

Interim guidance on strengthening community detection and response during the mpox outbreak

25 February 2025

Key points

- The ongoing spread of mpox outbreaks globally and in Africa is dynamic; transmission pathways have been described (e.g. human-to-human contact, animal-to-human) and continue to evolve. It is important to continue observing and documenting transmission patterns in communities and to better understand communities' perceptions and behaviours.
- An important component of community protection is early detection and response to contain outbreaks. Community-based surveillance (CBS) should be designed with communities at the centre (e.g. developing community case definitions).
- Effective detection starts with identifying populations at higher risk of exposure to mpox in the country and community, and co-designing approaches tailored for these populations.
- In the community, case detection should be bundled with risk communication, community engagement, infodemic management, infection prevention and control and health promotion. Community health workers, volunteers and members should have the capability and skills to perform these activities, thereby complementing their role in providing community care. Primary health care, district health and local surveillance officers have an important role to play in screening community alerts and reporting cases to the national surveillance system.
- Public health officials seeking to mount an integrated mpox response across all levels – health promotion, risk communication, detection, prevention and care – must build community partnerships.
- Primary health centres, clinics for the treatment of sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), private facilities, local hospitals and other health service providers should link with national disease surveillance and health information systems so they can effectively report suspected, probable and confirmed mpox cases.

Introduction: What is mpox?

Mpox, previously known as monkeypox, is a viral illness caused by the monkeypox virus (MPXV).¹ It causes a painful rash, enlarged lymph nodes, fever, headache, muscle ache, back pain and low energy or feeling sick. In most cases, the symptoms of mpox go away within a few weeks with supportive care. In some people, the illness can be severe or lead to complications and even death.

The virus is classified in two distinct clades: clade I (with subclades Ia and Ib), historically found in Central and East Africa, and clade II (with subclades IIa and IIb), historically found in West Africa. Originally recognized primarily as a zoonosis transmitted through contact with infected animals, mpox has seen several outbreaks in recent years that predominantly involved human cases. In May 2022, a global outbreak of clade IIb MPXV began that primarily affected men who have sex with men exposed through sexual contact. In the Democratic Republic of the Congo, the only clade identified has been I MPXV, which has been circulating from animals to humans in several endemic provinces of the country for many years.

In early 2024, scientists described for the first time subclade Ib MPXV, which since September 2023 has led to a large outbreak involving exclusively human-to-human transmission in previously unaffected provinces of South and North Kivu.

In July 2024, clade Ib spread to nearby Burundi, Kenya, Rwanda and Uganda; by November, cases had been detected outside Africa, in Germany, Sweden, United Kingdom of Great Britain and Northern Ireland, the United Arab Emirates, India and Thailand. The spread of mpox outbreaks globally and in Africa is dynamic and is being closely monitored by health agencies across and within countries.

MPXV spreads by two main routes: human-to-human transmission and animal-to-human spillover, where animals are part of a zoonotic cycle. Human-to-human transmission occurs through close physical contact with a person who has mpox, such as during family contact, caring practices, sports, etc., where lesions are exposed, or through sexual contact. Sexual routes can include direct skin-to-skin contact (e.g. touching), as well as skin-to-mucosal and mouth-to-mucosal contact (e.g. kissing, penetrative sex).

Contact with contaminated materials such as clothing and bedding can also lead to infection. MPXV may spread through infectious respiratory particles when there is prolonged face-to-face exposure in proximity to a person with mpox. During a woman's pregnancy, the virus may be passed to the fetus; during or after birth, it may be passed to the newborn. There is no information on whether MPXV can pass through breast milk, although MPXV has been detected in other body fluids.

Based on an individual risk-benefit assessment for mother and infant, WHO recommends that the mother avoid breastfeeding where possible until all skin lesions are healed and instead use alternative sources of nutrition. If that is not possible, WHO recommends that the mother exercise caution when breastfeeding if she has active lesions on her chest.² Although there are still gaps in knowledge about human-to-human transmission of mpox, evidence continues to be compiled from a number of countries.

MPXV may be transmitted from infected animals to humans through activities such as hunting, skinning, trapping, cooking, touching of infected carcasses or consumption of inadequately cooked meat. The animal reservoir of the MPXV remains unknown, but various mammals, including rats, squirrels and monkeys, can be infected and transmit the virus to humans.³

The global outbreak of MPXV clade IIb represents the biggest recorded outbreak of mpox that has been recorded to date, and although its acute phase was brought under control through a mix of behaviour change, infection immunity and vaccination, the virus continues to circulate and cause sporadic cases and outbreaks in several countries.⁴

Objectives of this guidance

To guide national, subnational and local health authorities and surveillance officers to enhance community detection and reporting capacities by leveraging local and community structures and mobilizing community health volunteers and other workforces through enhanced community partnerships.

End users

Surveillance officers and decision-makers at the national and subnational levels;

District or local health authorities and community partners, including community-based organizations and civil society organizations;

Nongovernmental organizations (NGOs) and other entities working at the local level that engage or are planning to engage communities and support extending surveillance structures to the community level.

