



**COMMANDER, U.S. PACIFIC COMMAND
(USPACOM)
CAMP H.M. SMITH, HAWAII 96861-4028**

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USPACOM INSTRUCTION 0507.1

Subj: PANDEMIC INFLUENZA (PI) PREPARATION AND RESPONSE PLANNING
GUIDANCE

- Ref:
- (a) ASD(HA) Memo, Guidance for Preparation and Response to an Influenza Pandemic caused by the Bird Flu (Avian Influenza), 21 Sep 2004
 - (b) National Response Plan, December 2004
 - (c) DOD Directive 3025.15, "Military Assistance to Civil Authorities," 18 Feb 1997
 - (d) GAO Report: Influenza Pandemic Plan needed for Federal and State Response. October, 2000
 - (e) ASD(HA) Charter of DOD Select Agents Response Task Force, July 26, 2002
 - (f) World Health Organization (WHO) Influenza Pandemic Preparedness Plan. The Role of WHO and Guidelines for National and Regional Planning. Geneva, Switzerland, 2005
 - (g) Department of Health and Human Services Pandemic Influenza Preparedness and Response Plan, 26 Aug 2004 (Draft)
 - (h) Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP) Vol 53, No RR06, 29 July 2005
 - (i) ASD(HA) Memo, "Policy for DOD Global, Laboratory-Based Influenza Surveillance (HA 99-008)," 13 Feb 1999
 - (j) NAVHOSPLAKES NOTICE "Response Guidelines for the Management of Pandemic/Avian Influenza" 5 Jan 2005
 - (k) Department of the Army, FM 100-23-1 "Multiservice Procedures for Humanitarian Assistance Operations" 31 October 1994 (Note: Appendix G addresses Office of Foreign Disaster Assistance Response Teams)
 - (l) DOD Instruction 6490.3, "Implementation and Application of Joint Medical Surveillance for Deployments," 7 Aug 1997
 - (m) Executive Order: Amendment to Emergency Order 13295 Relating to Certain Influenza Viruses and Quarantinable Communicable Diseases, April 1, 2005
 - (n) DSD Memo, Reporting "Immediate Response; Requests from Civil Authorities," 25 Apr 2005
 - (o) Interim CDC Recommendations for Infection Control in Health Care Facilities Caring for Patients with Known

24 AUG 05

- or Suspected Avian Influenza, 31 May 2005
- (p) CDC Bulletin, "Detection and Control of Influenza Outbreaks in Acute Care Facilities," Sep 2001
 - (q) Interim CDC Guidance about Avian Influenza for U.S. Citizens Living Abroad, 23 Aug 2005
 - (r) DODD 6200.3, Emergency Health Powers on Military Installations, 12 May 2003
 - (s) DODD 3025.14, Protection and Evacuation of U.S. Citizens and Designated Aliens In Danger Areas Aboard (Non-Combatant Evacuation Operations), 05 Nov 1990
 - (t) DODI 6205.4, Immunization of Other Than U.S. Forces for Biological Warfare Defense, 14 Apr 2000
 - (u) USPACOMINST 0237.1, Mortuary Affairs, 23 May 2005

Encl: (1) Medical Services
(2) Public Affairs
(3) Additional Resources

1. Purpose. To provide the initial concept of operations, implementing instructions, and planning guidance to preserve the fighting force, to maintain maximum operational readiness, and to slow the spread and reduce morbidity and mortality in affected populations in response to a Pandemic Influenza (PI) within the United States Pacific Command (USPACOM) Area of Responsibility (AOR), in accordance with references (a) through (u).

2. Applicability and Scope. This guidance applies to all USPACOM Directorates, USPACOM Service Components, Sub-Unified Commands, and all supporting agencies, Services and Commands. All or portions of these guidelines are applicable to all military members, nonmilitary persons under military jurisdiction, Federal employees, family members and all others eligible for care within the military healthcare system. This instruction will be supplemented with additional information in the near future and will be supported by operational orders and concept documents as conditions warrant.

3. Intelligence. Recent Asian avian influenza cases have raised concern that avian influenza could undergo genetic re-assortment or mutation, and become efficiently transmissible ("confirmed, sustained human-to-human transmission") resulting in a global pandemic. No avian influenza vaccine yet exists, and it could take 6 months or longer to develop and produce an effective vaccine after the pandemic's emergence. Because PI could spread rapidly and infect many military units, it poses a distinct threat to military operations in the Area of

Responsibility (AOR). Additionally, a global pandemic could place enormous strains on civilian resources, resulting in requirement for substantial military support to civilian organizations of partner and coalition governments.

4. Background and Operational Need. Historically four or five PI outbreaks have occurred per century. The most dramatic example was the 1918 "Spanish Flu" outbreak that resulted in millions of ill people, at least 600,000 deaths in the US, and 30-70 million deaths worldwide. It often struck individuals in the 15 - 45 year old age range as well as infants and elderly. Illness often developed rapidly. Many patients died within the first 48 hours following onset of symptoms. The outbreak was especially severe in military recruit camps where personnel assembled from throughout the U.S. A similar outbreak today might severely reduce a military Commander's capability.

a. Influenza viruses have the ability to mutate. When a virus that is highly pathogenic to birds (avian influenza) is able to mix with a virus that spreads rapidly from human-to-human, emergence of a new "super flu" that spreads rapidly and affects a high percentage of people becomes possible. A PI outbreak would result when this occurs. Scientific indicators show that this scenario might evolve from the virus that is currently affecting bird, pig, and other animal populations across Southeast Asia.

b. USPACOM's extensive exercises, training and operations throughout the Asia Pacific region, including disaster response and humanitarian assistance, routinely bring large numbers of personnel in contact with local populations, both military and civilian. These activities bring thousands of military personnel to countries where avian influenza has been reported. Smaller groups of U.S. military personnel, including those engaged in the search for, and recovery of remains of service personnel from prior conflicts in Asia, also work in multiple countries that have been affected by avian influenza and other emerging pathogens. This operational tempo along with today's highly mobile society and global air travel could dramatically increase the spread of this and other new viruses leading to rapid development of a pandemic.

c. During such an outbreak, military units in close quarters could experience between 20% and 50% of their force being infected in a matter of weeks. A significant percentage of these will require hospitalization. Not only might medical facilities be overwhelmed, military units could lose critical

24 AUG 05

team members. Many could remain ill for one to two weeks. While pandemic mortality rates are unpredictable, eventually becoming lower over time, current experience indicates that up to 60% of those hospitalized may die. Inpatient and logistics functions in many cases may be overwhelmed. In affected areas, Unit Commanders could easily be faced with a significantly reduced ability to move troops, generate aircraft sorties, move ships, and otherwise conduct operations.

d. As a secondary effect of PI, large-scale social unrest could develop due to fear of infection among individuals, their families, and their associates. All normal civic and business communities will be impacted and this could reduce capabilities to conduct operations in support of USPACOM units.

e. Commanders must take preparatory actions to ensure operational readiness is maintained and to slow the spread of PI when it occurs.

5. Definitions

a. Assumptions. A military term used in plan development which is described as "A supposition on the current situation or a presupposition on the future course of events, either or both assumed to be true in the absence of positive proof, necessary to enable the commander in the process of planning to complete an estimate of the situation and make a decision on the course of action." Valid assumptions have three characteristics: they are logical, realistic and essential for planning to continue.

b. Isolation. The separation of ill people who have a specific infectious disease from healthy people to eliminate the ill individual's direct contact with the healthy, and restrict the spread of disease. In most cases, isolation is voluntary; however, to protect the public, many levels of government (federal, state and local) have authority to compel isolation of potentially infectious people.

c. Limitations. For military planning, limitations have three broad categories: Constraints (actions we must do), Restraints (actions we cannot do), and Others (weather, terrain, etc.).

d. Noncombatant Evacuation Operations (NEO). Operations directed by the Department of State (DOS), or other appropriate authority whereby noncombatants are evacuated from foreign countries when their lives are endangered by war, civil unrest,

or natural disaster to safe havens or to the United States. NEO may be assisted by the military.

e. Other Than U.S. Forces (OTUSF). Collectively refers to noncombatant, non-uniformed U.S. citizens, as well as other select non-U.S. personnel, in accordance with reference (t), who are in high threat areas.

f. Pandemic. Widely epidemic disease; disease distributed throughout a region, continent, or globally.

g. Public Health Emergency Officer (PHEO). Individual appointed by local commanders exercising quarantine authority under reference (r) to provide expert advice on quarantine and isolation actions.

h. Quarantine. Restriction of movement or separation imposed on those not yet ill, but who have potentially been exposed to or are believed to be developing an infectious disease (i.e., they are incubating disease) to prevent disease spread.

i. Restriction of Movement. An order or technique empowered to and imposed by military commanders in response to emergencies using reference (r) of this plan. Essentially, it limits people's movement to prevent or slow the transmission of a communicable disease, including limiting ingress and egress to, from, or on a military installation, isolation or quarantine.

j. Social Distancing. For purposes of PI planning, a series of activities designed to lower the potential spread of a communicable disease such as: avoiding hand-shaking, maintaining greater than usual personal space from other people, canceling public gatherings like movies, concerts, group assemblies, etc.

k. Universal Precautions. Guidelines promulgated to help prevent the spread of infection. Universal precautions help protect patients and their family, friends, and health care providers from infection and include: the use of gloves when touching an infected person's mucus membranes; aggressive handwashing including washing immediately after removing gloves and immediately before and after contact with an infected person; and the use of other protective clothing such as respiratory protection and eye protection when in contact with an infected person.

24 AUG 05

6. Assumptions

- a. A PI outbreak will originate in the AOR.
- b. Subsequent waves of PI may occur weeks to months after the initial outbreak.
- c. A PI outbreak is expected to infect 20-50% of all age groups. Absent any protective or mitigating measures, this creates the potential for 80,000 to 200,000 ill DOD personnel within the AOR. An unknown proportion will require hospitalization, and a high proportion of those hospitalized may die. In addition, millions of ill civilian personnel in host nations can be expected, with a significant proportion of deaths.
- d. A PI outbreak will cause critical and inadequate military and civilian staffing levels, resulting in reduced logistical, readiness, and a decrease in overall functional capability of military units and/or civilian communities.
- e. PI will have second and third order effects. (e.g., induced economic hardships, destabilized governmental authorities, opportunities for hostile nations/non-state actors to exploit situations)
- f. Civilian agencies and host nation (HN) governments will request multiple forms of support from the U.S. and the DOD in the event of a PI outbreak in their jurisdictions.
- g. A PI outbreak will require an integrated response from multiple organizations including, but not limited to: on-base, local, state, federal, HN, and international organizations.
- h. Reference labs and testing facilities capable of identifying influenza will be available in the AOR, though not in all locations.
- i. PI is spread through the respiratory route and the incubation period (time from exposure to signs and symptoms of disease) will be 1 to 3 days.
- j. Infected individuals may be contagious one or two days prior to manifesting signs and symptoms of disease.
- k. A significant percentage of those infected will never develop signs or symptoms, yet still be infectious for a period

24 AUG 05

of time, thus making the clinical diagnosis difficult. This will seriously limit the efficacy of quarantine and isolation efforts.

l. Those who recover from PI will be immune to repeat infection and will be able to safely work with those who are infected with or ill with PI.

m. Human remains of PI victims will not be more infectious than the remains of those who have died of other aerosol-spreadable diseases (e.g., tuberculosis). Therefore, wearing full personal protective equipment (PPE) and practicing universal precautions will protect those who must handle remains of those who have died from PI.

n. Due to the highly infectious nature of influenza and large troop and unit movements within the Pacific Rim, (with the exception of most afloat Naval populations) efforts at quarantine and isolation will be only partially effective at preventing infection by PI, but may reduce the speed of disease spread.

o. To reduce the speed of disease spread, various forms of transportation will be controlled, including but not limited to, suspension of, or limitations on, medical evacuation from countries or regions once a PI outbreak is declared.

p. During a PI outbreak, some nations and U.S. states and territories will restrict transit of personnel from affected areas for at least a period of weeks to months.

q. International commercial air and shipping will be severely curtailed, disrupting personnel movement, exercises and operations.

r. International organizations and national authorities will impose specific travel restrictions on those infected with or suspected of having PI.

s. No effective vaccine will be available until approximately six months or longer after the development of confirmed, sustained person to person PI transmission.

t. Vaccine acceptance by the population will be high, once a safe vaccine against the PI strain is developed and produced.

u. PI vaccines will require administration by injection.

