

GUIDELINES FOR PANDEMIC INFLUENZA PREPAREDNESS AMONG REFUGEES AND OTHER POPULATIONS OF CONCERN TO UNHCR

Introduction

Influenza pandemics comprise multiple epidemics throughout the world at the same time, and have been recorded this century in the years 1918/19, 1957 and 1968/69. Influenza causes smaller, unsynchronised epidemics around the world on a yearly basis as a result of small changes in its physical structure. However, major changes in structure resulting from exchange of genetic material between human and animal influenza viruses are the cause of pandemics, with significant illness and death due to a lack of immunity to the new strain.

In 2003, SARS (Severe Acute Respiratory Syndrome) highlighted the vulnerability of the global community to new 'emerging' viruses. This threat was successfully controlled as a result of national and international infection control efforts. The recent identification of avian influenza H5N1 and its repeated transmission to humans with fatal disease has again presented a serious threat. At present H5N1 is hardly transmissible between humans. We cannot predict with precision the next pandemic influenza virus, whether or not it will originate from H5N1, its virulence, nor its subsequent morbidity and mortality.

High population densities in refugee settings combined with poor nutrition, barriers to accessing health facilities and poor sanitation could result in infection and mortality rates higher than in other populations. In the event of an emergency, limited resources for surveillance, infection control and disease management are unlikely to be directed towards refugees and other populations of concern (POCs) to UNHCR. Communication efforts may not take into account specific linguistic and cultural needs. Refugees and other POCs risk being stigmatised or blamed for disease transmission. Restriction of population movements and quarantine of whole camps may follow, without necessarily employing evidence-based principles.

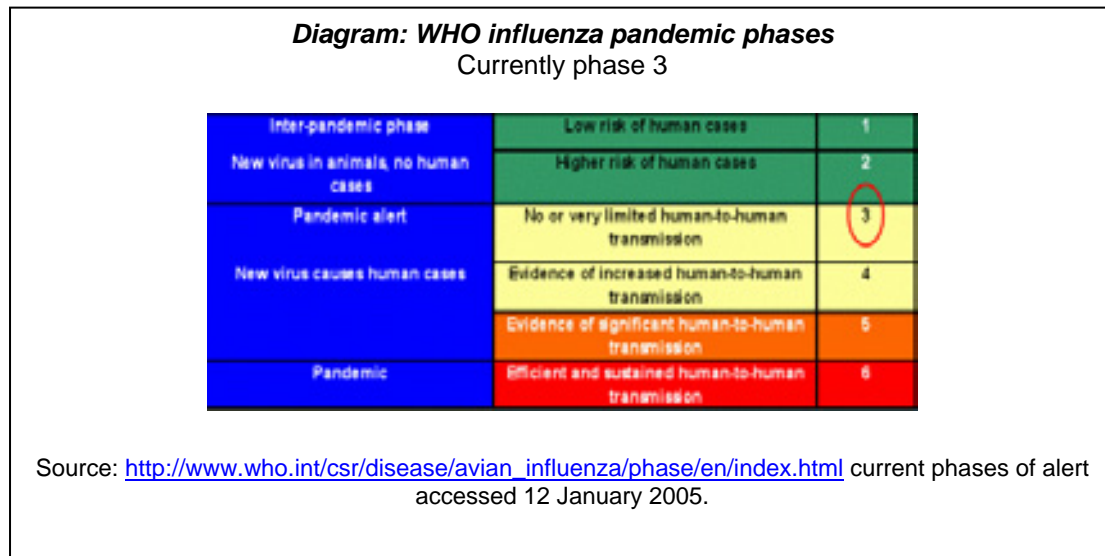
Control efforts may fail on both humanitarian and epidemiological grounds if POCs are excluded from preparedness and response plans. These guidelines have been developed to assist country offices in urgently developing preparedness plans.

Activities include access to diagnostic facilities and stockpiles of antiviral drugs, vaccines, personal protective equipment, and ancillary pharmaceuticals. Agencies delivering services to these populations need to be involved in coordination efforts at national, regional and global levels. Culturally and linguistically appropriate risk communication in displaced populations is a vital early step. If successful, this may enhance the effectiveness of animal and human surveillance through community participation. Training of health workers in infection control (including use of personal protective equipment) and disease management will also be necessary.

The effectiveness of any measures implemented (pharmaceutical or non pharmaceutical) will depend on the timing of implementation, the thoroughness of implementation, and the efficiency of human-to-human transmission of the pandemic virus, rather than solely on virus characteristics. Reductions in illness and death from other infectious diseases should follow if the plans are implemented. Activities in these documents have been summarised from WHO Global Influenza Preparedness Plan:

www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_2005_5.pdf to which country offices are referred for more details.

