Public Health Scotland

Monkeypox guidance for health protection teams

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NHS National Services Scotland

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Version history

Version	Date	Summary of changes
1.0	15/06/22	First publication
1.1	29/06/22	Move to passive surveillance of all contacts; active surveillance no longer required. Disposal of home testing waste clarified. APHA guidance on pet ownership added.
1.2	19/07/22	Remove links to Primary and Community Care guidance (archived). Align with UKHSA changes: HCID status (derogation) and waste re-categorisation Updated Principles consensus statement Change to condom usage advice (12 weeks instead of 8) (new guidance) Updated case def symptomology (proctitis added) Updated contact tracing Updated PHS labs Info note Updates Case/Contact info sheets Clarify wording on de-isolation. Add links to new UKHSA guidance (Events and mass gatherings) Add link to Autopsy HSE guidance. Isolation support
1.3	26/07/22	Updated case definition Information in Transmission Routes section updated Added advice to notify cases their details may be shared during flight and international contact tracing for specific purposes Addition of CMO Letter link to the pre and post-exposure vaccination section
1.4	16/08/22	Updated symptom list in case definition Updated actions for probable and possible cases Updated Household pets advice Aligned with GreenBook chapter update Added Blood, tissue, organ donation section Revised clade nomenclature to align with WHO

Contents

1. Purpose and Scope

This guidance aims to support those working in health protection teams (HPTs) across Scotland in managing Monkeypox cases and contacts. This guidance has been prepared rapidly and specifically in response to the May 2022 monkeypox outbreak and is subject to frequent update.

The guidance is based on the published **principles for monkeypox control in the UK four nations consensus statement** from the UK Health Security Agency (UKHSA) and associated UKHSA guidance documents found at **monkeypox guidance.**

This document should also be considered alongside:

- Antimicrobial Resistance and Healthcare Associated Infection Scotland (ARHAI) guidance **National Infection Prevention and Control Manual (NIPCM)** – specifically **NIPCM guidance for management of cases of monkeypox**
- Scottish Health Protection Network (SHPN) **guidance on the management of public health incidents (MPHI)**
- information for the public on **NHS inform**
- advice specific to clinical teams, to facilitate a risk stratified clinical approach and virtual management of cases on the **NHS England monkeypox page** – NHS boards have developed their own pathways for clinical management

This guidance does not replace individual expert clinical judgment nor local response arrangements. It is designed to support the development of those arrangements and assist in that response, while maintaining a reasonable expectation that agreed health protection principles and national policy are supported and implemented to good effect in line with the Public Health etc. (Scotland) Act 2008. This includes exercising functions in a manner which encourages equal opportunities and in observance of equal opportunities requirements. Employers should be advised to consider the specific conditions of each individual place of work and comply with all applicable legislation, including the Health and Safety at Work etc. Act 1974.

The latest version should always be referred to by checking the **PHS monkeypox page** for any updates or related guidance.

This guidance was produced in collaboration with a provisional guidance development group (GDG). HPTs and other stakeholders contributed to its development through regular feedback and comments. Comments on how to improve this guidance are welcome and can be sent to PHS guidance cell **phs.admin.guidancecell@phs.scot**

2. Background

Monkeypox is a viral zoonotic disease that to date has been identified primarily in central and west Africa, with small numbers of imported cases to the UK confined to travellers from countries in these regions. Since May 2022 however cases of monkeypox have been reported in multiple countries that are not endemic areas.

Two clades of monkeypox have been identified and have now been named by **WHO** as Clade I (formerly Congo Basin / Central African clade) and Clade II (formerly West African clade). Furthermore, Clade II consists of two subclades known as Clade II a and Clade II b. The group of variants largely circulating in the current global outbreak are Clade II b. Clade II is associated with a lower reported mortality than Clade I.

A very high proportion of cases in the 2022 multi-national outbreak are in gay, bisexual and men who have sex with men (GBMSM). The vast majority of cases in the UK have been in men age 20-50. Illness is so far assessed as mild, primarily self-limiting in adults with no reported deaths in the UK to date.

