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Mpox

CDNA National Guidelines for Public Health Units

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Title: Mpox CDNA National Guidelines for Public Health Units

Using these guidelines

These guidelines for public health units (PHUs) outline Australia's agreed national approach for the routine public health management of mpox. They consider available evidence at the time of publication to develop pragmatic guidance, including where evidence is still evolving or where jurisdictional approaches differ. Jurisdictions may implement policies that differ from these national standards based on local factors.

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Summary of revision history

Version	Date	Revised by	Changes
Version 5.0	16 December 2025	CDNA	Full revision to update evidence-based recommendations for public health response and align approaches for clade I and II.
Version 4.0	14 October 2024	CDNA	Full revision to update evidence-based recommendations for public health and strengthen clade I information.
Version 3.0	20 December 2022	CDNA	Full revision to present evidence-based recommendations for public health. Revised: The disease, Routine prevention activities, Surveillance objectives, Case management, Specific settings.
Version 2.0	08 September 2022	CDNA	Revised: The disease, Case management, Contact definitions, Contact management.
Version 1.0	27 July 2022	CDNA	Developed by the Monkeypox Working Group.

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Public health approach

This section outlines the public health response to notifications of mpox of any clade.

Priority

Mpox – the disease caused by the monkeypox virus (MPXV) – is a nationally notifiable disease.

Public health priority classification and response

Priority Classification	Public health response timeline
Urgent	Respond to suspected, probable, and confirmed cases immediately (within 24 hours).

Data entry timeline: Within 1 working day for all probable and confirmed cases.

States and territories may review and amend their response time according to assessed public health risk.

Data management

All confirmed and probable cases should be entered on to the National Notifiable Diseases Surveillance System (NNDSS) by state and territory public health units (PHUs), ideally within one working day of notification.

To note:

- The date of onset is the date that symptoms began, which may be prodromal/systemic symptoms, proctitis, or a rash. If asymptomatic infection, do not enter a date of onset.
- State and territory PHUs should document the clade, if tested, for each case's infection in the notifiable disease database.

The jurisdictional communicable disease branch should advise the National Incident Centre (NIC), if required (see Response procedure).

PHUs should complete enhanced mpox data fields, where possible. States and territories should transmit enhanced mpox data to the NNDSS in line with jurisdictional standards. Ideally, mpox enhanced data should be transmitted to the NNDSS on a fortnightly or monthly basis. Mpox data are checked quarterly by the Commonwealth.

Public health importance

Following the eradication of smallpox in 1980 and subsequent cessation of smallpox vaccination programs in the same year, MPXV has emerged as the most significant Orthopoxvirus for public health. Historically, MPXV primarily occurred in humans in Central and West Africa, often in proximity to tropical rainforests. Around 75% of cases during the 1980s were attributable to contact with infected animals (1–4). Before 2018, the only cases with secondary transmission outside Africa occurred in 2003 in the United States of America (USA), associated with contact with infected animals (5,6).

In early May 2022, multiple countries outside of the African continent reported outbreaks of MPXV clade IIb, predominantly associated with direct transmission of MPXV through sexual/intimate contact. On 20 May 2022, Australian health authorities detected cases associated with this global outbreak locally – this was the first time the virus had been detected in Australia (7).

The World Health Organization (WHO) declared the mpox outbreak, due to MXPV clade IIb, a public health emergency of international concern (PHEIC) on 23 July 2022, followed by Australia's declaration of mpox as a Communicable Disease Incident of National Significance on 28 July 2022 (stood down on 25 November 2022). From January 2022 to June 2025, over 100,000 mpox cases (largely MPXV clade IIb) were reported in more than 100 countries outside of Africa (8). Case numbers peaked in August 2022, followed by a significant decrease into late 2022 and onward, but transmission continues globally. In Australia, sustained locally acquired human-to-human transmission of MPXV clade IIb was observed in 2024 (9).

The WHO declared mpox a PHEIC for a second time on 14 August 2024, following the upsurge of clade Ib from the Democratic Republic of the Congo (DRC) to several neighbouring African countries from late 2023 (10). From January 2022 to June 2025, more than 43,000 mpox cases (largely MPXV clade Ib, but also clade Ia) were reported in 30 African countries, with the majority of cases from the DRC, Uganda, and Burundi (8).

By July 2025, imported MPXV clade Ib cases were reported in 18 countries outside of Africa, including Australia, and three countries outside of Africa reported imported clade Ia cases (8). The PHEIC status for mpox was declared over by the WHO on 5 September 2025 (11).

By October 2025, locally acquired clade Ib cases were reported in four European countries and the USA, indicating ongoing transmission in sexual networks in the community (12).

Public health response aims

The aim of the public health response to mpox in Australia is to suppress transmission of mpox and prevent future cases. This approach acknowledges the risk of ongoing incursions of mpox cases into Australia, and inability to eliminate all cases of mpox from Australia given the global epidemiology.

Priority populations

High-risk groups and settings

While diverse modes of transmission mean that anyone can acquire or transmit mpox, cases in the global clade IIb outbreak have occurred primarily, but not exclusively, in gay, bisexual, and other men who have sex with men (GBMSM+) (8,13), as has been seen in the Australian context. The ongoing clade Ib outbreak in the DRC and other African countries is also strongly associated with sexual contact/direct physical contact and household contact (14).

High-risk settings for transmission include:

- households (15)
- sex-on-premises venues (SOPV) (16–18)
- events, parties, or other venues where skin-to-skin contact and other intimate contact occurs (8,18–20)
- healthcare settings (though only 2% of cases in healthcare workers in the global clade IIb outbreak have reported a healthcare associated exposure) (8)
- countries or areas where mpox is endemic or there is a high risk of exposure (7).

Evidence of mpox transmission in schools and childcare settings outside of Africa is limited (21), and these have not been identified as high-risk settings in Australia. If a case is detected in a school or childcare setting, a risk assessment should be undertaken and guidance followed as in Case management and Contact management.

Groups at increased risk of severe disease

People infected with MPXV who may be at greater risk of more severe disease include:

- **Immunocompromised people:** Individuals immunocompromised due to uncontrolled human immunodeficiency virus (HIV) infection (CD4 count <350 cells/μL) or other immunocompromising conditions or treatments (22–26).
- **Pregnant people:** Evidence to support increased risk of severe disease in this group in the context of contemporary global outbreaks is mixed and often based

on small numbers. However, vertical transmission of MPXV can occur and may carry a high risk of pregnancy loss or severe congenital infection in some cases (27–31).

- **Children:** The WHO identifies children as groups who may be at greater risk of more severe disease, reflecting the data from the global outbreak of clade IIb indicating children younger than 5 years were twice as likely to be hospitalised due to mpox compared with people aged 15-44 years (25). Additionally severe outcomes in children have been recorded in clade I outbreaks in Africa, likely relating to factors such as malnourishment, co-infection and lack of access to healthcare and vaccination (14,15,25,32,33). It is unclear whether children in Australia may be at greater risk of severe disease due to the limited number of cases in this population notified in Australia to date.

Surveillance aims

Key surveillance objectives:

- Identify and describe the epidemiology of mpox cases to inform public health interventions.
- Identify clusters of mpox cases and sources of infection to minimise transmission through case and contact management.
- Enable effective prevention and control measures and effective communication strategies based on:
    - identified routes of transmission
    - at-risk groups, and
    - high-risk settings.
- Provide robust data to support efforts to reduce human-to-human transmission.