Challenges in detecting mpox in communities

Experiences in endemic countries and during the ongoing global mpox outbreak, which began in 2022, have made apparent several challenges in detecting mpox. To develop effective national and local strategies in detection, national governments and their subnational and local counterparts should address some of these challenges:

- Early symptoms may be non-specific and may include fever, headache and muscle pain, all of which can be caused by other health conditions as well. Acutely swollen lymph nodes are often a more specific sign of mpox.
- More typical symptoms are skin and mucosal lesions or rash, which must be differentiated from other eruptive skin conditions, such as measles, chickenpox and scabies. The mpox rash, however, is often distinctive and usually evolves in a typical manner.
- Lesions in the genital area may resemble those of herpes or syphilis.
- Persons with genital lesions may be reluctant to seek care and may resort to self-medication.
- Data from private clinics and NGOs that focus on HIV and/or other STIs, as well as those that specialize in care for sex workers, men who have sex with men or other groups, may not always be included in routine surveillance data collection. This can result in missed cases and unrecognized transmission chains, particularly among individuals with genital symptoms who might be more inclined to seek help from these facilities.
- In some contexts, the most common signs and symptoms of mpox may be associated with certain beliefs in local cultures, and therefore may not be reported through the public health surveillance system.
- Communication of mpox as a sexually transmitted condition has increased stigma and discrimination and may be discouraging individuals from seeking early consultation.
- Feedback suggests that sex workers may be increasingly reluctant to report their occupation for fear of discrimination or of losing clients. In countries where same-sex sexual contact or sex work is illegal, members of groups at risk may also fear arrest.

In countries where small numbers of imported cases are reported and resources may be limited, the risk of mpox spread may not be considered a public health priority in the face of other pressing problems. Similarly, if mpox affects primarily one population group, the risk of subsequent community transmission in different contexts may be underestimated.

National, subnational and local authorities may identify other challenges to early detection in communities and referral. It is important to identify and discuss these challenges with national and local health officials and partners so that responsive communication and detection strategies can be designed.

Identifying populations at risk of mpox

Identifying populations at risk of mpox occurs at different levels: nationally, locally and within communities. It is important that risk assessment involves community consultation and feedback, as well as higher-level discussions. Both geographical locations and populations engaged in behaviours that may put them at risk for mpox should be considered when prioritizing locations and groups for community engagement, risk communication, CBS activities and referral for care.

Considerations for populations at risk of infection

At the national perspective, what population groups are at risk? Who is at risk in localities or communities?²⁵ What areas and which groups should be prioritized for risk communication, community engagement and health promotion efforts?

- The risks for **individuals who engage with multiple sex partners, sex work and same-sex contact** may be compounded because they may have limited access to health facilities due to stigma or restrictive policies. National health programmes for HIV and other STIs have developed mechanisms for health promotion, disease prevention, disease surveillance and access to care and these can be maximized for mpox detection and care.
- **People who are living near or travelling through transit centres.** Travellers, including cross-country truck drivers, can be difficult to identify because they frequently change location. Because they may be unfamiliar with local health facilities, they may tend to self-medicate during early phases of their infection, which heightens the risk that they will transmit the virus to others. Case detection, risk communication, health promotion and clear advice on how to access health facilities in cross-border areas and check-points are important measures for detection. Due to the sometimes longer incubation period (which may be as short as a day or two or as long as 21 days), individuals in the early stages of the disease may still be travelling and their symptoms may not appear for a few days. People who frequent transit hubs, including informal settlements along long-distance trucking routes, may also be at risk of **exposure**.
- **Children living close to rural or wild animal habitats** where they may be exposed to infected animals (e.g. dead animals or consumption of undercooked bushmeat).
- **Hunters and bushmeat vendors** through exposure to body fluids during butchery.
- People with **close physical contact with individuals with the infection** have a higher risk of becoming infected themselves. These may include health workers, caregivers, family members, partners, workmates and schoolchildren.

- **Individuals in heavily populated areas** e.g. densely populated urban settings, camps for internally displaced persons, transit hubs, informal settlements, mining camps, prisons, etc., due to both population density and limited access to hygiene facilities.
- **Front-line workers** who first encounter and collect clinical samples (such as skin specimens) from persons who may have mpox are also at heightened risk of infection. It is therefore essential to provide them with adequate personal protective equipment (PPE); to ensure it is used; and to support them to stay informed about mpox updates and the epidemiological situation in their country and local area through regular training and education sessions.

