

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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October 2004

Increase in the Infant Mortality Rate among African Americans in Antelope Valley

The Problem

The Antelope Valley Service Planning Area (SPA 1) infant mortality rate has increased markedly from 5.0 infant deaths per 1,000 live births in 1999 to 10.6 in 2002 (See Figure 1).

Of particular concern is that the greatest increase in infant mortality occurred in the African American community (see Figure 2). The infant mortality rate among African Americans in Antelope Valley in 2002 was 32.7 per 1,000 live births, much higher than the rate of African Americans in Los Angeles County overall (13.1 per 1,000 live births). Although African

American births account for less than 20% of all live births in Antelope Valley, African American infant deaths comprised nearly 50% of all infant deaths in Antelope Valley in 2002. Fifty-three infant deaths were identified in Antelope Valley in 2002, compared to 43 deaths in 2001.

Community Involvement

In response to the alarming rate of infant mortality among African Americans in the Antelope Valley, the Board of Supervisors instructed the Director of Health Services to convene a working group consisting of various Los Angeles

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NEWEST PNEUMOCOCCAL CONJUGATE VACCINE RECOMMENDATIONS

Pneumococcal Conjugate Vaccine Shortage Resolved

Since February 2004, the Centers for Disease Control and Prevention (CDC) has recommended an abbreviated schedule for administering the 7-valent pneumococcal conjugate vaccine (PCV7) to healthy children. The abbreviated schedule has been modified twice since its implementation. On September 16, 2004, in the MMWR* [53 (36); 851-852], CDC announced that the production capacity and supply of the vaccine has now increased sufficiently to meet the national demand for vaccine if given in accordance with the routine schedule recommended by the Advisory Committee on Immunization Practices. Effective immediately, providers should resume administration of PCV7 according to the routine schedule for healthy children (Table A). There is no change in the schedule for high risk children, as these children should have continued to receive the routinely recommended schedule even during the months of vaccine shortage.

Children under 5 years who are at high risk for invasive pneumococcal disease because of certain immunocompromising or chronic conditions (e.g., sickle cell disease, asplenia, chronic heart or lung disease, diabetes, cerebrospinal fluid leak, cochlear implant, or human immunodeficiency virus infection) should be given the highest priority for catch-up vaccination (Table B). Healthy children aged <24 months who have not received any doses of PCV7 and healthy children aged <12 months who have not yet received 3 doses should have the next level of priority for catch-up vaccination.

Because of the frequency of health-care provider visits by children during their first 18 months, catch-up vaccination might occur at regularly scheduled visits for most children who receive vaccines from their primary-care providers. Programs that provide vaccinations but do not see children routinely for other reasons should consider a notification process to contact under-vaccinated children.

* www.cdc.gov/mmwr/preview/mmwrhtml/mm5336a8.htm

If you have questions about the PCV7 vaccination, contact the Immunization Program at 213-351-7800 (8:00 am to 5:00 pm weekdays).

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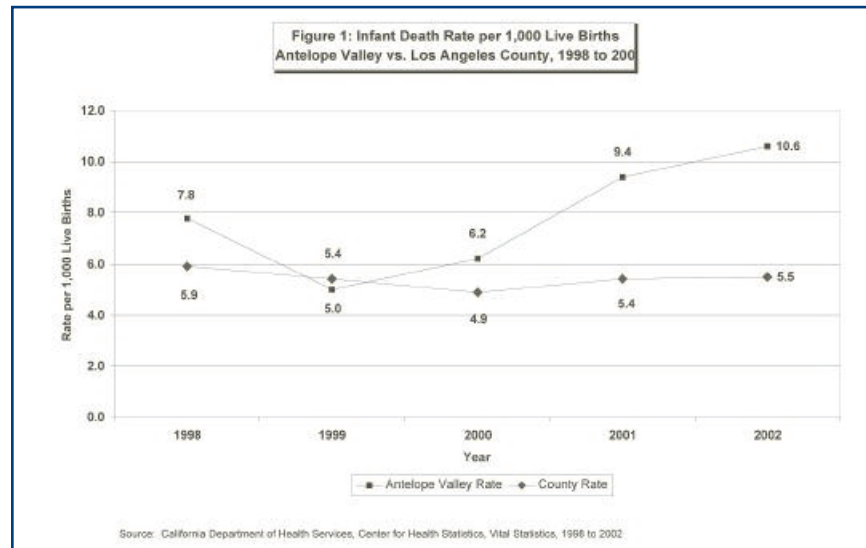
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Increase in the Infant Mortality (from page 1)



County Department of Health Services (DHS) departments, Antelope Valley community organizations, and health care organizations to address this serious issue. Three public meetings were held to review the data and potential causal factors, and to make recommendations to address the infant mortality problem. The workgroup issued five recommendations:

- Increase capacity and target access to high risk family support programs for African American women and their families;
- Decrease barriers to accessing care by increasing the number of women and infants that have medical insurance;
- Collaborate with and educate local health care providers to ensure quality care for African American women and their infants;
- Conduct an education and outreach/marketing campaign aimed at African American women and the local community regarding healthy life practices; and
- Conduct research to determine the causes of infant mortality in the Antelope Valley.

For the complete report, please visit: www.lapublichealth.org/mch/Updates/404-011.pdf.