Disease summary

On 28 November 2022, the WHO announced a change in disease name from monkeypox to mpox. Mpox is caused by infection with MPXV.

Infectious agent

Pathogen

MPXV is an enveloped double-stranded deoxyribonucleic acid (DNA) virus of the genus Orthopoxvirus (related to the Poxviridae family), which also includes variola virus (which causes smallpox), vaccinia virus (which is used to produce the smallpox vaccine) and cowpox virus (1).

MPXV has two distinct genetic clades.

- Clade I: formerly known as the Congo Basin or Central African clade and has two subclades, clades Ia and Ib.
- Clade II: formerly known as the West African clade and has two subclades, clades IIa and IIb (1,34).

Reservoir

The natural reservoir of MPXV remains unknown. However, the virus has been isolated from several African rodents and primates, including the Gambian pouched rat, tree squirrel, rope squirrel, and sooty mangabey monkey.

Mode of transmission

The primary mode of transmission for mpox is via direct contact with lesions (through broken skin or mucous membranes). Less frequently, transmission of mpox may occur via contact with materials contaminated with MPXV (35–37).

Other potential routes of transmission include:

- Indirectly via fomites (e.g., contaminated sheets and clothing).
- Aerosol-generating and percutaneous procedures (38,39).
- Animal to human transmission: Infrequently described but can occur through direct contact via bites or scratches and indirectly from contact with blood, bodily fluids, cutaneous lesions or mucosal lesions. There is also limited evidence to suggest that humans can transmit the virus to household pets (36,38,40).
- Vertical transmission (27,36,38,41,42), including reported pregnancy loss or congenital mpox due to MPXV clade Ib infection (31).

- Contact with blood and body fluids: Limited evidence suggests the potential for transmission through blood or via semen or vaginal fluids (13,43,44).
- Transmission via droplet exposure is uncommon (36,45–47), with no reported mpox cases attributed to inhalation/airborne transmission as a single route of transmission.

Summary of mpox transmission routes/settings by region and MPXV clade

Region/country	MPXV clade	Transmission route/setting
International outbreak (8)	IIb	Direct contact with skin or mucosal lesions during sexual activity among GBMSM+(87%) (based on 38,048 cases) Setting (data available for 8,736 cases): • party setting with sexual contact (57%) • household (9%) • healthcare (0.2%)
The DRC (14)	Ib	Total number of cases: 4,436 • sexual/physical contact (44%) • household contact (21%) • caregiving or healthcare activities (with exposure to bodily secretions or excretions) (7%)
The DRC (14)	Ia	Total number of cases: 459 • household contact (32%) • animal contact (22%) • interaction at school/market/church (13%) • sexual/physical contact (5%)
Sweden, the UK (48,49)	Ib (imported)	One imported clade Ib mpox case was reported in Sweden in 2024, acquired infection in Africa through close physical contact - no secondary transmission. Two imported clade Ib mpox cases were reported in the UK in 2024, acquired infection in African countries via massage/heterosexual contact. One case resulted in 3 secondary cases within the household (the partner and 2 children) and the other case had no secondary transmission.

Incubation period

The average incubation period for mpox is estimated to be 8 days, with a range of 3 to 21 days (50–52). There is no evidence to suggest the incubation period varies by clade, but it may be influenced by transmission route, with infections acquired through direct exposure (e.g., contact with broken skin or mucous membranes) having a shorter incubation period (53).

Infectious period

People with mpox are typically infectious from the onset of symptoms—either prodrome, rash, or proctitis (26). People remain infectious until all symptoms have resolved, and all lesions have formed scabs and fallen off, leaving fresh skin

underneath. Some people may not be aware of their exact symptom onset date, as initial symptoms may be very subtle or not visible (26,36,54–56).

There is limited evidence regarding infectivity pre-symptom onset. However, a small number of studies have demonstrated pre-symptomatic transmission, or presence of virus, up to 4 days prior to symptom onset (26,57–60).

Contact tracing is generally recommended from symptom onset. However, PHUs may consider undertaking contact tracing for up to 4 days pre-symptom onset for:

- exposures in highly susceptible populations (e.g. exposure on an oncology ward)
- sexual contacts (due to the potential for unrecognised anorectal or genital lesions and absent prodromal symptoms).

Symptomatic cases without visible lesions should be considered infectious until complete resolution of all symptoms, or after 21 days post symptom onset, whichever is longer. See Guidance for cases without visible skin lesions.

Asymptomatic cases should be considered infectious for 21 days after a positive test. See Guidance for asymptomatic cases.

Clinical condition

Clinical features

Mpox is usually a self-limiting disease with symptoms lasting 2 to 4 weeks.

The illness may have a prodromal period lasting 1 to 5 days, characterised by lymphadenopathy, fever (≥38 °C) or history of fever, headache, myalgia, arthralgia, back pain, and sore throat. Not all cases report prodromal symptoms (18,61).

A maculopapular rash is typical of mpox and may develop 1 to 5 days after the onset of fever. The rash may be generalised or localised, discrete, or confluent. It is classically described as centrifugal, more concentrated on the face and extremities than the trunk. Skin lesions often present first as macules (lesions with a flat base), which progress to papules (slightly raised firm lesions), vesicles (lesions filled with clear fluid), and pustules (lesions filled with yellowish fluid). Crusted scabbing usually begins 14 to 21 days after rash onset. Scabs then fall off, leaving dyspigmented scars (62).

Many cases associated with the global clade IIb outbreak have not presented with the classically described clinical picture for mpox outlined above (42,63). This relates to the mode of transmission predominantly being via sexual contact and attenuated illness among those vaccinated against mpox. Differing presentations have included the following:

- Lymphadenopathy, present in 20-60% of cases (8,13,64).
- Rash in 95% of cases (with 64% having ≤10 lesions) (13).

- Lesions which appeared in the genital or perianal area and did not spread further (68% of cases with mucosal lesions) (13).
- Absence of visible skin lesions in 5% of cases. People may present with proctitis, urethritis, rectal pain and/or rectal bleeding (13) and tenesmus. Vomiting, diarrhoea, nausea and abdominal pain may also occur (65). Lesions may also appear in the oral cavity (66).
- Rashes and lesions commonly appearing before the onset of fever, malaise and other constitutional symptoms (prodromal period) (13).
- Concomitant sexually transmitted infections were reported in 29% of mpox patients (13).

Clinical data from mpox cases in the DRC indicate distinct presentations for clade Ia and Ib, with higher proportions of respiratory symptoms (around 50%) and higher lesion counts (median counts: 91 for clade Ib cases; 163 for clade Ia cases), compared with clade IIb outbreaks (14). This difference likely reflects the greater virulence and systemic dissemination of clade I viruses. Additionally, environmental factors such as biomass smoke from wood and charcoal burning for cooking, common in the DRC (67), could plausibly exacerbate respiratory symptoms among mpox patients.

Imported clade Ib cases reported in Sweden (48), the UK (49) and other European countries (68) have shown mild to moderate illness characterised mainly by fever, localised vesiculopustular rash, and lymphadenopathy.

Complications and outcomes

Symptomatic manifestations of mpox can cause severe pain and affect vulnerable anatomic sites; painful proctitis or oral lesions may be the primary presentation. More severe complications of mpox include secondary infections such as cellulitis, bronchopneumonia, sepsis, encephalitis, and infection of the cornea with subsequent scarring and loss of vision. Severe dehydration may occur, secondary to vomiting, diarrhoea and oral lesions preventing adequate hydration (41).

