

Mpox – September 26, 2024

Public Health Goal

The occurrence of mpox in Canada is novel and the situation continues to evolve both nationally and globally. The public health guidance outlined in this document was developed in conjunction with the Federal guidance, “[Mpox: Public health management of cases and contacts in Canada](#)” and with input from Department of Environment and Climate Change (ECC), Provincial Public Health Laboratory Network (PPHLN) and provincial partners in Nova Scotia Health (NSH) such as Infection Prevention and Control (IPAC), and Public Health. Guidance is based on currently available scientific evidence, including information informed by national and international epidemiological data and is subject to change as new information becomes available. Public health ethics principles such as the use of least restrictive means, effectiveness, reciprocity, and proportionality were also considered in the development of the provincial guidance.

In Nova Scotia, the public health objectives of case and contact management are to:

- Rapidly stop ongoing transmission through prompt identification and follow up of cases and contacts and containment of outbreaks
- Decrease risk of exposure to populations with higher risk of severe disease to minimize morbidity and mortality
- Ultimately, eliminate chains of human-to-human transmission

For more information see: [Public Health Agency of Canada Mpox: Update](#)

IPAC measures in health care settings are beyond the scope of this document. See [Appendix A](#) for links to information.

For individual cases and contacts where situations are not covered in this guidance, Regional Medical Officers of Health (RMOH) have discretion to advise.

Case Definition

<https://novascotia.ca/dhw/populationhealth/surveillanceguidelines/surveillance-guidelines-mpox.pdf>

Causative Agent

Mpox is caused by monkeypox virus (MPV), which belongs to the *Orthopoxvirus* genus in the family *Poxviridae*, making it related to smallpox. There are 2 known subtypes (called clades):

1. Clade one (I) (*formerly known as Congo Basin or Central African clade*), which has recently been further divided into 2 subclades: Clade Ia and Clade Ib
2. Clade two (II) (*formerly known as West African clade*), which is further divided into 2 subclades: Clade IIa and Clade IIb

In Canada to date, clade II has been the only identified strain.

Source

The natural reservoir remains unknown, however, small mammals from endemic regions of Africa are thought to maintain the virus in the environment (e.g. dormice, Gambian pouched rats, rope squirrels, sun squirrels). Humans and non-human primates are considered incidental hosts.

Transmission

Mpox can be transmitted person-to-person or animal-to-human (i.e., zoonotic transmission), however, animals do not currently play a role in the spread of mpox in Canada.

Person-to-person:

- Direct contact with infected skin lesions or their drainage, scabs, body fluids or mucosal surfaces (e.g. mouth, genitalia and anorectal area)
 - e.g. physically close contact or oral mucosa contact such as kissing, anal sex, oral sex, or vaginal sex. MPV has been detected in semen. More evidence is needed to understand the significance of this finding on the potential for sexual transmission.
- Respiratory transmission such as contact with infected droplets generated by talking, breathing, coughing, and sneezing.
 - The potential for airborne transmission has been suggested, although it is not the primary mode of transmission and more evidence is needed. For this reason, this guidance reflects an element of precautionary public health measures (e.g. consistently and reliably wearing a well-fitted medical mask).
- Vertical transmission from an infected pregnant person to the fetus (congenital mpox). Transmission may also occur during close contact at birth.

- Indirect transmission through contact with materials (e.g. linens, towels, clothes, dressings), objects (e.g. razors, sex toys, utensils, needles, toothbrushes), or surfaces contaminated with MPV.

To date, the greatest risk of infection has been for people who closely interact with someone who is infectious, including sexual partners and household members. More studies are needed to understand the risk.

Incubation

The incubation period averages 7 to 10 days, with a range between 3 to 21 days.

Communicability

A person is most commonly contagious from the onset of initial lesions, until scabs have fallen off and new skin has formed (this is also referred to as *epithelialization* in this document); about 3 to 4 weeks.

Emerging evidence suggests that some cases may be contagious up to 4 days prior to symptom onset or during their early symptoms (prodrome). There is not enough evidence at this time to know with certainty, including whether certain exposures are higher risk during this period. Out of precaution, contact tracing should extend to potential contacts up to 4 days prior to symptom onset.

