Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

June 10, 2022

DEPARTMENT MEMORANDUM
No. 2022 - 0291

FOR: **ALL DIRECTORS OF THE CENTERS FOR HEALTH DEVELOPMENT, MINISTER OF HEALTH - BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO (MOH-BARMM), CHIEFS OF DOH HOSPITALS, ATTACHED AGENCIES, LOCAL HEALTH SYSTEMS DIVISION CHIEFS, AND OTHERS CONCERNED**

SUBJECT: **Additional Interim Guidance on the Management of Monkeypox**

I. RATIONALE

Last May 2022, the World Health Organization reported multiple cases of Monkeypox were identified in several non-endemic countries. Global studies are currently underway to further understand the epidemiology, sources of infection, and transmission patterns of this re-emerging disease. Currently, the country has no registered case of Monkeypox, and has initiated stricter border controls for incoming travelers and importation of animals (e.g., primates and rodents) from affected countries.

On May 24, 2022, the Department of Health (DOH) issued the Department Memorandum (DM) No. 2022-0220 entitled *"Interim Technical Guidelines for the Implementation of Monkeypox Surveillance, Screening, Management, and Infection Control"*. In response to the rapidly evolving international guidance on Monkeypox, this additional interim guidance is being issued as a supplement in order to provide a detailed guide for the local government units (LGUs) and DOH offices in responding to Monkeypox cases, particularly in terms of clinical recognition and management, isolation and quarantine protocols, infection prevention control measures, and referral of cases at all levels of healthcare.

II. CLINICAL RECOGNITION OF MONKEYPOX

A. Transmission Routes and Risk for Infection

1. Monkeypox virus can be transmitted through the following routes:
    a) Direct transmission through the following:
    b) Human-to-human: direct contact with infectious sores, scabs, or body fluids, including during intimate activities such as sex, kissing, cuddling, or

touching parts of the body with Monkeypox sores.

c) The current multi-country outbreak suggests that those who are at highest risk for infection are people who have had close physical contact with individuals with Monkeypox who are symptomatic.

d) It is not yet known whether the virus can be transmitted through semen or vaginal fluid.

e) Animal to human (zoonotic transmission): has been reported from bite or scratch, direct contact with the skin lesions, blood, tissue or excretions of infected animals, consumption of infected meat.

2. Indirect transmission through the following:
   a) Inhalation of infected respiratory droplets, usually occurring during prolonged face-to-face contact
   b) Contact with contaminated materials or fomites (e.g. contaminated bedding, clothing, linen)
3. Placental transmission can occur, leading to congenital Monkeypox.
4. The prevalence of asymptomatic transmission is unknown.

B. Clinical Presentation and Evolution of Monkeypox Infection

1. All healthcare workers shall be aware of the clinical evolution of Monkeypox.
2. Monkeypox infection occurs in several phases, specifically:
   a) Incubation Period: The incubation period lasts 7-14 days. The patient is asymptomatic during this period and is not contagious.

   b) Prodromal Phase: During the prodromal phase, the patient develops nonspecific constitutional signs and symptoms such as fever, headache, malaise, back pain, and lymphadenopathies, which can be unilateral, bilateral, regional, or generalized. Other flu-like symptoms such as chills, sore throat, nausea, vomiting, and a nonproductive cough may occur. A patient experiencing prodromal symptoms may be contagious.

   c) Rash or Cutaneous Phase: The rash or cutaneous phase follows shortly after the prodromal phase (usually in 4 days):
      (i) The lesions may occur in the palms, soles, genital, and anal areas.
      (ii) The lesions are generally painful until scabs form or crusting occurs, when they become pruritic.
      (iii) A patient with rash is contagious until all scabs have crusted and fallen off, which can occur in 14 - 21 days after symptom onset.

      Complications such as secondary bacterial infection, conjunctivitis, dehydration from nausea and vomiting, and pneumonia, may occur.

   d) Recovery phase: This usually occurs 14-21 days after onset of symptoms and patients are already considered non-infectious. Lesions begin to scab and heal which may eventually leave to residual scarring.

C. Screening for Symptoms and Exposure

1. Primary care providers shall observe a high index of suspicion for Monkeypox when evaluating people with macular, vesiculo-papular, or pustular rashes, particularly in the following groups:
   a. People reporting contact with people who have a similar rash or who have received a diagnosis of suspected or confirmed Monkeypox;
   b. People reporting sexual contact with the same sex or with multiple partners, and are presenting with lesions in the genital/perianal area or any other part of the body; and
   c. People reporting a significant travel history in the month before illness onset.

2. Primary care providers shall elicit signs and symptoms of Monkeypox infection during history-taking and physical examination, including:
   a. Fever, chills, myalgia, back pain, asthenia, or lymphadenopathy;
   b. Skin lesions such as vesicles or pustules that are deep-seated, firm, or hard, well-circumscribed, and usually located on the head, palms, and soles. The rash associated with Monkeypox may be confused with other diseases that are more commonly encountered in clinical practice (e.g., secondary syphilis, herpes, chancroid, and varicella-zoster);
   c. Lesions that umbilicate or become confluent and progress over time to scabs.
   d. Presence of atypical manifestations such as:
      i. Initial appearance of the characteristic rash in the genital and perianal areas;
      ii. Localized rash and lack of spread of the rash to other parts of the body;
      iii. Mild or non-existent prodromal symptoms

3. Primary care providers shall be familiar with the manifestations of Monkeypox compared to other infectious diseases presenting with rashes, including Chickenpox or Varicella. The comparison between Monkeypox and Chickenpox can be found in **ANNEX A.**

4. After initial assessment, primary care providers shall classify patients based on the set case definitions of Monkeypox as shown in **ANNEX B** and shall facilitate the collection and transport of specimens as per provisions stated in DM No. 2022-0220.

