## Human Monkeypox Infection

### Management of Contacts

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<td>Updated Risk Categorisation – greater use of PHRA in determining extent of risk/exposure, use of quarantine, modification of vaccine information, expansion of sexual contact management, amended contacts’ Instructions for Monitoring Forms and updated web links. The Contact Tracing Matrix has been removed to be a standalone document</td>
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1. Background

This document is intended to provide a guide to identification, assessment and surveillance of close contacts of cases of human monkeypox infection (HMI). It should be read in conjunction with Human Monkeypox Infection - Guidance for Clinicians and Public Health. Surveillance of close contacts should be undertaken using the Human Monkeypox Infection - Contact Management Form. This guidance is based upon the best available evidence on the management of contacts of HMI, but may need to be amended in light of evolving epidemiology or clinical presentation of HMI.

Monkeypox is an uncommon, occasionally serious zoonotic disease caused by the monkeypox virus (MPXV), a species of Orthopoxvirus. In Ireland, MPXV is classified as a Biosafety Level 3 pathogen. Most HMI cases tend to be mild and self-limiting – some are thought to be asymptomatic. HMI is not particularly transmissible between people, but great care should be taken during the management of patients and their belongings, which may have become contaminated. MPXV enters the body through broken skin (including microscopic breaks), the respiratory tract, or across mucous membranes (eyes, nose, or mouth). MPXV comprises two distinct strains; a less serious West African variant (WA-MPXV) and a more severe Congo Basin variant (CB-MPXV). To date, all exported cases of HMI have acquired their disease in Nigeria, all cases having been infected with the milder WA-MPXV strain.

1.1. Geographical Distribution of MPXV

Primary HMI cases have been recorded in countries where MPXV is naturally endemic, including Benin, Cameroon, the Central African Republic, the Democratic Republic of the Congo, Gabon, Ivory Coast, Liberia, Nigeria, the Republic of the Congo and Sierra Leone. A large outbreak in the United States in 2003 occurred when a cluster of cases in the US was linked to close contact with prairie dogs infected by rodents imported from Ghana. In the outbreak identified in the UK in May 2022, cases have arisen from a wide range of geographical locations, affecting a number of countries.
1.2. Transmission of HMI

HMI is usually transmitted by:

- bites or scratches from an infected animal
- handling an infected animal
- contact with objects contaminated by an infected animal (such as bedding)
- contact with, or consumption of infected bushmeat or
- contact with contaminated animal products (such as animal hides).

Person-to-person transmission of HMI, although less common, can occur through:

- contact with the rash, rash exudate, crusts or scabs of a case
- close physical exposure to a case, especially if the case is coughing or sneezing, leading to aerosolisation and inhalation of infected fluids:
  - seen especially in prolonged, close face-to-face particularly in family/household settings or
  - sexual contact –spread through sexual contact between gbMSMs is a recognised transmission route.¹
- contact with objects contaminated by an infected person, such as bed linen, clothing, personal bathroom/toileting belongings, personal effects and hand touch surfaces in vehicles, aircraft and other communal settings.

**Healthcare Settings:** Within healthcare settings, while caring for, or treating patients with HMI, or handling their clinical samples, there is a risk of onward transmission of HMI. This risk is greatest in the period before the case has been suspected/diagnosed. However, while experience from other countries would suggest that the risk of transmission to HCWs is low, even following incidents involving verified breaches in PPE, onward transmission to HCWs has occurred.

¹ In the May 2022 outbreak, ECDC noted that particular sexual practices (e.g., having multiple casual sexual contacts and/or multiple sexual partners, attending chemsex parties or mass event, such as Pride events) can further facilitate the transmission of monkeypox in persons with multiple sexual partners, including some groups of MSM, transgender and other populations (e.g. sex workers).
2. Recognising the Clinical Features of HMI

The **incubation period** of HMI averages 6–13 days (range 5–21 days). The **infectious period** begins with the onset of fever (or 24h before the initial appearance of rash if fever absent/onset date unknown) and extends until the skin lesions are fully healed/shed and dry.

The **cardinal prodromal clinical features** of HMI are:

- **fever** >38.5°C (sudden onset and present in the great majority of cases) ± **rigors**
- **headache** (frequently intense and severe)
- **lymphadenopathy** (often generalised)
- **fatigue** (often severe)
- back pain and myalgia commonly occur
- cough/sore throat and gastrointestinal symptoms occur less frequently.

