



DEPARTMENT OF THE NAVY  
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IN REPLY REFER TO

BUMEDNOTE 6220  
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6 May 2009

BUMED NOTICE 6220

From: Chief, Bureau of Medicine and Surgery  
To: Ships and Stations Having Medical Department Personnel

Subj: INTERIM GUIDANCE FOR H1N1 INFLUENZA VIRUS INFECTION

Ref: (a) SECNAV WASHINGTON DC 012125Z May 09 (ALNAV 034/09)  
(b) BUMEDINST 6200.17  
(c) DoD Directive 6200.3 of 12 May 2003  
(d) BUMEDINST 6220.12B  
(e) The Health Insurance Portability and Accountability Act of 1996 (HIPAA)  
(f) DoD 8580.02-R of 12 Jul 2007  
(g) CDC Interim Guidance on Antiviral Recommendations for Patients with Confirmed or Suspected Swine Influenza A (H1N1) Virus Infection and Close Contacts  
(h) NAVMED P-117, Manual of the Medical Department (MANMED), Chapter 15  
(i) OPNAVINST 3591.1E  
(j) OPNAVINST 5100.23G

Encl: (1) Antiviral Distribution Planning Guidance  
(2) Acronyms  
(3) References Web sites

1. Purpose. To provide interim expanded guidance (enclosure (1)), following reference (a), on the collection of specimens, reporting of cases, control measures, distribution plans, and use of antiviral agents for treatment and chemoprophylaxis of H1N1 influenza virus infection. This includes patients with confirmed, probable, or suspected H1N1 influenza virus infection and their close contacts.

2. Background. As the public concern continues to increase during this H1N1 influenza outbreak, we must remember that our people are our most valuable assets and the source of our strength. There are steps each of us can take to protect ourselves, our families, and our coworkers. The following guidance is provided to ensure we take the proper actions to protect our personnel and beneficiaries against this current threat. Force health protection is the responsibility of every commander and servicemember. The Public Health Emergency Officer (PHEO) will provide support and guidance on appropriate Force Health Protection measures per references (b) and (c). Enclosures (2) and (3) are provided for clarification.

3. Definitions

a. Infectious period for a confirmed case of H1N1 influenza virus infection is defined as 1 day prior to the illness onset to 7 days after onset.

b. Close contact means within about 6 feet of an ill person who is a confirmed or suspected case of H1N1 influenza infection during the case's infectious period.

c. Acute Febrile Respiratory Illness (AFRI). Fever of at least 100° F with recent onset of at least one of the following: rhinorrhea or nasal congestion, sore throat, or cough.

d. High-Risk. A person who is at high-risk for complications of H1N1 influenza infection is defined as the same for seasonal influenza.

e. Mask Use. The use of a simple physical barrier over the nose and mouth that allows unrestricted breathing and communication. This does not imply a fitted respirator for members of the general public nor enrollment in a respiratory protection program.

#### 4. Case Definitions for Infection with H1N1 Influenza Virus:

a. A suspected case of H1N1 influenza virus infection is a person with an AFRI with onset within 7 days of close contact with a person who is a confirmed case of H1N1 influenza virus infection, or within 7 days of travel to a community either within the United States or internationally where there are one or more confirmed H1N1 influenza cases, or resides in a community where there are one or more confirmed H1N1 influenza cases.

b. A probable case of H1N1 influenza virus infection is a suspected case with an AFRI and who is positive for influenza A by an influenza rapid test or an influenza immunofluorescence assay (IFA), but negative for H1 and H3 by influenza Real Time-Polymerase Chain Reaction (RT-PCR).

c. A confirmed case of H1N1 influenza infection is laboratory-confirmed as H1N1.

#### 5. Guidance

a. Guidance to our beneficiary population and our supported commanders must be consistent with respect to measures to protect members from influenza and to reduce its impact on readiness. Utilize and encourage standard infection-control measures. Reducing the transmission from person-to-person is primarily accomplished through simple measures such as hand washing, mask use, and reducing contact with known or possible infected persons. Antiviral use is not a primary control measure.

b. Providers should consider the possibility of H1N1 influenza virus infections in patients presenting with febrile respiratory illness. Early identification and segregation of suspected cases through the use of pre-clinic triage, identification, and mask application are critical. For suspected H1N1 cases, clinicians should obtain a respiratory Dacron-tipped nasopharyngeal swab for H1N1 influenza testing and place it in a refrigerator (not a freezer). Submit specimens to closest laboratory response network (LRN) facility for confirmation and subtyping. Contact the nearest Navy Environmental Preventive Medicine Unit (NEPMU) for LRN location and shipping support.

