INFLUENZA PANDEMIC PLAN FOR HONG KONG, CHINA
(March 2002)

1. Introduction

Purpose of influenza pandemic plan

1.1 Influenza viruses are unique in their ability to cause sudden, pervasive infection in all age groups on a global scale. Pandemics occur because of the ability of the virus to change into new types or strains. The worst natural disaster in modern times was the infamous "Spanish flu" (H1N1) of 1918, which caused more than 20 million deaths worldwide.

1.2 In Hong Kong, China, although the "Hong Kong flu" (H3N2) of 1968 was not as serious as the Spanish influenza pandemic, it was associated with high rates of illness and social disruption. The recent "Avian flu" in 1997 was caused by a new H5N1 influenza virus of avian origin. From May to December 1997, 18 cases of infection were confirmed with six deaths. Further cases in man ceased after the mass slaughter of chickens in late December 1997. Nevertheless, it had aroused global concern on the potential of this avian flu virus to become a pandemic strain in human.

Impact of influenza pandemic

1.3 The impact of an influenza pandemic will depend on several key factors. They include pathogenicity and transmissibility of the virus, the degree of immunity and general status of the population, environmental factors which facilitate virus transmission such as population density, human and animal contacts, and the effects of protective mechanisms like vaccines or chemoprophylactic agents.

1.4 According to the past experience on influenza pandemics, an attack rate between 10% and 40% in the community could be anticipated. Based on U.S. data, excess mortality would probably lie between 1 per 100 000 and 55 per 100 000

population.

1.5 These staggering figures will certainly affect economic activities substantially and create immense pressure on medical and health services. Moreover, these estimates underscore the need for advance planning to lessen the impact of a pandemic.

Purpose of influenza pandemic plan

1.6 The purpose of this influenza pandemic plan is to provide a guide on how to detect and respond to an influenza pandemic. The plan describes the emergency measures to be taken by the Department of Health (DH). It also briefly describes the roles and responsibilities of different parties in the emergency response.

2. Concept of Operations

Phases of influenza pandemic

2.1 An influenza pandemic will evolve through the following series of phases :

Phase	**Definition**
Pre-pandemic phase	Endemic level of influenza illness caused by circulating strains. No indication of any new virus type has been reported.
Pandemic phase □□ Novel virus alert □□ Pandemic alert	 Novel virus discovered overseas with pandemic potential or isolated locally from a single human case, without clear evidence of spread of such virus. Novel virus demonstrated person-to-person transmission and caused multiple cases.

□□ Pandemic period	Novel virus causing unusually high rates of morbidity and mortality (a sharp rise in influenza-like illness and its complications).
Post-pandemic phase	Cessation of successive pandemic waves, accompanied by the return of the usual activities cycle.

Essential activities

2.2 The essential activities for responding to an influenza pandemic include the following :

(i) Surveillance
(ii) Vaccination
(iii) Provision of medical services
(iv) Stocking of antiviral drug and other materials
(v) Response and communication

3. Pre-pandemic Phase

The following describes activities that are conducted regularly in relation to influenza illness.

Surveillance

3.1 The crucial activity is to maintain intensive surveillance to give early warning signal of an impeding pandemic and monitor antigenic changes in the virus. The current human influenza surveillance system consists of a network of 64 government general out-patient clinics (GOPCs), 47 private clinics, 4 Regional Health Offices, public hospitals, Government Virus Unit (GVU) and private laboratories. The GVU collects specimens from the system for influenza virus isolation to identify the prevailing strain. Atypical isolates would be sent to the Collaborating Centres for Virus Reference and Research on Influenza of the World Health Organization (WHO) for subtype confirmation. On the other hand, influenza surveillance in animals and poultry includes active surveillance at local farms, wholesale and retail markets.

3.2 It is important that each cluster of cases should be investigated thoroughly and suitable control measures be implemented accordingly, for example, enhanced animal surveillance and strengthened market hygiene in case of avian influenza outbreaks.

3.3 Influenza activities overseas should be closely monitored through the programme of international surveillance for influenza coordinated by the WHO and other established networks.

Vaccination

3.4 Currently, influenza vaccination is provided free for elderly in residential homes annually to protect them against severe complications of influenza infection.

3.5 Influenza vaccines are normally made by growing approved seed viruses in embryonated chicken eggs, purifying and chemically treating the harvest, and then adjusting the concentration against reference biological standards. In the case of a pandemic virus, an expected minimum 6-8 months will pass before new vaccine first begins to be distributed from manufacturers.

3.6 The issue of vaccination is important to consider in the pre-pandemic phase. The dilemma is that mass production of influenza vaccine would only commence when there was evidence of efficient person-to-person transmission and availability of a suitable seed virus and adequate embryonated eggs for culture and vaccine production. Mass production of vaccines takes about 6-8 months. This makes vaccination relatively impractical if the seat of infection is to arise in Hong Kong.

