

# Considerations for border health and points of entry for mpox

## Key points

- Health authorities should strengthen public health surveillance, risk communication, community engagement and emergency coordination efforts as well as disease prevention and clinical care related to mpox at and around relevant points of entry (PoEs), in close coordination with all governmental and non-State actors working at and around PoEs.
- Health measures specific for mpox that unnecessarily interfere with international traffic should not be implemented.
- If screening measures for mpox are implemented at PoEs, they should be based on a thorough risk assessment and reviewed regularly. To the extent possible, data should be collected on the effectiveness, cost-effectiveness and impact of screening measures.
- Stigmatization and discrimination related to mpox should be prevented or reduced by using non-stigmatizing language and creating an enabling environment where individuals feel secure to report symptoms and receive assessment and medical care.
- Persons with suspected or confirmed mpox and any individuals showing signs and symptoms compatible with mpox should refrain from non-essential travel and close contact with others.

## Introduction

On 14 August 2024, the Director-General of the World Health Organization (WHO) determined that the upsurge of mpox in a growing number of countries in Africa constitutes a new public health emergency of international concern under the International Health Regulations (IHR) (2005) (1).

Mpox is a viral illness caused by the monkeypox virus (MPXV) which is transmitted from person to person. MPXV has two clades, I and II: clade I, historically found in Central Africa, and clade II, historically found in West Africa. Previously known mainly as causing a zoonotic infection, the virus spread through contact with animals and thence to outbreaks in families and communities. In May 2022, a global outbreak of mpox emerged which ultimately reached more than 100 countries in all WHO regions. This outbreak was linked mostly to a new subclade of MPXV known as IIb, which spread mainly through sexual contact among men who have sex with men. Other key populations including sex workers; occasionally health workers or families have also been affected (2, 3).

Since first reported in the Democratic Republic of the Congo in 1970, mpox linked to clade I MPXV has continued to occur in remote areas where the disease is endemic. Over the past decade, the number of cases of mpox reported in that country has been rising, with further escalation in late 2022 when the Government declared an outbreak, as previously unaffected provinces increasingly reported their first cases of mpox. In 2023, outbreaks linked to sexual contact, and notably among sex workers, began to be documented in new areas with high population density and mobility, affected by conflict and intercommunal unrest, mining and other commercial activities and extensive cross-border movement of people. The result has been a large outbreak involving exclusively human-to-human transmission in the previously unaffected provinces of North and South Kivu, which was linked to a new virus strain named clade Ib MPXV that had not been previously reported to WHO. By August 2024, this strain had spread to four neighbouring



countries that had not previously reported mpox. At the same time, the ongoing global outbreak of clade 1b continued to affect countries in Africa (2, 3, 4).

The increase in the number of mpox cases observed in the Democratic Republic of the Congo and the growing number of countries in Africa reporting mpox (5) led to the declaration by the Director-General of a public health emergency of international concern. Several cases in newly-affected countries in Africa have been linked to travel between the eastern parts of the Democratic Republic of the Congo and neighbouring countries, with some cases identified at PoEs. In each of these newly-affected countries, clade 1b MPXV has been detected (6). Furthermore, cases have also been reported in urban environments such as the capital of the Democratic Republic of the Congo, Kinshasa, where the risk of cross-border transmission may be increased owing to the proximity of urban areas to PoEs (7).

Common symptoms of mpox are a skin rash or mucosal lesions, which can last 2–4 weeks, accompanied by fever, headache, muscle aches, back pain, low energy and swollen lymph nodes. Most people fully recover, but some individuals may experience serious complications, which can include severe pain; inflammation of the brain, lungs, heart or rectum; difficulty urinating; and loss of pregnancy. Children, pregnant women and people with weak immune systems (such as those living with HIV who are not taking antiretroviral treatment or have advanced HIV disease) are at risk for complications from mpox. Although mpox is clinically similar regardless of the causative viral clade, differences in clinical manifestations can appear linked to modes of transmission and characteristics of populations affected. More comprehensive epidemiological studies are needed to assess any clinical differences between MPXV clades.