During the global MPXV clade IIb outbreaks, 9% of cases were hospitalised, 0.4% admitted to an intensive care unit (ICU), and the case-fatality rate was 0.3% (8).

Based on mpox data from the DRC, 50% of mpox clade I cases were hospitalised, and the case-fatality rate was 4.4% for clade Ia and 0.6% for clade Ib (14). The high case-fatality rate for clade Ia is likely influenced by multiple factors, including varying diagnostic methods, co-existing medical conditions such as HIV, malaria and tuberculosis, treatment availability, and potentially higher virulence (69).

Mpox clade I cases identified in countries outside of Africa have presented with milder symptoms and no deaths have been reported (70). Additionally, of the first 16 cases identified in the UK, a case review identified high hospitalisation rates initially to manage isolation and perceived transmission risk, rather than due to disease

severity, with hospitalisation decreasing over time as the transmission route was better understood and clade Ib cases were managed in the community (71).

Reinfection

Mpox reinfection is very uncommon, occurring in less than 0.2% of reported cases (72). Documented reinfections typically occur in high-risk populations and are generally milder than the initial illness (73). Natural infection provides stronger and longer-lasting immunity than vaccination; about 85% of previously infected individuals remain seropositive at around two years, compared with approximately 32% for those vaccinated with the two-dose MVA-BN (JYNNEOS) vaccine (74).

Case classification

Surveillance case definition

See the CDNA Monkeypox virus infection – Surveillance case definitions.

Both **confirmed cases** and **probable cases** should be notified.

A suspected case definition has been developed in response to current multi-country outbreaks of mpox in non-endemic countries and may be discontinued as the outbreaks evolve. Suspected cases should not be notified to the National Notifiable Disease Surveillance System (NNDSS).

Clinicians and laboratories should notify cases to state and territory health departments in accordance with jurisdictional legislation and local guidance.

Laboratory case definition

See the Public Health Laboratory Network (PHLN) laboratory case definitions.

Testing

Patients with symptoms who present with a history suggestive of exposure to MPXV should have a specimen collected and be referred for laboratory testing. Testing of asymptomatic persons is not recommended, although treating clinicians may choose to arrange testing for asymptomatic high-risk contacts based on individual clinical risk (75).

Testing is performed in jurisdictional public or private medical laboratories. For further information on recommendations for laboratory testing please refer to the Public Health Laboratory Network Mpox Laboratory Case Definition. Specific advice from the specialist microbiologist at the testing laboratory may be sought to obtain advice on specimen collection, safe packaging, and transport.

Specimen collection and handling

General advice on specimen collection and handling is outlined in the Public Health Laboratory Network Guidance on Monkeypox patient referral, specimen collection and test requesting for general practitioners and sexual health physicians.

It is advisable to collect samples from more than one lesion where possible. However, excessive sample collection should be discouraged to minimise the risk to healthcare workers or laboratory personnel.

While lesion specimens are preferred, rectal, throat or nasopharyngeal swabs are also suitable. Such specimens may be collected in people with prodromal symptoms who present with no lesions (e.g., a contact who develops symptoms).

For further advice, including on appropriate personal protective equipment (PPE) and safe handling and transport of specimens, see the Public Health Laboratory Network Mpox Laboratory Case Definition.

Characterisation of clades, subclades, and lineages

Whole genome sequencing (WGS) is used to characterise clades, subclades, and lineages of MPXV; however, some public health reference laboratories may develop and use MPXV nucleic acid amplification (NAA) tests to distinguish between MPXV clade I and MPXV clade II infections.

Public health reference laboratories may conduct WGS of positive samples to:

- differentiate clades, subclades, and lineages
- monitor mutations to ensure routine NAA tests are fit for purpose
- assist, in conjunction with epidemiologic information, the identification of transmission links and/or clusters, where these are not already clear
- monitor *in silico* antiviral resistance patterns (76).

Decisions about WGS are made by individual states and territories after agreement between laboratory and public health professionals. Jurisdictions may choose to sequence strains where:

- there is a reasonable suspicion that the person is infected with MPXV clade I in the absence of clade and subclade specific NAA tests
- cases do not have epidemiological links and/or are atypical (e.g., a female with no GBMSM contact)
- an mpox outbreak is emerging (rather than as standard practice during a stabilised outbreak)
- jurisdictions have capacity and resources available for WGS.

Case management

Response procedure

PHUs should begin follow up investigation for all suspected, probable, and confirmed cases on the day of notification, to identify the source of exposure and contacts.

The jurisdictional communicable diseases unit should notify the National Focal Point within 3 working days via email to health.ops@health.gov.au if:

- there is concern regarding the potential for a mass transmission event or multi-jurisdictional outbreak
- the infection appears to have been acquired on a cruise ship or plane
- the infection appears to have been acquired via an unusual transmission pathway.

A risk-based approach is advised to inform case management and should be guided by the characteristics of case presentation and contact with those at risk of severe disease. Factors to inform a risk-based approach may include:

- disease severity or epidemiological links to a person with disseminated disease
- factors that may increase the risk of onward transmission, including disseminated rash/lesions, respiratory symptoms, aerosol generating procedures (AGPs), and higher-risk activities undertaken during the infectious period
- work or attendance at high-risk settings including healthcare, daycare/childcare, residential care facilities, and SOPV
- cases among individuals living or working in remote communities (including Aboriginal and Torres Strait Islander communities) where timely clinical assessment and intervention may be limited
- potential difficulties following exclusion and restriction criteria due to the social determinants of health, such as those experiencing homelessness, overcrowding or other social issues.

Case investigation

PHUs should respond to a case in collaboration with the treating clinician and/or local health service, and ensure that the following actions are taken:

- Samples for relevant pathology tests are collected and results are confirmed.

- Where possible, contact the treating doctor to ensure they have discussed the diagnosis with the person (or caregiver) and advise the need for the PHU to interview the case (or caregiver) for public health purposes.
- Interview the case (or caregiver) to ascertain symptom onset date and obtain the following information for the exposure period (from 21 days prior to symptom onset) and the infectious period (for duration of symptoms, or up to 4 days pre-symptom onset in some instances):
    - Symptoms and healthcare presentations.
    - Travel history.
    - Attendance at any high-risk settings or activities.
    - Any exposure with a confirmed or probable case and nature of the contact.
    - Details of sexual contacts and intimate partners, including recent travel history.
    - Details of living circumstances.
    - Smallpox and mpox vaccination status.
- Prioritise identification of contacts: In instances where sexual encounters are anonymous, or where people are unwilling or unable to provide details of contacts, consider whether the case can provide information to contacts either directly or via private messages on the dating/hook up apps on which they met.
- Identify the likely source of infection.
- Implement public health management of confirmed and probable cases, and their contacts. This includes providing advice around transmission prevention and arrangements for access to vaccination as post exposure prophylaxis (PEP) for contacts.
- Ensure people with mpox have access to contact numbers for the PHU and counselling services, to seek advice or support where required. See the Department of Health, Disability and Ageing website for a list of mental health and suicide prevention services.

Exposure investigation

PHUs should do the following:

- Aim to identify the source of infection from the information obtained during the case investigation.
- Undertake upstream testing of suspected cases, if appropriate, to identify the source, understand transmission pathways and risk factors, and inform public health action.
    - Discuss upstream testing with a clinical microbiologist to determine most appropriate method. This may not be feasible during high case

numbers, during which broader public health messaging and mechanisms to increase vaccination may be more effective.

