AfricaCDC
Centres for Disease Control and Prevention

Safeguarding Africa's Health

Mpox Surveillance

REPORTING PROTOCOL FOR AFRICAN UNION MEMBER STATES

August 2024

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Executive Summary

TThe mpox surveillance protocol presents a comprehensive approach to enhancing the detection and monitoring of mpox cases across communities, health facilities, and points of entry. The protocol prioritizes improving data collection, analysis, utilization and cross-border coordination to accelerate outbreak response. The protocol also underscores the importance of genomic sequencing to track the evolution and spread of the mpox virus, urging countries to systematically collect and share genomic data to support global surveillance and outbreak management efforts. The protocol outlines a comprehensive set of variables for case-based and aggregate reporting of mpox cases. It emphasizes the critical importance of timely and accurate reporting to the Africa Centers for Disease Control and Prevention (Africa CDC), establishing specific timelines for both non-endemic and endemic countries. Finally, it encourages countries to routinely monitor their surveillance systems using a set of proposed indicators to evaluate performance and identify areas for improvement. The overall goal of this protocol is to ensure a robust, standardized and coordinated approach to mpox surveillance, enabling early detection, prompt response, and effective management of the disease across Africa. Considering the ongoing public health emergency of continental security (PHECS) declared by the H.E. Dr. Jean Kaseya, Director General Africa CDC, Member States are encouraged to adopt the recommended standards to improve data standardization on the continent.

This document has been reviewed and validated by surveillance focal points from 18 African Union Member States

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Africa CDC is a continental autonomous health agency of the African Union established to support public health initiatives of Member States and strengthen the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats.

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Abbreviations and Acronyms

Africa CDC
Africa Centres for Diseases Control and Prevention

AU
African Union

EBS
Event-based surveillance

IDSR
Integrated Disease Surveillance and Response

IEC
Information, Education, and Communication

POE
Points of Entry

MS
Member States

WHO
World Health Organization

Mpox Surveillance Reporting Protocol for African Union Member States

Introduction

Mpox is a zoonotic infectious disease caused by the monkeypox virus (MPXV). The disease presents symptoms similar to smallpox but with lesser severity. The first human case of mpox was recorded in 1970 in the Democratic Republic of the Congo (DRC) and has subsequently been recognized as an endemic disease in several central and western African countries. There are two known clades of MPXV: clade I, previously called the Congo Basin clade with clade Ia and clade Ib (first identified in 2023) subtypes; and clade II, previously called the West African clade, which includes subclades IIa and clade IIb.

Since 2022, the African continent has been significantly affected by multi-country mpox outbreaks. From 1 January 2022 to 1 August 2024, a total of 42,260 cases and 1,537 deaths of mpox have been reported from 18 AU MS: Benin, Burundi, Cameroon, Central Africa Republic (CAR), Congo, Democratic Republic of Congo (DRC), Egypt, Ghana, Liberia, Morocco, Mozambique, Nigeria, Rwanda, Sudan and South Africa. Compared to 2022, there was a 79% increase in the number of cases reported in 2023. Looking at similar reporting periods in 2023 and 2024, there was a 98% increase in the number of cases reported in 2024 compared to 2023[1]

In 2024, five countries (Burundi, Côte d'Ivoire, Kenya, Rwanda, and Uganda) with no recent history of an mpox outbreak, have confirmed and reported cases of mpox[2]. Initial epidemiological investigations have highlighted cross-border movement as the key driver for spread, with most cases reporting travel history to DRC.

On 13 August 2024, the Africa Centres for Disease Control (Africa CDC) declared the multi-country mpox outbreak a public health emergency of continental security, with strong recommendations to improve surveillance and vaccine deployment in all AU Member States2. On 14 August 2024, the WHO Director-General declared mpox outbreak a public health emergency of international concern (PHEIC)[3].