For the latest epidemiological updates see:

- **PHS monkeypox page** for Scotland
- **UKHSA monkeypox latest updates** for UK

3. Clinical features

The symptoms of monkeypox begin 5 to 21 days (average 6 to 16 days) after exposure (i.e. the incubation period).

Classically, monkeypox presents with a viral prodrome of fever, headache, muscle/backache, lymphadenopathy, chills, exhaustion, joint pain, with a rash developing within 1 to 5 days after the appearance of fever. However, the prodrome phase does not always present, and the rash may be the first apparent symptom.

The rash often begins on the face or genital area then spreads to other parts of the body. A number of cases recently have reported only single or multiple genital lesions, or have started in the genital area before spreading elsewhere. A small number of individuals with confirmed monkeypox have presented with symptoms of proctitis and no visible skin lesions. Some of these individuals did subsequently develop perianal lesions, but a proportion showed no skin lesions at all.

The rash changes and goes through different stages before finally forming a scab which later falls off. The skin lesions (pox) go through four phases, starting with (1) flat spots turning into (2) raised spots, then to (3) blisters and finally (4) healing by scabbing or crusting over and falling off. Images of lesions can be seen on the UKHSA **monkeypox background information page**.

Clinical diagnosis of monkeypox can be difficult, and it may be confused with other infections such as herpes simplex virus, chickenpox or syphilis. In addition:

- areas of erythema and/or skin hyperpigmentation are often seen around discrete lesions
- lesions can vary in size
- lesions of different appearances and stages may be seen at the same point in time
- detached scabs may be considerably smaller than the original lesion

The disease in healthy adults is primarily self-limiting and with a low mortality. There is remaining uncertainty over potentially increased severity in children and in individuals who are highly immunocompromised or pregnant. Adults born before 1970 who have had smallpox vaccination may have a degree of protection.

Treatment for monkeypox is mainly supportive (e.g. pain relief) however antivirals may play a role in severe cases. The UK Government are leading on the sourcing of the antiviral Tecovirimat. There is currently very limited supply in the UK which is being reserved for confirmed, complicated hospitalised cases; National Procurement can support arranging access to the medicine on a case by case basis. There is no current public health application of antivirals for suspected cases or as post-exposure prophylaxis for contacts.

4. Transmission routes

Principles for monkeypox control in the UK: 4 nations consensus statement sets out the working assumptions of transmission routes based on the available data and expert opinion. These assumptions are aligned with the World Health Organization (WHO).

The dominant mode of transmission in this outbreak is through close skin-to-skin contact, primarily between sexual partners.

Transmission through droplet or fomite remains a possible risk. Although limited household transmission has been described in the UK during this outbreak, household transmission has been a feature of previous monkeypox outbreaks. Monkeypox virus has been detected in air and environmental samples in the hospital room of infected patients. None of the transmission events in the UK support airborne transmission. No transmission from cases to healthcare workers in healthcare settings have been recorded in the UK - PPE should be used in line with the requirements set out in **section 10**.

5. Infectious Period

The infectious period for monkeypox is from the first onset of the prodrome phase up to when all scabs have fallen off and there is intact skin underneath. There is no evidence that individuals are infectious before the onset of prodromal illness. Note that the scabs may also contain infectious virus material.

There are additional detailed criteria for ending of the isolation period set out in **section 9.2.1**.

6. Case definitions

Ensure you are referring to the latest UKHSA **monkeypox case definitions.**

6.1. Confirmed case

A person with a laboratory confirmed monkeypox infection (monkeypox PCR positive).

6.2. Highly probable case

A highly probable case is defined as a person with an orthopox virus positive result since 15 March 2022 and where monkeypox remains the most likely diagnosis.

Note that orthopox virus PCR testing is not undertaken in Scotland without monkeypox virus specific PCR testing. Therefore, it is unlikely highly probable cases will be identified in Scotland.

