



THE SENTINEL

Reporting on Preparedness



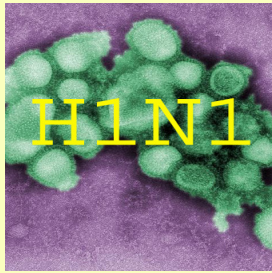
Public Health

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Influenza Pandemic: No longer IF, it's WHEN

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For some time we have been hearing that it is not if, but when, an influenza pandemic will happen. On June 11, 2009 the World Health Organization officially declared novel H1N1 a pandemic. The last influenza pandemics were the Hong Kong Flu in 1968, the Asian Flu in 1957 and the Spanish Flu in 1918.

While this novel H1N1 influenza strain has caused some anxiety, the symptoms have been similar to seasonal flu strains in both transmission and severity of illness. According to the World Health Organization and the Centers for Disease Control the virus has now spread around the world with the United States reporting more cases than other countries. Currently the U.S. accounts for over 40% of the worldwide reported cases.

Flu season in the southern hemisphere is in full swing and how the virus spreads there may indicate what the U.S. can expect this

fall. Activity in Georgia has been sporadic so far with cases primarily occurring at a few summer camps in our district.

This was not unexpected because the virus appears to infect children



and young adults under 24 years of age at a higher rate, most likely due to them not having as many years to build up immunity.

As communities prepared for pandemic influenza, there was much discussion about how everyday life could be impacted by the spread of illness. The response to H1N1 has been guided by recommendations from the CDC, and these have changed as the situation has developed. Early in the outbreak the

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Health and Human Services (HHS) takes steps toward 2009-H1N1 vaccine

HHS Secretary Kathleen Sebelius announced that the department will take necessary steps to prepare for the production of a vaccine for the H1N1 influenza virus. Approximately \$1 billion in existing funds will be used for clinical studies that will take place over the summer for the production of two potential vaccine ingredients. Here are some questions and answers from HHS about this project.

1. What do the new orders on these contracts support? The objective of the new orders on these contracts is to allow the U.S. government to manufacture and test vaccines against the newly emerging 2009-H1N1 virus for the U.S. pandemic influenza vaccine stockpile. This is an important step in order to build a stockpile of at least 40 million doses of 2009-H1N1 vaccine.

2. How is the 2009-H1N1 different from seasonal influenza? Each influenza season H1N1 is one of the viruses circulating in people and causing disease. The 2009-H1N1 has acquired H1 and N1 genes from swine to create a new version of the H1N1 virus (called 2009-H1N1) that is significantly different from the seasonal H1N1.

3. Will the seasonal vaccine protect me against the 2009-H1N1 influenza?

Preliminary analysis of serum from people immunized with the seasonal influenza vaccine done at the CDC suggests that the seasonal vaccine is unlikely to provide protection against 2009-H1N1.

4. Will this vaccine be made differently than the seasonal influenza vaccine?

No. This vaccine will be made using the same processes and facilities that are used to make the currently licensed seasonal influenza vaccines.

5. Will all this vaccine be injectable?

No. Some of the vaccine will be a live attenuated vaccine that is sprayed into the nose to immunize a person.

6. What about other vaccine manufacturing technologies, like recombinant or cell-based vaccines?

For this phase the U.S. government response has been focused on the currently licensed vaccine manufacturers. We are continuing to investigate how the U.S. government

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Health and Human Services takes steps toward 2009-H1N1 vaccine

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may use other technologies as part of the response to the 2009-H1N1.

7. When will the work on the 2009-H1N1 vaccine start? The work has already started to develop a vaccine, and these new orders on existing contracts are for the first large-scale manufacturing of ingredients that could be used in a potential H1N1 vaccine. Laboratories are already working on the generation of the seed viruses needed for vaccine production. These were available for the distribution to the vaccine manufacturers around June 1. Once the manufacturers have completed their seasonal influenza vaccine production, they will start production of the 2009-H1N1 vaccine.

8. What testing will be done on these vaccines? In addition to the usual testing done for seasonal influenza vaccines, there will be clinical testing in people to determine the most effective and safest dose to generate a strong immune response to the 2009-H1N1 virus.

9. How many doses will be needed to be immunized? This will be determined during the clinical studies. It could be one dose, like the seasonal vaccine, but it could be two doses since the population has little or no immunity to the 2009-H1N1 virus, which has not infected humans previously.

10. What is an adjuvant? An adjuvant is an additive to a vaccine that helps to generate a stronger immune response to the vaccine. When using an adjuvant it is often possible to reduce the size of the vaccine dose and the number of doses needed. So the use



H1N1 Influenza Virus

of an adjuvant can reduce the amount of vaccine needed to immunize a population.

11. Does the current seasonal influenza vaccine use an adjuvant?

No, there are currently no U.S. licensed influenza vaccines with adjuvant.

