Ethnic differences in selective neonatal BCG immunisation: White British children miss out

Ramesh Srinivasan¹, Leena Menon¹, Pat Stevens ², Ian Campbell ³, Mazin Alfaham¹.
¹ Department of Child Health, Llandough Hospital, Cardiff, UK.
² TB Control Service, Llandough Hospital, Cardiff, UK.
³ Department of Respiratory Medicine, Llandough Hospital, Cardiff, UK.

CORRESPONDING AUTHOR:
Dr. Ramesh Srinivasan, M.D
Specialist Registrar,
Dept. of Child Health, Llandough Hospital,
Penlan Road, Penarth, Cardiff, U.K.
CF64 2XX
Tel: +44 (0)2920 716863
Fax: +44(0) 2920716048
Email: ramsriniv@doctors.org.uk

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ABSTRACT:

Background: Tuberculosis (TB) is a re-emerging problem especially in the larger cities of Western Europe. Selective neonatal BCG (Bacille Calmette –Guerin) vaccination is recommended for infants at risk of TB in the United Kingdom. Neonatal BCG is safe and effective, with an overall protective value of 75%. This study aimed to assess BCG rates among at risk infants in Cardiff and the Vale of Glamorgan, South Wales in the year 2003.

Methods: A cohort of infants at risk for TB was identified from demographic data stored on a computerised maternity activity database. A manual search of immunisation records determined overall rates and the rates for infants belonging to various ethnic groups.

Results: Among 5308 infants born in 2003, 514 (9.6%) were at risk of TB. 423 (82.2%) of these infants were referred postnatally for BCG, of whom 391 received it. 26 of the 41 ‘at risk’ White British infants missed BCG, compared to 47 of the 288 Asian and 7 of the 39 Black African babies who also missed the vaccination. The BCG rate among White British infants was 36.5%, compared 83.6% for Asian infants from the Indian subcontinent. ($\chi^2 = 7.25$, p < 0.01) and the 82% for Black African infants. ($\chi^2 = 4.48$, p < 0.05).

Conclusions: The overall BCG rate among at risk infants in Cardiff was 76% during the study period. Vaccination rate was poor among White British infants compared to those from other ethnic groups. Enhanced awareness of health professionals in recognising the need for vaccinating certain White children at risk of TB is essential to improve BCG coverage in an increasingly multiethnic population.
INTRODUCTION:
Since the beginning of the nineteenth century notification rates for TB have been on the decline owing to improvements in living conditions, nutrition, introduction of anti-tuberculosis chemotherapy and BCG immunisation. However, Tuberculosis is now re-emerging especially in the larger cities of Western Europe. [1] Increasing levels of deprivation in the inner city areas and immigration of families from countries with high prevalence of TB are probably the important factors involved with this trend. [2]
In the United Kingdom (UK) notifications of TB declined tenfold between 1948 and 1987. However, the steady increase since then is a matter of concern. [3] In a survey conducted by the Public Health Laboratory Service in England and Wales the annual rate for newly notified cases were 10.93 per 100,000 populations in 1998. This represents an increase of 11 % from the survey in 1993 and 21 % from 1988.[4] Childhood TB notification rates in England and Wales decreased at an average rate of 7.2% each year from 1978 to 1988, but there has been a steady increase in notification rates ever since. [5] Surveillance of childhood TB from September 1996 to December 1999 conducted through the Welsh Paediatric Surveillance System reported 38 cases of TB and 59 children on chemoprophylaxis. The majority of cases were noted to be in the White population and most had not received BCG. [6] This was consistent with a previous study conducted in Wales. [7] Although South Wales is a low prevalence area, tuberculosis in childhood is increasing and preventive measures are clearly important. We therefore undertook this study to assess the coverage of a selective neonatal BCG immunisation programme aimed at vaccinating infants at risk for TB.