24 AUG 05

v. The DOD will have access to any Food and Drug Administration (FDA) approved PI vaccine stockpiles.

w. The DOD will have inadequate supplies of antiviral medications necessary to provide long-term prophylaxis and treatment for all PACOM personnel

x. The DOD will not be assured access to international organization or foreign nation medical stockpiles (e.g., non-FDA approved drugs or vaccines).

y. DOD reliance on "just-in-time" procurement (including contingency contracts) will compete with U.S. and foreign commercial business for availability of critical supplies.

z. Commanders must be prepared to rely upon limited information to mobilize a rapid and effective response.

7. Limitations

a. Constraints:

(1) Continue to conduct military operations and Theater Security Cooperation events in the region prior to identification of human-to-human transmission incident.

(2) Maintain operational readiness of U.S. Forces to conduct assigned operations.

(3) During certain Operational Stages of this instruction, require U.S. Forces to comply with certain guidance by DOD and non-DOD agencies.

b. Restraints:

(1) We are unable to develop an effective vaccine and provide it to our forces in advance of a PI outbreak.

(2) We are unable to routinely identify specific influenza strains (e.g. H5N1, H3N2) at most laboratories within the AOR.

(3) We cannot proactively vaccinate to prevent PI among U.S. Forces operating in the AOR.

24 AUG 05

(4) We cannot ensure personnel will be allowed to travel into or out of affected areas once a PI outbreak occurs

(5) We are unable to provide antiviral prophylaxis to all Service members and beneficiaries.

8. Legal considerations. Command legal advisors and PHEO play key roles in assessing potential public health emergencies and advising commanders. Military commanders' actions regarding restriction of movement on a military installation, of infected or possibly infected DOD and non-DOD personnel will be guided by reference (r). Other considerations may take precedence during a national emergency in response to any potential disaster situation or concurrent outbreak of hostilities in the AOR.

9. Mission. Plan and prepare to protect U.S. Forces and enhance their ability to execute a coordinated response to a PI outbreak in the AOR. USPACOM provides support to U.S. Forces and other designated personnel, and on order supports other government and civilian agencies in the AOR, in response to a PI outbreak, to minimize and/or delay the global spread of PI, reduce morbidity and mortality, prevent human suffering and ensure that U.S. and allied military forces maintain operational readiness.

10. Execution

a. Concept of Operations

(1) Commander's Intent. To preserve and maintain the operational capability of USPACOM forces, while simultaneously supporting international and interagency PI response efforts. USPACOM will take actions in conjunction and coordination with other nations, U.S. agencies and international organizations and will leverage their knowledge and capabilities while contributing to their efforts. ENDSTATE: Capability and flexibility is maintained to adequately prosecute required U.S. military operations in the Pacific area. All measures available to USPACOM have been implemented to control the spread of PI.

(2) General. For this instruction, PI is expected to evolve in five Operational Stages as described below. The numerical progression in these Stages reflects the development and progression that marks an operationally significant change in the pandemic. These Operational Stages are to be used in conjunction with World Health Organization's Phases (<http://www.who.int/>) that have been developed to describe the

24 AUG 05

evolution of the virus as opposed to operational significance. Local medical professionals will be prepared to translate between military operational language and WHO language likely to be used by other organizations during a PI outbreak. Operational Stages could be very short (e.g., 24 hours) or prolonged depending on multiple factors and will not necessarily occur sequentially. Due to the possibility of infected persons being infectious, yet not having symptoms, combined with the wide availability of rapid commercial transportation, PI might skip some of the Operational Stages, (e.g. we may jump from Stage 0 to Stage 3 as PI cases are identified around the PACOM AOR). USPACOM will notify ALCON of Operational Stage changes and provide guidance as the situation dictates. Reference Table 1.1 for example decision points for each Operational Stage.

(a) **Operational Stage 0 (OS-0)**. **No sustained human-to-human transmission identified.** This stage is when "routine" influenza virus circulates throughout the population causing yearly outbreaks. A new influenza virus is identified in humans. However, sustained human-to-human transmission and pandemic have not yet occurred.

(b) **Operational Stage 1 (OS-1)**. **Sustained human-to-human transmission is identified in areas without U.S. Forces** (except during exercises, unplanned operations and U.S. Embassy staff (e.g., Marine Security Guard Detachments, Defense Attaches, JUSMAGs, and Offices of Defense Cooperation)). This stage is reached when there is confirmation of human-to-human transmission of a new flu strain that can cause a pandemic in areas without major U.S. Force presence.

(c) **Operational Stage 2 (OS-2)**. **Sustained human-to-human transmission is identified in areas where U.S. Forces are located west of the International Date Line.** This area includes but is not limited to Diego Garcia, Korea, Japan, Thailand, Guam, and U.S. territories and possessions. While PI could theoretically leave areas uninfected, all areas will likely become involved at some point during a pandemic spread.

(d) **Operational Stage 3 (OS-3)**. **Broad sustained human-to-human transmission is identified in the AOR east of the International Date Line, or there is rapid spread anywhere within the AOR.** This area includes Hawaii, Alaska, and U.S. territories and possessions. This stage manifests markedly accelerated disease spread and impact within the AOR and significantly increased risk for spread to the Continental U.S. (CONUS).

(e) **Operational Stage 4 (OS-4)**. Spread to CONUS.

(3) The following Table provides example decision points that Commanders should consider during the evolution of a PI outbreak.

TABLE 1.1: Example Commander Decision Points

	REACTION	COMMANDER'S DECISIONS	KEY INDICATORS
STAGE 1 Sustained Human to Human transmission in areas without U.S. Forces	<ul style="list-style-type: none"> • Increase antiviral stockage • Request release of stockpiles • Prophylaxis for forces deploying to affected areas • Restrict travel • Retrograde non-essential personnel 	CD 1 – Direct increase in stockage of anti-virals/vaccinations CD 2 – Restrict travel to affected areas CD 2a – Cancellation of exercises CD 3 – Retrograde movement of personnel from affected areas	<ul style="list-style-type: none"> - Sharp increase in Influenza Like Illnesses (ILI) cases - Confirmed Human-to-Human H5N1 transmission - Proximity to U.S. Forces
STAGE 2 Sustained transmission from Human to Human in areas with U.S. Forces, West of international date line	<ul style="list-style-type: none"> • Implement travel restrictions and quarantine • Retrograde MILPERS • Prophylaxis for forces in affected areas • Strengthen coordination local DoD, and interagency 	CD 4 – Direct admin of anti-virals/vaccinations CD 5 - Stop all movement to/from affected area CD 6 – Continue 1) retrograde, 2) remain in place or 3) quarantine unaffected areas CD 6a – augment assets in affected areas	<ul style="list-style-type: none"> - Same indicators as Stage 1 - Host Nation response to outbreak - Ability to continue retrograde - Local health care capabilities
STAGE 3 Broad sustained Human to Human East of international date line	<ul style="list-style-type: none"> • Continue reactions above for infected areas • Increase coordination: local, DoD NORTHCOM, interagency • Limit/bar travel to CONUS 	CD 7 – Bar travel to and from HI/CONUS CD 7a -- Military closure of office spaces, schools, cancel events, mandatory at-home quarantine, etc	<ul style="list-style-type: none"> - Same indicators as Stage 2
STAGE 4 Spread to CONUS	<ul style="list-style-type: none"> • Limit opportunities for transmission (quarantine) • Increase coordination with HI public health and other agencies 	CD 8 – Military closure of office spaces, schools, cancel events, mandatory at-home quarantine, etc. (Reduce operations)	<ul style="list-style-type: none"> - Rapid and significant increase in local cases - Military and civilian clinics/hospitals overwhelmed

(4) In response to the above stages, general and specific tasks for USPACOM, its components, subunified and supporting commands are outlined throughout this instruction, particularly in paragraph 10.b. Response actions at each stage are intended to maintain operational readiness. Additional or accelerated actions may be required as the situation dictates.

24 AUG 05

(5) In the event of a PI outbreak, movement of USPACOM personnel may be limited in order to contain or delay the potential spread of infection. However, in the event that an outbreak is occurring in a country or region near USPACOM personnel but there is no medical indication that USPACOM personnel are yet infected (i.e., not in contact with infectious patients or animals), then USPACOM, at the direction of the Department of State (DOS), may conduct non-combatant evacuation operations (NEO) to move evacuees to a safe haven. Reference (s) provides details for NEO. Additionally, per reference (r), Commanders may independently direct movement of U.S. Forces and beneficiaries to remove them from high-risk areas, should conditions warrant. Appendix A to Enclosure (1) of this instruction describes the process for moving populations and patients during a PI outbreak. It is important that measures are in place to preclude movement of infected personnel to uninfected areas. Screening for presence of influenza-like illness (ILI) should occur prior to departure.

b. Tasks. Execute the following by stage, as applicable:

(1) U.S. Pacific Command (USPACOM):

(a) Operational Stage 0. No sustained human-to-human transmission identified.

1. Implement and exercise pertinent aspects of this instruction.

2. Ensure education plans are developed and implemented.

3. Develop and publish public affairs guidance.

4. Ensure communication procedures are in place.

5. Monitor disease occurrence in the AOR per reference (i) of this instruction. Define the process by which this information will be shared with Service Components and Sub-unified Commands.

6. Broadly coordinate PI planning and response activities with all cognizant entities, including but not limited to Department of Defense, Department of State, Joint Chiefs of Staff, World Health Organization, other UN agencies,

U.S. Forces Korea, U.S. Forces Japan, Center for Disease Control and Prevention, U.S. Agency for International Development, Defense Logistics Agency, Department of Health and Human Services, Department of Transportation, Department of Homeland Security, U.S. Customs, Armed Forces Medical Intelligence Center, the Air Force Institute of Operational Health, and the Naval Health Research Center, as appropriate. Update this instruction as appropriate.

7. Broadly coordinate PI planning and response with all cognizant local, state, territory, possessions, host nations, and coalition government's public health officials, including but not limited to Office of Civil Defense, State of Hawaii, Government of Guam, and supported possessions and territories. Update this instruction as appropriate.

8. Develop and/or promulgate initial force health protection guidelines to include but not limited to: updating vaccinations, use of personal protective equipment and practices, and avoidance of high-risk areas such as poultry/livestock farms and live animal markets.

9. Establish priorities for vaccination against PI.

10. Document pertinent preparation and response activities for lessons learned and after action reports.

11. Provide a plan for collection, chain of custody, transport, and securing samples that require management using appropriate Biological Safety Level (BSL) procedures.

12. Ensure systems and processes are in place to effectively track the status of USPACOM Forces and individual personnel with regard to their exposure, infection with PI, travel to affected countries/regions, etc.

13. Exercise PI response procedures.

(b) Operational Stage 1 (OS-1). Sustained human-to-human transmission is identified in areas without U.S. Forces. In addition to applicable actions taken in Stage 0:

1. Review, and exercise PI response procedures.

2. Review, update, and implement force health protection guidance including Force Health Protection (FHP)

24 AUG 05

messages, travel advisories and/or restrictions to target countries, public affairs guidance, and health education for USPACOM staff, components and subunified commands, as appropriate.

3. Authorize the administration of antiviral prophylaxis for personnel traveling to affected areas.

4. Increase coordination with local, state, territory, possession, host nation, coalition, international organizations and supported government public health officials so rapid notification can be made if PI enters the area.