Research Development

Much progress has been made in elucidating the causes of infant mortality in Antelope Valley. Preliminary analyses from birth and death records indicate that among the 53 infant deaths, 42% (22 infants) died within 24 hours of birth and an additional 26% (14 infants) died during the first 28 days of life. The majority of infants who died (40 infants) were born prematurely or with low birth weight. Eight infant deaths were from multiple gestations. In addition, the infant mortality rate was higher for mothers who initiated prenatal care in the second trimester compared to mothers who initiated prenatal care in the first trimester.

DHS Maternal Child & Adolescent Health (MCAH) staff is currently conducting a retrospective study of the Antelope Valley infant deaths that occurred in 2002 to identify risk factors that may be associated with infant mortality. Public health nurses and the medical community are joining forces to help collect information for this study. Medical charts and coroner reports will be reviewed, and mothers of the infants who died will also be interviewed.

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Increase in the Infant Mortality (from page 2)

The Los Angeles Mommy and Baby (LAMB) Project is an effort to understand adverse outcomes. The project aims to collect information on maternal stress, pre-existing medical conditions, quality of prenatal care and other factors associated with adverse birth outcomes such as low birth weight and preterm delivery. These two outcomes are highly associated with infant mortality in Antelope Valley. Surveys will be mailed out between October 2004 and February 2005 to a representative sample of approximately 750 women residing in Antelope Valley who recently delivered a baby.

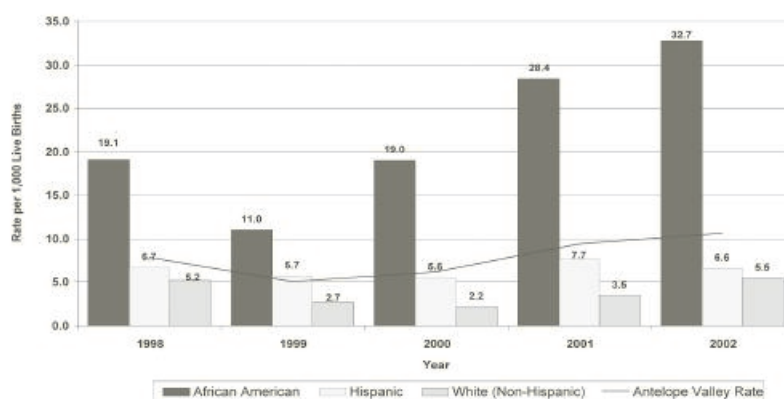
The Role of the Provider

According to Dr. Keith Campeau, Area Medical Director for SPA 1, an in-depth analysis of each case is critical in order to determine the root causes of the high infant mortality rates in the Antelope Valley. This is underway using the Fetal Infant Mortality Review (FIMR) process, using local public health nurses to do record extraction and maternal interviews. Data on prematurity and low birth weight from across the United States suggests that women's pre-conception and inter-conception health status may be determinative in the outcomes of extreme prematurity and low birth weight. Thus, identifying women who have risk factors for prematurity and low birth weight, or who have already had a baby born prematurely or with low birth weight, should be a primary strategy; these women can be enrolled in pre-conception programs that aim to prevent these problems. On average, the mothers of infants who died entered prenatal care late, especially African-American mothers. Therefore, ensuring access to early prenatal care may be another effective strategy to reduce infant mortality.

Programs such as the Black Infant Health Program, the Nurse Family Partnership Program, the Prenatal Care Guidance Program, and the Tarzana Treatment Center provide needed services to pregnant women, children and families. However, many of these programs are at capacity and without additional funding will not be able to enroll additional clients or provide more services.

The Comprehensive Perinatal Services program (CPSP) was created in 1984 to reduce the morbidity and mortality among low-income, Medi-Cal eligible pregnant women and their infants. The CPSP model emphasizes a comprehensive package of services addressing obstetrics, health education, nutrition, psychosocial services and case coordination. Comparing birth outcomes of CPSP clients against women who received standard prenatal care showed that low birth weight rates were reduced by one-third for those women who received comprehensive care.

Figure 2: Infant Death Rate per 1,000 Live Births by Race/Ethnicity in Antelope Valley, Los Angeles County, 1998 to 2002



Source: California Department of Health Services, Center for Health Statistics, Vital Statistics, 1998 to 2002

Currently, four obstetrical providers in SPA 1 are CPSP certified; however, only 2 are able to provide the full spectrum of services. Given the high infant mortality rate in Antelope Valley compared to the rest of Los Angeles County, it is crucial to identify the barriers that prevent all Medi-Cal eligible pregnant women from accessing comprehensive perinatal services. This will require the support of public and private providers, managed care health plans, and community based organizations in Antelope Valley.

Antelope Valley Partners for Health and the Antelope Valley Area Health Department have put together a resource directory for providers (Please refer to: www.avph.org/directory.htm).

Work on the five recommendations has already begun. The LAMB Survey is a key research activity needed to determine the causes of infant mortality in the Antelope Valley (Recommendation 5). The success of the LAMB Survey is contingent on the response rate so financial incentives are being provided to respondents. Patients who delivered a baby during May, June, or July of 2004, may receive a LAMB survey in the mail. We are asking all health care providers to encourage their patients who receive them to complete and return the surveys promptly.

Table A: PNEUMOCOCCAL CONJUGATE VACCINE SCHEDULE

Recommended schedules for pneumococcal conjugate vaccine vary with the child's age and the presence of underlying conditions. The schedules are given in the table below.

