CDC Contract for Additional 9 Million Doses of Influenza Vaccine for the 2000-01 Season

MMWR. 2000;49:999

CDC has contracted with Aventis-Pasteur, Inc. (Av-P) for the production of 9 million doses of influenza vaccine for the 2000-01 season. This additional production ensures that approximately the same quantity of influenza vaccine is available for the 2000-01 season as the previous year.1,2 The 9 million doses are not intended to substitute for vaccine that is already ordered and expected to be delivered.

For the 1999-2000 influenza season, approximately 77 million doses of influenza vaccine were distributed in the United States, of which 3 million doses were returned to the manufacturers. For the 2000-2001 influenza season, distribution of approximately 75 million doses is anticipated, including the 9 million doses contracted by CDC.

Av-P will give first priority to orders from providers who plan to vaccinate primarily high-risk persons. Applications for vaccine orders from health-care providers and programs should be sent directly to Av-P beginning November 3, 2000. Wholesale distributors can apply to purchase vaccine starting December 4, 2000, if doses remain available. Once an application has been received by Av-P, notification regarding order acceptance will be provided to the applicant before mid-December. Delivery of vaccine is anticipated to begin December 12, 2000, and end by early January 2001.

Additional information about the application process and vaccine availability is available through Av-P, telephone (800) 720-8972, or World-Wide Web, http://www.vaccineshoppe.com (click on Fluzone (Registered) Application Form link). Completed application forms can be faxed to (888) 889-7129. Orders for this vaccine will not be taken by telephone.

CDC’s National Immunization Program (NIP) has developed an “Influenza Vaccine Availability” website that will provide information about the availability of influenza vaccine from manufacturers and wholesale distributors and will list state health departments that may have information about vaccine availability among local providers. This website will be updated weekly. The website can be accessed at http://www.cdc.gov/nip/flu-vac-supply. The updated ACIP recommendations for influenza vaccine for the 2000-01 season and other influenza-related information can be accessed at http://www.cdc.gov/ncidod/diseases/flu/fluavirus.htm. Additional information and assistance can be obtained by contacting NIP by e-mail, nipinfo@cdc.gov, or by telephone, (800) 232-2522.

REFERENCES

Childhood Asthma Hospitalizations—King County, Washington, 1987-1998

MMWR. 2000;49:929-933

2 figures omitted

Since 1980, asthma prevalence, hospitalization, and mortality have been increasing in the United States.1 Because of concern about asthma morbidity in children in King County, Washington,2 Public Health-Seattle and King County (PH-SKC) conducted a study that analyzed trends in local hospitalizations for childhood asthma during 1987-1998. This report summarizes the results of this analysis, which indicate that the youngest children and the poorest communities have the highest rates of asthma hospitalization.

Nonconfidential data on all hospital discharges among persons aged 1-17 years for 1987-1998 were obtained from the Washington State Department of Health. Asthma hospitalizations were those discharges with an International Classification of Disease-Clinical Modification (ICD-CM), Ninth Revision, code 493.2 If a child had been hospitalized more than once during any year, each hospitalization was counted. Population estimates for the study were provided by the Washington State Department of Social and Health Services for intercensal years and the U.S. Census Bureau for 1990; study data were analyzed by poverty status, county health planning area (HPA), and age group (i.e., 1-4, 5-9, and 10-17 years). Using the postal code of residence and U.S. Census Bureau data, poverty status strata were <$5, 5%-9%, and ≥10% of the population living below the federal poverty level.† The 20 HPAs were defined by aggregating postal codes.3

Trends during 1987-1998 were evaluated with a chi-square test for trend.5 A simple chi-square was calculated using Epi Info 6.02 to compare subpopulation rates and to adjust for multiple hospital admissions in certain children.6,7 Results were considered significant if P<0.05. Subpopulation comparisons were made using 1998 data; 3-year average rates (1996-1998) were calculated to increase the stability of rates in HPAs with small populations.

During 1987-1998 in King County, childhood asthma admissions increased 53% (from 505 to 772 chil-
dren), and overall childhood hospitalization rates for asthma increased 17% (from 170 to 200 per 100,000 children) (P<0.001). During this period, the rate for all nonbirthrelated childhood hospitalizations decreased 28%, from 2689 to 1931 per 100,000 children. In 1998, for children aged 1-4 years, the hospitalization rate for asthma was 2.8 times higher than the rate for children aged 5-9 years (461 versus 164; P<0.001) and 4.8 times higher than the rate for children aged 10-17 years (97; P<0.001). The hospitalization rate for children aged 5-9 years was 1.7 times higher than the rate for those aged 10-17 years (164 versus 97; P<0.001). During 1987-1998, the hospitalization rates for asthma increased 34% among children aged 1-4 years and 17% among children aged 5-9 years (P<0.001); children aged 10-17 years showed no significant trend during this period.

