5. Public Health Management of cases and contacts of VHF

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5.1 Introduction and risk categorisation

Effective public health management of VHF is dependent on the IMMEDIATE preliminary notification by clinicians of potential cases to the Director of Public Health/Medical Officer of Health (DPH/MOH), as soon as a ***High Risk exposure*** scenario is suspected. Case definitions can be found here.

Risk exposure categorisation of potential cases is recorded on the Clinical Risk Assessment Form (signs, symptoms and exposure). For more information on risk categorisation for patients see guidance on Clinical Assessment, Risk Categorisation and Management in Acute and Primary Care.

5.2 Notification of a potential case

Medical practitioner notification to the DPH/MOH

Prompt notification of suspected viral haemorrhagic fever to the local DPH/MOH is essential, as the DPH/MOH is statutorily responsible for the investigation and control of all suspected cases of VHF. Notification is a legal requirement. [1]

The most likely site of presentation of a suspected case of VHF is in an acute hospital, either in the Emergency Department, or after admission. In this situation, the attending senior clinician on duty should immediately notify the DPH/MOH, according to how the suspected case has been categorised, as per the algorithm.

Presentation at points of entry (ports and airports)

The MOH/DPH may be first notified of a potential case of VHF if a person becomes ill when on board a plane or ship. Under the Shipping Regulations (SI No. 4 of 2008)) and Aircraft Regulations (SI No. 411 of 2009) the captain/pilot of the plane or ship is required to notify the DPH/MOH when he/she suspects that a person with an infectious disease is on board.

DsPH/MOH with Points of Entry in their geographic area should have agreed protocols and procedures in place with relevant bodies for the clinical and public health assessment of patients with potential infectious diseases of public health concern. These protocols should incorporate the need to consider if there is a risk of VHF, and the subsequent patient management, patient transport, infection control and contact management implications. An algorithm has been developed for the assessment of possible VHF cases presenting at airports and may be further adapted as appropriate and used.

[1] *"A medical practitioner, as soon as he or she becomes aware or suspects that a person on whom he or she is in professional attendance is suffering from or is the carrier of an infectious disease… shall forthwith transmit a written or electronic notification to a medical officer of health, and further in the case of … viral haemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo),… give immediate preliminary notification thereof to a medical officer of health" (SI 707 of 2003)*

Threshold for notification to the DPH/MOH

Medical practitioners should IMMEDIATELY notify *all symptomatic individuals* that have been categorised as ***High Risk* exposure** to the DPH/MOH, and should not wait until the diagnosis has been confirmed.

For patients who have been categorised as ***at risk (possibility of VHF)*** i.e. febrile patients (fever >37.5ºC or history of fever in the previous 24 hours) who have within 21 days before the onset of fever travelled within the specific local area of a country where VHF is endemic but who have no additional risk factors that would place them in the high-risk category, then notification to the DPH/MOH is not needed until confirmation, **or** if a VHF test is deemed necessary according to the algorithm

5.3 Actions by the DPH/MOH once notified of a ***high risk exposure*** SUSPECTED case

This section outlines the key actions for DPH/MOH in terms of preparation for convening a local OCT and contact tracing work in advance of confirmation of VHF case.

Prepare to set up a Local Outbreak Control Team

The DPH/MOH is responsible for establishing the local OCT to coordinate the overall response to the incident as indicated by national ID Regulations.[2]

- Members should be contacted, and informed that a ***high risk exposure*** *suspected case* has been identified.
- The DPH/MOH should consider whether additional resources will be needed locally to manage the outbreak control and contact tracing activities if the case is confirmed. This may include convening an internal departmental incident management team (IMT). Suspension of some non-priority work may also occur.
- Consideration should be given to putting the HSE Area Crisis Management Team on standby alert by contacting Emergency Management Office or OOH through Ambulance Control.

Prepare for contact tracing

- Pre-existing plans, surveillance forms, contact leaflets, supplies of thermometers and arrangements for assessment of symptomatic contacts should be checked, reviewed, and amended or updated as needed.
- Ensure availability of PPE and training in the use of PPE, though it is unlikely to be needed for contact tracing. For further information on the use of PPE, please see here.