Symptoms

Mpox infection typically presents first as systemic symptoms (prodrome) followed by a rash or lesions, although atypical presentations may occur:

1. **Prodrome:** Lasts between 0 to 5 days

- fever
- chills
- sore throat
- headache
- lymphadenopathy* (localized or generalized)
- fatigue
- musculoskeletal manifestations such as myalgia, arthralgia and back pain
- cough
- nausea, vomiting and diarrhea

*Lymphadenopathy is a distinctive feature of mpox, as compared to chickenpox and measles where lymphadenopathy is absent. Lymph nodes may swell in the neck (submandibular & cervical), armpits (axillary), or groin (inguinal) and occur on both

sides of the body or just one.

1. Rash or lesion eruption: Usually begins within 1 to 3 days of the prodrome.

In the clade II outbreak, there have been reports of lesions preceding or occurring in the absence of any prodromal symptoms. Lesions can be located anywhere on the body including face, eyes, palms and soles, oral mucous membranes, genitalia, anorectal and perianal area, and conjunctivae. In many of the cases, lesions have presented in oral, genital, anorectal, or perianal areas only and proctitis has been frequently reported.

Individual lesions typically evolve sequentially from macules to papules, vesicles, pustules, and finally crusts, which dry up and fall off. The rash usually lasts between 14 to 28 days, with lesions potentially appearing asynchronously through this period. The number of lesions varies from a few to several thousand. The lesions can coalesce, leading to widespread areas of skin erosion.

Mpox is usually a self-limited disease with the symptoms lasting from 2 to 4 weeks, but severe disease can occur. Complications of mpox can include myocarditis, severe pharyngitis, severe proctitis, secondary infections, bronchopneumonia, sepsis, encephalitis, and infection of the cornea with ensuing loss of vision.

The case fatality ratio (CFR) of mpox has historically ranged from 0 to 11 % in the general population and has been higher among young children, pregnant people, and immunocompromised individuals. Clade strain and structural factors such as availability of health care also play a role.

Clade Ia has a CFR of around 10%, while clade II, when occurring in endemic areas, has historically had a CFR of approximately 1 to 3%, though cases occurring outside endemic areas have rarely been fatal. The severity of the newer sub-lineage, clade Ib, is currently unknown; early evidence suggests a lower CFR compared to the original clade Ia. More information is needed. In Canada to date there have been no reported deaths related to mpox.

Diagnostic Testing

When mpox is suspected on clinical grounds, it should be confirmed with laboratory testing. Senders should contact the microbiologist on call (through QEII locating 902-473-2222/2220) when collecting specimens.

MPV is detected by polymerase chain reaction (PCR) testing that is available at the Central Zone (QEII) Microbiology Laboratory. Results are generally available within 24-48 hours up to 7 days. PCR testing can detect both mpox clade I and clade II but cannot differentiate. Positive specimens can be referred to the National Microbiology lab (NML) for genomic characterization on the request of public health when clade determination is needed (e.g. circumstances of severe disease or travel to areas where clade I is circulating).

Co-infections are possible and other more common infections that should be considered include herpes simplex virus (HSV), varicella zoster virus (VZV), hand-foot-mouth disease (enterovirus), syphilis, lymphogranuloma venereum (LGV), HIV, and chancroid (if epidemiologically supported).

Specimens that should be collected on a suspected case of mpox include:

- swab of lesion for MPV in viral transport media
- swab of lesion for HSV/VZV or enterovirus in viral transport media
- LGV (chlamydia) on a chlamydia swab – this can be from a lesion or a rectal swab in patients presenting with proctitis
- blood for syphilis and HIV serology
- chancroid on a bacterial swab (if indicated)

Additional information regarding specimen requirements and transport conditions can be found in the PPHLN: Provincial Microbiology User's Manual here:

<https://www.cdha.nshealth.ca/system/files/sites/116/documents/provincial-microbiology-users-manual.pdf>

Treatment

Treatment should be overseen by a clinician and details are out of scope for this document. Briefly, most mpox infections require only supportive treatment. The goals of care are to alleviate symptoms, manage complications, and prevent long-term sequelae.

