THE CSTE WASHINGTON REPORT

Marcia S. Mabee, MPH, PhD
Editor
11479 Waterview
Reston, Virginia 20190
mmabee@ix.netcom.com
703-709-3001

January 6, 2006 Volume 10, Number 1

INSIDE THIS ISSUE

… CONGRESS FINISHES APPROPRIATIONS

… MORE CHILDREN IN THE UNITED STATES WILL BE PROTECTED, AND BE PROTECTED FROM MORE DISEASES

… PROGRESS MADE IN ESTIMATING FREQUENCY OF BIRTH DEFECTS: NEW NUMBERS PROVIDE IMPROVED NATIONAL ESTIMATES FOR 18 BIRTH DEFECTS

… PARASITES SHOW SIGNS OF RESISTANCE TO MALARIA TREATMENT

EDITOR'S NOTE: The 2006 Childhood and Adolescent Immunization Schedule was released January 5, with the updated schedule including new recommendations that will help protect adolescents from meningitis and pertussis (also known as "whooping cough") and all children from hepatitis A. The annual childhood and adolescent immunization schedule is a joint effort of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The 2006 immunization schedule can be located at CDC's Morbidity and Mortality Weekly Report (MMWR) Recommended Childhood and Adolescent Immunization Schedule --- United States, 2006-- additional information is included in this Washington Report.

The *CSTE Washington Report* is provided as an information resource for members of the Council of State and Territorial Epidemiologists on federal legislation and regulation affecting public health and epidemiology in the U.S. Legislation cited in the report can be accessed via http://www.thomas.loc.gov Regulations cited can be accessed via http://www.gpo.gov

CONGRESS FINISHES APPROPRIATIONS – Congress completed all FY 2006 appropriations bills, including the Labor-HHS Education bill which funds all public health programs, before adjourning the first session of the 109th Congress just before the Christmas holiday. As reported in the December 15th CSTE Washington Report, the House adopted the second conference report, after the first one was defeated for underfunding an array of health programs, on a close 215-213 margin. Conferees had added back $90 million for rural health programs which bought enough support to pass the final bill. The Senate followed suit a few days later, but passed the bill late at night on a voice vote; no votes were recorded. A provision added to the Department of Defense Appropriations bill also cut all discretionary programs, except the Veterans Administration, by 1%. You can read the final conference report at, 109-337 at: www.thomas.loc.gov

Below are some specific numbers for selected health programs of interest:

Centers for Disease Control and Prevention

FY2005	$ 6,398,600,000
FY2006 Conference	$ 6,150,000,000
FY2006 – 1%	$ 6,088,500,000

Infectious Diseases, Immunization, AIDS, STDs, TB

FY2005	$ 1,674,000,000
FY2006 Conference	$ 1,710,200,000
FY2006 – 1%	$ 1,692,900,000

Chronic Diseases, Birth Defects and Disabilities

FY2005	$ 1,021,000,000
FY2006 Conference	$ 971,200,000
FY2006 – 1%	$ 961,488,000

Health Statistics, Infomatics, Health Marketing

FY2005	$ 228,700,000
FY2006 Conference	$ 223,800,000
FY2006 – 1%	$ 221,562,000

Environmental Health and Injury Prevention and Control

FY2005	$ 285,700,000
FY2006 Conference	$ 287,700,000
FY2006 – 1%	$ 284,823,000

Occupational Safety and Health

FY2005	$ 286,000,000
FY2006 Conference	$ 257,000,000
FY2006 – 1%	$ 254,430,000

Global Health

FY2005	$ 316,100,000
FY2006 Conference	$ 313,300,000

FY2006 – 1%	$	310,167,000

Public Health Research

FY2005	$	31,000,000
FY2006 Conference	$	31,000,000
FY2006 – 1%	$	30,690,000

Public Health Improvement and Leadership

FY2005	$	266,800,000
FY2006 Conference	$	206,500,000
FY2006 – 1%	$	204,435,000

Preventive Health and Health Services Block Grant

FY2005	$	118,500,000
FY2006 Conference	$	100,000,000
FY2006 – 1%	$	99,000,000

Public Health and Bioterrorism Preparedness Funds

FY2005	$	919,100,000
FY2006 Conference	$	832,000,000
FY2006 – 1%	$	823,680,000

Emergency Preparedness Stockpile

FY2005	$	466,700,000
FY2006 Conference	$	530,000,000
FY2006 – 1%	$	524,700,000

Infectious Disease Prevention and Control

FY2005	$	226,000,000
FY2006 Conference	$	229,059,000
FY2006 – 1%	$	226,800,000

Environmental Health – Health Tracking Grants

FY2005	$	24,400,000
FY2006 Conference	$	24,400,000
FY2006 – 1%	$	24,200,000

BRFSS

FY2005	$	7,640,000
FY2006 Conference	$	7,640,000
FY2006 – 1%	$	7,560,000

HIV/AIDS Surveillance

FY2005	$	58,000,000
FY2006 Conference	$	58,000,000
FY2006 – 1%	$	57,000,000

National Violent Death Reporting System

FY2005	$	3,469,000
FY2006 Conference	$	3,469,000
FY2006 – 1%	$	3,430,000

Injury Prevention and Control

FY2005	$	138,237,000
FY2006 Conference	$	140,440,000
FY2006 – 1%	$	139,035,000

Occupational Surveillance

FY2005	$	1,500,000
FY2006 Conference	$	1,500,000 (estimated)
FY2006 – 1%	$	1,500,000 (estimated)

