by the LSPs and member organizations, including the two Primary Care Trusts and North East Lincolnshire Council. The tool has been published as Part 3 of the North East Lincolnshire Community Strategy.

The authors of the paper acknowledge the fact that those required to use the tool to conduct integrated impact assessments/appraisals will often have little knowledge of health impacts/links with health outcomes. This is also true for economic and environmental impacts, and to this end work is under way locally to raise awareness and to deliver training in the use of the tool. Specialists in public health, sustainable development officers and environmental officers are involved and available to provide advice in their own field of expertise.

The appraisal/screening tool offers an aid to decision-making to identify any potential positive effects that can be enhanced or harmful effects that can be avoided, and points the way for a more in-depth health impact assessment, sustainability appraisal or environmental assessment if required. Theoretically, it offers immense potential for improving health and tackling health inequalities as well as improving the economic, social and environmental well-being (quality of life) of our communities. (The tool can be found on both Primary Care Trust internet sites at www.nelpct.nhs.uk or www.nlpct.nhs.uk.)

Although this paper provides an overview of HIA in relation to some other impact assessments it omits an area of crucial importance given the current climate of partnership working, the local authority well-being power and sustainable development responsibility, and the increased recognition of the wider determinants of health.

**References**


Yours faithfully

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**Hepatitis B vaccine uptake among injecting drug users**

Sirs,

We read with interest the paper by McGregor et al. and support the conclusions they reached, particularly with regard to the effectiveness of hepatitis B vaccination being targeted at high-risk groups. Because of the mode of spread of blood-borne viruses such as hepatitis B, contact tracing may raise complex interpersonal issues and the need for counselling and informed consent to allow further investigation to take place. Relatively few health care workers possess the training and experience required to carry this out, and misunderstandings may occur as to whose role this is. Family practitioners have a key role in that they know the patient and their social circumstances, but may not have the time available for extended consultation and often see this as a public health role.

In the autumn of 2001 the County Durham and Tees Valley Public Health Network carried out a survey of public health departments in all health authorities in England, Wales and Northern Ireland, while these still existed, to establish what proportion of them were informed of, and then followed up, cases of hepatitis B virus (HBV) infection and their relevant contacts. The principal aim was to ascertain the extent to which this latter vulnerable group was likely to be protected by the current recommended management for contacts or carriers of HBV infection.

A response rate of 87.2 per cent was obtained, the results indicating that almost all (93/95 (97.9 per cent)) consultants in communicable disease control (CsCDC) were informed of cases of HBV infection following identification of viral markers by their local microbiology laboratory. This was fortunate, as formal notification by a medical practitioner varied very much between districts. Only four (4.2 per cent) CsCDC were always notified, 53 (55.8 per cent) were notified sometimes, 32 (33.7 per cent) rarely and five (5.3 per cent) never. The Table indicates the variety of health workers involved in the follow-up of known cases of HBV infection and their contacts.

If selective immunization is to be successful at controlling HBV infection within our population, it must be effectively carried out in all risk groups, including contacts of cases. CsCDC are in a position to co-ordinate this through liaison with other health care agencies within a geographical area, yet this did not take place for cases and contacts of cases in 24 (25.3 per cent) and 26 (27.4 per cent) of the districts surveyed, respectively. It must also be remembered that the majority of cases informed to CsCDC will have had laboratory identification of HBV markers and will therefore be a minority of all cases of HBV infection.

The results of our survey indicated an inconsistency in the information provided and action undertaken in dealing with cases of acute HBV infection and their contacts. Perhaps the time has come for the Department of Health Advisory Committee on Hepatitis to develop formal standards for the completeness and timeliness of laboratory investigation of suspected cases, the speed of conveying results to attending physicians and CsCDC, and the subsequent speed at which those physicians, liaising with CsCDC, are expected to ascertain and vaccinate relevant contacts. An alternative, as suggested by McGregor et al., would be the introduction of universal hepatitis B vacc...
Correspondence as part of the childhood immunization programme, as recommended by the World Health Organization, or in adolescence, as is currently being offered to Glasgow school children.4

Universal immunization programmes have been successfully carried out in other western European countries such as Spain and Italy,5 the latter seeing a dramatic fall in incidence rates in young people.6 Similar action in the United Kingdom would help protect those at-risk groups in whom compliance is a particular problem, such as injecting drug users, and prevent prevalence levels rising to those seen elsewhere in Europe.

References
4 http://www.hepbwise.scot.nhs.uk.

Yours faithfully

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Table

Follow-up of cases and contacts in 95 health districts in England, Wales and Northern Ireland

<table>
<thead>
<tr>
<th>Follow-up by:</th>
<th>Cases (%)</th>
<th>95% CI</th>
<th>Contacts (%)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health medicine</td>
<td>71 (74.7)</td>
<td>64.6–84.8</td>
<td>69 (72.6)</td>
<td>62.1–83.1</td>
</tr>
<tr>
<td>Genitourinary medicine</td>
<td>51 (53.7)</td>
<td>40.0–67.4</td>
<td>47 (49.5)</td>
<td>35.2–63.8</td>
</tr>
<tr>
<td>Secondary care</td>
<td>43 (45.3)</td>
<td>30.4–60.2</td>
<td>25 (26.3)</td>
<td>9.0–43.6</td>
</tr>
<tr>
<td>Primary care</td>
<td>29 (30.5)</td>
<td>13.7–47.3</td>
<td>43 (45.3)</td>
<td>30.4–60.2</td>
</tr>
<tr>
<td>Other</td>
<td>8 (8.4)</td>
<td></td>
<td>9 (9.5)</td>
<td></td>
</tr>
</tbody>
</table>

Cl, confidence interval.