TPOXX (tecovirimat) is a Health Canada authorized treatment under an extraordinary use indication for human smallpox disease. TPOXX does not have an approved indication for the treatment of mpox in Canada. A licensed healthcare professional may use their clinical judgement to prescribe TPOXX off-label to treat mpox infections.

Public Health RMOHs can work with Infectious Disease specialists and/or other treatment specialists, to determine the need to access TPOXX on a case-by-case basis.

For more information on treatment for mpox, refer to PHAC's [Mpox: For health professionals](#) webpage.

PUBLIC HEALTH MANAGEMENT AND CONTROL

Case Management

Note: Case and contact management guidance remains the same regardless of clade.

Mpox is a self-limited disease, as such the majority of cases will be able to manage symptoms at home and in community. The ability to recover in the home and implement infection control measures is likely to vary depending on the following factors:

- If the case is a child or an adult who requires care
- The presence of additional infected or uninfected persons in the home
- The nature and extent of lesions in each case
- The need for hospitalization

Suspect Case:

- Notify case or their parent/guardian of need for **testing** if not already arranged
- Follow any additional public health measures **at discretion of RMOH**, including avoiding the following direct contact with others until diagnosis ruled out: contact with lesions, contact with mucous membranes, and sexual contact
- **Isolation is not required**

Probable Case:

- Notify case or their parent/guardian of need for **testing** if not already arranged
- Interview the case or parent/guardian to assess risk factors and collect further information pertaining to case details, such as symptoms, hospitalization, medical, travel and exposure history, previous vaccine, or infections
- Initiate contact tracing
- **Advise case to isolate at home and avoid household and other contacts until laboratory results are available. If negative, isolation is no longer required. If positive, continue isolation and follow as a confirmed case**

Confirmed Case:

- Notify case or their parent/guardian of positive test results
- Interview the case or parent/guardian to assess risk factors and collect further information pertaining to case details, such as symptoms, hospitalization, medical, travel and exposure history, previous vaccine, or infections
- Complete contact tracing
- **Advise case to isolate at home and avoid household and other contacts until meets criteria for isolation discontinuation (described below)**

Education and Case Follow up

During the **initial call** with a case, education should be provided from the pertinent sections: Isolation, Isolation Discontinuation, Case Recovery and Public Health Measures to Reduce Transmission of Mpox.

After confirmation of positive test results, a follow-up call should be made to the confirmed case **approximately 7 days later**. Additional follow-up may occur on a case-by-case basis.

Due to the emerging nature and atypical presentation of mpox disease, cases may need to be referred for clinical assessment by a healthcare practitioner to verify disease progression and/or whether criteria for isolation discontinuation (listed below) or recovery is met. This may be done in consultation with RMOH.

Isolation

Isolation is advised for probable and confirmed cases of mpox. Public Health works with cases to identify and mitigate any barriers to effective isolation in the home, as well as provide appropriate supports as needed. The unique characteristics of the case and their living situation should be considered (e.g., congregate living setting).

- If a private room for sleeping is not possible, the case should maintain as much distance as possible from others (e.g., by sleeping in separate beds).
- If a separate washroom is not possible, the case should clean and disinfect all surfaces and objects they have had contact with and immediately remove and launder used towels.
- If interactions with others is unavoidable cover all lesions with clothing or bandages (including when accessing common spaces, even if others are not

present). Wear a well-fitting, preferably medical, mask when around others. When this is not possible (e.g. child with mpox), other household members should wear a well-fitting, preferably medical, mask when in the presence of the case.

- If urgent medical care is required or other emergencies arise, the case should inform health care providers of mpox diagnosis prior to arrival, as well as ensure lesions are covered bandages and/or clothing and wear a well-fitting, preferably medical, mask.
- Reschedule non-urgent and elective appointments and/or arrange for virtual care where available
- Avoid travel to other cities, regions/provinces/territories or to other countries
- If traveling after isolation discontinuation, but prior to recovery, review and follow destination jurisdictional public health measures and/or restrictions prior to departure.

