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TO: ALL FULL AND ASSOCIATE MEMEBERS

COPY: LABOUR AFFAIRS COMMITTEE
MANNING AND TRAINING COMMITTEE

MULTI-COUNTRY MONKEYPOX OUTBREAK IN NON-ENDEMIC COUNTRIES

Action Required: ***Members are requested to disseminate the information in this circular kindly shared by WHO.***

Outbreak Summary

Since 13 May 2022, WHO has been notified of monkeypox cases by twelve non endemic Member States, across three WHO regions. Epidemiological investigations are ongoing, however, reported cases have no established travel links to endemic areas. Based on currently available information, cases have mainly but not exclusively been identified amongst men who have sex with men (MSM) seeking care in primary care and sexual health clinics. This circular will raise awareness, inform readiness and response efforts, and provide technical guidance for immediate actions.

The situation is evolving and WHO expects to identify more monkeypox cases as surveillance expands in non-endemic countries. Immediate actions focus on informing those most at risk for monkeypox infection with accurate information, to stop further spread. Current available evidence suggests those most at risk have close physical contact with someone with monkeypox, while symptomatic. WHO is also working to provide guidance to protect frontline health care providers and other at-risk health workers. WHO will provide more technical recommendations soon.

Description of the outbreak

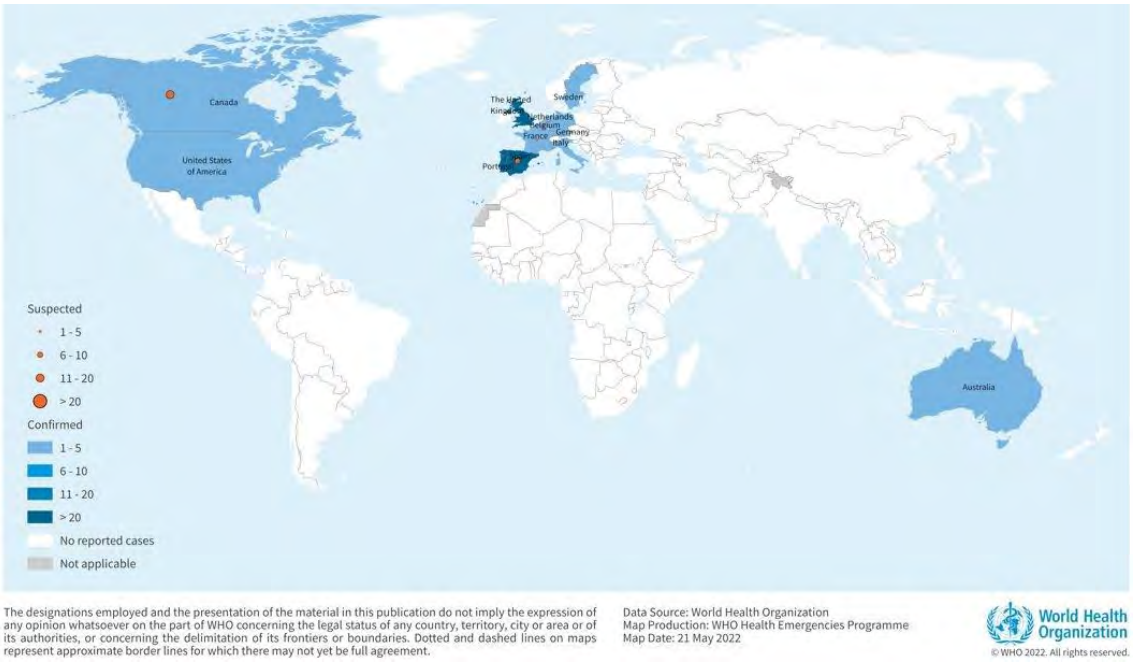
On 21 May, 13:00, WHO reported ninety-two confirmed cases, and twenty-eight suspected cases of monkeypox with investigations ongoing from 12 Member States not endemic for monkeypox virus, across three WHO regions and no deaths.