c. This notice expands the requirement in reference (d) such that all Navy Medical Department personnel under administrative control (ADCON) or operational control (OPCON) to any Navy or Marine Corps unit who diagnoses a patient with confirmed H1N1 influenza shall report that case within 24 hours by any means necessary to the Navy's Medical Event Reporting System (MERS). All probable and confirmed cases shall also be reported via the chain of command to the Navy and Marine Corps Public Health Center (NMCPHC), copied to and as directed by the Bureau of Medicine and Surgery (BUMED) Medical Operations Center (MOC). Reports shall contain whether case is probable or confirmed, inpatient or outpatient, sex, sponsor's social security number (SSN) with beneficiary category code prefix, sponsor's branch of Service, servicemember's command and projected return to duty date if applicable, collection date, and submitting medical treatment facility (MTF). NMCPHC will consolidate Navy Medicine data and provide it to the Armed Forces Health Surveillance Center (AFHSC).

d. Reference (e) specifically allows an exception for public health surveillance purposes. A covered entity (health care providers, government organizations providing health care, and health information systems) may disclose protected health information to public health authorities and their authorized agents for public health purposes including, but not limited to, public health surveillance, investigations, and interventions. The sharing of information for patient care, surveillance, and reporting during this outbreak is exempted from the Privacy Rule. Under reference (f), commanding officers can receive information on their unit members' medical status.

## 6. Nonpharmaceutical Community Mitigation Response

### a. Home isolation of cases and contacts

(1) Persons who develop AFRI should be strongly encouraged to self-isolate in their home for 7 days after the onset of illness or at least 24 hours after symptoms have resolved, whichever is longer. They should contact their physician by telephone.

(2) If a person must go into the community, they should wear a mask to reduce the risk of spreading the virus by coughing, sneezing, talking, etc.

(3) Exposed contacts should remain at home at the earliest sign of illness.

### b. Distancing interventions

(1) Avoid large gatherings of people.

(2) Wear a mask and wash hands prior to removal.

c. School dismissal and child care facility closures. Navy and Marine Corps personnel and family readiness may be significantly impacted by school and child care facility closures. However, these measures are effective in halting the spread of influenza such as H1N1. Family care plans should be activated to the maximum extent needed to maintain mission readiness.

## 7. Operational Force Health Protection Measures

### a. Individual Responsibilities

(1) Strict compliance with mask use and hand washing prior to removing the mask and after handling common-area items. Hands should be washed for a minimum of 20 seconds using liquid soap and water. Hand sanitizers may be used if hand washing facilities are not available and hands are not visibly soiled. Members should use enough hand sanitizer to completely wet all surfaces of the hands and should rub hands together until completely dry.

(2) Cough/sneeze etiquette should be followed. Members should cover both mouth and nose with a tissue or the upper sleeve if tissues are not available. Members should properly dispose of tissues in a wastebasket and wash hands or use a hand sanitizer afterwards.

(3) A simple mask should be used by those with a fever and respiratory symptoms suggestive of H1N1. Reserve N-95 mask use for those who are required to maintain close or continued contact with infected members.

### b. Environmental Measures

(1) Thorough cleansing of common-area items following use by any individual unit with any suspected, probable, or confirmed cases of H1N1. Use normally recommended cleaning products intended for disinfection or use bleach solution.

(2) In the recruit setting, allow wet sinks during inspections to ensure adequate hand washing among trainees.

(3) Strict compliance with decontamination protocols for areas of cross-contamination include the strict maintenance of adequate chlorination in swimming pools. Reduce the spread of infection in berthing areas through improved fresh-air exchange and by implementing alternating head-to-foot berthing and moving beds apart as far as a facility or afloat unit allows. Reducing berthing density reduces risk of disease spread.

### c. Administrative Measures

(1) Segregate members with suspected H1N1 and apply mask as soon as identified. Place mask on symptomatic member prior to sending to medical spaces and/or provide medical screening and treatment within living spaces.

(2) Within medical spaces, segregate members with suspected H1N1 from those with injuries or other symptoms through either physical relocation and/or mask use. Use masks even among cohorted personnel with suspected H1N1 to help prevent co-infection.