5. Patients should be thoroughly assessed based on both clinical and epidemiological factors. Other potential causes of discrete skin lesions or disseminated rash shall also be considered by collecting sufficient volume of samples to accommodate differential testing (e.g., varicella, hand foot and mouth disease, etc.). Negative results from these tests, accompanied by a clinical impression that MOST likely meets the case definition for a suspected case shall prompt the healthcare provider to request for Monkeypox testing.

III. MANAGEMENT OF CASES

A. Isolation Protocols based on Case Classification

1. Primary care providers shall determine the appropriate level of isolation for suspect, probable and confirmed cases (as defined in **ANNEX B)**, according to the patients' characteristics and the availability of the appropriate facility.
   a. Suspected or probable cases shall undergo isolation while awaiting the results of confirmatory tests.
   b. Suspected and probable cases who are eventually reclassified as discarded cases after negative confirmatory testing shall be managed according to the clinical impression of the healthcare provider.

2. The recommended criteria for determining the appropriate facility for isolation are as follows: **(ANNEX C)**
   a. Home isolation for stable patients who are capable of self-care or who have an able-bodied caregiver at home if needing assistance for activities of daily living (ADLs);
   b. Community-based facility isolation for i) stable patients who are not capable of self-care or who have no able-bodied caregiver at home if needing assistance for ADLs, and ii) for stable patients at risk of severe disease as shown in **ANNEX D** (e.g. immunocompromised, pediatric population, pregnant or breastfeeding women); and
   c. Hospital isolation for i) patients with severe disease, complications, or lesions located at anatomic areas that constitute a special hazard (e.g. eyes, mouth, genitals, anus), ii) patients with any other concurrent condition or comorbidity requiring hospitalization, and iii) clinically unstable patients.

3. All individuals in isolation shall be regularly followed-up and monitored by a healthcare provider. The progression of symptoms or the development of signs and symptoms that indicate severe disease (e.g. confluent lesions, hemorrhagic lesions, signs of sepsis, signs of encephalitis including altered sensorium, cough and difficulty of breathing that may herald bronchopneumonia) or complications (e.g. secondary bacterial skin infection, gastroenteritis with severe nausea/vomiting, dehydration) shall prompt coordinated transfer from home or facility isolation to a hospital with isolation capacity.

4. Healthcare providers shall determine the end of isolation or de-isolation and discharge, depending on the clinical status of the patient, and the fulfillment of clinical, lesion, and laboratory-based criteria. The criteria for de-isolation and discharge are shown in **ANNEX E**.

5. Healthcare providers should advise all patients with confirmed Monkeypox to abstain from sexual activities until **ALL** skin lesions have crusted, the scabs have fallen off, and a fresh layer of skin has formed underneath.

6. Healthcare providers should advise all patients with confirmed Monkeypox to observe consistent use of condoms during sexual activity (e.g., receptive and insertive oral/anal/vaginal) for 12 weeks **post recovery** to prevent potential transmission.

B. Home and Community Based Isolation and Quarantine Requirements

1. Accommodations
   a. Separate bedroom - no vulnerable person (e.g., immunocompromised individuals, children, pregnant and breastfeeding women) in the household

b. Cohorting of patients (confirmed with confirmed, suspected with suspected), provided that a minimum of 1-meter distance is maintained between patients, can be implemented if single rooms are not available
c. In non-domestic residential settings (e.g. prisons, custodial facilities, residential care facilities, custodial healthcare facilities), asymptomatic close contacts shall be managed in a single room with separate toilet facilities where possible

2. Site requirements
   a. Electricity, potable water, cooking source
   b. Accessible bathroom with toilet and sink, if possible, separate from family (if not available, disinfect bathroom after use)
   c. Solid waste and sewage disposal (Please refer to the Revised Implementing Rules and Regulations of Chapter XVII "Sewage Collection and Disposal, Excreta Disposal" PD 856 Code on Sanitation of the Philippines)
   d. Well-ventilated room with functioning doors and windows

2. Resource for patient care and support
   a. Line of communication for family and health workers
   b. A primary caregiver who will remain in the residence (not high risk for complications and educated on proper precautions)
   c. Family health plan and instructions to caregivers
   d. Masks, tissues, hand hygiene products
   e. Non-permeable occlusive dressings
   f. Digital thermometer (disinfected before and after use)
   g. Medications for pre-existing conditions and symptomatic treatment, as needed
   h. Psychosocial support materials or proposed activities during isolation,
   i. Meal preparation
   j. Household cleaning products

3. Human Resource
   a. Isolation facilities shall be staffed by healthcare workers and health facility staff
   b. Quarantine facilities may opt not to have a medical personnel