6.3. Probable case

A probable case is defined as anyone with an unexplained rash or lesion(s) on any part of their body (including genital/perianal, oral), or proctitis (for example anorectal pain, bleeding) and:

1. has an epidemiological link to a confirmed, probable or highly probable case of monkeypox in the 21 days before symptom onset

OR

2. reported a travel history to West or Central Africa in the 21 days before symptom onset

OR

3. is a gay, bisexual or other man who has sex with men (GBMSM)

OR

4. has had one or more new sexual partners in the 21 days before symptom onset

6.4. Possible case

A person with a febrile prodrome (fever ≥ 38°C, chills, headache, exhaustion, muscle aches (myalgia), joint pain (arthralgia), backache, and/or swollen lymph nodes (lymphadenopathy)) compatible with monkeypox infection where there is known prior contact with a confirmed case in the 21 days before symptom onset.

OR

A person with an illness where the clinician has a suspicion of monkeypox. This could include unexplained genital, ano-genital or oral lesion(s) (for example, ulcers, nodules), proctitis (for example, anorectal pain, bleeding).

7. Notification requirement

HPTs should communicate with all local clinicians and health services to be alert to the potential diagnosis, and be aware that under the provisions of the **Public Health etc. (Scotland) Act 2008** monkeypox is a notifiable disease and should be reported as outlined in **CMO letter (2022) 26**.

In practice, this means where a registered medical practitioner has reasonable grounds to suspect that a patient whom the practitioner is attending has monkeypox i.e. confirmed, probable and possible cases, they should notify the HPT. Medical practitioners should consider monkeypox as an urgent notification.

HPTs should notify PHS via the agreed routes. Possible and probable cases should be entered on HPZone and these will be extracted centrally. Confirmed or highly probable cases should be notified to PHS by email (PHS.monkeypox2022@phs.scot) and by phone. There is no need to notify PHS out-of-hours unless additional advice is required.

High consequence infectious disease statement

On 5th July, a **statement was agreed by the Advisory Committee on Dangerous Pathogens (ACDP) with four nation consensus** that monkeypox Clade II b currently in community transmission within the UK should no longer be classified as a **high consequence infectious disease (HCID)**.

Monkeypox is not considered an HCID:

- without travel to West or Central Africa and without a link to a traveller from those regions, and/or
- when confirmed by sequencing to be Clade II b

Monkeypox is considered an HCID:

- with a travel history to West or Central Africa, a link to a traveller from those regions, or
- with a link to a case which is known to be outside the current outbreak Clade II b
- when sequenced and known to be outside the current outbreak Clade II b
- when it results from a new zoonotic jump in any country or setting

It is vital to ensure that a travel history is taken in order to take the appropriate steps in relation to dealing with each monkeypox case appropriately. See **section 9.1.1**.

8. Testing

Clinical diagnosis of monkeypox can be challenging and a definitive diagnosis (confirmed case) requires PCR testing.

PCR testing is available at the regional laboratories at NHS Lothian and NHS GGC. The case definitions should be used to establish local clinical pathways to determine testing requirement.

All contacts who report symptoms to the HPT should be referred for assessment if they meet the case definition.

Testing decisions should be made by infectious disease specialists/clinical teams. Local pathways should be established including the use of regional networks when required. HPTs should advise non-specialist enquirers of this recommendation and direct them towards the pathway.