Age at First Dose	Total # of Doses	Schedule
2 - 6 months	4	2, 4, 6 months of age with a booster at 12-15 months of age ¹
7 -11 months	3	2 doses 4 to 8 weeks apart ² ; give the third (booster) dose after the first birthday and at least two months after the second dose
12 - 23 months	2	2 doses 6 to 8 weeks apart
24 - 59 months	1-2	2 doses if child is at high risk ³ ; 1 dose for healthy children ⁴

¹The first dose is usually given at 2 months of age, but it can be given as early as 6 weeks of age. The recommended interval between doses is 2 months, however, 4 weeks is the minimal interval. The AAP prefers that these doses be 6-8 weeks apart. The booster dose is given at least 2 months after the third dose.

²The AAP prefers that these doses be 6-8 weeks apart.

³Children between 24 and 59 months who are at high risk and who should be immunized with 2 doses (6 to 8 weeks apart) are children with:

- Sickle cell anemia
- Functional or anatomic asplenia
HIV infection or AIDS
- Other immunocompromising conditions due to malignancies, chronic renal insufficiency, nephrotic syndrome, organ transplant, high-dose steroid use, etc.
- Other chronic illnesses, e.g., diabetes, cardiac disease, pulmonary disease (except asthma), CSF leaks, cochlear implant

⁴The ACIP approves the use of VFC vaccine for all children 24 through 59 months of age, with priority given to vaccination of moderate-risk children including:

- Children between 24-35 months of age
- Children who are Alaskan Natives, American Indians, or African American
- Children who are in group day care (this does not include kindergarten children)

Dosage, Route and Site of Administration:

- Dose: 0.5 mL
- Route: Intramuscular (IM)
- Site: Anterolateral thigh in infants and the deltoid in toddlers and young children

Contraindications to Vaccination:

- Acute, moderate to severe illness until patient has improved
- History of a serious allergic reaction to a prior dose of pneumococcal conjugate vaccine or to a vaccine component, including diphtheria toxoid

Note: This vaccine can be given at same time as other routine childhood vaccines

Adverse Reactions:

- Injection site redness and/or soreness (10% to 30% of recipients)
- Fever (most fevers are low grade and resolve within one day)
- No serious adverse reactions have been reported.

Table B: PNEUMOCOCCAL CONJUGATE VACCINE CATCH-UP SCHEDULE

Below is the recommended pneumococcal conjugate vaccination regimens among children <5 years, by history and condition.

Age at Examination	Vaccination History	Recommended Regimen ¹	
2-6 months	0 doses	3 doses, 2 months apart; fourth dose at age 12-15 months	
	1 dose	2 doses, 2 months apart; fourth dose at age 12-15 months	
	2 doses	1 dose, 2 months after the most recent dose; fourth dose at age 12-15 months	
7-11 months	0 doses	2 doses, 2 months apart; third dose at 12-15 months	
	1-2 doses before age 7 months	1 dose at age 7-11 months, with another dose at 12-15 months (≥2 months later)	
12-23 months	0 doses	2 doses, ≥2 months apart	
	1 dose before age 12 months	2 doses, ≥2 months apart	
	1 dose at ≥12 months	1 dose, ≥2 months after most recent dose	
	2 or 3 doses before age 12 months	1 dose, ≥2 months after most recent dose	
24-59 months	Healthy Children	Any incomplete schedule	Consider 1 dose, ≥2 months after the most recent dose ²
	Children at high risk ³	Any incomplete schedule of <3 doses	1 dose, ≥ 2 months after the most recent dose and another dose ≥2 months later
		Any incomplete schedule of 3 doses	1 dose, ≥2 months after the most recent dose

¹ For children vaccinated at age <12 months, the minimum interval between doses is 4 weeks. Doses administered at ≥12 months should be ≥8 weeks apart.

² Providers should consider administering a single dose to unvaccinated, healthy children aged 24-59 months with priority given to children aged 24-35 months, African American children, American Indian or Alaska Native children not otherwise identified as high risk, and children who attend group day care centers.

³ Children with sickle cell disease, asplenia, chronic heart or lung disease, diabetes, cerebrospinal fluid leak, cochlear implant, human immunodeficiency virus infection or another immunocompromising condition, and American Indian or Alaska Native children in areas with a demonstrated risk for invasive pneumococcal disease more than twice the national average (i.e., Alaska, Arizona, New Mexico, and Navaho populations in Colorado and Utah).

Trick or Treat? . . . Lead in Mexican Candies

As Halloween approaches, it is increasingly important for parents to be aware of the danger that imported candies may present. DHS's Childhood Lead Poisoning Prevention Program warns consumers that high levels of lead have been found in candy made in Mexico by Dulmex. Consumers should avoid purchasing and consuming all Dulmex candies, especially coconut rolls, tamarind rolls, and tamarind lollipops.

The rolls may be packaged under the names "Casa de Dulce", "Juanita's", "Payaso", or "Mojave."

Lollipops are commonly packaged under the name "Bolirindo." These candies, and especially their wrappers, contain dangerously high levels of lead. Children who eat foods with high lead levels can suffer serious health problems that can cause permanent neurological damage.

The California State Food and Drug Branch (FDB) is asking County agencies to ensure that the candies are not sold at retail outlets. The FDB is also asking the public to report any sellers of the candy to the local FDB office of local health agency. The public is encouraged to report any sellers of the candy to the FDB by email at: fdbinfo@dhs.ca.gov. The FDB also provides an automated 24-hour toll free hotline for consumer complaints at the following number: 1(800) 495-3232.

For more information on lead poisoning you can visit the Lead Poisoning Prevention Program's website at www.lapublichealth.org/lead/index.htm, or call 800- LA 4 LEAD.

