

H1N1 influenza 09 (Human Swine Influenza) Infection 'Contain Phase'

Interim Guidelines for Australian Public Health Units

Version 2.0; Last updated: 26 May 2009, 1800 AEST

1. Summary

Public health priority

Urgent.

Case management

Investigation

- All persons meeting the definition for a '**Suspected**' case must be assessed urgently, including collection of nose and throat swabs if within 7 days of onset (or if still febrile), sent for urgent testing to a reference laboratory.
- Anti-influenza treatment should be offered to '**Suspected**', '**Suspected Influenza A-positive**', '**Probable**' and '**Confirmed**' cases provided it can be commenced within 48 hours of onset.
- Provide appropriate written information to all cases, including fact sheets on the disease and, if treatment is indicated, the use of neuraminidase antiviral medications. Ensure that cases are aware of the signs and symptoms of the disease, the requirements of isolation, Public Health Unit (PHU) contact details, and infection control practices and precautions appropriate to the home environment.

'Suspected', '**Suspected Influenza A-positive**', '**Probable**' and '**Confirmed**' cases must be isolated until the diagnosis is excluded or the infectious period is over.

Contact management

Contacts of '**Probable**' and '**Confirmed**' cases and '**Suspected Influenza A-positive**', if testing delays are expected, should receive prophylactic anti-influenza medication, and be home quarantined until either H1N1 influenza 09 (Human Swine Influenza) has been excluded in the case, or 7 full days have elapsed since the last exposure to H1N1 influenza 09 (Human Swine Influenza) Infection (that is, while the case is still considered to be infectious), if the contact has not become symptomatic during that time.

2. The disease

Infectious agent

H1N1 influenza 09 (Human Swine Influenza) is a novel influenza A virus infecting humans. Influenza viruses are composed of an RNA core surrounded by an envelope containing two surface glycoproteins — haemagglutinin and neuraminidase. These antigens have the ability to rapidly mutate and produce minor or major changes to the antigenic structure, known as antigenic drift and antigenic shift respectively. H1N1 influenza 09 (Human Swine Influenza) appears to be formed through reassortment of human and swine-origin influenza strains, creating a virus against which humans have little or no immunity.

Mode of transmission

Definitive information regarding the mode of transmission of H1N1 influenza 09 (Human Swine Influenza) is not yet available, however, it seems likely that it shares the same transmission dynamics as seasonal influenza, i.e. it is most commonly spread from person-to-person by inhalation of infectious droplets produced while talking, coughing and sneezing. Transmission may also occur through direct and indirect (fomite) contact. The virus may persist on hard surfaces for 1–2 days, particularly in cold or low humidity conditions. The virus may remain viable on hands for 5 minutes.

Incubation period

While the maximum incubation period could be 7 days, a shorter incubation period of up to 3 days is common. This may change as more information concerning characteristics of the H1N1 influenza 09 (Human Swine Influenza) virus becomes available.

Infectious period

The infectious period is assumed to be from 24 hours (one day) prior to the onset of symptoms until either 7 days after the onset of symptoms or until the resolution of fever, whichever is longer.

It is possible that some groups, especially children, might be contagious for longer periods, however, 7 days, or until or until the resolution of fever, should be used as the standard provided antivirals are taken and appropriate hygiene is practised.

Note: this may change as more information becomes available about the disease.

Clinical presentation

The characteristics of the typical presentation with H1N1 influenza 09 (Human Swine Influenza) are still to be determined. Seasonal influenza typically commences with symptoms of fever, cough, fatigue, sore throat, headache, myalgia, arthralgia and rigors or chills. Suggesting a similar profile, a study of confirmed cases of H1N1 influenza 09 (Human Swine Influenza) in a secondary school population reported the following frequency of symptoms: cough (98%), subjective fever (96%), fatigue (89%), headache (82%), sore throat (82%), runny nose (82%), chills (80%) and muscle aches (80%). Other common but less typical symptoms included nausea (55%), stomach ache (50%), diarrhoea (48%), dyspnoea (48%) and joint pain (46%). Ninety-five percent of cases of H1N1 influenza 09 (Human Swine Influenza) reported fever, plus cough and/or sore throat, which is a generally accepted definition for influenza-like illness.