A **PHS laboratory information note** is available with further detail on:

- testing provision
- sample requirements
    - detail of minimum PPE requirements for possible and probable cases is at **NIPCM guidance for management of cases of Monkeypox**
- transport and packaging
- laboratory safety
- notification of results
    - The Specialist Virology Centres will advise of positive and negative results by telephone or email to the requesting clinician or person indicated on email accompanying the submission form. Any results enquiries should be sent to:

      Edinburgh: **virologyadvice@nhslothian.scot.nhs.uk**

      Glasgow: **west.ssvc2@nhs.scot**

- It is the responsibility of the clinician caring for the patient to notify the local HPT whether samples are positive or negative. Notification should be made promptly on receipt of the result, and should include full patient details. This will enable appropriate public health actions to be taken without delay.
- HPTs can manually add the case to HPZone in anticipation of a test result being sent.
- Scottish laboratory test results will be shared with ECOSS and onward to HPZone
- On receipt of a positive test result, the local HPT should inform Public Health Scotland and other relevant parties within their health board, including ensuring that the local NHS Scotland diagnostic microbiology and virology laboratory who may be testing other samples are aware.

9. Public Health actions

9.1. Possible or Probable Case

9.1.1. Assess travel history

Wherever a possible or probable case first presents a travel history should be taken. If the receiving clinician has not done so HPTs should ensure this is completed as a priority. Where a travel history to West or Central Africa is identified in the 21 days before symptom onset please discuss with the Imported Fever Service, as these patients may need to be managed as having a high consequence infectious disease.

9.1.2. Refer for assessment

If approached by clinical or other local colleagues for advice on a possible or probable case, HPTs should advise of the locally designated assessment and testing pathway.

9.1.3. Isolation

Possible or probable cases awaiting assessment or test results should avoid close contact with others. The large majority of cases in this outbreak have been isolating at home.

There should be locally agreed monitoring and review mechanisms in place to support people at home. These arrangements should be agreed with local health protection teams with input from stakeholders who may include infectious disease services, sexual health, GP sub-committee, local authority partners and Health and Social Care Partnerships.

Guidance for monkeypox cases isolating at home is available on:

- SHPIR as a **document to be edited locally by boards to add HPT contact details**
- PHS website as a **public-facing version with no HPT contact details**

Where admission to a health or social care setting is required, guidance for management is available in **NIPCM guidance for management of cases of monkeypox.**

Isolation advice (how to isolate and mitigating the risk of transmission) for possible and probable cases is the same as for confirmed cases and is covered in **section 9.2.1**

There is no requirement for household or non-household contacts of possible and probable cases to be contact traced or to isolate pending assessment or testing of such cases.

9.1.4. Travelling for testing and assessment

As outlined in **principles for monkeypox control in the UK four nations consensus statement**, transport from the community to healthcare facilities and back again for possible cases, probable cases, highly probable cases, or confirmed cases, should be organised to minimise contact between cases and new contacts.

Where it can be operationalised by Boards, remote assessment of the need for testing, and provision of testing, of possible and probable cases at home may be undertaken.

Home-testing staff must wear PPE as outlined in **guidance for the management of monkeypox cases** and waste should be disposed of into a disposable rubbish bag followed by placing into a second disposable bag, tied securely and then disposed of through the case's usual domestic waste.

If otherwise well, possible, probable, highly probable and confirmed cases may drive themselves (or cycle, walk) to arrive at, and leave, healthcare settings. They should ensure they have an arranged appointment before travelling and that they have been provided with clear instructions advising where to report to on arrival. This will ensure that the appropriate IPC measures can be implemented.

Where an individual is required to drive or share a private vehicle with a possible, probable, highly probable or confirmed case for the purposes of assessment, testing or urgent care:

- the individual should preferably be an existing close contact of the case (e.g. household member) and not exposing themselves to new risk of transmission
- where possible, share the vehicle with the same person each time
- everyone in the car should wear a well-fitting surgical face mask or double-layered face covering while in the car
- all hard surfaces should be wiped down after the journey using a standard detergent or detergent wipes while still wearing the well-fitting surgical face mask or double-layered face covering
- cleaning waste and face masks/coverings should then be double bagged and disposed of as usual with domestic waste
- perform hand hygiene using soap and water or an alcohol based hand rub afterwards

Where remote/home assessment or testing is not possible and private transport is not available, public transport can be used as a last resort with a preference for private taxis ahead of communal vehicles. Further mitigations to consider include vehicle adaptations (screen or barrier to separate the driver from passenger), avoiding physical contact and maximising the distance between people in the vehicle (e.g. passenger sitting diagonally

behind the driver). Busy periods should be avoided to minimise time in the vehicle and contacts exposed.

