United Nations Medical Directors' Risk Mitigation Plan for Mpox Recommendations for UN Personnel

5 September 2024

- The following recommendations are provided by the UN Medical Directors to all UN Organizations and apply to all UN personnel to reduce the risk of UN personnel acquiring mpox.
- Mpox is a zoonotic *Orthopoxvirus* that has two clades: Clade I MPXV and II (which consists of two subclades IIa and IIb). Since September 2023 Clade Ib has been identified in the Democratic Republic of Congo (DRC). In early May 2022, cases of mpox have been reported from countries where the disease is not endemic and continue to be reported in several endemic countries. For more information about the multi-country outbreak identified from 2022 with Clade IIb, see here.
- In August 2024, an upsurge of cases was identified in Africa, with the epicenter being the Democratic Republic of Congo (DRC). Following this, on August 14, 2024 a public health emergency of international concern (PHEIC) was declared by the WHO.
- The WHO has released the full report of the first meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox 2024 which includes temporary recommendations here.
- **Duty stations should take into account any local host country/authorities' guidance and regulations when implementing these recommendations.**
- For questions, contact **DHMOSH Public Health Section** at dos-dhmosh-public-health@un.org

	Risk Categories	UN Medical Directors' Recommendations
1	**All UN personnel**	• All UN personnel should be aware that a new public health emergency of international concern (PHEIC) was declared due to Clade Ib with the most severely affected country being the Democratic Republic of Congo (DRC) in August 2024. Sexual transmission and close contact including men who have sex with men (MSM), gay and bisexual men have also been identified as a risk factor for acquisition. Cases in children have also been reported. See here for information on global trends. • Mpox is transmitted by close contact with lesions, bodily fluids, respiratory droplets, and contaminated materials such as bedding. Sexual contact with a person who has mpox is also a risk factor. Strict hand hygiene is recommended for mpox prevention as well as other infectious diseases. • Follow safe sex practices, including condom use. Condom use will not prevent contracting mpox if lesions are not covered but will protect against sexually transmitted infections. • Avoid eating inadequately cooked meat and other animal products of infected animals as this is a possible risk factor for this infection in certain settings. • If UN personnel develop a rash and other signs and symptoms listed in Section 4, they should seek medical attention. For more information see the WHO fact sheet on mpox.

		• Note that most people with mpox will typically have a self-limiting disease though some will have severe presentations and may be candidates for therapeutics. • Review latest information on mpox here including the countries involved and number of lab-confirmed cases globally and technical guidance WHO is providing for countries and health authorities. • WHO guidance on gatherings is available here. The WHO recommends that the decision-making process related to gatherings should rely on a risk-based approach. • Mass vaccination is not recommended for mpox at this time, but vaccination is recommended in some circumstances. Updated WHO's guidance on mpox vaccination is available here.
2	**UN personnel with health conditions**	• While mpox is usually a self-limiting disease, children (particularly those younger than 8 years old), pregnant or breastfeeding women, or persons who are immune compromised may be at risk of severe disease. • Pregnant/recently pregnant women with mild or uncomplicated mpox may not require hospital admission but monitoring in a health facility may be preferred. In general, those with a high risk of complications or with severe or complicated mpox should be admitted to the hospital for monitoring and clinical care and to prevent transmission to others. • Whether or not to stop breastfeeding in a mother with mpox should be assessed on a case-by-case basis.

