THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

OCT 2 2002

HEALTH AFFAIRS

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)
DIRECTOR, JOINT STAFF

SUBJECT: Policy for the Use of Influenza Vaccine - 2002-2003 Influenza Season

The Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) have developed recommendations for the 2002-2003 influenza season. Their recommendations are based solely on clinical and epidemiological risk factors for mortality and morbidity from influenza, and do not address military readiness. Influenza vaccine manufacturers have informed the DoD of a delay of influenza vaccine availability throughout the United States for the 2002-2003 influenza season. Therefore, in consultation with the Joint Preventive Medicine Policy Group, prioritization recommendations are provided to assist commanders, resource managers, and force surgeons in balancing our primary mission of maintaining optimal medical readiness with our responsibility for protecting medically vulnerable beneficiaries. Ultimately, influenza vaccine prioritization is a local decision based upon availability of vaccine. DoD policy requires all active duty personnel and reserve personnel on active duty in excess of 30 days (10 days for Naval Reserve personnel) be vaccinated against influenza.

For the 2002-2003 influenza season, in addition to previously recommended risk categories, ACIP and CDC encourage the vaccination of infants 6-23 months of age, and household contacts and out-of-home caretakers of children 0-23 months of age. Target vaccination of these groups should take place after the vaccination of higher risk/higher priority groups (see attached "Influenza Vaccine Prioritization Recommendations").

For the 2002-2003 influenza season, the Department has contracted for 3.06 million doses – 75% from Aventis-Pasteur, and the remaining 25% from Wyeth. Aventis will deliver 562,500 doses by September 30, 2002, and the remainder not later than November 30, 2002. Wyeth will deliver 406,000 doses by October 15, 2002, and the remainder by December 16, 2002 or sooner. Services will utilize early vaccine doses to target high priority populations in accordance with the attached prioritization recommendations. Full-scale vaccination campaigns for other lower priority groups will be delayed until reasonable attempts have been made to vaccinate higher priority groups and vaccine supplies are adequate. Immunizations should begin as soon as the vaccine is received. The optimum time for vaccination is October and November. However, over the last 25 influenza seasons (1976-2001), the peak month for influenza activity occurred in December only 4 times (16%). For 19 seasons (76%), the peak activity occurred January through March. As such, vaccination efforts should continue until vaccine supplies are depleted or through March. Vaccination of recruits should continue until the expiration date on the vaccine label (expected to be June 30, 2003). Steps to minimize wastage of vaccine are important, including refraining from stockpiling more vaccine than needed resulting in vaccine

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being unused. Any influenza vaccine from previous years cannot be used for the 2002-2003 season.

The US Air Force continues to be the executive agent for laboratory-based influenza surveillance. Sentinel sites are selected based on their location, mission, and training status. Installations interested in participating may contact the Air Force Institute of Environment, Safety, and Occupational Health Risk Analysis (AFIERA) by email at INFLUENZA@brooks.af.mil for further details. The Epidemiology Branch of AFIERA updates the influenza surveillance website (https://gumbo.brooks.af.mil/pestilence/influenza) twice each week during the influenza season. Results from the laboratory surveillance are reported weekly during the flu season in the DoD Weekly Influenza Surveillance Report published by the AFIERA.

In addition to this laboratory-based surveillance data, AFIERA will analyze data from the DoD Global Emerging Infection System (GEIS) Electronic System for the Early Notification of Community-based Epidemics for influenza-like illnesses, and DoD hospitalization data for influenza and influenza-related hospitalizations, and include these data in the weekly report. Monthly summary and final reports will be coordinated between AFIERA and DoD GEIS for submission to Health Affairs.

My point of contact at Health Affairs is COL Benedict Diniega, (703) 681-1711.

William Winkenwerder, Jr., MD

Attachment:
As stated

Copy to:
J-4 (HSSD)
Surgeon General, Army
Surgeon General, Navy
Surgeon General, Air Force
Director of Health and Safety, US Coast Guard
Director, TRICARE Management Activity
Defense Supply Center Philadelphia (ATTN: Mr. Fileccia)
Assistant Secretary of Defense (Reserve Affairs)

Influenza Vaccine Prioritization Recommendations for the 2002-2003 Influenza Season

1. This year, DoD has ordered 3.06 million doses of influenza vaccine from Aventis-Pasteur (75%) and Wyeth (25%). Aventis will deliver 562,500 doses by September 30, 2002 and the remainder NLT November 30, 2002. Wyeth will deliver 406,000 doses by October 15, 2002 and the remainder by December 16, 2002 or sooner.