The emergence of a new strain of clade I (known as clade Ib) has revealed sexual transmission as an additional route propagating the spread amongst high-risk groups (MSM, sex workers and their clients, etc.)[4]. There are currently knowledge gaps in the understanding of the severity and virulence of the new strain; however, initial research and reports from affected countries suggest that the viral mutation found in clade IIb and clade Ib is both necessary for sustained human-human spread and is also associated with less severe disease and a lower case fatality rate.. This situation has called for standardizing and enhancing existing surveillance efforts, especially with regard to data collection and reporting across all AU Member States.

This protocol establishes a standardized approach for enhanced case-based reporting and surveillance of mpox to improve early detection and reporting, and the continental situational awareness of mpox cases. This harmonized approach will improve understanding the outbreak transmission dynamics needed to inform public health decision-making for continental response and control efforts.

The protocol aims to:

1. Enhance existing mpox surveillance in Africa
2. Identify the populations most at risk to guide targeted interventions for mpox prevention and control
3. Accurately provide situational awareness of mpox in Africa
4. Understand the epidemiology, natural history and risk factors associated with mpox

Transmission

MPXV transmits zoonotically from animal-to-human or human-to-human. Transmission between animals and humans occurs from direct contact with infected blood, bodily fluids, lesions or infected fomites and consuming inadequately cooked meat from infected animals. Human-to-human transmission is mostly through close physical contact, including sexual contact and contacts amplified by sustained face-to-face contact, skin lesions, infected fomites, as well as mother-to-child

transmission via the placenta or at birth through close contact[1]

Clade Ia is primarily transmitted via zoonotic infection from a yet-unknown animal reservoir. Children under the age of 15 are over-represented, and this clade is endemic, reflecting this age group's higher risk of encountering small mammalian wildlife. Only limited human-human transmission of this clade has been reported, typically among close household contacts.

Clade Ib has a unique mutation that is associated with sustained human-human transmission and likely emerged within the last several years. Transmission has been highly associated with heterosexual sex networks, and as such, persons >15 years of age are over-represented among these cases. While sexual transmission appears to be driving current epidemiologic transmission cycles, similar to all mpox viruses, close contacts and household members may also become infected.

Clinical Presentation/Features

Symptoms in humans include fever, headache, muscle ache, chills, exhaustion, and swollen lymph nodes. The incubation period from exposure to infection can last between 3 and 17 days. During this time, a person does not have symptoms and may feel fine. Typically, mpox symptoms start within 21 days of exposure to the virus. If you have flu-like symptoms, you will likely develop a rash 1 to 4 days later. The disease is usually self-limiting for healthy individuals, and those vaccinated against smallpox or mpox, and the case fatality rate for clade Ia ranges between 1.4 to 10% while clade II is between 0.1 to 3.6%[5]. Although there is limited information to establish the average case fatality rate, preliminary data for the newly emerged clade Ib, show low death rates amongst infected cases. Immunocompromised individuals are more vulnerable to developing severe forms of the disease[6].

Mpox outbreak surveillance strategies

Enhancing existing surveillance remains one of the key strategies recommended to support the early detection of new cases and provide the needed situational awareness to inform response activities. This protocol recommends enhancing surveillance within communities and health facilities and, at the point of entries, linking these efforts to national and regional laboratories for confirmation.

A. Case-based surveillance in health facilities

Healthcare workers should be trained on the standard WHO case definitions for mpox[7], allowing for prompt detection and appropriate classification of cases. The national level should adopt the standard WHO case definition for mpox and disseminate this definition to all facilities to facilitate detection and reporting. In addition, responsible healthcare workers should use the standardized line list (box 1) to inform case-based data collection efforts in health facilities. This ensures standardized and comparable case reporting across AU Member States.

1 More information available in Africa CDC mpox factsheet 2024

Table 1: WHO Standard Case Definitions*

Suspected case

A person who is a contact of a probable or confirmed mpox case in the 21 days before the onset of signs or symptoms, and who presents with any of the following: acute onset of fever (>38.5°C), headache, myalgia (muscle pain/body aches), back pain, profound weakness, or fatigue;

OR

A person presenting with an unexplained acute skin rash, mucosal lesions or lymphadenopathy (swollen lymph nodes) . The skin rash may include single or multiple lesions in the ano-genital region or elsewhere on the body. Mucosal lesions may include single or multiple oral, conjunctival, urethral, penile, vaginal, or anorectal lesions. Ano-rectal lesions can also manifest as ano-rectal inflammation (proctitis), pain and/or bleeding.