Activities are staged to reflect WHO's classification of pandemic phases (see Diagram) and should provide clear, timed priorities for all stake holders involved.



Detailed technical guidelines on case investigation and infection control for refugees and displaced populations are under development with WHO and will be forwarded as soon as finalised. Some recommendations may need modification as developments occur.

For guidelines on containing H5N1 in poultry refer to The World Organisation for Animal Health (OIE) avian influenza homepage http://www.oie.int/eng/AVIAN_INFLUENZA/home.htm and the Food and Agricultural Organisation (FAO) avian influenza home page http://www.fao.org/ag/againfo/subjects/en/health/diseases-cards/special_avian.html.

Key Elements for Pandemic Influenza Planning

PANDEMIC ALERT PERIOD		
Phases	3	
Goal	Surveillance and containment	
Activities	Planning and coordination	<p>Inclusion of populations of concern (POCs) in national contingency planning efforts, including in stockpiles of antiviral drugs, vaccines, personal protective equipment, ancillary pharmaceuticals and supplies, and laboratory diagnostics.</p> <p>Inclusion of partner agencies delivering services to POCs in coordination efforts at national and field levels.</p> <p>Develop contingency plans for POCs.</p>
	Communication	<p>Emphasis should be on good hygiene. Influenza is transmitted by droplets which are either inhaled or which contaminate surfaces or food. Personal and public hygiene measures could effectively limit spread of pandemic influenza.</p> <p>National community education programs should include POCs. National communication materials should be adapted to suit local linguistic and cultural needs, and existing communications networks in the community should be utilised.</p> <p>Conduct risk communication with partners, health workers, and POCs, particularly in rural areas, including early distribution of educational information (verbal or written). General information on communications can be found at http://www.who.int/infectious-disease-news/IDdocs/whocds200528/whocds200528en.pdf.</p> <p>Information should include risks and risk avoidance; information on the next phase; promotion of prompt presentation for diagnosis when febrile; surface cleaning; regular hand washing with soap; respiratory hygiene (covering of the mouth during coughing or sneezing); and avoidance of affected farms/live poultry market if avian influenza has been confirmed in the area. In phase 3 where transmission is largely bird to human, education should include safe handling of poultry (disinfect hands and tools afterwards) and thorough cooking of poultry and eggs prior to consumption. http://www.who.int/csr/disease/avian_influenza/foodrisk2005_11_03/en/index.html. Five keys to safer foods information pamphlet and poster (in many languages including English, French, Arabic) http://www.who.int/foodsafety/consumer/5keys/en/</p> <p>For more information see WHO Non-pharmaceutical interventions: their role in reducing transmission and spread http://www.who.int/csr/disease/avian_influenza/pharmaintervention2005_11_3/en/index.html</p>
	Surveillance and diagnosis	<p>Early contact with national health officials and WHO influenza network specialists in host country. Identify focal points at settlement and sub-office levels. Establish focal points and diagnostic sampling procedures with National Influenza Centre if present (www.who.int/csr/disease/influenza/centres/en/index.html) or local WHO/MOH in advance so that assistance with diagnosis can be</p>

		<p>made promptly when needed.</p> <p>Inclusion of refugee camps in animal and human surveillance and early warning activities, particularly in rural areas and where associated with cross border population movements (eg repatriation programmes). Create informal surveillance networks with community leaders (rumour reporting) and health care providers, as adjunct to health facility surveillance.</p> <p>Report large numbers of bird or other animal deaths at the same time in the same place (for chickens, the FAO suggests the threshold for reporting chicken deaths is 1-5% mortality for 2 days) to national veterinary organisation or WHO/MOH.</p> <p>Report acute respiratory infections without other cause, clusters of unusual respiratory illness or deaths in humans to WHO/MOH or National Influenza Centre. Human blood and/or respiratory tract swabs should be collected, stored and transported according to WHO guidelines (URL:www.who.int/csr/disease/avian_influenza/guidelines/human_specimens/en/).</p>
	Procurement / improved infrastructure	<p>Ensure adequate access to clean water and waste disposal in the community; soap, narrow necked water containers, and covered buckets for households. Additional supplies and materials needs should be calculated.</p> <p>Infection control in health centres must be adequate. Ensure clean water supply, waste disposal (incinerators), latrines, and hand and surface disinfectants. Additional supply needs should be calculated. Create isolation rooms within medical facilities.</p> <p>Medical supply needs should be calculated and supplies procured eg masks, oxygen, sterile needles, fluids, antibiotics for respiratory infections.</p>
	Case management	<p>Ensure surge capacity and staff availability.</p> <p>Train health workers delivering services to refugees and other displaced populations on infection control (including use of personal protective equipment); disease management; and influenza pandemic risk</p> <p>Case management according to WHO guidelines http://www.who.int/csr/disease/avian_influenza/guidelines/clinical_manage/en/index.html</p>
Phases	4,5	
Goal	Surveillance and containment	
Activities	In addition to those activities listed under phase 3:	
	Planning and coordination	<p>UNHCR involved in national crisis committee as appropriate.</p> <p>Cross-border coordination and information sharing with neighbouring country offices.</p>
	Communication	Refine communications strategies and key messages.