Symptoms of pneumonia may be present if lower respiratory tract infection occurs (breathing difficulty, productive cough, bloody sputum, pain when breathing). Chest X-rays may show pneumonia. Acute respiratory distress syndrome (ARDS) may develop several days after disease onset.

3. Risk assessment

Routine prevention activities

Routine advice regarding hygiene and cough etiquette is relevant to human infections with H1N1 influenza 09 (Human Swine Influenza). No specific vaccine is currently available and preliminary reports suggest available seasonal vaccines are unlikely to provide protection.

Threat and vulnerability

As H1N1 influenza 09 (Human Swine Influenza) has not been seen in human populations before, the Australian community is susceptible to infection.

Risk mitigation

In the Delay Phase of the Australian response to a pandemic virus, public health activity is focussed on mitigating the risk of entry and transmission of the virus in the population through:

- Heightened awareness among incoming international passengers through measures such as positive pratique, signage in arrival halls and completion of passenger declaration cards
- Health screening clinics at international borders
- Heightened public and health care worker awareness, facilitating early case detection, isolation and treatment of cases, and appropriate management of exposed contacts
- Enhanced surveillance

4. Surveillance objectives

- To delay the onset of a H1N1 influenza 09 (Human Swine Influenza) epidemic, and thereby provide additional time for the development and administration of a vaccine to the community. Containment depends on:
 - the rapid identification and isolation and treatment of cases, and
 - the rapid identification, prophylaxis, quarantine and monitoring of contacts.
- To provide information about effective control and prevention measures, based on:
 - data gathered on the natural history of the disease, and factors that influence outcome.
 - the epidemiology of H1N1 influenza 09 (Human Swine Influenza) in Australia.

5. Data management

- Within 2 hours of notification during working hours, enter all '**Suspected**', '**Suspected - unresolvable**', '**Suspected Influenza A-positive**', '**Probable**' or '**Confirmed**' cases into NetEpi and/or other appropriate database. Cases are '**unresolvable**' if no PCR test was carried out.
- Case details should be entered into NetEpi by the jurisdiction managing the case, even if the case is a resident of another jurisdiction. This will occur when a case is staying in a jurisdiction other than their jurisdiction of usual residence or when a passenger is in transit but has been detained for management by a jurisdiction other than their jurisdiction of usual residence.
- When the case travels to the usual place of residence, the managing jurisdiction will forward all case details from NetEpi to the jurisdiction of usual residence for ongoing management.
- If a '**Suspected**' case, is in transit to another destination, and is fit to travel, the destination jurisdiction assumes responsibility for case management and enters data into NetEpi.
- Within 2 hours of any positive influenza A test result notified to the PHU, update case data in NetEpi and/or other appropriate database.

- Results from reference laboratories will be communicated to PHUs from the State/Territory disease control office within 1 hour of receipt.

6. Communications

- Inform the State/Territory disease control office by telephone within one hour of being notified of or recognition of a cluster of '**Suspected**' cases. A cluster in the Delay Phase is 2 or more cases with onset within 7 days where there is a plausible mechanism of transmission between the cases.
- Where a '**Suspected**' case is being managed by a jurisdiction other than that of the case's usual residence, the managing jurisdiction will keep the jurisdiction of residence informed of progress with the case.
- Positive results for influenza A or H1N1 influenza 09 (Human Swine Influenza) must be called through to the State/Territory disease control office or PHU in a timely fashion from the laboratory.
- The State/Territory disease control office should communicate positive H1N1 influenza 09 (Human Swine Influenza) results to the State/Territory Chief Health Officer (CHO) and to the Commonwealth Department of Health and Ageing Operations Centre in a timely fashion (health.ops@health.gov.au) and also phone through confirmed results for H1N1 influenza 09 (Human Swine Influenza).

