NASTAD
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May 23, 2005

Larry Pickering, MD
Executive Secretary
Advisory Committee on Immunization Practices
National Immunization Program
Centers for Disease Control and Prevention
1600 Clifton Road, MS E05
Atlanta, GA 30333

RE: DRAFT RECOMMENDATIONS ON HEPATITIS B IMMUNIZATION

Dear Dr. Pickering:

On behalf of the National Alliance of State and Territorial AIDS Directors (NASTAD), whose members are responsible for administering HIV prevention and care programs funded by the states and the federal government, I am writing to provide comments on the Advisory Committee on Immunization Practices (ACIP) draft statement on hepatitis B immunization. NASTAD members are increasingly responsible for developing and implementing adult viral hepatitis prevention and care programs, and are deeply concerned about the continued transmission of hepatitis B among persons at risk of or infected with HIV, STDs and/or hepatitis C. We believe that one of the most important roles of our public health system is to protect the health of our nation's most vulnerable populations. The low rates of immunization against hepatitis B virus (HBV) infection among adults at risk clearly highlights our failure in fulfilling this mission.

The draft hepatitis B immunization statement is quite comprehensive, and we applaud the Centers for Disease Control and Prevention (CDC) for developing such strong recommendations, particularly for persons visiting public health settings (e.g., STD clinics, HIV counseling and testing sites), infected with HIV or living with chronic liver disease. However, because of demonstrated obstacles and the practicalities of vaccine implementation in the field, we feel that the ACIP must go a step further and strengthen its recommendations to support age-based, universal hepatitis B vaccination for adults. We know that in busy public health settings, clinicians required to screen for sexual or drug risk behaviors may skip risk questions for a variety of reasons, and consequently miss vaccinating susceptible clients. Additionally, persons infected with hepatitis C may not have the financial means to receive a medical evaluation to determine the extent or scope of liver damage, and this should not serve as a barrier to vaccination. And finally, many persons at high risk of HIV, STDs or hepatitis C do not visit public health settings, and may be uncomfortable disclosing "risk" behaviors to a private sector medical provider.

The most effective way to ensure that all persons are protected against HBV infection is to recommend age-based universal hepatitis B vaccination for adults. An age-based rather than risk-based hepatitis B vaccination strategy may also serve to reduce the stigma associated with hepatitis B vaccine use and normalize the concept of vaccinating adults against diseases that cause cancer. An age-based strategy may also assist future efforts to implement the next important cancer-preventing vaccine: the vaccine to prevent Human Papillomavirus (HPV).

With a simple recommendation for age-based adult hepatitis B vaccination, organizations concerned with eliminating this disease will more easily be able to articulate a clear message to policy makers and seek adequate federal funding to support national adult vaccination programs.

As you revise the draft hepatitis B immunization statement, I urge you to take NASTAD's perspective into consideration. We greatly appreciate the significant effort CDC staff, ACIP members and others have committed to updating these important recommendations. If you have any questions or require any additional information, please feel free to contact me at 202-434-8090.

Sincerely,

Julie M. Scofield
Executive Director

cc: Myron J. Levin, MD, ACIP Chair
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