Any lesions should be covered by cloth (for example scarves or bandages) and a face covering must be worn.

Due to the theoretical airborne risk associated with those who have respiratory symptoms, where the case has respiratory symptoms (e.g. cough) any travel other than essential travel should be avoided.

9.2. Confirmed or Highly Probable Case

9.2.1. Isolation

Confirmed or highly probable cases should be advised to isolate until they meet the criteria for ending isolation set out in **UKHSA de-isolation and discharge of monkeypox-infected patients interim guidance**. Ending isolation in the hospital setting will be assessed by managing clinicians with involvement of HPT / IPCT as required.

Home isolation may be used for clinically well ambulatory confirmed or highly probable cases for whom it is judged by their clinician as safe and clinically appropriate, with ongoing clinical support for clinical management and public health support for isolation.

Advice for monkeypox cases isolating at home, including disposal of household waste, is available at **SHPIR - Monkeypox: case and contact information sheets (scot.nhs.uk)** (as a document to be edited locally by Boards to add HPT contact details) and a public facing version (no HPT contact details) at the **PHS monkeypox webpage**.

Advice for **virtual management of monkeypox cases** has been circulated to clinical teams.

Where possible, pregnant women and severely immunocompromised individuals (as outlined in **the Green book**) should not clinically care for individuals with confirmed, highly probable, probable or possible monkeypox, and should take additional precaution to avoid contact within the home.

9.2.1.1. Ending self isolation

Those who have been either diagnosed and managed at home throughout their illness, or who have been discharged from hospital to isolate at home, can be advised to end self isolation at home once they **meet both** of the following criteria:

- **Clinical criteria**: The patient has been assessed by telephone or video call and has been afebrile for 72 hours and is considered systemically well.
- **Lesion criteria**: There have been no new lesions for 48 hours; there are no oral mucous membrane lesions; all lesions have crusted over; **AND** all lesions on exposed skin (including the face, arms and hands) have scabbed over, the scabs have dropped off, and a fresh layer of skin has formed underneath

Lesions in other (non-exposed) areas should remain covered throughout the patient's time outside of their home or when in contact with other people.

Cases should continue to avoid close contact with immunosuppressed people, pregnant women, and children aged under 12. Cases should continue to be excluded from work if their work requires close contact with any of these groups. They should be advised to speak to their employer before returning to work as a risk assessment may be required for people who work in vulnerable settings and consideration given to redeployment or continued exclusion until **all lesions, including those on non-exposed areas, are fully healed**.

At this point, the individual may resume full normal activities with no restrictions.

9.2.2. Enhanced Surveillance

Enhanced surveillance is required for confirmed and highly probable cases only. **Detailed guidance and the agreed surveillance questionnaire** are available on SHPIR.

There is significant overlap between enhanced surveillance (**section 6.1.7**) and contact tracing therefore these activities should be combined in as efficient manner as possible to reduce burden on the case.

9.2.3. Undertaking the interview (sexual health)

At this time in the ongoing UK outbreak, cases of monkeypox are particularly associated with gay, bisexual and other men who have sex with men (GBMSM) and the public health response is being adapted accordingly. Contact tracing and enhanced surveillance is likely to involve taking a detailed sexual history. Resources are available on taking sexual histories from the British Association for Sexual Health and HIV in the **CEG National Guidelines – consultations requiring sexual history-taking**.

Additional support and input should be sought from local board sexual health colleagues and collaboration, or delegation of contact tracing and enhanced surveillance, may be preferred especially if the case has co-existing STI diagnoses. This work division is to be determined by local teams on a case-by-case basis, noting that gathering the necessary information as efficiently as possible is preferred by both case and the teams involved.