Isolation Discontinuation:

Isolation can be discontinued when the following criteria are met:

1. No new lesions have formed within the last 48 hours
2. No fever for 24 hours (without the use of antipyretics)
3. A) Lesions are crusted/scabbed, fallen off, and epithelialized (i.e., have a light pink/shiny pearl appearance)

OR

B) Lesions can be covered with bandages and/or clothing* AND a case must:

- Wear a well-fitting, preferably medical mask around all people (household and non-household)
- Avoid the following direct contact with others until recovered (defined below): contact with lesions, contact with mucous membranes, and sexual contact
- Avoid high-risk populations (children under 12, pregnant, and immunocompromised individuals) until recovered
- Continue to follow Public Health Measures to Reduce Transmission of Mpox until meets the definition of recovered

*Facial, oral, or any lesions that cannot be covered would exclude the case from isolation discontinuation until lesions epithelialized

Case Recovery

The case is considered **recovered** when lesions are epithelialized, they are afebrile for 24hrs (without the use of antipyretics), improved symptoms (e.g., headache, muscle pain, fatigue, respiratory symptoms), and they feel well enough to resume normal activities.

Due to unknowns about potential transmission, for **8 weeks** after lesion epithelialization recovered individuals should use barrier protection (e.g., condoms, dental dams) during all sexual activity. Barrier protection for up to 12 weeks may be recommended as a precautionary approach for those whose partner(s) are currently pregnant, planning to become pregnant, or are immunocompromised.

Recovered individuals should refer to [Canadian Blood Services](#) before donation of blood or any other bodily fluid or tissue for more information.

Public Health Measures to Reduce Transmission of Mpox

Avoiding direct contact with lesions helps to limit the transmission of the virus to others and is important **even if someone is fully immunized against mpox**. This is especially important for groups at higher risk for severe disease (e.g., children under 12 years of age, immunocompromised individuals, and pregnant persons).

The following are measures to reduce transmission of mpox:

- Avoid all contact with high-risk populations; children under 12, pregnant persons, and immunocompromised individuals
- Abstain from direct contact with others, including all sexual contact
- Do not donate blood or any other body fluid (including sperm) or tissue
- Limit unessential visitors
- Limit contact with other household members. This is especially important for groups at higher risk for severe disease outcomes (e.g., children under 12 years of age, immunocompromised individuals, pregnant persons).
- Do not share clothes, bedding, towels, utensils, toothbrushes, razors, sex toys, needles or any other items that may be contaminated with infectious particles from lesions or body fluids.
- Practice frequent hand hygiene and respiratory etiquette. Hand hygiene includes hand washing with soap and water or when hands are not visibly dirty, use of an alcohol-based hand sanitizer. Respiratory etiquette includes covering coughs and sneezes with a tissue or elbow, throwing the used tissue in the garbage, performing hand hygiene immediately after, and wearing medical

mask when around others.

- Consult a health care provider for advice if case must care for an infant (e.g. breastfeeding, single parent, etc.)
- Avoid contact with wild or domestic animals where possible

Recommendations for Environmental Hygiene

See [Appendix B](#)

High-Risk Populations

Immunocompromised individuals, pregnant persons, and children under 12 are at increased risk for poor health outcomes if exposed to mpox. Given the increased risk to these populations, suspect, probable, and confirmed cases must use extra precautions to avoid infecting these high-risk populations and closely follow the public health measures to protect these populations.

Limiting Caregiver Risk

When possible, only one individual in the home or alternative isolation site should provide direct care to the case, when needed (referred to as the “caregiver”).

The caregiver should **not** be someone considered vulnerable to severe mpox disease (e.g., child under 12 years of age, pregnant persons, or immunocompromised individuals).

Caregivers should self-monitor for symptoms for 21 days since their last exposure to the case while infectious (see *Contact Management* section below for further details). If symptoms develop, they should immediately notify Public Health and follow their instructions.

Caregivers should follow public health measures to reduce transmission of mpox.

Health care providers entering the home to provide medical care should follow their organizational occupational health and infection prevention and control protocols. For more information: [Appendix A: Infection Prevention and Control guidance](#).

Exclusions

Cases who meet criteria for isolation discontinuation must continue to isolate away from high-risk populations and associated settings (e.g., elementary schools, childcare settings, health care settings with immunocompromised individuals) until they meet the definition of recovered. *Consult RMOH if case was present in a high-risk setting while infectious.*

Health care facilities will manage patients with mpox based on their own guidelines.
See: [Appendix A: Infection Prevention and Control Guidance](#).

