



# **MONKEYPOX**

## **Health Sector Preparedness and Response Plan**

**Version 1 August 2022**

*Endorsed by the Director of Public Health*

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## Executive summary

### Strategic Plan

The goal of the global response to the multi-country outbreak of monkeypox is to stop the outbreak.

The goal of the national response in Vanuatu is to detect any imported case early and to stop human-to-human transmission.

The **strategic objectives** for achieving these goals are as follows:

1. Activation of coordination and emergency response mechanisms
2. Prevention and mitigation by limiting human-to-human transmission, including through quarantine and vaccination
3. Risk communication and community engagement
4. Early detection and isolation of any imported case
5. Clinical management of cases
6. Maintenance of essential health services

Details on these strategic objectives are outlined in the first section of this document.

### Operational Plan

The second part describes the **operational plan** based on the six strategic objectives. It outlines the interventions to be implemented for each strategic objective, grouped by capacity areas.

Standard Operating Procedures, guidelines, tools, flow charts and training packages have been developed to guide and support implementation of interventions contained in the plan.

## Background

### Epidemiology of Monkeypox

Monkeypox virus is an orthopoxvirus that causes a disease with symptoms similar to, but less severe than, smallpox. While smallpox was eradicated in 1980, monkeypox continues to occur in countries of central and west Africa. Two distinct clades are identified: the west African clade and the Congo Basin clade, also known as the central African clade.

Monkeypox is a zoonosis: a disease that is transmitted from animals to humans. Cases are often found close to tropical rainforests where there are animals that carry the virus. Evidence of monkeypox virus infection has been found in animals including squirrels, Gambian poached rats, dormice, different species of monkeys and others.

Since early May 2022, cases of monkeypox have been reported from countries where the disease is not endemic and continue to be reported in several endemic countries. Most confirmed cases with travel history reported travel to countries in Europe and North America, rather than West or Central Africa where the monkeypox virus is endemic. This is the first time that many monkeypox cases and clusters have been reported concurrently in non-endemic and endemic countries in widely disparate geographical areas.

### **Transmission and symptoms**

Anyone can catch monkeypox, especially if they have travelled to countries with cases. Monkeypox virus is transmitted through close contact with lesions, bodily fluids, respiratory droplets of an infected person or animal, or with material contaminated with the virus such as bedding.

Based on current available information for this outbreak, 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.

Monkeypox presents with fever, an extensive characteristic rash and usually swollen lymph nodes. It is important to distinguish monkeypox from other illnesses such as chickenpox, measles, bacterial skin infections, scabies, syphilis and medication-associated allergies.

The incubation period of monkeypox can range from 5 to 21 days. The febrile stage of illness usually lasts 1 to 3 days with symptoms including fever, intense headache, lymphadenopathy (swelling of the lymph nodes), back pain, myalgia (muscle ache), and an intense asthenia (lack of energy). The febrile stage is followed by the skin eruption stage, lasting for 2 to 4 weeks. Lesions evolve from macules (lesions with a flat base) to papules (raised firm painful lesions) to vesicles (filled with clear fluid) to pustules (filled with pus), followed by scabs or crusts.

Monkeypox is less contagious than smallpox and causes less severe illness. It is usually a self-limited disease, most people recovered without specific treatment, with symptoms lasting from 2 to 4 weeks. Medical complications can occur

### **Global update as of 22 July 2022:**

Since 1 January 2022, cases of monkeypox have been reported to WHO from 75 Member States across all 6 WHO regions.

As of 22 July 2022 at 17h CEST, a total of 16,016 laboratory confirmed cases and 73 probable cases, including 5 deaths, have been reported to WHO.

Since 13 May 2022, a high proportion of these cases have been reported from countries without previously documented monkeypox transmission. This is the first time

that cases and sustained chains of transmission have been reported in countries without direct or immediate epidemiological links to areas of West or Central Africa.

### ***Announcement of Monkeypox multi-country outbreak as a Public Health Emergency of International Concern:***

- Thursday, 21 July 2022: Second meeting of the International Health Regulations (2005) (IHR) Emergency Committee regarding the multi-country outbreak of monkeypox.
- Saturday, 23 July 2022: WHO Director-General's statement at the press conference following IHR Emergency Committee regarding the multi-country outbreak of monkeypox announcing the **Public Health Emergency of International Concern**.

Five elements were considered in deciding whether the multi-country outbreak of monkeypox constitutes a public health emergency of international concern.

1. The information provided by countries – which in this case shows that this virus has spread rapidly to many countries that have not seen it before.
2. The three criteria for declaring a PHEIC, which have been met: criteria 1) an extraordinary event, with risk which constitutes a 2) public health risk to other countries through the international spread, and potentially 3) requires a coordinated international response.
3. The advice of the Emergency Committee.
4. Scientific principles, evidence and other relevant information – which are currently insufficient and leave us with many unknowns.
5. The risk to human health, international spread, and the potential for interference with international traffic, which remains low for the moment.

A PHEIC is defined in the IHR (2005) as, “an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response”.

This definition implies a situation that is:

- serious, sudden, unusual or unexpected;
- carries implications for public health beyond the affected State's national border; and
- may require immediate international action.

### ***Current situation and preparedness and response status in Vanuatu***

As of 12 August 2022, no monkeypox cases have been detected in Vanuatu. The following actions have been undertaken:

- First press release issued on 1st June 2022

- Second press release issued on 27 July 2022
- WHO Interim guidance documents shared with relevant units:
  - Surveillance
  - Laboratory
  - Risk Communication and Community Engagement
  - Immunization
  - Clinical Management and IPC
- Specimen referral pathway for laboratory confirmation identified: VIDRL in Melbourne

## Strategic preparedness and response plan

### Goal

The goal of the global response to the multi-country outbreak of monkeypox is to stop the outbreak.

The goal of the national response in Vanuatu is to detect any imported case early and to stop human-to-human transmission.

### Strategic objectives

The strategic objectives of the Plan are:

1. Activation of coordination and emergency response mechanisms
2. Prevention and mitigation of Monkeypox infections by limiting human-to-human transmission, including through quarantine of contacts, isolation of cases.
3. Adequate risk communication and community engagement on Monkeypox to all communities, counter misinformation and stigma, focusing on high risk groups.
4. Early detection and isolation of suspected Monkeypox cases through an active and functional surveillance system, including contact tracing.
5. Proper clinical management of suspected and confirmed Monkeypox cases, including infection prevention and control and isolation of cases.
6. Maintain essential health service provision, delivered through approaches to prevent and mitigate Monkeypox infections.

**The confirmation of one case of monkeypox is considered an outbreak**



The Preparedness and Response plan is aligned with WHO Temporary recommendations issued on 23 July 2022 (Annex 1). As of 12 August 2022, Vanuatu falls under the first group of country with not yet reported cases of monkeypox. Recommendations for other groups of countries are presented in full in the Annex.

### ***Temporary Recommendations issued by the WHO Director-General in relation to the multi-country outbreak of monkeypox***

These Temporary Recommendations apply to different groups of States Parties, based on their epidemiological situation, patterns of transmission and capacities. Each States Party, at any given point in time, falls either under Group 1 or under Group 2. Some State Parties may also fall under Group 3 and/or Group 4.

All Temporary Recommendations are expected to be implemented in full respect of established principles of human rights, inclusion and the dignity of all individuals and communities.

- First, those that have not yet reported a case of monkeypox, or have not reported a case for more than 21 days;
- Second, those with recently imported cases of monkeypox and that are experiencing human-to-human transmission;
- The third group of countries is those with transmission of monkeypox between animals and humans; and
- The fourth is countries with manufacturing capacity for diagnostics, vaccines and therapeutics.

#### **Group 1: States Parties, with no history of monkeypox in the human population or not having detected a case of monkeypox for over 21 days**

**1.a.** Activate or establish health and multi-sectoral coordination mechanisms to strengthen all aspects of readiness for responding to monkeypox and stop human to human transmission.

**1.b.** Plan for, and/or implement, interventions to avoid the stigmatization and discrimination against any individual or population group that may be affected by monkeypox, with the goal of preventing further undetected transmission of monkeypox virus. The focus of these interventions should be: to promote voluntary self-reporting and care seeking behaviour; to facilitate timely access to quality clinical care; to protect the human rights, privacy and dignity of affected individuals and their contacts across all communities.

**1.c.** Establish and intensify epidemiological disease surveillance, including access to reliable, affordable and accurate diagnostic tests, for illness compatible with monkeypox as part of existing national surveillance systems. For disease surveillance purposes, case definitions for suspected, probable and confirmed cases of monkeypox should be adopted.

**1.d.** Intensify the detection capacity by raising awareness and training health workers, including those in primary care, genitourinary and sexual health clinics, urgent care / emergency departments, dental practices, dermatology, paediatrics, HIV services, infectious diseases, maternity services, obstetrics and gynaecology, and other acute care facilities.

