



# ANVISA

Agência Nacional de Vigilância Sanitária

**TECHNICAL NOTE GVIMS/GGTES/DIRE3/ANVISA No. 03/2022  
GUIDELINES FOR PREVENTION AND CONTROL OF  
MONKEYPOX IN HEALTH SERVICES - updated on 06/02/2022.**

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TECHNICAL NOTE GVIMS/GGTES/DIRE3/ANVISA No. 03/2022 GUIDELINES FOR MONKEYPOX PREVENTION AND CONTROL

IN HEALTH SERVICES - 06/02/2022

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# SUMMARY

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**Change of this version of the Technical Note: 06/02/2022**

Pages 29 and 30 – Waste Management: text highlighted in gray

## INTRODUCTION

Monkeypox, also known as monkeypox, is a viral zoonosis (a virus transmitted to humans from animals) with symptoms similar to those seen in the past in smallpox patients, but with a less severe clinical presentation. It was discovered in 1958 when two outbreaks of a smallpox-like disease occurred in colonies of monkeys kept for research, hence the name "Monkeypox". The first human case of Monkeypox was recorded in 1970 in the Democratic Republic of Congo, during a period of intensified efforts to eliminate smallpox.

Since then, Monkeypox has been reported in humans in other Central and West African countries. The declaration of eradication of smallpox in the Americas was given in 1973, on the 22<sup>nd</sup> meeting of the Directing Council of PAHO and, in 1980, with the declaration of eradication of smallpox in the world, vaccination was not mandatory in Brazil. Since then, Monkeypox has emerged as the most important orthopoxvirus for public health. Monkeypox occurs mainly in central and western Africa, often in close proximity to tropical forests, and has increasingly appeared in urban areas. Animal hosts include a variety of rodents and non-human primates.

Monkeypox is caused by the Monkeypox virus, which is an enveloped double-stranded DNA virus that belongs to the genus Orthopoxvirus in the family Poxviridae. There are two distinct genetic clades of Monkeypox virus: the Central African (Congo Basin) clade and the West African clade. The Congo Basin clade has historically caused more severe disease and was considered more transmissible.

The geographic division between the two clades has so far been in Cameroon, the only country where both virus clades have been found.

Several animal species have been identified as susceptible to Monkeypox virus. This includes rope squirrels, tree squirrels, Gambian rats, voles, non-human primates and other species. Uncertainty remains about the natural history of Monkeypox virus and further studies are needed to identify the exact reservoir(s) and how the circulation of the virus is maintained in nature.

Since 1970, human cases of Monkeypox have been reported in 11 African countries: Benin, Cameroon, Central African Republic, Democratic Republic of Congo, Gabon, Côte d'Ivoire, Liberia, Nigeria, Republic of Congo, Sierra Leone and South Sudan. In the years 1996 and 1997, an outbreak was reported in the Democratic Republic of Congo with a lower case fatality rate and a higher than normal attack rate. A concomitant outbreak of chickenpox (caused by the varicella virus, which is not an orthopoxvirus) and monkey chickenpox was found, which could explain real or apparent changes in transmission dynamics in this case. Since 2017, Nigeria has experienced major outbreaks, with over 500 suspected cases and over 200 confirmed cases and a fatality rate of approximately 3%.

Monkeypox is a disease of importance to global public health, being endemic in West and Central African countries and presenting confirmed cases in non-endemic countries. In 2003, the first Monkeypox outbreak outside Africa occurred in the United States of America and was related to contact with pet dogs from infected cases. These pets were housed with Gambian rats and voles imported from Ghana. This outbreak has led to more than 70 cases in the US. In more recent years, Monkeypox has also been reported in travelers from Nigeria in Israel (2018), the United Kingdom (2018, 2019, 2021 and 2022), Singapore (2019) and the United States of America (2021).