**Rash**: develops 1-3 (and up to 5) days after fever onset, beginning on the face (most densely) and commonly in the oral cavity, before spreading caudally, primarily to the soles of feet and palms of hands, while sparing the trunk (unless infection is severe). Fever and rash frequently appear concurrently.

The rash develops though a series of stages that take about 2-4 weeks to complete, depending on disease severity (see rash images [here](#) and [here](#)):

- macular/maculopapular (red/raised)
- vesicular (fluid-filled)
- pustular (pus-filled)
- umbilicated (dimpled pustules)
- drying (flattening pustules)
- scabbing (with lid formation)
- haemorrhagic (blood-filled blisters)
**NB:** In cases involving gbMSM, the rash commonly involves only the anogenital area. Although an anogenital rash may frequently appear characteristic, it may also appear atypical or it may be modified in appearance (see Section 5. Clinical Features in *Human Monkeypox Infection - Guidance for Clinicians and Public Health*).

The clinical course of HMI tends to be more severe in the case of infants, children under 12, pregnant women and in the immunosuppressed, especially those with HIV. Scabs/crusting may not be fully shed for more than three weeks. Cases are no longer infectious once all crusts have been shed, and scarred skin tissue is completely dry.

The clinical course of cases associated with the latest May 2022 outbreak appear to have a modified clinical course, with milder systemic symptoms (fever may be absent) and a rash that is primarily, though not exclusively restricted to the anogenital region.

### 3. Assessment of Potential HMI Contacts

The aims of surveillance of HMI contacts are to:

- Categorise contacts by risk of disease acquisition
- Minimise onward transmission of infection
- Detect early symptoms in contacts suggestive of the onset of HMI
- Provide advice and information to contacts and
- Support secondary cases in accessing appropriate clinical care.

Contact tracing of HMI can be very resource intensive. In HMI incidents in developed countries, the numbers of contacts identified following exposure to an imported primary case has varied from a few dozen contacts to more than two hundred. Those identified as contacts will require monitoring and surveillance (See Section 2.4. Surveillance of Contacts).
3.1. Definition of Contact

A contact is a person who has been in direct or indirect contact* with a confirmed case, i.e. contact with unhealed skin lesions, oral/respiratory secretions, urine, faeces, vomitus, blood, skin/skin intimate contact, sexual contact or a person who has shared a common space (anyone who has been in close physical proximity such as living in the same household, sharing a room with, or a having close proximity to a confirmed case, or other close contact scenarios in which the person may have had contact with the case or surfaces touched by the case) since the onset of the case’s fever, or within 24h of the onset of the case’s rash.² Determination of degree of contact will require public health risk assessment to varying degrees in various settings. The Contact Tracing Matrix lays out the approach to management of contacts.

*Direct and indirect contact:

- **Direct contact:** contact with an HMI case, case materials (e.g., bedlinen, clothing, healthcare equipment, surfaces touched by a case with palmar lesions), lesion material or bodily fluids of the case (including soiled surfaces). This type of contact would most commonly involve household contacts, sexual partners, other close contacts (e.g. immediate inflight or work contacts) and those providing care to a patient, including healthcare workers (HCWs) who did not implement appropriate precautions – see Section 2.2 Healthcare Workers below.

- **Indirect contact:** those coming within 1m of the case and their personal space (which will also include HCWs).

The following should be considered HMI contacts requiring initial assessment, if exposure occurred during the case’s infectious period/within 24h of rash onset:

- household members of the case
- sexual partners of the case
- skin/skin intimate contact with the case

• HCWs caring for a case, including ambulance crews/paramedics and other first responders and exposed HCWs in community settings (see Section 2.2 Healthcare Workers below)
• those who have spent at least one night in the residence during the period when the case is infectious
• contacts in another location at which the case may have stayed overnight (hotel or another household).
• certain passengers and flight crew accompanying a case on an international flight (see Section 2.3 below)
• face to face and other direct contact in travel, occupational or social settings

Contacts can be classified as zero, low, intermediate or high risk, depending on nature and proximity of contact. Their management may depend on whether or not they are HCWs (See Appendix 1). Categorisation of contacts into risk groups will involve undertaking an Infection and Prevention Control Risk Assessment in the hospital setting or a Public Health Risk Assessment (PHRA) in the community setting, to determine risk and the contacts’ subsequent management.