Provision of medical services

3.7 Medical consultations for influenza-like illnesses (ILI) are mainly provided by the GOPCs and private practitioners.

Serious complications would be managed in the public or private hospitals.

Stocking of antiviral drugs and other materials

3.8 Sufficient material resources must be accumulated at this stage prior to the arrival of a pandemic. Close liaison with various manufacturers and suppliers should be maintained to ensure an adequate supply of drugs (e.g. antiviral drugs, antibiotics, antipyretics and antihistamines) and consumables within a short period of time.

Response and communication

3.9 A contingency plan is ready to mobilize laboratory staff and reagents when a pandemic arrives. Training of laboratory personnel is required in this phase, as such skills cannot be easily learnt in a short time.

3.10 The necessary publicity and educational materials on the prevention of influenza in a pandemic situation should be prepared. Examples include Announcement of Public Interests (APIs), sound scripts, hotlines, information notes and messages for uploading on the Internet.

4. Pandemic Phase

4.1 The ultimate decision on activating the activities in the pandemic phase should rest on the Central Government with input from the DH. Consultation may be made with the Special Investigation Group on Influenza.

Surveillance

4.2 The sentinel and laboratory surveillance should be enhanced. Activation of activities of the pandemic phase should be based on the following factors :

Novel virus alert

□□ A novel virus discovered overseas is shown to have

pandemic potential

- Laboratory identification of a novel virus from a human case

Pandemic alert

(i) Laboratory indication of novel virus as the prevailing strain of influenza virus
   - Increasing number of novel virus isolates
   - Increasing percentage of novel virus isolates among all influenza
   - Novel viruses taking over other types of influenza viruses
   - Change in genetic structure of novel virus

(ii) Evidence of secondary spread of novel virus
   - Secondary cases appear after index cases
   - Serosurvey among close contacts indicate high level of seroconversion
   - Large number of people coming down with ILI within a short period of time

Pandemic period

(i) Multi-focal cluster or outbreaks of novel virus
   - Among schools, nurseries, institutions etc.
   - Widespread over the territory

(ii) Unusual increase in ILI, associated with novel virus outbreaks

(iii) Unusual increase in deaths, associated with novel virus outbreaks

Vaccination

4.3 Once a view is taken that Hong Kong is entering a pandemic phase based on available epidemiological data, DH will alert the WHO which may consider initiating vaccine development.

4.4 If a safe and efficacious vaccine is available, it would be justified to give to as many as people as possible, as the price to pay for an influenza pandemic far outweighs that of a vaccine. However, in the event of a pandemic, vaccine

demand is likely to exceed supply. The decision as to who should receive the vaccine then becomes important. Priority should be given to those who are needed to maintain the essential services of the community, e.g. health care workers, police and ambulance personnel. An effective communication mechanism with the public on vaccine supply needs to be established in advance.

4.5 As in other vaccination programmes, information leaflets and consent forms should be made ready beforehand. It is also important to keep record of vaccination and monitor the adverse effects following vaccination.

Provision of medical services

4.6 The level of medical services provision in DH should be decided by the Headquarters of DH.

4.7 Extended GOPC service provision may be achieved in a number of ways, activated in the following order :

(i) Increase GOPC/evening clinic quota and reduce apportion of chronic appointments

(ii) Increase the number of evening GOPCs

(iii) Extend hours of GOPC service

(iv) Mobilize other clinic services in the following order :

- Chest clinics
- Family health, elderly health and student health service centres
- Other specialty clinics

4.8 During the peak of the pandemic, amantadine will be given as presumptive treatment for ILI. A guideline on its use will be issued for doctors' reference. This guideline will also be distributed to general practitioners (GPs) and hospitals. Each patient visiting the clinic will be given health advice.

Stocking of antiviral drugs and other materials

4.9 Amantadine prophylaxis should only be used under clear

indications because of its incidence of side effects (14%, mainly neurological and gastrointestinal). The objective of amantadine prophylaxis is to maintain essential services, by protecting those who are key to maintaining social order, health and safety of the public. These will include :

- Health care workers providing direct patient care or handling of specimens e.g. doctors, nurses and paramedics working in hospitals or outpatient clinics
- Staff responsible for patient rescue and transfer e.g. ambulance crew, auxiliary forces
- Staff responsible for maintenance of social order e.g. police, fire services, immigration, correctional services, custom and excise
- Staff running essential services e.g. electricity power companies, water supplies, social welfare, telecommunications, Hong Kong Observatory, funeral services, drainage

4.10 Different officers should be assigned to liaise with the above parties to determine the mechanism for the delivery of chemoprophylaxis and monitoring of side effects.

Response and communication

4.11 Relevant parties need to be informed when the pandemic phase is activated.

4.12 The Interdepartmental Co-ordinating Committee should be convened to coordinate actions between different government bureaux and departments.