**1.e.** Raise awareness about monkeypox virus transmission, related prevention and protective measures, and symptoms and signs of monkeypox among communities that are currently affected elsewhere in this multi-country outbreak (e.g., importantly, but not exclusively, gay, bisexual and other men who have sex with men (MSM) or individuals with multiple sexual partners) as well as among other population groups that may be at risk (e.g., sex workers, transgender people).

**1.f.** Engage key community-based groups, sexual health and civil society networks to increase the provision of reliable and factual information about monkeypox and its potential transmission to and within populations or communities that may be at increased risk of infection.

**1.g.** Focus risk communication and community support efforts on settings and venues where intimate encounters take place (e.g., gatherings focused on MSM, sex-on-premises venues). This includes engaging with and supporting the organizers of large and smaller scale events, as well as with owners and managers of sex on premises venues to promote personal protective measures and risk-reducing behaviour.

**1.h.** Immediately report to WHO, through channels established under the provision of the IHR, probable and confirmed cases of monkeypox, including using the minimum data set contained in the WHO Case Report Form (CRF).

**1.i.** Implement all actions necessary so as to be ready to apply or continue applying the set of Temporary Recommendations enumerated for Group 2 below in the event of first-time or renewed detection of one or more suspected, probable or confirmed cases of monkeypox.

## **Health systems capacity**

The main health systems capacity/areas required at national and sub-national level are:

- Emergency coordination mechanisms
- Point of Entry Measures and international travel
- Risk Communication and Community Engagement
- Surveillance and case investigation
- Contact tracing
- Laboratory
- Clinical Management and IPC
- Mental Health and Psycho-Social Support (MHPSS): Mental health care of patients with monkeypox



- Immunization

The following sections are based on the Temporary recommendations issued by WHO on 23 July 2022 and WHO Interim guidance (Annex 1).

### ***Incident management, planning and multisectoral coordination:***

The structure of response mechanisms and stakeholders is shown in Annex 2.

### **Health Incident Management System and Health Emergency Operations Centre (EOC)**

Health IMS is activated and the Health Incident Management Team is formed by the MOH Executive in recognition of the need for management and coordination of health activities related to preparedness and response for Monkeypox. The Health IMT operate from the Emergency Operations Centre (EOC). These EOCs are formed at national and provincial levels.

The IMT/EOC for Monkeypox perform five core functions to support the Emergency Operations System.

1. Management and Coordination,
2. Information and Planning,
3. Health Operations,
4. Operations Support and Logistics,
5. Finance and administration.

The Terms of reference for the Emergency Operations Centres are:

- Management and coordination of operations on a regular basis (from daily to weekly depending on the situation): coordination with implementing partners, health operations, risk communication, logistics, admin-finance
- Regular briefing and update meeting
- Regular production of Situation Reports for dissemination (from daily to weekly depending on the situation)

### **Health Technical Advisory Group**

The Health Technical Advisory Group (HTAG) was endorsed by the Ministry of Health Executive Committee on 30 April 2020. This document presents selected technical recommendations related to Monkeypox as issued by the HTAG to the Vanuatu Ministry of Health.

### ***Points of entry measures and international travel***

Based on WHO temporary recommendations (Annex 1)

#### **2.f. International travel**

**2.f.i.** Adopt and apply the following measures:

Any individual:

- With signs and symptoms compatible with monkeypox virus infection; or being considered a suspect, probable, or confirmed case of monkeypox by jurisdictional health authorities; or
- Who has been identified as a contact of a monkeypox case and, therefore, is subject to health monitoring, should avoid undertaking any travel, including international, until they are determined as no longer constituting a public health risk. Exemptions include any individual who need to undertake travel to seek urgent medical care or flee from life-threatening situations, such as conflict or natural disasters; and contacts for whom pre-departure arrangements to ensure the continuity of health monitoring are agreed upon by sub-national health authorities concerned, or, in the case of international travel, by national health authorities;
- Cross-border workers, who are identified as contacts of a monkeypox case, and, hence, under health monitoring, can continue their routine daily activities provided that health monitoring is duly coordinated by the jurisdictional health authorities from both/all sides of the border.

**2.f.ii.** Establish operational channels between health authorities, transportation authorities, and conveyances and points of entry operators to:

- Facilitate international contact tracing in relation to individuals who have developed signs and symptoms compatible with monkeypox virus infection during travel or upon return;
- Provide communication materials at points of entry on signs and symptoms consistent with monkeypox; infection prevention and control; and on how to seek medical care at the place of destination;

WHO advises against any additional general or targeted international travel-related measures other than those specified in paragraphs **2.f.i** and **2.f.ii**.

***Risk communication and community engagement***

The following section is based on <https://www.who.int/publications/i/item/WHO-MPX-RCCE-2022.1>

The goal of the RCCE response is to help control the outbreak and prevent onward transmission of monkeypox by informing and engaging affected populations.

The key objectives of RCCE activities for monkeypox are to:

- raise awareness,
- manage risk perception,
- maintain trust in health authorities and response measures,

- and proactively communicate to support people at risk to make informed decisions to protect themselves and others from infection and severe disease.
- RCCE activities must strike an appropriate balance of being informative and specific to higher risk populations without cultivating stigma or excluding other persons or groups potentially at risk.
- Clear, targeted, and intense efforts are needed to provide information where it will reach people at risk, including sexually active MSM and sex workers.

### **Surveillance and case investigation**

The following section is based on <https://www.who.int/publications/i/item/WHO-MPX-Surveillance-2022.2>

The key objectives of surveillance and case investigation for monkeypox in the current context are:

- to rapidly identify cases and clusters of infections and the sources of infections as soon as possible in order to provide optimal clinical care;
- to isolate cases to prevent further transmission;
- to identify and manage contacts; to protect frontline health workers; and
- to tailor effective control and prevention measures based on the most commonly identified routes of transmission.

**One case of monkeypox is considered an outbreak.** Because of the public health risks associated with a single case of monkeypox, clinicians should report suspected cases immediately to national or local public health authorities regardless of whether they are also exploring other potential diagnoses, according to the case definitions above or nationally tailored case definitions.

Probable and confirmed cases should be reported immediately to WHO through IHR national focal points (NFPs) under the International Health Regulations (IHR 2005).

### **Contact tracing**

The following section is based on <https://www.who.int/publications/i/item/WHO-MPX-Surveillance-2022.2>

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 more quickly identify their exposure, so that their health status can be monitored and they can seek medical care quickly if they become symptomatic.

Case-patients should be interviewed to elicit the names and contact information of all such persons. Contacts should be notified within 24 hours of identification.

In the current context, as soon as a suspected case is identified, contact identification and contact tracing should be initiated, while further workup of the source case is ongoing to determine if the case can be classified as probable or confirmed; in the event that the case is discarded, contact tracing may be aborted.

### **Laboratory**

The following section is based on <https://www.who.int/publications/i/item/WHO-MPX-laboratory-2022.1>

The national laboratory (VCH) and sub-national laboratories (NPH) and private laboratories/practitioners should be ready to correctly collect and package samples (swabs) for monkeypox suspected cases. Training on sample collection, packaging and overseas shipment procedures is required.

Any individual meeting the definition for a suspected case should be offered testing. The decision to test should be based on both clinical and epidemiological factors, linked to an assessment of the likelihood of infection.

Due to the range of conditions that cause skin rashes and because clinical presentation may more often be atypical in this outbreak, it can be challenging to differentiate monkeypox solely based on the clinical presentation, particularly for cases with an atypical presentation.

### **Specimen to be collected**

The recommended specimen type for laboratory confirmation of monkeypox is skin lesion material, including swabs of lesion surface and/or exudate, roofs from more than one lesion, or lesion crusts. Swab the lesion vigorously, to ensure adequate viral DNA is collected. Both dry swabs and swabs placed in viral transport media (VTM) can be used. Two lesions of the same type should be collected in one single tube, preferably from different locations on the body and which differ in appearance. Lesions, crusts and vesicular fluids should not be mixed in the same tube. If resources permit it, two tubes may be collected to minimise risk of poor sampling or inhibitors, however only one should be tested and the second should only be tested in case the first provides inconclusive results. In addition to a lesion specimen, the collection of an oropharyngeal swab is encouraged. However, data on the accuracy of this specimen type for diagnosis is limited for monkeypox, therefore a negative throat swab specimen should be interpreted with caution.

### **Packaging and shipment of clinical specimens**

Specimens should be stored refrigerated or frozen within an hour of collection and transported to the laboratory as soon as possible after collection. Correct handling and storage of specimens during transportation is essential for accurate diagnostic testing (see Annex 3). Transport of specimens should comply with any applicable national and/or international regulations, including the UN Model Regulations and

any other applicable regulations depending on the mode of transport being used. For international transport, specimens from suspected probable or confirmed cases of MPXV, including clinical samples, viral isolates and cultures should be transported as Category A, UN2814 "infectious substance, affecting humans." All specimens being transported should have appropriate triple packaging, labelling and documentation.

Testing for the presence of MPXV should be performed in appropriately equipped laboratories by staff trained in the relevant technical and safety procedures. Confirmation of MPXV infection is based on nucleic acid amplification testing (NAAT), using real-time or conventional polymerase chain reaction (PCR), for detection of unique sequences of viral DNA. PCR can be used alone, or in combination with sequencing.