Reported cases so far have no established travel links to an endemic area. Based on current information, cases have mainly but not exclusively identified amongst men who have sex with men (MSM) seeking care in primary care and sexual health clinics.

Table 1. Cases of monkeypox in non-endemic countries reported to WHO between 13 to 21 May 2022 as at 13:00

Country	Confirmed	Suspected
Australia	1-5	-
Belgium	1-5	1-5
Canada	1-5	11-20
France	1-5	1-5
Germany	1-5	-
Italy	1-5	-
Netherlands	1-5	-
Portugal	21-30	-
Spain	21-30	6-10
Sweden	1-5	-
United Kingdom	21-30	-
United States of America	1-5	-
Total	**92**	**28**

Figure 1. Geographical distribution of confirmed and suspected cases of monkeypox in non-endemic between 13 to 21 May 2022, as at 13:00.



To date, all case samples confirmed by PCR were of the West African clade. Genome sequence from a swab sample from a confirmed case in Portugal, indicated a close match of the monkeypox virus causing the current outbreak, to exported cases from Nigeria to the United Kingdom, Israel, and Singapore in 2018 and 2019.

Identification of confirmed and suspected cases of monkeypox with no direct travel links to an endemic area represents a highly unusual event. Limited surveillance to date in non-endemic areas is now expanding. WHO expects reports of more cases in non-endemic areas. Available information suggests that human-to-human transmission is occurring among people in close physical contact with cases who are symptomatic.

In addition to this new outbreak, WHO continues to receive updates on the status of ongoing reports of monkeypox cases through established surveillance mechanisms (Integrated Disease Surveillance and Response) for cases in endemic countries, as summarized in table 2. Endemic countries are Benin, Cameroon, the Central African Republic, Democratic Republic of the Congo, Gabon, Ghana (identified in animals only), Côte d'Ivoire, Liberia, Nigeria, the Republic of the Congo, Sierra Leone, and South Sudan.

Table 2. Cases of monkeypox in endemic countries between 15 /12 /21 to 1/5/22

Country	Time period	Cumulative cases	Cumulative deaths
Cameroon	15 December 2021 to 22 February 2022	25	<5
Central African Republic	4 March to 10 April 2022	6	<5
Democratic Republic of the Congo	1 January to 1 May 2022	1238	57
Nigeria	1 January 2022 to 30 April 2022	46	0

Epidemiology of the disease

Monkeypox is a viral zoonosis with symptoms like smallpox patients, although clinically less severe. It is caused by the monkeypox virus part of the *orthopoxvirus* genus. There are two clades of monkeypox virus: West African and Congo Basin. The name monkeypox originates from initial discovery in monkeys in Denmark in 1958. The first human case was identified in a child in the Congo in 1970.

Monkeypox virus transmits from one person to another by close contact with lesions, body fluids, respiratory droplets, and contaminated materials such as bedding. The incubation period of monkeypox is usually from 6 to 13 days but can range from 5 to 21 days.

Various animal species are susceptible to monkeypox virus. Uncertainty remains on the natural history of the virus and further studies required to identify the exact reservoir(s) and how nature maintains virus circulation. Eating inadequately cooked meat and other animal products of infected animals is a risk factor.

Monkeypox is usually self-limiting but may be severe in some individuals, such as children, pregnant women, or those with immune suppression due to other health conditions. Human infections with the West African clade appear to cause less severe disease than the Congo Basin clade, with a fatality rate of 3.6% and 10.6% for the Congo Basin clade.

Public health response

- Genomic sequencing, where available, undertaken to determine the monkeypox virus clade(s) in this outbreak
- Further public health investigations are ongoing in non-endemic countries that have identified cases, including extensive case finding and contact tracing, laboratory investigation, clinical management and isolation provided with supportive care.
- Deploying monkeypox Vaccination, if available, to manage close contacts, e.g., health workers. WHO will convene experts to discuss vaccination needs.