3.2. Healthcare Workers

A risk assessment should be carried out to identify all HWCs that had contact with the case, to determine the degree of contact and the level of PPE being used during contact. In previous international incidents, transmission to HCWs has largely occurred in the interval before a diagnosis of HMI had been suspected, although onward transmission to HCWs has been uncommon in incidents involving exportation of HMI to developed countries.
HCWs who should be considered for risk assessment as contacts include:
• those who had direct and indirect contact with the case or the case’s personal belongings or surroundings – this includes all HCWs in the Emergency Department, on the patient’s ward and in other affected areas of the hospital who did not implement appropriate precautions
• laboratory staff who directly handled clinical specimens from the case on an open bench (i.e. outside a biosafety cabinet and not to handling standards appropriate to a group 3 biological agent)
• domestic healthcare staff handling linen, clothing and other personal items of the case who did not implement appropriate precautions
• other diagnostic staff who had contact with the case while undergoing investigations such as clinical imaging who did not implement appropriate precautions
• Ambulance/Paramedical/First Responder staff, including ambulance and other paramedical staff who did not implement appropriate precautions
• Primary care staff if the case attended GP surgery

HCW contacts during the infectious period are classified on the basis of risk (exposure risk category):

• **Zero Risk (Cat 0):** Laboratory staff operating to recognised quality standards for handling specimens relating to a monkeypox case and other HCW with no known contact with a symptomatic monkeypox case in the last 21 days.

• **Low Risk (Cat 1):** HCW involved in care of monkeypox case not wearing appropriate PPE for contact > 1 metre from a case and has had no direct contact with contaminated objects

• **Intermediate Risk (Cat 2):** Unprotected exposure to a symptomatic monkeypox case, their body fluids or potentially infectious material or contaminated fomites

• **High Risk (Cat 3):** Unprotected direct contact or high risk environmental contact with a case, their body fluids or potentially infectious material (including clothing, personal bathroom/toileting belongings or bedding) without wearing appropriate PPE. This includes:
  - inhalation of droplets or dust from cleaning contaminated rooms
  - mucosal exposure to splashes
  - penetrating sharps injury from contaminated device or through contaminated gloves.

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3 In the UK, the only secondarily infected HCW was a member of a hospital’s domestic staff who is thought to have become infected from aerosolised lesion material contained in soiled hospital bed sheets.
**Appropriate PPE for HMI management** – should include:

- an impervious long-sleeved gown
- disposable Nitrile Gloves
- respiratory protection (FFP2/FFP3 respirator face mask), and
- eye protection (face shield or goggles) for all interactions that may involve contact with the patient or potentially contaminated areas in the patient’s environment.

Airborne precautions should be added if any [aerosol-generating procedures are to be undertaken](#). An initial risk assessment should be undertaken to determine if any modification of approach is required, and contacts assessed in terms of the necessary level of PPE as advised by the IPC Team.

For full details on PPE requirements [Interim Infection Prevention and Control Precautions for healthcare workers for Possible or Confirmed Monkeypox](#).

### 3.3. Community Contacts

An assessment should be undertaken by Public Health to identify potential community contacts. Such contacts are also classified on the basis of risk:

- **Zero Risk (Cat 0):** No known contact with symptomatic monkeypox case in last 21 days or passengers seated more than 3 rows from a case on plane, or community face to face contacts
- **Low Risk (Cat 1):** Community contact <3 hours and <2 metres from a symptomatic case or passengers seated within 3 rows of case on plane, except for passengers sitting directly next to the case on plane for 4-8h duration
- **Intermediate Risk (Cat 2):** Unprotected exposure to a symptomatic monkeypox case, their body fluids or potentially infectious material or contaminated fomites, prolonged continuous community face to face contact (3-6h <2 metres), or passengers seated directly next to case on plane for >8h duration
- **High Risk (Cat 3):** Unprotected direct contact or high risk environmental contact with a case, their body fluids or potentially infectious material (including on clothing, personal bathroom/toileting belongings or bedding). This includes:
Bed sharing contacts
- Close, physically intimate contacts
- Household contacts and
- Sexual contacts and other having close physical contact with the case. NB condom use during period of contact with case will not alter risk of transmission, or mean categorisation to a lower risk category.