### ***Clinical management and IPC***

The following section is based on <https://www.who.int/publications/i/item/WHO-MPX-Clinical-and-IPC-2022.1>

Caring for patients with suspected or confirmed MPX requires early recognition of suspects, rapid implementation of appropriate IPC measures, testing of likely pathogens to confirm diagnosis, symptomatic management of patients with mild or uncomplicated MPX and monitoring for and treatment of complications and life-threatening conditions such as severe dehydration, severe pneumonia and sepsis.

The role of MPX-specific therapeutics remains experimental and can be used under RCTs (preferred) or expanded access protocols.

Implementation of appropriate IPC measures with engineering, administrative and personal protective equipment (PPE) controls is essential to mitigate and control transmission of MPX in health care and community settings. All patients with MPX should receive respectful, patient-centred care that maintains dignity, privacy and confidentiality.

### **Screening, triage, isolation and clinical assessment**

At the first point of contact with the health system, screening and triage be performed for all persons who present with a rash and fever or lymphadenopathy, according to locally adapted WHO case definition (), to identify individuals that have suspected or confirmed MPX.

After screening and isolation, triage patients with suspected MPX using a standardized triage tool (such as the WHO/IFRC Interagency Integrated Triage Tool); and evaluate the patient to determine risk factors and presence of severe disease.

Test suspected patients for MPX.

## **Management of mild or uncomplicated monkeypox**

Patients with suspected or confirmed MPX with mild, uncomplicated disease and not at high risk for complications can be isolated at home, for the duration of the infectious period, as long as a home assessment determines infection prevention and control (IPC) conditions are fulfilled at home setting.

A home assessment should be conducted when deciding to isolate and care for a person with suspected or confirmed MPX with mild uncomplicated disease in a home setting.

A patient with mild, uncomplicated MPX cared for at home should be isolated in an area separate from other household members and away from shared areas of the home (i.e. a separate room or area with a curtain or screen).

Caution should be taken when handling and cleaning linens, household surfaces and during waste disposal.

Patients with MPX be given symptomatic treatment such as antipyretics for fever and analgesia for pain.

Patients with MPX be assessed for their nutritional status and given adequate nutrition and appropriate rehydration.

Counsel patients with mild MPX about signs and symptoms of complications that should prompt urgent care.

Conservative treatment of rash lesions should be performed dependent of their stage with aims to relieve discomfort, speed healing and prevention of complications, such as secondary infections or exfoliation.

Antibiotic therapy or prophylaxis is not to be used in patients with uncomplicated MPX. However, lesions should be monitored for secondary bacterial infection (i.e. cellulitis, abscess) and if present treated with antibiotics with activity against normal skin flora, including *Streptococcus pyogenes* and methicillin-sensitive *Staphylococcus aureus* (MSSA).

## **Antiviral and other therapies**

In patients with MPX, it is preferable to use antivirals under randomized clinical trials (RCTs) with collection of standardized clinical and outcome data to rapidly increase evidence generation on efficacy and safety and, when not possible, antivirals may be used under expanded access protocols, such as MEURI (Monitored Emergency Use of Unregistered and Investigational Interventions) (3).



## **Caring for sexually active populations**

All patients should be advised to abstain from sex until ALL skin lesions from MPX have crusted, the scabs have fallen off and a fresh layer of skin has formed underneath.

Based on the precautionary principle, WHO suggests the use of condoms consistently during sexual activity (receptive and insertive oral/anal/vaginal) for 12 weeks after recovery to prevent the potential transmission of MPX.

## **Infection prevention and control**

Contact and droplet precautions be implemented for any suspect patient with MPX. In addition to contact and droplet precautions, airborne precautions should be implemented if varicella zoster virus (i.e. chickenpox) is suspected and until it is excluded.

Contact and droplet precautions be implemented for any confirmed patient with MPX. In addition to contact and droplet precautions, respirators should be used.

Airborne precautions be implemented if aerosol-generating procedures (AGPs) are performed.

Areas within the health care facility frequently used by the patient or where patient care activities occur and patient care equipment should be cleaned and disinfected as per national or facility guidelines.

Linens, hospital gowns, towels and any other fabric items should be handled and collected carefully.

All bodily fluids and solid waste of patients with MPX should be treated as infectious waste.

Patients isolated with MPX should have measures put in place to support patient interaction with family and visitors to promote well-being.

The main IPC interventions are:

- Training on IPC principles and practices, including table-top and simulation exercise for health care workers, cleaners, porters, ambulance drivers, POE staff
- Provision of hand washing facilities and supplies
- Ensure sufficient stocks of PPE (monitor and procure)
- Develop tools and visual aids for proper PPE use
- Risk communication on hand and cough hygiene
- Waste management
- Dead body management and funeral/burial practices
- Environmental cleaning and disinfection updates done in the TOT IPC slides. IPC team is planning to produce short video clips for cleaners on how to safely use

appropriate PPE, prepare cleaning solutions/disinfectants and the principles of decontamination etc..

### ***Mental Health and Psycho-Social Support (MHPSS): Mental health care of patients with monkeypox***

The following section is based on <https://www.who.int/publications/i/item/WHO-MPX-Clinical-and-IPC-2022.1>

Prompt identification and assessment for anxiety and depressive symptoms in the context of MPX should be done. Initiation of basic psychosocial support strategies and first-line interventions for the management of new anxiety and depressive symptoms should be taken.

Psychosocial support strategies should be the first-line interventions for management of sleep problems in the context of acute stress.

Patients isolated with MPX should have measures put in place to support patient interaction with family and visitors to promote well-being.

### ***Immunization***

The following section is based on <https://www.who.int/publications/i/item/who-mpx-immunization-2022.1>

Based on currently assessed risks and benefits and regardless of vaccine supply, mass vaccination is not required nor recommended for monkeypox at this time.

Human-to-human spread of monkeypox can be controlled by public health measures including early case-finding, diagnosis and care, isolation and contact-tracing. All decisions around immunization with smallpox or monkeypox vaccines should be by shared clinical decision-making, based on a joint assessment of risks and benefits, between a health care provider and prospective vaccinee, on a case-by-case basis.

Post-exposure prophylaxis (PEP): For contacts of cases, PEP is recommended with an appropriate second- or third-generation vaccine, ideally within four days of first exposure (and up to 14 days in the absence of symptoms), to prevent onset of disease.

Pre-exposure prophylaxis (PrEP): PrEP is recommended for health workers at high risk of exposure, laboratory personnel working with orthopoxviruses, clinical laboratory personnel performing diagnostic testing for monkeypox, and outbreak response team members as may be designated by national public health authorities.

Vaccination programmes should be accompanied by a strong information campaign, robust pharmacovigilance, and conduct of vaccine effectiveness studies.

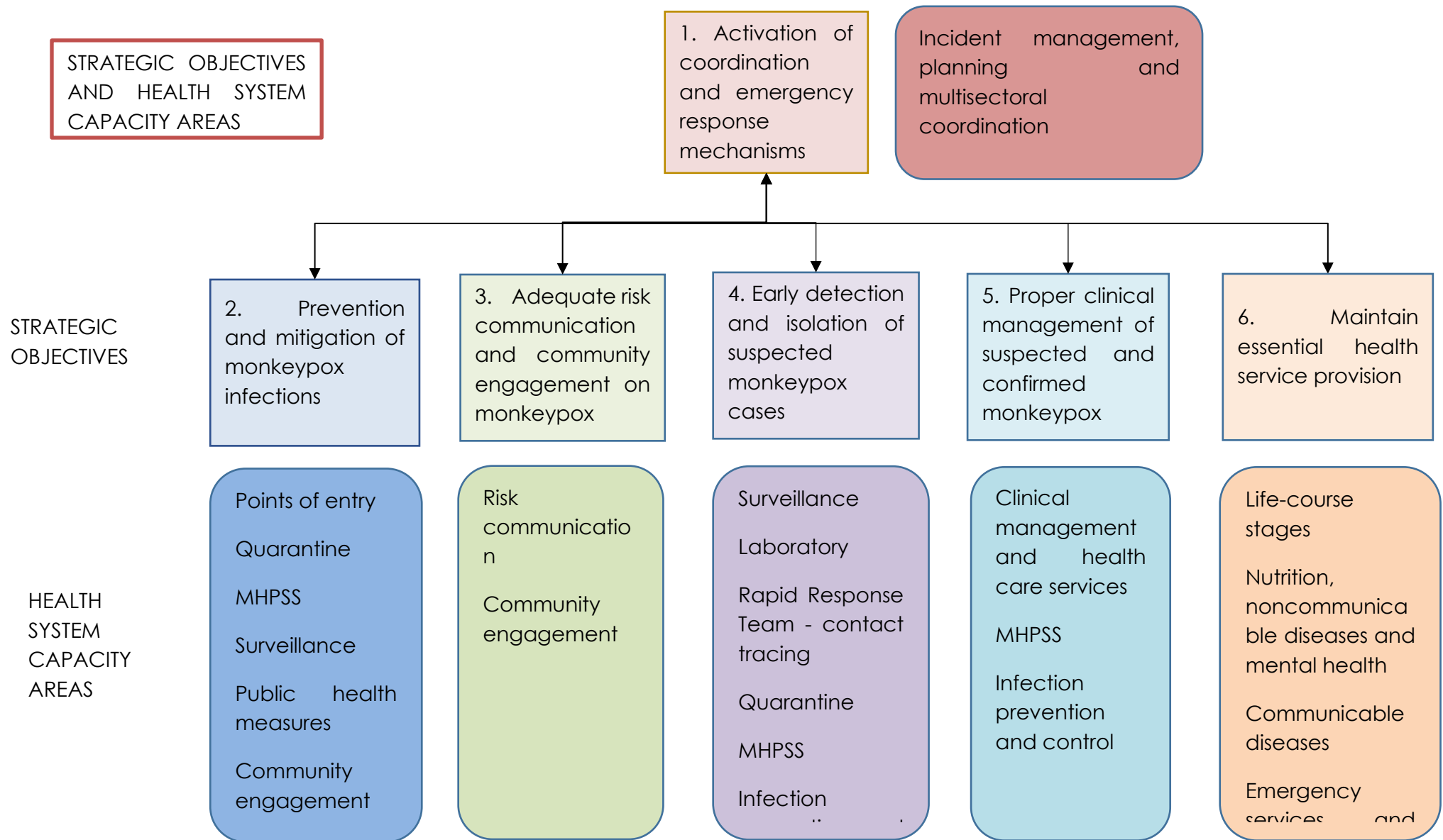
All efforts should be made to administer vaccines for monkeypox within a framework of collaborative research and randomized clinical trial (RCT) protocols with standardized data collection tools for clinical and outcome data.