C. Household and Facility-Based Care

1. General Precautions on Sanitation
   a. Proper hand hygiene (i.e. hand washing with soap and water or use of an alcohol-based hand rub) by infected persons and household contacts after touching lesion material, clothing, linens, or environmental surfaces that may have had to contact with lesion material;
   b. Activities such as dry dusting, sweeping, or vacuuming shall be avoided as they may aerosolize the virus. Wet cleaning methods are preferred.
   c. Laundry (e.g., bedding, towels, clothing) may be washed in a standard washing machine with warm water and detergent; bleach may be added but is not necessary;

i. Items of potentially infected clothing or linen shall be placed in a water-soluble (alginate) bag, sealed or tied and placed inside an impermeable bag for transport to the laundry facility;

ii. Gloves and masks shall be worn when handling soiled laundry to avoid direct contact with contaminated material;

iii. Soiled laundry shall not be shaken or otherwise handled in a manner that may disperse infectious particles;

d. Dishes and other eating utensils shall not be shared. Soiled dishes and eating utensils shall be washed in a dishwasher or by hand with water and soap;

e. Contaminated surfaces shall be cleaned and disinfected. Standard household cleaning/disinfectants may be used in accordance with the manufacturer's instructions or a 1:100 dilution of household sodium hypochlorite (bleach). Disinfecting surfaces using FDA-registered and approved standard household cleaning materials.

2. Personal Protective Equipment

a. All persons who are suspected, probable, or confirmed to have Monkeypox shall wear a medical-grade/well-fitted surgical mask. Patients shall also be encouraged to wear a long-sleeved gown or outfit/clothing that ideally covers all lesions.

b. Medical grade masks are recommended for use by vulnerable populations (elderly, with comorbidities, immunocompromised), all persons with any symptoms suggestive of Monkeypox, and the general population in high transmission risk settings based on their community risk or nature of work.

D. In-patient Care

1. Personal Protective Equipment

a. Healthcare workers caring for suspect, probable, or confirmed Monkeypox patients, and for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment, shall wear the appropriate PPE as follows:

i. Long-sleeved, fluid-repellent, disposable gown

ii. Disposable gloves

iii. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face)

iv. NIOSH-approved N95 filtering facepiece or equivalent, or higher-level respirator, ideally fit-tested.

b. Appropriate PPE shall be used in performing activities such as cleaning and disinfection.

2. Observe Transmission Based Precautions in addition to Standard Precautions. Monkeypox virus can be transmitted by more than one route: contact, droplet and even common vehicle transmission. Thus, additional precautions beyond Standard

Precautions are necessary such as Transmission Based Precautions especially in hospitals. These are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens. For Monkeypox cases, combinations of Transmission Based Precautions are to be used. Although there is insufficient information recommending the continuous use of airborne precautions and being a minor form of transmission for Monkeypox, airborne precautions shall be implemented in the performance of aerosol-generating procedures (AGPs). (See **ANNEX F**).

E. Treatment Protocols

1. Treatment for Monkeypox is mainly supportive and is directed at relieving symptoms such as fever, body malaise, and exhaustion. Use of antipyretics, anti-inflammatory, and non-steroidal anti-inflammatory drugs (NSAIDS) may be warranted. Increased oral fluid intake may also be beneficial.

2. Currently, no anti-viral or immune globulin treatments have been locally approved and authorized for the treatment of Monkeypox by the FDA. Existing processes and requirements of the FDA and HTAC shall be followed in the evaluation and prior to procurement of antiviral therapies for Monkeypox.

   Meanwhile, varicella and/or shingles vaccines are recommended based on currently approved indications but are not protective against monkeypox.

3. Supportive treatment of skin lesions shall be provided to patients to relieve discomfort, hasten the healing and prevent complications.

4. Treatment with antibacterials is indicated only for those with superimposed or secondary bacterial infections of the skin, eyes, or mucosal lesions. Similarly, antibacterials for the treatment of pneumonia should only be initiated when there is a suspicion of bacterial infection such as that by *Staphylococcus aureus*. Treatment with antibiotics shall be guided by a licensed physician.

5. Treatment of complications (e.g. pneumonia, sepsis, encephalitis, dehydration) shall be provided according to existing clinical guidelines or standards of care.

6. Provision of adequate nutrition and appropriate rehydration shall follow nutritional and fluid status assessment.

IV. MANAGEMENT OF CONTACTS

A. Quarantine. Quarantine of close contacts shall be as follows, based on their respective exposure risk categories as shown in **ANNEX G. The exposure risk of healthcare workers can be assessed using the algorithm in ANNEX H.**

1. **High-risk contacts** of a confirmed case are required to undergo quarantine for 21 days from the date of exposure. They shall undergo active surveillance.

2. **Intermediate-risk contacts** of a confirmed case are **not** required to undergo quarantine but shall observe the following precautions for 21 days from the last exposure:
   a. Avoid contact with immunosuppressed people, pregnant women, and children;
   b. Exclude self from work or consider an alternative working arrangement (AWA) for 21 days if work involves contact with immunosuppressed people, pregnant women, and children;
   c. Avoid travel except for medical reasons and remain close to home for the duration of surveillance;
   d. Continue to observe MPHS;
   e. Isolate and be tested if symptoms develop.

   They shall undergo active surveillance.

3. **Low-risk contacts** of a confirmed case are **not** required to undergo quarantine but shall continue to observe MPHS. They shall isolate and be tested if symptoms develop. They shall undergo passive surveillance.

