

Flu Pandemic Planning Must Continue, Levitt Says

BY MICHELE G. SULLIVAN

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Getting six cell-based influenza vaccine manufacturing plants up and running in the United States should be the first of four priorities for the next Secretary of Health and Human Services, advised Secretary Mike Leavitt.

"The highest priority of the next administration should be to expand U.S. production of cell-based technology, so that in a 6-month period, we could generate enough pandemic flu vaccine in this country to protect every American," Secretary Leavitt said during a Webcast. "We have invested more than \$1 billion in this, and now have six companies in various stages of implementing either cell-based manufacturing or expanded egg-based vaccine production. The goal is to complete these contracts by 2011."

The importance of cell-based vaccine manufacturing can't be overstressed, he said. GlaxoSmithKline, MedImmune Inc., Novartis, DynPort Vaccine Co., Solvay Pharmaceuticals Inc., and Sanofi Pasteur have all received federal grant money to develop vaccines. "There are not enough chickens in the world to get this done in the case of a pandemic. These contracts have to be fulfilled and the factories built."

Second, the free international sharing of viral samples for vaccine research needs to be addressed, he said. "We need to strongly defend the sample-sharing network against short-term opportunism. For years, nations have freely shared viral samples, and this is now being threatened by nations who want to hold their

samples for compensation—they feel the virus is their intellectual property and insist on royalties if anyone makes a vaccine out of it."

A January 2007 decision by Indonesian authorities to withhold all clinical specimens from suspected cases of human bird flu A (H5N1) fueled this concern. According to the World Health Organization, which manages international sample sharing, the country rescinded this ban in March 2007. But the idea that countries could turn a profit from research samples seems to have taken root in some of the international community, according to a recent report of the European Centre for Disease Prevention and Control.

The May 2008 report noted that "to date, no other countries have publicly made moves like those of Indonesia, although some others have been considering their positions. Other countries not traditionally concerned have been supporting the Indonesian position; the debate has become politicized internationally and attitudes have hardened." (See http://ecdc.europa.eu/pdf/ECDC_influenza_briefing.pdf.)

The international community must take a strong stand against these tactics, Secretary Leavitt said. "Meeting their demands would result in the downfall of our very important sharing strategy. The system would fail and subject the entire world to more danger."

Third, the new administration will also need to concentrate on countermeasure distribution. "We have an important stockpiling system [of medications and equipment] and we can get massive amounts of supplies anywhere in the U.S. within 2 hours. But getting the pills into the people is our Achilles' heel and it needs

work. Not every state is prepared to handle this, and this failure is potentially catastrophic."

Ultimately, distribution will be a state and local issue. "Public health is a local responsibility because localities are better at accomplishing this mission than the federal government is. Before leaving this administration, I want to release a state-by-state evaluation so people can know if their officials are meeting the standards we need to achieve."

Tough economic times, Medicaid growth, and a new culture of disaster dependence might interfere with local commitments to pandemic planning, however. "We have to resist the tendency for local and state governments to use budget limitations to upwardly allocate disaster preparedness. Public health is one of a number of important functions being crowded off the budget table by the unconstrained growth of Medicaid eating up state budgets."

Also, he said, "A cultural change that began with Hurricane Katrina has begun to drive a federalization of public health. But I want to tell you, the state or community that fails to prepare, with the expectation that the federal government will come to the rescue at the last moment, will be tragically disappointed."

Finally, HHS must keep pandemic preparedness on national and local agendas. "The media buzz about bird flu has died down, but the virus has not," he said. Publicity is a tightrope act, in that "when we discuss it in advance, we come off as alarmist, but if we don't discuss it until it starts, then none of our preparations will be adequate. We need to speak of this in a way that stimulates discussion, not panic." ■

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involves identifying outbreaks quickly so that an immunization campaign can focus on the area of the outbreak and prevent the spread of disease.

In addition, the program provides vitamin A supplements and other care to prevent deaths from measles in those children who become ill, Dr. Gerberding said. "The success of the last few years indicates that when we can apply these strategies, we save lives."