(3) Remove members with suspected or probable H1N1 from physical training to reduce the risk of worsening the outcome.

(4) Units with significant attack rates of H1N1 should reduce physically demanding activities for all members to minimize the progression of the illness among those members who have not presented for medical care or those with minimal symptoms.

(5) Instructors at recruit training centers having close contact with recruits or common-area items should wash hands and faces thoroughly and change clothing prior to leaving the training area to prevent spread to families and community. This applies to medical personnel caring for H1N1 patients as well.

(6) Immediately remove food handling and other service personnel with confirmed, probable, or suspected H1N1 from duties until cleared by medical.

(7) Active duty servicemembers and civilian workers who are pregnant and can continue to work should be placed at a worksite where exposure to potential H1N1 affected individuals is minimal. In the hospital setting, pregnant active duty health care workers should not work in a direct patient care role. Strong consideration should be given to telework.

d. Planning Measures

(1) Movement restriction (to include isolation, quarantine, and sequestration of units) is a viable means by which to decrease spread of infection. If recommending widespread movement restrictions, consider carefully the potential mission impact and logistical requirements. All such decisions should be coordinated through agency PHEO as described in reference (c).

(2) Prior to deployment for both ashore and afloat units, development of a health threat assessment of the area to be visited is key for commanding officers and their medical departments to determine appropriate force health protection measures. Important sources of medical intelligence information include the National Center for Medical Intelligence country brief, U.S. Embassy defense attachés, unit advance coordination element site visits, etc. If the H1N1 threat level is considered low risk, following appropriate Center for Disease Control (CDC) guidance and interim recommendations for the prevention of possible undetected H1N1 infection transmission to embarked personnel is reasonable. If the H1N1 health threat level is determined to be moderate to high risk, consider the geographic proximity and number of cases reported when considering mission.

8. Antivirals

a. Follow the most current CDC guidance, reference (g), posted on the CDC Web site. The CDC guidance, on the date of release of this notice, for antiviral treatment for confirmed, probable, and suspected cases, along with post-exposure prophylaxis, is as follows:

(1) Recommendations for use of antivirals may change as data on antiviral susceptibilities become available. Empiric antiviral treatment should be considered for confirmed, probable, or suspected cases of H1N1 influenza infection. Treatment of hospitalized patients and patients at

higher risk for influenza complications should receive higher prioritization. Antiviral treatment with oseltamivir (Tamiflu) or zanamivir (Relenza) should be initiated as soon as possible after the onset of symptoms. Evidence for benefits from treatment in studies of seasonal influenza is strongest when treatment is started within 48 hours of illness onset. However, some studies of treatment of seasonal influenza have indicated benefits, including reductions in mortality or duration of hospitalization even for patients whose treatment was started more than 48 hours after illness onset. Recommended duration of treatment for oseltamivir is 75 mg twice a day for 5 days. Recommendations for use of antivirals may change as additional data on antiviral susceptibilities and effectiveness become available. Antiviral doses recommended for treatment of H1N1 influenza infection in adults or children 1 year of age or older are the same as those recommended for seasonal influenza. Oseltamivir use for children less than 1 year of age was recently approved by the U.S. Food and Drug Administration (FDA) under an emergency use authorization (EUA). Dosing for these children is age-based. Additional guidance can be found at the following CDC link: <http://www.cdc.gov/swineflu/recommendations.htm>.

(2) Either oseltamivir or zanamivir for antiviral chemoprophylaxis of H1N1 influenza virus infection is recommended. Dosage and duration of post-exposure antiviral chemoprophylaxis using oseltamivir is 75 mg once daily for 10 days after the last known exposure to a confirmed case of H1N1 influenza infection. Although generally discouraged since it can rapidly deplete medication stocks and lead to early resistance, pre-exposure chemoprophylaxis can be given if the need arises during the potential exposure period and can be continued for 10 days after the last known exposure to a confirmed case of H1N1 influenza infection. Oseltamivir can also be used for chemoprophylaxis under the EUA.

(3) The FDA, the CDC, and the Department of Homeland Security do not classify antivirals as psychotropic medications (drugs with primary activity in the central nervous system). Given this consensus and after analyzing available data, BUMED agrees that antivirals are not psychotropic medications. As with all medications, antivirals have been associated with various side effects, to include rare neuropsychiatric events. Because the virus itself also impacts the central nervous system, these side effects may well represent symptoms caused by the virus itself. Antiviral therapy and prophylaxis is warranted in all populations at risk due to known infection or exposure to include the following:

- (a) Personnel Reliability Program participants.
- (b) Special Duty Personnel as outlined in reference (h). Subcategories include:
  - 1. Class I-III aviation personnel.
  - 2. Selected passengers, project specialists, and personnel in sensitive assignments.
  - 3. Diving personnel.