B. Post Exposure Vaccination

1. If available, vaccines shall be pre-positioned and prioritized for populations in need for post-exposure prophylaxis, specifically those with high and intermediate exposure risk to the index case, such as the following. Specific examples are provided in **ANNEX G.**

Table 1. Contacts Prioritized for Post-Exposure Vaccination

Exposure Risk Category	Description of Exposure
HIGH RISK	**Unprotected direct contact or high-risk environmental contact** such as: **Direct exposure** of **broken skin or mucous membranes** to a confirmed, symptomatic Monkeypox case, their body fluids or potentially infectious material (including clothing or bedding) **without wearing appropriate PPE*** *OR* **Penetrating sharps injury** (including cleaning or laboratory staff)
INTERMEDIATE OR MEDIUM RISK	**Unprotected exposure to infectious materials including droplet or airborne potential route** such as: **Intact skin-only contact** with a symptomatic Monkeypox case, their body fluids or potentially infectious material or contaminated fomite *OR* No direct contact but **within 1 meter** of symptomatic Monkeypox case **without wearing appropriate PPE** *OR* Passengers seated **directly next** to case on plane

2. Notwithstanding available developments on vaccines, post-exposure vaccination is not recommended for contacts with low-risk exposures and for the general population.

For dissemination.

By Authority of the Secretary of Health:

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Undersecretary of Health
Public Health Services Team

ANNEX A. CLINICAL FEATURES OF MONKEYPOX VERSUS CHICKENPOX

Clinical Features	Monkeypox	Chickenpox
Systemic Signs and Symptoms	Fever, headache, myalgia, back pain, asthenia Other flu-like symptoms (e.g. nonproductive cough) **Lymphadenopathy**, can be unilateral or bilateral *(distinguishing sign from smallpox and chickenpox)*	Fever, malaise, anorexia, headache Lymphadenopathy not common
Typical Sequence of Rash	Enanthem (tongue, mouth) → macular → papular → vesicles and pustules→umbilication, scabbing, and desquamation	Macular → papular → vesicular lesions → pustules → crusting
Synchronicity of Rash	Locally synchronous (lesions at a particular area are of the same stage)	Asynchronous: all stages of development are present at the same time
Rash Distribution	Centrifugal (more abundant on face, extremities than on trunk)	Centripetal (more abundant on trunk than on face, extremities)
Other rash characteristics	Typically painful Becomes pruritic once scabs form Slower progression	Typically pruritic Rapid progression

Sources:
US Centers for Disease Prevention and Control. (2018). *Monkeypox.* https://www.cdc.gov/poxvirus/Monkeypox/clinicians/clinical-recognition.html
US Centers for Disease Prevention and Control. (2021). *Chickenpox (Varicella).* https://www.cdc.gov/chickenpox/hcp/index.html#features
Freer, G., & Pistello, M. (2018). Varicella-zoster virus infection: natural history, clinical manifestations, immunity and current and future vaccination strategies. The *New Microbiologica*, 41(2), 95–105. 95.pdf (newmicrobiologica.org)

ANNEX B. CASE AND CONTACT DEFINITIONS FOR MONKEYPOX

Case Classification	Case Definition
Suspected Case	1. A person of any age presenting with an unexplained acute rash **AND** 2. One or more of the following signs or symptoms: a. Headache; b. Acute onset of fever (>38.5°C); c. Myalgia; d. Back pain; e. Asthenia; f. Lymphadenopathy; **AND** 3. For which the following common causes of acute rash do not explain the clinical picture: varicella zoster, herpes zoster, measles, herpes simplex, bacterial skin infections, disseminated gonococcal infection, primary or secondary syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, molluscum contagiosum, allergic reaction (e.g., to plants); and any other locally relevant common causes of papular or vesicular rash. As per WHO, it is <u>not necessary</u> to obtain negative laboratory results for listed common causes of rash illness in order to classify a case as suspected.
Probable Case	A person meeting the case definition for a suspected case **AND** One or more of the following: • has an epidemiological link (face-to-face exposure, including health care workers without respiratory protection; direct physical contact with skin or skin lesions, including sexual contact; or contact with contaminated materials such as clothing, bedding or utensils) to a probable or confirmed case of Monkeypox in the 21 days before symptom onset; • reported travel history to a Monkeypox endemic country in the 21 days before symptom onset; • has had multiple sexual partners in the 21 days before symptom onset; • is hospitalized due to the illness.
Confirmed Case	A case meeting the definition of either a suspected or probable case and is laboratory confirmed for Monkeypox virus by detection of unique sequences of viral DNA either by real-time polymerase chain reaction (PCR) and/or whole genome sequencing.
Discarded Case	A case meeting the definition of either a suspected or a probable case but laboratory testing of lesion fluid, skin specimens or crust by PCR and/or WGS is negative for Monkeypox. **Negative oropharyngeal swab (OPS) samples do not rule out Monkeypox*

ANNEX C. RECOMMENDED CRITERIA FOR HOME, FACILITY-BASED OR HOSPITAL-BASED CARE OF PATIENTS WITH SUSPECTED, PROBABLE, AND CONFIRMED MONKEYPOX

Patient Characteristics	Home Isolation[a]	Facility-based Isolation[b]	Admission to a hospital
Stable patient capable of self-care or with an able-bodied caregiver if needing assistance for ADLs	YES	YES	NO
Stable patient not capable of self-care or without an able-bodied caregiver if needing assistance for ADLs	NO	YES[c]	NO
Stable patient at risk of severe disease (e.g. immunocompromised, pediatric population, pregnant or breastfeeding women)	NO	YES[d]	YES
Patient with severe disease (e.g. hemorrhagic disease, confluent lesions, sepsis, encephalitis, or other conditions requiring hospitalization), complications (e.g. secondary bacterial skin infection; gastroenteritis with severe nausea/vomiting, diarrhea, or dehydration; bronchopneumonia; concurrent disease or other comorbidities requiring hospitalization), or lesions located at anatomic areas that constitute a special hazard (e.g. eyes, mouth, genitals, anus)	NO	NO	YES
Any **clinically** unstable patient	NO	NO	YES