2. The following prioritization (Priority 1-highest priority, Priority 7-routine priority) seeks to balance our primary task--maintain optimal military readiness--with our responsibility to protect our most vulnerable populations. Where possible, vaccination of mission critical military personnel and high-risk medical individuals will proceed in parallel (Priorities 1, 2, and 3). For eligible beneficiaries, Military Treatment Facilities (MTFs) and operational force surgeons should prioritize administration of influenza vaccine in the following order:

a. Priority 1:

1) Priority 1A: Operational military personnel (Service-specific determination):

a) Operational forces forward deployed in support of Combatant Commander operational requirements in areas of high security risk (e.g., Southwest Asia, Korea, Eastern Europe, "STANS");

b) Forces embarked or afloat two or more weeks (may include pre-deployment underway work-up periods) (vaccine should be administered at least two weeks prior to getting underway);

c) Other forward deployed forces;

d) Special duty personnel expected to regularly transit multiple geographic areas or otherwise pose particular operational and epidemiologic risks, such as airlift aircrews. Ideally, vaccine should be administered at least two weeks prior to deployment;

e) Those on 96-hour alert status, and other alert forces as defined by the joint regulation on Immunizations and Chemoprophylaxis;

f) Early deployers through C+14.

2) Priority 1B. Defense Enrollment Eligibility Reporting System (DEERS) enrollees, whether or not on active duty, with high-risk medical conditions including:

a) Persons age 65 years of age and older enrolled in TRICARE Senior Prime at an MTF, or who otherwise receive the majority of their medical care at the MTF through an identified primary care manager (PCM) or ongoing patient-provider relationship. This age group historically has about 90% of the mortality from pneumonia and influenza;

b) Adults and children with chronic disorders of the pulmonary or cardiovascular system, including asthma;

c) Adults and children who have required regular medical follow-up or hospitalization during the preceding year for chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus);

d) Residents of long term care facilities (where applicable);

e) Women who will be in the second or third trimester of pregnancy during the influenza season. Pregnant women who have medical conditions that increase their risk for complications from influenza should be vaccinated, regardless of the stage of pregnancy;

f) Children and teenagers (age 6 months to 18 years) who are receiving long-term aspirin therapy, and therefore might be at risk for developing Reye's syndrome after influenza infection. Since high-risk children aged<9 years who are receiving vaccine for the first time need a booster dose 1 month after the initial dose, vaccinate these children as early as possible.

b. Priority 2: Health-care workers (including civilian employees and volunteers) with direct patient contact (due to the increased potential to transmit influenza virus infection to high-risk persons).

c. Priority 3: Trainee populations, including basic and advanced trainees, academy students and officer trainees. Trainees are at higher risk for epidemic influenza, but are theoretically easier to prophylax against influenza A than operational active duty members. Epidemiologic data suggest influenza B is less common than influenza A, particularly in these groups, and influenza B incidence usually peaks later in the season when vaccine supplies may be more widely available. Trainee groups should be under special hand-washing precautions at all times to reduce person-to-person transmission of respiratory viruses, including influenza and adenovirus.

d. Priority 4: Other groups in close contact with high-risk persons, such as employees in long term care facilities, household members (age 6 months and older) of medically high risk patients, and military training instructors.

e. Priority 5: All other military members in priority for deployment (those scheduled to deploy, then those on mobility status).

f. Priority 6: Other active duty members (including Guard and Reserve on active status) and emergency essential DoD civilians at OCONUS facilities:

1) Between 50 and 64 years of age;

2) Younger than 50 years of age.

g. Priority 7: All other beneficiaries:

1) Between 50 and 64 years of age;

2) Infants age 6 months through 23 months;

3) Household contacts (age 6 months and older) and out-of-home caretakers of children age 0 day to 24 months;

4) All other beneficiaries.

(Note: This priority scheme may be altered in the event of an epidemic outbreak requiring a focused management effort for a specific population. Alteration of priorities will be at the direction of the Service epidemiology centers and higher headquarters (SG) level preventive medicine authority.)

3. For other recommendations and guidance to include the use of diagnostics and antiviral drugs, and mass immunization campaigns, please refer to the Advisory Committee on Immunization Practices (ACIP) statement on the Prevention and Control of Influenza in the Center for Disease Control and Prevention (CDC) Morbidity and Morbidity and Mortality Weekly Report (MMWR) dated April 12, 2002 (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5103a1.htm).

4. Delay mass vaccination campaigns for lower risk beneficiaries (Priority 7) until the beginning of December when most vaccine should be delivered.

5. Health care providers should be reminded that influenza is a reportable medical event for the DoD Reportable Medical Events System (RMES). Reported cases should meet the definition for a confirmed case of influenza contained in the Tri-Service Reportable Events document which is available on the Army Medical Surveillance Activity website (http://amsa.army.mil/AMSA/amsa.ns.home.htm). Confirmed influenza cases should be reported promptly to the Service surveillance center utilizing existing Service-specific reportable medical events systems.

- Army Medical Surveillance Activity (AMSA)
  DSN 662-0471 http://amsa.army.mil/AMSA/amsa_home.htm
  CML (202) 782-0471

- Navy Environmental Health Center (NEHC)
  DSN 377-0700 http://www-nehc.med.navy.mil/
  CML (757) 953-0700

- Air Force Institute of Environment, Safety, and Occupational Health Risk Analysis (AFIERA)
  DSN 240-3471 https://gumbo.brooks.af.mil/pestilence/influenza
  CML (210) 536-3471

- Coast Guard Directorate of Health and Safety (G-WKH-1)
  COMM (202) 267-1725 e-mail sludwig@comdt.uscg.mil