3.4. Surveillance of Contacts

The levels of surveillance of HMI contacts are:

- **Passive Surveillance (Low Risk – Category 1):** This involves self-monitoring for the symptoms of HMI. It comprises twice daily temperature checks, and frequent self-monitoring for the appearance of symptoms for 21 days following last contact. The contact can continue to attend work and undertake normal social activities for the period of surveillance. Should symptoms develop, the contact should immediately exclude themselves from work and immediately alert a designated Public Health contact point and be referred for clinical assessment. Once symptoms are identified, they should abstain from sexual contact.

- **Active Surveillance (Intermediate Risk - Category 2):** This involves self-monitoring for the symptoms of HMI. It comprises twice daily temperature checks, and frequent self-monitoring for the appearance of symptoms for 21 days following last contact. The contact can continue to attend work and undertake normal social activities for the period of surveillance. Travel outside area of residence should be discussed with Public Health. The contact is contacted daily by a public health staff member to ensure absence of symptoms. If symptoms develop, the contact should immediately exclude themselves from work, self-isolate, and immediately alert their Public Health liaison and be referred for clinical assessment. Once symptoms are identified, they should abstain from sexual contact.

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4 Condom use will not protect against all sexual exposure
5 This will include sex workers who have had contact with the case
• **Active surveillance (High Risk - Category 3).** This too involves self-monitoring for the symptoms of HMI. The contact must check their temperature twice daily, and frequently monitor themselves for the appearance of symptoms. The contact is contacted daily by a public health liaison person to ensure absence of symptoms. The contact can continue to attend work and undertake normal social activities for the period of surveillance. Travel outside area of residence should be restricted. If symptoms develop, the contact should immediately exclude themselves from work, self-isolate, and immediately alert their Public Health liaison and be referred for clinical assessment. Once symptoms are identified, they should abstain from sexual contact.

Should a PHRA determine that a High Risk Contact should be considered for quarantine, such contacts should self-isolate at home for 21 days. For those contacts who are visiting Ireland and have no home address, alternative accommodation arrangements will be required. Category 2 and 3 Contacts should avoid contact with severely immunosuppressed people, pregnant women and children aged under 12, where possible, subject to an infection and Prevention Control or Public Health Risk Assessment, as appropriate.

All sexual contacts (Cat 3) of confirmed HMI cases should be advised to abstain from sexual intercourse/intimacy for a duration of 21 days from last contact.

### 4. Public Health Surveillance Actions

The contact under surveillance should be fully informed of the reasons for, and conditions surrounding surveillance.

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6 Certain Category 3 contacts may, on the basis of a PHRA, be considered to require quarantine for 21 days from the date of their last contact with the case, if the level of exposure, or other factors are considered such to significantly increase the risk of transmission.
• The contact should be informed of the case’s diagnosis, and why their exposure to the case has resulted in them requiring surveillance (monitoring will be a term more familiar to the contact).

• The contact should check their temperature twice daily with a digital thermometer. They should be familiarised with the main symptoms of HMI (outlined on the Contact Monitoring Form) and they should be provided with the 24/7 Public Health contact mobile phone number. They should keep this number safe and to hand.

• The Contact Monitoring Form should be completed on all contacts, and the contact provided with the Daily Monkeypox Contact Monitoring Chart, which they should use to document their twice daily temperature. This chart is intended to serve as an aide memoire to the contact to ensure they carry out their temperature checks.

• The contact should be encouraged to call their Public Health contact if they have any worries or concerns about their physical condition, or about surveillance.

• They should be advised to avoid close physical contact with young children, pregnant women and immunocompromised persons for the period of quarantine, where possible. If the contact’s household contains such people, a PHRA will be necessary to identify and manage the risk.

• All sexual contacts of HMI cases should abstain from sexual contact for the duration of surveillance.

• Contacts under active surveillance should be informed that their public health liaison will call them daily to ensure that they have not developed symptoms, and to answer any queries.

• Contacts in passive surveillance should be instructed to call their local public health contact if they develop symptoms.