5. Coordinate augmentation and support to local governments within the AOR with military medical advice and resources, when requested.

6. Conduct an initial availability assessment of personnel, medications, supplies, and equipment (e.g. laboratory testing gear, ventilators in hospitals, and disposable surgical masks for patients) needed for responding to PI. Make adjustments as appropriate. Assist commanders and military treatment facilities (MTF) in obtaining adequate supplies, as needed.

7. Direct the establishment of a Single Integrated Medical Logistics Manager (SIMLM)/Lead Agent or any successor organization, as needed.

8. In response to spreading PI, consider suspending non-critical military operations in order to preserve personnel availability for critical response for PI operations.

9. Establish policies for restriction of personnel movement and use of prophylaxis and personal protective equipment for U.S. Forces required to deploy to areas experiencing PI outbreak (including APODs/SPODs).

10. Coordinate with Department of State (DOS) and other federal agencies through established channels on all pertinent aspects of health service support for affected U.S. citizens in foreign countries and selected foreign nationals.

(c) Operational Stage 2 (OS-2). Sustained human-to-human transmission is identified in areas where U.S. Forces are based west of the International Date Line. Actions may be applied to geographic areas within a country to avoid excessive

restrictions on uninfected areas. In addition to actions taken in previous stages:

1. Increase state of awareness for medical staff and general public by advising all military units to be alert for evidence of illness in their units.

2. Through coordination with the Components, the use of Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), Joint Medical Work Station (JMeWS) as available, and in conjunction with the DOD-Influenza Surveillance Program Manager, monitor disease patterns in the AOR and provide guidance to the components and sub-unified commands, as appropriate.

3. Emphasize force health protection measures (Reference paragraph 10.c.(6)). Collaborate with CDC and WHO to define terms such as "likely exposure", "subsequent cases", "probable cases", and "confirmed cases".

4. Expand antiviral prophylaxis administration following priorities established in paragraph 10.c.(6) of this instruction.

5. In coordination with component and sub-unified commands, direct movement/redistribution/cross-leveling of in theater HSS forces, resources and support as required. Redistribution of supplies may be conducted to support areas with the highest incidence while also considering stocks for subsequent waves. Subsequent waves of a pandemic may occur months after initial outbreak.

6. Coordinate with Joint Staff, ASD(HA), USPACOM Public Affairs and CDC for internal and external media releases.

7. Coordinate external public releases with state, local, and host nation public health officials.

8. Coordinate with Department of Health and Human Services in conjunction with DOD influenza resources (reference (i)) in reviewing surveillance and epidemiological data, determining the risk of the pandemic, and ensuring adequate apportionment of antivirals to USPACOM.

24 AUG 05

(d) Operational Stage 3 (OS-3). Broad sustained human-to-human transmission is identified in the AOR, east of the International Date Line or there is rapid spread anywhere within the AOR. Stage 3 is established to provide operational awareness as the PI outbreak approaches the Continental United States (CONUS) and to assure coordinated effort to reduce spread to CONUS. In addition to response actions for Stage 2:

1. Increase coordination with Hawaii public health and government authorities regarding port and airport quarantine and general travel restrictions as well as local public health measures.

2. Increase coordination with the U.S. Public Health Service, U.S. NORTHCOM and U.S. TRANSCOM regarding movement of personnel into and from CONUS.

3. Coordinate with OSD, JS and/or other agencies for possible augment of HSS or other personnel from CONUS in order to ensure operational readiness and ability to conduct assigned PI response efforts.

(e) Operational Stage 4 (OS-4). Spread to the Continental United States (CONUS). In addition to applicable actions taken in previous stages:

1. Prepare forces to augment CONUS medical facilities, if feasible. As the pandemic recedes at OCONUS sites, some personnel may have developed immunity to the PI and will be needed to support operations elsewhere.

2. Prepare to retrograde supplies and equipment needed to manage PI outbreak in CONUS.

(2) Commanders, United States Forces Korea; United States Forces Japan; Alaskan Command; Pacific Air Force; United States Pacific Fleet; United States Army Pacific; and United States Marine Corps Forces Pacific. Specified tasks by stage include, as appropriate:

(a) Operational Stage 0 (OS-0): No sustained human-to-human transmission identified.

1. Based on this instruction, develop, implement, and exercise a component-specific contingency plan for response to a PI; ensure contingency plans address:

24 AUG 05

a. Isolation and quarantine (home, work, installation, voluntary, involuntary) capabilities as well as instructions for social distancing.

b. Expansion of medical facilities.

c. Procedures and resources required to contain and treat U.S. personnel and OTUSF exposed / possibly exposed to PI.

d. Mental health and chaplain services for emergency workers and their families.

e. Education plans.

f. Public Affairs guidance per enclosure (2) to this instruction.

g. Communication procedures.

h. Continuity of Operations (COOP) considerations.

i. Logistics plans which incorporate the following:

(1) Internal security, transportation and essential life support services to include: potable water, emergency subsistence, emergency shelter, field sanitation and first response medical care for quarantine, isolation, and related support.

(2) Adequate stocks and resupply of antivirals and other essential supplies/equipment such as masks, respirators, personal protective equipment, soap, etc.

(3) A mortuary affairs plan to include identification and disposition of remains.

2. Identify and correct any critical shortfalls that would negatively impact a mass casualty response in AOR.

3. When directed, promptly notify USPACOM of available and/or needed theater medical assets via MEDSITREPs.

24 AUG 05

4. Coordinate PI response plan with local state, territory, possession, host nation and coalition public health officials.

5. Coordinate with host nations to identify facilities that could be used to provide additional hospitalization/patient holding capability for eligible U.S. beneficiaries during a PI outbreak. Engage in early coordination and planning.

6. Establish, as needed, cooperative agreements with sister services and other government agencies for facility use, patient movement, etc.

7. Promulgate initial force health protection guidelines to include but not limited to: updating vaccinations, use of personal protective equipment and practices, and avoidance of high-risk areas such as poultry/livestock farms and markets.

8. Identify U.S. Forces and OTUSF who require vaccination against PI in order to maintain operational capability.

10. Modify NEO plans, as needed, to ensure medical/epidemiological screening for PI at all embarkation, en-route stops, and debarkation sites. Incorporate additional PI considerations, as appropriate.

11. Order and preposition antivirals and vaccinations, when they become available, for administering according to established procedures and criteria.

12. Monitor disease occurrence in the AOR and respective jurisdictions per reference (i) of this instruction and in accordance with procedures that USPACOM or its lead agent have developed to ensure a common operational picture of the PI situation/development.

13. Provide support to supporting MTFs in developing and executing PI response plans. Individual MTF plans shall include provisions for:

a. Increasing staff and emergency training of volunteer staff.

24 AUG 05

b. Implementing quarantine and isolation procedures.

c. Instituting personal protective measures for caregivers. All persons who are not immune to PI must wear gloves and gowns when entering a room with a contaminated patient (contact isolation). In addition, those coming within three feet of the patient should use eye and respiratory protection. These guidelines may be altered as more information becomes available on the PI strain.

d. Maintaining real time awareness of all developments in the theater PI situation.

14. Ensure that each installation's mass casualty plans include responses to PI.

15. Document pertinent preparation and response activities for lessons learned and after action reports.

16. (USFK and USFJ Only) Initiate negotiations with Host Nations Governments for additional support during PI outbreak.

(b) Operational Stage 1 (OS-1). Sustained human-to-human transmission is identified in areas without U.S. Forces. In addition to applicable actions taken in previous stages:

1. Review, exercise and execute PI response plans.

2. Implement force health protection measures and emphasize PI guidance for travelers to reduce Service personnel exposure to potential influenza sources and environments (e.g., poultry farms and live animal markets). Ensure FHP guidance is provided at points of departure and entry

3. Implement an education plan that will increase level of PI awareness for medical staff and the general public, and advise all military units to be alert for evidence of influenza-like illness in their unit.

4. Administer antiviral (e.g., oseltamivir) prophylaxis for personnel traveling to affected areas.

5. On order, restrict travel and personnel movement of U.S. Forces to areas experiencing a PI outbreak

24 AUG 05

(including APODs/SPODs). Mission essential personnel entering such areas will be provided with antiviral prophylaxis and vaccines, when available, and individual protective equipment. Restriction of personnel is necessary to avoid moving unexposed personnel into an area experiencing an outbreak and/or to avoid allowing potentially infectious personnel to return to a PI-free area.

6. Increase coordination with local, state, federal, territory, possession, host nation, coalition, international organizations and supported government public health officials so that rapid notification can be made if PI enters the area.

7. Be prepared to augment and support local, state, federal, territorial and host nation governments with medical advice and resources, to include quarantine operations, when requested.

8. Conduct an initial availability assessment of personnel, medications, supplies, and equipment (e.g. laboratory testing gear, ventilators in hospitals, and disposable surgical masks for patients) needed for responding to PI. Make adjustments as necessary.

9. Conduct preliminary preparations for MTFs to receive/manage significant patient loads and identify other facilities for possible expansion, and arrival of infectious isolated, and quarantined individuals.

10. Cancel or postpone all non-critical operations, exercises, or activities in areas with confirmed, sustained, human-to-human transmission of influenza.

11. In accordance with Service guidelines, exercise collection and transport of specimens to DOD laboratories for routine screening and confirmatory evaluation. See www.who.int/csr/disease/avian_influenza/guidelines/reference_labs for a list of WHO reference laboratories for avian influenza. DOD laboratories vary in their capability to conduct confirmatory testing.

12. Increase medical surveillance of influenza-like illnesses (ILI) using laboratory-based surveillance to identify pathogens of concern. Conduct daily ILI reporting to higher headquarters medical authorities. Daily reporting includes but is not limited to:

a. ILI cases with severe respiratory complications.

b. Substantial increase from baseline rate of ILI cases.

c. Any unique cases that warrant attention by public health authorities.

13. Review and update Mortuary Affairs plan.

14. Develop a communications plan including hotlines and other communication services.

15. Notify USPACOM of medical resource status and deficiencies (personnel, equipment, supplies).

16. When an effective vaccine becomes available, vaccinate U.S. military personnel and OTUSF in accordance with priorities established in this instruction to maintain operational capability.

17. When appropriate, coordinate with U.S. Embassy and other federal agencies through established channels on all pertinent aspects of health service support for affected U.S. citizens in foreign countries and selected foreign nationals.

(c) Operational Stage 2 (OS-2). Sustained human-to-human transmission is identified in areas where U.S. Forces are based west of the International Date Line. Actions may be applied to geographic areas within a country to avoid excessive restrictions on uninfected areas. In addition to actions taken in previous stages:

1. Implement an education plan that will raise the level of awareness for medical staff and the general public throughout the AOR, and advise all military units within the AOR to be alert for evidence of influenza-like illness in their unit.

2. Emphasize force health protection measures and emphasize strict compliance with universal precautions to limit the spread of PI.

24 AUG 05

3. Expand antiviral prophylaxis administration using priorities established in this instruction.

4. Prepare MTFs to receive/manage significant patient load and prepare other facilities for possible expansion, and arrival of infectious isolated, and/or quarantined individuals.

5. Execute Mortuary Affairs plan, as needed.

6. Report, to higher headquarters, mission impacts due to loss of personnel or other factors.

7. On order, be prepared to move non-infectious U.S. military and other authorized personnel out of the area at risk in advance of the pandemic's spread.

8. Expand family support activities including mental health and chaplain services to support staff and family members.

9. Consider distribution/redistribution of antiviral stocks to support areas with the higher incidence.

10. Conduct investigation of installation public health if the initial outbreak hits a U.S. military population. Coordinate with civilian public health authorities as appropriate.