- Investigate other plausible sources, such as the household or workplace, if the person has no identified sexual source of infection.

Exclusions and restrictions

PHUs should advise cases to undertake the following exclusions and restrictions during their infectious period, including the prodromal and rash stages of the illness.

Until they meet the clearance criteria, cases are **recommended to do** the following:

- Keep lesions covered when around other people or animals—use a waterproof dressing or bandage and then cover with clothing.
- Do their own laundry.
- Always practice careful hand and respiratory hygiene.
- Limit close contact with household members and pets where possible, by sleeping in a separate room and/or using a separate or ensuite bathroom.
- Work from home, if possible, unless risk is assessed by PHU as suitable to attend the workplace*.
- Clean and disinfect any shared spaces (including bathrooms), appliances or items immediately after use.

If the case is unable to cover their lesions due to disseminated disease or there is potential generation of infectious droplets due to oral lesions, pharyngitis, or respiratory symptoms, the case should isolate (at home or in hospital) and wear a surgical mask when around other people or animals. PHUs may undertake a risk assessment to determine whether a person with lesions that can be covered up and respiratory involvement (e.g., oral lesions or sore throat only) does not need to isolate and may be permitted to resume usual activities with general case exclusion guidance, including wearing a mask when around other people.

Cases are **recommended to avoid** the following while infectious:

- Close or intimate contact with others, including all sexual activity.
- Sharing clothing, bedding, towels, or unwashed cutlery and crockery with others.
- Touching their face or rubbing their eyes, especially if blisters are present on or near their eyes or hands.
- Entering high-risk settings such as early childhood education and care services, aged care, healthcare settings, and settings with young children and those at higher risk of severe disease, including for work, unless seeking

medical attention or on the advice of the PHU after a risk assessment has been undertaken*.

- Contact with people who are at higher risk of severe disease, including immunosuppressed people, pregnant people, and young children.
- Donating any human tissue, including blood, cells, tissue, breast milk, semen, or organs (see Case clearance for additional restriction periods).
- Travel domestically or internationally without prior discussion with the PHU.

Cases may be able to attend secondary/higher educational settings if preventative measures can be followed independently.

The PHU should conduct an assessment of the case's living situation, the ability of the case and their household members to follow the above advice, and whether they live with any people at increased risk of severe disease. Based on this assessment, the PHU may need to consider providing additional advice and support to mitigate risk.

*PHUs may conduct a risk assessment for cases who work in or visit high-risk settings and cannot work from home. The risk assessment should consider: the disease severity, the type and nature of work, number and location of lesions, the presence or absence of respiratory symptoms, and whether the person works with particularly susceptible populations. Cases must cover all lesions and may be advised to wear a surgical mask when in high-risk settings.

**Cases who are advised to isolate at home should stay at home unless they need to leave for essential reasons (such as seeking medical care).

Case clearance

Cases can resume most normal activities when all lesions have crusted, scabs have fallen off, and a fresh layer of skin has formed underneath.

The PHU or managing clinician (where appropriate), will advise on clearance of a case.

For **12 weeks following clearance**, cases should:

- use a condom during sexual activity (receptive and insertive oral/anal/vaginal sex) (42,44)
- not donate semen.

Cases should not donate blood until 4 weeks after they have fully recovered. Refer to Lifeblood guidance.

Longer periods may apply for the donation of breast milk, organs, tissues, cells, and other biological products, as advised by the relevant tissue collection authority.

Guidance for cases without visible skin lesions

For symptomatic cases (e.g., with proctitis) without visible skin lesions, PHUs should recommend that they follow the same exclusion and restriction requirements as

cases with visible lesions as above, until complete resolution of all symptoms, or after 21 days post symptom onset, whichever is longer.

Guidance for asymptomatic cases

International reports of asymptomatic MPXV infection in cases associated with the ongoing clade IIb outbreak are rare and generally only detected and described in research studies. There is limited evidence available to determine whether asymptomatic cases are infectious (75,77). In the event an asymptomatic case is detected, they should be managed as per other confirmed cases and can be considered cleared 21 days after their positive test.

Case education

PHUs should ensure people with mpox have been advised about:

- mpox symptoms, transmission and duration of infectivity
- how to prevent passing on mpox to others, including personal hygiene and infection prevention and control measures
- seeking treatment or medical assistance if required
- the importance of contact tracing to notify close contacts of their risk.

PHUs should provide information about appropriate social services available to support people with mpox at risk of complex social situations.

Refer to information for cases for more information.

Treatment

The clinical management of mpox is the responsibility of the treating clinician.

Mpox is generally self-limiting. Most cases will not require specific treatment, other than supportive management of symptoms or treatment of complications (e.g., antibiotics for secondary cellulitis).

Advice on clinical management can be sought from an infectious diseases physician and/or sexual health physician, particularly in persons with, or at risk of, severe disease. If antiviral treatment is indicated, it should be initiated in consultation with an infectious diseases physician and/or sexual health physician.

For further advice, refer to the Australian Human Mpox Treatment Guidelines.

Infection prevention and control

Healthcare workers should use a risk-based approach to select appropriate PPE and infection prevention and control interventions when caring for individuals with suspected or confirmed mpox. The risk assessment should consider:

- the type of care or procedures to be undertaken for the individual
- severity of symptoms, dissemination of disease and respiratory involvement
- clinical setting (primary care or acute care), including the potential for transmission to others and ability to isolate cases.

Note: the mode of transmission for mpox is primarily the same, regardless of clade.

In all healthcare settings, mpox cases should be managed in a single room with a dedicated ensuite.

Use **contact precautions**, in addition to **standard precautions**, where the risk of onward transmission is considered low (e.g., a single lesion that can be covered completely or proctitis only).

Use **droplet precautions**, in addition to **contact and standard precautions**, if there is disseminated disease or respiratory symptoms/involvement.

PPE for combined droplet and contact precautions includes the use of a gown or apron, gloves, surgical mask, and eye protection.

A risk assessment should be undertaken to inform the use of a particulate filtration respirator, considering the level of exposure and nature of activity, when performing AGPs (including airway management), or for providing care to patients admitted to a healthcare facility with disseminated disease or respiratory symptoms/involvement.

Deroofing lesions and throat swabs are not considered to be AGPs in this context, although they may generate droplets (78). Healthcare workers should wear PPE for combined droplet and contact precautions when performing these procedures.

See the Australian Guidelines for the Prevention and Control of Infection in Healthcare.

Active case finding

In the event of a large exposure event or outbreak, active case finding should be considered. The extent to which this is taken should be proportionate to the risk. The avenues used may depend on the severity of disease, including information about the clade (if available), public sentiment and fatigue relating to public health messaging, and risk groups affected. Targeted public communications may be preferential compared to general communications.

PHUs should consider the following:

- Alerting clinicians (local doctors, sexual health clinics, emergency departments and laboratories) in the area via clinician alerts or targeted clinician communications, with an emphasis on diagnosis, testing and notification to the local PHU. This may be done by clinician alert or other means.
- Targeted communications to at-risk groups, including via relevant non-government and peer-based organisations, specific venues such as SOPV.

- Broader public communications regarding increasing mpox risk, vaccination for at-risk populations, high risk activities, symptoms to monitor for, and where to seek testing.

Contact classification

Contact identification

PHU staff should directly follow up, or provide information to, all medium and high-risk contacts.