7. Case definition

Case definitions may need to change depending on the epidemiological characteristics of the new influenza virus, and the stage of the H1N1 influenza 09 (Human Swine Influenza) response.

The most up to date case definitions are at: DoHA Health Emergency Website:

<http://www.healthemergency.gov.au/internet/healthemergency/publishing.nsf/Content/healthprof>

8. Laboratory testing

- '**Suspected**' cases should be tested for respiratory viruses using nose and throat swabs, provided this can be done within 7 days of onset (unless the case remains febrile). Nasopharyngeal aspirates are not recommended unless the specimen can be collected safely in a controlled clinical setting.
- Swabs from suspected cases should be sent directly an appropriate State/Territory laboratory for urgent testing for H1N1 influenza 09 (Human Swine Influenza).
- Specimens should be tested for H1N1 influenza 09 (Human Swine Influenza) and/or influenza A. Any test positive for influenza A by PCR (or other methods) should be subtyped and specific PCR H1N1 influenza 09 (Human Swine Influenza) tests conducted. Samples testing H1N1 influenza 09 (Human Swine Influenza) positive should be confirmed at the WHO Collaborating Centre for Influenza (WHOCC) in Melbourne if they are from cases not epidemiologically linked to a confirmed case (in jurisdictions where community transmission is not apparent), or if they are the first positive case in a jurisdiction without known H1N1 influenza 09 (Human Swine Influenza) activity.
- Serum should be collected for future serological testing for suspect cases where presentation is more than 7 days after onset, and may also be collected at the same time as swabs are collected in other cases, where feasible. Where serum for acute serology is collected, serum for convalescent serology should be collected 3 weeks later.

9. Case investigation

Response times

Investigation

Begin the investigation immediately upon notification of a **'Suspected'** (see *Onward travel*), **'Suspected Influenza A-positive'**, **'Probable'** or **'Confirmed'** case.

Response procedure

Case investigation

PHU staff should:

- discuss the case with the notifying clinician, and confirm the onset date and symptoms of the illness using the current case definition
- confirm clinical findings and results of relevant pathology tests, and recommend that testing for other respiratory pathogens be considered, if appropriate.
- determine if the case or relevant care-giver has been informed of the diagnosis before interviewing the case
- review case and contact management
- obtain an exposure history (including a travel history, contact with other cases or high-risk exposures [e.g., contact with other **'Suspected'**, **'Suspected Influenza A-positive'**, **'Probable'** or **'Confirmed'** case(s) or a laboratory worker]) and identify the likely source of infection
- commence identification of all close contacts of **'Suspected Influenza A-positive'**, **'Probable'** or **'Confirmed'** cases. For confirmed cases include questioning on close contact with pigs or commercial birds. If present, contact State/Territory Chief Veterinary Officer
- determine if there was possible in-flight exposure of passengers and following appropriate standard operating procedures for this event (see **Attachment A**)
- advise regarding appropriate infection control practice
- follow-up the case over subsequent days to determine outcome, and enter relevant information into hard-copy records and NetEpi and/or other databases, as appropriate.

Note. If interviews with cases are conducted face-to-face, the person conducting the interview ideally should be vaccinated with the seasonal influenza vaccine, have a thorough understanding of infection control practices and be competent in using appropriate PPE.

Onward travel

A **'Suspected'** case who is arriving from overseas may continue **ticketed connecting** travel to their final destination in Australia if the duration of flight is less than 4 hours. This does not include onward international travel, or travel on other modes of domestic or international public transport (e.g. trains, trams, ships). Travel by car is acceptable using appropriate precautions.

Onward travelling cases must receive verbal and written information about appropriate infection control measures and must agree to wear a surgical mask while in the terminal and aircraft, and practise hand hygiene.