On 15 May 2022, the World Health Organization (WHO) was notified of 4 confirmed cases of Monkeypox from the UK. Two days later, two other countries reported cases: Portugal and Sweden. All cases reported no history of travel to an endemic area and there was no link between reported cases in different countries. As of May 20, 2022, there are already 11 countries with reported cases:

Australia, Belgium, Canada, France, Germany, Italy, Portugal, Spain, Sweden, United Kingdom

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and United States of America.

To date, the Americas region has reported three cases of Monkeypox, in Canada (2) and the United States of America (1). These cases have no recent travel history to endemic West or Central African countries and most early cases were detected in sexual health clinics.

The geographical scenario of cases in Europe suggests that transmission may have been ongoing for some time, so the occurrence of additional cases in other countries cannot be ruled out. It is important to note that no associated deaths have been reported so far.

The WHO believes that more Monkeypox cases will be identified as surveillance expands in non-endemic countries. There is currently limited epidemiological and laboratory information, and the number of reported cases is likely to be underestimated, in part due to the following factors:

- the relatively mild symptoms in many cases with localized rash and lymphadenopathy, so many people may not seek medical attention;
- lack of early clinical recognition by healthcare professionals of a previously known infection in only a few countries;
- difficulty in surveillance of possible cases in different geographic regions and
- possibility of missing diagnostic tests, reagents, and other supplies.

Immediate actions focus on informing those who may be most at risk of infection with accurate information in order to prevent further spread. Current available evidence suggests that individuals who are most at risk are those who have had close physical contact with symptomatic people.

In view of this world scenario, and the possibility of the emergence of Monkeypox cases in Brazil, Anvisa, as the national coordinator of actions for the prevention and control of infections related to health care, prepared this Technical Note with the objective of guiding the health services of the country on the need to implement preparedness and response measures based on the prevention and control of Monkeypox transmission within these services, from of the knowledge we have so far. Updates may be published as new evidence is identified.

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## STREAMING

Monkeypox is mainly transmitted through direct or indirect contact with blood, body fluids, skin lesions or mucosa from infected animals. Secondary transmission, that is, person-to-person, can occur through close contact with infected respiratory secretions, skin lesions of an infected person, or with contaminated objects and surfaces.

Respiratory droplet transmission often requires prolonged personal contact, which puts healthcare workers, family members, and other close contacts of infected people at greater risk. However, the longest documented transmission chain in a community has increased in recent years from 6 to 9 successive person-to-person infections. This may reflect declining immunity in all communities due to the cessation of smallpox vaccination.

Although close physical contact, that is, intimate contact, is a risk factor observed in the transmission of confirmed cases in non-endemic countries, sexual transmission has never been described. Thus, studies are needed to better understand this risk.

Vertical transmission or during close postpartum contact can also occur.

The period of disease transmission ends when the crusts of the lesions disappear.

## SIGNS AND SYMPTOMS

The incubation period (interval from infection to onset of symptoms) for Monkeypox is usually 6 to 13 days, and can range from 5 to 21 days.

Clinically, the infection can be divided into two periods:

- **The feverish period (between days 0 and 5):** characterized by fever, severe headache, adenopathy (swelling of the lymph nodes), back pain, myalgia (muscle pain) and severe asthenia (lack of energy). Adenopathy is an important sign for the differential diagnosis of Monkeypox with other diseases that may present similar symptoms such as

chickenpox and measles);

- **The period of rash (between 1 and 3 days after the onset of fever):** when the different stages of the rash appear, which usually affects the face first and then spreads to the rest of the body. The most affected areas are the face (in 95% of cases), palms of the hands and soles of the feet (in 75% of cases). The oral mucosa (in 70% of cases), genitalia (30%) and conjunctiva (20%) are also affected, as well as the cornea. The rash progresses sequentially from macules (flat-based lesions) to papules (slightly raised, firm lesions), vesicles (lesions filled with clear fluid), pustules (lesions filled with yellowish fluid), and crusts, which occurs in about 10 days and after that these crusts dry and fall off. The number of injuries varies. In severe cases, the lesions may coalesce until large portions of skin are detached.