11. Coordinate external public affairs releases with local, state, federal, and host nation public health officials.

12. Plan for local distribution/administration of CDC or other central stockpile drugs or vaccines.

(d) Operational Stage 3 (OS-3). Broad, sustained human-to-human transmission is identified in the AOR, east of the International Date Line or there is rapid spread anywhere within the AOR. Operational Stage 3 response actions include all actions defined for Stage 2. Stage 3 is established to provide operational awareness as the PI outbreak approaches the Continental United States and to assure coordinated effort to reduce spread to CONUS.

(e) Operational Stage 4 (OS-4). Spread to the Continental United States (CONUS). In addition to applicable actions taken in previous stages:

1. Be prepared to provide forces to augment CONUS medical facilities. Some personnel may have developed immunity to the PI and be needed to support CONUS operations.

2. Be prepared to provide supplies and equipment needed to manage a PI outbreak in CONUS.

(3) Commander, United States Army Pacific. Be prepared to coordinate veterinary support and advice through U.S. Army Medical Command and Pacific Region Veterinary Command in surveillance, mitigation, and management of suspected or confirmed infected avian or animal populations.

(4) Commander, Special Operations Command, Pacific. Identify requirements for influenza pandemic support and coordinate with area medical facilities and healthcare providers to ensure personnel are integrated into response and training plans.

(5) USPACOM Direct Reporting Units: Center of Excellence in Disaster Management (COE), Joint POW/MIA Accounting Command, Joint Intelligence Center Pacific, and Asia-Pacific School for Strategic Studies. Ensure all assigned personnel stay cognizant of PI issues in forward operating locations, and when working with Non-Governmental Organizations (NGOs)/Private Venture Organizations (PVOs). Report any significant PI issues to HQ USPACOM. Due to their unique relationship with NGOs, the COE will:

(a) Operational Stage 0 (OS-0): Maintain contacts with relevant NGOs and health authorities to monitor disease occurrence.

(b) Operational Stage 1 (OS-1): Support/facilitate PACOM interface and information sharing with relevant NGOs and health authorities.

(c) Operational Stage 2 (OS-2): Support/facilitate PACOM interface, information sharing and coordination with relevant NGOs and health authorities

(d) Operational Stage 3 and 4 (OS-3 and OS-4): Support/facilitate PACOM interface and information sharing with

24 AUG 05

relevant NGOs and health authorities to improve coordination of emergency response.

(6) Commander, U.S. Northern Command: As directed, and in coordination with CDR USPACOM, provide additional medical forces to meet HSS requirements for PI response in the AOR.

(7) Commander, U.S. Joint Forces Command

(a) As directed, and in coordination with CDR USPACOM, provide additional medical forces to meet HSS requirements for PI response in the AOR.

(b) Request that CDR USJFCOM ensure all forces deploying to the USPACOM AOR meet FHP requirements as identified in this instruction and/or other directives that provide the most current information available on effective PI protection and response.

(c) As directed, provide additional support to augment USPACOM forces affected by PI.

(8) Commander, U.S. Transportation Command. Request CDR USTRANSCOM follow this instruction regarding regulation of movement of patients exposed/possibly exposed to PI. Upon declaration of Operational Stage 2, the following tasks would apply:

(a) Prepare for increased numbers of patient movement requests and patient movement missions.

(b) On order, move non-infectious U.S. military and other authorized personnel out of the area in preparation for pending outbreak.

(c) Coordinate with USPACOM components in the PI screening of all personnel transiting through an APOD/SPOD to limit potential dispersal of PI to multiple locations within the movement and evacuation system. This screening includes USTRANSCOM aircrews, NEO and other personnel utilizing the transport system.

(9) TRICARE. The nature of a PI outbreak will necessitate coordination of TRICARE Pacific with International SOS. Coordination with the TRICARE Pacific Medical Director and the ISOS Medical Director is authorized and encouraged.

24 AUG 05

(10) Collaborating Organizations. The nature of a PI outbreak will necessitate coordination with many DOD organizations outside of the AOR and with many federal, state and local organizations. See enclosure 3 for a listing of key organization and resources they have available. Interagency coordination of plans is authorized and encouraged.

c. Coordinating Instructions

(1) Restriction of Movement. Military commanders may restrict movement of military personnel in response to emergencies in accordance with reference (r) of this instruction. This may include isolation, quarantine, travel advisories/restriction, and home quarantine. Upon confirmation of PI diagnosis, movement of the infected individual from place of treatment or isolation will be delayed until the individual is no longer infectious.

(a) Reference (r) also directs the appointment of a PHEO to coordinate a medical response to emergencies and advise the commander in determining whether or not restriction of movement techniques should be invoked. All decisions to invoke restriction of movement should be coordinated with the PHEO, legal consultants, and local authorities, including public health agencies.

(b) Multiple methods to restrict movement may be employed simultaneously to contain a PI outbreak. Options include keeping the base population on post until they are determined non-infectious, limiting contact of the base population with the off-post population or restricting the movement of uninfected populations. Monitoring of quarantined contacts and isolated patients, as well as appropriate infection prevention and control techniques will be employed.

1. Quarantine. During a PI outbreak, quarantine may be effective at slowing the spread of the disease during the initial days of the outbreak. Personnel suspected of being exposed to PI and not displaying symptoms (for example: fever, headache, muscle aches, prostration, sore throat, cough and nasal discharge) may need to be quarantined to prevent secondary spread of disease until determined to be non-infectious. Installation commanders will determine the most appropriate method of quarantine for their personnel and for establishing procedures to ensure direct observation of personnel taking antivirals. Quarantine options may include establishing quarantine stations/buildings and quarantining

24 AUG 05

personnel by restricting them to their home. Note: Quarantine duration may be modified by USPACOM as more information becomes available.

2. Isolation. Patients infected with suspected or known PI will be placed in, and remain in isolation until they recover from their period of communicability or they expire. After becoming ill, patients will normally continue to be infectious for about 5 days, young children for about 7 days.

(c) Arrangements must be in place for the transfer of any symptomatic contacts to the MTF or medical holding area for isolation, evaluation, and care, without transmitting infection to others during movement. This will primarily be accomplished by masking of symptomatic persons, as well as use of personal protective equipment by transport personnel. Personnel will be considered non-infectious through: 1) being asymptomatic during a 10-day observation period for adults (a 14-day observation period for children under 18 years of age); 2) having negative diagnostic laboratory confirmation; and/or 3) receiving antivirals for prevention and treatment, per appendix B to enclosure (1) of this instruction. Note: The specifics of negative diagnostic laboratory testing are evolving, requiring consultation with medical personnel for current guidance.

(d) Aircrews. Decisions to curtail general military air transportation will be made by CDR USPACOM in conjunction with Combined Force Air Component Commander (CFACC) or the Director of Mobility Forces (DIRMOBFOR). Decisions regarding administration of antiviral prophylaxis of aircrews will be made in accordance with respective Service flight medicine directives. In general, a trial of antiviral medication while in non-flight status should be conducted to assure aircrews do not suffer side effects that interfere with safe flight operations.

(2) Laboratories should prepare to process significant numbers of specimens quickly during the early stages of a pandemic to determine if respiratory patients have been infected with the predominant PI strain. Specimen collection procedures and testing can be obtained at any supporting U.S. MTF, the Air Force Institute for Operational Health, Risk Surveillance Division (AFIOH/RSRH)

(<https://gumbo.brooks.af.mil/pestilence/Influenza/>), or WHO reference laboratory (www.who.int) in the AOR. Reference laboratories should handle "suspect case" samples as a top priority with rapid processing under Biosafety-Level-4 conditions. Sample results will be disseminated to DOD, CDC,

and WHO Influenza Program Offices. Viral isolates should be submit to CDC for possible use in vaccine development.

(3) Demand for mortuary affairs support may be considerable. Despite efforts to save lives and prevent injury, PI might result in high mortality rates and overwhelming of individual mortuary facilities. In the event of PI, the DOD may be required to mitigate the potential complications posed by mass fatalities. In addition, provisions must be made to identify, transport or dispose of large numbers of human remains.

(4) Hospitals should plan to treat a high number of patients with respiratory distress. Support of greater numbers of critically ill patients will require increased medical staff, more ventilators, and more monitoring equipment. Requests for additional support will be coordinated through the USPACOM Surgeon's office. Flu Surge software found at <http://www.cdc.gov/flu/flusurge.htm> provides a modeling tool to estimate hospital PI workload. Limitations identified by this and similar models can be used to advise the hospital's chain of command of potential shortfalls.

(a) Medical and public health needs will be significant. The DOD will use existing resources when initially responding to a PI event affecting military populations and installations.

1. Planning and coordination with local authorities, including host nation public health authorities, will be critical to assure optimum use of hospital facilities.

2. In the event DOD hospital assets are overwhelmed, host nation hospital assets will be used, when available, as authorized by Status of Forces Agreement (SOFA)/coordination support agreements.

3. Significant differences in the medical care requirements of patients will be experienced, particularly during peak PI impact periods. Few PI patients will require surgery. Instead, there will be a greater need for nursing and respiratory support.

(b) Patient Management. At the onset of a disease outbreak, the Centers for Disease Control and Prevention (CDC) will define the terms for probable, suspect, and confirmed cases. USPACOM will use these CDC definitions. Additionally,

24 AUG 05

Annex 8 of reference (g) outlines a range of activities that could be taken to prevent PI spread in hospitals and communities.

1. Patients suspected of having PI will be masked and isolated as soon as recognized. Treatment and prophylaxis protocols are described in detail in appendix B to enclosure (1) of this instruction.

2. Medical evaluation for patients suspected of having PI will include routine evaluation to determine influenza type (i.e. Type A or not Type A) and applicable microbiological and radiological evaluation as required.

3. Patients known to have PI will not need decontamination prior to entering either civilian or military treatment facilities. They will, however, need to be masked (i.e., disposable surgical mask) in order to prevent the spread of respiratory droplets that may infect others.

(c) Facilities. Military treatment facilities must have patient-care plans that address treatment, provide respiratory support, and stress general medical support and management. Contingency planning for large numbers of cases must be done well in advance of a pandemic to maximize effectiveness. If the number of seriously ill patients exceeds MTF capacity, buildings other than hospitals may be converted into treatment facilities. Military facility commanders may require extra support, as buildings other than medical facilities are pressed into service. Commanders may consider cooperative arrangements with sister services and other government agencies in some locations. Such arrangements require coordination with appropriate approving authorities. Provisions should be made for increased staff or for emergency training of volunteer staff.

1. Military healthcare facilities will serve as joint assets to maximize the availability of beds and services. Joint staffing of facilities is not a prerequisite for joint use. Service Components with medical assets outside the affected area should be prepared to assist as needed. This may include sending personnel and equipment to other locations/bases to support quarantine/isolation medical treatment/holding sites.

2. Existing fixed medical treatment facilities may require expansion. Service Components will ensure hospital contingency plans address expansion, quarantine and isolation

capabilities. Options to be considered include: opening unused portions of MTFs, using non-medical facilities as expansion areas, and transferring non-infectious patients. Additional resources/requirements (to include staffing, equipment, etc.) should be identified, planned for, and resourced accordingly.

(5) Patient Movement

(a) Patients suspected of incubating PI will not be moved to a PI-free area until it has been determined that they are non-infectious. They will be placed in either a quarantine or isolation facility depending on presence or absence of signs and/or symptoms, and considered non-infectious through: (1) being asymptomatic during a 10-day observation period for adults or 14-day observation period for children, (2) having negative diagnostic laboratory confirmation on influenza A screening, and/or (3) completed a course of antivirals for treatment as discussed in appendix B of enclosure (1) of this instruction. Patients who have developed symptoms of active disease will be moved to a treatment facility. Following recovery, patients may be returned to duty or considered for further evacuation. Note: The utility of quarantine and isolation can be expected to diminish as PI spreads.

(b) Patient movement may be restricted locally or regionally when dealing with a suspected or known PI. Enclosure (1) of this instruction provides details. Plans must include provisions for in-place care of patients.