9.2.4. Contact tracing

Contact tracing is required for symptomatic monkeypox cases only. A monkeypox case is defined as a case that meets the **confirmed** or **highly probable** case definition.

A matrix of contact definitions and required follow-up actions is found in the **UKHSA monkeypox contact tracing guidance**. Each identified contact should be categorised according to the matrix and managed according to **Section 9.3**.

It is advised that all contacts should be managed via passive surveillance. Where occupational exposure or exposure of patients in a healthcare setting may have occurred, occupational health and IPCT should be involved as appropriate.

Liaison between Boards is vital where contacts move between Board areas and should be managed as per business as usual to allow ongoing surveillance and any vaccine arrangements. Ensure all contacts have clear instruction of who to contact should symptoms develop. Orphan contacts should be managed by their Board of Residence of the contact.

Cases and contacts in other UK nations should be passed directly by HPT to the local health protection teams in **England**, **Wales** or **Northern Ireland**.

9.2.5. Blood, tissue, cell or organ donation

Where it is identified that a confirmed or highly probable case has made a blood, tissue or cell donation at any point during their infectious period then the Scottish National Blood Transfusion Service (SNBTS) should be advised by email (**nss.snbtsdcst@nhs.scot**) and in-hours by telephone 0131 314 7391 / 5520. Out of hours the SNBTS on call consultant can be contacted via 0131 314 1794.

Donation or receipt of organs or other medical donations (e.g. sperm donation) should be followed up with the clinicians or services responsible.

A full position and evidence statement on monkeypox and blood, tissue, cell or organ donation is available from the **Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee**.

9.2.6. Venue or setting notification

Where it is identified that a community setting has been visited in the infectious period by a confirmed or highly probable case, settings with lower risk of transmission (e.g. case attended restaurant, bar, cinema) do not require further action (i.e. no warn and inform / routine communication with setting / attempt to identify further contacts by discussing with setting).

Where the exposed setting is assessed as having a higher risk of transmission due to skin-to-skin contact, potential contamination with body fluids / enclosed settings (e.g. sex-on-premises venues, massage and saunas, health or social care, prisons, homeless shelters) then the HPT should risk assess whether to attempt to identify exposed persons in the setting and whether to involve environmental health or IPC colleagues.

- Guidance for the management of cases in prisons and places of detention is available in the **UKHSA monkeypox guidance for prisons and places of detention.**

- Guidance for planning events and mass gatherings is available in the **UKHSA monkeypox guidance for planning events and mass gatherings** and should be reviewed by HPTs in order to support public health management of local events.

- **advice for cleaning sex-on-premises venues** is available on SHPIR

The risk assessment should consider the type and duration of contact during the visit; any contact or exposure of others to lesions; vulnerabilities of those exposed; and time elapsed since the exposure.

Where clusters of cases are identified around a single setting then HPT should consider additional actions including the potential for a warn and inform exercise. PHS should be notified.

9.2.7. Flight and international contact tracing

Where a symptomatic confirmed or highly probable case travelled on a plane (domestic or international) during their infectious period this should be notified to PHS via email (**PHS.monkeypox2022@phs.scot**) (during working hours) and via phone call (only for out of hours) in order for flight contact tracing assessment to be undertaken. The case should be advised their details may be shared for specific purposes only, such as with an airline for risk assessing the flight contacts or with UKHSA for onward sharing with foreign public health authorities for them to make a public health risk assessment.

PHS should also be notified of any cases or contacts with international or offshore exposures to ensure this information can be passed to National Focal Points. Only passengers seated directly next to a case on a plane would be considered contacts (Medium risk, Category 2).

See **section 9.3.4** for consideration of cases who intend to travel during their infectious period against public health advice.

9.2.8. Household pets

There is a risk that pets or other animals could become infected or contaminated with the virus through close contact with an infected person and spread the virus to others. For this

reason, cases should avoid close contact with pets and other animals as much as you can and practice good hygiene before and after nay contact that does occur.