• Contacts should be advised that if they do develop symptoms they should leave work, self-isolate at home (if possible), and limit their contacts.

• Should a PHRA determine that a High Risk Contact should be considered for quarantine, the contact should have the limitations imposed by the 21 days of quarantine explained:
  o They should not leave the house or attend work
  o They should not socialise outside the home
They should not have visitors to the home
- They should postpone all non-urgent hospital and other health appointments.
- They should not go shopping (they can organise grocery delivery or have relatives/friends undertake shopping for the contact, similar to what happened during the COVID-19 pandemic).

- Contacts should be reminded that the likelihood of their developing HMI is low and that if they do develop disease, most cases are mild and self-limiting.

5. Vaccination of Contacts

Vaccinia virus vaccine is partially protective against other Orthopoxviruses, and if administered within four days of infection, can prevent onset or modify the course of clinical disease. **ECDC recommends** that a ‘third generation’ smallpox vaccine - MVA-BN/Imvanex - can be offered as post exposure prophylaxis to contacts including:

- Healthcare workers caring for patients,
- First-line responders, and
- Individuals with close contact exposure to MPXV in outbreak settings (this should be guided by risk assessment on the basis of numbers of contacts and level of exposure risk).

Post-exposure prophylaxis (PEP) with Imvanex may be offered to high and intermediate risk contacts. Contacts should be evaluated for the need for PEP vaccination following risk assessment.

Use of PEP vaccination should be offered only after a careful benefit/risk ratio assessment, including the type and timing of last exposure, age group, medical history particularly regarding immune status and other underlying conditions that would indicate that they are at high risk for severe HMI. Consideration should be given to offering staff in specialist infectious disease units involved in the care of confirmed case-patients, preexposure prophylaxis with Imvanex.

**For full information on use of vaccination in the management of HMI**, see NIAC’s **Immunisation Guidelines**, Chapter 20a Smallpox (variola)/Monkeypox.
**NB:** Vaccinated contacts may develop vaccine reactions in the 48 hour post-vaccination that can mimic prodromal symptoms of HMI, and should be advised of this possibility (see EMA Product Sheet – Imvanex Smallpox Vaccine⁷).

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Appendix 1 – Instructions for Passive Monitoring

You recently came into for a patient who was diagnosed as having monkeypox. Monkeypox can be spread between people, but it is not easily spread. However, as it can be spread from person to person, people who had contact with this patient are being monitored to ensure that they do not develop monkeypox symptoms, as a precautionary measure. You can attend work as usual and undertake normal social activities. If your contact with the monkeypox case was sexual, we advise that you abstain from sexual intercourse for the period of your monitoring. Any non-essential medical or dental treatment including vaccination should be postponed. You have been given a Public Health contact number to use when you need to

However, it is important that for the 21 days following your contact with the patient, you monitor yourself for the early symptoms of monkeypox in the following ways:

1. **Check your temperature twice daily** - on getting up in the morning and during the evening. Use a digital thermometer and follow the maker’s instructions. Take your temperature in your mouth. Leave at least 20 minutes between taking exercise or consuming warm or cold drinks or food, and checking your temperature. You should record your temperature in the Contact Monitoring Chart you have been given. If you feel unwell at any time any way, please check your temperature.

2. **Monitor yourself for the earliest symptoms of monkeypox.** Check in with your body regularly. In particular, look out for:
   - Feverishness
   - Chills/shivering
   - Development of swollen glands (behind your ear, around the angle of your jaw, beneath your jaw, in your armpit, and in each groin)
   - Unusual fatigue/tiredness
   - Unusual/persistent headache
   - Cough/sore throat
   - Any skin rash

3. **If you become unwell** – if you develop a temperature of 38.5°C or more, or if you develop any of the above symptoms, call your local Public Health contact person immediately.

It is important to remember:

- Monkeypox is not very infectious
- You cannot pass monkeypox on to your family if you do not develop any symptoms and
- Even if you do develop symptoms of monkeypox, most cases are mild and self-limiting.

