

## Preliminary guidelines for prevention and control of viral hepatitis A in IDP camps in Vavunia

### General information

#### Viral hepatitis A

Hepatitis A is usually a self-limited viral illness lasting 2 weeks. However, the disease can vary in clinical severity from a mild illness to a severely disabling illness. The incubation period range from 15-50 days (mean 30 days). Typical clinical symptoms include acute fever, malaise, anorexia, nausea and abdominal discomfort followed a few days later by dark urine and jaundice. A person is most infectious in the 14 days before jaundice (yellowing of conjunctive and skin) occurs, and then infectivity wanes during the first week of having jaundice (the period of communicability). Symptoms usually last several weeks, although up to 15% of cases may have relapsing hepatitis for up to 12 months. Chronic infection does not appear to occur. Immunity following infection is life-long.

Hepatitis A is transmitted primarily by the faecal-oral route. HAV survives well in the environment; it can remain on a person's hands for several hours, on environmental surfaces for more than a month, at room temperature and in food kept at room temperature for considerably longer.

Transmission occurs through,

- **eating food that has been handled and contaminated by an infectious person**
- **drinking contaminated water**
- handling linen and towels soiled with the faeces of an infectious person
- direct contact (including sexual) with an infectious person
- Ingestion of filter-feeding shellfish (e.g. oysters).

#### Laboratory criteria for diagnosis

Liver function tests are usually abnormal. Diagnosis requires serological confirmation.

1. Anti-HAV IgM demonstrates recent infection or vaccination and becomes detectable 14 days before the onset of clinical symptoms and may persist for 4 months or longer.
2. IgG positive serology demonstrates immunity from prior infection or previous vaccination. Anti-HAV IgG becomes detectable shortly after anti-HAV IgM and usually persists for life.

## Case Classification

1. Confirmed: A suspected case that is laboratory confirmed

2. Probable:

A probable case requires clinical evidence and epidemiological evidence.

Clinical evidence includes - clinical hepatitis (jaundice and/or bilirubin in urine) without a non-infectious cause.

### Epidemiological evidence

Contact between two people involving a plausible mode of transmission at a time when:

- one of the cases is likely to be infectious (from two weeks before the onset of Jaundice to a week after onset of jaundice);

AND

- the other has an illness that starts 15-50 (average 28-30) days after this contact;

AND

- at least one case in the chain of epidemiologically linked cases (which may involve many cases) is laboratory confirmed.

3. Suspected: A case that is compatible with the clinical description

## Treatment

Hepatitis A is usually self-limited and therefore treatment is supportive only.

Attention should be paid to identify of early signs and symptoms of liver failure which could complicate the disease in a small proportion of patients.

## Management of Cases

- All cases (following provisional diagnosis) should be **notified** to the MOH of the area (Cheddikulam MOH in the case of IDPs in Welfare Centers in Manik Farm).
- **Isolation:** For proven hepatitis A, enteric precautions should be taken during the first 2 weeks of illness, but no more than 1 week after onset of jaundice. During this period they should not share the same toilet.

*Since this measure has been less feasible within the camps under the prevailing conditions where there has been a severe lack of latrine facilities and water for drinking and other purposes, the current practice has been to isolate the cases in a designated*

*hospital (Puvarasankulam Hospital in Vavunia). However, due to the lack of facilities available at the designated hospital to cater a large number of cases, logistical problems resulting in failure for early isolation, other social and security constraints it is suggested to isolate the cases, as soon as they have been identified as having the disease, within the Welfare Centre premises itself, in a facility designated for isolation of hepatitis A cases. Proposed facility may be a temporary installation with separate latrine facilities and water supply in adequate amounts. It has to be located at a site which is easily accessible to the health care workers for further care.*

- Adequate measures should be taken for concurrent disinfection i.e. sanitary disposal of faeces and urine.
- **Health education:** Should advice on the importance of practicing good hygiene measures to prevent transmission to others. Information includes emphasizing the importance of good hand-washing practice before and after using toilet, sanitary disposal of the faeces, urine and blood. to avoid handling/preparing food for 7 days after onset of symptoms, not to share items such as razors, or injecting equipment.
- Investigation of contacts and source of infection: Search for missed cases and maintain surveillance of contacts in the patient's household and people exposed to the same risk.

## Management of Contacts

### Definition of a contact

A contact is defined as a person who has had close contact with the confirmed case during the two weeks before and one week after the onset of jaundice and usually includes:

- household and/or sexual contacts;
- Others sharing the same latrines/latrine utensils
- staff and children at child care centres/pre-school, particularly where children are in nappies or being toilet trained;
- if case is a food–handler, other food–handlers working with him / her; and
- residential care

### Management

Primary Health Care workers (especially PHI) should provide contacts of the case with advice as appropriate and should monitor the situation for further cases. They should identify the incubation and infectious period to alert others (probable contacts) of potential time period of risk.

## Epidemic measures

- Mode of transmission and the source of transmission should be identified. Common sources of infection should be eliminated.
- Effective use of hepatitis A vaccine in community-wide outbreak situations requires identification of an appropriate target group for immunization, the initiation of immunization early in the course of the outbreak and the rapid achievement of high (approximately 70% at least) first-dose vaccine coverage levels. This is hardly feasible during the current epidemic which has originated well before the IDPs were relocated at the present locations.
- Special efforts should be made to improve sanitary and hygienic practices to eliminate fecal contamination of food and water.
- Health education needs to be strengthened to promote good hygiene practices before and after toilet use, before preparing and eating food. Kitchen staff should be specifically advised on importance of good hygiene.

## **Epidemiology Unit**

**Ministry of Healthcare & Nutrition**

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