Where direct follow up by PHUs is not possible, or where the case is not willing or able to provide details of contacts to the PHU for follow up, other strategies should be used to help ensure potential contacts receive public health advice. For example, PHUs may provide written information for the case to pass onto potential contacts, which could include the case messaging their sexual partner/s via direct messaging through social media or 'hook up' apps.

See Case Management – Response Procedure.

Contact definitions

Mpox contact definitions

Contact type	Definition of exposure during the case's infectious period	Examples
High risk	• Contact via broken skin or mucous membranes with an mpox case (while infectious), potentially contaminated materials (including bed linens and healthcare equipment), crusts, or bodily fluids. **OR** • Exposure to aerosols from an mpox case undergoing an aerosol-generating procedure in an enclosed room while the contact was not wearing appropriate PPE[1].	• Sexual or intimate partners, including at sex parties. • Carer is a case with disseminated or uncovered lesions who has provided physical personal care to young children (contact) such as assistance with dressing, toileting, bathing and feeding, and where close contact through sharing a bed, hugging and/or kissing occurs. • Someone whose eyes, nose, mouth, orifice, or exposed wound has had contact with bodily fluid from a case. • Healthcare workers present in an enclosed space during an aerosol-generating procedure without wearing appropriate PPE[1]. This may be in a patient's room, or in a curtained area, e.g. in an emergency department.
Medium risk	• Contact with an mpox case via intact skin (while case is infectious), potentially contaminated materials (including bed linens and healthcare	• Healthcare workers providing personal care to an mpox case in a hospital setting while not wearing appropriate PPE[1] or in the case of a PPE breach.

equipment), crusts, or bodily fluids, while the contact was not wearing appropriate PPE[1].

OR

- Exposure to aerosols from an mpox case, while the contact was not wearing appropriate PPE[1], during an aerosol dispersing activity that may create aerosols from oral secretions, skin lesions or resuspension of dried exudates (e.g., shaking of soiled linens, showering patients, or conducting examinations or procedures involving the oropharynx).

- Cleaning or laundry staff who have changed or laundered the bedding of an mpox case who has rash/lesions without wearing appropriate PPE[1].
- Attendance at a higher risk social setting or situation (79) when an mpox case attended during their infectious period[2].
- Household contacts, where the case has not covered their lesions while being in communal areas.

Notes:

[1] **Appropriate PPE** as determined by the PHU based on a risk assessment including the nature of contact, likely transmission pathway/s and setting type, noting the minimum standard defined in Case management. Refer to jurisdictional and local guidelines/policies.

[2] **A higher risk social setting or situation** constitutes those settings where the nature of interaction may pose some risk of transmission (e.g. raves, festivals, and other mass gatherings where there is likely to be prolonged close contact). A risk assessment should consider the case's symptoms and location of lesions. This should be limited to identifiable social contacts unless broader communications for the venue is considered necessary by the PHU.

Contact management

PHUs should advise contacts to **monitor** for signs and symptoms of mpox for 21 days after the date of their last exposure to the case. All contacts should be encouraged to practise good hand hygiene and respiratory etiquette.

Management of mpox contacts

Type of contact	Recommended contact management

High risk	**Surveillance:** Active self-monitoring[1].
	
	Post exposure prophylaxis (PEP) administration[2]: Vaccination should be offered if not fully vaccinated. See the Australian Immunisation Handbook. Antiviral PEP may be considered under specified circumstances. See the Mpox Treatment Guidelines.
	
	Testing priority: Urgent if symptoms develop[3].
	
	Additional recommendations:
	
	For **21 days** from last exposure:
	• Abstain from sexual activity.
	• Continue attending work as long as remain symptom free. If working in a high-risk setting[4] or employment that requires close physical contact with others, attending an educational setting or a high-risk setting (e.g., healthcare, aged care, childcare settings), the PHU should conduct a case-by-case risk assessment. Generally, healthcare workers or carers in a high-risk setting may be permitted to continue working depending on their role, exposure risk, pre-exposure vaccination status and risk to others. This may include recommending wearing a surgical mask.
	• Outside of work, avoid:
	  ○ Childcare and aged care facilities
	  ○ Healthcare facilities unless seeking medical attention.
	• Avoid close physical contact with those potentially at higher risk of severe infection (young children, older people, immunocompromised people, and pregnant people).
	• For contacts who are <5 years old, the PHU should conduct a risk-assessment to determine whether exclusion from an educational or care setting or other places attended by other young children is required. This may depend on the ability for close symptom monitoring of the child, the exposure risk, and vulnerability of the setting. Children aged 5 years and over should generally be permitted to attend educational settings with careful monitoring for symptoms; PHUs should undertake a risk assessment including age, vulnerability of the setting and additional caring needs.
	• Reconsider domestic and international travel due to reduced ability to isolate or access healthcare if symptoms develop, and requirements for strict isolation in some countries.
	• Do not donate breast milk, organs, tissues, cells or semen. Longer periods may apply as advised by the appropriate collection authority.
	
	For **28 days** from last exposure:
	• Do not donate blood. See Lifeblood guidance.

Medium risk	**Surveillance:** Active self-monitoring[1]
	
	PEP administration[2]: Vaccination should be offered if not fully vaccinated. See the Australian Immunisation Handbook. Antiviral PEP may be considered under specified circumstances. See the Mpox Treatment Guidelines.
	
	Testing priority: High if symptoms develop[3]
	
	Additional recommendations:
	
	For **21 days** from last exposure:
	• If working in a high-risk setting[4], ensure the contact remains symptom free. PHUs should assess and manage workers, residents, and attendees in these settings on a case-by-case basis.
	• Children may attend caring and educational settings and have contact with other young children if closely monitored for symptoms.
	• Outside of work, avoid:
	  ○ Aged care facilities
	  ○ Healthcare settings unless seeking medical attention.
	• Avoid close contact with those at potential higher risk of severe infection (young children, older people, immunocompromised people, and pregnant people), where possible.
	• Use a condom during sexual activity (receptive and insertive oral/anal/vaginal sex).
	• Do not donate breast milk, organs, tissues, cells or semen. Longer periods may apply as advised by the appropriate collection authority.
	
	For **28 days** from last exposure:
	• Do not donate blood. See Lifeblood guidance.

Notes:

[1] Active self-monitoring is the contact watching for signs or symptoms compatible with mpox infection; if they appear, follow case exclusion and restriction criteria and seek medical review. If the contact is facing difficulty accessing medical review call the PHU for assistance. During the incubation period the PHU may choose to regularly monitor high and medium risk contacts (by phone, email, text) to check for the emergence of any signs or symptoms at intervals if there are concerns about the contact's health literacy, self-efficacy, or if other supports are needed.

[2] For current ATAGI recommendations and the latest evidence for mpox vaccines, please see the Australian Immunisation Handbook.

[3] Treating clinicians may choose to test asymptomatic high-risk contacts based on an assessment of individual clinical risk, e.g. if the patient is immunocompromised. This should not delay PEP administration if appropriate.

[4] High-risk settings are defined as childcare, aged care and disability facilities, and healthcare environments.

Contact education

PHUs should, at a minimum, provide the following information to contacts:

- Mpox symptoms, transmission routes and likely risk of developing mpox.
- How to seek testing if symptoms develop.
- A contact phone number for the PHU.

If a large number of contacts is identified in a facility or institution, information to residents, workers or attendees may be distributed via the facility or institution manager.

Refer to the information for contacts section below for further information.

