

SPEECH BY MR KHAW BOON WAN, MINISTER FOR HEALTH, AT PRESS CONFERENCE ON INFLUENZA A (H1N1), 22 JUNE 2009, 4:00 PM AT ESPLANADE ROOM, MICA

Statement by Minister for Health Mr Khaw Boon Wan at the Press Conference on Influenza A (H1N1), Esplanade Room, MICA, 22 June 2009, 4pm

1 Two months have passed since H1N1 was first diagnosed in Mexico. It has now become a global pandemic.

2 In North America, the countries there had no opportunity to contain the outbreak. The virus went into community spread almost immediately.

Containment Strategy

3 Asian countries had a week to activate their containment measures at the borders. They put up a robust response to slow down the spread of the virus for a few precious weeks of preparation time, even though we all knew that given the nature of influenza, community spread is inevitable. Australia, Japan, New Zealand put up very strong containment measures and managed to hold up the virus at the borders for about a month. But eventually, the virus still slipped into the wider community and the number of infected cases simply grew exponentially. In two weeks, Melbourne saw its cases soar to 1,000. They in turn became a source of many exported cases. Half of our imported cases came from Australia, double the number from the US.

4 There were 3 waves of exported cases to Singapore. The first wave came from the US. The second wave came from Australia. It is a bigger wave as the volume of travellers from there is bigger than from the US. The third wave began last week, from fellow ASEAN countries, including the Philippines and Thailand. This will potentially be a big wave, given our close proximity.

5 Against these challenging circumstances, Singaporeans are putting up a very good fight against the virus. Many took our advice and behaved responsibly. Many infected cases sought early treatment and made use of the 993 ambulance service. Many more people put up with the inconvenience of home quarantine. I am grateful to them for their social spirit. As a result, we have bought ourselves valuable time. We can be very proud of our achievements. For 7 weeks, there was no local transmission. All our confirmed cases were imported. We were able to track down every imported case and every of their known close contacts and isolate them promptly. By now we had contact traced more than 1,000 close contacts and put every one in quarantine. Our contact tracing teams work diligently round the clock in two shifts, 7 days a week to track down every known close contact. They deserve our praise.

6 However, we know that eventually we will also have community spread here. Some patients do not have symptoms and they will slip through the borders and infect others without even realising it. This is in the nature of influenza virus. That is why it is so contagious. It is not because these patients are irresponsible. Let's not blame them.

Recalibrating Our Strategy

7 Last week, we have the first sign of community spread. Over the weekend, the signs have become more prominent. By now, we have 142 confirmed cases. Local community spread cases number 24; this is 17% of

the total confirmed cases (please refer to tonight's press release for latest figures). From the experience in Melbourne and elsewhere, we have crossed the tipping point beyond which local transmissions will grow rapidly. This may well happen this week.

8 Our objective remains unchanged, which is to minimise casualties. However, our strategy must change as circumstances change. When the number of cases is low, we put our resources to trace and isolate all known suspect cases. As the number escalates, we are shifting our resources to detect and treat infected cases, paying particular attention to high-risk patients. These are the adjustments that we have been making in recent days and the week ahead. They correspond to a shifting of our alert level from yellow-containment to yellow-mitigation. The transition will be gradual and not abrupt, and will be guided by the local epidemiology of the disease.

9 First: we will take a much more focused approach to contact tracing. So far, most of the contact tracing pertains to air passengers sitting close to confirmed cases. With community spread, the likelihood of infection has now shifted to the local community instead of only in the aeroplane cabin. We have started to scale down such contact tracing. Contact tracing henceforth will be decided on a case by case basis by our public health experts, taking into account the medical condition of the infected patients while in flight. Isolating close family members of confirmed cases however remains a useful control measure. Likewise, temperature screening at borders remains useful. One in four of our imported cases were picked up by the scanners.

10 Second: we have ramped up our laboratory facilities. All our major hospital labs are now capable of testing H1N1, or will soon be.