National reporting

The DPH/MOH should immediately report ***high risk exposure*** suspected cases nationally to the National Clinical Director for Health Protection. The purpose of this is to:

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[2] *"On becoming aware, whether from a notification or intimation under these regulations or otherwise, of a case or a suspected case of infectious disease or a probable source of infection with such disease, a medical officer of health, or a health officer on the advice of a medical officer of health shall make such enquiries and take such steps as are necessary or desirable for investigating the nature and source of such infection, for preventing the spread of such infection, and for removing conditions favourable to such infection."*

- agree how the outbreak response will be organised, including if and when the National Public Health Outbreak Response Team (NPHORT) is to be convened, how this will liaise with the Local Outbreak Response Team, and prepare the communications strategy for the incident; see here for suggested membership
- inform HPSC as the National Focal Point and the on call specialist/consultant in Public Health
- inform the local Public Health Area

5.4 Actions by DPH/MOH once case is CONFIRMED

The DPH/MOH should notify HPSC and the on call specialist/consultant in Public Health. Written notification should also be submitted via healthprotectionhpsc@hpsc.ie. In turn, HPSC is obliged to notify the World Health Organization (WHO) under the International Health Regulations (2005).

Local Outbreak Control Team

- The DPH/MOH should convene and chair the Local Outbreak Control Team, in consultation with the hospital where the patient is being managed. This will be a major multidisciplinary collaborative effort.
- If the case is moved to the National Isolation Unit (NIU), the DPH/MOH HSE Public Health Area A would be the liaison point between the local outbreak response team and the NIU.

5.5 National Public Health Outbreak Response Team (for PHEIC)

One confirmed case of VHF is considered a Public Health Emergency of International Concern (PHEIC). It is likely that The National Public Health Outbreak Response Team Plan will be activated.

Once a potential PHEIC is detected IHR requires State Parties to assess all reports within 48 hours and to notify WHO through the National Focal Point if the event is notifiable. NPHORT is activated to coordinate this public health assessment and response. The DPH/MOH from the local outbreak control team (and the DPH/MOH in HSE Public Health Area A should the case be moved to the NIU) would also be in attendance at this NPHORT meeting. For further information on International Health Regulations, please see here.

5.6 Contact tracing

The purpose of contact tracing is to:

1. Monitor those who have been in close contact with a VHF case to ensure early detection of disease if they have been infected. This will lead to early identification and management and, in most cases, better clinical outcomes
2. Prevent onward transmission to others

NOTE: Contact tracing is initiated IMMEDIATELY after a case of VHF is confirmed, in Ireland.

Contact tracing is done by public health in conjunction with the hospital team (which depending on local arrangement might include; infectious disease consultant/admitting physician, infection prevention and control, clinical microbiologist and occupational health physician). It is usual that:

- Community based contacts will be monitored by Public Health
- Healthcare workers, including laboratory staff, will be monitored by a defined pathway as identified by the Healthcare Facility. HCWs who have fitness for work concerns should be referred to OH as per local processes.
- Hospital in-patient contacts will be monitored by infection prevention and control and clinical microbiologist.
- Humanitarian aid workers, including healthcare workers, who have returned from VHF affected areas, will be monitored by Public Health

Definition of a contact

A contact of a VHF case is defined as an asymptomatic person who has been exposed in the previous 21 days to a symptomatic infected person or to a symptomatic infected person's secretions, excretions or tissues which could include laboratory specimens, soiled environment or contact with infected human remains

Contacts that have been exposed to VHF as determined by a risk assessment are assigned to the appropriate monitoring category by Public Health Doctor (PHD) /Occupational Health Service (OHS) /Infection Prevention and Control Team (IPCT).