Detailed advice for cases and isolating contacts with household pets has been published by the Animal and Plant Health Agency (APHA) for **pet owners who are isolating because of monkeypox**. This advice is also provided in case and contact information sheets.

APHA should be contacted by the HPT if any animals are present within a household with a confirmed, probable or possible case of monkeypox. The local Field Services offices should be the initial point of contact. Contact details for all offices in Scotland can be found at **Contact APHA.**

The HAIRS Risk assessment is available online. See the **qualitative assessment of the risk to the UK human population of monkeypox infection in a canine, feline, mustelid, lagomorph or rodent UK pet**

9.2.9. Compensation and support

Provision of compensation to provide for any loss incurred in complying with a request or order made by a board should be processed in line with Section 56/57/58 of the **Public Health etc. (Scotland) Act 2008** as required.

Where contacts of confirmed or highly probable cases are identified through other routes e.g. sexual health, they need to be referred to the Health Protection Team for follow-up. Where exclusion is required e.g. for high risk contacts who are either voluntarily or legally excluded from work with vulnerable groups these exclusions must be undertaken by **Competent Persons** in line with Section 56/57/58 of the **Public Health etc. (Scotland) Act 2008**.

Isolation should not prevent access to any required clinical care. Confirmed, probable and possible cases should seek help from medical services via phone initially, as advised on **NHS inform.**

Waverley Care are offering one-to-one support via video and phone calls to GBMSM living in Scotland and currently isolating due to monkeypox. Any isolating case should be offered a referral, and if they consent a name, contact point (email or phone number) and

any additional information relevant to the individual's support that they have consented to be shared should be sent to **referral@s-x.scot**. Individuals may self-refer via the **Looking for Support online form**

9.2.10. Following end of infectious period

The end of the isolation period is set out in **section 9.2.1**.

There is no available evidence of monkeypox in genital excretions, however a precautionary approach for the use of condoms for 12 weeks after infection is recommended.

9.3. Advice for contacts of confirmed or highly probable cases

See **principles for monkeypox control in the UK four nations consensus statement** and **Monkeypox contact tracing guidance** for follow up actions for each category of contact. Passive surveillance is advised for all contacts.

The contact follow-up period is 21 days from the last exposure to the confirmed or highly probable case. For the purposes of calculating follow-up periods, the last day of exposure should be counted as Day 0.

In the case of ongoing contact, the start date for follow-up would typically be the same as the date the case began to isolate away from the household contacts. Where separation between household contacts and the case cannot be achieved to a level that the HPT assesses as sufficient, contacts may be considered as having ongoing exposure and their follow-up period extended accordingly.

Classification of household contacts as higher risk or lower risk should be considered on a case-by-case basis with using the **UKHSA monkeypox contact tracing guidance**. Considerations would include sleeping arrangements, house layout and shared facilities / towels etc.

An information sheet should be sent to the contacts as per the contact's classification. **Information sheets** are available on SHPIR to send to each category of contact and the case.

9.3.1. Passive follow-up of contacts

Passive surveillance is advised for all contacts. They should not be contacted daily during the follow up period but should be given a designated HPT contact point to phone if they develop any symptoms, so that they can be followed up. HPTs are not required to contact these individuals at the end of their monitoring period, but their follow-up period end date should be made clear to them when they are first contacted.

9.3.2. Restrictions on work duties

High risk contacts (category 3) are to stay away from work for the duration of their follow-up period if work involves contact with immunosuppressed people, pregnant women or children aged under 5 years (not limited to healthcare workers) e.g. nursery staff or midwives.

If clinically well to do so, these contacts may continue to work from home or be reassigned to other work duties where contact with vulnerable groups is not required. Discuss with occupational health.

All other contacts can continue to work as usual.

9.3.3. Symptomatic contacts

Any contact who develops monkeypox symptoms, as set out in their contact information sheet, should be advised to:

- phone their designated HPT contact point straight away
- stop working and return home to self-isolate, ideally by private transport (see **section 9.1.3**)
- be referred for assessment through local clinical pathways

9.3.4. Overseas travel

For cases or contacts planning to travel out of the UK, as related to exposure risk categorisation in the **UKHSA monkeypox contact tracing guidance**.