METHODS:
We conducted a review of the selective neonatal BCG immunisation programme within the Cardiff and Vale NHS trust which serves the population of Cardiff City and the Vale of Glamorgan, South Wales. Local guidelines exist for the identification of infants at risk for TB who should be referred for BCG vaccination. This is shown in table 1. [3, 8-11]

| Parents originating from India, Pakistan, Bangladesh, Asia, Africa, Eastern Europe, Central & South America, Caribbean and Middle east even if UK born. |
| Parents who are asylum seekers / refugees from any country. |
| Parent/ close living relative with active TB or a past history of TB. |
| Parent/ close living relative who is a close contact of pulmonary TB and has been asked to attend for screening. |
| Those from travelling families |
| History of parental drug abuse. |

Table 1: Selective neonatal BCG immunisation: Criteria for referral (TB control service, Cardiff and Vale NHS trust).

There is a single tick box for TB risk in the antenatal clerking sheet. The information needed to categorise risk is assessed at the pregnancy booking interview. All midwifery staff are provided with the above criteria for identifying need for selective neonatal BCG vaccination. However sensitive information relating to drug abuse and travelling status may be difficult to elicit and details are not explicit in these forms apart from the need to vaccinate these infants. (in some cases this information may be available only postnatally) This data is held on a computerised maternity database maintained by the Cardiff birth survey. However, referral to the BCG clinic takes place postnatally by midwifery staff following birth of the infant. If missed at discharge, infants can also be referred by the health visitor, general practitioner or other health care professionals to be vaccinated by the team of two TB clinical nurse specialists who run the BCG vaccination service. A manual documentation of referrals received, along with the original or faxed referral forms, are kept
The aim is to vaccinate infants within six weeks of birth. Details of vaccination are recorded on BCG vaccination cards. Infants not immunised by 3 months of age are tuberculin tested. If found to be tuberculin negative, they are vaccinated. Infants found to be tuberculin positive are referred to local paediatric services for investigations and appropriate management. The vaccination process is summarised in figure 1.

Demographic data on pregnancies delivered between 1 January and 31 December 2003 were available from the maternity database. A list of infants at risk for TB was generated. Details of post-natal referral and vaccination outcome were retrieved from the manual records kept by the TB team. The efficacy of the vaccination process was determined by calculating the percentage of infants at risk who received BCG. In addition, vaccination rates among infants belonging to various ethnic groups were computed and differences analysed using the chi-square test.

RESULTS:

Of the 5308 live births recorded in the year 2003, a total of 514 infants (9.6%) were identified to be at risk for TB from computerised records based on antenatal information. Referrals for vaccination (done postnatally) were received for only 423 infants (82.2%). By 1 March 2004, 391 infants had received vaccination i.e. 76.0% of at risk infants or 92.4% of those referred. Nineteen infants (3.6%) had failed to attend repeated appointments. Five infants (0.9%) could not be traced. Eight infants (1.5%) were awaiting vaccination in the subsequent weeks. The pattern of BCG vaccination is depicted in figure 2.

The largest group (56%) of infants at risk were born to Asian parents originating from the Indian subcontinent (Indian, Pakistani & Bangladeshi) and 83.6% of these infants received BCG. The vaccination rate among infants born to Black African parents was much the same (82%). Out of 41 White British infants only 15 received BCG (36.5%). 25 of these 41 infants (61%) were not referred and one infant was not brought to BCG clinic despite repeated appointments. The vaccination rate was 71% among the 146 infants from the remaining ethnic groups which included Chinese (n=16), other Black (n=7), other White (n=6), other Asian (n=31), mixed (n=52), unclassified (n=28) and not stated (n=6) as shown in table 2.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>‘at risk’ (frequency)</th>
<th>Vaccinated (frequency)</th>
<th>Uptake (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian-Pakistani</td>
<td>96</td>
<td>81</td>
<td>84.3</td>
</tr>
<tr>
<td>Asian - Indian</td>
<td>124</td>
<td>102</td>
<td>82.2</td>
</tr>
<tr>
<td>Asian - Bangladeshi</td>
<td>68</td>
<td>58</td>
<td>85.3</td>
</tr>
<tr>
<td>Black African</td>
<td>39</td>
<td>32</td>
<td>82.0</td>
</tr>
<tr>
<td>White British</td>
<td>41</td>
<td>15</td>
<td>36.5</td>
</tr>
<tr>
<td>Other ethnic groups</td>
<td>146</td>
<td>103</td>
<td>70.5</td>
</tr>
<tr>
<td>Total</td>
<td>514</td>
<td>391</td>
<td>76.0</td>
</tr>
</tbody>
</table>

Table 2: Vaccination uptake status according to ethnicity

There were significant differences in the vaccination rates between...
White British Infants compared to Asian and Black African infants. 
Asian 83.6 % vs. White British 36.5 %; $\chi^2 = 7.25, \ p < 0.01$; Black African 82 % vs. 
White British 35.6 %; $\chi^2 = 4.48 \ p < 0.05$.