Background

Lead poisoning is one of the most common pediatric health problems in the United States.^{4,5,2} Elevated blood lead levels (BLLs) result primarily from exposure to lead-based paint or from associated lead-contaminated dust and soil; however, other sources of lead exposure, including folk remedies, Mexican terra cotta pottery, and certain imported candies, also have been associated with elevated BLLs in children.¹

Earlier this year, State Public Health Officer Dr. Richard Joseph Jackson, warned that lead has been found in four seasonings imported from Mexico⁵: "Lucas Limon", "Lucas Acidito", "Super Lucas", and "Super Jovy Chili Powder". These seasonings, eaten as candies by children, come in a cylindrical container around 1 ounce in content, with a prominently displayed logo of a goose head wearing glasses on top of a circle, except "Super Jovy Chili Powder", packed in a cylindrical container with a red label and red cap. These products can be found in small markets and flea markets throughout California.

Since 1993, the State Department of Health Services has been warning consumers of high levels of lead in imported candies, most of these of Mexican origin. Among these are *Picarindo* (Tamarind candy), *Vero Rebanaditos*, *Vero Mango*, *Vero Elotes*, *Chaca Chaca* (Chili and apple pulp candy), *Storck Eucalyptus Menthol Candy* (Philippines), *Dulmes brand-Bolirindo*, *Margairta-brand Tamarindo Pulpa*, *Licona Tamarind*, *Jarrita Chonita-Tejocote*, and *Brinquitos* (Chili Candy).

How contamination occurs

Lead contamination of candy occurs in different ways. This includes the candy packaging material, which is a source most often found in candies imported from Mexico.² The printed cellophane candy wrappers may present a significant risk for

lead exposure. In 1999, an investigation implicated tamarind candy as the potential source of lead exposure for a child with a significantly elevated blood lead level (BLL).³

There is also a wide range of other factors that affect lead levels in children, including exposure to other sources of lead (either in the diet or due environmental exposure), nutritional status, and their body size. Since these provisional levels were established, evidence has accrued to suggest that adverse effects of lead exposure occur in young children at levels below 10 mcg per dL. Many experts now believe there is no "safe" level of lead in a child's body. Lead can also permanently damage the central nervous system, resulting in learning disabilities, behavioral disorders, and other long-term health problems.

In 1992, scientists at the US FDA estimated that for children age 6 years or younger, the ingestion of 60 micrograms of lead per day from all sources in the diet could result in blood lead levels that reached the CDC's level of concern (i.e., 10 micrograms of lead per deciliter of blood). Dietary lead exposure resulting in a blood lead level of concern for children older than age 6 were 150 mcg, 250 mcg per day for pregnant women to avoid fetal blood leads exceeding the level of concern, and 750 mcg per day for other adults. From these estimates, a provisional tolerable daily intake was derived by applying a protection factor of 1/10 to provide some margin of safety and to take into account uncertainty in the estimates. Thus, children age 6 and under should be exposed to no more than 6 mcg/day from all dietary sources.

On the other hand, childhood lead poisoning has been found endemic in areas of extreme poverty and substandard housing. Hispanic children of indigent, poorly educated, disenfranchised families are at disproportionate risk. Risk management is contingent upon consideration of the interrelationships between socioeconomic, politics, and culture.

Many children, especially in Southern California, are assumed to share these characteristics. Interestingly, associated with these findings is the perception in many Latin American countries of lead poisoning mainly related to gasoline, as the major problem, and other sources including industrial emissions, battery recycling, paint and varnishes, contaminated food and water, and radiators repair work, a small industry that is abundant in Mexico and other developing countries, as the main focus of attention for lead poisoning, with very little attention to candies. All variables that well may represent important risk factors associated with children's lead poisoning through candies.

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Holiday Safety Tips

The holidays are an exciting time of year for children and adults. However preventable injury-related hospitalizations and deaths during this time of year are not uncommon. The Consumer Product Safety Commission reports that 110,000 children under 15 years of age are treated in emergency departments for toy-related injuries each year in the U.S. Half of these injuries were among children younger than 5 years of age. The United States Fire Administration reports that every year household fires occurring during the holiday season injure 2,600 individuals and cause over \$930 million in damage. In 2002, the Department of Transportation's National Highway Traffic Safety Administration reported 4,943 traffic deaths in the U.S. between Thanksgiving and New Year; 41.5% of these involved alcohol. Traffic related injuries during this same time period resulted in more than 43,000 hospital emergency department visits.

The Injury and Violence Prevention Program recommends the following tips for a safe holiday season.

CHILD-SAFE GIFT BUYING

To ensure a safe, happy and exciting holiday season keep these age-appropriate safety guidelines in mind when choosing gifts for children. It is okay to tell a child that a certain toy is unsafe for them.

Infant to 3-years of Age

- Avoid toys with small removable parts. These are a choking hazard
- Children under 4 years can choke on parts with a diameter of 1-3/4 of an inch or less
- Look for sturdy construction on potential small parts
- Toys with strings, straps, or cords longer than 7 inches are a strangulation hazard
- Balloons are not recommended for children in this age group

Gift Ideas:

- For infants: soft dolls, stuffed animals without buttons or small attachments, or cloth covered books
- For ages 1-3 years: books, blocks, shape toys, or balls larger than 1-3/4 inches are recommended

Ages 4-8

It is recommended that you **DO NOT** buy electric toys for this age group as they are a potential burn hazard

Gift Ideas:

- Children in this age group are physically active and creative. Good gifts include non-toxic arts and craft supplies, books, musical instruments, and outdoors toys

Ages 8 and Older

- Electrical trains and battery-operated toys are okay for this group, but...
- Never allow a child to change the batteries
- Always check for loose wires

Gift Ideas:

- Remember the importance of physical activity as this age group approaches puberty and may be drawn to sedentary video games. While some children may enjoy physical activity,

others may need more encouragement so sports equipment is an appropriate gift. Remember: **NEVER** give a bicycle, scooter, skateboard, roller blades/skates, as a gift without providing a helmet and other appropriate protective gear!