3	**UN personnel that are contacts of mpox cases**	• Contact tracing should occur for contact of suspected mpox cases. WHO guidance on surveillance, case definition (for surveillance purposes), and contact tracing is available here.
		• **Contacts are 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 of, has had one or more of the following exposures with a probable or confirmed case of mpox:
		  ○ *Direct skin-to-skin and skin-to-mucosal physical contact (such as touching, hugging, intimate or sexual contact)*
		  ○ *Contact with contaminated materials such as clothing or bedding (including materials dislodged from bedding or surfaces during handling of laundry or cleaning of contaminated rooms)*
		  ○ *Prolonged face-to-face respiratory exposure in close proximity*
		  ○ *Respiratory exposure (i.e. possible inhalation of) or eye mucosal exposure to lesion material (e.g., crusts/scabs) from an infected person*
		Note: the above applies to healthcare workers potentially exposed in the absence of proper use of appropriate PPE. Contacts of cases with mpox should be monitored or self-monitor for 21 days from last contact with the case or contaminated materials and monitored for signs and symptoms including rash, headache, acute onset of fever (> 38.5°C), lymphadenopathy (swollen lymph nodes), myalgia (muscle and body aches), back pain, asthenia (profound weakness). Temperature should be monitored twice daily.
		• Contacts of cases should be notified within 24 hours of identification of case.
		• Asymptomatic contacts should not donate blood, tissue, organs, breast milk, or semen when they are under symptom surveillance. Non-essential travel is discouraged.
		• During the symptom surveillance post-contact, no quarantine or exclusions are necessary as long as no symptoms develop.

		• If a contact develops symptoms other than a rash, they should be isolated and monitored closely for a rash for five days. If no rash develops, they can resume temperature monitoring for 21 days. If a rash does develop, they should be isolated and evaluated as a suspect case, including lab testing for mpox.
4	**UN health workers**	• UN health workers should be aware of the WHO mpox **case definitions** available here. • UN health workers should review WHO online courses on mpox available here (*Mpox: Introductory course for African outbreak contexts*) and here (*Mpox: Epidemiology, preparedness and response from African outbreak contexts*) and here (*Mpox and the 2022-2023 global outbreak*).*[Note that these trainings may not reflect the 2024 guidance.]* • UN health workers should be aware of the clinical presentation (signs and symptoms) of mpox. 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. Lesions can be present in the mucous membranes as well. • Treatment of mpox patients includes supportive care and might include the use of antivirals depending on severity. Significant pain and psychological distress have also been frequently described which might need specific management. Please see WHO guidance on Clinical Management and IPC here for more information on when therapeutics can be considered and appropriate PPE utilization. Training of HCWs in order to detect cases is critical. It is important to note that during this mpox outbreak, clinical presentation has been atypical from that of the classical mpox presentation. • NEW: PPE posters on steps to put on and remove PPE for mpox is available on the WHO website. • Nosocomial cases of mpox transmission have been previously reported. Exposure to bedding and other contaminated fomites represents an important risk. Health workers at risk include cleaners and others who may come into contact with patients or health care waste. • Health workers should always follow standard precautions for all patients at all times which includes not touching any rash without gloves as well as a point of care risk assessment. • Standard precautions include strict adherence to hand hygiene and appropriate handling of contaminated medical equipment, laundry, and waste and cleaning and disinfection of environmental surfaces. More information is available here. At the first point of contact with the health system, screening, triage and prompt isolation and assessment for the presence of severe disease should be conducted for all those presenting with rash and fever or lymphadenopathy. • Individuals with mild/uncomplicated mpox and not at high risk of complications should isolate at home. • Patients with mpox should be placed in their own room. Cohorting (confirmed with confirmed, suspected with suspected) can be implemented if single rooms are not available. Allow for 1-2 m between patients. • Contact and droplet precautions should be used including gloves, gown, and eye protection; in addition, healthcare workers should use respirators when managing mpox cases. More information available here. Airborne precautions for aerosol-generating medical procedures should be used. Airborne precautions should also be applied if varicella zoster virus (chickenpox virus) is suspected and until it is excluded.

