UK Health Security Agency

Clade I mpox contact tracing guidance

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What this guidance is for

Clade I mpox is classified as a high consequence infectious disease (HCID). This guidance describes the risk assessment and categorisation of contacts of confirmed HCID (clade I) mpox cases to ensure they are offered appropriate isolation and vaccination advice.

Mpox contact tracing guidance

A contact is anyone who has been directly exposed to an infected person, their blood or other body fluids, excretions or tissues during their infectious period (see next section for details on the infectious period).

It is a public health responsibility:

- to identify, assess, and categorise contacts of a case with clade I mpox
- to appropriately monitor higher risk contacts
- to arrange further evaluation for contacts who develop symptoms within 21 days of the last possible exposure

As soon as a patient has been confirmed as a clade I mpox case, all those who have had contact with the patient during their infectious period (see below) should be identified (in some high-risk cases, identifying contacts may have begun before confirmation). Each potential contact should be assessed for risk of exposure and categorised appropriately for subsequent public health follow-up.

Risk assessment and follow-up of clade I mpox contacts

Separate guidance is available for the management of contacts of clade II mpox cases (clade II mpox is not classified as an HCID).

For the purposes of contact tracing, an individual with mpox is considered infectious from when their symptoms start, until their lesions have scabbed over, all the scabs have fallen off and a fresh layer of skin has formed underneath. This may take several weeks. See the guidance on de-isolation and discharge of patients with mpox for more information. For those who have tested positive for mpox but who have no symptoms, for example if a contact has been tested during their potential incubation period, their infectious period starts from the date of their first positive test result.

Public health professionals undertaking a risk assessment should use the matrix below, and may also take into account additional factors around the exposure, for example the clinical

status of the case at the time of exposure. The risk of transmission will be higher if there are widespread lesions on uncovered areas (for example, the hands or face), or if the case was displaying respiratory symptoms at the time of contact. Principles regarding transmission and infectious and incubation periods have been published in the mpox technical briefing 9. Information regarding recommendations for post exposure prophylaxis (PEP) can be found in the Green Book.

Guidance for personal protective equipment (PPE) to be used within healthcare settings is outlined in the NHS guidance on infection prevention and control measures for clinically suspected and confirmed cases of mpox in healthcare settings. This includes information on PPE to be used during cleaning and decontamination procedures. The PPE required when cleaning and decontaminating a non-healthcare setting is outlined in the guidance for environmental cleaning and decontamination in non-healthcare settings.

Classification of contacts and follow-up advice for HCID (clade I) mpox

This guidance provides principles for risk assessment and follow-up of contacts of confirmed clade I mpox cases during their infectious period.