The passenger should be provided with a letter to present to the airline(s) involved in the onward flights indicating that the passenger is permitted to travel provided the passenger wears a mask and practises hand hygiene.

Where time permits before the connecting flight, swabs may be taken and (if indicated) anti-influenza treatment should be provided. If swabs are not taken at the border nursing post, then anti-influenza treatment should be given with clear instruction that swabs need to be obtained at the final

destination, within 24 hours of commencing anti-influenza medication. The onward destination State/Territory disease control office must be informed immediately of the impending arrival of the **'Suspected'** case, including whether there is a need for testing and/or administration of anti-influenza treatment once the **'Suspected'** case arrives.

The use of Health Declaration Cards for contact tracing applies to International flights. If there is in flight exposure on domestic flights there is limited information available to undertake contact tracing. Airlines may keep manifests for a short period (24 hrs), but it will not include the address of the passenger. A public announcement may be required to alert passengers to the risk of exposure.

Case treatment

Anti-influenza treatment should be given to **'Suspected'**, **'Suspected Influenza A-positive'**, **'Probable'** and **'Confirmed'** cases as soon as possible and within 48 hours of illness onset. Anti-influenza treatment may be commenced more than 48 hours after onset in rare circumstances where clinically indicated.

Anti-influenza medications have been shown to attenuate disease in cases of seasonal influenza if given early in the course of the illness (within 48 hours of developing symptoms).

Whilst information on the effectiveness of anti-influenza medications in the clinical setting for H1N1 influenza 09 (Human Swine Influenza) is currently not available, studies have shown that the H1N1 influenza 09 (Human Swine Influenza) virus is susceptible to oseltamivir (Tamiflu) and zanamivir (Relenza), but is resistant to amantadine.

Education

Provide appropriate written information to all cases, including fact sheets on the disease and, if treatment is indicated, the use of neuraminidase antiviral medications. Ensure that cases are aware of the signs and symptoms of the disease, the requirements of isolation, PHU contact details, and the infection control practices and precautions appropriate to the home environment. Hygiene measures should be described to the contact (ensure they have hand washing facilities or alcohol-based hand rub, some surgical masks and a supply of tissues. If the patient does not have this equipment, where possible distribute a 'Home Isolation Pack' (which may be requested from the National Medical Stockpile, by a CHO, in the first instance).

Isolation and restriction

'Suspected', **'Suspected Influenza A-positive'**, **'Probable'** and **'Confirmed'** cases must be isolated until the diagnosis is excluded or the infectious period is over (see section 2, above). Isolation should be from humans, pigs and birds.

Cases in home isolation should wear a surgical mask when in the same room as other household members and stay at least 1 metre distant. They should sleep in a separate room.

Case isolation may be ceased when the case is no longer in the infectious period, or when H1N1 influenza 09 (Human Swine Influenza) has been excluded OR an alternative diagnosis that is consistent with the case's symptoms has been made.

Where cases refuse to comply with isolation voluntarily, counselling should be used to encourage co-operation and appropriate behavioural change. Cooperation may also be improved where mechanisms can be put in place to facilitate delivery of groceries and the like. Cases should also be informed of the powers to enforce isolation available within the relevant State/Territory Public Health legislation and the Commonwealth *Quarantine Act 1908*.

A Public Health Order or an order into Quarantine could be issued where the case is not compliant with isolation (please call the State/Territory disease control office for local advice).

PHUs should ensure that isolated cases are contacted at least every 24 hours to assess clinical progress.

Where **'Suspected'**, **'Suspected Influenza A-positive'**, **'Probable'** or **'Confirmed'** cases are staying in a hotel, motel or similar accommodation, refer to the *Interim Guidance to Managers of Hotels used to Quarantine Contacts of Suspected and Confirmed Cases*, including the provision of further assessment.

Active case finding

Alert local doctors to notify suspected cases to PHUs or disease control units promptly. Search for cases among contacts of **'Suspected Influenza A-positive'**, **'Probable'** and **'Confirmed'** cases.