11 Third: we have geared up all our public hospitals to handle H1N1 cases. 993 ambulances have begun sending suspect patients to all public hospitals, and not just TTSH and KKH. We have also refined our workflow. 993 ambulances now send the majority of the suspect cases judged by the hospitals to be very mild to go home after the swabs are taken and the patients can rest at home while they wait for the lab results. This has made the experience much more convenient for people. I of course expect such people to behave responsibly and rest at home while waiting for the results since they are clearly unwell, and not go out.

12 Fourth: As we need to create capacity for H1N1 patients with co-morbidities we will refine the treatment protocol for infected cases. Not all patients need to be hospitalised. Many will simply be put on antiviral treatment and be home quarantined and asked to monitor their condition. We will also review the use of Tamiflu for close contacts of confirmed cases.

13 Fifth: we are gearing up our polyclinics and a few hundred GPs to treat suspect H1N1 cases. We call them PPC: Pandemic Preparedness Clinics and are recognised by their PPC decals with a big tick and the word "Ready". They are ready to treat all walk-in suspect flu cases and will refer only some categories of high-risk suspect patients to public hospitals. We will use the next few days to publicise these PPCs. When the local epidemiology and biosurveillance data confirm significant community spread and need to move from containment to mitigation, we will signal to the public to use these PPCs instead of going to the hospitals, if their flu conditions are mild. This may happen soon.

14 Sixth: we will secure adequate supply of H1N1 vaccine for our people. Besides our existing supply contract with a vaccine manufacturer, we are in active negotiation with other vaccine manufacturers to diversify our supply of H1N1 vaccine. An important consideration will be which manufacturer can promise the best delivery timeline. As these are new vaccines, they will be subject to clinical trials which will take months. We should therefore be realistic about the timeframe for availability of a safe to use vaccine.

15 Seventh: our scientific committee is actively evaluating the genome of the virus here. The good news is that the virus remains identical with the virus in North America. There was an earlier foreign news report from Brazil claiming that the virus there has mutated significantly but the report has since been found to be flawed. The consensus view is that the virus remains of "moderate risk" as described by the WHO. Singaporeans therefore do not need to panic over the community spread of the virus. Almost all infected cases will be able to fully recover. Tamiflu and Relenza remain effective against this disease. "Moderate risk" however does not mean "no death". Like the seasonal flu, there will be some deaths. The data from North America suggested a case fatality rate of 0.37%, i.e. with 1000 infected cases, we can expect a few deaths. North America has already reported over 100 deaths and Australia, its first death. That is why we need to target high risk patients, especially those with underlying medical conditions, and to render them the best chance of a full recovery. That is why we need to allow our hospitals to focus on the high-risk cases and not be distracted or overwhelmed by hundreds of mild cases.

Conclusion

16 Overall, last week has been eventful, in the development of the outbreak in Singapore. We expect this development; we know that June will be challenging for us, given the large number of returned holiday travellers. But the 7-week headstart has been extremely useful to allow us to gear up our system for the community spread phase of the outbreak.

17 Singaporeans should carry on their lives normally, but do keep up a high standard of personal hygiene. Do remember the WHO advice: W (wash hands often: all Singaporeans), I (inform public and regular updates: Government), S (stay apart from others: all patients), E (etiquette when sneezing, coughing: all patients). For people in high-risk categories, such as pregnant women, people with asthma or on kidney dialysis, immunosuppressant drugs or on chemotherapy and several other conditions, they will need to be more cautious. For example, they could wear a mask when they go out. In the coming week, we will publicize our advice on what they should do; we will also send them direct mailers.

18 H1N1 is now globally pandemic, like other seasonal flu strains. We have to learn to co-exist with it. That is why we are carrying on with the Asian Youth Games, and will be carrying on with school re-opening and our National Day Celebrations in August, and F1. The reopening of schools will raise the risk of local transmission from infected students who recently return from overseas. That is why it is important to get the recently returned students to stay at home for a week before they rejoin schools. MOE will provide details soon.

19 Overall, life must continue as normally as possible. We will still take some targeted control measures, as and when an event occurs, e.g. to close a school when a significant cluster is found, or to isolate a competing team from other athletes as we did yesterday.