Hospitalization rates for asthma among children residing in areas where poverty was greatest were significantly higher than rates among children residing in other areas. In 1998, among children in the county’s high-poverty areas, 353 per 100,000 asthma hospitalizations occurred, which was 1.7 times the rate in medium-poverty areas (212; P<0.001), and 3.0 times the rate for residents in areas with the lowest poverty (119; P<0.001). During 1987—1998, rates for the low-poverty and medium-poverty areas increased significantly (P<0.01). Asthma-related hospitalization rates also increased significantly for the high-poverty areas during 1987-1995 (p=0.011) but decreased from 1995 to 1998 (P=0.008).

During 1996-1998, hospitalization rates varied significantly among HPAs (P<0.001). The rates for central and southeast Seattle HPAs, adjacent to Seattle’s urban center, were not significantly different from each other but were significantly different from the HPAs in the rest of the county. The rate in the aggregated central and southeast HPA area (512 per 100,000) was 2.7 times the rate in the rest of the county (191 per 100,000; P<0.001). The central and southeast Seattle HPA area also had the highest proportion of residents living below the poverty level (22% in central and southeast Seattle compared with 7% in the rest of the county) and the highest proportion of blacks (31% compared with 3%) and Asians/Pacific Islanders (28% compared with 9%).

**CDC Editorial Note:** The extent of asthma morbidity is estimated with various measures, including data from surveys, outpatient visits, hospital discharges, and emergency department visits. Local hospitalization data have the advantage of wide availability and the capacity for analysis by age groups, geographic regions and, in some states, race/ethnicity. Hospital discharge rates also may be a persuasive measure for communities seeking to reduce the burden of asthma. The reasons for the increase in childhood asthma hospitalizations in King County are unclear; however, they may be related to an increased prevalence of asthma or increasing severity of asthma in this area.

A higher rate of asthma hospitalizations in King County occurred among children residing in poor neighborhoods, although the risk has increased for all King County children. A recent analysis of asthma hospitalizations in New York City also found a correlation between low median family income and increased asthma hospitalization rates.8

The findings in this report are subject to at least five limitations. First, the analysis by neighborhood poverty level reported on postal code poverty levels reported from the 1990 U.S. census. If the poverty level of postal codes has changed, postal codes may have been assigned to a poverty category that did not reflect their current status. Second, poverty level was assigned ecologically and may not reflect a person’s status. Third, geographic groupings were based on reported postal code. Because no other address data were available, erroneously reported postal codes may lead to misclassification by either poverty level or HPA. Fourth, race/ethnicity differences that may be independent of poverty status in asthma hospitalization may account for some findings.9 Finally, patients who received effective treatment in a primary-care setting may be less likely to be hospitalized, thus underestimating asthma severity and morbidity.

The use of local hospitalization data has helped to mobilize institutional and community-based support and interventions and has directed them to areas of greatest need. In response to the asthma problem identified in this area, the King County Asthma Forum was created by PHSKC and the American Lung Association of Washington to facilitate communication among community-based organizations about asthma prevention, diagnosis, and management. PHSKC, the Master Home Environmentalist Program, the University of Washington, the Washington Toxics Coalition, and other partners have implemented Healthy Homes, an intervention and evaluation project whose goal is to reduce exposure to indoor asthma triggers among 300 low-income households of children with asthma. On the basis of data from this report, in central and southeast Seattle, PHSKC has collaborated with a neighborhood pediatric clinic to fund the Asthma Outreach Project10 that provides comprehensive case management for children with asthma.

**REFERENCES**


STALKING IS A FORM OF VIOLENCE THAT may lead to physical injury or homicide and may have disabling social and psychological consequences. Although the legal definition varies among jurisdictions, all 50 states have antistalking laws. Louisiana defines stalking as the willful, malicious, and repeated following or harassing of another person with the intent to place that person in fear of death or serious bodily injury. Information is limited on the prevalence of stalking and its impact on the victim. To gather population-based surveillance data on stalking and other forms of interpersonal violence, the Louisiana Office of Public Health conducted a random-digit-dialed telephone survey among residents regarding experiences and perceptions related to safety and violence. This report summarizes the results of the survey, which indicate that 15% of the women surveyed reported being stalked during their lifetime. Data were collected from Louisiana residents aged greater than or equal to 18 years on a monthly basis from July 1, 1998, to June 30, 1999. Eligible households were selected randomly from a list of possible telephone numbers that had been filtered to eliminate unused and business exchanges. The respondent interviewed from each household was selected randomly. If an eligible household refused to participate or if the desired respondent could not be reached, a substitute number was selected randomly from the list. The survey ensured confidentiality, and respondents gave informed consent for participation. Of 4763 eligible respondents, 1808 (38%) completed the interview; 1171 (65%) were women. This report describes the findings among women respondents. Age and race of survey participants matched the 1990 census data for Louisiana, except that women aged 18-24 years compos 8% of the survey sample and composed 14% of women in Louisiana. Participants ranged in age from 18 to 99 years (median: 46 years); 71% were white, and 28% were black, whereas among female Louisiana residents aged greater than or equal to 18 years, 69% were white, and 29% were black. Participants were classified as having ever been stalked if they answered “yes” to the question, “Have you ever been stalked, harassed, or threatened with violence for more than one month by someone who would not leave you alone?” Women who reported having been stalked also were asked whether they had experienced physical injuries and stress-related problems and the level of fear invoked by stalking.