Monkeypox is usually a self-limiting disease with symptoms lasting 2 to 4 weeks. Severe cases occur most commonly among children and are related to the extent of exposure to the virus, the patient's health status, and the nature of complications. Underlying immune deficiencies can lead to worse outcomes.

While smallpox vaccination was protective in the past, today people under 40 or 50 years of age (depending on the country) can be more susceptible to Monkeypox due to the cessation of smallpox vaccination campaigns worldwide following the eradication of the disease.

Complications of Monkeypox can include secondary infections, bronchopneumonia, sepsis, encephalitis, and corneal infection with consequent loss of vision.

Historically, the Monkeypox case fatality rate has ranged from 0 to 11% in the general population and has been highest among children. In recent times, the case fatality rate has been around 3%.

## **SURVEILLANCE**

All health professionals working in any type of health service (primary care, outpatient clinics, offices, clinics, hospitals, etc.) pustules and crusts that are often associated with



fever, adenopathy, and myalgia.

Suspected cases, including potentially exposed health workers, must be immediately notified, as per guidelines from the Ministry of Health, so that timely actions can be implemented.

To systematize surveillance actions, health services must follow notification guidelines, as well as case definitions established by the Ministry of Health.

## **DIAGNOSIS**

The clinical differential diagnosis that should be considered includes other exanthematous diseases such as chickenpox, measles, bacterial skin infections, scabies (scabies), syphilis, and allergic reactions. Adenopathy during the prodromal stage of the disease may be a clinical feature to distinguish Monkeypox from chickenpox or other diseases or conditions.

In Brazil, bovine vaccinia occurs, caused by the “vaccinia virus”, known as cowpox, whose symptoms and skin lesions are very similar to the picture described for Monkeypox. Bovine vaccinia, therefore, is a diagnosis to be thought of in an appropriate epidemiological context. Herpes lesions (labial, genital or zoster) resemble those of Monkeypox and should also be considered in the differential diagnosis.

At the moment, laboratory confirmation will be done by molecular testing (q-PCR) followed by the sequencing technique.

## **IDENTIFICATION AND FOLLOW-UP OF CASES AND CONTACTS WITHIN HEALTH SERVICES**

Contact tracing and identification, education on measures to prevent the transmission of this disease within health services, as well as its control are fundamental public health measures to control the spread of Monkeypox. In addition to allowing the interruption of transmission, it can also prevent people at greater risk from developing serious diseases by early identification of their exposure.

If a suspected case is identified in the health service, tracking and identification of contacts should be started immediately, in order to establish the necessary measures to prevent the spread of this virus to other people.

## CONTACT DEFINITION

A contact is defined as a person who has been exposed in different contexts to a suspected or confirmed case of Monkeypox during the infectious period, from the onset of symptoms of the case until all crusting of the skin lesions has fallen off.

Regarding contact, the following situations should be considered:

Direct contact with a person with suspected or confirmed Monkeypox (e.g. dialogue less than 1m away without wearing a mask, direct contact with secretions, wounds/skin rashes, physical contact without subsequent hand hygiene, sexual contact, etc.);

- Contact with contaminated materials and surfaces, such as clothing, thermometers or bedding of a suspected or confirmed person;
- Health professional during health care: no use or incorrect use of a surgical mask during the care of the suspected or confirmed patient OR no use or incorrect use of a respiratory protection mask (N95/PFF2 or equivalent) while performing generative procedures of aerosols to suspected or confirmed patients OR without gloves and apron and without subsequent hand hygiene, after contact with secretions, wounds/skin rashes of a suspected or confirmed person and contaminated materials and surfaces.

**Note 1:** Health care workers who have unprotected exposures (i.e. do not wear appropriate PPE) to patients with Monkeypox or have contact with potentially contaminated materials do not need to be excluded from work if they do not show symptoms during the monitoring period, but should be monitored for symptoms, which includes taking temperature at least twice a day for 21 days after exposure. Prior to reporting to work each day, the healthcare professional should be interviewed for evidence of any relevant signs/symptoms (malaise, headache, fever, chills, pain in

the mouth or throat, malaise, fatigue, rash, and swollen or inflamed lymphadenopathy/nodes).