4. Nuclear field personnel.
5. Ionizing radiation workers.
6. Submarine duty personnel.
7. Naval special warfare and special operations personnel.
8. Explosives handlers and explosives motor vehicle operators.
9. Landing craft air cushion personnel.
10. Firefighting personnel.

(c) Weapons Handlers

1. Personnel who carry small arms as outlined in reference (i).

2. This instruction applies to all Active and Reserve Navy personnel; all Navy law enforcement and security personnel (military, civilian, and contract personnel) and to all personnel whose duties require them to be armed.

(d) Naval Criminal Investigative Service personnel.

(e) All other personnel not previously mentioned.

(4) Antiviral chemoprophylaxis post-exposure with either oseltamivir or zanamivir is recommended for the following:

(a) Medically high-risk personnel

1. Household and ashore or afloat unit close contacts who are at high-risk for complications of influenza (e.g., persons with certain chronic medical conditions, persons 65 or older, children younger than 5 years old, and pregnant women) of a confirmed, probable, or suspected case.

2. School children who are at high-risk for complications of influenza (children with certain chronic medical conditions) who had close contact (face-to-face) with a confirmed, probable, or suspected case.

3. Travelers to Mexico who are at high-risk for complications of influenza (e.g., persons with certain chronic medical conditions, persons 65 or older, children younger than 5 years old, and pregnant women).

(b) Medical personnel

1. Health care workers or public health workers who were not using appropriate personal protective equipment during close contact with an ill confirmed, probable, or suspected case of H1N1 infection during the case's infectious period.

2. Mission-critical personnel who may have unanticipated contact and whose absence due to illness would cause loss of critical capabilities.

(c) Other personnel

1. Active duty members ashore or afloat who are classified as a close contact of a confirmed case should be considered for antiviral prophylaxis.

2. Close contacts of a probable or suspected case may also be treated as directed by the cognizant health care provider based on the clinical situation (unavailability of definitive testing, case travel history, symptoms, etc.).

3. Civil servants in critical job areas are eligible for treatment via the occupational health clinics under the provisions of reference (j). Such treatment is solely for the purpose of returning the worker as soon as possible to full duty and does not imply nor require a causal association for purposes of workers' compensation programs. However, Department of Defense (DoD) is liable under the Federal Employees Compensation Act for any side effects of any medications prescribed to civil servants for either prophylaxis or treatment. This does not apply to contract personnel.

(5) During the initial stages of an influenza outbreak other measures such as mask use and hand washing are essential to reducing the transmission of infection. Only after application of such measures should additional measures, to include antiviral use, be considered. Ring treatment and prophylaxis, a strategy where cases and close contacts receive antiviral medications, is highly effective in slowing the spread of disease while conserving strategic stockpiles of therapeutics.

(6) Children under 1 year of age are at high risk for complications from seasonal human influenza virus infections. The characteristics of human infections with H1N1 viruses are still being studied, and it is not known whether infants are at higher risk for complications associated with H1N1 infection compared to older children and adults. Limited safety data on the use of oseltamivir (or zanamivir) is available from children less than 1 year of age, and oseltamivir is not licensed for use in children less than 1 year of age.

(7) Oseltamivir and zanamivir are "pregnancy category C" medications, indicating that no clinical studies have been conducted to assess the safety of these medications for pregnant women. Because of the unknown effects of influenza antiviral drugs on pregnant women and

their fetuses, oseltamivir or zanamivir should be used during pregnancy only if the potential benefit justifies the potential risk to the embryo or fetus. The manufacturer's package inserts should be consulted in these situations.