Abbreviation: ADLs - activities of daily living

[a]Minimum requirements for home isolation include a separate, well-ventilated room, preferably with their own toilet and bathroom. There should also be an oversight from a health professional or a local government unit. standard, contact, droplet, and airborne precautions should be maintained (DC 2022-0002; DM 2020-0090; UK HSE 2022)

[b]Facility with electricity, potable water, cooking source, solid waste, and sewage disposal measures, where they are provided their own well-ventilated rooms (at least with more than 3 feet or 1 meter of separation between patients) with a lavatory inside, and adequately staffed. A negative pressure room is not required, but standard, contact, droplet, and airborne precautions should be maintained (JAO 2020-0001; UK HSE 2022)

[c]This would depend on the availability of the staff in the facility. Should admission in the facility is not possible due to manpower concerns, it is the responsibility of the isolation facility to ensure the continuity of care by referring to other isolation facilities as necessary.

[d]The isolation facility should have the infrastructure and resources needed for care, has adequate personnel who can constantly monitor the patient, and is able to immediately refer to a higher-level facility if specialized care is needed.

Definitions of severe disease and risk of severe disease adapted from: US Centers for Disease Control and Prevention. (2022, May 26). *Interim Clinical Guidance for the Treatment of Monkeypox.* https://www.cdc.gov/poxvirus/Monkeypox/treatment.html

ANNEX D. CLINICAL FEATURES OF PATIENTS AT RISK OF SEVERE DISEASE AND PATIENTS WITH SEVERE DISEASE

Patients at risk of severe disease	Patients with the following conditions may be at risk for severe disease: • Immunocompromised individuals (e.g., human immunodeficiency virus/acquired immune deficiency syndrome infection, leukemia, lymphoma, generalized malignancy, solid organ transplantation, therapy with alkylating agents, antimetabolites, radiation, tumor necrosis factor inhibitors, high-dose corticosteroids, being a recipient with hematopoietic stem cell transplant <24 months post-transplant or ≥24 months but with graft-versus-host disease or disease relapse, or having autoimmune disease with immunodeficiency as a clinical component) • Pediatric populations, particularly patients younger than 8 years of age • Pregnant or breastfeeding women • Persons with one or more complications (e.g., secondary bacterial skin infection; gastroenteritis with severe nausea/vomiting, diarrhea, or dehydration; bronchopneumonia; concurrent disease or other comorbidities)
Patients with severe disease	The following are manifestations of severe disease: • Hemorrhagic disease • Confluent lesions • Sepsis • Encephalitis • Other conditions requiring hospitalization
Definitions of severe disease and risk of severe disease adapted from: US Centers for Disease Control and Prevention. (2022, May 26). *Interim Clinical Guidance for the Treatment of Monkeypox.* https://www.cdc.gov/poxvirus/Monkeypox/treatment.html	

ANNEX E. DE-ISOLATION CRITERIA AND RECOMMENDED ACTIONS STRATIFIED ACCORDING TO ISOLATION LOCATION

<table>
<tr><th colspan="2">Location of Isolation</th><th>De-isolation Criteria</th><th>Recommended Actions</th></tr>
<tr><td colspan="2">Home</td><td>Clinical* AND Lesion Criteria+ are met</td><td rowspan="3">Full de-isolation - may resume normal activities</td></tr>
<tr><td colspan="2">Isolation Facility</td><td>Clinical* AND Lesion Criteria+ are met</td></tr>
<tr><td rowspan="3">Hospital</td><td rowspan="2">All reasons for hospitalization have been resolved</td><td>Clinical* AND Lesion Criteria+ are met</td></tr>
<tr><td>Only Clinical* OR Lesion Criteria+ are met</td><td>May be discharged but continue home or facility isolation</td></tr>
<tr><td>The patient has improved but still needs hospitalization due to medical reasons</td><td>Clinical*, Lesion Criteria+ AND Laboratory Criteria^ are met</td><td>Full de-isolation
May be transferred to a regular (non-isolation) area/room</td></tr>
<tr><td colspan="2"></td><td>Only 1 or 2 out of 3 criteria are met</td><td>Maintain on isolation until all criteria are met</td></tr>
</table>

***Clinical Criteria:** The patient is judged clinically well enough for safe de-isolation as judged by the clinical team managing the patient.

+ Lesion Criteria: There have been no new lesions for 48 hours AND there are no mucous membrane lesions AND all lesions have crusted over, all scabs have dropped off, and intact skin remains underneath

^ Laboratory Criteria: The patient is MPX PCR-negative on these samples: throat swab, urine, EDTA blood (if no blood sample was sent previously because the patient remained well throughout admission, this sample may be omitted from the laboratory criteria)

Note: Clinical and lesion criteria should be thoroughly assessed by the patient's healthcare provider. The healthcare provider should regularly follow-up and monitor the patient during the entire duration of isolation.