Populations at greater risk of poor outcome or severe infection

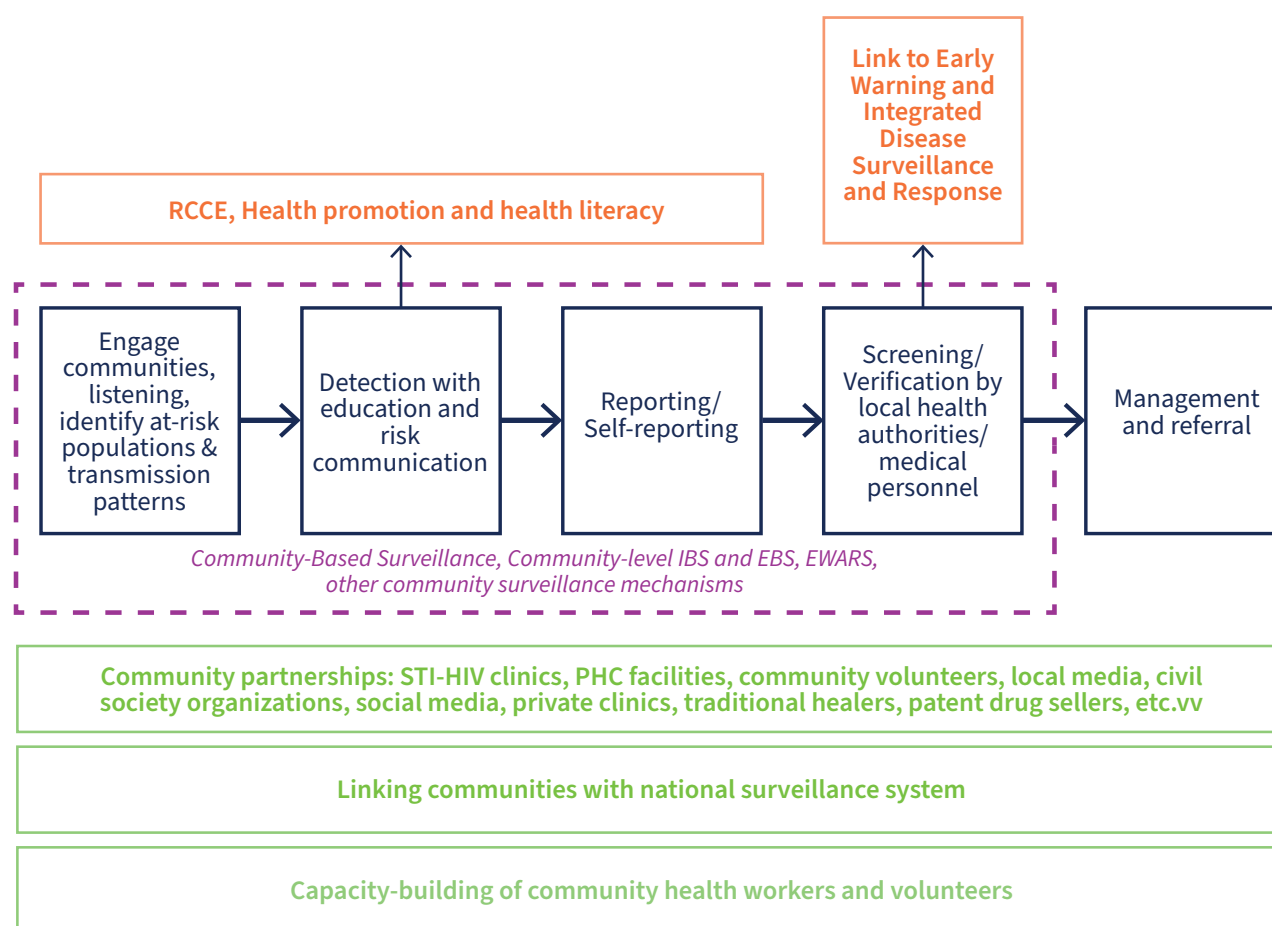
The following individuals are at higher risk of severe disease and medical complications from mpox:

- **Pregnant women**, who are also at risk for poor pregnancy outcomes, such as fetal loss;
- **Children**, especially in contexts of concurrent disease outbreaks, such as measles, or in places where malnutrition or food insecurity is common;
- **Immunocompromised individuals**, including those living with untreated or uncontrolled HIV infection or those who have advanced HIV disease; well-controlled HIV infection is not a risk factor for severe disease.

Are there other populations and communities in the country who are at risk of infection, or at greater risk of poor outcome or severe infection?

Recent national and local epidemiological data can provide useful information about populations at risk of disease and disease transmission. Contextual understanding of populations at greatest risk in communities where there is sustained transmission can be obtained through situation reports from health ministries, reports from local health authorities, NGOs and academic partners regarding trends in confirmed mpox cases and through integrated outbreak analytics (IOA). This information can then support further community-level actions for risk communication and community engagement and CBS.

Figure 1. Community-centred detection of mpox



Note: Community-level detection of alerts⁶ is facilitated through different actions that may be under way at the same time. Communicating risk, health education and community detection are done by the same community health volunteers (CHVs) or community health workers (CHWs). Reporting refers to the process whereby CHVs or CHWs inform local health surveillance officers of signals for diseases with salient symptoms. Self-reporting occurs when a person (e.g. someone who has a rash or a sore mouth) consults a health facility and expresses concern about possibly having a condition such as mpox. The role of primary health care (PHC) and local health authorities is crucial in linking these processes to national surveillance and clinical care. CBS may be developed with a One Health approach to include detection, reporting and linkage to response through collaboration with the local and community animal health sector.

Identifying transmission patterns

Having identified populations with increased vulnerability to mpox, health officials must also understand transmission patterns in their national and local contexts. As community-sourced information is collected, national, subnational and local/district authorities and community actors may consider asking the following questions:

- Where could transmission occur? Where does it most often occur?
- Where do individuals first seek help from a health worker?
- Are there times of the year when mpox is reported more frequently?
- Who are the people who may be contacts of the individuals with mpox and how can they be protected?
- What behaviours and activities (e.g. participation in large events) increase the risk of getting or spreading the disease? What do community members know? What do community members identify as important to them?

