U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

DATE: **September 14, 2021**

TO: **Robert Fenton, Jr.**
Senior Response Official
Operations Allies Welcome (OAW) Unified Command Group (UCG)

FROM: **Rochelle P. Walensky, MD, MPH**
Director, Centers for Disease Control and Prevention (CDC)

RE: **Directive to Immediately Implement CDC Public Health Standards to Contain and Mitigate On-Going Multiple Measles Outbreaks**

OVERVIEW

Measles is an exceptionally contagious infectious disease; around 9 out of 10 people who are not protected will become infected following exposure to measles virus. Measles virus can remain infectious for up to two hours in an airspace after an infected person leaves an area and be carried to large numbers of susceptible people very rapidly. In 2000, measles was declared eliminated from the United States, meaning the disease is no longer endemic in this country. However, travelers continue to bring measles into the United States. Urgent public health action and implementation of public health standards are needed following the detection of six confirmed and 17 additional suspect cases of measles in Afghan evacuees as part of Operations Allies Welcome; these cases are an indicator of potentially much larger imminent outbreaks. Given its extreme infectiousness, in refugee and other congregate settings the identification of even one case of measles is considered an outbreak. To date, state and local public health authorities are investigating six outbreaks in Afghan evacuee populations; these outbreaks have already exposed hundreds in several hospitals. Immediate implementation of CDC public health standards is imperative to prevent introduction of measles into U.S. communities and respond to multiple concurrent measles outbreaks; this includes 21-day quarantine after receiving the MMR vaccine. Healthcare facilities are already at limited capacity as they battle the ongoing COVID-19 pandemic which requires tremendous workforce and laboratory assets.

Measles outbreaks in refugee camps and other congregate settings lead to high morbidity and mortality (5-34%). The large number of unvaccinated Afghan evacuees, as seen already, has the potential to seed countless U.S. community outbreaks. A typical measles case costs >$30,000 and threatens unvaccinated infants (generally <12-18m), the immunocompromised, and other unvaccinated individuals. CDC strongly advises the following public health standards be

immediately implemented to address the ongoing outbreaks of measles, prevent introduction of measles into U.S. communities, and protect the evacuees. Doing so with the highest sense of urgency is critical, especially during the COVID-19 pandemic, which has reduced routine immunization coverage and increased vulnerability to measles outbreaks.

These outbreaks represent a major public health threat and rapid mass vaccination and expanding quarantine and isolation capacities are essential.

It is CDC's assessment that the following measures are urgently needed to protect the public health of evacuees and the U.S. population:

1. The Department of Defense (DOD) pause all flights from all OCONUS sites until all OCONUS-based evacuees can receive measles, mumps, and rubella (MMR) and varicella (chickenpox) vaccinations.
2. DOD immediately implement a mass vaccination campaign for all evacuees at OCONUS sites and CONUS safe havens.[1]
    a. Pregnant women should be evaluated for immunity by serology and, if non-immune, offered immunoglobulin.
    b. Medical contradictions in CDC guidance at https://www.cdc.gov/vaccines/vpd/mmr/public/index.html should also be followed.
3. DOD initiate measles surveillance and active case finding among all individuals at the site, including evacuees, staff, contractors, and volunteers.
4. Evaluate current status and assess expansion of quarantine and isolation capacities and capabilities. Crowding should be minimized, while ventilation and indoor air quality should be increased to the greatest extent possible.
5. All evacuees remain in quarantine for 21 days after receiving the MMR vaccine. Evacuees who were exposed together may be quarantined together.
    a. Evacuees who develop an active measles case remain in isolation through 4 days after rash onset.
    b. The Office of Refugee Resettlement should consult with CDC regarding the custody transfer of unaccompanied children who have not completed 21 days of quarantine post-vaccination.
6. DOD notify *prior to transfer*, Emergency Medical Services (EMS) and receiving healthcare facility of the patient's potential exposure to measles if an evacuee is sent for healthcare services. EMS and the receiving facility should be notified of the vaccination status of the patient, who should immediately be placed in an airborne infection isolation room upon arrival at the facility, for evaluation and care.
7. DOD immediately report any confirmed or suspect cases to CDC who intend to travel by commercial aircraft. Do Not Board orders will be issued by CDC/Department of Homeland Security (DHS) for any known measles cases that have not followed public health requirements for isolation and attempt to travel by air.