WHO has developed surveillance case definitions for current monkeypox outbreak in non-endemic countries.

Case definitions will be updated, as necessary.

Suspected case:

Anyone presenting in a monkeypox non-endemic country with an unexplained acute rash **AND** One or more of the following signs or symptoms, since 15 March 2022:

Headache	Acute onset of fever (>38.5ºC),
Lymphadenopathy (swollen lymph nodes)	Myalgia (muscle and body aches)
Back pain	Asthenia (profound weakness)

AND for which the following common causes of acute rash do not explain the clinical picture: varicella zoster, herpes zoster, measles, Zika, dengue, chikungunya, herpes simplex, bacterial skin infections, disseminated g*onococcus* infection, primary or secondary syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, molluscum contagiosum, allergic reaction (e.g., plants); and other locally relevant common causes of papular or vesicular rash.

N.B. It is not necessary to obtain negative laboratory results for listed common causes of rash illness to classify a case as suspected.

[2] Monkeypox endemic countries: Benin, Cameroon, Central African Republic, Democratic Republic of the Congo, Gabon, Ghana (animals only), Côte d'Ivoire, Liberia, Nigeria, the Republic of the Congo, and Sierra Leone. Benin and South Sudan have documented importation previously. Countries currently reporting West African clade cases are Cameroon and Nigeria. With this case definition, all countries except these four should report new monkeypox cases within the current outbreak.

Probable case:

A person meeting the definition for a suspected case **AND** one/ more of the following:

- has an epidemiological link (face-to-face exposure, including health workers without eye and respiratory protection); direct physical contact with skin or lesions, including sexual contact; or contact with contaminated materials e.g., clothing, bedding, or utensils to a probable /confirmed monkeypox case 21 days before symptom onset
- reported travel history to a monkeypox endemic country 21 days before symptoms t
- had multiple or anonymous sexual partners in the 21 days before symptom onset
- has a positive result of an *orthopoxvirus* serological assay, in the absence of smallpox vaccination or other known exposure to orthopoxviruses
- hospitalized due to the illness

Confirmed case:

A case defined as either a suspected or probable case and laboratory confirmed for monkeypox virus by detecting unique sequences of viral DNA by real-time polymerase chain reaction (PCR) and/or sequencing.

Discarded case:

A suspected or probable case for which laboratory testing by PCR and/or sequencing is negative for monkeypox virus.

WHO risk assessment

Endemic monkeypox disease normally geographically limited to West and Central Africa. Identification of confirmed and suspected monkeypox cases without any travel history to an endemic area in multiple countries is atypical, hence, an urgent need to raise monkeypox awareness and undertake comprehensive case finding and isolation (with supportive care), contact tracing and supportive care limiting further onward transmission.

Only elder persons have cross-protective immunity from smallpox vaccination, as populations worldwide under 40 or 50 no longer benefit from protection from prior smallpox vaccination programmes. There is little immunity to monkeypox among younger people living in non-endemic countries since the virus has not been present there.

Historically, vaccination against smallpox had protected against monkeypox. While a vaccine (MVA-BN) and tecovirimat were approved for monkeypox, in 2019 and 2022 respectively, these countermeasures are not yet widely available.

Based on currently available information, cases have mainly but not exclusively identified amongst men having sex with men (MSM) seeking care in primary care and sexual health clinics. No deaths reported to date. However, the extent of local transmission is currently unclear, as surveillance is limited. There is a high likelihood of identification of further cases with unidentified chains of transmission, including in other population groups. With countries across WHO regions reporting cases, other countries are likely to identify cases.

The situation is evolving and WHO expects more monkeypox cases as surveillance expands in non-endemic countries. So far, there have been no deaths associated with this outbreak. Immediate actions focus on informing those most at risk for monkeypox infection with accurate information, stopping further spread and protecting frontline workers.