**Note 2:** A contact who develops initial signs/symptoms other than rash should be isolated and closely observed for signs of rash within the next 7 (seven) days. If no rash develops, contact can return to temperature monitoring for the remainder of the 21 days. If the contact develops a rash, they must be isolated or self-isolated as appropriate, they must be fully evaluated as a suspected case, and a sample must be collected for laboratory analysis to test Monkeypox.

### **CONTACT TRACKING**

It is recommended that the health service define strategies for monitoring contacts (whether patients or health professionals) every 24 hours to observe the appearance of signs and symptoms for a period of 21 days since the last contact with a patient during the infectious period.

Signs and symptoms include headache, fever, chills, sore throat, malaise, fatigue, maculopapular skin lesions, and lymphadenopathy. Contacts should have their temperature checked at least twice a day.

Asymptomatic contacts (including healthcare professionals) should not donate blood, cells, tissues, organs, breast milk or semen during monitoring. In case the contact is a visitor or companion, he/she must be instructed not to return to the service, in the role of visitor or companion, before the period of 21 days. In addition, household contacts of people with suspected or confirmed Monkeypox should not come to the service in the role of visitor or escort.

If a contact develops a rash, it should be isolated and evaluated as a suspected case and a sample collected for laboratory analysis for Monkeypox.

### **TREATMENT AND VACCINATION**

There are no specific treatments for Monkeypox virus infection. The symptoms of this

disease usually go away naturally. It's important to care for the rash by letting it dry or covering it with a damp bandage to protect the affected area, if necessary. The patient should be instructed to avoid touching wounds in the mouth or eyes. In addition, clinical care for patients hospitalized with Monkeypox must be fully optimized to alleviate the symptoms, manage complications and prevent long-term sequelae, in addition to measures to prevent secondary infections.

Smallpox vaccination has been shown to help prevent or alleviate the disease and protect against Monkeypox, with an effectiveness of 85%. People vaccinated against smallpox have been shown in the past to have some protection against Monkeypox. However, it should be noted that smallpox vaccination ended in 1980; after that, the disease was declared eradicated.

However, smallpox vaccines are no longer available on the market for the general population and as Monkeypox cases are rare, universal vaccination is not indicated, even because, today, there are no vaccines against Monkeypox registered in Brazil.

## **GUIDELINES FOR PREVENTION AND CONTROL OF TRANSMISSION OF MONKEYPOX IN HEALTH SERVICES**

### **CRISIS PREPARATION: CONTINGENCY PLAN**

It is recommended that the health service prepare and implement a Contingency Plan containing strategic actions to deal with possible cases of Monkeypox, including the management of human and material resources.

In addition, surveillance for this disease must be structured in order to capture the possible occurrence of suspected or confirmed cases coming from the community or from within the health service itself. For this, it is necessary to follow the guidelines contained in this Technical Note and those published by the Situation Room, implemented on 05/23/2022, within the scope of the Ministry of Health.

It is suggested that health service structures such as the Hospital Infection Control

Service/Commission (SCIH/CCIH), Hospital Epidemiology Center and Patient Safety Center (NSP), work together with representatives of the multidisciplinary teams of the sectors/units, of the Specialized Service of Engineering and Occupational Medicine (SESMT) of the Internal Commission for Accident Prevention (CIPA), of workers' representatives and of the service's management, so that they configure a Strategic Crisis Committee, responsible for elaborating, implementing and monitoring the Contingency Plan.