Mpox spreads from person to person mainly through close contact with a person who is infected with MPXV, including skin-to-skin, mouth-to-mouth, or mouth-to-skin contact, and can also include being face-to-face with someone who has mpox (such as talking or breathing close to one another, an activity that can generate infectious respiratory particles). The virus can also spread through contaminated materials – such as clothing, bedding, towels, objects, electronic devices and surfaces – or infected animals (3). Based on currently available epidemiological data, the new mpox outbreaks linked to clade 1b MPXV initially spread between adults through close physical contact, including sexual contact within networks of sex workers and their clients, for instance in border areas (8). However, over time, the outbreak has expanded and evolved, affecting other

adults and children in new contexts where people are at risk, such as among displaced persons, refugees and migrants. Anyone can contract mpox, especially persons in close contact with someone who is infected, including adults and children within households and other settings. In August 2024, the Director-General issued temporary recommendations to States Parties experiencing the upsurge of mpox – including, but not limited to, Burundi, the Democratic Republic of the Congo, Kenya, Rwanda and Uganda – and extended the existing standing recommendations to all other States Parties for an additional 12-month period until August 2025 (6).

In May 2024, WHO published a strategic framework for enhancing prevention and control of mpox (2024–2027) (9). To complement this strategy, and in response to the declaration of a public health emergency of international concern, WHO has also developed in collaboration with partners a global strategic preparedness and response plan for mpox, which aims to provide a comprehensive approach to stop human-to-human transmission of MPXV through coordinated global, regional and national efforts (10). The purpose of this interim guidance document is to provide authorities with technical advice on considerations for border health and points of PoEs with respect to mpox, including international travel by air, water or land between countries and territories. This guidance covers all outbreaks of mpox, in the context of the global outbreak ongoing since 2022 and with particular attention to the current upsurge of mpox in the Democratic Republic of the Congo and neighbouring countries in Africa. It aims to complement broader frameworks with technical guidance and considerations for border health, cross-border collaboration and interventions at PoEs, including One-health approaches. WHO regularly updates mpox technical documents and related resources and publishes them in the mpox outbreak toolbox on the WHO website (11).

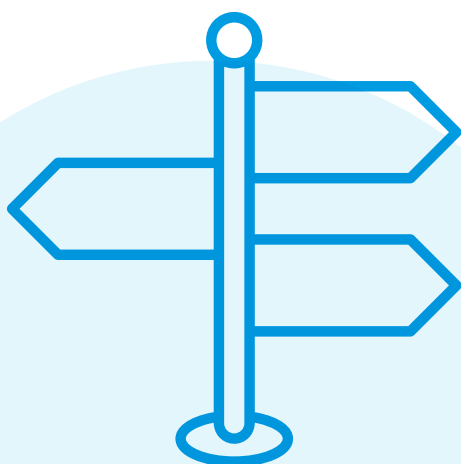


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## How this interim guidance was developed

This interim guidance provides advice to support the implementation of the standing and temporary recommendations issued by the Director-General in line with the required capacities and provisions of the IHR (2005). Its content is based on the legal provisions and requirements of the IHR (2005) (12); WHO's existing guidance on surveillance, contact tracing, clinical care, infection prevention and control, and risk communication and community engagement for mpox (11); WHO's handbook on the management of public health events in aviation, onboard ships and in land borders (13, 14, 15); and WHO's latest systematic reviews of evidence on the effectiveness and impact of travel-related health measures.

Various consultation processes were undertaken throughout the development of this interim guidance, during which relevant stakeholders had the opportunity to review and provide input to its content. These included internal consultations across all technical areas within the Incident Management Support Team established in WHO Headquarters for the mpox response, as well as with the technical counterparts for border health and PoEs in all six regional offices. Furthermore, key partner agencies were consulted, including the International Civil Aviation Organization, the International Maritime Organization, the International Organization for Migration, the International Labour Organization, the United Nations World Tourism Organization, the International Air Transport Association and the WHO Collaborating Centre for PoEs at the University of Thessaly in Greece.