WHO advice

Additional cases and further onward spread in countries currently reporting cases and other Member States is likely. Investigate any suspected monkeypox case and if confirmed, isolate until lesions crust, the scab falls off and a fresh layer of skin forms underneath.

Countries should identify signals related to patients presenting with an atypical rash that progresses in sequential stages – macules, papules, vesicles, pustules, scabs, at similar development over all affected body areas that may be associated with fever, enlarged lymph nodes, back pain, and muscle aches. These individuals may present to various community and healthcare settings including but not excluding primary care, fever clinics,

sexual health services, infectious disease units, obstetrics and gynecology, urology, emergency departments and dermatology clinics. Increasing awareness among potentially affected communities, and health care providers and laboratory workers, is essential to identify and prevent further secondary cases and effectively manage the current outbreak.

Considerations relating to surveillance and reporting

Surveillance

current surveillance and monkeypox case investigations aim to rapidly identify cases, clusters, and sources of infection immediately to provide optimal clinical care, isolate cases to prevent further transmission, identify and manage contacts and tailor effective control and prevention methods based on commonly identified routes of transmission.

In non-endemic countries, a case is an outbreak. Due to the public health risks associated with a single monkeypox case, clinicians should report suspected cases immediately to national or local public health authorities whilst also exploring other potential diagnoses. Report cases immediately, according to the case definitions above or nationally tailored case definitions. Report Probable and confirmed cases immediately to WHO via IHR National Focal Points under the International Health Regulations (IHR 2005).

Countries should look for signals from patients with unusual rash, vesicular or pustular lesions or lymphadenopathy, often associated with fever, in various community and health care settings, including but not only primary care, fever clinics, sexual health services, infectious disease units, obstetrics and gynecology, and dermatology clinics. Rash-like illness surveillance should intensify, and guidance given to collect skin samples testing.

Reporting

Case reports should include at a minimum the following information: date of report; reporting location; name, age, sex and residence of the case; date of onset of first symptoms; recent travel history; recent exposure to a probable or confirmed case; relationship and nature of contact with probable or confirmed cases (where relevant); recent history of multiple or anonymous sexual partners; smallpox vaccination status; presence of rash; presence of other clinical signs or symptoms as per case definition; date of confirmation (where done); method of confirmation (where done); genomic characterization (if available); other relevant clinical or laboratory findings, particularly to exclude common causes of rash as per the case definition; whether hospitalized; date of hospitalization (where done); and outcome at time of reporting.

A global case reporting form is under development.

Considerations related to case investigation

During human monkeypox outbreaks, close physical contact with infected persons is the most significant risk factor for infection. If monkeypox is suspected, investigation should comprise (i) patient clinical examination using appropriate infection prevention and control (IPC) measures, (ii) questioning the patient about infection sources and presence of similar disease in their community and contacts, and (iii) safe collection and dispatch of specimens for laboratory examination. Data to capture is listed under ‘Reporting.’ Exposure investigation should cover the period between five and 21 days before symptom onset. Isolate any patient with suspected monkeypox during the presumed and known

infectious periods, during the prodromal and rash stages, respectively. Laboratory confirmation of suspect cases is important but should not delay public health action implementation. Investigate suspected presence of similar disease in the patient's community or amongst contacts.

Retrospective cases found by active search may no longer have clinical monkeypox symptoms (but recovered from acute illness) but may exhibit scarring and other sequelae. Collect epidemiological information from retrospective cases and active ones. Retrospective cases cannot be laboratory confirmed; however, assess serum from retrospective cases for anti-orthopoxvirus antibodies to aid case classification.

Human or animal Samples taken from those with suspected monkeypox infection, should be managed by trained staff working in suitably equipped laboratories, strictly following National and international regulations on transport of infectious substances strictly during sample packing and transportation to testing laboratories. Carefully plan considering national laboratory testing capacity. Inform Clinical laboratories before submitting samples from suspected or confirmed monkeypox cases, to minimize risk to laboratory workers and safely perform laboratory tests essential for clinical care.