This Plan should define the practical actions necessary to face this crisis situation within the service, including: surveillance and data management of infected patients and professionals or case contacts; notification of cases, development and implementation of clinical protocols and workflows (screening of suspected and infected patients and professionals, removal and return to work of positive professionals, among others); internal communication for all the institution's professionals; training and dissemination of protocols, flows and adequate use of PPE; monitoring of professionals regarding adherence to implemented actions; daily monitoring of supplies; in addition to mechanisms that promote the awareness of the entire health service team about actions that must be taken to face these infections.

It is important that the service periodically monitors the implementation and adherence to the actions of the Contingency Plan, in order to make the necessary adjustments and improvements. Monitoring the Plan also favors the detection of points for improvement, such as, for example, reinforcing guidelines for a certain group of hospital professionals, readjusting flows, emergency actions in cases of scarcity of material and human resources, etc. This monitoring and contingency plan adjustments must also take into account the current epidemiological situation, as well as all the learning and experiences acquired over time or disseminated by other institutions.

#### PRECAUTIONARY MEASURES

Proper case management should be established to prevent nosocomial

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transmission, with adequate flow of triage to isolation rooms (at any level of care), avoiding contact with other patients in waiting rooms or rooms with inpatients for other reasons.

Standard precautions assume that all persons are potentially infected or colonized by a pathogen that can be transmitted in the healthcare setting and should be implemented in ALL visits, regardless of the patient's diagnosis.

Standard precautions involve the use of PPE according to risk assessment of exposure to blood and other body fluids or secretions, hand hygiene, cleaning and disinfecting surfaces, safe handling of health products and clothing, in addition to reprocessing, proper disposal of waste, among other components.

In this way, in addition to **standard precautions**, which must be implemented for any patient in all healthcare facilities, and considering the mode of transmission of Monkeypox, during the care of patients with suspected or confirmed this disease, the following precautions should additionally be implemented:

#### **1. Contact precautions + Droplet precautions**

At **contact precautions** are aimed at preventing the transmission of monkeypox by direct and indirect contact, thus involving, among other measures, patient isolation, the use of an apron and gloves whenever the professional touches or handles patients, in addition to products and surfaces used by the patient. same.

Already the **droplet precautions** aim to prevent the transmission of Monkeypox through respiratory droplets, which are larger than 5 µm and can reach the upper respiratory tract, that is, the mucosa of the nasal cavities and the mucosa of the oral cavity. This type of precaution involves patient isolation and requires the use of a surgical mask whenever the healthcare professional who is providing care at a distance of less than 1 meter or when entering the patient's isolation room/area, among other measures.

In summary, when caring for patients with suspected or confirmed Monkeypox, **Standard precautions should be implemented, along with contact and droplet precautions**, which involves, among other guidelines, hand hygiene (water and soap OR alcoholic preparations) and the correct use of PPE: goggles or face shield, apron, surgical mask, procedure gloves and patient isolation (preferably in a private room).

## 2. Contact precautions + for aerosols (in some specific situations\*\*)

### Other Guidelines for the Isolation Room or Cohort Area

Health care facilities must maintain a record of all persons providing direct assistance or entering rooms or care areas for suspected or confirmed Monkeypox patients.

The room, ward or isolation area or cohort area must remain with the door closed, have the entrance signposted with an alert referring to precautions for droplets/aerosols and contact, in order to prevent the entry/passage of patients and visitors from other areas or professionals working elsewhere in the health service.

Access should be restricted to professionals involved in direct patient care.

Immediately before entering the room, ward, isolation area or cohort area, the following should be available:

- Hand hygiene conditions: 70% alcohol preparation dispenser and washbasin/sink with liquid soap dispenser, support for paper towels, paper towels, trash can with lid and opening without manual contact.
- Appropriate PPE, as described above.
  - Furniture for storage and appropriate container for disposal of PPE.

**WARNING:** It is noteworthy that even in isolation areas, health professionals must remove the apron and gloves after each service, not being allowed to use the same apron or gloves for the care of more than one patient. And remember, always after removing these PPE, hand hygiene must be

performed.