(8) Special Considerations for Children. Aspirin or aspirin-containing products (e.g., Bismuth subsalicylate – Pepto Bismol) should not be administered to any confirmed or suspected ill case of swine influenza A (H1N1) virus infection aged 18 years old and younger due to the risk of Reye's syndrome. For relief of fever, other anti-pyretic medications are recommended such as acetaminophen or non steroidal anti-inflammatory drugs.

b. MTF pharmacies do not need to individually purchase stores of antiviral medications, oseltamivir and zanamivir. Outside the continental United States (OCONUS), MTFs have on hand a complement of medications to cover 30 percent of their population at risk (PAR). Inside the continental United States (CONUS), MTFs have on hand stock for 10 percent PAR coverage.

c. Prescriptions for oseltamivir and zanamivir shall only be filled when prescribed or approved by MTF providers. Civilian prescriptions shall be reviewed by an MTF provider via a system or process conducted away from the pharmacy window.

d. Fleet and Marine Corps units should have in their direct possession enough oseltamivir to provide treatment to cases and close contacts for approximately 30 percent of attached personnel when deploying. On small ships and attack submarines, enough oseltamivir should be stored onboard for the entire crew to be treated or receive post-exposure prophylaxis since living spaces are close together.

e. Vaccinations for other diseases may have a beneficial role to play in an influenza outbreak. Beneficiaries should be current for pneumococcal, tetanus diphtheria, and annual influenza vaccination.

9. Reports. The reporting requirements of this notice are covered under the report control symbol established in reference (d).

  
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Distribution is electronic only via the Navy Medicine Web site at:  
<http://navymedicine.med.navy.mil/default.cfm?selTab=Directives>

ANTIVIRAL DISTRIBUTION PLANNING GUIDANCE

1. Point of Distribution (POD) Guidance

a. The following provides a very brief synopsis of existing guidance for developing a POD plan for military installations' commanders.

(1) General Guidance

(a) Installations should consider the following factors when deciding on the scale of the mass prophylaxis plan.

1. The size and number of target populations needed to maintain installation operations and carry out the base's mission.

2. The availability of local civilian medical and public health resources during a public health emergency response.

3. The ability of the installation and its MTF to serve as a POD and provide medical countermeasures to its entire beneficiary population.

(2) Command and Control

(a) PHEO will determine the existence of a public health emergency and advise the MTF and installation commander on declaring a public health emergency, implementing control measures, and administering medical countermeasures via the activation of a POD(s). In coordination with the PHEO, the installation commander will give the order to activate mass prophylaxis POD(s) and administer medical countermeasures.

(b) The MTF commander will, upon notification from the installation commander, direct the POD manager to activate the POD(s) and will stand-up the Hospital Command Center (HCC).

(3) Organization. The organizational structure may be expanded and/or contracted to fit the size and scope of the event.

(a) POD Manager. Responsible for the command and control activities of the POD(s), will communicate and coordinate with the Emergency Operations Center (EOC) (if activated) and the MOC. In most scenarios, the senior pharmacist assumes the role of POD manager.

(b) Pharmacy Team. Participates in the POD/strategic national stockpile (SNS) planning process before, during, and after a mass prophylaxis event, manages prophylaxis dispensing, and tracks/manages prophylaxis inventory.

(c) Clinical Team. Responsible for providing clinical personnel to perform medical triage, medical evaluation, vaccinations, and other necessary clinical duties.

(d) Patient Administration Team. Provides administrative support to the POD including management of Information Management/Information Technology (IM/IT) issues, forms distribution, and data collection.

(e) Medical Logistics Team. Responsible for medical and non-medical supplies requests and acquisition (i.e., food, water, tables, etc.).

(f) Medical Security Team. Responsible for security of POD personnel, pharmaceuticals, vaccines, and materials as well as controlling entry and exit access for duration of POD operations.

(g) Manpower Team. Responsible for providing support such as runners, greeters, patient movement, etc.

(h) Facilities Team. Responsible for facilities operations.

(i) Public Health Team. Work with the PHEO to develop the scale of the response for the installation and have it approved by the MTF command center. Ensures ongoing coordination with State or local public health officials in the development of the installation's mass prophylaxis plan. Provides epidemiological surveillance in order to guide planning and response efforts. Conducts required briefings and provides educational handouts to patients in the POD briefing room. Participates in risk communication activities for mass prophylaxis operations.

#### (4) Planning

(a) Installation Demographics. Identify and determine the number of active duty and civilian workforce, as well as the location and population size of military dependents residing on the installation and other health care beneficiaries attached to the installation MTF.

(b) POD Site. Choice of POD sites should be guided by knowledge of installation demographics, accessibility for various types of transportation (i.e., emergency vehicles, buses, handicap vehicles, military transportation, and handicap access). Capacity and capability to handle traffic volume, size of operation, storage requirements (supplies and stockpiling), equipment, security, and communication infrastructure. Potential POD sites to consider include the gymnasium, auditorium, school, or aircraft hangers.