### ***Continuity of essential services***

Considerations for continuity of essential services include:

- Essential health services for continuity identified
- Adopt monitoring tool/system to assess delivery and any gaps
- Identify what services can be delayed (for months or year) without health impact eg survey
- Adapt or modify any national protocols or guidelines based on global/PIC guidance
- Identify any alternative points of delivery for services eg repurposed venue, or facility which does not accept COVID-19 patients
- Identify any new or expanded outreach mechanisms for specific services
- Identify any services which will move to primary health care facilities
- Forecast medication and consumable needs for extended time period. Plan for local transport issues
- Awareness raising activities so public are aware of where services are now available
- Establish effective triage for all facilities
- Assess changes in staffing needs as a result of service provision changes and ensure rostered accordingly
- Identify triggers for activation of alternative service delivery options
- Ensure staff with modified duties receive necessary guidance and/or training for modified roles
- Assess whether any external group eg CSO or private sector (eg private pharmacy) will be considered for some service delivery
- Identify essential staff to travel for cold chain maintenance or immunization related services
- Prepare and ensure IPC for immunization (PPEs available, physical distancing during immunization etc)
- Develop SOPs for distribution of vaccines and other essential commodities to provinces and health centers

**Figure 5.** Strategic objectives and health system capacities



## Operational preparedness and response plan

### Overview

The operational plan describes the interventions to be implemented for each strategic objective grouped by capacity areas. Furthermore, the plan outlines how interventions will be adjusted, intensified or scaled-up as transmission scenarios evolve.

### Objectives and interventions

Based on WHO temporary recommendations and the strategic objectives of the Plan:

1. Activation of NHEOC and provincial Health EOC. PHE? (TBD)
2. Prevention and mitigation of Monkeypox infections by limiting human-to-human transmission, including through quarantine of contacts, isolation of cases and vaccination?
  1. Point Of Entry (POE): provide information to inbound travellers on signs and symptoms and where to seek care
  2. Develop SOPs for quarantine and isolation (home and health care settings)
  3. Explore vaccines supply with partners. Vaccination of HCW and contacts (TBD)
3. Continue risk communication and community engagement on Monkeypox to all communities, counter misinformation and stigma, focusing on high risk groups:
  1. Develop communications materials for general public and for HCWs
  2. Raise awareness among general population through press releases/press conference, talk back show, HPU FB page
  3. Raise awareness among risk groups through work with WSB, V-Pride, VFHA, private health providers for awareness and sensitisation
    1. TOT at national level
    2. Awareness sessions conducted through various networks by stakeholders
  4. Disseminate accurate information through PTAG, Area Councils
4. Early detection and isolation of suspected Monkeypox cases through an active and functional surveillance system
  1. Develop SOPs and training package based on WHO Interim guidance
  2. Develop Lab SOPs on sample collection, packaging, storing
  3. Training of HCW, including CSOs and private health providers, on Monkeypox case definition, IPC/PPE use, reporting and contact tracing
  4. Disseminate reporting forms and CRF (Kobo collect)
  5. Develop database (Go.Data)
5. Proper clinical management of suspected and confirmed Monkeypox cases, including infection prevention and control and isolation of cases
  1. Develop SOPs and training package based on WHO Interim guidance

2. Training of HCW, including CSOs and private health providers, on case definition and case management, including PPE and isolation
3. Stock-take of PPE in country and ensure that sufficient stocks of PPE are available at health facility level.
6. Maintain essential health service provision, delivered through approaches to prevent and mitigate Monkeypox infections



## Annexes

Annex 1: WHO temporary recommendations

Annex 2: Structure of response mechanism and stakeholders

Annex 3: Case definitions for monkeypox surveillance

Annex 4: Definition of a contact and risk level

Annex 5: Detailed operational plan

Annex 6: Capacity areas, responsible agencies and tools

Annex 7: Initial communication materials

## **Annex 1: WHO Temporary recommendations**

Temporary Recommendations issued by the WHO Director-General in relation to the multi-country outbreak of monkeypox

These Temporary Recommendations apply to different groups of States Parties, based on their epidemiological situation, patterns of transmission and capacities. Each States Party, at any given point in time, falls either under Group 1 or under Group 2. Some State Parties may also fall under Group 3 and/or Group 4.

All Temporary Recommendations are expected to be implemented in full respect of established principles of human rights, inclusion and the dignity of all individuals and communities.

### ***Group 1: States Parties, with no history of monkeypox in the human population or not having detected a case of monkeypox for over 21 days***

**1.a.** Activate or establish health and multi-sectoral coordination mechanisms to strengthen all aspects of readiness for responding to monkeypox and stop human to human transmission.

**1.b.** Plan for, and/or implement, interventions to avoid the stigmatization and discrimination against any individual or population group that may be affected by monkeypox, with the goal of preventing further undetected transmission of monkeypox virus. The focus of these interventions should be: to promote voluntary self-reporting and care seeking behaviour; to facilitate timely access to quality clinical care; to protect the human rights, privacy and dignity of affected individuals and their contacts across all communities.

**1.c.** Establish and intensify epidemiological disease surveillance, including access to reliable, affordable and accurate diagnostic tests, for illness compatible with monkeypox as part of existing national surveillance systems. For disease surveillance purposes, case definitions for suspected, probable and confirmed cases of monkeypox should be adopted.

**1.d.** Intensify the detection capacity by raising awareness and training health workers, including those in primary care, genitourinary and sexual health clinics, urgent care / emergency departments, dental practices, dermatology, paediatrics, HIV services, infectious diseases, maternity services, obstetrics and gynaecology, and other acute care facilities.

**1.e.** Raise awareness about monkeypox virus transmission, related prevention and protective measures, and symptoms and signs of monkeypox among communities that are currently affected elsewhere in this multi-country outbreak (e.g., importantly, but not exclusively, gay, bisexual and other men who have sex with men (MSM) or

individuals with multiple sexual partners) as well as among other population groups that may be at risk (e.g., sex workers, transgender people).

**1.f.** Engage key community-based groups, sexual health and civil society networks to increase the provision of reliable and factual information about monkeypox and its potential transmission to and within populations or communities that may be at increased risk of infection.

**1.g.** Focus risk communication and community support efforts on settings and venues where intimate encounters take place (e.g., gatherings focused on MSM, sex-on-premises venues). This includes engaging with and supporting the organizers of large and smaller scale events, as well as with owners and managers of sex on premises venues to promote personal protective measures and risk-reducing behaviour.

**1.h.** Immediately report to WHO, through channels established under the provision of the IHR, probable and confirmed cases of monkeypox, including using the minimum data set contained in the WHO Case Report Form (CRF).

**1.i.** Implement all actions necessary so as to be ready to apply or continue applying the set of Temporary Recommendations enumerated for Group 2 below in the event of first-time or renewed detection of one or more suspected, probable or confirmed cases of monkeypox.

***Group 2: States Parties, with recently imported cases of monkeypox in the human population and/or otherwise experiencing human-to-human transmission of monkeypox virus, including in key population groups and communities at high risk of exposure***

**2.a. Implementing coordinated response**

**2.a.i.** Implement response actions with the **goal of stopping human-to-human transmission** of monkeypox virus, with a priority focus on communities at high risk of exposure, which may differ according to context and include gay, bisexual and other men who have sex with men (MSM). Those actions include: targeted risk communication and community engagement, case detection, supported isolation of cases and treatment, contact tracing, and targeted immunization for persons at high risk of exposure for monkeypox.