### **Insulation Duration**

Specific precautions (contact, droplets or aerosols) and isolation of patients with Monkeypox should be implemented until the crusting of the lesions has completely disappeared and a new layer of skin has formed, as this is the period in which the period of disease transmissibility. However, even after this period, standard precautions should be maintained.

If the suspicion of Monkeypox is ruled out, precautions and isolation should be adjusted according to the mode of transmission of the diagnosed disease.

### **OTHER COMPONENTS OF PRECAUTIONS TO BE FOLLOWED IN CARE FOR PATIENTS WITH SUSPECTED OR CONFIRMED MONKEYPOX**

- Whenever possible, equipment and health products used in the care of suspected or confirmed cases of Monkeypox should be used exclusively for the patient, as in the case of stethoscopes, sphygmomanometers and thermometers. If this is not possible, all medical devices used on these patients must be cleaned and disinfected or sterilized (according to their purpose) before being used on other patients. Considering that it is a disease whose form of transmission also occurs through contact, it is oriented, considering the precautions for contact, that all health products used by the patient are subjected to at least disinfection, even products classified as non-critical.
- Patients and caregivers should be instructed not to share plates, cups, cutlery, towels, clothes, bedding or other items with other people.
- Professionals should be instructed on care when handling equipment used in patient care in order to avoid skin and clothing contamination.

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- Professionals should be instructed to make sure that products and equipment used on the patient have been cleaned and reprocessed correctly and safely before being used on other patients.
- Professionals should be instructed on care when handling soiled clothing (eg, bedding, towels, personal clothing) to avoid contact with wound material. Soiled laundry should never be shaken or handled in a way that could disperse infectious particles. Must be packaged and sent to the health services clothing processing unit. There is no need to dispose of clothing used by suspected or confirmed patients. Follow the guidelines of the Health Services Clothing Processing Manual, published by Anvisa: [https://www.anvisa.gov.br/servicosade/manuais/processamento\\_roupas.pdf](https://www.anvisa.gov.br/servicosade/manuais/processamento_roupas.pdf)
- Ensure procedures are being performed correctly for cleaning and disinfecting environmental surfaces in the patient care location. Sanitizing products properly regulated by Anvisa must be used (there are still no special recommendations for this virus). Follow the manufacturer's recommendations for concentration, contact time and care in handling and the guidelines contained in the Surface Cleaning and Disinfection Manual published by Anvisa:
- <https://www.gov.br/anvisa/ptbr/centraisdeconteudo/publicacoes/servicosdesaude/publicacoes/manual-delimpeza-e-desinfeccao-de-superficies.pdf/view>

#### OTHER GENERAL PREVENTION MEASURES

Health services must prepare, make available in writing and keep available, rules and routines of the procedures involved in the care of suspected or confirmed cases of Monkeypox, such as: flow of patients within the health service, procedures for putting on and taking off PPE , procedures for removing and processing clothes/articles and products used in assistance, routines for cleaning and disinfecting surfaces, routines for removing residues, among others.

Professionals involved in the care of suspected or confirmed cases of Monkeypox must be trained in the prevention measures that must be adopted.

In addition, these other measures must be implemented:

- The number of companions of suspected or confirmed patients of Monkeypox should be limited to only those essential for the patient's physical or emotional well-being, those guaranteed by law, and those who can assist in the care of the patient (eg, trained caregivers).
  - It is recommended to suspend visits to the infected patient. The resumption of visits must be very well evaluated by the care team and SCIH/CCIH of the health service.
    - o Encourage the use of alternative mechanisms for interaction between patients and visitors, such as video calling applications on cell phones or tablets (pay attention to the hygiene of these devices between uses, if offered by the health service itself).
    - o In pediatric units, the change of companions should be discouraged, in addition to avoiding visits for children.
    - o Establish procedures to guide, monitor and manage all companions, which include:
      - instructions for the use of face masks in all health service locations and frequent hand hygiene;
      - restriction of movement within the service, staying only in the patient's room/box or areas designated by the service;
      - information for the proper use of PPE, in accordance with the institution's current companion policy.
      - Instruct the companion not to touch or hold other children, in the case of pediatric units.
- Provide instructions, prior to entry of companions into patients' rooms/ areas/boxes, on hand hygiene, limited touching surfaces and use of PPE, in accordance with current health facility policy.