(c) USPACOM will coordinate patient evacuation requirements through the Theater Patient Movement Requirement Center-Pacific (TPMRC-P) for patients requiring intra-theater patient movement. TPMRC-P will coordinate inter-theater patient movement through USTRANSCOM's Global Patient Movement Requirements Center (GPMRC). The TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES) will be the means of communicating patient movement requests (PMRs). USFJ/USFK should be prepared to establish a Joint Patient Movement Requirements Center to facilitate patient movement if necessary.

(6) Force Health Protection (FHP). The following FHP measures are critical to maintaining operations readiness in the PACOM AOR:

(a) Chemoprophylaxis, e.g. antivirals, will be administered in the following priority:

24 AUG 05

1. Operational units present in a PI affected area.
2. Operational units who must enter a PI affected area.
3. Other active duty personnel in or entering a PI affected area.
4. Non-active duty personnel and OTUSF in a PI affected area.

(b) When a PI vaccination becomes available, individuals will be vaccinated following the same priorities.

(c) USPACOM promulgates current FHP measures for influenza. Contact USPACOM at DSN: (315) 477-7854 or (808) 477-7854 to obtain the latest information/measures.

(d) Service Components will maintain preventive medicine programs including immunizations as directed by the DOD. Vaccinating against routine influenza will lower the risk of routine influenza-related respiratory disease that could compound or confuse identification and management of PI.

(e) Adequate supplies of appropriate antivirals and antibiotics will be stored at locations under U.S. control as designated by cognizant component commanders. Geographic areas for stockpile are discussed in paragraph 11.a.(2) below. Stockpile locations within these geographic areas should be determined based on ability to administer, manage, and maintain security of stockpile, as well as proximity to U.S. DOD population concentrations.

(f) Components will provide medical support and FHP for forces and noncombatants that are transiting the component's respective airports and seaports. Supporting forces entering the PACOM AOR to serve in a PI infected area will be provided appropriate education, medicinals and vaccinations prior to departure from their home station.

(g) Individuals will be provided education to make them aware of PI, help them understand PI management procedures such as isolation, quarantine, social distancing and to enforce simple actions to reduce the risk of infection including:

1. Compliance with the routine influenza vaccination program to ensure everyone receives their annual flu.

2. Avoid poultry farms and bird markets and contact with animals in live markets or contact with any surfaces appearing contaminated with waste from poultry or live animals. Avoid sick or dead poultry.

3. Emphasize hand washing to avoid infection. As with other infectious illnesses, one of the most important precautions is careful and frequent hand washing. Cleaning hands often, using either soap and water or waterless alcohol-based hand rubs, removes potentially infectious materials from the skin and helps prevent disease transmission.

4. Proper food preparation. Influenza viruses are destroyed by heat; therefore, as a precaution, all foods from poultry, including eggs and poultry blood, should be thoroughly cooked.

(7) Surveillance

(a) An accurate common operating picture of the location and intensity of PI will be critical to commanders, medical personnel, and higher headquarters. The Consolidated Health Care System (CHCS), as well as laboratory results review, and reportable medical events surveillance will be used at points of care whenever possible to provide awareness of any increase and spread in Influenza-Like-Illnesses (ILI). Joint Medical Work Station (JMeWS) and its Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) module will be used to consolidate data and provide information on the emergence of ILI outbreaks. Data will be collected daily at each point of care. Points of care will include established MTFs and any other non-medical facility requisitioned for use as a treatment facility. Collection and reporting processes will expand greatly during an outbreak. Commanders must assure their access to surveillance information and adequate staff and resources to conduct effective surveillance.

(b) To assist in rapid, theater-wide sharing of information about PI occurrence, component and sub-unified commanders will implement the JMeWS at their subordinate points of care and appropriate operational headquarters.

24 AUG 05

(8) Collection and Shipment of PI Lab and Patient Samples. Points of care will collect samples as directed or as required clinically and ship per guidelines outlined in <http://www.wpro.who.int/avian%5Fflu/> or provided by AFIOH/RSRH in <https://gumbo.brooks.af.mil/pestilence/Influenza/>. The units will ship samples to DOD MTFs or, after confirming readiness to receive specimens, to WHO labs listed on <http://www.who.int/csr/disease/influenza/collabcentres/en/index.html#ref>, as well as the DOD-Influenza Surveillance Laboratory located at Brooks City Base, TX.

(9) Other Than U.S. Forces (OTUSF)

(a) Under most circumstances, DOD medical forces may treat local and DOD civilians only under emergency situations and then must coordinate early transfer of patients to civilian providers and facilities.

1. With a PI outbreak, DOD resources may be required to treat OTUSF, to include possible U.S. civilian noncombatant populations.

2. DOD medical facilities will be prepared to care for and treat infectious noncombatant patients in the event they cannot be moved or transferred to civilian or host nation medical facilities.

(b) When a vaccine becomes available, initial distribution and immunization may be directed by USPACOM to optimally preserve operational capability and control PI spread. As vaccine supplies increase, further immunization will be according to priority established in paragraph 10.c.(6) (a) of this instruction.

(c) Coalition forces may be provided access to DoD medical care when these requirements are defined in existing agreements or Status of Forces Agreements (SOFA)

(10) Host Nation Support. It is essential to identify local host nation facilities that could be used to provide additional hospitalization/patient holding areas for U.S. casualties during a PI situation. Early coordination and planning must be conducted. USPACOM will conduct the required HN and/or DOS coordination, or will designate an organization/command to lead this coordination and planning in each country or geographic area.

24 AUG 05

(11) When ordered, NEO plans will provide for medical screening for early PI signs and symptoms such as fever and flu-like illness, at all embarkation, en route stops at which personnel can depart ships or aircraft, and debarkation sites. The process for evacuating non-combatants in a PI situation is described in more detail in Appendix A to enclosure (1) of this instruction.

11. Administration and Logistics

a. Medical logistics

(1) Resupply, to include medical material management and biomedical maintenance, is a Service responsibility until the Single Integrated Medical Logistics Management (SIMLM) or any successor system is established.

(2) Ideally, Service components should preposition or have ready access to a 30-day of supply of approved antivirals and other essential medical supplies to support the U.S population at an installation. The population supported will be determined by subunified and regional commanders and includes active duty, civilians, contractors and beneficiaries. Stockpile locations are Korea, mainland Japan, Okinawa, Guam and Hawaii due to heavy U.S. Forces concentration and Singapore due to its proximity to the expected source for PI.

(3) Emergency surge requirements for antivirals such as oseltamivir (Tamiflu®) must be requested through the Defense Supply Center-Philadelphia (DSC-P) via normal medical resupply channels at the component/sub-unified level. If a component or sub-unified command receives a back order status from DSC-P, the commands should notify USPACOM via command SITREPS or via telephone. USPACOM can be reached at (808) 477-7882 (DSN 315-477-7882) during the duty day or (808) 477-7227 (DSN 315-477-7227) during non-duty hours.

(4) DOD's antiviral stockpile is scheduled for prepositioning in Japan. Release and re-distribution of these antivirals may be requested by USPACOM upon reaching Operational Stage 1. Re-distribution of other essential items in the AOR, requests for off-label use of antivirals, and local acquisition of antivirals from host nation sources will be centrally coordinated by USPACOM. Notify USPACOM via SITREP message or other expeditious means for such requests.

24 AUG 05

b. Public Affairs. Refer to enclosure (2) for details. The media will play an important role in a PI event. Public Affairs shall take a proactive role in addressing the impact of PI on military personnel and resources, and in providing additional information to DOD beneficiaries. The USPACOM Public Affairs Office is the lead staff directorate for the internal and external public release of information on PI events.

c. Mental health and chaplain services. Commanders must plan for mental health and chaplain services for emergency workers and their families, especially when these workers are deployed away from their home base. Mental health and chaplain services will also be provided for PI casualties and their families and to assist the health care workers dealing with multiple severe cases and deaths. To maximize support, these activities should be done in coordination with the Red Cross. Interdisciplinary stress management teams have been effective in other challenging settings.

d. Mortuary Affairs. Refer to reference (u) for details. The need for mortuary affairs could rapidly become significant during and immediately following a PI outbreak. Commanders will include a mortuary affairs plan in their logistic plan, to include the disposition of remains.

12. Command, Control, Communications

a. Command. Normal USPACOM command relationships apply. During execution, CDR USPACOM is the supported commander while other combatant commanders and agencies are in support.

b. Communications. When ordered, CDR USPACOM and designated JTF will conduct crisis communications planning to fulfill C4 requirements in support of mission execution.

c. Medical Communications

(1) Routine coordinating communication between the USPACOM and Service Components will be by e-mail whenever feasible. Alternate means of communications include telephone, fax, teleconference, video teleconference, and Defense Message System (DMS) message.

(2) TRAC2ES will be used for communicating patient movement requests (PMRs).

24 AUG 05

(3) JMeWS will be used when available to provide a joint medical common operating picture throughout the theater.

(4) Service components will immediately inform the USPACOM of any suspected/probable/confirmed cases of PI. These cases also will be reported through existing Service epidemiology hubs to the Defense Medical Surveillance System (DMSS) and AFIOH/RSRH. Service hubs and DMSS will report any suspect/probable/confirmed cases to Health Affairs (Program Director, Military Public Health). In addition, the reporting MTF will comply with local/state/CDC/WHO requirements for reporting infectious diseases.



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Distribution: (USPACOMINST 0902.1)
List I, II, III B
DSC-P

24 AUG 05

MEDICAL SERVICES

- Ref:
- (a) Geneva Convention for the Amelioration of the Condition of the of the Wounded and the Sick in Armed Forces in the Field, 12 August 1949
 - (b) Geneva Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea, 12 August 1949
 - (c) Geneva Convention Relative to the Treatment of Prisoners of War, 12 August 1949
 - (d) Geneva Convention Relative to the Protection of Civilian Person in Time of War, 12 August 1949
 - (e) Joint Pub 4-0, Doctrine for Logistic Support of Joint Operations, Final Coordination, 06 April 2000
 - (f) Joint Pub 4-01, Joint Doctrine for the Defense Transportation System, 19 March 2003
 - (g) Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations, 30 July 2001
 - (h) Joint Pub 4-02.1, JTTP for Health Service Logistics Support in Joint Operations, 6 October 1997
 - (i) Joint Pub 3-11, Joint Doctrine for Operating in a NBC Environment, 11 July 2000
 - (j) Joint Pub 4-02.2, JTTP for Patient Movement in Joint Operations, 30 December 1996 DOD
 - (k) Joint Pub 4-05, Joint Doctrine for Mobilization Planning, 22 June 1995
 - (l) AR 40-562/BUMEDINST 6230.1H, Immunization and Chemoprophylaxis, 1 November 1995
 - (m) DOD Directive 4515.13R, Air Transportation Eligibility, November 1994
 - (n) DOD Directive 6000.11, Patient Movement, 9 Sep 1998
 - (o) DOD Directive 6490.2, Joint Medical Surveillance, 30 August 1997
 - (p) DOD Instruction 6490.2, Implementation and Application of Joint Medical Surveillance for Deployments, 7 August 1997
 - (q) USPACOMINST 6530.2H, USPACOM Joint Blood Program
 - (r) USPACOMINST 6200.1, Force Health Protection Program for Deployments, 25 January 2000
 - (s) USPACOMINST 4652.1 series, U.S. Pacific Command Joint Medical Regulating Office Handbook
 - (t) OPNAVINST 6530.4 series, Department of the Navy Whole Blood Program
 - (u) FM 4-02 Force Health Protection in a Global Environment, February 2003
 - (v) The Emergency War Surgery, (second U.S. Revision of the Emergency War Surgery NATO Handbook), published by DOD, 1988
 - (w) Joint Staff Memorandum, J-4A, 00106-93, Medical Surveillance Report, 28 January 1999

24 AUG 05

1. Purpose. To provide a concept of operations, assign tasks, and provide guidance to ensure an effective theater health service support (HSS) system that supports operations in the Basic Instruction, and conforms to guidance contained in references (a) through (w).
2. Applicability. See Basic Instruction paragraph 2.
3. Assumptions. See Basic Instruction paragraph 6.
4. Limitations. See Basic Instruction paragraph 7.
5. Mission. When directed, USPACOM deploys the appropriate HSS resources and infrastructure to support response to PI, in order to preserve the operational readiness of USPACOM Forces and to limit or delay the spread of PI.
6. Execution. Refer to Basic Instruction. Comprehensive HSS hinges on the synergy developed through inter-service mutual cooperation, host nation support (HNS) agreements and, as this order is jointly executed, sharing and cross-leveling of HSS resources among the services.