**2.a.ii.** Empower affected communities and enable and support their leadership in devising, contributing actively to, and monitoring the response to the health risk they are confronting. Extend technical, financial and human resources to the extent possible and maintain mutual accountability on the actions of the affected communities.

**2.a.iii.** Implement response actions with the goal of **protecting vulnerable groups** (immunosuppressed individuals, children, pregnant women) who may be at

risk of severe monkeypox disease. Those actions include: targeted risk communication and community engagement, case detection, supported isolation of cases and treatment, contact tracing. These may also include targeted immunization which takes into careful consideration the risks and benefits for the individual in a shared clinical decision-making.

## **2.b. Engaging and protecting communities**

**2.b.i.** Raise awareness about monkeypox virus transmission, actions to reduce the risk of onward transmission to others and clinical presentation in communities affected by the outbreak, which may vary by context, and promote the uptake and appropriate use of prevention measures and adoption of informed risk mitigation measures. In different contexts this would include limiting skin to skin contact or other forms of close contact with others while symptomatic, may include promoting the reduction of the number of sexual partners where relevant including with respect to events with venues for sex on premises, use of personal protective measures and practices, including during, and related to, small or large gatherings of communities at high risk of exposure.

**2.b.ii** Engage with organizers of gatherings (large and small), including those likely to be conducive for encounters of intimate sexual nature or that may include venues for sex-on-premises, to promote personal protective measures and behaviours, encourage organizers to apply a risk-based approach to the holding of such events and discuss the possibility of postponing events for which risk measures cannot be put in place. All necessary information should be provided for risk communication on personal choices and for infection prevention and control including regular cleaning of event venues and premises.

**2.b.iii.** Develop and target risk communication and community engagement interventions, including on the basis of systematic social listening (e.g., through digital platforms) for emerging perceptions, concerns, and spreading of misinformation that might hamper response actions.

**2.b.iv.** Engage with representatives of affected communities, non-government organizations, elected officials and civil society, and behavioural scientists to advise on approaches and strategies to avoid the stigmatization of any individual or population groups in the implementation of appropriate interventions, so that care seeking behaviour, testing and access to preventive measures and clinical care is timely, and to prevent undetected transmission of monkeypox virus.

## **2.c. Surveillance and public health measures**

**2.c.i.** Intensify surveillance for illness compatible with monkeypox as part of existing national surveillance schemes, including access to reliable, affordable and accurate diagnostic tests.

**2.c.ii.** Report to WHO, on a weekly basis and through channels established under the provision of the IHR, probable and confirmed cases of monkeypox, including using the minimum data set contained in the WHO Case Report Form (CRF).

**2.c.iii.** Strengthen laboratory capacity, and international specimens referral capacities as needed, for the diagnosis of monkeypox virus infection, and related surveillance, based on the use of nucleic acid amplification testing (NAAT), such as real time or conventional polymerase chain reaction (PCR).

**2.c.iv.** Strengthen genomic sequencing capacities, and international specimens referral capacities as needed, building on existing sequencing capacities worldwide, to determine circulating virus clades and their evolution, and share genetic sequence data through publicly accessible databases.

**2.c.v.** Isolate cases for the duration of the infectious period. Policies related to the isolation of cases should encompass health, psychological, material and essential support to adequate living. Any adjustment of isolation policies late in the isolation period would entail the mitigation of any residual public health risk.

**2.c.vi.** During the isolation period, cases should be advised on how to minimise the risk of onward transmission.

**2.c.vii.** Conduct contact tracing among individuals in contact with anyone who may be a suspected, probable, or confirmed case of monkeypox, including: contact identification (protected by confidentiality), management, and follow-up for 21 days through health monitoring which may be self-directed or supported by public health officers. Policies related to the management of contacts should encompass health, psychological, material and essential support to adequate living.

**2.c.viii.** Consider the targeted use of second- or third-generation smallpox or monkeypox vaccines (hereafter referred to as vaccine(s)) for post-exposure prophylaxis in contacts, including household, sexual and other contacts of community cases and health workers where there may have been a breach of personal protective equipment (PPE).

**2.c.ix.** Consider the targeted use of vaccines for pre-exposure prophylaxis in persons at risk of exposure; this may include health workers at high risk of exposure, laboratory personnel working with orthopoxviruses, clinical laboratory personnel performing diagnostic testing for monkeypox and communities at high risk of exposure or with high risk behaviours, such as persons who have multiple sexual partners.

**2.c.x.** Convene the National Immunization Technical Advisory Group (NITAG) for any decision about immunization policy and the use of vaccines. These should be informed by risks-benefits analysis. In all circumstances, vaccinees should be informed of the time required for protective immunity potentially offered by vaccination to be effective.

**2.c.xi.** Engage the communities at high risk of exposure in the decision-making process regarding any vaccine roll out vaccine.

#### **2.d. Clinical management and infection prevention and control**

**2.d.i.** Establish and use recommended clinical care pathways and protocols for the screening, triage, isolation, testing, and clinical assessment of suspected cases of persons with monkeypox; provide training to health care providers accordingly, and monitor the implementation of those protocols.

**2.d.ii.** Establish and implement protocols related to infection prevention and control (IPC) measures, encompassing engineering and administrative and the use of PPE; provide training to health care providers accordingly, and monitor the implementation of those protocols.

**2.d.iii** Provide health and laboratory workers with adequate PPE, as appropriate for health facility and laboratory settings, and provide all personnel with training in the use of PPE.

**2.d.iv.** Establish, update, and implement clinical care protocols for management of patients with uncomplicated monkeypox disease (e.g., keeping lesions clean, pain control, and maintaining adequate hydration and nutrition); with severe symptoms; acute complications; as well as for the monitoring and management of mid- or long-term sequelae.

**2.d.v.** Harmonise data collection and report clinical outcomes, using WHO Global Clinical Platform for monkeypox.

#### **2.e. Medical countermeasures research**

**2.e.i.** Make all efforts to use existing or new vaccines against monkeypox within a framework of collaborative clinical efficacy studies, using standardized design methods and data collection tools for clinical and outcome data, to rapidly increase evidence generation on efficacy and safety, collect data on effectiveness of vaccines (e.g., such as comparison of one or two dose vaccine regimens), and conduct vaccine effectiveness studies.

**2.e.ii.** Make all efforts to use existing or new therapeutics and antiviral agents for the treatment of monkeypox cases within a framework of collaborative clinical efficacy studies, using standardized design methods and data collection tools for clinical and outcome data, to rapidly increase evidence generation on efficacy and safety.

**2.e.iii.** When the use of vaccines and antivirals for monkeypox in the context of a collaborative research framework is not possible, use under expanded access protocols can be considered, such as the Monitored Emergency Use of Unregistered and Investigational Interventions (MEURI), under certain circumstances, using harmonized data collection for clinical outcomes (such as WHO Global Clinical Platform for Monkeypox).



## 2.f. International travel

### 2.f.i. Adopt and apply the following measures:

- Any individual:
- With signs and symptoms compatible with monkeypox virus infection; or being considered a suspect, probable, or confirmed case of monkeypox by jurisdictional health authorities; or
- Who has been identified as a contact of a monkeypox case and, therefore, is subject to health monitoring, should avoid undertaking any travel, including international, until they are determined as no longer constituting a public health risk. Exemptions include any individual who need to undertake travel to seek urgent medical care or flee from life-threatening situations, such as conflict or natural disasters; and contacts for whom pre-departure arrangements to ensure the continuity of health monitoring are agreed upon by sub-national health authorities concerned, or, in the case of international travel, by national health authorities;
- Cross-border workers, who are identified as contacts of a monkeypox case, and, hence, under health monitoring, can continue their routine daily activities provided that health monitoring is duly coordinated by the jurisdictional health authorities from both/all sides of the border.

### 2.f.ii. Establish operational channels between health authorities, transportation authorities, and conveyances and points of entry operators to:

- Facilitate international contact tracing in relation to individuals who have developed signs and symptoms compatible with monkeypox virus infection during travel or upon return;
- Provide communication materials at points of entry on signs and symptoms consistent with monkeypox; infection prevention and control; and on how to seek medical care at the place of destination;

WHO advises against any additional general or targeted international travel-related measures other than those specified in paragraphs **2.f.i** and **2.f.ii**.

***Group 3: States Parties, with known or suspected zoonotic transmission of monkeypox, including those where zoonotic transmission of monkeypox is known to occur or has been reported in the past, those where presence of monkeypoxvirus has been documented in any animal species, and those where infection of animal species countries may be suspected including in newly affected countries***

**3.a.** Establish or activate collaborative One Health coordination or other mechanisms at federal, national, subnational and/or local level, as relevant, between public health, veterinary, and wildlife authorities for understanding, monitoring and managing the risk of animal-to-human and human-to-animal transmission in natural habitats, forested and other wild or managed environments, wildlife reserves,

domestic and peri-domestic settings, zoos, pet shops, animal shelters and any settings where animals may come into contact with domestic waste.