Considerations related to contact tracing

Contact tracing is a key public health measure to control the spread of infectious disease pathogens such as monkeypox virus. It allows for the interruption of transmission and can also help people at a higher risk of developing severe disease to identify exposure more quickly to monitor their health status and can seek medical care faster if symptomatic. When a suspected case is identified, initiate contact identification and contact tracing. Interview case patients to elicit names and contact information of all such persons. Notify contacts within 24 hours of identification.

Definition of a contact

A contact is 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
- contact with contaminated materials such as clothing or bedding

Contact identification

Cases should identify contacts across various contexts, including household, workplace, sexual contacts, healthcare, transportation, sports, social gatherings, and other interactions. Attendance lists, passenger manifests, etc. can help identify contacts.

Contact monitoring

Monitor contacts at least daily for onset of signs/symptoms for up to 21 days from the last patient contact or their contaminated materials during infection. Signs/symptoms of concern include headache, fever, chills, sore throat, malaise, fatigue, rash, and

lymphadenopathy. Contacts should monitor their temperatures twice daily. Asymptomatic contacts should not donate blood, cells, tissue, organs, breast milk, or semen while under symptom surveillance. Asymptomatic contacts can continue routine daily activities such as travelling to work and attending school (i.e., no quarantine is necessary), but should remain close to home whilst under surveillance.

Monitoring Options by public health authorities are dependent on available resources. Monitor contacts passively, actively, or directly.

- In passive monitoring, identified contacts receive information on signs/symptoms to monitor, permitted activities, and how to contact the public health department if signs/symptoms develop.
- Active monitoring is when public health officials are responsible for checking at least once a day to see if a person under monitoring has self-reported signs/symptoms.
- Direct monitoring is a variation of active monitoring that involves at least daily either physically visiting or visually examining via video for signs of illness.

A contact developing initial signs/symptoms other than rash should be isolated and closely watched for signs of rash for the next week. If no rash develops, the contact can return to temperature monitoring for the rest of the 21 days. Isolate the contact who develops a rash, evaluate as a suspected case, and collect a specimen for monkeypox test analysis.

Monitoring exposed health workers and caregivers

Any health worker or household member who has cared for a person with probable or confirmed monkeypox should be alert to developing symptoms that could suggest monkeypox infection, especially within 21-days after the last date of care. Health workers should notify infection control, occupational health, and public health authorities to guide about a medical evaluation.

Health workers with unprotected exposures (i.e., not wearing appropriate PPE) to patients with monkeypox or contaminated materials do not need exclusion from work duty if asymptomatic, but should undergo active surveillance for symptoms, including measuring temperature at least twice daily for 21 days following exposure. Before attending work each day, interview the worker about evidence of any relevant signs/symptoms above.

Healthcare workers who care for or have been in direct or indirect contact with monkeypox patients while adhering to recommended IPC measures may undergo self-monitoring or active monitoring as determined by local public health authorities.

Consider post-exposure vaccination (ideally within four days of exposure) in some countries for higher risk contacts such as health workers and laboratory personnel.

Travel-related contact tracing

Public health officials should work with travel operators and public health counterparts in other locations to assess potential risks and to contact passengers and others who may have had contact with an infectious patient while in transit.

Considerations related to risk communication and community engagement

Two-way communication on monkeypox related risks and engagement of at-risk and affected communities on prevention, detection, and care, is essential to prevent further spread of monkeypox and control the current outbreak. This includes providing public health advice through channels explaining how the disease transmits, its symptoms, preventive measures and overseeing suspect or confirmed infection. This should combine with targeting community engagement to population groups most at risk, working closely with health care providers, including sexual health clinics, and civil society organizations.