Population level prevention

PHUs may consider undertaking the following measures to prevent sustained transmission of mpox in the community:

- Develop and disseminate mpox educational material to groups at higher risk of infection and severe disease (see Priority populations). Establish partnerships with local sexual health clinics, primary health care services, primary health networks, and Aboriginal community-controlled organisations, to facilitate testing and clinician awareness and education, and connect cases and contacts with relevant community support organisations. GPs and primary care facilities play a vital role in testing for mpox.
- Engage with local community-controlled organisations for the LGBTQIA+ community, people living with HIV, SOPVs, sex workers, and Aboriginal and/or Torres Strait Islander people to assist with targeted communications on universal prevention measures and importance of vaccination.

PHUs should take steps to promote community awareness by making guidance publicly available for at risk people (and the wider community where necessary), to minimise their risk of infection, including the following advice:

- Exchange contact information with any new sexual partner(s) during periods of local mpox transmission to facilitate contact tracing if required (see Response Procedure).
- Use condoms and perform hand hygiene after condom use, particularly if:
  - having sex while travelling
  - attending SOPVs or events where intimate contact with a large number of people occurs (noting that condoms may not be sufficient to stop transmission from uncovered lesions, and MXPV may still transmit in these settings via close contact or fomites, such as through contact with contaminated clothes/linen).
- Check Smart Traveller guidance prior to departure if travelling to countries where mpox is endemic (particularly Central and West Africa).

Vaccination

Vaccines to prevent or reduce mpox infection and severity are available (80). Both primary vaccination and post exposure prophylaxis (PEP) can reduce the likelihood of widespread community transmission and should be promoted to high-risk groups.

Refer to:

- the Australian Immunisation Handbook mpox page for advice specific to available vaccines and their use for primary vaccination and PEP

- the ATAGI Clinical guidance on the use of vaccines for the prevention of mpox for further advice on vaccine effectiveness and waning immunity.
- The Australian mpox treatment guidelines for advice on therapeutic options and prevention and management of vaccine-related complications relating to the second-generation vaccine.

Aboriginal and Torres Strait Islander Peoples and communities

Identification of mpox in an Aboriginal and Torres Strait Islander community should prompt active case and contact management by the PHU, undertaken in partnership with the affected community.

A small number of mpox clade II cases have been reported among Aboriginal and Torres Strait Islander people in Australia. To date, there have been no documented outbreaks in Aboriginal or Torres Strait Islander communities. It is important to note that limitations in surveillance and reporting may under detect the true burden of disease in Aboriginal and or Torres Strait Islander people.

The risk of severe disease in Aboriginal and/or Torres Strait Islander people and communities remains uncertain and warrants close monitoring and early action to reduce the risk of transmission.

Communications with the community regarding targeted action may be undertaken in partnership with the local Aboriginal Community Controlled Health organisation (ACCHO) and other relevant community-led organisations, as appropriate. Community and local stakeholder engagement should be central to any community-based response and should continue throughout implementation to ensure actions are culturally appropriate.

PHUs must remain cognisant and responsive to the intersection of stigma and discrimination that an Aboriginal and Torres Strait Islander community member may face if diagnosed with mpox. The PHU should work with the person to determine their preferred services to access, including cultural sensitivities related to gender.

Special situations

Sex on premises venues (SOPV)

To minimise the risk of an outbreak occurring at an SOPV, PHUs should encourage venues to do the following:

- Display informative posters and provide clear information about mpox:
    - symptoms and the need for patrons to seek medical assessment and testing if symptoms develop
    - transmission (primarily through sexual and close contact)
    - prevention and risk reduction strategies, including primary vaccination and PEP.
- Ensure appropriate infection prevention and control measures are taken to prevent the spread of mpox including:
    - routine cleaning and disinfection
    - waste disposal.

In the event a case or cases are reported to have attended an SOPV whilst infectious, a PHU may consider the following outbreak management strategies:

- Encourage SOPV owners and/or proprietors to notify the PHU if they become aware of a mpox case attending their venue.
- Distribute messages to patrons of the venue, through venue owners and/or proprietors, advising date and time of attendance of the mpox case.
- Advise patrons and staff to monitor for symptoms and to seek medical advice as soon as possible if they develop symptoms.
- Provide advice to venues regarding:
    - cleaning and disinfection, including increasing frequency of cleaning for surfaces that may contact people's skin, areas soiled with bodily fluids or lubricant, and frequently touched objects/surfaces.
    - not undertaking activities that may cause particulate dispersal, such as sweeping (wet cleaning methods are preferred), and shaking used linen, clothing, or towels before laundering.
    - waste management (i.e., waste [paper towels, tissues, condoms] should be double bagged before being disposed through standard waste management).
- The PPE that should be worn by staff undertaking cleaning, waste disposal and laundering, which at a minimum should include a fluid resistant surgical mask, non-sterile disposable gloves, a disposable apron, and protective eyewear where there is a risk of splashes or sprays of fluids into the face and eyes.
- Consider offering SOPV outreach vaccination programs.

Methods of messaging and the ability to contact trace may be limited due to the willingness of patrons to provide contact information. Messaging through mainstream media may not have adequate reach, and avenues to provide messaging through partnerships with non-government organisations should be explored. Best practice may require assessment on a case-by-case basis.

Congregate living settings

Congregate living settings are facilities or other housing where people who are not related reside in close proximity and share at least one common room (e.g., sleeping room, kitchen, bathroom, living room). This can include correctional and detention facilities, shelters for people experiencing homelessness or family violence, group homes, dormitories at institutes of higher education, boarding schools, seasonal worker housing, residential substance use treatment facilities and other similar settings—but *not* healthcare settings.

In the event of a case in a congregate living setting, PHUs may consider the following outbreak management strategies:

- Undertake contact tracing to identify staff, volunteers or residents who may have been exposed to a mpox case.
- Ensure appropriate infection prevention and control measures are undertaken including the cleaning and disinfection of areas where people with mpox spent time while infectious, waste and laundry management, the accessibility of handwashing facilities and provision of and training in the use of appropriate PPE.
- Distribute messaging to staff, volunteers and residents providing information about mpox and advising a case has been detected.
    - Clearly communicate and provide information about mpox prevention, including the potential for transmission through close, sustained physical contact, including sexual activity.
- Advise staff, volunteers, and residents who develop mpox symptoms to seek testing and medical evaluation and facilitate this if required.
- Recommend that people identified to have mpox should have their own bedroom and bathroom facilities; where this is not possible, cohorting of cases may be recommended:
    - If cohorting is not possible, ensure residents with mpox maintain physical distancing from others, cover any skin lesions with clothing, bandages, or a sheet or gown and wear a well-fitting disposable mask over their nose and mouth in situations where they are unable to physically distance.
- Recommend that a dedicated laundry space should be identified for residents in isolation, and that anyone handling laundry should wear appropriate PPE

(as per advice in SOPV section above) and that the below procedure for waste management be followed:
    - Use a plastic bag to contain all the waste in the infected person's area, then tie the bag off and directly dispose of it into the general waste stream (not recycling).
    - Perform hand hygiene immediately after disposing of waste.
- Recommend that the number of staff engaging with cases is reduced to those essential for operations or care.
- Direct staff and volunteers who test positive to follow the same advice for existing cases. If there are workforce shortage concerns, a risk assessment for workplace attendance may be undertaken by a PHU on case-by-case basis.
- Consider recommending vaccination on a case-by-case basis, including PEP and targeted primary vaccination for certain groups within the facility.

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Appendix 1: Information for cases and contacts

About mpox

Mpox (previously known as monkeypox) is a viral illness that has been found in Africa for some years. Since 2022, it has spread around the world, including in Australia.