- International travel is not advised for high risk (Cat 3) or medium risk (Cat 2) contacts or cases, who should be isolating at home.

- Where a case or category 2 or 3 contact does advise that they plan to travel regardless of the public health advice the HPT should try to discourage this, and failing that mitigate the risk to others. Contacts traveling against public health advice should be advised to discuss any travel plans with their travel insurance company and disclose the fact they have been identified as a contact of a monkeypox case. They should also consider the accessibility of appropriate health care services in the country they are visiting, in the event they were to develop symptoms whilst overseas. In the event of a confirmed case or highly probable case or symptomatic contact who intends to travel against public health advice HPTs may wish to consider the use of the Public Health Act to restrict travel on a case by case basis.

- If a case or category 2 or 3 contact declares they intend to travel, HPT should inform PHS as soon as possible via telephone and email (**PHS.monkeypox2022@phs.scot**) in order that PHS can liaise with the National Focal Point of the country that they are visiting. The notification should include the name, DOB, email/ phone contact details, travel plans, destination in country (if known), and a brief case or contact history for context.

9.4. Pre and post-exposure vaccination

Guidance on the use of vaccination as pre- and post-exposure prophylaxis is available at **UKHSA monkeypox vaccination recommendations.** This guidance is updated frequently, and the latest version should be checked on this webpage. Vaccination guidance is based on policy outlined in the **Green Book (Immunisation Against Infectious Diseases) Chapter 29**.

Individuals who are considered to be in the priority groups should be offered pre-exposure vaccination, as outlined in the **CMO letter.**

Post-exposure vaccination for contacts should be used in line with **Monkeypox vaccination recommendations** and **Monkeypox contact tracing guidance**. PHS does not need to be informed before arranging access to post-exposure vaccination.

Previous monkeypox infection is not a contra-indication to vaccination. However with constrained vaccine supply, vaccination of confirmed cases should be deferred until supply allows consideration of those at on-going risk once fully recovered. Whether prior monkeypox infection protects against future infection is currently unknown, but based on analogy from smallpox infection and from live smallpox vaccine, it seems likely that re-infection will be unusual, particularly in the short term.

Vaccinations delivered in sexual health services should be recorded on NASH, where available. In sexual health services where NASH is not available, and in other settings where vaccine is being administered (e.g. occupational health), vaccination should be recorded using the PHS template and submitted weekly.

The **process for requesting vaccine** is available in **SHPIR**.

Vaccine specific training and other education resources for healthcare practitioners relating to Monkeypox are available in TURAS.

Public information on vaccination for monkeypox can be accessed on **NHS inform**. An **information leaflet** is also available on the PHS website.

The immunisation coordinators and the Scottish Immunisation Programme are regularly updated on any new developments on vaccination by the PHS Immunisation Team, via National Incident Management Team (NIMT) and other recognised means of communication.

10. Infection Prevention and Control

Infection Prevention and Control (IPC) precautions for healthcare settings are those as outlined in monkeypox guidance within the **National Infection Prevention and Control Manual**.

Advice for monkeypox cases isolating at home, including disposal of household waste, is available in the **information sheets for people with monkeypox isolating at home** on SHPIR and on the **PHS monkeypox webpage**.

IPC cleaning advice specifically for owners, managers and staff of sex-on-premises venues is available on SHPIR at **advice for cleaning sex-on-premises venues** for HPTs to share with relevant settings in their area.

For managing infection risks when handling the deceased, see **Guidance for the mortuary, post-mortem room and funeral premises, and during exhumation**.

11. Public information

Public information on monkeypox is maintained on **NHS inform.**

Advice on monkeypox and international travel is on **Fit for Travel.**

Other public facing information on monkeypox can be found on the **Public Health Scotland website.**