**DISCUSSION:**
BCG vaccination is an effective preventive measure against TB, although estimates of its 
efficacy vary enormously between different studies. In a meta analysis of four randomised 
control trials addressing the efficacy of neonatal BCG, an overall protective rate of 74 % 
was demonstrated. It was higher (78%) for miliary TB but slightly lower (64%) against TB 
meningitis [12]. BCG vaccination recommendations for infants vary among the various 
countries of Western Europe and even among cities of the same country in a few instances. 
In France, Finland and Portugal BCG vaccination in infancy is universal, while only high 
risk groups are targeted in Belgium, Greece and the UK. Infants belonging to high risk 
groups receive the vaccine in Milan (Italy) and Corke (Ireland) while those born in Rome 
and Dublin do not [1].
The Department of Health for England, the Welsh and Scottish office [3] and the British 
Thoracic Society [13] currently advise targeting infants belonging to high risk groups for 
vaccination. Our data demonstrated an overall BCG rate of 76 %. Ahmed and Hicks from 
Bristol showed a rate of 13.3 % (14), whilst Gill and Scott reported 6 % in Bolton. [15]. 
Both these studies demonstrated improvements to over 80 % after intensive training of 
midwifery and health visiting personnel. Wyllie and Eastham from Middlesborough found 
a 42% rate [16], whilst Deshpande demonstrated a 51 % BCG rate by at risk infants in 
Shropshire [17]. It is important to note that none of the previous studies emphasised the low 
BCG uptake among White British infants at risk. The differences in the percentage rates 
between the different ethnic groups in our study is concerning, a third of White British 
infants compared with over 80 % for Asian and Black African infants. White British infants 
at risk of TB would be predominantly referred under three categories- Family history of 
TB, parental drug abuse or belonging to travelling families. The low uptake among White 
British infants may be attributed to the failure of health care professionals to appreciate that 
among this ethnic grouping there are certain infants at increased risk of TB. Presuming 'no 
risk' for TB just because an infant is of White ethnicity is seemingly, the reason for this 
occurrence.
Lack of computerised post natal records linking up to antenatal data and lack of 
communication among health care professionals are possible shortcomings. Practical 
difficulties are also inherent in the implementation of such a selective immunisation 
programmes in that the definition of what is considered at high risk is not always 
straightforward and some children in need of immunisation may be missed primarily due to 
lack of this awareness. Lack of written communication from those assessing risk initially, 
shortages of BCG supply, travelling families, changes of infant surnames add to the 
difficulty of ensuring adequate BCG uptake. 
The results of this study have been presented to the midwifery teams and at Paediatric and 
Obstetric departmental meetings. Documentation of ethnicity on BCG vaccination cards 
and record of the indication for referral have been implemented. Increased awareness of 
perinatal staff regarding the high risk categories for TB and heightened perception of the 
vulnerability of a certain group of White infants are the keys to improving coverage. The 
results of this study have a wider applicability recognising that we live in an increasingly 
multiethnic European society which brings forth certain common health care provision 
issues.
REFERENCES:


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CONFLICT OF INTEREST AND SOURCES OF FUNDING: None.
Midwife booking the pregnancy identifies infants at risk of TB.

Indicates the need for BCG vaccination after birth.

Postnatally, midwife completes referral card at infant discharge after birth

Referral faxed / sent to TB clinic via internal mail.

TB clinic schedule an appointment < 6 weeks of age

Infant receives BCG vaccination.

Figure 1: Process of BCG vaccination
Figure 2: Uptake of Neonatal BCG vaccination in Cardiff and Vale of Glamorgan (2003)