10. Control of environment

If hospital, residential care facility or multi-purpose service-acquired infection is suspected, infection control experts should review the facility's infection control procedures. Staff conducting the review must have a thorough understanding of infection control practices, be competent in using PPE and ideally should have been vaccinated with the current seasonal influenza vaccine.

11. Contact management

Contact definition

Only people in close contact with a **'Suspected Influenza A-positive'**, a **'Probable'**, or a **'Confirmed'** case require public health intervention. Therefore, contacts are defined as people who were, during the infectious period (see section 2) of a **'Suspected Influenza A-positive'**, a **'Probable'** or a **'Confirmed'** case:

- household members
- close workplace contacts, including people sharing an office or cubicle area or whose work has brought them into close physical proximity (sitting within one metre for at least 15 minutes) with the case, but not people who share general office space
- members of a case's class or child care group and their teacher / child care supervisor, where the case is a child in the same class for 4 hours or more
- others in close physical proximity (sitting within one metre for at least 15 minutes), but not other people who share the classroom, where the case is a child in multiple classes in a day (such as in a typical secondary school setting)
- other contacts identified by a case, household members or workplace associates of the case, as having been in close physical contact (hugging, kissing, sitting within one metre for at least 15 minutes).
- passengers and crew travelling on an aircraft with a **'Confirmed'** case as defined below:
 1. passengers seated in the same row, and within two (2) rows in front of and behind the case;
 2. any passengers identified by the case who moved from elsewhere in the aircraft to spend more than 15 minutes near the case;
 3. airline staff (unless they did not service the section of the plane in which the **'Confirmed'** case was seated).

Contact the State/Territory disease control office if further guidance is required.

At the diagnosis of a '**Suspected Influenza A-positive**' or '**Probable**' case, PHU staff should follow up immediate household contacts, and prepare a list of other contacts. Tracing of contacts outside the immediate household should commence at confirmation of the diagnosis of H1N1 influenza 09 (Human Swine Influenza). Where significant delays are expected before receipt of confirmation, then tracing of these contacts may commence at diagnosis of a '**Suspected Influenza A-positive**' or '**Probable**' case.

For '**Suspected Influenza – Unresolvable**' and '**Suspected Influenza A-positive – Unresolvable**' cases, PHU staff should trace immediate household contacts to determine whether there was likely to have been transmission to them, and if they are symptomatic, arrange testing and management of the contacts as above.

Chemoprophylaxis

Contacts of '**Probable**' and '**Confirmed**' cases-- and if significant delays in confirmation are expected, of '**Suspected Influenza A-positive**' cases should receive anti-influenza medication in order to reduce the risk of infection and transmission, provided it is commenced within 7 days of last contact with the case while the case was still infectious.

Particularly vulnerable contacts (e.g., those with underlying disease) of '**Suspected**' cases should be considered for prophylaxis. The anti-influenza prophylaxis should be for 10 days.

Education

PHUs should counsel contacts about their risk and about the symptoms of H1N1 influenza 09 (Human Swine Influenza), and provide a copy of appropriate fact sheets. Hygiene measures should be described to the contact (ensure they have hand washing facilities or alcohol-based hand rub, some surgical masks and a supply of tissues, in case they subsequently become infectious. If the contact does not have this equipment, where possible distribute a Home Isolation Pack.

Quarantine and restriction

Where significant delays are expected before confirmation, contacts of '**Suspected Influenza A-positive**' cases should be quarantined at home and advised as follows.

- Leaving the home is not permitted except for essential purposes, as agreed by the PHU or delegate, and provided they remain more than 1 metre away from other people at all times.
- They should remain more than 1 metre away at all times from other people in the house if at all possible.
- Where possible, they should sleep in a room on their own.

Contacts of '**Probable**' and '**Confirmed**' cases should be quarantined at home and advised as follows.

- They must not leave the house.
- They must not go to work, school, college, or public or social events.
- They should remain more than 1 metre away at all times from other people in the house if at all possible.
- Where possible, they should sleep in a room on their own.