But about 540 children die from measles worldwide each day, she added. The goal of the Measles Initiative is to reduce measles deaths by 90% worldwide by 2010, compared with 2000.

"We have to refocus our efforts in countries where the immunization rates are low," Dr. Gerberding said.

The Southeast Asia region (as defined by the WHO) is "the hot spot for measles transmission," she said. According to the WHO, about 130,000 of the estimated 136,000 measles deaths in that region occurred in India, when about 8.5 million children did not receive a measles vaccine through routine immunization services. Of the estimated 136,000 deaths from measles in the region in 2007, about 130,000 occurred in India, according to the WHO.

The Measles Initiative was launched in 2001 with the goal of reducing deaths from measles worldwide. In addition to the five health organizations, the initiative is supported by funding from other business and charitable partners including the Bill and Melinda Gates Foundation, the Kessler Family Foundation, and Merck & Co. ■

Broader Vaccination Window May Boost Visits

BY KERRI WACHTER

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WASHINGTON — Expanding the traditional window for influenza vaccination would expand the number of vaccination opportunities by increasing the number of pediatric office visits, based on data for 77.6 million children from a national survey during the 2004-2005 flu season.

By expanding the vaccination window either 6 months earlier or 6 months later, the overall number of children between 0-18 years with at least one provider visit jumped from 11.1 million to 23.4 million (July through December) or to 18.2 (October through March), Dr. Richard G. Judelsohn reported in a poster at the jointly held annual Inter-science Conference on Antimicrobial Agents and Chemotherapy and the annual meeting of the Infectious Diseases Society of America. MedImmune LLC, which makes Flumist nasal influenza vaccine, sponsored the study. Dr. Judelsohn's coauthors are employed by MedImmune.

In 2008, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices expanded its recommendation that all children aged 6 months to 18 years receive the seasonal flu vaccine each year. But many children do not visit a health care provider during the traditional flu vaccine window (Oct. 1–Dec. 31). The need for additional office visits for the vaccine could be a barrier to increasing flu vaccination.

The researchers used data from the

Medical Expenditure Panel Survey, a federally funded survey of families, medical providers, and employers nationwide. Data from the 2004-2005 flu season was used to assess the number of children with existing medical provider office visits during specific monthly intervals. In particular, they identified the number of children with one or more provider visit for various intervals by adding 1, 2, or 3 months before or after the Oct. 1–Dec. 31 period.

They also looked at the data for five distinct age groups: less than 12 months, 12-23 months, 2-4 years, 5-8 years, and 9-18 years. Well visits were summarized separately from other provider visits because these may represent the greatest yield vaccination opportunity.

"With expansion of the traditional vaccination window, the largest percentage increase in the number of chil-

dren with a provider visit is seen in children 5-18 years of age," wrote Dr. Judelsohn, a professor of pediatrics at the University at Buffalo (N.Y.), and his colleagues. The percentage jumped from 27% between October and December to 46%-48% having a visit during either 6-month window.

"Overall, the proportion of children with existing visits decreases with increasing age," they wrote. In all, 59% of children younger than 23 months had a visit between October and December, compared with 27% of children aged 5-18 years. Among children with a visit, the proportion with well child visits also decreases with increasing age.

"The early months of July, August, and September appear to be important for reaching school-aged children during well visits, with the biggest increase seen including August," they noted. ■

Estimated Number of Children With at Least One Provider Visit (in millions)

Age group	Population size	Vaccination window		
		Oct.-Dec.	July-Dec.	Oct.-Mar.
<12 months	3.9	2.1	2.7	3.1
12-23 months	4.1	1.6	2.5	2.3
2-4 years	12.3	2.2	4.5	3.9
5-8 years	15.6	1.7	3.9	2.7
9-18 years	41.7	3.4	9.8	6.2
Overall	77.6	11.1	23.4	18.2

Note: Based on 2004-2005 data from the Medical Expenditure Panel Survey.

Source: Dr. Judelsohn