12. How will it be decided if an adjuvant will be used in this vaccine?

Experts will review the safety and immunogenicity data from the clinical testing of this vaccine and make a determination based on what is the safest and most effective dosage for the generation of a strong immune response.

13. What is an influenza pandemic?

An influenza pandemic is a global outbreak of disease that occurs when a new influenza virus appears in the human population, causes serious illness, and then spreads easily from person to person. Unlike seasonal influenza, people will have little immunity to the virus that causes a pandemic. Visit www.hhs.gov for more information.



Pandemic Influenza: No longer if, it is when

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federal government called for schools with only one confirmed case of the novel H1N1 virus to close. This was a radical change from the pandemic severity index guidance created during the planning period. The pandemic severity index called for schools to close when there were hundreds of thousands of reported cases around the nation. But soon thereafter, it was determined that this novel strain of flu was acting very similar to seasonal flu. The symptoms, so far, have been mild to moderate and infected people are recovering in just a few days without anti-viral drugs. The guidance changed again such that schools could re-open and would only close if they determined that significant absenteeism caused a disruption in the ability of the organization to function normally.

There was also some confusion on the guidance for anti-viral drugs. The CDC recommends that anti-viral drugs be prescribed only for those high-risk individuals who have underlying health conditions which could make them more susceptible to influenza complications. The proper use of anti-virals (or any drug) is very important to make sure that illnesses do not become resistant to these medications.

Testing of the influenza samples has also changed as the situation has developed. In the beginning of this outbreak, the CDC began testing many people presenting with

influenza-like illness for influenza to gather surveillance data. Positive tests for influenza A were sent to the CDC lab for further sub-typing of the virus. From these tests, the CDC determined that the virus was spreading and that the H1N1 virus was prevalent in the U.S. The CDC's recommendation then changed to sub-type only those tests from individuals who were hospitalized to help determine the severity of the illness.

As cases of novel H1N1 began to show up in summer camps, the Georgia Division of Public Health amended the CDC's recommendation to also test a few samples of each cluster of illness. This was done for epidemiological surveillance (how and where the virus was spreading) only.

Confirmed cases of H1N1 include only those specimens tested and subtyped by the CDC lab or the Georgia Public Health Lab. This means that there are probably many more people infected with the H1N1 virus than the official record for the state shows. This same syndrommic surveillance system is used for tracking seasonal influenza and is intended to show flu activity in the region and not actual cases. Using this system, the CDC can fairly accurately estimate the number of people with influenza each year. For more information about this reporting system, go to <http://www.cdc.gov/flu/weekly/> Deaths related to influenza are reported on a case-by-case basis.

News Briefs and Resources for Emergency Preparedness

The **U.S. Chemical Safety Board (CSB)** has unveiled a newly re-designed website that includes imbedded flash videos, a photo gallery and a new accident news feed. The website can be beneficial to public health, hazmat teams, and other responders to learn about accidents that are happening or to gather information from previous responses to accidents. The 'video room' features safety videos that can be used for educational and training purposes. Visit www.csb.gov to learn more. CSB is an independent federal agency charged with investigating industrial chemical accidents.

The **Next of Kin Registry (NOKR)** was established in 2004 as a free tool for daily emergencies and national disasters. This free proactive service stores emergency contacts, next of kin, and vital medical information, which could be useful to emergency response agencies and family members.

NOKR says their system has been used in identifying persons in the 2009 Washington State flooding, 2008 California Wildfires, 2008 Hurricanes and 2008 Iowa Flooding Disasters. The stored information is accessible only by Emergency Services Sector agencies that have registered with NOKR at

<http://nokr.org/nok/restricted/agencies.htm>. The general public can visit <http://nokr.org> to obtain more information or to apply for its service. NOKR is a non-partisan; non-profit 501(c)(3) humanitarian organization dedicated to bridging rapid emergency contact information.

The **Center for Domestic Preparedness (CDP)** in Alabama is offering "WMD Hazardous Materials Evidence Collection (PER-201)". It is important for emergency services members from all disciplines to understand the principles of protecting a crime scene. The best way to do this is to be trained in the correct techniques of evidence collection, use the FBI's Crime Scene Search Protocol, use personal protective equipment and perform technical decontamination of personnel and collected materials. One of the significant components of the course is introducing non-law enforcement attendees to the FBI's Crime Scene Search Protocol, considered a universal approach to evidence collection. To learn more about the training or to register, go to www.cdp.dhs.gov/index.html. CDP covers the cost of travel to and from courses, lodging, meals and materials for the training.



Generator gives District Office the power to keep going

District 2 Public Health recently installed a generator to provide the district office with emergency power during a power outage or disaster. Hall County government technicians supervised the installation and will maintain the generator as part of the scheduled maintenance of the facility. The generator will supply power for important district functions, to include the District Operation Center, the refrigeration of vaccines, and availability of computer servers, such that continuity of operations will be assured during a disaster.