Definitions of exposure categories

Definition of high risk exposure

- Close face-to-face contact (e.g. within one metre) without appropriate personal protective equipment (including eye protection) with a probable or confirmed case who is coughing, vomiting, bleeding, or who has diarrhoea
- Direct contact (of exposed mucous membranes or non-intact skin) with body fluids (including mouth-to-mouth kissing), tissues, or any materials soiled by body fluids from a probable or confirmed case
- Percutaneous injury (e.g. with a needle) exposure laboratory specimens of a probable or confirmed case
- Participation in autopsy, resuscitation or funeral rites with direct contact with human remains, including body fluids, of a probable or confirmed case in or from affected area without appropriate personal protective equipment;
- Unprotected sexual contact with a case within three months after the case has recovered from Viral Haemorrhagic Fever (VHF);
- Direct contact with bush meat, or bats or primates, living or dead in/from affected areas

Definition of *low risk exposure*

- Close face-to-face or physical contact (including skin-to-skin contact, such as hugging or

shaking hands) with a symptomatic case that has no coughing, vomiting, bleeding or diarrhoea.

- Household contact of a symptomatic case (please note: based on local public health risk assessment, there may be some exceptions)
- Other settings such as classroom or office room level contact with a symptomatic case, subject to risk assessment.
- Casual or physical contact with a feverish but ambulant and self-caring VHF case (e.g. sharing a seating area including airplane transport; receptionist tasks etc.)

NOTE: If a person returning from an affected area with no known exposure risks as outlined above, comes to the attention of Public Health, the provision of information and advice is sufficient.

Definition of healthcare workers with occupational exposure

- **Low risk**:
  - Occupational exposure of anyone working in a healthcare setting involved in caring for a case of VHF, *or* dealing with inanimate objects contaminated or possibly contaminated with blood and/or body fluids, *or* laboratory workers processing specimens of a VHF case while using **appropriate personal protective equipment (PPE)**
- **High risk**:
  - Occupational exposure of anyone working in a healthcare setting involved in caring for a case of VHF, *or* dealing with inanimate objects contaminated or possibly contaminated with blood and/or body fluids, *or* laboratory workers processing specimens of a VHF case is considered to be a high risk exposure where:
    - there is a breach in PPE (e.g. needle-stick injury, or incorrect donning and doffing technique)

      OR
    - when not wearing appropriate PPE

NOTE: Given the **continuous nature** of the occupational exposure for some healthcare staff when caring for VHF patients, healthcare workers will be **actively monitored by a pathway identified locally**.

Contact tracing and the subsequent management of contacts are based on the following current knowledge about VHF:

- The incubation period of VHF can be as long as 21 days
- Only symptomatic patients can transmit the disease. Infectiousness starts with the onset of symptoms
- Transmission may occur through direct contact (of exposed mucous membranes or non-intact skin) with the patient or blood or other bodily fluids of the patient
- Dead bodies and their blood and bodily fluids remain infectious
- There is no evidence of airborne transmission but precautions are warranted when droplet-generating symptoms (such as vomiting, coughing) are present or aerosol-producing procedures are performed.
- Transmission via inanimate objects contaminated with infected bodily fluids (fomites) is possible

Once a case is CONFIRMED, the following steps should be taken when identifying contacts:

- Consider the stage of the illness and the likely level of viraemia at the time of exposure – infectiousness increases with progression of clinical illness
- Trace the movements of the index VHF patient for up to **21 days** prior to onset of illness with a view to establishing the source of infection
- Prepare a list of all potential contacts who are at risk of developing the disease. This will be obtained from the index case or his/her proxy
- Inform HPSC of any international contacts via healthprotectionhpsc@hpsc.ie and the on call specialist/consultant in Public Health
- Identify and interview all potential contacts using the standardised form (**VHF Contact Assessment Form)** and assign a risk category to these potential contacts
- The process of informing a contact of their status should be done with tact and empathy since being a contact can be associated with a serious health outcome. It is important that appropriate and sufficient support is provided to the contact throughout the follow-up period
- Emergency Management and Mental Health have developed guidance on mental health needs following a major emergency
- EVD vaccine is currently unlicensed in Ireland.