If at any stage you have any questions or concerns, please call your local Public Health contact person.
Appendix 2 – Instructions for Active Monitoring

You recently came in contact with a patient who had monkeypox. Monkeypox can be spread from person to person, but not easily. However, as it can be spread between people, anyone who had contact with the monkeypox patient is being monitored to ensure that they do not develop symptoms. You can attend work as usual and undertake normal social activities. You should avoid close physical contact with young children, pregnant women and immunocompromised persons for the period of monitoring. If your household contains such people, your Public Health contact person can advise you. If your contact with the monkeypox case was sexual, we advise that you abstain from sexual intercourse for the period of your monitoring. Any non-essential medical or dental treatment including vaccination should be postponed. Public Health contact person will call you every weekday for 21 days, to actively monitor your progress. **It is very important that you monitor yourself** for the early symptoms of monkeypox in the following ways:

1. **Check your temperature twice daily** - on getting up in the morning and during the evening. Use a digital thermometer and follow the maker’s instructions. Take your temperature in your mouth. Leave at least 20 minutes between taking exercise or consuming warm or cold drinks or food, and checking your temperature. You should record your temperature in the Contact Monitoring Chart you have been given. If you feel unwell in any way, please check your temperature.

2. **Monitor yourself for the earliest symptoms of monkeypox.** Check in with your body regularly. In particular, look out for:
   - Feverishness
   - Chills/shivering
   - Development of swollen glands (behind your ear, around the angle of your jaw, beneath your jaw, in your armpit, and in each groin)
   - Unusual fatigue/tiredness
   - Cough/Sore Throat
   - Any skin rash

4. **If you become unwell** – if you develop a temperature of 38.5°C or more, or if you develop any of the above symptoms, call your local Public Health contact person immediately. If you feel very unwell then you should seek medical attention. In the case of an emergency call 112/999 and tell them that you have had contact with a case of monkeypox.

It is important to remember:

- Monkeypox is not very infectious
- You cannot pass monkeypox on to your family if you do not have any monkeypox symptoms, and
- Even if you do develop symptoms of monkeypox, most cases are mild and self-limiting.

If at any stage you have any questions or concerns, please call your local Public Health contact person.
Appendix 3 – Instructions for Quarantine/Active Surveillance

You recently came in contact with a patient who had monkeypox. Monkeypox can be spread from person to person, but not easily. However, as it can be spread between people, anyone who had contact with the monkeypox patient is being monitored to ensure that they do not develop monkeypox symptoms. As you had close contact with this patient, you should quarantine at home for 21 days since your last contact. This means that you should not attend work, or undertake your normal social activities or go shopping. You should avoid as far as possible close physical contact with young children, pregnant women and immunocompromised people for the period of quarantine. If your household contains such people, your Public Health contact person can advise you. If your contact with the monkeypox case was sexual, we advise that you abstain from sexual intercourse for the period of your quarantine.

Any non-essential medical or dental treatment including vaccination should be postponed. Your Public Health contact person will call you every day for 21 days, to actively monitor your progress. It is very important that you monitor yourself for the early symptoms of monkeypox in the following ways:

1. **Check your temperature twice daily** - on getting up in the morning and during the evening. Use a digital thermometer and follow the maker’s instructions. Take your temperature in your mouth. Leave at least 20 minutes between taking exercise or consuming warm or cold drinks or food, and checking your temperature. You should record your temperature on the Contact Surveillance Chart you have been given. If you feel unwell in any way, please check your temperature.

2. **Monitor yourself for the earliest symptoms of monkeypox.** Check in with your body regularly. In particular, look out for:
   - Feverishness
   - Chills/shivering
   - Development of swollen glands (behind your ear, around the angle of your jaw, beneath your jaw, in your armpit, and in each groin)
   - Unusual fatigue/tiredness
   - Cough/Sore Throat
   - Any skin rash

3. **If you become unwell** – if you develop a temperature of 38.5°C or more, or if you develop any of the above symptoms, call your local Public Health contact person immediately. If you feel very unwell then you should seek medical attention. In the case of an emergency call 112/999 and tell them that you have had contact with a case of monkeypox.

It is important to remember:
   - Monkeypox is not very infectious
   - You cannot pass monkeypox on to your family if you do not have any monkeypox symptoms, and
   - Even if you do develop symptoms of monkeypox, most cases are mild and self-limiting.

If at any stage you have any questions or concerns, please call your local Public Health contact person.
Appendix 5: Human Monkeypox Infection Case Definition

See [here](#) for the Interim Monkeypox Case Definition