All Ages

- Always read labels for age recommendations
- Always read instructions to show your child how to properly use any new toy
- Propelled toys such as darts are not recommended for children of any age
- Avoid toys with lead-based paint
- Toy guns, pellet, and BB guns should be avoided as gift options
- Avoid toys that produce loud noises as they can impair a child's hearing
- Immediately discard plastic wrappings which can lead to suffocation among small children
- Avoid buying toys with sharp points or edges

Holiday Decorating Safety Tips

Holiday Trees

- When purchasing an artificial tree, look for a "Fire Resistant" label
- When purchasing a live tree, check for freshness. Keep the stand filled with water so it does not dry out and become a fire hazard
- Never leave tree lights lit on a live tree when you are not at home
- Always place your Christmas tree away from fireplaces, radiators, or portable heaters
- Be sure that your tree is mounted on a sturdy base and placed out of the way of traffic to ensure that children cannot pull it over onto themselves
- Only use flame-resistant or non-combustible materials to trim a tree
- Never use lighted candles on trees
- Choose tinsel or artificial icicles made of non-lead material
- With small children, avoid decorations that are sharp or breakable, keep trimmings with small removable parts out of their reach to avoid them swallowing small pieces, and avoid trimmings that resemble candy or food.
- Follow container directions carefully to avoid lung irritation while decorating with artificial snow sprays.

Continued on page 8

Holiday Safety Tips (from page 7)

- Avoid placing small or breakable ornaments on lower branches where small children can reach them

Fireplaces

- Use care with "fire salts," which produce colored flames when thrown on wood fires. They contain heavy metals that can cause intense gastrointestinal irritation and vomiting if eaten. Keep them away from children
- Do not burn wrapping papers in the fireplace. A flash fire may result as wrappings ignite suddenly and burn intensely

Holiday Lighting

- Always use indoor lights indoors and outdoor lights outdoors
- Before using lights outdoors, check labels to be sure they have been certified for outdoor use
- Check for broken or cracked sockets, frayed or bare wires, and loose connections. Throw out damaged sets
- Use no more than three standard-sized strings of lights per single extension cord
- Never use electric lights on a metallic tree; they can become charged with electricity from the lights and can result in an electrical shock if touched
- Stay away from power or feeder lines leading from utility poles into older homes
- Fasten outdoor lights securely to trees, house walls, or other firm supports to protect the lights from wind damage. Use only insulated staples to hold strings in place, not nails or tacks. Or, run strings of lights through hooks (available at hardware stores.)
- Use caution when removing outdoor holiday lights. Never pull or tug on lights - they may unravel and inadvertently wrap around power lines.
- Outdoor electric lights and decorations should be plugged into circuits protected by ground fault circuit interrupters (GFCIs). Portable outdoor GFCIs can be purchased where electrical supplies are sold. GFCIs can be installed permanently to household circuits by a qualified electrician.
- When you leave home and before you go to bed, be sure to turn off all holiday lights

HOLIDAY DRIVING SAFETY

During the holidays, traffic increases considerably with people traveling to visit family, shop, and celebrate. It is also a popular time for people to socialize with alcohol, increasing the number of irresponsible drivers.

On the Road

- Wear a safety belt at all times
- Always place children in age appropriate restraints
- Place all children less than 12 years old in the back seat at all times
- Never drink and drive
- Always use a designated driver
- Even if you are not drinking, always be alert to others on the road who may be driving irresponsibly

HOSTING A RESPONSIBLE HOLIDAY PARTY

- Have non-alcoholic beverages available for guests
- Serve light foods such as meats and cheeses to help retard the effects of alcohol
- Arrange for an official designated driver for your party
- Find alternate transportation for intoxicated guests or persuade them to spend the night
- Be responsible for your guests, even if it means taking their car keys

HOLIDAY TRAVEL SAFETY

During the holidays, take extra care in assuring your own security and that of your home.

Airline Travel

- Drink plenty of "water" to keep hydrated
- Avoid drinking alcohol on planes, as this increases dehydration
- Wear layers on plane rides so that you can regulate your own temperature
- Pay attention to the safety and evacuation presentation given by flight attendants
- Remember to take necessary medications (prescribed and over the counter)
- If prone to air or sea sickness take necessary precautions such as patches or Dramamine
- Keep photo identification with you at all times
- Do not pack completely wrapped presents in your luggage. This will make it more difficult to pass through security screeners.