Table 1 summarises the **care pathways for contacts after exposure risk assessment.**

Table 1: Care pathways for contacts after exposure risk assessment

NON-HEALTHCARE WORKER (non-HCW)	
High risk exposure* 1. **Information:** high risk non-HCW letter with monitoring instructions and 24/7 contact details, information leaflet 2. **Pack:** temperature chart and thermometer 3. **Monitoring:** active monitoring, daily contact with PHD/OHS/IPCT 4. **Travel restriction:** not to leave Ireland for 21 days since last contact, discuss travel within Ireland with PHD/OHS, remain reachable during monitoring period 5. **Work/social restriction:** generally none but assess on a case by case basis depending on amount of exposure, type of work. 6. Use **barrier contraception or avoid unprotected sex** for 21 days 7. **Blood donation:** defer for at least 2 months from date of last exposure 8. **Fever or symptoms:** contact their monitoring team immediately 9. **Communications:** Communicate as appropriate with contact's GP, receiving hospital, NIU, HPSC, National Director for Health Protection , LOCT, HSE Communications 10. **Non-VHF related healthcare**: **if non-urgent**, individuals should contact their GP or other healthcare provider by phone in the first instance and inform the public health area department of issue and any plans to attend a healthcare facility. **For urgent related healthcare,** individuals should call an ambulance and inform ambulance control that they are a contact undergoing active monitoring for VHF.	**Low risk exposure** 1. **Information:** low risk non-HCW letter with monitoring instructions and 24/7 contact details, information leaflet 2. **Pack:** temperature chart and thermometer 3. **Monitoring:** passive monitoring only, contact PHD/OHS/IPCT if fever or symptoms 4. **Travel restriction:** Generally no travel restriction but assess on case by case basis, remain reachable during monitoring period 5. **Work/social restriction:** none 6. Use **barrier contraception or avoid unprotected sex** for 21 days 7. **Blood donation:** defer for at least 2 months from date of last exposure 8. **Fever or symptoms: The person is to** contact their local Public Health Department liaison immediately 9. **Communications:** Communicate as appropriate with contact's GP, receiving hospital, HPSC, National Director for Health Protection (+/- AORP-CL and national lead HTPP) , LOCT, HSE Communications 10. **Non-VHF related healthcare**: **if non-urgent**, individuals should contact their GP or other healthcare provider by phone in the first instance and inform the public health area department of issue and any plans to attend a healthcare facility. **For urgent related healthcare,** individuals should call an ambulance and let ambulance control know that they are a contact undergoing passive monitoring for VHF.
HEALTHCARE WORKERS (HCW) **	

High risk exposure* Discuss with National Isolation Unit re possible PEP	Low risk exposure
1. **Information**: high risk HCW letter with monitoring instructions and 24/7 contact details, information leaflet. This will be provided by HCF identified pathway 2. **Pack**: temperature chart and thermometer 3. **Monitoring:** active monitoring, daily contact with PHD/ OHS depending on local arrangements as per the defined pathway identified by the HCF 4. **Travel restriction:** not to leave Ireland for 21 days since last contact, discuss travel within Ireland with PHD/OHS, remain reachable during monitoring period 5. **Work/social restriction:** Can attend office work. No clinical care or work in patient care areas. Generally no social restrictions but assess on case by case basis 6. Use **barrier contraception or avoid unprotected sex** for 21 days 7. **Blood donation:** defer for at least 2 months from date of last exposure 8. **Fever or symptoms:** contact their monitoring team immediately 9. **Communications:** Communicate as appropriate with contact's GP, receiving hospital, NIU, HPSC, National Director for Health Protection (+/- AORP-CL and national lead HTPP) , LOCT, HSE Communications 10. **Non-VHF related healthcare**: **if non-urgent**, individuals should contact their GP or other healthcare provider by phone in the first instance and inform the public health area department of issue and any plans to attend a healthcare facility. **For urgent related healthcare,** individuals should call an ambulance and inform ambulance control that they are a contact undergoing active monitoring for VHF.	1. **Information:** low risk HCW letter with monitoring instructions and 24/7 contact details, information leaflet 2. **Pack:** temperature chart and thermometer 3. **Monitoring:** active monitoring, daily contact with PHD/ OHS 4. **Travel restriction:** Generally no travel restriction but assess on case by case basis, discuss travel within Ireland with PHD/OHS, remain reachable during monitoring period 5. **Work/social restriction:** none 6. Use **barrier contraception or avoid unprotected sex** for 21 days 7. **Blood donation:** defer for at least 2 months from date of last exposure 8. **Fever or symptoms: The HCW is to** contact their local Public Health Department liaison immediately 9. **Communications:** Communicate as appropriate with contact's GP, receiving hospital, HPSC, National Director for Health Protection (+/- AORP-CL and national lead HTPP)LOCT, HSE Communications 10. **Non-VHF related healthcare**: **if non-urgent**, individuals should contact their GP or other healthcare provider by phone in the first instance and inform the public health area department of issue and any plans to attend a healthcare facility. **For urgent related healthcare,** individuals should call an ambulance and let ambulance control know that they are a contact undergoing passive monitoring for VHF.