- a. Concept of Operations. Refer to Basic Instruction.

- (1) General. HSS is a national responsibility. U.S. HSS will also be provided to U.S. Forces and specific population categories. All other nations participating in coalition operations should establish sufficient HSS for their own forces regardless of operational command and control of those forces during employment.

- (2) HSS planning is a Service specific responsibility. Adequate HSS will be planned for and provided to all U.S. forces. However, because of the potential enormity of a pandemic, all deployed medical assets will be considered JOINT assets and will be used to support all U.S. forces.

- (3) Treatment of casualties will be provided through coordinated and integrated joint use of deployed and fixed medical resources.

- (4) Hospitalization. U.S. DOD medical facilities exist throughout the AOR to provide medical care for U.S. Forces and beneficiaries assigned to garrison and forward-deployed units. The Services maintain inpatient medical treatment facilities and multiple outpatient clinics to provide peacetime healthcare.

7. Patient Movement. Refer to the Basic Instruction and Appendix A to this enclosure. Aeromedical Evacuation (AE) assets are based in Japan to provide strategic AE throughout the PACOM AOR. All patient movement requirements are coordinated through the Theater Patient Movement Requirements Center - Pacific (TPMRC-P) located at Hickam AFB, HAWAII using the TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES). PACAF and USTRANSCOM/Air Mobility Command (AMC) provide weekly AE channel flights to/from PACAF bases throughout the PACOM AOR. Other opportune and non-routine missions are coordinated as required. Additionally, alternate methods of patient care and movement can be obtained through civilian sources such as the International SOS at www.internationalsos.com. The 24-hour ISOS Singapore or Sydney TRICARE dedicated phone lines and email addresses for the Asia-Pacific region are as follows:

ISOS Singapore (for all other remote Western Pacific (WESTPAC) countries, including Madagascar): (65) 6338-9277
Email for SOS Singapore (please address to both email addresses):
Sin.Tricare@internationalsos.com &
sin.medical@internationalsos.com

SOS Sydney (Australia, New Zealand, American Samoa, Fiji, Palau, and Saipan): (61) (2) 9273 2760
Email for SOS Sydney: SydTricare@internationalsos.com

(1) Host Nation Support (HNS). In general, HNS for direct medical care and supplies will be considered only when those facilities/supplies meet U.S. standards of care. HNS is used routinely under the DOD healthcare management plan (TRICARE) to obtain medical care for DOD members and other beneficiaries. Inpatient care is available through TRICARE contracts throughout the AOR as needed to meet HSS requirements.

(2) Other Service Support. In addition to the basic instruction, consider the following:

(a) Medical Assistance to DOD and non-DOD contractors. Joint policy for providing medical care to DOD and non-DOD contractors is being developed and will be promulgated when it becomes available. In a setting of overwhelming PI, prioritized care for U.S. citizens including non-military personnel, may be necessary.

(b) Medical Assistance to Allied/Coalition Military Personnel. Within U.S. capability, allied/coalition forces personnel will receive stabilization treatment in U.S. hospitals

24 AUG 05

in USPACOM and return to national control at the earliest opportunity. In any case, Components will implement procedures for capturing and reporting costs for providing such care.

(c) Care of Host Nation Civilians. Within available capabilities, U.S. MTF's will provide HSS to Host Nation Civilians who are directly supporting U.S. forces. Host Nation civilians will be returned to national control as soon as medically indicated.

(d) Mortuary Affairs. Mortuary support to U.S. forces, to include search, recovery, identification, and disposition of remains and personal effects, will be provided IAW USPACOMINST 0237.1, Mortuary Affairs, 23 May 2005.

(e) Civil Affairs. Service components will conduct Civil Affairs programs as directed by USPACOM. Medical units will participate in these Civil Affairs programs.

(3) Force Health Protection. See Basic Instruction paragraph 10.c.(6).

(4) Theater Evacuation Policy. PI patients will be treated in place and not evacuated until recovered. Non-PI patients may be evacuated at any clinically appropriate point as required in order to maintain hospital capacity.

(5) Dental Services. During a PI outbreak, dental care may be limited to treatment necessary to relieve suffering and alleviate impairment of an individual's ability to adequately perform assigned missions. Routine dental service support will be provided on an area basis and in the setting of an overwhelming pandemic will be of reduced priority. Under such circumstances, commanders may direct dental personnel to be used throughout the theater in a medical treatment and care role consistent with individual capabilities.

(6) Veterinary Services. See Basic Instruction. CDR USARPAC will coordinate with U.S. Army Medical Command and Pacific Region Veterinarian Command for veterinary support to all U.S. Forces deployed to the PACOM AOR. Eighth U.S. Army will provide Veterinary Services for U.S. Forces deployed to the Korean Peninsula and augment the AOR as required. Responsibilities include:

(a) Emphasize the control of zoonotic diseases and endemic animal diseases and the importance of adequate prevention and treatment measures.

(b) Conduct vigorous inspections of CONUS-grown or packaged foodstuffs.

24 AUG 05

(c) Inspect indigenous food grown above ground or locally prepared or packaged to include food-processing facilities.

(d) In the setting of PI, be particularly vigilant to the health of local bird populations and the potential for animal harbor or vector of PI.

(7) Humanitarian Assistance (HA). The USPACOM will provide specific HSS guidance for HA as required. To be coordinated with the Department of State, the plans will support the overall effort, and may include evacuation, hospitalization, victim identification, public health information and education for the affected populace.

a. Tasks. See Basic Instruction.

b. Coordinating Instructions

(1) Subordinate commands will avoid unilateral actions that significantly and adversely affect medical support provided to other commanders until concurrence of those commanders has been obtained via USPACOM.

(2) The Joint Patient Medical Regulating Centers-Korea and Japan (JPMRC-K and JPMRC-J, respectively), when stood up, will provide bed status reports for all units to the Theater Patient Movement Regulating Center-Pacific (TPMRC-P). Both JPMRCs will request movement of patients from their hospitals to other USPACOM or CONUS medical treatment facilities through the TPMRC-P. TPMRC-P will provide theater CASF and MTF bed status reports to USPACOM and USTRANSCOM.

(3) The USPACOM and Component/Sub-Unified Commands and their staffs will coordinate efforts to ensure effective medical support to the PI medical response strategy.

8. Administration and Logistics

a. Medical Logistics. Refer to the Basic Instruction. The following are recommended personal protective equipment for responding to PI: face shields/protective goggles, disposable gloves for clinical use (small, medium, and large), reusable gloves for cleaning, hair cover, high efficiency masks (N-95) for medical staff and others coming into contact with PI patients, disposable surgical masks for patients, disposable long-sleeved gowns, and disposable plastic aprons.

b. Reports. Component or subordinate unified commands will submit all reports in accordance with Joint Pub 6-04.1, U.S. Message Text Formatting System:

(1) Notify the parent service organization of U.S. personnel admitted to a host nation or U.S. component command

24 AUG 05

hospital as expeditiously as possible. Notification of NOK will be IAW Service guidelines.

(2) Notify appropriate national military authorities of all military personnel from that nation who are hospitalized in U.S. military medical facilities.

(3) Submit medical regulating reports IAW reference (m).

(4) Submit daily medical situation reports (SITREPs) (Appendix C of this enclosure) as part of/or in addition to command SITREP.

(5) Assure daily disease incidence/event information is available via JMeWS.

9. Command and Control

a. Command

(1) CDR USPACOM is the supported CDR for the deployment of PI response forces.

(2) The USPACOM Surgeon maintains a direct coordination relationship with the USPACOM service component surgeons. The Surgeon is responsible for employment of assets to effectively support the overall PI strategy throughout the AOR.

b. Command Control, Communications and Computer Systems

(1) No single dedicated medical communications network exists throughout USPACOM. Each Service has significant organic capability with its hospitals or command and control elements. Moreover, interoperability among the components is limited.

(2) The Aerospace Evacuation (AE) Control Team embedded within the Air and Space Operations Center maintains HF capability within the AE system. This system provides a patient reporting mechanism and communications capability to support AE operations. Each air evacuation control center, mobile aeromedical staging facility, and AE liaison team has HF capabilities. Locations for these elements will be published when stood up.

(3) Joint Medical Work Station (JMeWS) will be used, when available, to provide a joint medical common operating picture throughout the theater. Medical staff at all levels of command will use of the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) module to review consolidated data to assess the PI threat and take appropriate actions.

24 AUG 05

Appendices:

A -- Movement During a PI Incident

B -- Antiviral Use for Prevention and Treatment

C -- Format for Medical Situation Reports (MEDSITREPS)

MOVEMENT DURING A PI INCIDENT

1. Purpose. To provide guidelines for the management and movement of mass populations and patients during a PI incident.

2. Concept of Operations

a. In the event of a PI outbreak, movement of affected or potentially-affected USPACOM personnel will be limited in order to contain or delay the potential spread of infection. A local treatment-in-place approach will generally be used to reduce risk of secondary spread of PI. When an outbreak occurs in an OCONUS country or region, USPACOM may direct movements in advance of occurrence of illness in order to limit the spread of PI and/or preserve the fighting force. Additionally, at the direction of the DOS, USPACOM may be called on to conduct non-combatant evacuation operations (NEO) to remove personnel from high-risk areas to safe havens. The guidelines in references (r) and (s) pertain.

b. In preparation for such an event, this Appendix describes the recommended evacuation concept. Figure 1 to this enclosure graphically demonstrates this concept. Depending on the incidence of PI in the immediate geographical area and logistical resources, quarantine and isolation procedures may be required at the start of the process.

(1) Quarantine: During a PI outbreak, quarantine may be effective at slowing the spread of the disease during the initial days of the outbreak. As the outbreak expands, the use of quarantine loses its effectiveness. Ideally, populations to be quarantined will be subdivided into small groups of ten depending on available facilities, staff and resources. Personnel in each group should begin and complete quarantine at the same time, without addition of new personnel to that group during the course of quarantine. For PI, the directed quarantine duration is two incubation periods. For adults this is a total of 10 days from the time of entry of the last person into the quarantine area. For children this is a total of 14 days from the time of entry as long as all adults are quarantined for at least 10 days. If, during quarantine someone develops an active case of PI, that person is moved to isolation and treatment and the remaining personnel restart their quarantine period. The need for this additional quarantine drives recommendation for small quarantine groups of 10. At the completion of this quarantine period, individuals will be eligible for movement/evacuation.

24 AUG 05

(2) Isolation: Personnel with active PI will be held in isolation, receive antivirals for treatment, and receive medical care until they recover. Recovered patients will be eligible for movement/evacuation, or for further assignment in the area as needed.

c. When an evacuation is ordered, all individuals to be evacuated will report to designated evacuation centers for screening:

(1) **Individuals with no PI signs or symptoms, no known encounters with persons experiencing PI symptoms, or no known encounters with animals potentially infected with PI.** (See Figure 1, Block I of this enclosure) The Commander may immediately direct the evacuation of these individuals out of the affected area after clinical screening for influenza like illnesses but without further quarantine, as the situation warrants. However, if there is reasonable suspicion that these individuals may have been exposed to PI, the Commander may direct these individuals into quarantine per para. 2.b.(1) above.