		• Lesions should be covered where possible, and the patient should wear a medical mask when within 1-2m of HCWs.
		• UN health workers should isolate patients that are suspected mpox cases and transfer them to a facility where they can be managed appropriately and be familiar with appropriate MEDEVAC procedures. The mainstay of treatment is supportive care and symptomatic management, though tecovirimat has been used for treatment of some cases, typically those with severe disease or those with risk factors for severe disease (see Section 2 above).
		• UN health workers should be aware of how to collect and properly submit samples for diagnosis of mpox (see Section 7).
		• Health workers that have had unprotected exposure to patients with mpox can continue to work but should undergo active surveillance for symptoms including twice a day temperature checks for 21 days. Those who have cared for patients but have not had any PPE breeches can undergo self-monitoring or active monitoring determined by public health authorities.
		• **Post-exposure vaccination** for high-risk contacts (e.g. health workers or lab personnel without PPE) with a smallpox or mpox vaccine is recommended, as well as for contacts of cases within 4 days of exposure (and up to 14 days) though supply of vaccines may be limited. Information on high/intermediate/low/no risk contacts is available in the CDC presentation. Information on Vaccine FAQ from WHO is available here.
		• **Pre-exposure vaccination** with mpox vaccine is recommended for HCWs at high risk of exposure (e.g., diagnostic laboratory workers working with *orthopoxviruses*, clinical laboratory personnel performing diagnostic testing for mpox, and outbreak response team members).
		• NEW: WHO recommends vaccination for persons at high risk of exposure to mpox in an outbreak. The identification of populations at risk of exposure is limited in some settings by the available epidemiological data. To allow the greatest flexibility with respect to local risk assessment, varied modes of transmission and response options, populations to consider for vaccination may include:
		  ○ based on local epidemiology, members of a geographically defined area or community (e.g. village), including children, with a documented high risk of exposure to persons with mpox;
		  ○ sex workers; gay, bisexual or other men who have sex with men (MSM) with multiple sexual partners; or other individuals with multiple casual sexual partners;
		  ○ health workers at risk of repeated exposure; clinical laboratory and health-care personnel performing diagnostic testing for mpox or providing care; and outbreak response team members (as designated by national public health authorities);
		  ○ contacts of persons with mpox, ideally within 4 days of first exposure (contacts may include children, others in the household or in congregate settings – such as prisons, schools, health facilities or residential facilities).
		• If a case is detected it should be reported to local health authority and WHO for completion of the WHO Case Report Form (CRF) is recommended.

5	**Cleaners in healthcare settings**	• Cleaners may be at risk of exposure to mpox due to the nature of their job particularly if they handle used linens • Cleaners should follow cleaning protocols and if in the room with a patient, apply contact, and droplet precautions in addition to standard precautions. Respirators are recommended for cleaners given that virus may contaminate bedding.

		• Linen, hospital gowns, towels and other fabric items should be handled and collected carefully.
6	**UN personnel living in congregate living settings**	• Given the possible modes of transmission of mpox the congregate living setting might pose a risk of contracting mpox given close proximity with others. • Methods to prevent mpox spread is outlined in other sections and also apply here. • In addition see WHO publication of public health advice on mpox and congregate settings: settings in which people live, stay or work in proximity. These include the importance of hand hygiene, covering lesions where possible and cleaning and disinfection. Ensure linens, towels and clothing from an infected individual is laundered separately from other laundry.
7	**UN personnel with suspect / confirmed / probable mpox**	• Any suspected case should be immediately isolated and investigated for mpox including diagnostic testing by polymerase chain reaction (PCR) • The best diagnostic specimens are taken directly from lesion material (skin, fluid or crusts) collected by vigorous swabbing. In the absence of lesions, testing can be done with oropharyngeal or, depending on clinical presentation and exposure, rectal swabs. See here for more information about diagnostic testing. • Isolation of UN personnel with confirmed/probable mpox should occur until all lesions are crusted over, no new lesions are seen, and scabs have fallen off with fresh layer of skin formed underneath. • WHO guidance on surveillance, case investigation, and contact tracing is available here. • In most instances isolation and recovery can occur at home. See here for more information.
8	**UN personnel who are planning to travel**	• Any individual who has signs/symptoms compatible with mpox should not travel. Known contacts of a mpox case (as is thereby subject to health monitoring) should avoid undertaking travel until otherwise advised. • The WHO advises against any additional general or targeted international travel-related measures other than the exceptions above.