Contacts are not required to wear masks. If contacts become symptomatic with fever or acute respiratory symptoms they should inform the PHU or delegate immediately and not wait to be contacted.

The PHU should ensure that contacts are followed-up on a daily basis for 7 days after the last contact with the infectious case to affirm that symptoms of H1N1 influenza 09 (Human Swine Influenza) have not developed, and to ensure that the contact is observing restrictions and is taking any prescribed

anti-influenza medication. This follow-up may be performed directly by PHU staff or by other suitably trained personnel. Symptom self-assessment would be facilitated if the contact has access to a thermometer and is competent in its use.

If a quarantined contact develops symptoms, the PHU should arrange medical assessment in an isolated area such as an isolation room within an ED or in an influenza clinic or, where feasible, at a home visit. This assessment must take place in a setting where risk is managed through the use of appropriate infection control precautions.

Where contacts refuse to comply with quarantine, further education and counselling should be provided. Cooperation may also be improved where mechanisms can be put in place to facilitate delivery of groceries and the like. Contacts should also be informed of the powers to enforce quarantine available within relevant State/Territory Public Health legislation and/or the Commonwealth *Quarantine Act 1908*. The PHU should contact the State/Territory disease control office for further advice if contacts are uncooperative.

Where contacts of '**Probable**' or '**Confirmed**' cases -- and if significant delays in confirmation are expected, of '**Suspected Influenza A-positive**', cases -- are required to be quarantined in a hotel or motel, the hotel management should be informed that a room is occupied by a person who is not unwell or likely to be a threat to others, but is a contact of a case. Quarantine procedures should be discussed with the management, including cleaning guidelines, as outlined in the *Interim Guidance to Managers of Hotels used to Quarantine Contacts of Suspected and Confirmed Cases*.

If a contact in hotel quarantine becomes a case, management of this case should be discussed with the hotel management.

Criteria for lifting quarantine restrictions: Quarantine of contacts may be ceased when:

- the person for whom they are a contact has been excluded as a case, or
- 7 full days have elapsed since the last exposure to H1N1 influenza 09 (Human Swine Influenza) (that is, while the case is still considered to be infectious), if the contact has not become symptomatic during that time.

12. Special situations

'Suspected' cases occurring on ships

International travellers may present as '**Suspected**' cases at seaports. The State/Territory disease control office will normally coordinate the management of such cases. PHUs may be required to assist in the screening and management of '**Suspected**' cases and contacts on and ships. Contact the State/Territory disease control office for advice.

13. Additional sources of information

Department of Health and Ageing:

<http://www.healthemergency.gov.au/internet/healthemergency/publishing.nsf>

State and Territory Health Departments:

NSW Department of Health – Human Swine Influenza Investigation

http://www.health.nsw.gov.au/publichealth/swine_flu.asp

Victorian Government - Swine Influenza - Influenza A (H1N1) virus
<http://www.health.vic.gov.au/ideas/diseases/swine-influenza>

Queensland Swine Flu Response
<http://www.health.qld.gov.au/swineflu>

Western Australian Department of Health – Human Swine influenza
http://www.public.health.wa.gov.au/2/949/2/swine_flu.pm

SA Department of Health – Human Swine Influenza
<http://flu.sa.gov.au/Swineflu.aspx>

NT Government Department of Health and Families – Swine Influenza Outbreaks
http://www.health.nt.gov.au/Centre_for_Disease_Control/index.aspx

Tasmanian Government – Human Swine Flu Outbreak
<http://www.pandemic.tas.gov.au/>

ACT Health - H1N1 Flu (Swine Flu)
<http://health.act.gov.au/c/health?a=da&did=10098808&pid=1240874209>

Attachment A

Standard Operating Procedure: Contact tracing following possible in-flight exposure:

Introduction

Planning should be commenced when a **suspected case** is identified who was potentially infectious in flight, to allow sufficient time for the NIR to complete the complex process of locating Health Declaration Cards (HDC) and seating arrangements from passenger lists.

