be provided to Aboriginal individuals, living on and off reserve, from 6 months to 18 years of age inclusive.

Identifying eligible clients:

4. How can Aboriginal persons be identified in a culturally sensitive manner?

Aboriginal persons include First Nations individuals, Métis, and Inuit people. Self-identification by community members as Aboriginal or as being of Aboriginal descent is sufficient criteria for eligibility for this program.

It is recommended that a question about ethnicity be included in all client encounters.

Some providers may be unsure about how to inquire about ethnicity in a culturally sensitive manner. The Health Research and Educational Trust Disparities Toolkit (2009) suggests language similar to the following:

"We want to make sure that our clients are offered all of the immunizations for which they are eligible. It is therefore our standard of practice to ask every client about their ethnic background. Would you describe yourself or your child as being of Aboriginal ancestry?"

5. Should Aboriginal ethnicity be recorded?

Please follow your local policy and procedures for recording the provision of this Hep A program to Aboriginal clients.

Vaccine dose and programmatic issues:

6. What are the recommended doses and intervals?

Routine:

- Infants: Dose 1, 0.5 mL IM at 6 months of age
 Dose 2, 0.5 mL IM at 18 months of age

This schedule was chosen because the infant schedule at 12 months contains 4 or 5 injections (PCV13, MCC, MMR, Varicella and influenza [influenza offered from October to April]), while the 18 month schedule contains only 1 (DTaP-IPV-HIB).

- Unimmunized Children at School entry (4-6 years of age):
Dose 1, 0.5 mL IM
Dose 2, 0.5 mL IM after an interval of 6 months
- Children who have received 1 dose prior to school entry (4-6 years of age):
Dose 2, 0.5 mL IM at presentation and after an interval of at least 6 months from previous dose.

Permissive:

- Children presenting for first dose prior to school entry (18 months - 3 years)
 - Can be given 2 doses of vaccine, 6 months apart
- Children and adolescents 7 to 18 years of age (inclusive):
 - Provide on an opportunistic basis.
 - Use age appropriate dosage for hep A vaccine product used.
 - Provide 2 doses, at least 6 months apart.
 - Provide 3 doses (0, 1 and 6 months) for individuals who are HIV positive

For more information see:

<http://www.bccdc.ca/dis-cond/comm-manual/CDManualChap2.htm>

7. What is the minimum age for a first dose of Hepatitis A vaccine?

The minimum age for a first dose of Hepatitis A vaccine is 6 months (26 weeks) of age. The minimum interval between dose 1 and dose 2 is also 6 months.

Note: infants that started their immunizations at 8 weeks of age may be presenting for their 6th month visit at 24 weeks of age, if they have maintained the 8 week intervals between visits. Determine eligibility for the Hep A vaccine at the 4 month immunization visit. If the infant is eligible to receive Hepatitis A vaccine, schedule the next appointment when the infant will be **chronologically** 6 months of age, to avoid two separate visits for the “6th months” needles and hepatitis A vaccine.

8. The currently-supplied pediatric vaccine is licensed for use up to 17 years of age, and the adult vaccine currently available is licensed for use starting at 19 years of age. How do we provide vaccine to someone who is 18 years old?

The recommendation in this situation is to use a 1 mL dose of the adult formulation (Havrix® 1440 ELU) to immunize the client. This “off label” use is the most practical solution to addressing the age gap between the currently available products. When a different vaccine is supplied, check the upper age for administration to children. And the lowest age for administration to adults, and choose the appropriate vaccine/dose for the client. For example, Havrix® pediatric formulation (720 ELU) will be supplied shortly and can be used for children to 18 years of age.

9. If an 18 year old does not return for the second dose in the vaccine series until they are 19 years of age or older, do we provide the second dose at this later age?

The BC guidelines describe the “once eligible, always eligible” principle (Section IIA, Immunization Schedules). The series would be completed at whatever age the eligible client presents for the second dose.

10. The pediatric hepatitis A vaccine product monographs indicate the vaccines are licensed for infants at 12 months of age. Can these vaccines be given at 6 months of age?

Yes. Numerous studies have demonstrated the immunogenicity and safety of the vaccine given at 6 months of age.

11. What if a client presents for dose 2 more than 6 months after dose 1?

When dose 2 has not been given 6 months after dose 1, the second dose should be administered when the individual presents. There is no need to restart the series.

12. Is post vaccination serology indicated?

The high response rate to the vaccine makes routine serologic testing unnecessary. Commercial testing is not sensitive enough to reliably pick up vaccine induced immunity.

13. What is the expected duration of protection?

Studies suggest that protection will persist for at least 20 years. There are no recommendations for booster doses at this time.

References

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