If traveling with children

- Make sure to keep them near you at all times
- Keep them in a child restraint system at all times during the flight
- Make sure they are seated away from the aisle where they could get hurt by passing people or carts
- Bring safe toys for them to play with

SECURING YOUR HOME WHEN YOU ARE AWAY

- Get an automatic timer for your lights
- Ask a trusted neighbor to watch your home and pick up your mail and/or newspapers
- Do not display gifts where they can be seen from outside
- Take inventory of your home before you leave
- Make sure you have secure locks on your windows and doors

Perinatal HIV: Still a Public Health Problem in Los Angeles County

Despite major successes in reducing mother-to-child transmission of HIV infection through early identification and treatment with antiretrovirals, the existing perinatal HIV prevention system is unable to reach all HIV-infected pregnant women in Los Angeles County and mother-to-child transmissions still occurs. With active surveillance for HIV-exposed infants, Figure 1 shows that the perinatal HIV transmission rate for infants born in the county has increased from 2% in 2002 to 5% in 2003.

Nearly all of the infections (92%) occurring from 1999-2003 resulted from missed opportunities for prevention due primarily to lack of prenatal care or failure to identify and treat the mother for HIV during her pregnancy. A total of 44 (9%) of the 488 reported HIV-positive mothers giving birth during these years did not receive any of the recommended antiretroviral treatment—this includes ZDV during pregnancy, at labor and delivery, and postpartum to the infant to prevent HIV transmission. Subsequently, 19 (42%) of these women transmitted HIV to their newborn. In sharp contrast, only 1% of the HIV-positive mothers receiving any of the recommended treatment protocol transmitted HIV to their newborn demonstrating the importance of prenatal treatment.

DHS's Pediatric Spectrum of HIV Disease (PSD) project has been following HIV-exposed and infected children receiving care in Los Angeles County since 1989. A proportion of these children were born in other counties, or states. Activities include active surveillance at 8 pediatric HIV

specialty hospitals countywide (as described previously in *The Public's Health*¹). In 2003, PSD identified 9 HIV-infected infants born between 2002 and 2003. Among the mothers of these infected infants, 5 had no prenatal care, 2 were incarcerated (including 1 with no prenatal care), 2 did not seek HIV specialty care even though they knew they were HIV-infected, and 1 was never offered HIV testing while pregnant or during labor or delivery.

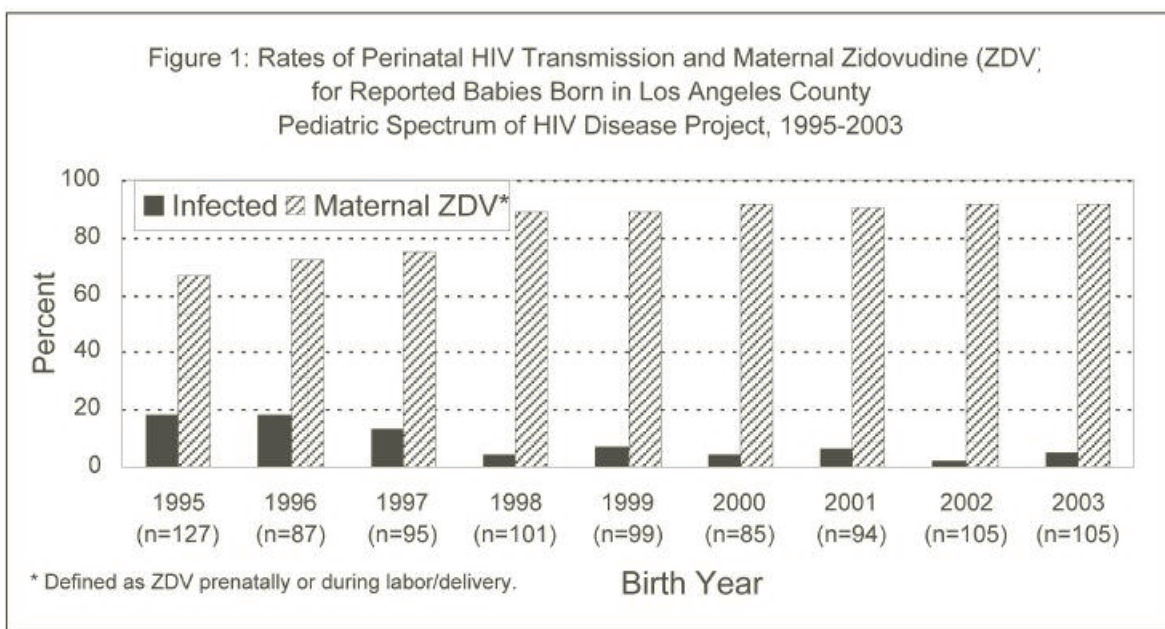
Two of the mothers with no prenatal treatment self-identified as HIV positive at labor and delivery, and despite receiving ZDV at labor and delivery and neonatal ZDV for the newborn, HIV transmission still occurred.