- How is the virus transmitted in the local context among specific groups, e.g. children, pregnant women, immunocompromised individuals, sex workers, travelers, etc.?
- Does case detection occur more frequently in certain areas, e.g. certain regions or provinces in the country, types of health facilities (PHC or STI-HIV clinics), cross-border areas, etc.)?
- Is there a zoonotic component to transmission, e.g. consumption of bushmeat, exposure to infected animals or to a cluster of sick or dead animals, etc.?

CBS, together with ongoing sensitization of community members to reduce stigma around mpox and to enhance rapid seeking of care, can help health officials better understand the full burden of disease and transmission dynamics in communities.⁶

Community-centred approaches to detection

Engaging communities to understand the risk for mpox.

Engaging communities to understand the risk and promoting health are important steps towards partnership for community actors in preparedness, readiness and response. Health workers and surveillance officers should have a deeper understanding and perception of what the community understands about mpox and its importance to them as a community. This deeper understanding can be developed through community dialogue sessions and other approaches. Perception depends on many factors, including proximity to the outbreak and the outbreak's relevance to daily life.

Community perceptions of a hazard can shift over time. For example, something that may have seemed unimportant to a community a month ago may be seen as urgent today if an outbreak approaches the community or suddenly emerges nearby.

As situations change, health officials must work closely with the nearest health facility staff, community health workers and volunteers to increase the flow of information and discussion within the community. Health officials should encourage community health workers to work closely with trained professionals (e.g. anthropologists, social workers, researchers) to increase community dialogue, research and other activities. (Refer to the Guidance and Trainings section of this guidance for more information.)

Plans and interventions should be co-designed with communities to reflect their resources, structures and concerns, so that these will be easily implementable, and not pushed aside as unimportant. During this process, health officials should identify community partners, community resources and populations with increased vulnerability. It is important to recognize that community members may not consider mpox to be a priority health risk. Therefore, health officials should consider including other key community concerns (e.g. acute watery diarrhoea, animal health risks, etc.) to strengthen community engagement around CBS, thereby facilitating community support even at the initiation of CBS activities, when the perceived risk of mpox may be low.

Detection with education and risk communication.

Communities can use education to enhance their detection of mpox cases. Messages and education materials should include all modes of transmission, advice for disease prevention and when and how to report. Community health workers, volunteers, first responders and CBS informants can implement these activities effectively. CBS, sensitization about the benefits of seeking care and efforts to reduce stigma, when employed together, can help community members identify the full burden of disease and improve their understanding of virus transmission.

Community-based surveillance. CBS is the systematic detection and reporting of events of public health significance within a community by community members.⁶ For mpox, the goal of CBS is for health alerts that meet the mpox community case definition to be reported immediately to health centres.⁷ Wherever CBS is already in place, this effort should be integrated into existing programmes. In addition to using community event-based surveillance, many countries have been using community indicator-based surveillance. It links priority diseases to simple signs and symptoms that can be reported through the CBS reporting mechanism, thereby complementing facility-based reporting on probable and confirmed cases.

In the case of mpox, many countries have opted to use a more sensitive community case definition, such as “fever and rash”, which already serves as a community case definition for measles in many countries and is likely to be used to describe other conditions, such as chicken pox and scabies, as well.

Several actors have suggested a generic community case definition for mpox, but there remains a need for community case definitions to be co-developed and adapted in each country and local context. This needs to be done in coordination with respective health ministry and community leaders to ensure they use a common language that describes signals appropriately (see the information box below).

CBS volunteers may come from different backgrounds and may include community health workers, volunteers, community animal health workers, teachers, traditional healers and others. Communities may also have other types of community-level surveillance that can be used to detect and report mpox signals.

The primary objective of CHWs and CBS volunteers should be to identify people with symptoms, provide infection prevention measures and refer the people for care. Guidance exists to support countries and communities in evaluating whether CBS is fit for their context.⁸ Countries may also choose to organize CBS in high-risk areas, such as areas with emergencies, border areas, transit points and settlements for internally displaced persons.⁷

Community health workers should work in close collaboration with the **community animal health** services, as they can provide local information on unusual events (e.g. clusters of animal illnesses and deaths) and appropriate prevention measures. Community animal health workers and district/local veterinarians also need country and local updates on mpox among animals or between animals and humans.