Contact Management

Contact tracing is a key strategy for reducing ongoing transmission of mpox by identifying all contacts exposed during the infectious period.

Public Health will work with cases to collect detailed information regarding potential exposures during their infectious period. As well, will assess level of risk, notify contacts deemed high-risk of their potential exposure, and provide appropriate advice and education as listed below.

Contacts assessed as having a **high-risk exposure** may be eligible for post-exposure immunization with Imvamune vaccine (see below).

Contact tracing efforts may not always be directed at individuals and instead encompass groupings of individuals present in settings (e.g., large events, urban centres, or shared social networks) where high-risk transmission could have occurred. Reaching contacts considered to have high-risk exposure related to settings where contacts are anonymous may require more collaborative and/or outreach approaches (e.g., outreach to communities, business owners, stakeholder engagement, awareness campaign, etc.).

If an individual self-presents to their health care provider with an exposure to a mpox case the health care provider should contact Public Health. Public Health in collaboration with the RMOH, will determine the need for contact management, including eligibility for post-exposure immunization, based on an assessment of the details available.

High-Risk Exposure Criteria:

- Direct contact with a case's skin or mucosa including biological fluids, respiratory secretions, skin lesions, scabs, or drainage
- Direct skin or mucosa contact with a case's unwashed bedding, linens, towels, clothing, lesion dressings, utensils, razors, needles, sex toys, etc.
- Sexual contact with a case
- Interaction with a case within 2 meters, for 3 hours or greater accumulated over 24 hours without the use of a medical mask

Clinical judgment should be used to determine if post-exposure immunization is appropriate for a contact that does not meet the high-risk exposure criteria

Examples of high-risk exposures include:

- Sexual partner
- Household members
- Roommate in a group home or student residence
- Health Care Providers (HCP) without appropriate PPE as per Infection Prevention and Control guidance. HCP should refer to their Occupational Health policies

The following information should be provided to all contacts of probable or confirmed mpox cases:

- **Eligibility regarding post-exposure immunization of high-risk contacts**
- Date of potential high-risk exposure
- Public health measures to reduce transmission
- Self-monitoring for any signs and symptoms for the 21-day period following last exposure, including: fever $\geq 38^{\circ}\text{C}$, new skin rash, chills, and new lymphadenopathy (lymph nodes may swell in the neck (submandibular & cervical), armpits (axillary), or groin (inguinal) and occur on both sides of the body or just one)
- If no symptoms then they can continue routine daily activities (e.g., attend work, school), but are encouraged to wear a medical mask when in contact with others).
- What to do if they develop symptoms (see probable case)
- Encourage contacts to try avoiding medications that are known to lower fever (e.g., acetaminophen, ibuprofen, acetylsalicylic acid) as these medications could mask an early symptom of mpox.

Immunoprophylaxis

Imvamune vaccine is authorized in Canada for active immunization against mpox for adults aged 18 and older. As part of Nova Scotia's mpox prevention strategy, Imvamune is offered as a pre-exposure immunization to individuals who meet eligibility criteria as outlined in the following policies: [Publicly Funded Vaccine/Immunoglobulin Eligibility](#) and [Publicly Funded Vaccine Eligibility for Individuals at High Risk of Acquiring Vaccine Preventable Diseases](#).

Interim Guidance for Post-Exposure Immunization

It is recommended that all high-risk contacts of a confirmed or probable case are rapidly identified and post-exposure immunization should be provided to those eligible. Although Imvamune is authorized for adults aged 18 and older, off-label use in pediatric populations should be considered for those meeting the criteria for post-exposure immunization and may be offered at their clinician's discretion.