(c) Communications. POD locations should have landline telephone capability to supplement cellular, radio, or satellite communications, which may be unavailable or overloaded during this event. Additionally, pre-existing video and audio equipment (e.g., audio-visual equipment) may reduce logistical burdens when planning briefings at the POD site(s).

(d) Facility Support. Proposed POD locations should have space for temporary storage and safe removal of medical waste, on-site potable water supply, electrical wiring capable of supporting multiple electrical and electronic appliances (e.g., coolers, computers), restrooms, and a staff staging/rest area. It is critical to consider backup power generation capacity (arrange coordination with power production on your installation).

(e) Storage. POD sites should have facilities for controlled storage of antibiotics and vaccines, including electrical outlets for cold storage containers requiring external power supplies. In addition, these sites should have separate areas for storage of medical supplies, communication equipment, and information dissemination material that may require different levels of security.

(5) Deactivation. The PHEO will provide guidance to the installation commander for determining when prophylaxis is near completion and demobilization should commence.

## ACRONYMS

ADCON	Administrative Control
AFHSC	Armed Forces Health Surveillance Center
AFRI	Acute Febrile Respiratory Illness
BUMED	Bureau of Medicine and Surgery
CDC	Centers for Disease Control
CONUS	Inside the Continental United States
DoD	Department of Defense
EOC	Emergency Operations Center
EUA	Emergency Use Authorization
FDA	U.S. Food and Drug Administration
H1N1	Influenza A
HCC	Hospital Command Center
HIPAA	Health Insurance Portability and Accountability Act of 1996
IFA	Immunofluorescence Assay
IM/IT	Information Management/Information Technology
LRN	Laboratory Response Network
MERS	Medical Event Reporting System
MOC	Medical Operations Center
MTF	Medical Treatment Facility
NEPMU	Navy Environmental Preventive Medicine Unit
NMCPHC	Navy and Marine Corps Public Health Center
OCONUS	Outside the Continental United States
OPCON	Operational Control
PAR	Population at Risk
PHEO	Public Health Emergency Officer
POD	Point of Distribution
RT-PCR	Real Time-Polymerase Chain Reaction
SNS	Strategic National Stockpile
SSN	Social Security Number

### REFERENCES WEB SITES

- Ref: (a) SECNAV WASHINGTON DC 012125Z May 09 (ALNAV 034/09)  
(Available at: <http://www.npc.navy.mil/NR/rdonlyres/539FA908-5FB5-4572-AF08-22D71CBB9940/0/ALN09034.txt>)
- (b) BUMEDINST 6200.17  
(Available at: <http://navymedicine.med.navy.mil/Files/Media/directives/6200.17.pdf>)
- (c) DoD Directive 6200.3 of 12 May 2003  
(Available at: <http://www.dtic.mil/whs/directives/corres/pdf/620003p.pdf>)
- (d) BUMEDINST 6220.12B  
(Available at: <http://navymedicine.med.navy.mil/Files/Media/directives/6220.12B.pdf>)
- (e) The Health Insurance Portability and Accountability Act of 1996 (HIPAA)  
(Available at: <http://aspe.hhs.gov/admnsimp/pl104191.htm>)
- (f) DoD 8580.02-R of 12 Jul 2007)  
(Available at: <http://www.dtic.mil/whs/directives/corres/pdf/858002rp.pdf>)
- (g) CDC Interim Guidance on Antiviral Recommendations for Patients with Confirmed or Suspected Swine Influenza A (H1N1) Virus Infection and Close Contacts  
(Available at: <http://www.cdc.gov/h1n1flu/recommendations.htm>)
- (h) NAVMED P-117, Manual of the Medical Department (MANMED), Chapter 15  
(Available at: <http://navymedicine.med.navy.mil/Files/Media/mmd/MMDChapter15.pdf>)
- (i) OPNAVINST 3591.1E  
(Available at: <https://doni.daps.dla.mil/Directives/03000%20Naval%20Operations%20and%20Readiness/03-500%20Training%20and%20Readiness%20Services/3591.1E.pdf>)
- (j) OPNAVINST 5100.23G  
(Available at: <https://doni.daps.dla.mil/Directives/05000%20General%20Management%20Security%20and%20Safety%20Services/05-100%20Safety%20and%20Occupational%20Health%20Services/5100.23G.pdf>)