Box 1. How community case definitions are applied

Community case definitions are simple and refer to easy-to-recognize signs and symptoms that community volunteers and lay persons can use to identify and share signals with supervisors and health authorities. Community case definitions can vary between countries and regions and are influenced by the ways communities perceive and detect illness. One goal is to not duplicate community case definitions where an existing one can serve the purpose, e.g. using an existing country signal or community case definition for other illnesses characterized by rash and fever if that signal or definition is already broad enough to include potential mpox cases. Community case definitions should be developed with community participants and partners so that they capture local perceptions, health knowledge and experience. Here are examples of community case definitions for mpox (other examples are included in the references):

- Fever and rash, which may include additional symptoms, such as runny nose, tiredness, headache, generally feeling unwell, swelling under the arms and groin area.⁸
- A person who has a rash or one or more sores that appear suddenly, on any part of the body, but on at least one of the following body parts: face, palm(s) of the hands, soles of the feet, genital area (penis, scrotum, vulva). Lesions may vary in appearance but are often well circumscribed or defined. (Community case definition in the Democratic Republic of the Congo (DRC), developed by WHO and the Ministry of Public Health of the Democratic Republic of the Congo.)⁹

Adaptations of community case definitions should consider established community case definitions by WHO⁶, health ministries, ministries responsible for animal health and wildlife, national communicable disease control (CDC) agencies, the World Organisation for Animal Health, the Food and Agriculture Organization of the United Nations, etc. Local languages and phrasing, including literacy levels and common terminology, may also influence community case definitions. Often, visual illustrations are needed to facilitate identification.

Reports of signals meeting the community case definition should be forwarded to a CBS supervisor, surveillance focal point, community nurse or community physician for verification, investigation, confirmation of illness and provision of care, as indicated in national protocols for reporting based on international standards.⁸ While awaiting verification, community health workers and volunteers should support key local actions, including advice about and support for home isolation (if recommended by authorities), avoidance of direct, close or intimate contact with others, especially in cases where skin lesions are present.

Establishing whether there is an epidemiological link to a similar case or to a high-risk exposure may also be useful in community detection. It can be helpful to ask questions, such as:

- Has the person had contact with someone who could have mpox?
- Could the person have had contact with an infected animal or infected meat?
- Has the person been in a place or places where close contact between people is common, such as schools, marketplaces, venues of sports events, public transport?
- Has the person travelled to any area known to be endemic for or affected by mpox in the past 30 days?

These questions can be narrowed down by indicating a time frame, geographic area or specific set of circumstances for tracing possible contacts. In certain situations, and depending on cultural acceptability, it may be necessary to ask if the person may have been exposed to mpox through sexual contact. The person must be approached with empathy and in a location that allows the person to speak confidentially. Health professionals or selected community health volunteers (e.g. HIV peer counselors) should be trained to ask sensitive questions and advised on how to share this information.

Community-level clinical case identification

Community health nurses and doctors should refer to national and global guidelines and protocols for identification and management of mpox cases.⁷

Based on the assessment of the community nurse or physician, patients may be advised to isolate at home with precautions, ensuring they have PPE, adequate nutrition and psychosocial support.¹⁰ Other symptoms should be adequately managed. Patients who need urgent care must be referred immediately to the nearest health facilities or hospitals.

Monitoring patients and caregivers at home can be done by trained community health workers or outreach teams by telephone, telemedicine or email, initially daily (when possible) or as considered clinically necessary after initial assessments. The patient's willingness to engage in medical assessments should also be considered and counselling provided accordingly.²

If the case assessed is other than mpox, the patient will be advised and managed appropriately. As noted, fever and rash may also be presenting symptoms for chickenpox, herpes, measles, scabies, shingles, syphilis and other diseases. Home isolation, supportive care and monitoring should still be continued along with education and psychosocial support.

Understanding community transmission. The strategy for community detection should be approached with understanding of current or expected transmission in a given locality. Community detection should be guided by transmission patterns, i.e. no known transmission, sporadic transmission or sustained community transmission. Different transmission patterns may occur within one country. It is important to discuss with surveillance officers, local authorities and community partners the best approach for community surveillance.

Community members. Countries can enhance the capacity of existing community members or informants to detect mpox and increase local awareness. Most settings work with community health workers and volunteers, including first responders, pharmacists, community animal health workers, traditional healers, schoolteachers and other community members. Community members are the source of signals that alert health professionals to the presence of a suspected case of mpox or an mpox chain of transmission. Community partners should be trained to recognize symptoms of mpox and to know community case definitions, prevention strategies, reporting modes and the status of the country and their locality. Community partners should be consulted for contextual information on mpox, local terms for symptoms and diseases and community case definitions, especially if it is an area that has experienced mpox cases before.

Partnerships with community agencies that people trust. When community and family members get sick or have any kind of symptoms, they may consult a close group of people they trust. These can be family members, their community organizations, faith groups, community health volunteers, other workers familiar to them or groups with common concerns and interests (e.g. persons living with HIV or LGBT associations). It is important to identify and map these potential informants so that they can be engaged in detection and response and provided with correct information on mpox transmission, prevention, symptoms and where to refer for any concerns.

Information on where to go for consultation. It should be made easy for individuals and families to notify appropriate health authorities when they discover a suspected case of mpox or to ask questions about mpox. Contact details, phone numbers, hotlines and addresses of health facilities and hospitals for referral should be made available through the news media, social media, posters, community health workers and volunteers and community centres. Individuals who think they have symptoms of mpox and need guidance should report to the local primary health-care facility, community health workers and volunteers or public health offices for advice.

Supporting community-based surveillance activities

Communities have a key role to play in activities led by local health authorities to detect and coordinate an integrated response to mpox. National and subnational governments should engage communities – especially communities at higher risk of transmission – in different activities.