General practitioners and professional bodies

4.13 For GPs and professional bodies, it will be paramount to secure their support to open up clinics during the pandemic period. Guidelines on ILI management and presumptive treatment with amantadine should be provided to them.

Hospital Authority (HA)

4.14 For HA hospitals, there is a need to set up a working group to

coordinate medical services between HA and DH. Important issues to discuss will include clinical case definitions, referral procedures, management guidelines, amount of specimens to be sent to the GVU, and coordination between GOPC and Accident & Emergency services.

The public

4.15 Communication with members of the public will be a critical issue to handle, as lack of information or mis-information can cause undue panic even to the point of civil disaster. A daily press release or press briefing may be necessary to update the public on the latest news about the pandemic. Within DH, the Information Unit should coordinate different information channels and act as the departmental spokesperson. The relevant APIs should be broadcast. Hotlines to answer public enquires should be set up and updates and health message put onto the Internet as often as necessary.

WHO and overseas health authorities

4.16 Contact with the WHO and other international health authorities as appropriate should be made informing the progress of the pandemic.

Pandemic assessment

4.17 All the relevant epidemiological data should be monitored closely.

Closure of non-essential public places

4.18 The decision to close down public gathering places for public health protection requires assent from the Central Government. Closing down certain premises may slow down the progression of the epidemic, but is unlikely to stop it altogether. Balance should be struck between social disruption, economic losses and mortality. Under a severe pandemic, suspension of nurseries, day care centres and

schools is probably warranted. Closure of transport without natural ventilation may also be recommended.

Laboratory support

4.19 The laboratory contingency plan should be activated and its manpower and capacity must be enhanced. The GVU should look for changes in the influenza virus with further passages and the emergence of drug resistance.

Mortuary support

4.20 Effective ways to handle the significant increase of mortuary workload and capacity should be found in case of excess deaths from the pandemic.

5. Post-pandemic Phase

5.1 The decision to stand down the contingency measures and to declare the pandemic over again rests with the Central Government.

Surveillance

5.2 When the pandemic is over, surveillance activities must continue to monitor the early signs of a second wave. Serological studies may be conducted to ascertain the percentage of people affected by the pandemic.

Vaccination

5.3 If vaccination has not been carried out before, preparations should be made to vaccinate the population to protect them from a second wave. Defining the vulnerable groups for priority vaccination should take into consideration the epidemiological and clinical presentations exhibited by the pandemic virus strain.

Provision of medical services

5.4 The normal clinic services will be resumed in phases to tie in

with the reduction in medical consultations.

Stocking of antiviral drugs and other materials

5.5 Amount of amantadine and other materials consumed should be checked and adequate quantities be replenished to prepare for the second wave or next pandemic.

Response and communication

5.6 The essential activities are to disseminate public information and evaluate efforts and outcome.

5.7 After the pandemic period is over, DH will undertake the following :

(i) Assessment of the overall impact of the pandemic
(ii) Evaluation of lessons learned from the pandemic that will assist in responding to future pandemics
(iii) Update of the influenza pandemic plan

6. Summary

6.1 The above contingency plan provides the framework for various control measures to be undertaken when Hong Kong, China faces an influenza pandemic. It calls for collaboration and cooperation among various sectors beyond the health sector. It is hoped with the concerted efforts from every party and organization in the local community, the impact of the influenza pandemic can be minimized to the least.

Department of Health
Government of Hong Kong Special Administrative Region
March 2002

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1.2 In Hong Kong, China, although the "Hong Kong flu" (H3N2) of 1968 was not as serious as the Spanish influenza pandemic, it was associated with high rates of illness and social disruption. The "Avian flu" in 1997 was caused by a new H5N1 influenza virus of avian origin. From May to December 1997, 18 cases of infection were confirmed with six deaths. Further cases in man ceased after the mass slaughter of chickens in late December 1997. Nevertheless, it had aroused global concern on the potential of this avian flu virus to become a pandemic strain in human.

1.3 In February 2003, two cases of H5N1 infection with one death were detected in Hong Kong. The World Health Organization (WHO) activated its global influenza laboratory network and called for heightened global surveillance.

Impact of influenza pandemic

1.4 The impact of an influenza pandemic will depend on several key factors. They include pathogenicity and transmissibility of the virus, the degree of immunity and general status of the population, environmental factors which facilitate virus transmission such as population density, human and animal contacts, and the effects of protective mechanisms like vaccines or chemoprophylactic agents.

1.5 According to the past experience on influenza pandemics, an attack rate between 10% and 40% in the community could be anticipated. Based on U.S. data, excess mortality would probably lie between 1 per 100 000 and 55 per 100 000 population.

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2. Concept of Operations

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Department of Health
Government of Hong Kong Special Administrative Region
July 2003 (revised)