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

23 July 2022 (source: [link](https://www.who.int/news/item/23-07-2022-second-meeting-of-the-international-health-regulations-(2005)-(ihr)-emergency-committee-regarding-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 State 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.

**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 the 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 the 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 in 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 spillovers 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.