(2) **Individuals with possible PI signs or symptoms or encounters with someone experiencing PI signs or symptoms.** (See Figure 1, Block II of this enclosure) Report to a separate center(s) located at a facility other than a hospital and separate from center for unexposed individuals in paragraph 2.c.(1) above. These individuals will be quarantined consistent with paragraph 2.b.(1) above. If symptomatic, they will be isolated, receive treatment dosage of antivirals and be transferred for care as required.

(3) **Individuals with possible PI signs or symptoms or encounters with someone experiencing PI signs or symptoms and additional in-patient medical needs.** (See Figure 1, Block III to this enclosure) Report to designated hospital. These individuals will be quarantined consistent with para 2.b.(1) above in the hospital and receive additional hospital care for other medical needs.

(4) **Individuals with confirmed PI.** (See Figure 1, Block IV of this enclosure) Report to the designated isolation facility/hospital. These individuals will be isolated and treated consistent with paragraph 2.b.(2) above.

24 AUG 05

d. Upon release from quarantine or isolation, individuals may be moved as necessary. Care must be taken to preclude potential re-exposure to PI while awaiting movement. Medical screening at the point of departure will occur to ensure individuals do not display PI signs or symptoms, such as fever, headache, muscle aches, prostration, sore throat, cough, and nasal discharge.

(1) If no signs or symptoms develop en route to CONUS, or elsewhere, personnel will be moved onward as directed by USNORTHCOM/parent command or Service.

(2) However, should someone become develop signs or become symptomatic en route, the entire group of passengers and crew must be retained for further quarantine or isolation. Such individuals will be directed to an isolation location upon debarkation consistent with paragraph 2.b.(2) above, while individuals without signs of illness and non-symptomatic will be directed to a quarantine location consistent with paragraph 2.b.(1) above. Upon recovery or completion of quarantine, these individuals will be moved onward as directed by USNORTHCOM/parent command or Service.

e. Other Related Items.

(1) Worried Well. These individuals will be screened according to personal exposure history and objective clinical signs and triaged appropriately. The "worried well" population may be significant. The number of "worried well" individuals, while unpredictable, may be reduced through active information awareness programs and ongoing education.

(2) Individuals Presenting at Military Treatment Facilities (MTFs) for Assistance. During a PI event, individuals may present themselves directly to the MTFs instead of designated evacuation center(s) for triage and screening. Commanders will incorporate procedures in their plans, such as entry control and personal protection measures to prevent disease spread and preserve operational integrity.

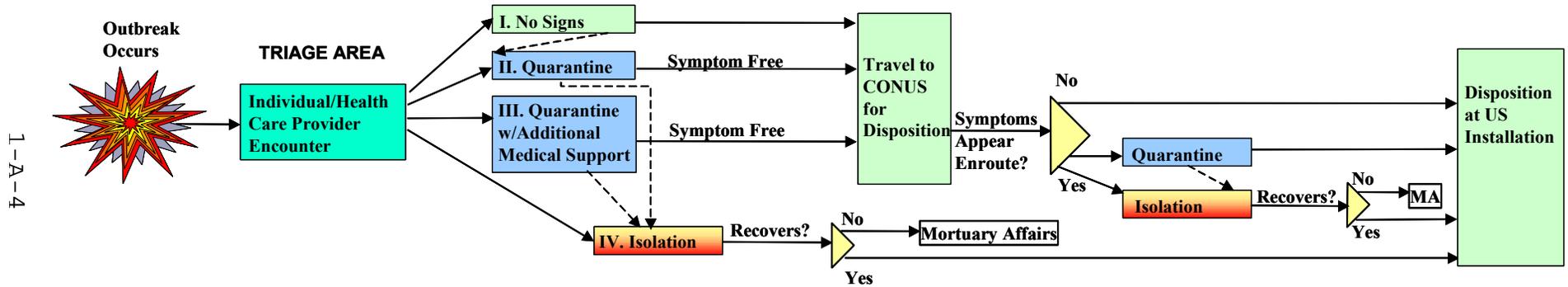


FIGURE 1, PI INCIDENT MASS MOVEMENT

- **Block I:** Individuals with no PI signs or symptoms, no known encounters with persons experiencing PI symptoms, or no known encounters with animals potentially infected with PI. (See para 2.c.(1) this enclosure for additional details).
- **Block II.** Individuals with possible PI signs or symptoms or encounters with someone experiencing PI signs or symptoms. (See para 2.c.(2) this enclosure for additional details).
- **Block III:** Individuals with possible PI signs or symptoms and additional in-patient medical needs. (See para 2.c.(3) this enclosure for additional details).
- **Block IV:** Individuals with confirmed PI. (See para 2.c.(4) this enclosure for additional details).

ANTIVIRAL ADMINISTRATION AND USE FOR PREVENTION
AND TREATMENT

1. Providers should review <http://www.cdc.gov/flu/professional/treatment> for the most current CDC guidance on medications and dosages as this may supercede guidance listed below. DOD has approved bulk purchase and stockpiling of Oseltamivir phosphate (oseltamivir, Tamiflu®) for DOD personnel during a PI outbreak for treatment and prophylaxis. Appropriate use is essential to gain maximal benefit while preserving supplies of this limited resource.

2. Antivirals can be used for both treatment and as prophylaxis. The objective of treatment with antivirals is to restore health in infected people, while the primary objectives of prophylaxis is to diminish the spread of disease and allow personnel to return to duty without being subject to quarantine restrictions.

a. Treatment.

(1) Proven effective at reducing complications of influenza but only reduces lost work time by one day on average.

(2) Appropriate dosage is 75mg orally, twice daily for 5 days, beginning within two days of onset of symptoms.

b. Prophylaxis of contacts of ill individuals.

(1) Proven effective at reducing transmission of influenza to family members of exposed individuals.

(2) Appropriate dosage is 75mg orally, once daily for 7 days, beginning as soon as illness in a close contact is presumed.

(3) Children may shed virus longer than adults, therefore contacts of ill children will require 10 days of prophylaxis.

b. Prophylaxis of unexposed individuals.

(1) This strategy should be primarily for use in operational units and essential personnel due to the potentially long duration of prophylaxis, and rapid consumption of limited drug supplies.

(2) The dose of oseltamivir is 75mg orally once daily

24 AUG 05

(3) The duration is 8 weeks, or for the period of each pandemic wave, or for 7 days following departure from the affected area.

d. References:

(1) Cooper NJ, Sutton AJ, Abrams KR, Wailoo A, Turner D, Nicholson KG. Effectiveness of neuraminidase inhibitors in treatment and prevention of influenza A and B: systematic review and meta-analyses of randomized, controlled trials. *BMJ*. Jun 7 2003;326(7401): 1235.

(2) Welliver R, Monto AS, Carewicz O, et al. Effectiveness of oseltamivir in preventing influenza in household contacts: a randomized controlled trial. *JAMA*. Feb 14 2001; 285(6):748-754.

(3) Hayden FG, Atmar RL, Schilling M, et al. Use of the selective oral neuraminidase inhibitor oseltamivir to prevent influenza. *N Engl J Med*. Oct 28 1999; 341(18):1336-1343.

MEDICAL SITUATION REPORTS (MEDSITREPS)

1. When directed by CDR USPACOM, component, subunified and regional command surgeons will submit a medical situation report (MEDSITREP) daily NLT 2400 (WHISKEY or Hawaiian Time), with an "as of" time of 2100. If the Hospital Ship is present and in support of PI operations, she will be included in the Naval Component Commander's report. Serialize each report for tracking purposes. Use the format below.

2. The preferred method of transmission is by AUTODIN; however, GCCS messages, facsimiles, electronic mail transmission, and voice reports on voice network may be used if necessary. Transmission will generally be on NIPR/open net, but may be via secure means when deemed appropriate. Note that the medical section on the commander's daily SITREP will NOT be used in lieu of the MEDSITREP. The medical section of the commander's daily SITREP should contain information or issues of particular significance to the commander and that require communication to higher authority.

OXXXXXXZ MON YY
FM//XXXXXXXXXX//
TO//USPACOM HONOLULU HI/J07/PAO/J1/J3/J5/JOCMED//
CLASS//U N C L A S S//
OPN/EX//OPERATION OR EXERCISE//
SUBJ//MEDSITREP NUMBER XXX/AS OF XX0900I MON YY//
REF//A//DOC/COMUSPACOM PANDEMIC INFLUENZA OPS
RMKS//1.THE SUMMARY BELOW IS PROVIDED PER REF A:

PART 1 (CURRENT STATUS)

WORKLOAD (12-HR PERIOD):	WIA	DIS(PI)	NBI	TOTAL
ADMISSIONS:	XXX	XXX(XX)	XXX	XXX
OUT-PATIENT VISITS:	XXX	XXX(XX)	XXX	XXX
RETURNS-TO-DUTY:	XXX	XXX(XX)	XXX	XXX
EVACUATIONS:	XXX	XXX(XX)	XXX	XXX
DEATHS:				
DOA:	XXX	XXX(XX)	XXX	XXX
DOW:	XXX	XXX(N/A)	XXX	XXX
DIED OF PI:	N/A	(XXX)	N/A	XXX
PATIENTS WAITING EVAC:		XXX XXX	XXX	XXX
HOSPITAL BEDS:	NUMBER	STATUS		
OCCUPIED	XXXX	GREEN		
AVAILABLE:	XXXX	AMBER (based on percent occupied)		
OPERATING ROOMS				
# OPERATIONAL:	XXXX			
HRS OF BACKLOG:	XXXX			

24 AUG 05

DEDICATED EVAC ASSETS:	ON-HAND	PERCENT FMC	STATUS
GROUND:	XXXX	XX	GREEN
AIR AMBULANCES:	XXXX	XX	GREEN
FIXED WING:	XXXX	XX	GREEN
BLOOD (UNITS):	ON-HAND	AVAILABLE	
	XXXX	XXXX	AMBER
NUMBER OF UNITS USED LAST 24 HOURS:			
CLASS VIIIA:			
MES:	XXXX	XXXX	AMBER
SUPPLIES:	XXXX	XXXX	AMBER
CRITICAL EQUIP:	XXXX	XXXX	GREEN

CRITICAL SHORTFALLS: Describe any issues, which, if not resolved will prevent improvement as well as lead to a degradation of the status reported above. Report staffing shortfalls by MOS.

NARRATIVE. Use this section to specify what are the causes of the reported degradations, and what is being done to resolve these deficiencies. Additionally, comment on the incidence of disease experienced.

PART 2 (72-HOUR PROJECTION)

A. HOSPITAL BEDS:	NUMBER	STATUS	
OPERATING:	XXXX	GREEN based on force flow & RSOI	
AVAILABLE:	XXXX	AMBER based on ANTICIPATED occupancy	
B. AVERAGE EVAC DELAY (DAYS):			
OPZONE 1 TO 2A:	XX		
OPZONE 2A TO 2B:	XX		
C. DEDICATED EVAC ASSETS:	ON-HAND	PERCENT FMC	STATUS
GROUND:	XXXX	XX	GREEN
AIR AMBULANCES:	XXXX	XX	GREEN
FIXED WING:	XXXX	XX	GREEN
D. BLOOD (UNITS):	XXXX	XX	AMBER
E. CLASS VIIIA:			
MES:	XXXX	XX	AMBER
SUPPLIES:		XX	AMBER
CRITICAL EQUIP:		XX	GREEN
F. STAFFING:		XX	AMBER
G. CRITICAL SHORTFALLS: Describe any issues which if not resolved will prevent improvement as well as lead to a degradation of the status reported above. Report staffing shortfalls by MOS.			
H. NARRATIVE. Use this section to specify what are the causes of the reported degradations, and what is being done to resolve these deficiencies.			