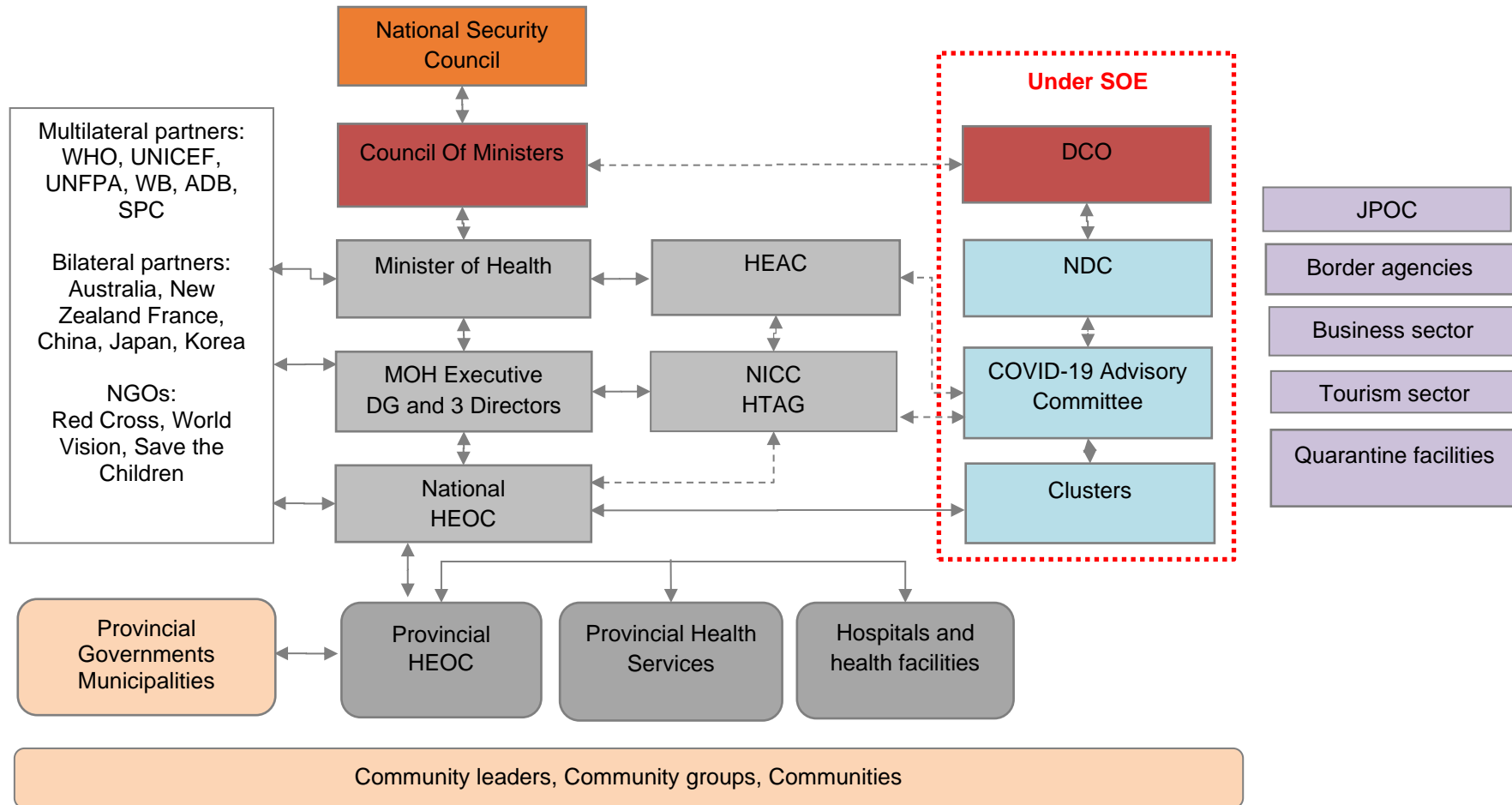
**3.b.** Undertake detailed case investigations and studies to characterize transmission patterns, including suspected or documented spill overs from, and spillback, to animals. In all settings, case investigation forms should be updated and adapted to elicit information on the full range of possible exposures and modes of both zoonotic and human-to-human transmission. Share the findings of these endeavours including ongoing case reporting with WHO.

***Group 4: States Parties with manufacturing capacity for medical countermeasures***

**4.a.** States Parties who have manufacturing capacity for smallpox and monkeypox diagnostics, vaccines or therapeutics should raise production and availability of medical countermeasures.

**4.b.** States Parties and manufacturers should work with WHO to ensure diagnostics, vaccines, therapeutics, and other necessary supplies are made available based on public health needs, solidarity and at reasonable cost to countries where they are most needed to support efforts to stop the onward spread of monkeypox.

## Annex 2: Structure of response mechanism and stakeholders, including under State of Emergency (SOE)



ADB: Asia Development Bank; DCO: Development Committee of Officials; VCH: Vila Central Hospital; JPOC: Joint Police Operation Center; HEAC: Health Emergency Advisory Committee; MOH: Ministry of Health; NGOs: non-government organizations; NICCC: National Immunization Coordination Committee; NHEOC: National Health Emergency Operations Center; NPH: Northern Provincial Hospital; MOH: Ministry of Health; NDC: National Disaster Committee; SOE: State of Emergency; UNICEF: United Nations Children Education Fund; WB: World Bank; WHO: World Health Organization.

### Annex 3: Case definitions for Monkeypox surveillance

The case definitions for Monkeypox have been updated based on the Interim guidance by WHO updated on 24 June 2020 (original guidance from 20 May 2022). Countries may need to adapt case definitions depending on their own epidemiological situation.

Monkeypox case definition	
<b>Suspected case</b>	<p>A person of any age presenting since 01 January 2022 with an unexplained acute rash or one or more acute skin lesions</p> <p>AND</p> <p>one or more of the following signs or symptoms:</p> <ul style="list-style-type: none"> <li>• Headache</li> <li>• Acute onset of fever (<math>&gt;38.5^{\circ}\text{C}</math>)</li> <li>• Lymphadenopathy (swollen lymph nodes)</li> <li>• Myalgia (muscle pain/body aches)</li> <li>• Back pain</li> <li>• Asthenia (profound weakness)</li> </ul> <p>AND</p> <p>for which the following common causes of acute rash or skin lesions do not fully explain the clinical picture: varicella zoster, herpes zoster, measles, herpes simplex, bacterial skin infections, disseminated gonococcus 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.</p> <p>N.B. It is not necessary to obtain negative laboratory results for listed common causes of rash illness in order to classify a case as suspected. Further, if suspicion of monkeypox infection is high due to either history and/or clinical presentation or possible exposure to a case, the identification of an alternate pathogen which causes rash illness should not preclude testing for MPXV, as coinfections have been identified.</p>
<b>Probable case</b>	<p>A person meeting the case definition for a suspected case</p> <p>AND</p> <p>One or more of the following:</p> <ul style="list-style-type: none"> <li>• has an epidemiological link prolonged face-to-face exposure in close proximity, including health workers without appropriate PPE (gloves, gown, eye protection and respirator); 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</li> <li>• has had multiple or anonymous sexual partners in the 21 days before symptom onset</li> <li>• has detectable levels of anti-orthopoxvirus (OPXV) IgM antibody (during the period of 4 to 56 days after rash onset); or a four-fold rise in IgG antibody titre based on acute (up to day 5-7) and convalescent (day 21 onwards) samples; in the absence of a</li> </ul>

	<p>recent smallpox/monkeypox vaccination or other known exposure to OPXV</p> <ul style="list-style-type: none"> <li>• has a positive test result for orthopoxviral infection (e.g. OPXV-specific PCR without MPXV-specific PCR or sequencing)</li> </ul>
<b>Confirmed case</b>	Laboratory confirmed monkeypox virus by detection of unique sequences of viral DNA by real-time polymerase chain reaction (PCR)c and/or sequencing.
<b>Discarded case</b>	A suspected or probable case for which laboratory testing of lesion fluid, skin specimens or crusts by PCR and/or sequencing is negative for MPXV. Conversely, for example, a retrospectively detected probable case for which lesion testing can no longer be adequately performed (i.e. after the crusts fall off) would remain classified as a probable case.

## **Annex 4: Definition of a contact and risk level**

### **Definition of a 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 workers without appropriate PPE)
- direct physical contact, including sexual contact
- contact with contaminated materials such as clothing or bedding

### **Risk level of the contacts: *updated 24 June 2022***

#### **High risk**

- Direct exposure of skin or mucous membranes to skin or respiratory secretions of a person with confirmed, probable or suspected monkeypox, their body fluids (e.g., lesion vesicular or pustular fluid) or potentially infectious material (including clothing or bedding) if not wearing appropriate PPE. This includes:
  - inhalation of droplets or dust from cleaning contaminated rooms
  - mucosal exposure due to splashes from body fluids
  - physical contact with someone who has monkeypox, including direct contact during sexual activities. This includes face-to-face, skin-to-skin or mouth-to-skin contact or exposure to body fluids or contaminated materials or objects (fomites)
- normally sharing a residence (permanently or occasionally) during the presumed incubation period with a person who has been diagnosed with monkeypox, or
- a penetrating sharps injury from a contaminated device or through contaminated gloves.