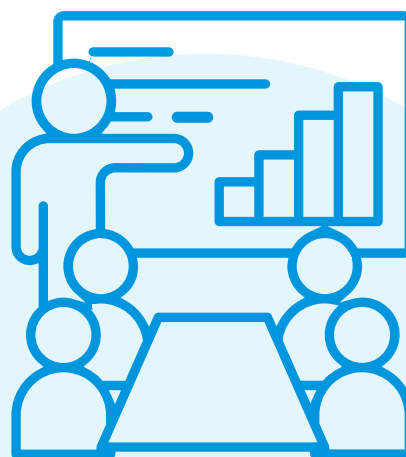


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## Target audience

The target audience of this interim guidance includes:

- national and subnational health authorities, including National IHR Focal Points
- authorities responsible for implementing the IHR (2005) at PoEs
- representatives of government and non-State actors and their partners working at and around PoEs, including those in the travel, immigration, customs, security, trade and transport sectors
- public health professionals and health workers involved in disease surveillance, risk communication and community engagement, emergency preparedness and response, infection prevention and control, animal health and environmental health at and around PoEs or in the context of international air, water or land travel
- civil society organizations, faith-based organizations, community-based volunteers and carers, and humanitarian workers
- regional authorities, including regional economic committees.



## Policy considerations

WHO advises States Parties to the IHR (2005):

- to strengthen public health surveillance, risk communication, community engagement and emergency coordination efforts as well as disease prevention and clinical care related to mpox at and around relevant PoEs (see further details in the section below on Technical considerations);
- to refrain from implementing health measures specific for mpox that may unnecessarily interfere with international traffic, taking into account the following caveats:
  - » The IHR (2005) do not define the term “travel restrictions”. Article 43 (Additional health measures) refers to those which significantly interfere with international traffic and defines such interference as the refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods, and the like, or their delay, for more than 24 hours. States Parties implementing any such additional health measures must inform WHO within 48 hours of implementation and provide to WHO the public health rationale and relevant scientific information for those, which WHO will share with other States Parties (12).
  - » If screening measures for mpox are implemented at PoEs in accordance with Article 23 (Health measures on arrival and departure) of the IHR (2005), they should be based on a thorough risk assessment and reviewed regularly. To the extent possible, data should be collected on the effectiveness, cost-effectiveness and impact of screening measures. A recent WHO scientific review of the evidence on the effectiveness of syndromic entry and exit screening for epidemic-prone diseases of travellers at ground crossings concluded that there is insufficient evidence to develop guidelines for or against such measures and called for further research in this area (16). In line with the standing recommendations, States Parties should refrain from using temperature screening for mpox at PoEs given the lack of high-quality evidence to support its implementation.
  - » Proof of testing or vaccination for mpox should not be required as a condition for entry to or exit from a country.

In accordance with the IHR (2005), the human rights, dignity and fundamental freedoms of travellers, including those of mobile and cross-border transport workers, must be respected. The collection and management of any personal data for reporting and contact-tracing purposes must be done in line with privacy and personal data protection principles (17, 18). If measures are implemented at PoEs, they should be adequately planned to avoid overcrowding and resources should be made available for travellers to follow hand hygiene and other recommended practices to avoid close contact with others.



## Technical considerations

WHO advises health authorities:

1. to enhance **emergency multisectoral coordination** between the public health, travel, transport, immigration, border management, customs, security, labour, tourism, animal, environmental and other relevant sectors and stakeholders working at PoEs or in the context of international travel through the following actions:

- a) Develop PoE multisectoral, One-health, interoperable and risk-based public health contingency plans, if these are not already available, or testing existing plans through simulation exercises and updating them to ensure their readiness for the management of mpox cases; these plans should take into consideration the key role played by mobile and cross-border transport workers and employers (19).