MORE CHILDREN IN THE UNITED STATES WILL BE PROTECTED, AND BE PROTECTED FROM MORE DISEASES -- The 2006 Childhood and Adolescent Immunization Schedule was released January 5, with the updated schedule including new recommendations that will help protect adolescents from meningitis and pertussis (also known as "whooping cough") and all children from hepatitis A. The annual childhood and adolescent immunization schedule is a joint effort of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The 2006 immunization schedule can be located at CDC's Morbidity and Mortality Weekly Report (MMWR) Recommended Childhood and Adolescent Immunization Schedule --- United States, 2006

" This new schedule reflects the great strides we are making to protect children against serious diseases," said Anne Schuchat, M.D., director of the National Immunization Program at the Centers for Disease Control and Prevention (CDC). "Thanks to new vaccines, we can now protect children and adolescents from more diseases than at any time in our history. In almost every case, vaccines are the best and most effective way to prevent the harm that is caused by these infectious diseases."
The recently licensed meningococcal conjugate vaccine (MCV4) is being recommended to protect against meningococcal disease, while the new Tetanus, Diphtheria and acellular Pertussis recommendation stems from the availability of new "booster" vaccines known as Tdap that will help reduce the number of cases of whooping cough among adolescents. Under the updated schedule, these vaccines would be routinely administered to children when they are 11 to 12 years old.

Another update to the childhood immunization schedule involves influenza vaccination. The health groups expanded the annual influenza vaccination recommendation to now include all children and adults with neurological conditions that can cause breathing or swallowing difficulties (e.g., spinal cord injuries, seizure disorders, or other neuromuscular disorders).

In addition, the new schedule includes updates for hepatitis A and hepatitis B vaccination. The hepatitis A vaccine recommendation has been expanded to include vaccination of all children at one year of age. Children who have not been vaccinated at 1 to 2 years of age should be vaccinated at visits during the pre-school years. Previously, the CDC's Advisory Committee on Immunization Practices (ACIP) had recommended routine vaccination only for children living in the 17 states that had the greatest number of reported hepatitis A cases. It is estimated that there are 20,000 to 30,000 cases of hepatitis A per year, with the majority of cases reported in areas where the vaccine has not been recommended. The new recommendation recognizes the need to protect all children, regardless of where they live, and is expected to greatly reduce the number of hepatitis A infections in the United States.
The hepatitis B vaccination recommendation has been strengthened to emphasize vaccination of all infants beginning at birth and the screening of all pregnant women for hepatitis B surface antigen (HBsAg), which is a marker for the disease. The new recommendation states that vaccination of infants born to HBsAg negative mothers should only be delayed in rare circumstances and then only if a physician's order to withhold the vaccine and a copy of the mother's HBsAg negative laboratory report are documented in the infant's medical record.

Additional background information on new recommended vaccines

Meningococcal Polysaccharide Diphtheria Toxoid Conjugate Vaccine (MCV4): This vaccine was licensed in January 2005. It is now recommended for routine vaccination of children 11-12 years old, and is also recommended for previously unvaccinated adolescents when they enter high school, and college freshmen living in dormitories. Meningococcal disease is a rare but serious bacterial infection that strikes up to 3,000 Americans every year. This new vaccine offers protection against four of the most common serogroups (A, C, Y, W-135) that cause meningococcal disease and is a step forward in protecting adolescents and adults from meningococcal disease.

Booster tetanus, diphtheria and pertussis (Tdap) vaccine for adolescents 11 and 12 years of age: This vaccine will be given in place of the tetanus-diphtheria (Td) booster typically given to adolescents. Tdap is also recommended for adolescents 13 through 18 years of age who did not receive the Td vaccine when they were 11 to 12 years of age. However, all adolescents 11 to 18 years of age who have already been vaccinated with Td are encouraged to receive a dose of Tdap at intervals shorter than 10 years to add protection against pertussis. Infants less than 12 months of age have a high risk of pertussis-related complications, hospitalizations and death. Vaccinating adolescents and adult contacts may also reduce the risk of transmitting pertussis to infants. Although pertussis is most serious in infants, it can also be serious in adolescents and adults.