Based on Public Health investigation:

- Imvamune vaccine should be offered to asymptomatic individuals with high-risk exposure to a probable or confirmed case of mpox (as defined under *Contact Management*), or within a setting where transmission is happening, if they have not received two doses of Imvamune as pre-exposure immunization.
- Post-exposure immunization with Imvamune should be offered **within 4 days** of exposure; however, it can be offered **up to 14 days** after exposure to potentially prevent or attenuate infection. After 28 days, a second dose of Imvamune vaccine should be offered if mpox infection does not develop regardless of ongoing exposure status.
- Vaccine should **not** be offered to individuals who are symptomatic and who meet the definition of suspect, probable, or confirmed case of mpox or who have a prior history of infection with mpox.
- Individuals who have previously received a live replicating first- or second-generation smallpox vaccine in the past and who sustain a high-risk exposure to a probable or confirmed case of mpox, should be offered a 2-dose series of Imvamune with minimum interval of 28 days.
- Individuals who have only received a single dose of Imvamune vaccine pre-exposure and subsequently sustain a high-risk exposure to mpox should be offered a second dose as soon as possible provided there has been an interval of at least 28 days following the initial dose and if mpox infection does not develop.
- Individuals who received a 2-dose series of Imvamune pre-exposure prophylaxis and subsequently sustain a high-risk exposure to mpox do not require any additional doses.

For more information on Imvamune, including how to access Imvamune, use in special populations, contradictions and precautions, administration, etc. please see:

- [*Nova Scotia Department of Health and Wellness Imvamune Vaccine Information for Healthcare Providers*](#)
- [*NACI Interim guidance on the use of Imvamune® in the context of a routine immunization program*](#)

Please note that provincial immunoprophylaxis guidance is subject to change as new evidence becomes available.

Appendices

Appendix A: Infection Prevention and Control Guidance

[Nova Scotia Health Infection Prevention and Control Mpox Resources](#)

[PHAC Interim guidance on infection prevention and control for suspect, probable or confirmed monkeypox within Healthcare settings - Canada.ca](#)

Appendix B: Recommendations for environmental hygiene

Adopted from [PHAC's Mpox: Recommendations on hand and environmental hygiene](#)

Hand hygiene

Wash hands regularly with soap and water (for at least 20 seconds). If soap and water are not available an alcohol-based hand sanitizer with at least 60% alcohol may be used. Ensure hands are clean before touching common surfaces and objects in the home.

Caregivers should perform hand hygiene:

- before and after contact with the case
- before putting on and after removing gloves, and
- after touching surfaces/items that the case has had contact with.

Disposable glove use

Perform hand hygiene prior to putting on gloves. If gloves become soiled or torn while providing care: remove them, perform hand hygiene and put on a new pair.

Handling laundry

Laundry should be performed prior to cleaning and disinfecting surfaces and objects, to decrease opportunities for cross-contamination.

If possible, the case should be responsible for handling their own laundry (e.g., clothes, towels, bed linens, etc.).

Contaminated laundry must be washed in a standard washing machine using the hottest water setting with detergent and must be completely dried using a high temperature setting in a drying machine. The laundry from a case must be washed separately from the laundry of individuals who do not have mpox.

Contaminated laundry should be transported carefully to avoid dispersing infectious particles in the air or on surrounding surfaces or objects; avoid shaking or handling the contaminated laundry. Dirty laundry should be transported to the washing machine in a basket that can be cleaned and disinfected or in a leakproof disposable garbage bag.

- Clean and disinfect laundry basket as instructed below.
- Put the garbage bag used to transport dirty laundry into a second laundry bag, close securely and properly discard following the waste management instructions below.
- Do not put clean laundry into the laundry basket (before cleaning and disinfecting) or garbage bag used to take dirty laundry to the washing machine.
- Any other surfaces that may have come in contact with contaminated laundry should be cleaned and disinfected after use as described below.

Additional steps for caregivers handling laundry:

- Wear a well-fitting medical mask and gloves. The mask and gloves should be properly disposed of after use and hand hygiene should be performed as described above.
- Ensure the contaminated laundry does not come in contact with skin or clothing
- Cover any skin that could potentially come in contact with the contaminated laundry (e.g., consider wearing long pants, long sleeves, an apron)
- If clothing comes in contact with the contaminated laundry, the clothing should be removed and cleaned in the same manner as the contaminated laundry, and separately from the laundry of individuals who do not have mpox

If laundry must be done outside the home, Public Health should be made aware to review above education and if needed, assist in identifying supports to ensure contaminated items can be laundered appropriately.

Cleaning and disinfecting hard surfaces and objects

It is recommended that surfaces and objects that the case may come in contact with are cleaned and then disinfected after each use, this is particularly important for high- touch surfaces and objects (e.g., tabletops, countertops, faucets, toilets, door handles, light switches, computer keyboards).