If further testing indicates the person on the flight is an **influenza A positive suspected case**, further planning decisions can be made regarding the scope of the potential contact tracing exercise.

Contact tracing is *enacted* when the person on the flight is **confirmed** to have H1N1 influenza 09 (human swine influenza).

Note the use of HDC applies to International flights. If there is in flight exposure on domestic flights there is limited information available to undertake contact tracing. Airlines may keep manifests for a short period (24 hrs), but it will not include the address of the passenger. A public announcement may be required to alert passengers to the risk of exposure.

Standard Operating Procedure

1. State and Territory (S&T) Health Department identifies potential need for contact tracing following possible in-flight exposure

Definition of possible in-flight exposure: when a suspected case has travelled in the period 24 hours prior to the onset of symptoms, and up to 7 days post symptom onset (as long as fever has subsided by this point).

2. S&T Health contact NIR via health.ops@health.gov.au and provide the name of the **suspected case who was potentially infectious in-flight** and their flight details.

With this information the NIR can commence searching for the appropriate flight list and HDC, or if required, put processes in train to recover the incoming passenger cards from the flight. The NIR also contacts the airline for the manifest, and cross checks the information provided.

3. If the case becomes an **influenza A positive suspected case**: DoHA will request additional information on the influenza A positive suspected case from S&T Health (see below).
 - Senior officers within the State and Territory Health Department will consult with senior officers at DoHA decides who initiates contact DoHA and S&T Health to agree (on a case by case basis) on their respective roles and responsibilities. This includes who will contact passengers, the airline involved, airport management and airline attendants. State and Territory Health Departments are responsible for the delivery of antivirals

Options:

- a. State and Territory Public Health undertakes all contact and arranges appropriate interventions, with DoHA to post out home quarantine support packs if requested.
 - b. Centrelink initiates first contact. DoHA posts out home quarantine support packs. State and Territory Public Health arranges antiviral distribution (process for liaison between Centrelink and State and Territory Public Health yet to be clarified). Centrelink undertakes follow up contact.
 - c. State and Territory Public Health initiates first contact and arranges antiviral distribution. DoHA posts out home quarantine support packs if requested. Centrelink undertakes follow up contact.
4. If quarantine packs are required under options a or c, the CDNA or AHPC member should request the packs (which are part of the NMS) from DoHA via health.ops@health.gov.au with a cc to the senior DoHA officer involved in the discussions outlined above.
 5. The CDNA Chair, CDNA representatives from the affected S&T and DoHA consider need for CDNA meeting if multi-jurisdictional response required.
 6. Contact tracing commences if the case is **laboratory confirmed** (including positive on swine flu specific PCR tests). Airline attendants and Passengers rows in front, row with case, 2 rows behind are provided with prophylaxis and advised to stay in home quarantine.
 7. Senior officers at DoHA and S&T Health discuss media engagement/public communication strategy, and possible activation of NHEMRN. Consistent messages to be agreed and shared.

What information is required for contact tracing following in-flight exposure?

To avoid additional information requests, DoHA would like to flag the information that may be requested to assist location of the HDC, decision making and communication. When the NIR is notified of an influenza **A positive suspected** case who was potentially infectious in-flight, the following information may be requested to be provided if available.

Demographics

- Name
- Sex
- Date of birth
- Flight number
- Flight date of arrival
- Seat number
- Did the person move seats during the flight? If yes, which other seats and for how long, if known
- Region/s of travel
- Was the passenger in a group or individual travel

Clinical

- Date of onset of illness
- Symptoms
- Is the person still ill? If not, how long did the fever persist?
- How was the case detected?
 - AQIS via pratique / cabin crew reported illness?
 - Thermal Scanner
 - Health Declaration Card

- Presented to GP/ED /Community health
- Laboratory results
- Has a sample been sent for further laboratory testing at WHOCC?