*See Section 10 for contacts medically evacuated from an affected area because of a high risk exposure **HCW contacts of a case in Ireland will be managed by their hospital's Occupational Health Service

A risk assessment is carried out for each identified contact:
PH are responsible for risk assessing community contacts of a case diagnosed in Ireland and others such as returning humanitarian aid workers (HAW). HAWs are classified according to the roles and responsibilities they had while on secondment. Those who are involved in clinical care while on secondment are termed 'healthcare workers' and all others as 'non-healthcare workers', regardless of whether or not they are healthcare workers in Ireland. Those who were not working as healthcare workers in a VHF-affected area, but will be working as a healthcare worker in Ireland should not return to work in a clinical setting unless approved by the public health physician carrying out their risk assessment.

For returning HAWs:

- **If an exposure risk assessment identifies that a humanitarian aid worker returning from an affected area has had a high risk exposure this case should be discussed with Mater Hospital's National Isolation Unit (NIU) in Dublin who may wish to consider Post Exposure Prophylaxis (PEP)**
- Exposure risk assessments for returning healthcare workers will be carried out within one day of their return to Ireland, Monday to Sunday
- Exposure risk assessments for returning non-healthcare workers will be carried out during routine office hours Monday to Friday
- OHS are responsible for risk assessing healthcare worker contacts of a case diagnosed in Ireland
- IPCT are responsible for risk assessing inpatient contacts of a case diagnosed in Ireland.

Assignment of contacts to the appropriate monitoring category

Contacts who have been exposed to VHF as determined by a risk assessment are assigned to the appropriate monitoring category by PHD/OHS/IPCT.

- All HCW regardless of exposure type are assigned to the **active monitoring category as identified in the HCF pathway**
- Non-HCW contacts with **high-risk exposure** are assigned to the **active monitoring** category
- Non-HCW contacts who are considered **low risk** are assigned to the self-monitoring category

The required length of monitoring should be ascertained including end date. Contacts require to be monitored **until 21 days** have elapsed since their last known exposure to VHF. The end date should be recorded on the Temperature Chart provided to the contact as part of their Contact's Pack.

NOTE:

- All contacts assigned to monitoring categories will be provided with written instructions
- Individuals who after risk assessment are deemed not to meet the definition of a contact will not require monitoring but will be provided with information.
- If a contact with a high risk exposure has been treated with PEP in the NIU they will be assigned to the active monitoring category as soon as they have completed PEP treatment.

5.7 Advice and provision of information

- The contact is informed by PHD/OHS/IPCT and advised with regard to their level of risk and given verbal and written information as part of a Contact's Pack.
  - The contents of the pack will vary according to the exposure risk determined.
  - It may be possible to email written information to a contact whilst waiting for delivery of the pack by postal mail or courier service from the relevant Public Health area department
- Contacts are instructed on the type of monitoring that is to commence and provided with written instructions
- Contacts assigned to self or active monitoring will be provided with 24/7 telephone contact details for their local Public Health area department so that they can contact the PHD/OHS/IPCT at any time should they develop fever (>37.5^{0}C) or symptoms
- Contacts are advised of any restrictions that may apply
- All contacts should be advised to defer blood donation for at least 2 months from date of last exposure

5.8 Monitoring and follow-up of contacts for development of symptoms

Individuals deemed to have had contact with VHF are monitored by relevant local services for fever or symptoms for a period of **21 days following** their last known exposure.

Active monitoring category

Contacts with a high risk exposure and all healthcare workers who have been exposed are assigned to the active monitoring category as per the local identified pathway.