Criteria adapted from: UK Health Security Agency [UKHSA]. (2022, May 30). *De-isolation and discharge of Monkeypox-infected patients: interim guidance.* https://www.gov.uk/guidance/de-isolation-and-discharge-of-Monkeypox-infected-patients-interim-guidance

ANNEX F. TRANSMISSION-BASED PRECAUTIONS TO BE USED FOR MONKEYPOX CASES

Types of Transmission Based Precaution	Description of the Mode of Transmission	Actions to be Taken
1. Droplet precaution	• Droplet precautions refer to avoidance of contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 um in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. • Droplets are generated primarily during coughing, sneezing, or talking and during the performance of certain procedures such as suctioning and bronchoscopy. • Transmission via large-particle droplets requires close contact between source and recipient persons.	• **Source control:** In addition to hand hygiene, fully cover eyes, nose and mouth with a well-fitted mask, goggles or face shield. • **For appropriate patient placement** please refer to Annex C on the recommendations for Home-, Facility-, and Hospital-based Care • **Appropriate use of PPE:** Don mask upon entry into the patient room or patient space. • **Limit transport and movement of patients** outside of the room to medically-necessary purposes. If transport or movement outside of the room is necessary, instruct the patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette.
2. Contact precaution	• Contact precautions apply to specified patients known or suspected to be infected or colonized (presence of microorganism in or on patient but without clinical signs and symptoms of infection) with epidemiologically important microorganisms that can be transmitted by direct or indirect contact.	• **For appropriate patient placement** please refer to Annex C on the recommendations for Home-, Facility-, and Hospital-based Care • **Appropriate use of PPE:** In addition to hand hygiene, use disposable gown and gloves before room entry and discard before room exit. • **Use dedicated or disposable equipment.** Clean and disinfect
a. Direct-contact transmission	• Involves skin-to-skin contact and physical transfer of microorganisms to a	

Types of Transmission Based Precaution	Description of the Mode of Transmission	Actions to be Taken
	susceptible host from an infected or colonized person, such as occurs when personnel turn patients, bathe patients, or perform other patient-care activities that require physical contact. • Can also occur between two patients (e.g., by hand contact), with one serving as the source of infectious microorganisms and the other as a susceptible host.	reusable equipment before use on another person. • **Limit transport and movement of patients** outside of the room to medically-necessary purposes. When transport or movement is necessary, cover or contain the infected or colonized areas of the patient's body. Remove and dispose of contaminated PPE and perform hand hygiene prior to and after transporting patients. Don clean PPE to handle the patient at the transport location. • **Prioritize cleaning and disinfection of the rooms** of patients on contact precautions, ensuring rooms are frequently cleaned and disinfected (e.g., at least daily or prior to use by another patient if at the outpatient setting), focusing on frequently-touched surfaces and equipment in the immediate vicinity of the patient.
b. Indirect-contact transmission	• Involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment.	
3. Airborne precautions	• Occurs by dissemination of either airborne droplet nuclei (small-particle residue {5 um or smaller in size} of evaporated droplets that may remain suspended in the air for long periods of time) or dust particles containing the infectious agent.	• Source control: put a mask on the patient. • **For appropriate patient placement** please refer to Annex C on the recommendations for Home-, Facility-, and Hospital-based Care • Appropriate use of PPE: Fit-tested NIOSH-approved N95 or higher level respirator for healthcare personnel.

Types of Transmission Based Precaution	Description of the Mode of Transmission	Actions to be Taken
		• Limit transport and movement of patients outside of the room to medically-necessary purposes. If transport or movement outside an AIIR is necessary, instruct patients to wear a surgical mask, if possible, and observe Respiratory Hygiene/Cough Etiquette. Healthcare personnel transporting patients who are on Airborne Precautions do not need to wear a mask or respirator during transport if the patient is wearing a mask and infectious skin lesions are covered.

ANNEX G. EXPOSURE RISK CATEGORIES OF CONTACTS AND MANAGEMENT

Exposure Risk Category of Contacts[1]	Description of Exposure	Management			
		Post-exposure Vaccination	Quarantine	Testing	Surveillance
HIGH RISK	**Unprotected direct contact or high-risk environmental contact** such as: **Direct exposure** of **broken skin or mucous membranes** to a confirmed, symptomatic Monkeypox case, their body fluids or potentially infectious material (including clothing or bedding) **without wearing appropriate PPE**[2] *OR* **Penetrating sharps injury** (including cleaning or laboratory staff) Examples: • Healthcare setting: ○ Body fluid in contact with eyes, nose, or mouth ○ Penetrating sharps injury from used needle ○ Contact in room during aerosol-generating procedure (AGP) without appropriate respiratory PPE ○ Changing a patient's bedding without appropriate PPE • Household or Community setting: ○ Body fluid in contact with eyes, nose, or mouth ○ Sexual or intimate contact ○ Household contact: sharing a residence with a person who has been diagnosed with Monkeypox and spending at least one night in the residence during the period when the case is infectious	Yes	Yes, 21 days If symptoms (prodromal symptoms or rash) develop, isolate	Yes, if symptoms develop	Active monitoring
INTERMEDIATE OR MEDIUM RISK	**Unprotected exposure to infectious materials including droplet or airborne potential route** such as: **Intact skin-only contact** with a symptomatic Monkeypox case, their body fluids or potentially infectious material or contaminated fomite *OR* No direct contact but **within 1 meter** of symptomatic Monkeypox case **without wearing appropriate PPE** *OR* Passengers **seated directly next** to case on plane Examples: • Healthcare setting: ○ Clinical examination of patient before diagnosis without appropriate PPE	Yes	No, but patient should adhere to the following: • Avoid contact with immunosupressed people, pregnant women and children • Exclude from work or consider alternative working arrangement (AWA) for 21 days if work involves contact with immunosuppressed people, pregnant women,	Yes, if symptoms develop	Active monitoring