#### **Medium risk**

- no direct contact but close proximity in the same room or indoor physical space as a symptomatic monkeypox patient, if not wearing appropriate PPE.

#### **Lower or minimal risk**

- contact with a person with confirmed, probable or suspected monkeypox or an environment that may be contaminated with monkeypox virus, while wearing appropriate PPE and without any known breaches of PPE or of donning and doffing procedures
- community contact, such as being in an outdoor setting with a symptomatic case without close proximity or physical contact
- no known contact with a symptomatic monkeypox case in the last 21 days, or
- laboratory personnel handling routine clinical blood samples or other specimens not directly related to monkeypox diagnostic testing.



## Annex 5: Detailed operational plan

### GROUP 1: STATES PARTIES, WITH NO HISTORY OF MONKEYPOX IN THE HUMAN POPULATION OR NOT HAVING DETECTED A CASE OF MONKEYPOX FOR OVER 21 DAYS

OBECTIVES	INTERVENTIONS
1. Activation of coordination and emergency response mechanisms	<ul style="list-style-type: none"> <li>• <b>1.a.</b> Activate or establish health and multi-sectoral coordination mechanisms to strengthen all aspects of readiness for responding to monkeypox and stop human to human transmission.</li> </ul>
2. Prevention and mitigation of COVID-19 infections by limiting human-to-human transmission	<ul style="list-style-type: none"> <li>• <b>1.b.</b> Plan for, and/or implement, interventions to avoid the stigmatization and discrimination against any individual or population group that may be affected by monkeypox, with the goal of preventing further undetected transmission of monkeypox virus. The focus of these interventions should be: to promote voluntary self-reporting and care seeking behaviour; to facilitate timely access to quality clinical care; to protect the human rights, privacy and dignity of affected individuals and their contacts across all communities.</li> </ul>
3. Adequate risk communication and community engagement on COVID-19 to all communities and counter misinformation	<ul style="list-style-type: none"> <li>• <b>1.b.</b> Plan for, and/or implement, interventions to avoid the stigmatization and discrimination against any individual or population group that may be affected by monkeypox, with the goal of preventing further undetected transmission of monkeypox virus. The focus of these interventions should be: to promote voluntary self-reporting and care seeking behaviour; to facilitate timely access to quality clinical care; to protect the human rights, privacy and dignity of affected individuals and their contacts across all communities.</li> <li>• <b>1.e.</b> Raise awareness about monkeypox virus transmission, related prevention and protective measures, and symptoms and signs of monkeypox among communities that are currently affected elsewhere in this multi-country outbreak (e.g., importantly, but not exclusively, gay, bisexual and other men who have sex with men (MSM) or individuals with multiple sexual partners) as well as among other population groups that may be at risk (e.g., sex workers, transgender people).</li> <li>• <b>1.f.</b> Engage key community-based groups, sexual health and civil society networks to increase the provision of reliable and factual information about monkeypox and its potential transmission to and within populations or communities that may be at increased risk of infection.</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>1.g.</b> Focus risk communication and community support efforts on settings and venues where intimate encounters take place (e.g., gatherings focused on MSM, sex-on-premises venues). This includes engaging with and supporting the organizers of large and smaller scale events, as well as with owners and managers of sex on premises venues to promote personal protective measures and risk-reducing behaviour.</li> </ul>
4. Early detection and isolation of suspected COVID-19 cases through an <i>active and functional surveillance system</i>	<ul style="list-style-type: none"> <li>• <b>1.c.</b> Establish and intensify epidemiological disease surveillance, including access to reliable, affordable and accurate diagnostic tests, for illness compatible with monkeypox as part of existing national surveillance systems. For disease surveillance purposes, case definitions for suspected, probable and confirmed cases of monkeypox should be adopted.</li> <li>• <b>1.d.</b> Intensify the detection capacity by raising awareness and training health workers, including those in primary care, genitourinary and sexual health clinics, urgent care / emergency departments, dental practices, dermatology, paediatrics, HIV services, infectious diseases, maternity services, obstetrics and gynaecology, and other acute care facilities.</li> <li>• <b>1.h.</b> Immediately report to WHO, through channels established under the provision of the IHR, probable and confirmed cases of monkeypox, including using the minimum data set contained in the WHO Case Report Form (CRF).</li> </ul>
5. Proper clinical management of suspected and confirmed SARI/COVID-19 cases, including <i>infection prevention and control and isolation of cases</i> :	<ul style="list-style-type: none"> <li>• <b>2.d.</b> Clinical management and infection prevention and control <ul style="list-style-type: none"> <li>◦ <b>2.d.i.</b> Establish and use recommended clinical care pathways and protocols for the screening, triage, isolation, testing, and clinical assessment of suspected cases of persons with monkeypox; provide training to health care providers accordingly, and monitor the implementation of those protocols.</li> <li>◦ <b>2.d.ii.</b> Establish and implement protocols related to infection prevention and control (IPC) measures, encompassing engineering and administrative and the use of PPE; provide training to health care providers accordingly, and monitor the implementation of those protocols.</li> <li>◦ <b>2.d.iii</b> Provide health and laboratory workers with adequate PPE, as appropriate for health facility and laboratory settings, and provide all personnel with training in the use of PPE.</li> <li>◦ <b>2.d.iv.</b> Establish, update, and implement clinical care protocols for management of patients with uncomplicated monkeypox disease (e.g., keeping lesions clean, pain control, and maintaining adequate hydration and nutrition); with severe symptoms; acute complications; as well as for the monitoring and management of mid- or long-term sequelae.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>◦ <b>2.d.v.</b> Harmonise data collection and report clinical outcomes, using WHO Global Clinical Platform for monkeypox.</li> </ul>
6. Maintain essential health service provision, delivered through approaches to prevent and mitigate COVID-19 infections	<ul style="list-style-type: none"> <li>• Identify and map essential health services and facilities</li> <li>• Identify healthcare workers and health facilities for essential health services and for COVID</li> <li>• Identify essential staff to travel for cold chain maintenance or immunization related services</li> <li>• Prepare and ensure IPC for immunization (PPEs available, physical distancing during immunization etc)</li> <li>• Develop SOPs for distribution of vaccines and other essential commodities to provinces and health centers</li> </ul>

**GROUP 2: STATES PARTIES, WITH RECENTLY IMPORTED CASES OF MONKEYPOX IN THE HUMAN POPULATION AND/OR OTHERWISE EXPERIENCING HUMAN-TO-HUMAN TRANSMISSION OF MONKEYPOX VIRUS, INCLUDING IN KEY POPULATION GROUPS AND COMMUNITIES AT HIGH RISK OF EXPOSURE**

OBJECTIVES	INTERVENTIONS
1. Activation of coordination and emergency response mechanisms	<p><b>2.a. Implementing coordinated response</b></p> <ul style="list-style-type: none"> <li>• <b>2.a.i.</b> Implement response actions with the goal of stopping human-to-human transmission of monkeypox virus, with a priority focus on communities at high risk of exposure, which may differ according to context and include gay, bisexual and other men who have sex with men (MSM). Those actions include: targeted risk communication and community engagement, case detection, supported isolation of cases and treatment, contact tracing, and targeted immunization for persons at high risk of exposure for monkeypox.</li> <li>• <b>2.a.ii.</b> Empower affected communities and enable and support their leadership in devising, contributing actively to, and monitoring the response to the health risk they are confronting. Extend technical, financial and human resources to the extent possible and maintain mutual accountability on the actions of the affected communities.</li> <li>• <b>2.a.iii.</b> Implement response actions with the goal of protecting vulnerable groups (immunosuppressed individuals, children, pregnant women) who may be at risk of severe monkeypox disease. Those actions include: targeted risk communication and community engagement, case detection, supported isolation of cases and treatment, contact tracing. These may also include targeted immunization which takes into careful consideration the risks and benefits for the individual in a shared clinical decision-making.</li> </ul>
2. Prevention and mitigation of COVID-19 infections by limiting human-to-human transmission	<ul style="list-style-type: none"> <li>• <b>2.c.vii.</b> Consider the targeted use of second- or third-generation smallpox or monkeypox vaccines (hereafter referred to as vaccine(s)) for post-exposure prophylaxis in contacts, including household, sexual and other contacts of community cases and health workers where there may have been a breach of personal protective equipment (PPE).</li> <li>• <b>2.c.viv.</b> Consider the targeted use of vaccines for pre-exposure prophylaxis in persons at risk of exposure; this may include health workers at high risk of exposure, laboratory personnel working with orthopoxviruses, clinical laboratory personnel performing diagnostic testing for monkeypox and communities at high risk of exposure or with high risk behaviours, such as persons who have multiple sexual partners.</li> <li>• <b>2.c.x.</b> Convene the National Immunization Technical Advisory Group (NITAG) for any decision about immunization policy and the use of vaccines. These should be informed by risks-benefits analysis. In</li> </ul>