If a surface or object is visibly soiled, it should first be cleaned with regular household cleaning products. After cleaning, the surface must be disinfected using a standard household Health Canada approved disinfectant (with Drug Identification Numbers (DIN)) effective against viruses. Ensure manufacturer's instructions, including the required wet contact time, are being followed when using cleaning and disinfectant products.

- Disposable gloves should be worn while cleaning and disinfecting items.
- Hard surfaces and flooring should be cleaned using wet clothes or mops rather than dusted or swept to prevent dispersing virus into the environment.
- Single-use disposable cleaning equipment (e.g. disposable paper towels) is recommended.
- If disposable cleaning materials are not available, reusable cleaning and disinfection cloths may be used but must be laundered after each use following the Handling Laundry section above. Discard the cleaning products after use if unable to launder them.

Additional steps for caregivers:

- Wear a well-fitting medical mask in addition to disposable gloves. The mask and gloves should be properly disposed of after use and hand hygiene should be performed as described above.
- Cover any skin that could potentially come in contact with contaminated surfaces.
- If clothing comes in contact with the contaminated laundry, the clothing should be removed and cleaned in the same manner as the contaminated laundry, and separately from the laundry of individuals who do not have mpox.

Learn more about [surface disinfectants for emerging viral pathogens](#).

After the case has recovered, the rooms they accessed in the home should be cleaned and disinfected. This will lower the potential risk of transmission to other household members or visitors.

Waste management

Where possible, only the case should handle contaminated waste and garbage bags. To reduce the risk to others within the household and those collecting garbage:

- Keep contaminated waste (e.g. bandages, gloves, masks, tissues, food packaging) separate from other household waste in a lined trash can.
- Contaminated waste should be double bagged using a good quality and leak-proof garbage bag, and securely tied.

- When handling garbage bags for disposal, the case or caregiver if needed, should use clean gloves and always practice hand hygiene immediately after following the guidance above.
- Ensure other people, and animals, including rodents, are unable to access contaminated items by placing bags in animal-proof garbage bin until municipal pick-up. If possible, store bins indoors until municipal pick up.

Cleaning furniture and carpets

Avoid vacuuming which can disperse virus into the environment unless the case lives alone, then may use a vacuum with a high-efficiency particulate air (HEPA) filter that is well maintained as per product/user guidelines.

Try to avoid contaminating upholstered furniture and other materials that cannot be laundered by placing coversheets, waterproof mattress covers, blankets, or tarps over them.

Upholstered furniture and carpets should be steam cleaned where possible after all skin lesions have healed.

- Visible soiling can be removed using commercially available cleaning products.
- Clean upholstered furniture and carpets that require removal of visible soil using commercially available cleaning products or professional steam cleaning.

After the case has recovered from mpox, the home should be thoroughly vacuumed without others present, especially if they're at risk of more severe disease from mpox. Follow these steps:

- Spray fabric-safe disinfectant on all upholstered furniture and carpets.
- Vacuum thoroughly with a HEPA filter, if available.
- Ventilate the home for at least an hour by opening windows or doors and turning on bathroom or kitchen fans to help remove any potentially infectious particles and lower the risk of transmission to other household members or visitors.

Cleaning dishware and utensils

The case should not share dishes and utensils. Where possible, the case should handle and wash their own dishes and utensils.

It is not necessary for the case to have dedicated and separate utensils if they are properly washed between uses in a dishwasher or by hand with hot water and soap.

References and Resources

[Mpox - Government of Nova Scotia, Canada](#)

[Mpox: Public health management of cases and contacts in Canada - Canada.ca](#)

[Public Health Agency of Canada Epidemiological summary report 2022-2023 mpox outbreak in Canada](#)

[Mpox: For health professionals - Canada.ca](#)

[Mpox : Outbreak update - Canada.ca](#)

[Public Health Agency of Canada: Risk assessments for public health professionals](#)

[Public Health Agency of Canada: Mpox and animals](#)

[World Health Organization: Mpox fact sheet](#)

[Disease Outbreak News \(who.int\)](#)

[Mpox | Poxvirus | CDC](#)