Exposure Risk Category of Contacts[1]	Description of Exposure	Management			
		Post-exposure Vaccination	Quarantine	Testing	Surveillance
	○ Entering patient's room without wearing appropriate PPE and within 1 meter of the case ○ Subsequent patients in consulting room after a confirmed case was seen and prior to room cleaning ○ Spillage or leakage of laboratory specimen onto intact skin • Community setting: ○ Driver and passengers in shared car or taxi with case • Plane setting: ○ Passenger seated directly adjacent to a case		and children • Avoid travel except for medical reasons and remain close to home for the duration of surveillance • Observe minimum public health standards • If symptoms (prodromal symptoms or rash) develop, isolate		
LOW RISK	**<u>Protected physical contact or droplet exposure OR no physical contact, unlikely droplet exposure</u>** 1. **<u>Protected physical contact or droplet exposure</u>** such as: **Not** high or intermediate risk but contact with confirmed Monkeypox case or an environment contaminated with Monkeypox while **wearing appropriate PPE (with no known breaches)** Examples: • Healthcare setting: ○ Healthcare staff working in an infectious disease unit wearing appropriate PPE ○ Person undertaking decontamination of rooms where a confirmed case has stayed, while wearing appropriate PPE 2. **<u>No physical contact, unlikely droplet exposure</u>** such as: Healthcare worker (HCW) involved in care of Monkeypox case **not wearing appropriate PPE** for **contact between 1 and 3 meters** and has had **no direct contact with contaminated objects** *OR* Community contact **between 1 and 3 meters** of a symptomatic case *OR* Passengers who have been seated **within 3 seats** in front and at the back of a case AND passengers seated at each sides, but not seated directly beside a case on plane (ANNEX I) Examples: • Healthcare setting: ○ Staff entering patient room without PPE and without direct contact with patient or their body fluids and maintaining a distance of more than one meter from patient • Community setting: ○ People who stayed between 1-3 meters away from a case, with no direct contact	**No**	**No,** may still do routine activities and travel as long as asymptomatic Observe MPHS	Yes, if symptoms develop	Passive

Exposure Risk Category of Contacts[1]	Description of Exposure	Management			
		Post-exposure Vaccination	Quarantine	Testing	Surveillance
	• Plane setting: ○ Passengers who have been seated within 3 seats in front and at the back of a case AND passengers seated at each sides, but not seated directly beside a case on plane				
NONE	**Not high, intermediate or low risk contact** such as: No known contact with symptomatic Monkeypox case in last 21 days *OR* Passengers seated more than 3 rows away from the case on plane	No	**No,** may still do routine activities and travel as long as asymptomatic Observe MPHS	No	No

[1] WHO Definition of Contact
A contact is defined as a person who, in the period beginning with the onset of the source case's first symptoms, and ending when all scabs have fallen off, has had one or more of the following exposures with a probable or confirmed case of Monkeypox:

- face-to-face exposure (including health care workers without appropriate PPE);
- direct physical contact, including sexual contact; OR
- contact with contaminated materials such as clothing or bedding.

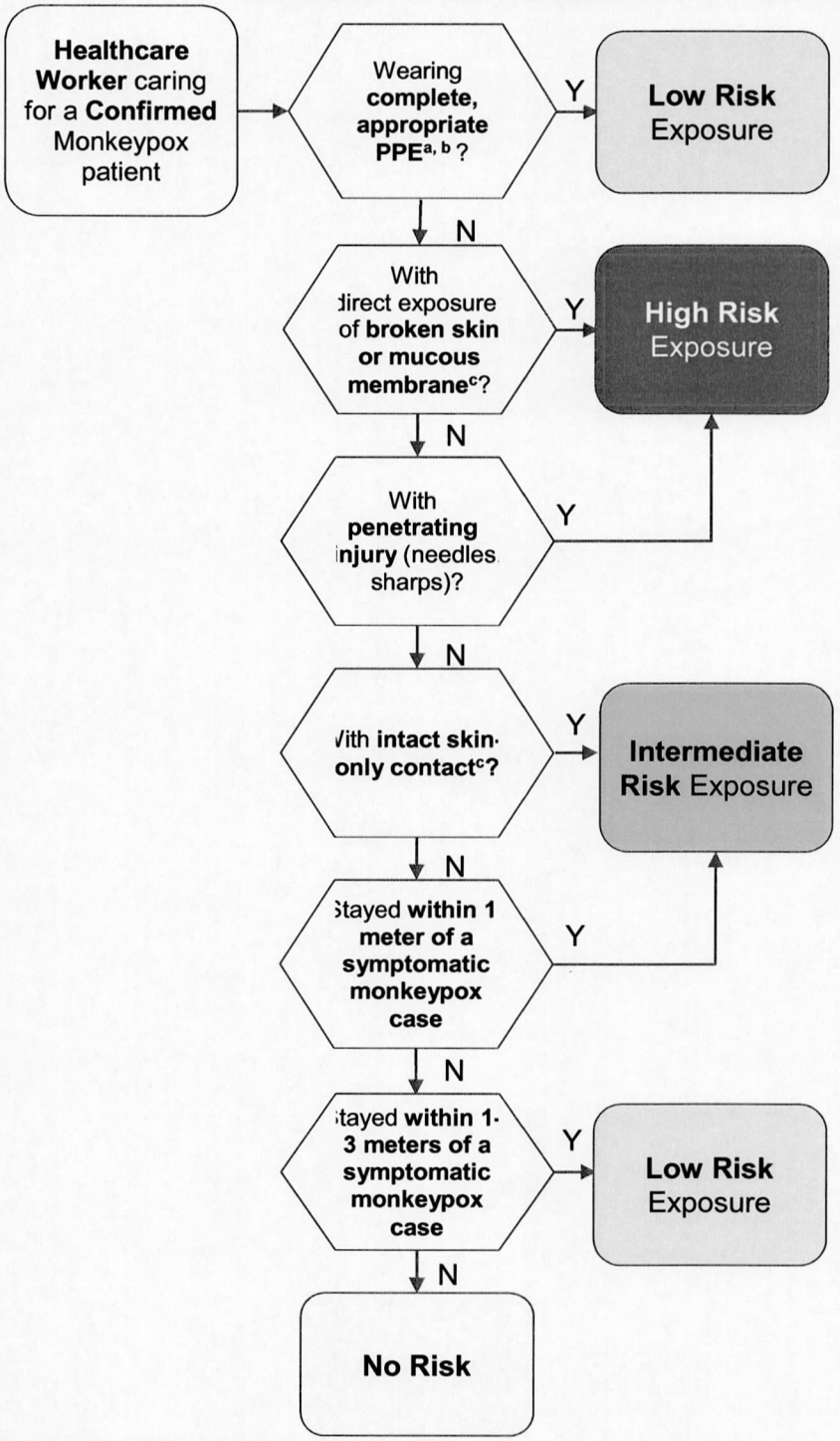
[2]Appropriate PPE definition (for HCWs):