24 AUG 05

STATUS RATING SCALE

ITEM	GREEN	AMBER	RED	BLACK
Hospital beds (% occupied)	0 – 75	76-85	86-95	96-100
Ground Ambulances (FMC/On Hand)	>85	75-85	60-74	<60
Air Ambulances (FMC/On Hand)	>85	75-85	60-74	<60
Dedicated Fixed Wing Aircraft (FMC/On Hand)	>85	75-85	60-74	<60
Blood	>85	75-85	60-74	<60
Medical Equipment Sets (on-hand)	>85	75-85	60-74	<60
Medical Supplies (DOS)	>20	12-20	7-11	<7
Critical Equipment	>90	75-90	60-74	<60
Staffing	>90	75-90	60-74	<60

PUBLIC AFFAIRS

1. SITUATION. See Basic Instruction. Paragraph 11.b. of the Basic Instruction defined the USPACOM Public Affairs Office as the lead staff directorate for the internal and external public release of information on Pandemic Influenza (PI) events.

a. General. This Annex provides general guidance for the handling of Public Affairs matters in support of USPACOM PI Instruction and describes the process by which public affairs guidance will be developed and at what level of government that guidance will be approved. Additionally, anticipated questions and proposed responses for likely media requests will be addressed in specific PAG and tailored for the general public. It is critically important to expeditiously and effectively articulate relevant and required information to describe the process (and expected timeline for updates, etc...) for informing the public regarding efforts to respond to the PI threat in the USPACOM area of operations (AOR). This announcement may be in conjunction with or in coordination with the Center for Disease Control (CDC), the Department of Health (DOH), the Department of State (DOS), Department of Defense (DOD), or other applicable U.S. Government agencies.

b. National Media. In the advent of an outbreak of avian influenza or some type of PI within the AOR, U.S.- based media can be expected to be supportive of USG, DOH, DOS, DOD responses to mitigate the spread of any type of pandemic (avian) influenza. The focus of media attention will be upon what the U.S. government is doing to prevent the spread of disease, where the public can get the latest information on a variety of subjects relating to the outbreak, and in general the "Who, What, Why, Where, When and How" regarding the disease. The media will concentrate on DOD response options and will look to Washington, not the USPACOM HQ for these answers. It will be through DOD/DOS and likely other government agencies (OGAs), that the American public will be kept informed of the proactive, positive and successful actions being undertaken to prevent further outbreaks, abate the disease, vaccinate against the disease (if and when a vaccination is developed and available). Like the tsunami affecting countries bordering the Indian Ocean, fighting a PI outbreak will be of global interest. The USG and DOD will look to foster international support for DOD responses. It is important to note that the first responders may be predominantly military as they are often best equipped for short-notice and expedient responses to a variety of crises.

24 AUG 05

Since 9/11 both the media and the American public have become better informed of USPACOM's roles, missions, activities and capabilities in the Pacific AOR. The media's desire, as well as that of the general public's, for constant information will be linked to their trust in DOD/USPACOM as a reliable honest-broker of information that may relieve their anxiety dealing with the unknown. Many journalists have proven themselves to be responsible guardians in terms of protecting sensitive information and being smart stewards of how to report upon crises of global significance. The media is not the enemy, so it is important to provide them with the information they will need to report upon and share with the general public. This Annex recognizes the need to inform the American public in the face of their fears and anxiety and at the same time protecting USPACOM's need to safeguard lives and accomplish its critically important mission(s).

c. Policy and Public Affairs Posture

(1) The OSD (PA) provides overall guidance for the formulation of public affairs guidance (PAG) and approves USPACOM proposed PAG after coordination with the Joint Staff, DOS, DOH, CDC and other USG agencies as appropriate.

(2) Public affairs planning and execution will be of critical importance in responding to the spread of any PI.

(3) In general, public affairs posture will be active regarding any PACOM personnel affected, non-combatant evacuation operations (NEO) of U.S. citizens or the redeployment of personnel. It is important to maintain contact with the media to provide immediate information to the public that is timely and accurate and to dispel false information that may inflame rumors or create hysteria. (OASD/PA will coordinate national level guidance in the event a spread of PI becomes evident.)

d. Assumptions Regarding Public Affairs Planning

(1) PI Outbreak or potential for epidemic will be of global interest and will require significant USPACOM assets to be initially dedicated to the effort to prevent (further) outbreak of the disease, the provide aid wherever possible and/or directed.

(2) PI Outbreak will be initially a USPACOM response/lead, but can expect DOD or other USG agency to take

the lead at a very early timeframe. USPACOM will then become the significant supporter to activities within the AOR.

(3) DOD and other USG agencies will likely conduct daily press conferences in their respective areas that may require USPACOM's PA constant coordination.

(4) USPACOM will not become the public face of DOD responses. USPACOM will provide DOD with information and possibly a PA LNO to ensure USPACOM equities are protected and limit the number of inadvertent disclosures.

(5) National media interest in USPACOM response operations will be minimal and will focus on the DOD and USG responses. USPACOM and its components may expect a surge of media queries initially, but can expect that to shift back to DOD within 24-48 hours as DOD and other USG agencies will have the lead as the subject matter experts and are best suited to address the specifics of the disease, the possibilities of outbreaks and all other aspects of fighting the spread of the disease. All requests for specific information including requests for on-camera interviews by the Commander and other high-ranking personnel and media embed opportunities will all be directed to USPACOM Public Affairs.

2. MISSION. Provide public affairs support to USPACOM PI Instruction and provide the public the maximum amount of accurate information concerning the crisis consistent with OPSEC and personnel safety.

3. EXECUTION

a. Concept of Operations.

(1) Deliberate Planning Process. USPACOM PA will serve as the coordinating element for public affairs planning within the AOR and coordinate all PA efforts with OASD/PA and other USG agencies as directed.

(2) PA COA's will be specifically identified within the public affairs guidance (PAG) and tailored to support the mission as outlined by the Commander, USPACOM.

(3) Public Affairs Guidance (PAG) will be developed by the USPACOM public affairs in coordination with OASD (PA) and incorporate input from subordinate commands as appropriate. This guidance will be provided in draft form to OASD (PA) for

24 AUG 05

coordination by SECDEF, JCS and interagency levels and the finalized PAG will be issued by OASD (PA).

b. Tasks

(1) General

(a) Command Relationships. Public affairs command relationships will be in normal PACOM command relationships.

(b) The OASD (PA) will coordinate and disseminate USPACOM's proposed PAG and plan to all supporting commands within DOD, the DOS and other government agencies.

(2) OASD (PA)

(a) Solicit specific information from USPACOM daily for press briefings and releases as appropriate.

(b) Provide information release authority to designated commands with detailed instructions on reporting requirements in terms of time and content.

(c) Provide ongoing changes to approved USPACOM PA guidance, as well as message feedback on coverage by major U.S. media.

(3) Other PA Planner Responsibilities. As required.

(4) GCC PA Responsibilities. As required.

(5) Component Commands.

(a) Upon request, provide USPACOM with proposed public affairs statements and questions and answers for active and reserve affected components.

(b) Coordinate PA annexes of supporting plans with component logistics, communications, operations, and other planners, as appropriate.

(c) Be prepared to respond directly to guidance and requests for assistance from the other Unified Commands, government agencies and OASD (PA).

24 AUG 05

(d) Research and identify alternate means of communications for emergency public information program broadcasts.

c. Coordinating Instructions.

(1) Component public affairs guidance will be coordinated with USPACOM PAO.

(2) There will be no initial release of information about any disease outbreak, or response operations by any command until after the initial release is made by White House DOS or DOD level spokesperson, or until directed by higher authority.

(3) After the initial announcement, OASD (PA) may delegate release authority to USPACOM and other affected GCCs if appropriate.

(4) USPACOM Public Affairs activities

(a) Media Relations USPACOM PA can expect to direct media queries to OASD/PA and other USG agencies who are more knowledgeable about the disease outbreak and the status of combating the disease.

(b) Internal Information. Public affairs personnel at USPACOM Headquarters and component commands will disseminate as widely as possible command information aimed at keeping all personnel abreast of the current situation as it develops, the components' role, and command objectives in dealing with the crisis.

(c) Community Relations. USPACOM PA and component PAOs will initiate community relations contacts to key civic leaders' activities as appropriate to support USG, DOD and USPACOM public affairs strategies and objectives.

(5) PAO Points of Contact.

Organization	DSN/COM/FAX
OASD-PA (USPACOM Desk)	DSN: 312-227-1252/5131 Comm: 703-695-3895
Joint Staff (USPACOM Desk)	DSN: 312-227-4272 Comm: 703-697-4272
USPACOM	DSN: 315-477-1341

USPACOMINST 0507.1

24 AUG 05

	Comm: 808-477-1341
PACAF-PA	DSN: 315-448-3220/3230 Comm: 808-448-3220/3230
COMPACFLT-PA	DSN: 315-471-9220/3769 Comm: 808-471-9220/3769
USARPAC-PA	DSN: 315-438-6350 Comm: 808-438-6350

ADDITIONAL RESOURCES:

US

US Department of Health and Human Services (DHHS)

<http://www.hhs.gov/>

- **DHHS - Pandemic Influenza Response and Preparedness Plan**
<http://www.dhhs.gov/nvpo/pandemicplan/>
- **National Vaccine Program Office**
<http://www.dhhs.gov/nvpo/pandemics/>
- **US Centers of Disease Control and Prevention (CDC)**
<http://www.cdc.gov/> CDC does not work alone. They work in partnership with other agencies within the Department of Health and Human Services and across the U.S. government; with world, state, and municipal governments; with the private sector, health care organizations, academic institutions, and international and U.S.-based nongovernmental organizations.
- **CDC Information about Influenza Pandemics**
<http://www.cdc.gov/flu/avian/gen-info/pandemics.htm>
- **CDC Key Facts About Avian Influenza (Bird Flu) and Avian Influenza A (H5N1) Virus**
<http://www.cdc.gov/flu/avian/gen-info/facts.htm>
- **CDC Organization & partners**
<http://www.cdc.gov/about/cio.htm>

Deployment Health Clinical Center

<http://www.pdhealth.mil/influenza.asp>

Center for Infectious Disease Research and Policy - Pandemic Influenza - Latest News

<http://www.cidrap.umn.edu/cidrap/content/influenza/panflu/index.html>

UN

World Health Organization (WHO)

<http://www.who.int>

- **Avian Influenza**
http://www.who.int/mediacentre/factsheets/avian_influenza/en/
- **Avian Influenza (Western Pacific Region)**
http://www.wpro.who.int/health_topics/avian_influenza/
- **WHO list of Influenza Centers Worldwide:**
<http://www.who.int/csr/disease/influenza/centres2004/en/index.html>

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- **WHO Regional Office for the Western Pacific**
<http://www.wpro.who.int/>

UNICEF <http://www.unicef.org/>

UNHCR <http://www.unhcr.ch/>

World Health Organization for Animal Health (OIE)
http://www.oie.int/eng/en_index.htm

Food and Agriculture Organization (FAO) <http://www.fao.org/>

Other International Organizations (IOs)

International Committee of the Red Cross <http://www.icrc.org/>

International Federation of Red Cross and Red Crescent Societies
<http://www.ifrc.org/>

Non Government Organizations (NGOs)

Medicins Sans Frontieres (MSF)

<http://www.msf.org>

International Rescue Committee <http://www.theirc.org/>

Merlin <http://www.merlin.org.uk/>

Epicentre <http://www.theatre-epicentre.org/>

Southeast Asia Region

**Association of Southeast Asian Nations (ASEAN) Disease
Surveillance Net**

http://www.asean-disease-surveillance.net/ASNCoIns_List.asp

Asia Pacific Economic Cooperation (APEC) - Regional response

http://www.apec.org/apec/apec_groups/som_special_task_groups/health_task_force/apec_information_on.html

Asia Development Bank (ADB)

<http://www.adb.org/BirdFlu/default.asp>