One hundred seventy-six (15%) women reported having been stalked during their lifetime, and 23 (2%) women reported currently being stalked. Of the 176, 132 (75%) women reported they believed the stalking to be somewhat dangerous or life threatening; of these, 89 (67%) indicated they had reported the situation to the police. Other measures reported to stop harassment included changing usual behavior (70%), moving (36%), purchasing a gun (11%), and obtaining a restraining order (11%). Forty-two (32%) of the 132 women reported injuries from being assaulted by their stalker, such as swelling, cuts, scratches, bruises, strains or sprains, burns, bites, broken teeth, or knife or gunshot wounds. Seventy-one (55%) women reported experiencing stress that interfered with their regular activities for greater than 1 month.

Among the women who perceived their stalking to be dangerous or life threatening, 67 (51%) identified the perpetrator as someone known to them but other than an intimate partner (i.e., boyfriend, former boyfriend, spouse, or former spouse); no stalking was reported among same sex partners. Forty-three (33%) women identified the perpetrator as someone known to them but other than an intimate partner (i.e., relative, acquaintance, friend, or other). Seventeen (13%) women were stalked by a stranger, and five (4%) were stalked by a perpetrator that they were unable to identify.

Those women who had been in an intimate relationship with their stalker were more than four times as likely to report that they had sustained an injury than those women who had not been in an intimate relationship with their stalker (35 of 67 versus seven of 60; relative risk=4.5; 95% confidence interval=2.2-9.3). None of the women who reported having been stalked by a stranger and who believed the stalking was somewhat dangerous or life threatening reported sustaining an injury.

CDC Editorial Note: The findings in this report indicate that 15% of women surveyed in Louisiana reported having been stalked during their lifetime. Social and psychological sequelae of stalking were more prevalent than physical sequelae. More women reported experiencing stress from being stalked than experiencing physical injury.

The findings in this report are consistent with data from the National...
Violence Against Women Survey (NVAWS)\textsuperscript{3}; both surveys showed that stalking had adverse psychological and social consequences. NVAWS did not measure physical injuries resulting from stalking because their definition of stalking precluded physical contact; however, NVAWS separately measured physical violence and found that 81\% of those reporting stalking also reported having been physically assaulted by the same person.\textsuperscript{4}

The findings in this report are subject to at least two limitations. First, quantifying the validity of self-reports of stalking is difficult because no “gold standard” exists for comparison. Additional research is needed on experiences of violence to determine the validity and reliability of different data collection methods (e.g., face-to-face interviews, telephone surveys, and paper and pencil surveys). Second, the population surveyed may not be representative of Louisiana. Because persons without telephones were not surveyed, and because of the low response rate, nonparticipants may differ from participants on study outcomes. However, the racial composition of survey participants was representative of the state.

The data in this report suggest that reliable estimates of stalking may be difficult to obtain using traditional data sources (e.g., health-care providers and law enforcement agencies) because 68\% of the women who experienced stalking did not sustain a physical injury and 33\% did not report the stalking to the police. A population-based survey may help characterize the burden of stalking and other types of interpersonal violence. However, the identification of victims in health-care and law enforcement settings also may help characterize persons at high risk for injury from stalking and enable referral of those persons for services and secondary prevention activities.

Surveillance is the basis for the epidemiologic approach to public health problems.\textsuperscript{5} If violence prevention is to be approached using the public health model, an accurate description of the problem is the first step.\textsuperscript{7} State- and local-level data on the prevalence of interpersonal violence can assist health departments in tailoring intervention programs to the specific needs and conditions in their communities.

REFERENCES
7 available

Levels of Diabetes-Related Preventive-Care Practices—United States, 1997-1999

\textbf{MMWR. 2000;49:954-959}

2 tables, 1 figure omitted

\textbf{PERSONS WITH DIABETES ARE AT INCREASED RISK FOR SERIOUS COMPLICATIONS (E.G., BLINDNESS, KIDNEY FAILURE, MAJOR-DIGIT-DIALED PHONE SURVEY OF THE NATIONAL CENTER FOR HEALTH STATISTICS, 1997-1999. THIS ANALYSIS WAS RESTRICTED TO RESPONDENTS WHO ANSWERED “YES” TO THE QUESTION, “HAS A DOCTOR EVER TOLD YOU THAT YOU HAVE DIABETES?”.