1) Long-sleeved, fluid-repellent, disposable gown;
2) Disposable gloves;
3) Eye protection (i.e., goggles or a face shield that covers the front and sides of the face); and
4) NIOSH-approved N95 filtering facepiece or equivalent, or higher-level respirator, ideally fit-tested.

Definition of Contact adapted from: World Health Organization. (2022 May 22). *Surveillance, case investigation and contact tracing for Monkeypox: Interim Guidance.* https://www.who.int/publications/i/item/WHO-MPX-surveillance-2022.1

Exposure Risk Categories adapted from: UK Health Security Agency [UKHSA]. (2022, June 6). *Recommendations for the use of pre and post exposure vaccination during a Monkeypox incident.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1080838/Recommendations-for-pre-and-post-exposure-vaccination-during-a-Monkeypox-incident-6-june-2022.pdf

ANNEX H: ALGORITHM FOR EXPOSURE RISK DETERMINATION FOR HEALTHCARE WORKERS IN THE PHILIPPINES



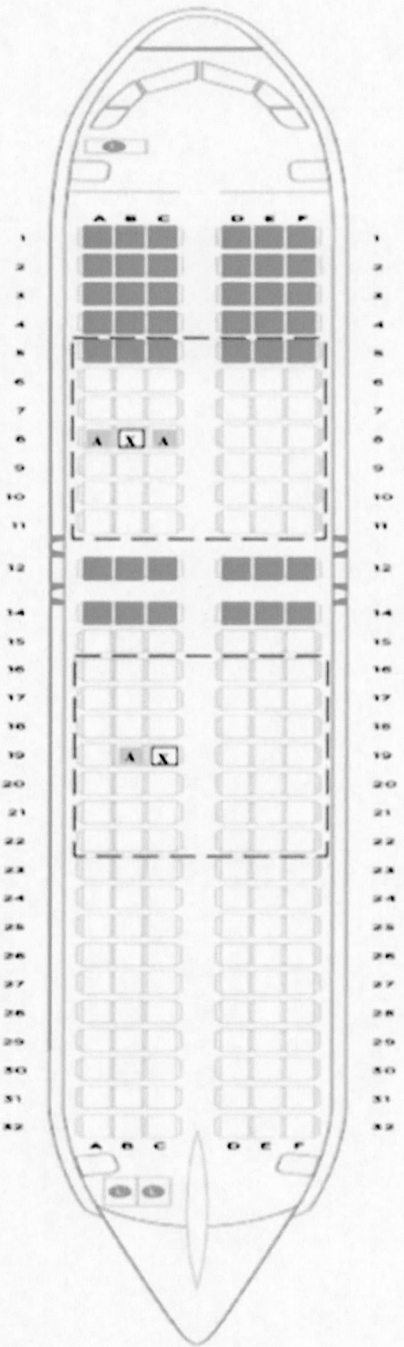
[a]Appropriate PPE for HCWs:

1. Long-sleeved, fluid-repellent disposable gown;
2. Disposable gloves;
3. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face); and
4. NIOSH-approved N95 filtering facepiece or equivalent, or higher-level respirator, ideally fit-tested.

[b] No breaches, spillages or leaks

[c] To a confirmed, symptomatic Monkeypox case, their body fluids, or potentially infectious material (including clothing or bedding)/contaminated fomite

ANNEX I: PLANE SETTING ILLUSTRATION



Legend:
X - indicates the source case

A - refers to the person seated directly next to the case

(box with broken edges) - marks the seats of passengers seated within 3 seats in front and at the back of a case AND passengers seated at each sides, but not seated directly beside a case

Plane illustration adapted from: https://www.airasia.com

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