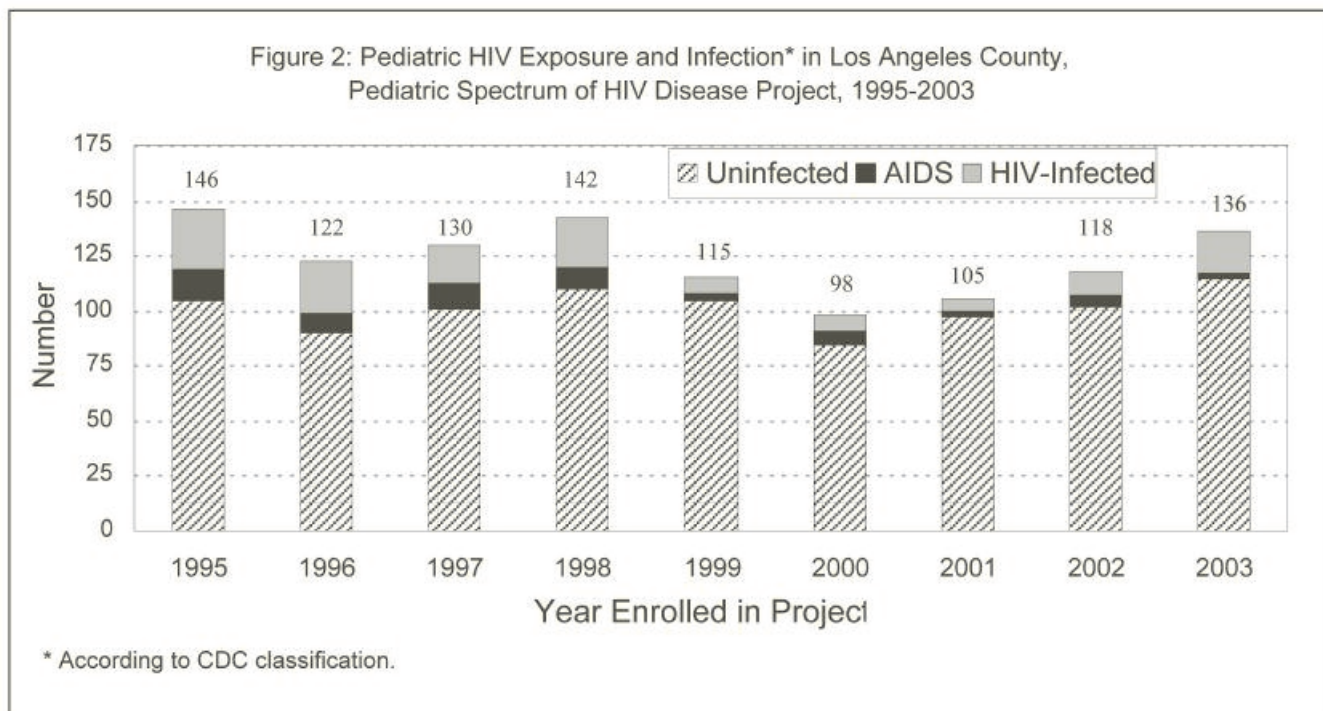
Also reported to PSD in 2003 were 13 children (from birth cohorts 1988-2001) infected perinatally; all were diagnosed as being born to HIV positive mothers after birth. In two cases, one mother refused HIV care despite knowing HIV positive status and one refused HIV testing and counseling during pregnancy.

In 2003, PSD enrolled a total of 139 HIV-exposed children—the most children reported since 1998 (Figure 2). While the proportion of children with AIDS continues to decline, the overall number and proportion of children with HIV-infection in 2003 was the greatest in 5 years. These numbers reflect a continuing trend of children with HIV coming to Los Angeles County from foreign countries and neighboring counties for treatment and follow up, as well as missed opportunities for perinatal prevention from babies born to women in earlier birth cohorts.

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The number of children with HIV-infection reported in 2003 was the greatest in 5 years.





Reports of perinatally infected children have continued into the first part of 2004. PSD recently enrolled 9 new cases of pediatric HIV infection including 4 with AIDS and 3 infants born in 2004. Only one child had been followed previously or treated for HIV, the others were newly diagnosed with HIV. Ages ranged from 1 month to 9 years, most (n=5) were from neighboring counties and two were foreign born. Among the mothers of these children: one was never offered testing, one did not disclose her HIV status, and one did not receive follow-up care for her infant. Among the 4 older children, 2 children were identified after their mothers tested HIV positive and 2 were identified because of HIV-related symptoms.

In summary, the continuing and increasing numbers of HIV-infected children and infants in the county reflect several disconcerting trends and issues that all healthcare professionals should address:

1. Maternal-infant transmission of HIV is still a public health problem in Los Angeles County.
 - A persistent percentage of pregnant HIV-infected women receive no prenatal care. For these women, it is critical that labor and delivery hospitals are prepared to offer rapid HIV testing and treatment at labor and delivery as well as counseling about breastfeeding and treatment for HIV-exposed newborns.
 - 2 Unfortunately, presently only a few hospitals in our county have instituted rapid HIV testing at labor and delivery.
 - Pregnant women in the jails need to be offered HIV testing and those who are infected must be closely followed through delivery.

- California Health and Safety Code (Sections 125085, 125090, 125105, 125107, described previously in The Public's Health³ and available online⁴) mandates HIV testing with the mother's consent as a routine part of prenatal care. If the mother refuses, providers should counsel her about the routine nature of the test and the importance and availability of treatment to prevent transmission to the child.
 - Documentation of HIV testing in prenatal charts is required. If at labor and delivery there is no documentation of a prenatal HIV test, the hospital should be prepared to offer the rapid test and treat those who test positive.
 - If a woman tests positive during pregnancy, every attempt should be made to refer her to a prenatal HIV-specialty center to obtain a thorough evaluation and appropriate care both for herself and to prevent transmission to her child. Because some women may have difficulty accepting their HIV diagnosis and resist going to the specialty center, case management is essential for these women.
2. Some HIV-mothers were not tested for HIV during their pregnancy and both they and their children may go many years without an HIV diagnosis.
 - Pediatricians need to remember that HIV is still a rule-out disease in children with a chronic illness or HIV-related symptoms.

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Perinatal HIV (from page 10)

- Physicians of mothers with an HIV diagnosis need to inquire about the possibility that the mother's children are also infected and urge that those children be tested.
3. Because our county has a large population of foreign-born residents who come from countries where prenatal HIV testing may not be standard of care, these mothers and children are especially likely to miss out on HIV-prevention resources. As such, individuals from foreign countries will continue to be a public health concern.