[1] All evacuees should receive an MMR vaccine, unless they can provide proper documentation of previous vaccination. As is customary during measles outbreak responses in humanitarian emergency settings, verbal affirmation of previous vaccination is insufficient; evacuees without proper documentation will be vaccinated, which does not pose a medical risk.

8. All U.S. Government departments and agencies ensure current and future staff supporting evacuees, including contractors, trainees, and volunteers, are current on measles vaccination.
9. For OCONUS sites,
    a. DOD confer with the host government and immediately report individuals that intend to leave OCONUS sites prior to receiving vaccinations; and
    b. DOD institute no-touch health screening measures (i.e., rash checks, temperature screening, and request to self-report if symptomatic) during the boarding process as an additional precaution.

RATIONALE

Failing to swiftly execute the measures outlined above will likely result in increased exposure to evacuees and personnel supporting OAW operations, including safe havens. Further, evacuees who have not been vaccinated (41% of children under five years are not currently protected against measles) pose a public health threat. In contrast to COVID-19, an infectious individual with measles can expose everyone in a large, shared airspace (e.g., within an auditorium, on an aircraft, etc.). This makes contact tracing and individual quarantine less useful and prevention through vaccination far more urgent.

A measles case is infectious four days before and four days after the rash onset; this means exposures can occur before appearance of the typical rash and thus before measles is recognized. If a case is determined to be infectious while at a safe haven, due to the congregate nature of the setting, there is the potential for exposure of many evacuees, and thus contact tracing in the current context of safe havens would be extraordinarily difficult. Persons who are exposed and not vaccinated promptly require quarantine. The space available for quarantine and isolation measures at the safe havens remains extremely limited; most are currently at or beyond maximum occupant capacity.

In the six confirmed cases, the infection onset began at different OCONUS sites, indicating disease circulating at more than one site. Additionally, there is a high likelihood the measles cases originated in Afghanistan, given the multiple OCONUS sites implicated in confirmed cases, the very low measles vaccination rates in Afghanistan, the high measles endemicity in Afghanistan (ranked seventh for measles outbreaks), and the degraded security situation leading to a humanitarian crisis in Afghanistan. These considerations place all evacuees at significant risk across the full migration journey and at all OCONUS and CONUS sites, including origin and departure ports of entry and transportation conveyances. Case ascertainment for febrile, rash illness is extremely difficult in the current circumstances and the number of detected cases is most certainly an undercount of the true case numbers, as well as the number of potentially exposed persons.

The best protection against measles is MMR vaccine, which provides long-lasting protection against all strains of measles. One dose of MMR vaccine is about 93% effective at preventing measles; two doses are about 97% effective. U.S. national coverage for MMR is over 90%, yet pockets of low coverage from vaccine hesitancy, access challenges, and diverted public health resources due to COVID-19 mitigation efforts exist in all states and could sustain measles

transmission in the community if introduced. Notably, children under the age of 12 months are not yet recommended to receive vaccination and remain vulnerable in the US public. Children who are behind on childhood immunizations face a particular threat. Varicella vaccine is recommended to be given in conjunction with MMR because both are live vaccines that must be separated by 28 days unless given simultaneously. Separate administration will extend the time required on CONUS sites.

Ensuring all evacuees departing OCONUS sites are vaccinated and a fully vaccinated population at CONUS sites will mitigate the number, size, financial and human cost and reduce strain on community public health and healthcare system of outbreaks that need to be managed in the coming weeks.

CURRENT CDC REGULATORY AUTHORITIES:

At this time, CDC does not have federal authority to issue federal quarantine or isolation orders for individuals confirmed with measles or considered exposed to measles. Quarantine and isolation measures are public health standard practice for measles, but CDC cannot under current authorities apprehend, detain, or conditionally release infectious or exposed persons for measles at this time. Measles, however, is considered a nationally notifiable disease; healthcare providers are required to report known cases to state and local public health departments to institute contact tracing.

DIRECTIVE

CDC strongly advises that the UCG immediately implement these public health protection measures to the greatest extent possible.

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