- b) Develop or review and update standard operating procedures for managing suspected or confirmed cases of mpox at PoEs or during travel and in the context of all population movements, by means including but not limited to: specific procedures for case identification, isolation, reporting to public health authorities, provision of urgent on-site care, transportation services, referral to medical facilities, case investigation and contact tracing; thorough cleaning, disinfection and waste management of facilities and conveyances; and management of infected animals.

- c) Identify and/or establish technical agreements with transportation services and referral hospitals, clinics and health services that can diagnose and provide care for people with suspected or confirmed mpox.

- d) Coordinate with PoE stakeholders and transport operators to ensure that recommended procedures at PoEs and on conveyances are applied for appropriate infection prevention and control, hand hygiene, cleaning, disinfection and waste management, including when handling potentially-infected animals.

- e) Cooperate with conveyance operators, travel, transport, tourism, labour and migration authorities and other stakeholders at and around PoEs, for instance through established multisectoral coordination mechanisms, to facilitate case management and contact tracing, including internationally, at PoEs or throughout the travel continuum.

- f) Increase the visibility of tailored risk communication and public health messages targeting travellers and relevant PoE staff, as well as community-based actors, humanitarian workers and faith-based organizations, through appropriate channels and at exit and entry points.

For further information, please refer to WHO's interim rapid response guidance on clinical management and infection prevention and control for monkeypox (20).

2. to strengthen **surveillance, case investigation and contact tracing** at and around PoEs, while avoiding stigmatization and discrimination, by the following actions.

- a) Establish or review and update standard operating procedures for the identification, reporting and response to suspected and/or confirmed cases of mpox with the involvement of all relevant PoE sectors and stakeholders.

- b) Inform and sensitize all PoE sectors and stakeholders (health and non-health), including conveyance operators and crew, about the signs and symptoms of mpox (3); particularly those travelling to and from areas and countries experiencing an upsurge in cases of mpox.

- c) Sensitize health personnel, including clinicians, about mpox signs, symptoms, differential diagnosis, current epidemiology, case definitions, process to isolate a suspect case, request for laboratory testing, epidemiological investigation, provision of medical care, recommended infection prevention and control measures, and procedure for reporting to public health authorities. Such efforts should be implemented at health clinics in/around the PoEs as well as among all medical/other relevant crew working on conveyances (for instance, aircrafts or ships), as people with suspected cases may be identified or seek care in these settings.



d) Analyse and map trends in cross-border movement of human beings, animals and freight, in particular at and around PoEs and border communities adjacent to countries experiencing an upsurge of mpox or where mpox is endemic in order to identify at-risk populations and inform the geographical location of public health interventions. This should be done by: (i) identifying areas, routes – especially those leading to large urban settings, designated and non-designated PoEs as well as priority ground crossings – and points along the border with high volumes of cross-border movements, and critical points of congregation where travellers and mobile workers may have frequent interaction with at-risk local communities, such as sex workers along trade corridors, parking facilities and transport hubs; and (ii) linking analytical data on cross-border movements and population mobility trends with community event-based surveillance data for enhancing mpox surveillance and risk communication efforts.

e) Enhance cross-border surveillance and collaboration, establishing or building on existing cross-border coordination mechanisms for data sharing using a One-Health approach, and identifying opportunities to collaborate on: (i) collection and sharing of information on cross-border mobility and public health data, including those for use in international contact tracing; (ii) sharing of resources for isolation of suspected cases, their transport and referral to health facilities for assessment and care, and for collection, transport and testing of samples; and (iii) coordinated public health and risk communication efforts between border health authorities, referral clinics/hospitals, transportation services and local communities.

f) Implement contact tracing. When a suspected case is detected on board a conveyance, PoE and conveyance operators should follow the advice provided by public health authorities. A case-by-case, context-specific risk assessment should be conducted taking into consideration the specific characteristics according to the type of travel, PoE (airport, port or ground crossing) and conveyance (such as aircraft, ship, train, truck or coach), as well as evidence on the modes of transmission of mpox.