It is usually mild and most people recover fully in 2-4 weeks, but some people can get very sick.

Mpox is spread through very close contact with other people, including sex and close touch.

For more information, see:

- Mpox | Australian Centre for Disease Control
- Mpox (Monkeypox) - symptoms, treatment and prevention | healthdirect

Information for cases

Symptoms

Symptoms may include flu-like symptoms such as fever, swollen lymph nodes, muscle aches and pains, fatigue, headache, back pain, and a rash.

The rash usually starts 1 to 4 days after the flu-like symptoms, but some people only get the rash. The rash can be very mild (only one or two pimples) through to being widespread (lots of bumps and pimples all over the body).

For symptoms of mpox and what to expect, refer to Mpox | Australian Centre for Disease Control

What do I need to do?

Public health officers may contact you to ask how you might have become infected and for contact tracing. They may contact you by phone, email or text message. To reduce the risk of spreading mpox to other people, follow the advice below until your doctor of local public health unit has cleared you of the infection.

Personal care

- Keep lesions covered when around other people, if you can – use a waterproof dressing or bandage and cover with clothing.

- Wear a surgical mask when around other people or animals if you have lesions in the mouth, sore mouth or throat, or respiratory symptoms (such as cough).
- Wash your hands regularly with soap and warm water.
- Cover your mouth and nose with a tissue when coughing or sneezing – dispose of used tissues in the waste yourself.
- Avoid touching your face or rubbing your eyes, especially if you have blisters on or near your eyes or hands.

Around the house

- Limit close contact with household members, where possible. Sleep in a separate room and use a separate bathroom.
- Do not share clothing, bedding or towels, and do your own laundry. When handling these items, carers should wear appropriate protective equipment.
- Do not share unwashed cutlery and crockery.
- Clean and disinfect any shared spaces (including bathrooms) and items immediately after use.
- Work from home, if possible. The public health unit will let you know whether you can go to your workplace. This will depend on what work you do, your symptoms and the risk of passing mpox on to others.

Avoid the following while you are infectious (able to pass on the illness to others)

- Avoid close or intimate contact with others, including all sexual activity.
- Do not enter early childhood education and care services, aged care or healthcare facilities – unless seeking medical attention or advised by the public health unit that you can attend for work purposes.
- Avoid places or contact with those at higher risk of severe disease. These include young children, older people, people with poor immunity, and pregnant people.
- Avoid close contact with animals, particularly dogs and rodents.
- Do not donate any human tissue, including blood, cells, tissue, breast milk, semen, or organs. Longer periods may apply, depending on the biological product – check with the relevant collection authority.

Do I need to stay at home?

Your local public health unit may advise you to stay at home. This will depend on how severe your symptoms are, location of rash/lesions and risk of passing mpox on to others.

It is recommended you do the following any time you leave home:

- cover any rash or lesions (e.g., waterproof dressing or bandage, long sleeves, long pants)

- avoid close contact with others, and
- wear a surgical mask if you have respiratory symptoms (cough, sore throat) or lesions in the mouth.

If you need to seek urgent medical attention, let the emergency department or general practice know beforehand that you have mpox.

In a medical emergency always seek immediate health care or phone 000.

How should I clean my house?

Bathrooms, toilets and surfaces that are frequently touched	Regularly clean with a household detergent and warm water followed by a disinfectant. Alternatively, you can use a 2-in-1 cleaner and disinfectant solution. Use single-use or washable cloths/wipes.
Dishes and eating utensils	Wash in a dishwasher (preferably set at 60°C or above) or by hand with hot water and detergent.
Linen, towels, and clothing	Handle items yourself and keep separate from other people's items. Wash items with laundry detergent at the highest possible temperature on a regular cycle. Dry clothes as per normal. Clean and disinfect surfaces afterwards (e.g. the lid or handle of the washing machine) and wash your hands. Place coversheets, waterproof mattress covers or blankets over upholstered furniture and other porous materials that cannot be washed. If you need help with linen and laundry, the person helping should wear a surgical mask, gloves and protective eyewear. They should also avoid direct contact with items.
Waste	Place waste in a plastic bag at the point of use (e.g. in the bathroom). Tie off and place it directly into the general waste bin. Wash hands with soap and hot water afterwards.

Getting back to normal

Public health officers, or your doctor, will let you know when you have cleared the mpox infection and are no longer infectious. It is important to thoroughly clean and disinfect your home and wash linen after you are cleared, to resume normal activities.

It is not known how long the mpox virus remains in semen and other genital fluids.

It is recommended that for **12 weeks** after clearance you:

- use condoms during sexual activity – this is to reduce the risk of spreading the infection to sexual partners
- do not donate semen.

For information about blood donation following mpox infection, see the Lifeblood website.

Re-infection in the future is possible. Speak to your doctor about how to reduce your risk.

Information for contacts

Symptoms

Mpox symptoms may include flu-like symptoms such as fever, swollen lymph nodes, muscle aches and pains, fatigue, headache, back pain, and a rash.

The rash usually starts 1 to 4 days after the flu-like symptoms, but some people only get the rash. The rash can be very mild (only one or two pimples) through to being widespread (lots of bumps and pimples all over the body).

For symptoms of mpox and what to expect, refer to Mpox | Australian Centre for Disease Control

Why am I a contact?

You are considered a contact because you have had close interaction with someone who has mpox, and you may be at risk of developing mpox.

What can I do to prevent mpox?

Vaccination is generally recommended to prevent mpox in people at higher risk of getting the infection because of lifestyle factors or possible exposures at work.

Vaccination is also recommended after exposure to a person with mpox. It is most effective at preventing mpox infection if given within 4 days of contact with the infected person. But it can still reduce the severity of infection if given within 5 to 14 days of contact.

Your public health unit will discuss the risks and benefits of vaccination. They will advise whether you should be vaccinated.

What do I need to do?

It can take up to 21 days for people to develop mpox symptoms after having close contact with someone with mpox. Your public health unit or doctor will advise when your monitoring period is over.

For 21 days from your last contact with a person who has mpox or until advised by your doctor or the public health unit:

- Monitor for symptoms of mpox.
- If you develop symptoms of mpox, including a temperature of 38°C or above, stay at home and avoid others. Call your public health unit for advice about getting tested for mpox.

- If you need urgent medical attention, phone ahead and let the emergency department or general practice know you are coming. Wear a surgical mask if you have any respiratory symptoms (like cough or sore throat) or lesions in the mouth. Cover any rash and lesions and take this fact sheet with you.

In a medical emergency always seek immediate health care or phone 000.

Sometimes people who are contacts of a person with mpox develop very mild symptoms or have no symptoms and don't realise they have mpox infection until later in their illness.

To reduce the risk of giving mpox to other people, for 21 days from your last contact with a person who has mpox, or until advised by your doctor or public health unit:

- Wash your hands frequently using soap and warm water or an alcohol-based hand rub.
- Cover your mouth and nose when sneezing and coughing with paper tissues. Put used tissues into a rubbish bag and wash hands.
- Your public health unit will advise about whether you can go to work, or in the case of children, attend school or childcare. This will on where you work, your risk, and what your job is. Do not go to work if you develop any symptoms until you have spoken with your doctor or public health unit.
- Do not have sex (including genital touching, vaginal, anal, and oral sex).
- Avoid childcare and aged care facilities (unless you work there and have been advised by your public health unit you can return to work). Avoid healthcare facilities unless seeking medical attention.
- Outside of work, avoid contact with young children, older people, people with poor immunity and pregnant people.
- Do not donate breast milk, organs, tissues, cells or semen. Longer periods may apply – check with the relevant collection authority.