- **Planning and coordination.** Include communities in assessing risk, preparing local contingency and response plans, organizing community committees, holding regular coordination meetings and preparing evaluations or after-action reviews.
- **Verification and investigation.** Once a signal is detected, it should be referred to CBS supervisors and health professionals closest to the community, first for verification of the signal and then for confirmation through laboratory diagnosis, if available. Community health workers and volunteers may be asked to help with investigation, interviews and data collection from suspected cases.
- **Contact tracing.** As occurred in the recent COVID-19 response, community health workers and volunteers may be requested to assist in contact-tracing efforts that may include house visits, calls and interviews.⁷ Community health workers and volunteers involved in contact tracing should have more training. In certain settings, such as in small rural communities, contact tracing for sexual partners could be very sensitive. Alternative approaches could be considered, e.g. maximizing help from peer HIV counselors.
- **Care and monitoring of isolated patients.** Community health workers and volunteers may be organized to support home-based care and regular monitoring of patients in self-isolation, including those receiving mental health and psychosocial support (MHPSS). They should be provided with up-to-date knowledge on how to monitor and support patients at home under the supervision of a local community nurse or doctor.¹¹

In different stages of readiness and response to mpox, national and subnational authorities should ensure the availability of community feedback mechanisms to understand community risk perception, knowledge and health-seeking behaviour. The primary purpose of these is to enhance community trust and ensure responses are tailored to and aligned with community needs and understanding. Prevention, surveillance and outbreak management efforts conducted with strong community participation are often more effective. Community feedback can be gained through participation in community councils, town hall meetings, hotlines and other formal and informal ways.

Community partnerships for detection and surveillance

Building community partnerships is an essential strategy for health promotion, risk communication, detection and care for mpox patients across all levels of the response. Following a risk assessment, existing community networks, including various options for care, should be mapped across the care continuum to strengthen alignment across key stakeholders.

STI-HIV clinics. Ensure health education materials are available. They should link with health professionals and hospitals for updated health information, case management, sample collection, referral and data reporting to national surveillance systems. These clinics may also have a network of trusted peer counselors who can be engaged for risk communication, health promotion, case detection, contact tracing, etc.

Primary health-care facilities and nearest hospitals. PHC facilities should be able to triage, verify and refer possible mpox cases. They communicate with local health authorities and local surveillance officers who can provide guidance for referral and home-based care. In many settings, they also supervise community health workers and volunteers and work closely with communities for health education and promotion. Ensure availability of health education materials on mpox, PPE for community health workers and volunteers, and medicines and supplies to support home care. PHC facilities should link with national and local surveillance systems for verification, investigation and data reporting. Furthermore, adequate care at the nearest facility should be available, when needed. Experiences in CBS during outbreaks have shown that, if communities do not have access to adequate and free health care, CBS will be neither effective nor sustainable. Though that obvious fact is often forgotten, all actors working alongside communities should advocate for this.

Private clinics and the informal health sector. Private health clinics (e.g. primary care or paediatric clinics, dermatology, etc.) and the informal health-care sector (traditional healers, patent drug sellers, etc.) may be among the first line of care-seeking for mpox patients. This may be due to their typically lower cost, patients' limited access to health-care providers in the formal sector or the higher confidence that some patients place in local practitioners. However, in many countries, practitioners in this sector are not integrated into the formal surveillance system, meaning potential cases may be missed and the opportunity to detect and prevent transmission chains may be lost. Consideration should be given to including all practitioners who provide care in awareness and surveillance activities.

Community volunteers and key informants are important community partners for health promotion activities, including health education, community outreach for

testing, community-level detection, contact tracing and referral. They can also support home care and monitoring of isolated patients. Community volunteers should receive regular education on mpox updates and the epidemiologic status of the disease in the country and in their locality. Community volunteers and informants may come from sectors in human health, animal health and agriculture, as well as from civil society organizations. Faith-based organizations, religious leaders, traditional healers, members of women's and youth groups and other sectors in the community may also be included.

Community-based and civil society organizations

can support health promotion, risk communication and detection of possible mpox cases. NGOs or specialist groups, such as those supporting sex workers or men who have sex with men, or HIV and LGBT groups, can be engaged to fight stigma, as they often hold the trust and confidence of their population. Risk communication materials should be made available, and members of these groups should know how to refer to health facilities; those who provide health-care services should be included in activities to diagnose and treat cases. Workers in the **local tourism industry** should also be made aware of the issues involved, as they can be engaged in detection efforts.