	Surveillance and diagnosis	Ensure that partners are conducting contact tracing of infected people, incorporated into national surveillance activities.
	Case management	<p>Ensure that partners are isolating infected patients (or at least putting all infected people together in one room with other patients separated by a curtain). Current guidelines can be found at: http://www.who.int/csr/disease/avian_influenza/guidelines/Guidelines_for_health_care_facilities.pdf. Follow up-dated WHO/national infection control guidelines, case definitions, treatment protocols, case finding algorithms.</p> <p>Ensure that symptomatic persons and persons seeking treatment in waiting rooms and other risk areas should wear surgical masks. Health care workers and first responders should be trained in the use of standard, well fitted surgical masks. Fitted N95 respiratory masks if available can be used with staff trained in their use, particularly for high risk procedures such as intubation. Gloves, gowns and eye protection are advised when treating patients with pandemic influenza.</p>
	Antivirals and vaccines	Ensure that POCs are included in antiviral¹ or vaccination² programmes should they reside in areas selected for targeted based on sound epidemiological principles. POCs should have access to WHO antiviral stockpile on equal basis as host nationals, based on epidemiological principles.
	Restriction of movement	<p>Ensure that partners are implementing voluntary home confinement of contacts with infected persons.</p> <p>Quarantine and restriction of population movement (including cross-border movements) should be based on effective disease control principles. Movements to affected areas from non-affected areas, and from affected areas to non-affected areas (including repatriation programmes) will usually be restricted (according to national/WHO recommendations).</p>

¹ Antiviral Drugs

Limited clinical studies have suggested that the antiviral drugs oseltamivir (Tamiflu®) and zanamivir (Relenza®) may reduce both the severity and duration of infection if given early. The use of these agents in pandemic influenza has been proposed in the form of post-exposure prophylaxis, as a holding measure to slow transmission whilst vaccine production occurs. As with vaccines, the barriers in the refugee setting are cost and availability, despite a recent eight-fold increase in production capacity reported by WHO. Importantly, WHO is securing a centralised stockpile of 3 million treatment courses of antivirals. This is specifically for use in the first areas to be affected by an emerging pandemic virus once human-to-human spread is demonstrated, in order to contain it or delay international spread. Success of this approach will depend on high levels of surveillance and logistic support to investigate as rapidly as possible suspected cases. At camp level, shortage of drugs will mean prioritisation is necessary. This ideally should be in keeping with national pandemic strategy for targeting of antivirals. Decisions to target populations should be on epidemiological grounds: populations of concern to UNHCR should have access to the WHO stockpile if epidemiologically indicated.

² Vaccines

Currently available vaccines against seasonal influenza are not designed to protect against pandemic influenza and will not protect people against H5N1. An effective vaccine against pandemic influenza cannot be produced until it starts spreading between humans. Until then, global priorities are geared towards early identification and scaling up capacity for production once a vaccine is possible. The WHO estimates current vaccine production capacity globally to be 300 million doses per year- far below the number needed for a global pandemic. Furthermore it is estimated that commercial production would not start for three to six months following the emergence of a pandemic strain. Prioritisation of vaccine in the face of limited supply will be necessary, and medical staff (both expatriate and local) should be vaccinated as soon as it is available.

PANDEMIC		
Phase	6 (all countries affected)	
Goal	Reduce death, illness and social disruption	
Activities	Communication and coordination	<p>Communication with national government, the health ministry and the UN Country Team will be crucial in gaining up-to-date information regarding the epidemic in the general population.</p> <p>Rapid dissemination of this information to populations of concerns and partners.</p> <p>Coordination of activities with national government and UN Country Team</p>
	Infection control	<p>Ensure that hygiene measures are emphasised among POCs, including hand washing with soap, respiratory hygiene, and disinfection of potentially contaminated surfaces in the household.</p> <p>Ensure that partners have stopped contract tracing and quarantining as it will no longer be feasible or effective and is not recommended by WHO.</p> <p>Ensure that health workers and first responders should wear N95 or surgical masks; infected persons should wear surgical masks.</p> <p>Once all countries are affected by pandemic influenza, Ensure that partners have stopped isolation of infected persons as this will no longer be effective, however health facilities should be arranged to limit transmission (such as facing beds head to foot).</p>
	Disease surveillance and case management	<p>Human resources should not be focused on surveillance in this period, but deployed to treatment of cases, dissemination of information and messages to the population and maintenance of essential services.</p>