For 28 days from your last contact with a person who has mpox, do not donate blood. For more information, see the Lifeblood website.

Your public health unit may provide additional advice on avoiding physical contact with others, working from home or wearing a surgical mask.

How will I be contacted by the public health unit?

You may be contacted regularly by public health staff to check on your temperature and any new symptoms. This may be by phone, email, or text message.

Who do I contact if I have symptoms or questions?

You should contact your local public health unit.

Appendix 2: Sample case investigation form

MPOX CASE INVESTIGATION FORM			
PHU		**Completed by**	**Date completed**
NOTIFICATION			
Date of notification	___ /___/_____	**Date of initiation of response**	___ /___/_____
First Notifier		**Telephone**	**Fax**
Notifier type	☐ Laboratory ☐ Doctor ☐ Hospital (not laboratory) ☐ Other – specify_____		
Treating doctor	**Name**		**Address**
	Practice name		**Fax**
	Telephone		**Email**

CASE FOUND BY	
How case was identified	☐ Clinical presentation ☐ Contact tracing / epidemiological investigation ☐ Clinical and epidemiology ☐ Antenatal screening ☐ Screening (excluding antenatal) ☐ Unknown

CASE DEMOGRAPHICS			
Surname	**Given name**	**DOB** ___ /___/_____	**Age at onset** __ yrs__ mons
Sex at birth	☐ Male ☐ Female ☐ X (another term) – specify_____ ☐ Not stated		
Gender at diagnosis	☐ Man or male ☐ Woman or female ☐ Non-binary ☐ Other – specify_____ ☐ Not stated		
Address	**Suburb**	**State/Territory**	**Postcode**
Telephone	**Mobile**	**Email**	
Other contact	**Telephone**		
Indigenous status ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal/Torres Strait Islander ☐ Not Indigenous ☐ Not Stated			
Country of birth ☐ Australia ☐ Other: specify _____ **Primary language** ☐ English ☐ Other: specify_____			
Interpreter required ☐ No ☐ Yes: specify _____			
Occupation	**Occupation location**		
General Practitioner	**Name**	**Address**	
	Practice name	**Fax**	

	Telephone	**Email**

CLINICAL DETAILS			
Symptoms present	☐ Yes ☐ No ☐ Unknown		
Onset of first symptoms	Date ___ /___/____	Time: _____ AM / PM	
Signs and symptoms			
Rash/Lesions ☐ Yes ☐ No ☐ Unknown		**Fever ≥ 38°C** ☐ Yes ☐ No ☐ Unknown	
Description of rash/lesion ☐ macules ☐ vesicles ☐ pustules ☐ scabs ☐ healed			
Rash/lesion location ☐ Face ☐ Mouth ☐ Arms ☐ Hands ☐ Feet ☐ Legs ☐ Thorax ☐ Genital/perianal ☐ All over body			
Headache ☐ Yes ☐ No ☐ Unknown		**Cough** ☐ Yes ☐ No ☐ Unknown	
Lymphadenopathy ☐ Yes ☐ No ☐ Unknown		**Lymphadenopathy - location** ☐ **Inguinal** ☐ **Axillary** ☐ **Cervical**	
Chills or sweats ☐ Yes ☐ No ☐ Unknown		**Itch** ☐ Yes ☐ No ☐ Unknown	
Vomiting/nausea ☐ Yes ☐ No ☐ Unknown		**Oral ulcers** ☐ Yes ☐ No ☐ Unknown	
Fatigue ☐ Yes ☐ No ☐ Unknown		**Conjunctivitis** ☐ Yes ☐ No ☐ Unknown	
Myalgia ☐ Yes ☐ No ☐ Unknown		**Sore throat:** ☐ Yes ☐ No ☐ Unknown	
Other (specify) : _____			
Existing medical conditions	☐ Yes ☐ No ☐ Unknown If Yes, provide details_____		
Pregnancy status	☐ Yes (number of weeks gestation __) ☐ No ☐ Post-birth (infection detected at or after delivery) ☐ Unknown		

HOSPITAL ADMISSION		
Hospitalised	☐ Yes ☐ No ☐ Unknown If Yes, hospital name _____	
	Date admitted ___ /___/____	**Date discharged** ___ /___/____
Treating doctor	**Name** _____	**Position** _____ **Telephone** _____
ICU admission	☐ Yes ☐ No ☐ Unknown	If Yes, dates of ICU admission ___ /___/____ to ___ /___/____

TREATMENT DETAILS				
Treatment	**Frequency**	**Route**	**Commencement date**	**Completion date**

VACCINATION HISTORY

Vaccinations

Dose	Vaccination type	Vaccination date	Validation method
1			
2			

OUTCOME

Case recovered ☐ Yes ☐ No ☐ Unknown

Case died ☐ Yes ☐ No ☐ Unknown If Yes, was autopsy conducted ☐ Yes ☐ No ☐ Unknown

Assessment ☐ Died of notified condition ☐ Died of other cause

LABORATORY

Test type	Specimen type	Specimen body site	Specimen collection date	Test result
PCR	☐ Blood ☐ Swab of lesion ☐ Swab other ☐ Biopsy ☐ Other, specify:_____		_____/_____/_____	☐ Detected ☐ Not detected ☐ Not done
Genotyping			_____/_____/_____	☐ clade Ia ☐ clade Ib ☐ clade IIa ☐ clade IIb

EXPOSURE HISTORY

Exposure Period

Date: ___ /___/____ **to** ___ /___/____

(21 days before onset date) (onset date)

Exposure to infectious case

Contact with an infectious case of mpox in 21 days before symptom onset ☐ Yes ☐ No ☐ Unknown

If Yes, Name _____ DOB _____ Date of last contact with a case ___ /___/____

Exposure Type

Sexual partner ☐ Yes ☐ No ☐ Unknown		**Household** ☐ Yes ☐ No ☐ Unknown	
Travel ☐ Yes ☐ No ☐ Unknown		**Healthcare worker** ☐ Yes ☐ No ☐ Unknown	
Workplace ☐ Yes ☐ No ☐ Unknown		**School/childcare** ☐ Yes ☐ No ☐ Unknown	

Other exposure, specify _____

Sexual Exposure (Gender of sexual/intimate partners for the mpox case)			
Cisgender male ☐ Yes ☐ No ☐ Unknown		**Cisgender female** ☐ Yes ☐ No ☐ Unknown	
Transgender male to female ☐ Yes ☐ No ☐ Unknown		**Transgender female to male** ☐ Yes ☐ No ☐ Unknown	
Non-binary contact ☐ Yes ☐ No ☐ Unknown		**No sexual contact** ☐ Yes ☐ No ☐ Unknown	

TRAVEL HISTORY			
Location	**Dates travelled**	**Country/state visited**	**Place visited (hotels stayed, etc.)**

Contact with animals

During the exposure period, did the case have contact with animals/hunting in an mpox endemic country? ☐ Yes ☐ No ☐ Unknown

Type of animal _____ **country of contact**_____

Details _____

PLACE OF ACQUISITION

Place infection acquired ☐ Overseas (countries_____)

☐ Australia (State/Territory_____ Post code_____)

CONTACT TRACING

Name	Sex	Age/DOB	Phone	Email	Type of contact	Risk assessment High/Medium	Actions/ comments