	<p>all circumstances, vaccinees should be informed of the time required for protective immunity potentially offered by vaccination to be effective.</p> <ul style="list-style-type: none"> <li>• <b>2.c.xi.</b> Engage the communities at high risk of exposure in the decision-making process regarding any vaccine roll out vaccine.</li> </ul>
3. Adequate risk communication and community engagement on COVID-19 to all communities and counter misinformation	<p><b>2.b. Engaging and protecting communities</b></p> <ul style="list-style-type: none"> <li>• <b>2.b.i.</b> Raise awareness about monkeypox virus transmission, actions to reduce the risk of onward transmission to others and clinical presentation in communities affected by the outbreak, which may vary by context, and promote the uptake and appropriate use of prevention measures and adoption of informed risk mitigation measures. In different contexts this would include limiting skin to skin contact or other forms of close contact with others while symptomatic, may include promoting the reduction of the number of sexual partners where relevant including with respect to events with venues for sex on premises, use of personal protective measures and practices, including during, and related to, small or large gatherings of communities at high risk of exposure.</li> <li>• <b>2.b.ii</b> Engage with organizers of gatherings (large and small), including those likely to be conducive for encounters of intimate sexual nature or that may include venues for sex-on-premises, to promote personal protective measures and behaviours, encourage organizers to apply a risk-based approach to the holding of such events and discuss the possibility of postponing events for which risk measures cannot be put in place. All necessary information should be provided for risk communication on personal choices and for infection prevention and control including regular cleaning of event venues and premises.</li> <li>• <b>2.b.iii.</b> Develop and target risk communication and community engagement interventions, including on the basis of systematic social listening (e.g., through digital platforms) for emerging perceptions, concerns, and spreading of misinformation that might hamper response actions.</li> <li>• <b>2.b.iv.</b> Engage with representatives of affected communities, non-government organizations, elected officials and civil society, and behavioural scientists to advise on approaches and strategies to avoid the stigmatization of any individual or population groups in the implementation of appropriate interventions, so that care seeking behaviour, testing and access to preventive measures and clinical care is timely, and to prevent undetected transmission of monkeypox virus.</li> </ul>
4. Early detection and isolation of suspected COVID-19 cases through	<p><b>2.c. Surveillance and public health measures</b></p> <ul style="list-style-type: none"> <li>• <b>2.c.i.</b> Intensify surveillance for illness compatible with monkeypox as part of existing national surveillance schemes, including access to reliable, affordable and accurate diagnostic tests.</li> </ul>

<p><i>an active and functional surveillance system</i></p>	<ul style="list-style-type: none"> <li>• <b>2.c.ii.</b> Report to WHO, on a weekly basis and through channels established under the provision of the IHR, probable and confirmed cases of monkeypox, including using the minimum data set contained in the WHO Case Report Form (CRF).</li> <li>• <b>2.c.iii.</b> Strengthen laboratory capacity, and international specimens referral capacities as needed, for the diagnosis of monkeypox virus infection, and related surveillance, based on the use of nucleic acid amplification testing (NAAT), such as real time or conventional polymerase chain reaction (PCR).</li> <li>• <b>2.c.iv.</b> Strengthen genomic sequencing capacities, and international specimens referral capacities as needed, building on existing sequencing capacities worldwide, to determine circulating virus clades and their evolution, and share genetic sequence data through publicly accessible databases.</li> <li>• <b>2.c.vii.</b> Conduct contact tracing among individuals in contact with anyone who may be a suspected, probable, or confirmed case of monkeypox, including: contact identification (protected by confidentiality), management, and follow-up for 21 days through health monitoring which may be self-directed or supported by public health officers. Policies related to the management of contacts should encompass health, psychological, material and essential support to adequate living.</li> </ul>
<p>5. Proper clinical management of suspected and confirmed SARI/COVID-19 cases, including <i>infection prevention and control and isolation of cases:</i></p>	<ul style="list-style-type: none"> <li>• <b>2.c.v.</b> Isolate cases for the duration of the infectious period. Policies related to the isolation of cases should encompass health, psychological, material and essential support to adequate living. Any adjustment of isolation policies late in the isolation period would entails the mitigation of any residual public health risk.</li> <li>• <b>2.c.vi.</b> During the isolation period, cases should be advised on how to minimise the risk of onward transmission.</li> </ul> <p><b>2.d. Clinical management and infection prevention and control</b></p> <ul style="list-style-type: none"> <li>• <b>2.d.i.</b> Establish and use recommended clinical care pathways and protocols for the screening, triage, isolation, testing, and clinical assessment of suspected cases of persons with monkeypox; provide training to health care providers accordingly, and monitor the implementation of those protocols.</li> <li>• <b>2.d.ii.</b> Establish and implement protocols related to infection prevention and control (IPC) measures, encompassing engineering and administrative and the use of PPE; provide training to health care providers accordingly, and monitor the implementation of those protocols.</li> <li>• <b>2.d.iii</b> Provide health and laboratory workers with adequate PPE, as appropriate for health facility and laboratory settings, and provide all personnel with training in the use of PPE.</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>2.d.iv.</b> Establish, update, and implement clinical care protocols for management of patients with uncomplicated monkeypox disease (e.g., keeping lesions clean, pain control, and maintaining adequate hydration and nutrition); with severe symptoms; acute complications; as well as for the monitoring and management of mid- or long-term sequelae.</li> <li>• <b>2.d.v.</b> Harmonise data collection and report clinical outcomes, using WHO Global Clinical Platform for monkeypox.</li> </ul>
6. Maintain essential health service provision, delivered through approaches to prevent and mitigate COVID-19 infections	<ul style="list-style-type: none"> <li>• Identify and map essential health services and facilities</li> <li>• Identify healthcare workers and health facilities for essential health services and for COVID</li> <li>• Identify essential staff to travel for cold chain maintenance or immunization related services</li> <li>• Prepare and ensure IPC for immunization (PPEs available, physical distancing during immunization etc)</li> <li>• Develop SOPs for distribution of vaccines and other essential commodities to provinces and health centers</li> </ul>

## Annex 6: Capacity areas, responsible agencies and tools

Capacity areas	Responsible MOH Unit/Agencies	Strategy, guidelines, SOPS
<b>Incident management, planning and multisectoral coordination</b>	Policy and Planning	Monkeypox strategy
<b>Vaccination</b>	EPI	TBD
<b>Points of entry</b>	Surv/Shefa Health/Border agencies	TBD
<b>Quarantine</b>	Shefa Health/Quarantine coordinator	TBD
<b>Surveillance</b>	Surveillance	Information note to healthcare providers
<b>Rapid Response Team - Contact tracing</b>	Surveillance	TBD
<b>Laboratory</b>	VCH Lab	TBD
<b>Clinical management and health care services</b>	VCH	TBD
<b>Infection prevention and control</b>	IPC Unit	TBD
<b>Risk communication and community engagement</b>	HPU	Factsheet, posters, social media posts, radio tokbak slots
<b>Public health and social measures</b>		TBD
<b>Mental health and psycho-social support (MHPSS)</b>	MHPSS Unit	TBD
<b>Scenario and response simulation</b>	Policy and Planning	TBD
<b>Continuity of essential services</b>		TBD



# MONKEYPOX: WHAT YOU NEED TO KNOW

There is currently an outbreak of monkeypox in some countries that do not normally have cases:

- Most people recover fully without treatment, but in some cases, people can get seriously ill
- It is called 'monkeypox' because it was first found in monkeys
- While the risk to the general public is low, WHO is responding to this outbreak as a high priority
- What we know about the outbreak is changing fast – we are learning more every day

Symptoms of monkeypox include:

- Rash with blisters on face, hands, feet, body, eyes, mouth or genitals
- Fever
- Swollen lymph nodes
- Headaches
- Muscle and back aches
- Low energy



You can catch monkeypox through close contact with someone who has symptoms including:

- Skin-to-skin contact
- Face-to-face contact
- Mouth-to-skin contact
- Touching infected bedding, towels, clothing or objects



Protect yourself from monkeypox by avoiding close contact with someone who has symptoms:

- Avoid skin-to-skin, face-to-face and mouth-to-skin contact, including sexual contact
- Clean hands, objects, surfaces, bedding, towels and clothes regularly
- Wear a mask if you can't avoid close contact and when handling bedding, towels and clothes
- Ask people if they have symptoms before you have close contact
- Using condoms may not prevent monkeypox spreading during sexual contact, but can prevent other sexually transmitted infections

If you think you have monkeypox:

- Get advice from a health worker
- Isolate at home if possible
- Protect others by avoiding close contact with them
- Wear a mask and avoid touching if you need to have close contact

**Stigmatising people because of a disease is NEVER ok.**

**Anyone can get or pass on monkeypox**

24/05/2022