Animal health sector. The animal health sector should be familiar with transmission of disease through animals and meat and events that signal MPXV transmission, e.g. clusters of sick animals, etc. At the local and community levels,

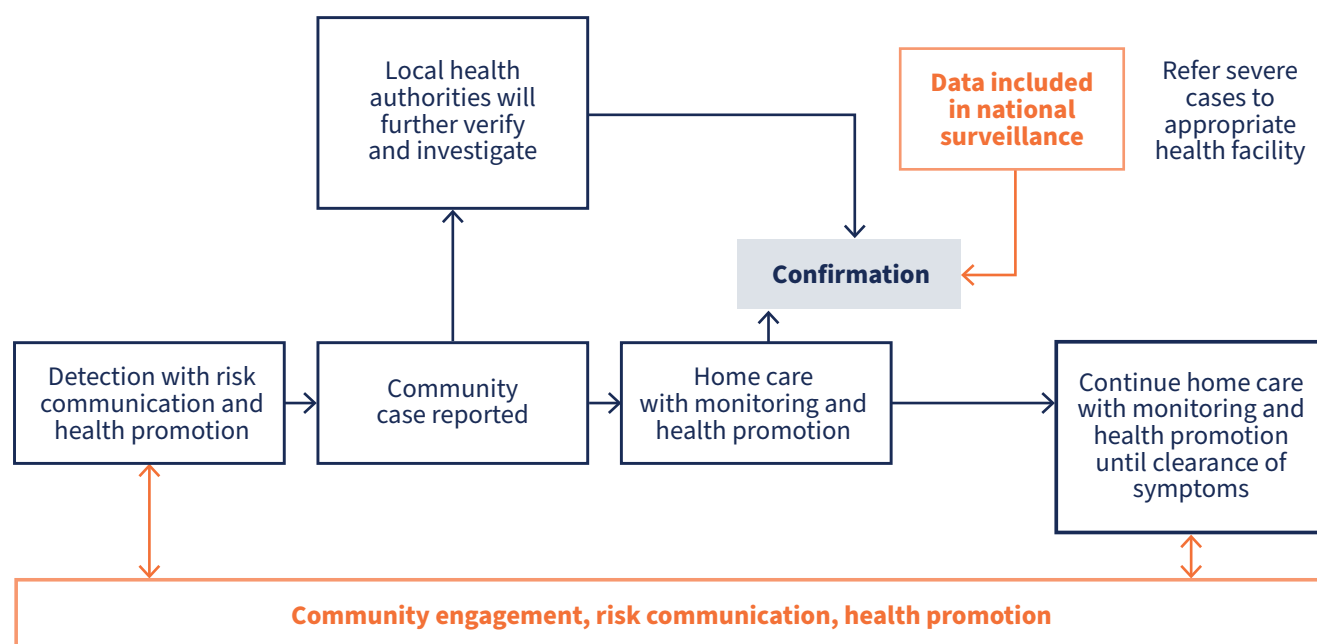
these include the local veterinary officers and community animal health volunteers. They work closely with farmers, food producers and markets. Health education and risk communication materials should also be available in animal health sector facilities, offices and other strategic locations.

Local media can be essential partners for disseminating correct health information about mpox. Local media should provide their readers and viewers with advice on where patients with symptoms (i.e. fever, rash and other symptoms) can go for consultation. Sensitivity is called for here, since overemphasis on the role of sexual transmission can result in stigma and may cause patients to self-medicate instead of seeking professional help.

Schools should have updated information on mpox that emphasizes how transmission occurs. School health officers and nurses should be familiar with mpox symptoms and know how to report and where to refer suspected cases for verification. It will be important to engage communities and parents in any intervention involving schools to avoid unintended consequences, such as panic and absenteeism. Risks need to be carefully explained in context.

Cross-border agencies posted in communities are important stakeholders to detect individuals infected with the virus. PPE and education materials should be available, and staff should be updated on mpox symptoms, the reporting and referral system and the country situation.

Figure 2. Community steps in detection, alert, investigation, home care, confirmation and referral



Note: This is a simplified version of the risk communication and health promotion activities taking place in communities that include health literacy teachings and links to home care and referral sites. Once a signal is detected, proper advice should be given to minimize the risk of viral transmission during the investigation. Local health authorities should refer to national detection, care and referral guidelines and standard operating procedures for home care, if relevant.

Linking with the national surveillance system

Link with national surveillance and integrated disease surveillance and response

Primary health centres, STI-HIV clinics, private facilities and local hospitals should link with national disease surveillance and health information systems so they can effectively report suspected, probable and confirmed mpox cases. Public health surveillance systems, including early warning systems, CBS and other surveillance systems (e.g. for HIV, malaria, maternal and child health, tuberculosis, etc.) should also feed into national, integrated disease surveillance and response at all levels for verification, risk assessment, contact tracing, sample collection and referral. These health facilities and surveillance systems should also receive updated information and clinical advice from national/subnational levels and referral hospitals for advice on home care, self-isolation, public health and social measures and epidemiological situation updates.

Understanding country priorities for surveillance

Countries have current surveillance priorities, e.g. tuberculosis, malaria, neglected tropical diseases, polio, etc. Because of the multi-country outbreak of mpox between May 2022 and June 2024, many countries have integrated mpox into their surveillance systems.

However, various countries have competing interests for health and disease surveillance. National decision-makers are advised to integrate community-level detection into their existing surveillance systems and programming. Furthermore, national officials should find out if they are legally required to include mpox on their national list of notifiable diseases, and to allow contact tracing among target groups.