Exposure risk	Description	Example scenarios	Public health advice	Recommendation for PEP
High (category 3) Unprotected direct contact or high-risk environmental contact	Direct exposure of broken skin or mucous membranes to an HCID (clade I) mpox case, their body fluids or potentially infectious material (including clothing or bedding) without wearing appropriate PPE. This includes: • inhalation of droplets or dust from cleaning contaminated rooms • mucosal exposure to splashes • penetrating sharps injury from contaminated device or through contaminated gloves • people who have shared a residence (shared kitchen and/or bathroom and/or living space) either on a permanent or part time basis with a person who has been diagnosed with mpox and who have spent at least one night in the residence during the period when the case was infectious	Household contact (shared kitchen and/or bathroom and/or living space). Sexual or intimate contact (including kissing) with or without a condom. Body fluid in contact with eyes, nose, or mouth. Penetrating sharps injury from used needle. Cleaning any setting (including domestic) where a case has been without appropriate PPE. Person in room during aerosol generating procedure without appropriate respiratory PPE. Changing a patient's bedding without appropriate PPE.	Active monitoring. Daily communication with contact for 21 days after last exposure. **Self-isolation for 21 days post-exposure.** Provide category 3 contact information sheet and contact number. Avoid sexual or intimate contact and other activities involving skin to skin contact for 21 days from last exposure. Avoid contact with immunosuppressed people [note 1], pregnant women, and children aged under 5 years where possible for 21 days from last exposure. Contact should not travel for 21 days after last exposure, this includes in the UK and internationally [note 2].	Offer PEP with MVA-BN vaccine (Imvanex®), as soon as possible after exposure and within 4 days from first exposure. Vaccination may be offered up to 14 days after first exposure, in those at higher risk of serious mpox infection (immunosuppressed people, pregnant women and children aged under 5). Refer to the Green Book for further information
Medium (category 2) Unprotected exposure to infectious materials including droplet or airborne potential route	Intact skin-only contact with an HCID (clade I) mpox case, their body fluids or potentially infectious material or contaminated fomites (excluding household contacts, as above). Or: Passengers seated directly next to a case on a plane (or any other mode of transport where it is known that they have sat next to the case). Or: No direct contact but within 1 metre of a case without wearing appropriate PPE.	Clinical examination of patient before diagnosis without appropriate PPE. Entering patient's room without wearing appropriate PPE and within 1 metre of the case. Driver and passengers in shared car or taxi with case, or sitting next to case on plane. Subsequent patients in consulting room after a clade I mpox case was seen and prior to room cleaning. Spillage or leakage of laboratory specimen onto intact skin. Face-to-face contact with a case less than 1 metre distance apart (without barrier or screen).	Active monitoring. Daily communication with contact for 21 days after last exposure. **Self-isolation not required for this category of contact.** Provide category 2 information sheet and contact number. Avoid sexual or intimate contact and other activities involving skin to skin contact for 21 days from last exposure. Consider exclusion from work for 21 days following a risk assessment if working with immunosuppressed people [note 1], pregnant women or children aged under 5 years (not limited to healthcare workers).	Offer PEP with MVA-BN vaccine (Imvanex®), as soon as possible after exposure and within 4 days from first exposure. Vaccination may be offered up to 14 days after first exposure, in those at higher risk of serious mpox infection (immunosuppressed people, pregnant women and children aged under 5 years). Refer to the Green Book for further information.

Exposure risk	Description	Example scenarios	Public health advice	Recommendation for PEP
			International travel is not advisable [note 2]. Risk assess whether contacts who are children require exclusion from school (for example, if they will be in contact with children aged under 5).	
Low (category 1) Protected physical or droplet exposure Or: No physical contact, unlikely droplet exposure	Contact with an HCID (clade I) mpox case or contaminated environment while wearing appropriate PPE (with no known breaches). Passengers seated within 3 rows from an HCID (clade I) mpox case on plane, or cabin crew attending the compartment where case was sitting, except for passengers sitting directly next to the case Or: Passengers on the same bus, train or other mode of non-plane mass transport, unless it is known that they sat next to the case. Or: Community contact between 1 and 3 metres of a case. Or: Face-to-face contact with a case less than 1 metre distance apart with a barrier/screen in between case and contact. Or: Healthcare worker involved in care of a case not wearing appropriate PPE, but without direct contact **and** maintained a distance between 1 and 3 metres **and** no direct contact with body fluids or potentially infectious material.	Healthcare staff working in HCID specialist unit wearing appropriate PPE. Person undertaking decontamination of rooms where a confirmed case has stayed, while wearing appropriate PPE. Entering patient room not wearing PPE, without direct contact with patient or their bodily fluids, and maintaining a distance of more than 1 metre from patient. Passengers on the same bus, train or other non-plane mass transport as the case where it is not known where they sat in relation to the case.	Passive monitoring. Provide category 1 information sheet and contact number. Can continue with routine activities and travel as long as asymptomatic.	Do not offer PEP.

Note 1: Immunosuppressed patients, as per the Green Book definition, includes those with primary or acquired immunodeficiency, or individuals on immunosuppressive therapy, and includes those with: solid organ cancer, haematological disease and/or stem cell transplant, Child's-Pugh class B or C liver cirrhosis, stage 4 or 5 chronic kidney disease, immune mediated inflammatory disorders (including neurological and rheumatological conditions) treated with B-cell depleting therapy within 12 months, uncontrolled HIV, solid organ transplant recipients.

Note 2: If the contact has travelled overseas before being contact traced, or if they are intending on travelling overseas, health protection teams (HPTs) should get in touch with the International Health Regulations National Focal Point to discuss. For healthcare worker cases, occupational health teams should contact their HPT about these contacts.

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