For contacts who are assigned to active monitoring they will:

- Record their temperature twice daily using an approved thermometer
- Monitor themselves for symptoms (see VHF Contact Active Monitoring Form)
- PHD/local HCF identified service/IPCT to obtain measured temperatures daily using either an SMS text messaging system (if available) or telephone contact. **Note:** if the contact under active monitoring using an SMS messaging system does not respond to the text message then a follow-up phone call is required.
- If the contact develops a fever (>37.5^{o} C) or symptoms during the active monitoring period:
  - **HCWs** with fever or symptoms should immediately notify the emergency contact team identified by local HCF
  - **Non-HCWs** with fever or symptoms should immediately notify PHD.
- Avoid the use of anti-pyretics while undertaking monitoring.

Self-monitoring category

Contacts with low risk exposure are assigned to the self-monitoring. For contacts who are assigned to self-monitoring they will:

- Be provided with necessary written information and instructions
- Record their temperature twice daily using an approved thermometer
- Monitor themselves for symptoms (see VHF Contact Active Monitoring Form)
- If the contact develops a fever (>37.5° C) or symptoms during the active monitoring period:
  - **HCWs** with fever or symptoms should immediately notify the emergency contact team identified by local HCF
  - **Non-HCWs** with fever or symptoms should immediately notify PHD
- Avoid the use of anti-pyretics while undertaking monitoring.

5.9 Referral of contacts who develop fever (>37.5°C) or symptoms for hospital clinical assessment

Public Health local area departments will have a system in place whereby community contacts can contact them at any time should they become unwell. Inpatient contacts will be monitored by IPCT / hospital staff for signs and symptoms.

PHD/local HCF identified service/IPCT should discuss the case with a clinician in the NIU or the receiving hospital or both.

- There should be a low threshold for referral for hospital assessment
- The contact is asked to self-isolate[3]
- Transport options are assessed

Key points on transportation

- Under **NO circumstances should the contact drive** themselves to a hospital and they **should NOT use public transport**.
- The contact can be transported to hospital by ambulance or driven in private transport by someone they have been in contact with within the previous 24 hours. Being driven by private transport should only be considered if a contact has **mild symptoms** and is fully ambulant. Options should be considered on a case by case basis
- If they have symptoms such as **vomiting or diarrhoea** they should be transported by **ambulance**
- If in doubt, transport should be by ambulance. VHF ambulance service risk assessment can be accessed here.

For contacts that are to be referred for medical assessment at the receiving hospital:

- Inform the designated contact point in the hospital that a VHF contact now has a fever or symptoms and requires acute medical assessment

[3] The contact should immediately isolate themselves from other people and also animals such as household pets (particularly dogs and cats).

- If contact is to be transported by ambulance speak to ambulance control and then advise patient of arrangements
- If contact is travelling by private transport speak to patient and driver of car to provide instructions for their arrival at the hospital
- The receiving hospital should be asked to update PHD
- If IPCT/ HCF identified pathways for HCW contact identification refer a contact for medical assessment they should inform public health
- The contacts' database should be updated

Note: In some situations, **after discussion with the NIU, the contact may be referred directly to the NIU.** Transfer is arranged by NIU who contacts the National Ambulance Service and activates the VHF transfer protocol.

5.10 Collection, updating, and reporting of contact data

Forms

The relevant forms (VHF Contact Assessment Form and VHF Contact Active Monitoring Form) should be completed.

Contacts' management log

- The contacts' management log should be used for all contacts
- It should be updated daily by PHD/OHS/IPCT
- PHD is responsible for integrating all contact data returned from HCF on HCW contacts and IPCT on inpatient contacts and other contacts (e.g. returned HAW)
- The contacts' management log can be used locally for maintaining data but this is not essential

Reporting contact data

Contacts of a case diagnosed in Ireland:

Diagnosis of a case of VHF in Ireland will constitute a **national public health emergency** resulting in a requirement for timely information on a daily basis

- PHD will be required to report daily to the HPSC via healthprotectionhpsc@hpsc.ie by midday (Monday – Sunday) on all contacts of the case using the agreed contacts' management log.
- If a contact who is being monitored by HCF/IPCT develops symptoms the HCF/IPCT should notify PHD
- PHD should notify the HPSC and the National Director for Health Protection if a contact develops symptoms by phone as soon as possible
- Updates should be provided to the LOCT and may also be required separately for RCMT, NPHORT, and NPHET.