Perinatal HIV infection is a preventable disease. Despite this, children are still becoming infected. Accordingly, it is crucial that the county continues active surveillance for pediatric HIV exposure and infection. It is only with good data that we can monitor progress towards the elimination of perinatal HIV transmission and trends in pediatric HIV. While PSD closed September 30, 2004, the collection of perinatal HIV surveillance data and the monitoring of new HIV infections will continue by the HIV Epidemiology Program.

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4. California Health and Safety Code Sections 125050-125119.5. Available at: www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=125001-126000&file=125050-125119.5

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New CDC-Funded HIV Studies: National HIV Behavior Surveillance Project and the Morbidity and Risk Behavior Surveillance Project

DHS' HIV Epidemiology Program (HEP) has recently received funding from CDC for two large multi-site national projects: the National HIV Behavior Surveillance Project (NHBS) and the Morbidity and Risk Behavior Surveillance Project (MRBS).

NHBS was funded in 25 U.S. metropolitan statistical areas and aims to develop and implement a behavioral surveillance system to monitor changes in HIV-related risk behaviors and access to HIV prevention services as part of CDC's HIV Prevention Strategic Plan through 2005. The first behavioral risk group identified for inclusion in the behavioral surveillance system is the population of men who have sex with men (MSM), ages 18 and older, who reside in Los Angeles County. In subsequent years, injecting drug users (IDU) and heterosexuals at increased sexual risk who reside in Los Angeles County will be included in the national HIV behavioral surveillance (NHBS) effort. In the first year of subject sampling for MSM, the goal is to interview up to 1500 MSM and to conduct HIV testing on a minimum of 500 of these men. HIV prevalence and HIV incidence will be estimated in

national sites that conducted both phases of the Young Men's Survey: Baltimore, Dallas, Miami, Los Angeles, New York, San Francisco. Data collection for the MSM phase will be completed by January 2005, at which time efforts will turn to collecting HIV-related risk data on 500 male and female IDUs.

The goal of MRBS is to identify and collect data on a national, representative sample of HIV-infected persons in care. In Los Angeles County, a sample of approximately 30 HIV care providers will be selected yearly and 400 patients will be randomly sampled from these providers for an interview and medical record abstraction. Patients will be administered a standardized questionnaire on risk behaviors, health care utilization, medication history, testing history, and socio-demographics and extensive clinical data will be abstracted from patient medical records. Data from MRBS will be used to monitor trends in risk behaviors; AIDS and non-AIDS related conditions; medication utilization and adherence; and health care utilization among a representative sample of persons in care for HIV infection, providing high quality data for HIV prevention and care planning in LAC and elsewhere.

Epidemiology and Prevention of Vaccine-Preventable Diseases

This live, two-day course is designed to provide updates on schedules, contraindications, standard immunization practices, vaccine-preventable diseases, and vaccine management and safety. For each vaccine-preventable disease, participants will learn to describe the disease, list the groups at highest risk, identify those for whom routine immunization is recommended, describe characteristics of the vaccine used to prevent the disease and discuss current immunization issues. Registration forms are available at: www.lapublichealth.org/ip/train&conf/EPVPD.pdf. Form must be mailed; no fax or telephone registrations will be accepted. Register by close of business on Nov 1, 2004.

Date: Nov 18-19, 2004
 Time: 8:00 am – 5:00 pm
 Location: Torrance Marriott,
 3635 Fashion Way
 Torrance, CA 90503



313 North Figueroa Street, Room 212
 Los Angeles, California 90012

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Selected Reportable Diseases (Cases)* - May 2004

Disease	THIS PERIOD May 2004	SAME PERIOD LAST YEAR May 2003	YEAR to date May		YEAR END TOTALS		
			2004	2003	2003	2002	2001
AIDS*	141	238	874	968	2,590	1,719	1,354
Amebiasis	8	10	29	48	121	102	139
Campylobacteriosis	68	81	345	392	1,093	1,067	1,141
Chlamydial Infections	2,989	2,910	15,719	15,328	36,555	34,688	32,670
Encephalitis	0**	8	19	25	41	61	41
Gonorrhea	703	667	3,752	3,172	8,008	7,800	7,443
Hepatitis Type A	25	29	148	156	376	438	542
Hepatitis Type B, Acute	6	8	31	32	56	29	44
Hepatitis Type C, Acute	0	1	3	0	0	3	1
Measles	0	0	0	0	0	0	8
Meningitis, viral/aseptic	1**	44	138	221	899	466	530
Meningococcal Infections	2	1	17	16	34	46	58
Mumps	0	0	1	6	10	16	17
Non-gonococcal Urethritis (NGU)	128	116	640	607	1,393	1,393	1,429
Pertussis	0	5	52	75	128	170	103
Rubella	0	0	0	0	0	0	0
Salmonellosis	88	55	432	338	996	956	1,006
Shigellosis	26	26	137	347	671	974	684
Syphilis, primary & secondary	31	39	174	189	442	364	188
Syphilis, early latent (<1 yr.)	36	31	168	164	365	353	209
Tuberculosis	77	54	246	269	949	1,021	1,046
Typhoid fever, Acute	1	1	4	6	16	33	17

* Case totals are provisional and may vary following periodic updates of the database.

** Interim case totals lower than anticipated due to delays resulting from processing West Nile Virus cases.