Agreement with local/district, subnational and national authorities

Identification of populations with increased vulnerability to mpox and community strategies should be spearheaded or carried out by working closely with national and subnational authorities and affected or potentially affected communities. Subnational and local health authorities should be engaged when their respective areas are assessed as becoming high-priority areas for risk communication, readiness and surveillance for mpox. Community case definitions should be discussed with national authorities so that these can be effectively integrated into national disease case definitions, integrated disease surveillance and response, and lists of notifiable diseases. This will allow better understanding of local cultures and behaviours, especially among target populations. Mechanisms should be in place to receive feedback and concerns from subnational, district/local and community health workers on a regular basis.

An opportunity to strengthen CBS

Strengthening of community-based case detection and early warning coupled with risk communication and health promotion represents an opportunity to enhance community and local systems for disease surveillance and response. Capacity building of local and community health workers, volunteers and partners should be planned to build local capacity for early warning, not only for mpox, but also for other communicable diseases and public health events, through an all-hazards approach.

Development of this interim guidance

This interim guidance was contributed by the Inter-Agency Community of Practice (CoP) for CBS, which was composed of 14 member agencies. The overall framework and approach were developed through review of existing guidance related to community-level detection, care and response and an initial discussion among CoP members on 27 August 2024. The initial draft was reviewed by technical experts from WHO, the International Federation of Red Cross and Red Crescent Societies (IFRC), the United States Centers for Disease Control and Prevention (US CDC), the United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID), the United Kingdom Public Health Rapid Support Team (UK-PHRST)/ London School of Hygiene and Tropical Medicine (LSHTM), Médecins Sans Frontières (MSF), the Robert Koch Institute (RKI) and other CoP members, ensuring alignment with recently developed guidance on CBS, surveillance, risk communication and community engagement (RCCE), IPC, home and clinical care. Prior to publication, the final draft was reviewed by WHO regional offices, selected countries and end users.

The Inter-Agency Community of Practice for CBS was organized in October 2023 to spearhead collaboration, experience sharing, development of key guidance, documentation and working modalities at the global, regional and subregional levels among partners engaged in CBS. Initial members included WHO, IFRC, UNICEF, US CDC, USAID and MSF. Additional agencies implementing community-level surveillance were invited in 2024.

This interim guidance on strengthening community detection and response during the mpox outbreak is based on views, expert opinions and experiences from countries and partners. The framework has been reviewed with insights from outbreak response in the DRC. WHO is currently supporting health ministries in coordinating response efforts and in collaboration with partners such as the IFRC. WHO aims to contact more countries to document evidence and experiences on how CBS facilitates early detection and community reporting and linking of data to national surveillance systems. We will update this guidance once more information is available.

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For further information on mpox

- [Mpox \(monkeypox\) factsheets](#) (WHO)
- [WHO Mpox \(Monkeypox\) outbreak toolbox](#)
- [2022-2024 Mpox \(Monkeypox\) Outbreak: Global Trends](#) (28 August 2024, WHO)
- [Strategic framework for enhancing prevention and control of mpox- 2024-2024](#)
- [WHO EPI-WIN webinar: Global mpox strategy for elimination and control: Open consultation](#) (28 June 2023)
- [Surveillance, case investigation and contact tracing for mpox \(monkeypox\): Interim guidance](#), 20 March 2024
- [WHO Mpox Questions and answers](#) (17 August 2024)
- [IFRC Interim guidance on using community-based surveillance for mpox](#) (30 August 2024)
- [Monkeypox: What have we learned from recent socio-behavioural surveys – A Data Snapshot on Monkeypox Outbreak and Social Behaviours October 2022](#) – Collective Service for RCCE
- [Africa CDC Mpox Surveillance Reporting Protocol for African Union Member States](#) (August 2024)
- [WHO infection prevention and control and water, sanitation and hygiene measures for home isolation for mpox in resource-limited settings](#), Interim operational guide (October 2024)
- [Infection Prevention and Control of Mpox in Healthcare Settings](#) (US CDC)
- [Resources for health professionals on mpox](#) (European CDC)
- [General information on mpox](#) (European CDC)

Relevant guidance and training for community partners

MHPSS

- [UNICEF Community-based mental health and psychosocial support in humanitarian settings](#)
- [IASC Community-Based Approaches to MHPSS Programmes: A Guidance Note](#)
- [IOM Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement](#)

Home care for mpox

- [WHO public advice on recovering from mpox \(monkeypox\) at home](#) (2 September 2022)
- [Mpox: Isolation and Infection Control At Home](#) (US CDC)

Primary health care and referral

- Mpox [Infection Prevention and Control in Healthcare Settings](#) (US CDC)

Epidemic control in communities

- [IFRC Epidemic Control Toolkit](#)
- [IFRC Epidemic Control for Volunteers: Training Manual](#)
- [IFRC Epidemic preparedness tools and resources](#)

Health risk monitoring

- [Integrated Outbreak Analytics by Social Science in Humanitarian Action Platform](#) also see Integrated Outbreak Analytics in [YouTube](#)

Community-based surveillance

- [IFRC Community-based surveillance knowledge hub](#)

Information on community-based surveillance and community case definitions

- [Africa CDC Mpox Surveillance Reporting Protocol for African Union Member States](#) (August 2024)

Guidance for community dialogues

- [Risk communication and community engagement readiness and response toolkit: mpox](#) (WHO 2024)
- [Community engagement and accountability in emergencies: Research and tools](#) (IFRC 2023)

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