g) In the context of air travel, States Parties should systematically use the Passenger Health Locator Form (21). In aircraft, the guidelines of the International Air Transport Association for cabin crew on a suspected communicable disease can be used (22). These state that travellers seated in the same row, two rows in front and two rows behind the ill traveller, as well as the cabin crew who served the suspected case, should be contacted to assess the risk of exposure and monitoring requirements. Nonetheless, in the context of mpox, a case-by-case risk assessment should be conducted taking into account the evidence on modes of transmission.

h) Under circumstances where many travellers are on board and have frequent close physical contact and social interactions in spaces where predetermined seats may not be assigned (such as sea or river cruises), the identification of contacts may be more challenging than for air travel and may require additional individual assessments. In and around ground crossings bordering countries experiencing an upsurge in cases of mpox, additional risk factors may play a role such as contact with potentially infected animals and the sale, preparation and consumption of bushmeat. When a suspected case is identified, public health authorities should liaise with PoE stakeholders and conveyance operators to notify travellers about the risk of possible exposure.

i) Sensitize public health authorities working at PoEs and other PoE stakeholders about animal species that may be infected with MPXV, clinical signs of concern in animals, processes to handle animals that are sick or dead, requesting laboratory testing, epidemiological investigation and reporting procedures relating to possible or documented human contact with animals suspected to carry MPXV.

For further information, please refer to WHO's interim guidance on surveillance, case investigation and contact tracing for mpox (23).





3. to tailor **risk communication, community engagement** and infodemic management strategies and actions for travellers within the local context with the following aims.

a) Prevent or reduce stigmatization and discrimination related to mpox, using non-stigmatizing language and creating an enabling environment where individuals feel secure to report symptoms, receive assessment and medical care.

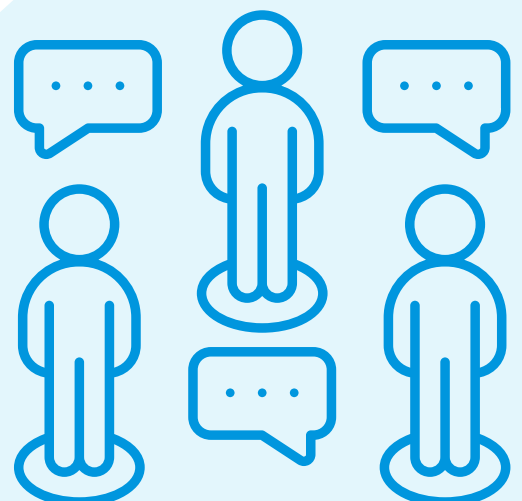
b) Identify target audience groups with a particular focus on vulnerable populations in areas experiencing or at risk of mpox outbreaks such as:

- i. travellers to and from areas experiencing an mpox outbreak
- ii. persons travelling across borders for work, including traders, merchants, conveyance operators (for example truck drivers) and sex workers
- iii. highly mobile and cross-border communities
- iv. migrants, refugees and asylum seekers
- v. public health or health care staff working at the PoEs
- vi. PoE stakeholders, for instance immigration, border and customs, and security staff
- vii. travel, transport and tourism stakeholders.

c) Ensure risk communication messages are developed together with and tailored to target audiences' cultural and linguistic needs, including on both sides of the border in the context of ground crossings in countries experiencing an upsurge in mpox cases. Information may include signs and symptoms of mpox, modes of transmission, recommended protective and infection prevention and control measures, and guidance on what should be done if compatible symptoms develop and how to seek medical care in the country of departure or destination. Persons with suspected or confirmed mpox and any individuals showing signs and symptoms compatible with mpox should refrain from non-essential travel and close contact with others. Contacts of persons with mpox should not be quarantined. Conversely, they are advised to refrain from sexual activity for 21 days (the maximum incubation period) (23).

d) Apply the most appropriate and trusted channels for targeting information, such as news or social media, printed materials (for example, posters, banners, pamphlets and advisory material), public announcements or engagement of community stakeholders and any other means that is used to reach the desired target audience, including at cross-border communities.

For further information, please refer to WHO's risk communication and community engagement readiness and response toolkit for mpox (24).



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## Plans for updating

WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance will expire one year after the date of publication.

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