PROGRESS MADE IN ESTIMATING FREQUENCY OF BIRTH DEFECTS: NEW NUMBERS PROVIDE IMPROVED NATIONAL ESTIMATES FOR 18 BIRTH DEFECTS -- Among the 18 major birth defects studied, orofacial clefts (cleft lip and cleft palate) were the most common birth defect in the United States, affecting an estimated 6,800 infants annually, according to the Centers for Disease Control and

Prevention (CDC) estimates released in its journal Morbidity and Mortality Weekly Report (MMWR). Major birth defects are conditions that are present at birth and have a serious, adverse impact on health, development or functional ability.

The condition with the second highest prevalence was Down syndrome, which affects about 5,500 infants a year. Among the 18 major birth defects selected for this study, each of 10 different types of birth defects affected more than 1,000 babies per year.

“Birth defects are a leading cause of death in the first year of life,” said José Cordero, director of CDC’s National Center on Birth Defects and Developmental Disabilities. “With more accurate estimates of how often and where birth defects are occurring, we hope to learn more about how we can prevent them. With improved information, we can better plan for and address the health and education needs of children with birth defects.”

Although federal, state and local surveillance data suggest that approximately 3 percent of babies born in the United States are affected by a major birth defect of some type, this is the first effort to develop population-based national prevalence estimates for these 18 specific birth defects.

The data used to develop the national estimates came from 1999-2001 National Birth Defects Prevention Network (NBDPN) information for 11 states: Alabama, Arkansas, California, Georgia, Hawaii, Iowa, Massachusetts, North Carolina, Oklahoma, Texas and Utah. These states are the only ones that send staff to hospitals to review records and identify babies with the 18 major birth defects for which the national prevalence was estimated.

CDC used the pooled state-level data and applied it to the U.S. population overall after adjusting for race/ethnicity or the age of the mother. The report represents important progress toward estimating national prevalence for 18 major birth defects using population-based data. The population-based national estimates are important to help plan for children’s health care and educational needs, and to help determine resource needs for basic and public heath research.

For example, national prevalence estimates were previously made for neural tube defects including spina bifida (failure of the spine to close properly during fetal development resulting in significant damage to the nerves and spinal cord) and anencephaly (failure of the top of the neural tube to close properly resulting in absence of a major portion of the brain and skull) to assess the impact of folic acid fortification. These efforts found that neural tube defects declined 26 percent following folic acid fortification of the U.S. cereal and grain supply.

The National Birth Defects Prevention Network collects data from 34 participating states on up to 45 major birth defects. The CDC assisted in the development of the NBDPN and supports the organization’s surveillance activities. The network’s efforts to standardize and improve methods for identifying birth defects and tracking surveillance have

facilitated important projects such as the estimates published today. The support of the March of Dimes has also been critical in this effort.

January is Birth Defects Prevention Month, designed to highlight steps women can take to help achieve a healthy birth. In addition, January 9-16 is Folic Acid Awareness Week, highlighting the importance of folic acid – a B-vitamin – in preventing neural tube defects.

PARASITES SHOW SIGNS OF RESISTANCE TO MALARIA TREATMENT -- Some malaria parasites show signs of potential resistance to artemisinin derivatives, drugs derived from the sweet wormwood plant, *Artemisia annua*, according to the National Academies. Malaria treatments containing artemisinins typically cure 90 percent of patients within days, even in areas with parasites resistant to other drugs.

Malaria is responsible for more than a million deaths every year, according to the World Health Organization. Falciparum malaria, caused by the protozoan parasite *Plasmodium falciparum*, is the deadliest form of the disease in humans and the focus of most research on resistance to antimalarial drugs. Scientists recently analyzed *P. falciparum* from blood samples of patients in Cambodia, French Guiana, and Senegal to set up an early-warning system for signs of resistance. They found no molecular signs of resistance to an artemisinin derivative in samples from Cambodia, but they did find evidence of resistance in some samples from French Guiana and Senegal. In a study published in the British medical journal *The Lancet*, the scientists stressed the need for increased vigilance and a coordinated and rapid deployment of drug combinations to avert further development of resistance to artemisinin-derived drugs.

There are several National Academies reports on malaria control. The Institute of Medicine report *Saving Lives, Buying Time: Economics of Malaria Drugs in an Age of Resistance* offers recommendations on maximizing the effectiveness of antimalarial drugs, emphasizing the use of artemisinin-based combination therapies, and the creation of a global subsidy that would make these effective combination treatments affordable and widely available in nations heavily afflicted by the disease. *Microbial Threats to Health: Emergence, Detection, and Response* discusses the current state of knowledge and policy pertaining to emerging and re-emerging infectious diseases and urges the U.S. government play a significant role in building the capacity of poor countries to monitor, prevent, and respond to disease outbreaks. The National Research Council report *Malaria Control During Mass Population Movements and Natural Disasters* reviews recent scientific literature relevant to establishing malaria control programs in situations involving forced migration, conflict, and other emergencies.