Risk communication should utilize insights from social listening detecting public sentiment and addressing rumours and misinformation. Provide health information and advice to avoid stigmatization of certain groups such as men having sex with men (MSM). Key messages include:

- **Prevention** - Someone with direct contact with an infected person, including sexual contact can get monkeypox. Self-protection steps include avoiding skin to skin or face to face contact with anyone with symptoms, practicing safer sex, cleaning hands with water and soap or alcohol-based hand rub, and respiratory etiquette.

- **Detection and care** - If people develop a rash, accompanied by fever or a feeling of discomfort or illness, they should contact their health care provider and assessed for monkeypox. Persons suspected or confirmed as having monkeypox should isolate until the scabs have fallen off and abstain from sex, including oral sex. During this period, patients can get supportive treatment to ease monkeypox symptoms. Anyone caring for a person sick with monkeypox should use appropriate personal protective measures, including wearing a mask, and cleaning objects, & surfaces touched.

- **Reporting** - Any rash-like illness during travel or after should be immediately reported to a medic, including information about all recent travel, sexual history, and smallpox immunization history. Residents and travellers to monkeypox-endemic countries should avoid contact with sick mammals that could harbour monkeypox virus and refrain from eating or handling wild game.

Considerations related to large gatherings

The Media have raised concerns regarding amplification of the spread of monkeypox virus in the context of large gatherings. Large gatherings may represent a conducive environment for the transmission of monkeypox virus as they entail close, prolonged, and frequent interactions among people, which in turn can expose attendees to contact with lesions, body fluids, respiratory droplets, and contaminated materials.

While exact monkeypox transmission mechanisms are under investigation, and differ from SARS-CoV-2, general precautionary measures recommended against COVID-19 should protect from monkeypox transmission.

Any person meeting the suspected, probable, and confirmed case definition detailed above should avoid close contact with any other individual and not attend large gatherings. WHO is closely monitoring the current outbreak. No current specific measures prevent holding, postponing, or cancelling a mass gathering in areas with cases, but share information with prospective attendees of mass gatherings to make informed decisions.

Considerations related to clinical management & infection prevention and control in health care settings

Health workers caring for patients with suspected or confirmed monkeypox should implement standard, contact and droplet precautions. These precautions apply in any health facility including outpatient services and hospitals. Standard precautions include strict adherence to hand hygiene, appropriate handling of contaminated medical equipment, laundry, waste and cleaning and disinfection of environmental surfaces.

Recommend prompt isolation of suspected or confirmed cases in a single room with adequate ventilation, dedicated bathroom, and staff. Implement Cohort (confirmed with confirmed, suspected with suspected) if single rooms are not available, ensuring 1-meter minimum distance between patients. Recommended PPE includes gloves, gown, medical mask, and eye protection – goggles or face shield. The patient should wear a medical mask when they come into close contact (under 1m) with health workers or other patients if they can tolerate it. Also, use a bandage, sheet, or gown to cover lesions to minimize potential contact. Dispose of PPE before leaving the patient isolation area.

If aerosol generating procedures (AGPs) (i.e., aspiration or open suctioning of respiratory tract specimens, bronchoscopy, intubation, cardiopulmonary resuscitation), is immediately required then use a respirator (FFP2 or EN certified equivalent or US NIOSH-certified N95) by health care workers and not a medical mask.

Continue Isolation and transmission-based precautions until resolution of symptoms (including any rash and scabs that have fallen off and healed).

Consider deployment of pharmaceutical countermeasures including specific antivirals (i.e., tecovirimat, approved for monkeypox, but not yet widely available) under investigational or compassionate use protocols, particularly for those with severe symptoms or who may be at risk of poor outcomes (those immune suppressed). A recently approved monkeypox vaccine is not yet widely available. Some countries may hold smallpox vaccine products for use according to national guidance. Any request for vaccine products may potentially be available in limited quantities through national authorities, depending on the country.

Based on current available information WHO does not recommend that Member States adopt any international travel-related measure for both, incoming and outgoing travelers.

WHO will provide interim technical guidance in the coming days.

Natalie Shaw
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