#### IMPLEMENTATION OF ENGINEERING CONTROLS AND MEASURES ADMINISTRATIVE

It is recommended to design and install engineering controls to reduce or eliminate exposures, protecting staff and patients from infected individuals.

Some examples of engineering controls might include:

- Adaptation of environments with appropriate space to make PPE available and facilitate the dressing and undressing of professionals;

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- Barriers or physical partitions for guidance and care for patients/companions;
- Adoption of partitions between patients in shared areas.

In addition, it is recommended to adopt some administrative measures to avoid crowds in common areas, such as example, cafeterias, pantries, cafeterias and rest/rest rooms; installation of markings and flags to control the distance between professionals, patients and companions within the health services.

## WASTE MANAGEMENT

[http://bvsms.saude.gov.br/bvs/publicacoes/classificacao\\_risco\\_agentes\\_biologicos\\_3ed.pdf](http://bvsms.saude.gov.br/bvs/publicacoes/classificacao_risco_agentes_biologicos_3ed.pdf) : *It includes biological agents that are capable of transmission, especially via the respiratory route, and that cause potentially lethal diseases in humans or animals, for which there are usually prophylactic and therapeutic measures. They represent a risk if disseminated in the community and in the environment, and can spread from person to person.*

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Therefore, all waste from the care of suspected or confirmed patients of Monkeypox must be included in the **Group A - Subgroup A1**, according to Resolution RDC/Anvisa No. 222, of March 28, 2018, available at: [https:// www.gov.br/anvisa/ptbr/assuntos/noticias/anvisa/2018/confira-nova-regra- sobre-residuos-de-servicos-de-saude](https://www.gov.br/anvisa/ptbr/assuntos/noticias/anvisa/2018/confira-nova-regra-sobre-residuos-de-servicos-de-saude) :

Waste must be packed in red bags, which must be replaced when they reach 2/3 of their capacity or at least once every 48 hours, regardless of volume and identified by the symbol of infectious substance. The bags must be contained in washable material containers, resistant to puncture, rupture, leakage and tipping, with a lid provided with an opening system without manual contact, with rounded corners.

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These wastes must be treated before final environmentally appropriate disposal.

It should also be noted that according to RDC/Anvisa nº 222/2018, health services must prepare a Health Services Waste Management Plan - PGRSS, which is the document that points out and describes all actions related to the management of waste from health services, observing its characteristics and risks, contemplating aspects related to generation, identification, segregation, packaging, collection, storage, transport, destination and environmentally appropriate final disposal, as well as actions to protect public health, of the worker and the environment.

### COLLECTION AND TRANSPORT OF LABORATORY SAMPLES

Samples collected from persons suspected of having Monkeypox must be handled safely by trained personnel working in properly equipped laboratories.

National and international regulations on the transport of infectious substances must be strictly followed during sample packaging and transport to reference laboratories.

Reference laboratories must be informed in advance about the shipment of these samples so that they can minimize the risk to laboratory workers. Thus, it is important to verify the guidelines of the Ministry of Health, regarding reference laboratories and the system that must be followed for sending samples to these laboratories.

### ATTENTION!

This Technical Note (NT) presents infection prevention and control measures considering information available so far, and can therefore be updated as new scientific evidence emerges.

However, health professionals or Brazilian health services can determine more RIGOROUS prevention and control actions than those defined in this NT, based on a case-by-case assessment and according to their reality and available resources.

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It is still important to highlight that the SCIH/CCIHS have the autonomy to determine other HAI prevention and control actions, as well as adapt the guidelines contained in this NT, considering the characteristics of the service, its patients and the available resources, in order to improve the safety of patients and professionals working in the health service.

## REFERENCES

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