Mark Palen, District Emergency Preparedness Director commented, "In the event of a local power failure, this valuable asset will allow us to maintain contact with state operation centers, and to be responsive to the needs of our counties."



Top right: unloading the generator

Top Left: site preparation is complete

Left: positioning the generator for installation

Right: ready to install the generator





Metro Statistical Area (MSA) / Cities Readiness Initiative (CRI) Exercise Held

On June 11, 2009 a statewide exercise involving the 28 counties included in the Cities Readiness Initiative (CRI) and Metropolitan Statistical Area (MSA) was held. District 2 Public Health's objective for the exercise was to test call down capabilities. This was a two-part objective with a call down for the Point of Dispensing contacts and also for Public Information Officers from selected partner agencies.

The two CRI counties in our district are Dawson and Forsyth, so only organizations in those counties were part of the exercise.

The exercise began at 9:00 a.m. with a call down announcement on the Southern Linc radio statewide talk group. Emergency Preparedness personnel monitored WEB EOC in the District Operations Center as details were given to participating districts and responses were logged.

Each district chose the level of 'play' for their respective dispensing sites with many opening multiple Points of Dispensing and increasing capabilities throughout the day.

Participants from Forsyth County were Emergency Management (EMA), law enforcement, and public health. Participants from Dawson County also included EMA, law enforcement and public health. The Northeast Georgia Mountains Medical Reserve Corps emergency communications group (HAM radio operators) also participated in the exercise. They passed emergency exercise messages to and from different locations.

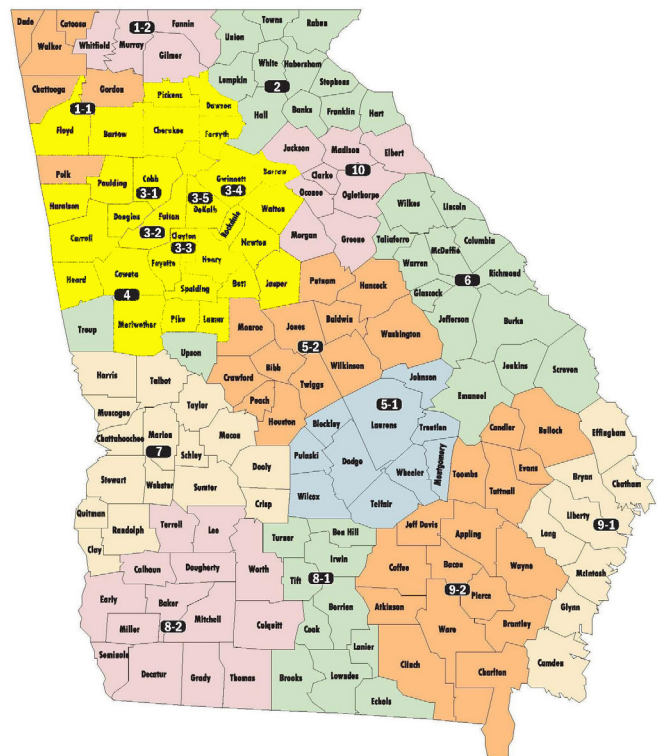
For the public information part of the exercise, the District 2 Public Information Officer (PIO) contacted PIOs from Forsyth County Schools, Forsyth County government and Forsyth County Fire and Emergency Services. Responses from these agencies were received within 30 minutes.

The Cities Readiness Initiative (CRI) is a federally funded effort to prepare major U.S. cities and metropolitan areas to effectively respond to a large scale bioterrorism event by dispensing antibiotics to their entire population within 48 hours of the decision to do so. CRI cities and metropoli-

tan statistical areas (MSA) are selected based on population, geographic location and potential vulnerability to a bioterrorism threat. Georgia's lone CRI city is Atlanta but the MSA includes 21 counties which, in turn, involves several public health districts.

The CRI project began in 2004 with 21 cities nationwide. In 2005, additional funding from the CDC added an additional 15 cities, and in 2006, an additional 36 cities were added for a total of 72 CRI cities nationwide. Currently, there is at least one CRI city in each state. Funding for the CRI is through the CDC's Public Health Emergency Preparedness (PHEP) Cooperative Agreement.

Yellow filled counties are CRI/MSA counties



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David N. Westfall, M.D., CPE
District Health Director

Mark Palen
Emergency Preparedness Director

Nina Cleveland-Hall
Emergency Preparedness Specialist

Donna Sue Campbell
Emergency Preparedness Liaison

Dave Palmer
Emergency Preparedness PIO
Editor of *The Sentinel*
dbpalmer@dhr.state.ga.us