Women who were told they had diabetes only during pregnancy were excluded from this analysis. Persons with self-reported diabetes were asked, “When was the last time you had an eye exam in which the pupils were dilated?”, “About how many times in the last year has a health professional checked your feet for any sores or irritations?”, “About how often do you check your blood for glucose or sugar?”, and “About how many times in the last year has a health professional checked your feet for any sores or irritations?”.

Persons who reported having seen a health professional for their diabetes during the preceding year were asked if they had their feet examined, and only patients who had seen a health professional for their diabetes during the preceding year and heard of the term “glycosylated hemoglobin” or “hemoglobin A one C?” were asked if they had received a HbA1C measurement. Persons who were not asked the questions were considered not to have received the services. Data were analyzed to determine the level of use of each preventive-care practice, by state, in the 40 states that had at least 2 years of data during 1997-1999. In addition, sociodemographic characteristics associated with use of each preventive-care practice were examined. Data were weighted to reflect the age, sex, and racial distribution of the adult, noninstitutionalized population of each state, and all estimates were age-adjusted to the 2000 U.S. adult population. Data were analyzed using SAS software, with SUDAAN to calculate point estimates and 95\% confidence intervals.

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Among adults with diabetes in the 40 states, substantial gaps exist between current levels of preventive-care practices and the 2010 targets. Sociodemographic characteristics associated with each preventive-care practice varied by practice. Men were more likely than women to have their feet examined. Persons aged ≥45 years were more likely to report having a dilated eye examination, persons aged ≥75 years were less likely to perform SMBG, and persons aged <45 years were more likely to have their HbA1C measured. Non-Hispanic whites were more likely to perform SMBG than were persons from other racial/ethnic groups. Persons with at least a high school education and with health insurance were more likely to receive each of the four preventive-care practices.

Levels of preventive-care practices varied by state for each practice. The proportion of persons who received an annual dilated eye examination ranged from 47.0 to 81.0, who received an annual foot examination ranged from 42.4 to 69.4, who self-monitored their blood glucose ranged from 29.7 to 65.3, and who received a HbA1C measurement ranged from 16.9 to 42.4. Three states (Alaska, Maine, and Massachusetts) met the dilated eye examination target, and one state (Montana) met the self-monitoring of blood glucose target; no state met the annual foot examination or HbA1C measurement target.

The only characteristics that were consistent across each preventive-care practice were education level and health insurance status. These findings suggest that socio-economic status and access to health care have an effect on the receipt of diabetes-related preventive-care practices. Further examination is needed to determine the role of sex, age, and race on receipt of preventive care. The variation by state in receipt of preventive care may, in part, result from differences in demographic distribution, physician practice patterns, health-care system characteristics, and patient attitudes.

The findings in this analysis are subject to at least two limitations. First, persons who live in nursing homes and in households without telephones are not included in this survey; therefore, these results cannot be generalized to these segments of the population. Second, because the data were self-reported, they are subject to recall bias and may be underestimated or overreported.

CDC, in collaboration with 59 state and territorial diabetes control programs, provides leadership for a coordinated, multifaceted approach to increasing awareness and education about diabetes, improving the quality of diabetes care, promoting early detection of diabetic complications, and monitoring trends in the quality of care received by persons with diabetes. CDC and the National Institutes of Health will cosponsor the National Diabetes Education Program, which develops educational tools and community-based interventions and establishes public and private partnerships to address the needs of persons with diabetes and raise general awareness about the disease. CDC also supports Diabetes Today, a program that provides health professionals and community leaders with the skills needed to mobilize communities and improve diabetes care. CDC also is working with managed-care partners to determine how to improve care for persons with diabetes. Project TRIAD (Translating Research into Action for Diabetes) is a multicenter study that includes several managed-care organizations. Information on these prevention programs is available on the World-Wide Web at http://www.cdc.gov/diabetes/projects/index.htm.

Erratum: Vol 49, No. 40 (JAMA. 2000; 284:2310-2311)

MMWR. 2000;49:940

In the article, “Outbreak of Rift Valley Fever—Saudi Arabia, August-October, 2000” on page 907, three names were misspelled in the “Reported by” section. The correct spellings are G Al Gasabi, Ministry of Health, Saudi Arabia; T Madani, Ministry of Health, Saudi Arabia; and YY Al Mazrou, Laboratories and Blood Banks, Riyadh.