Other contacts (e.g. returned HAW):

The SPHM on-call at the HPSC and the National Director for Health Protection should be notified by

PHD if
(a) a contact with a high-risk exposure is identified or
(b) a contact develops symptoms

Individuals who after risk assessment are deemed not to meet the definition of a contact:

- Are provided with verbal and written information

Contacts with a high risk exposure who have household pets (e.g. dogs or cats):

- should consider making alternative pet care arrangements if possible during the monitoring period to avoid the need for pet quarantine should the contact become ill and expose the pet(s) to VHF
- if pet(s) remain in the household and the contact becomes unwell they should isolate themselves immediately from any pet(s) to avoid exposing the pet(s) to VHF
- Further advice on VHF pet exposure can be found here.

5.11 Prophylaxis and vaccination options for different VHFs

Prophylaxis

Any prophylaxis decisions in terms of the various VHFs should be made in consultation with the ID Consultant in the NIU.

Vaccination options for EVD

At present the Ebola vaccine, rVSV-ZEBOV by Merck, is unlicensed in Ireland. The use of the vaccine to date has been in high risk outbreak settings in endemic countries only. Further information on the use of the vaccine is available on the WHO website.

5.12 Communicating with healthcare professionals, HSE management, media

Primary Care

The contact's GP should be informed by PHD/IPCT/pathways identified by the HCF that their patient:

- has been exposed to VHF, the context of exposure
- the date of last exposure
- is categorised as a high / low risk contact
- is being monitored [self / active] until the end date identified

The GP should be advised on what to do should a contact seek medical advice

Receiving hospital

- The contact's receiving hospital should be informed by PHD/ /IPCT/pathways identified by the HCF

National Isolation Unit (NIU), Mater Hospital

- If an exposure risk assessment identifies that a humanitarian aid worker returning from an affected area has had a high risk exposure this case should be discussed with the NIU who may wish to consider post-exposure prophylaxis.

NOTE: In the event that a HAW who is being monitored is returning to work in a healthcare setting in Ireland, the PHD should notify the relevant OHS and IPCT.

IPCT should inform PHD if an inpatient contact of VHF is being discharged so that PHD can continue their monitoring in the community.

PHD should alert and update the following as required:

- LOCT
- National Director for Health Protection
- HPSC

Media

Should a case of VHF be confirmed in Ireland:

- The LOCT will discuss a communications strategy for the media, the public and staff at an early stage.
- The strategy will be agreed locally and nationally in conjunction with relevant others such as NPHORT, NPHET, HPSC, and HSE's national communications office

In the context of monitoring of e.g. a returned Humanitarian Aid Worker (HAW):

- Any such media queries are to be referred to communications locally, who will refer such queries nationally as necessary
- It may be necessary to prepare a draft media statement in conjunction with relevant others e.g. local PHD, receiving hospital, HPSC, HSE local communications department
- PHD should alert and update the relevant nominated VHF spokespersons as necessary

5.13 Preparedness activities

VHF is a very unusual condition and has not been diagnosed to date in Ireland. However, due to the nature of the disease, the implications for contacts and the need for contact tracing, it is important to maintain preparedness to deal with a case.

The DPH/MOH should agree with local Consultants in Emergency Medicine how best to circulate information on current outbreaks as they are notified (WHO IHR alerts, EWRS etc). For regular disease alerts, emergency department staff should be advised to go to the website. For urgent and recent alerts that are not currently in the public domain on websites, but that front-line staff need to know

without delay, the DPH/MOH should discuss how best to do this with hospital management and Consultants in Emergency Medicine.

The DPH/MOH should work with hospital and GP colleagues to incorporate VHF specific requirements (importance of travel history, algorithms, danger/warning signs, and how to identify countries where VHF outbreaks are occurring) in communicable disease education and training within the hospital and primary care setting.

The DPH/MOH should use the national guidance to inform a local plan for response in the event of notification of a case. This would include protocols at points of entry, procedures for management of suspected cases, OCT arrangements, media management, up-to-date contact lists etc. The plan should also take into consideration the arrangements needed if the VHF case is part of a bioterrorism incident. This locally developed plan and procedures should be exercised, in conjunction with Emergency Planning.