AND

for which the following common causes of acute rash or skin lesions do not fully explain the clinical picture: varicella zoster, herpes zoster, measles, herpes simplex, bacterial skin infections, disseminated gonococcus infection, primary or secondary syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, molluscum contagiosum, allergic reaction (e.g., to plants); and any other locally relevant common causes of papular or vesicular rash.

Probable case

A person presenting with an unexplained acute skin rash, mucosal lesions or lymphadenopathy (swollen lymph nodes). The skin rash may include single or multiple lesions in the ano-genital region or elsewhere on the body. Mucosal lesions may include single or multiple oral, conjunctival, urethral, penile, vaginal, or anorectal lesions. Ano-rectal lesions can also manifest as ano-rectal inflammation (proctitis), pain and/or bleeding. AND One or more of the following:

- has an epidemiological link to a probable or confirmed case of mpox in the 21 days before symptom onset
- has had multiple and/or casual sexual partners in the 21 days before symptom onset
- has a positive test result for orthopoxviral infection (e.g., OPXV-specific PCR without MPXV-specific PCR or sequencing)

Confirmed case

A person with laboratory confirmed MPXV infection by detection of unique sequences of viral DNA by real-time polymerase chain reaction (PCR) and/or sequencing.

*Countries will adopt and adapt the standard case definitions to come up with their customized working case definitions which are based on their epidemiological context

Table 2: Community case definition

Any person with an unexplained, recently appearing skin rash or swollen lymph nodes. The skin rash can include single or multiple lesions in the genital region or elsewhere on the body including the mouth and eyes.

B. Cased-based surveillance in the community

In countries where event-based surveillance (EBS) is not in place or in areas where community health workers have not been trained on EBS, simplified case definitions (Table 2) could be used to help identify cases. Simplified community case definitions could also be used in areas with established community mpox transmission to improve active case finding efforts in communities.

C. Event-based surveillance

Existing EBS efforts could be leveraged to support the early detection and reporting of mpox-related events occurring within the community, at health facilities, or along border regions and at points of entry (POE). The following general signals, or something similar that countries already have in place, can support detection of mpox-related events:

1. **Within the Community:**

   e. Any health-related event that raises concern, fear, and alarm
   f. Unusual or unexpected cluster of disease or death (human or animal)
   g. Severe illness or death in human(s) after contact with a sick or dead animal(s)
   h. Two or more people with an unexplained, recently appearing skin rash
   +/- recent travel history for POE or in countries never reporting mpox

2. **Within a health facility:**

   a. One or more patients with similar illness that do not respond to standard treatment
   b. Large, unexpected, sudden increases in admissions for any illness of the same type, including patients in intensive care units
   c. Illness in a healthcare worker after caring for a

patient(s) with a similar illness

d. For more information on EBS please see the Africa CDC Event-Based Surveillance Framework

D. Surveillance at points of entry

Africa CDC recommends surveillance at all points of entry (POEs) including air, land and sea. Enhanced screening at PoEs can help identify travel-related cases. Africa CDC recommends:

- Screening and sensitization of travellers and conveyance operators. Screening should include detecting symptoms of mpox such as rash, fever, and completing a questionnaire asking for presence of any signs/symptoms or exposure to mpox. Suspected cases should undergo secondary screening which involves an in-depth interview, a focused medical and laboratory examination and should be conducted by a trained health care professional.[8]
- Provided mpox information, education, and communication (IEC) materials to travellers, conveyance operators, and POE staff, as well as targeted risk communication and community engagement.
- Strengthening reporting, collaborations and data sharing mechanisms across borders including establishment or strengthening cross border committees at border districts.
- Training of POE staff & border communities on signal detection and reporting for suspected mpox
- Harmonisation of data collection and reporting tools for the neigbouring Member States on Mpox.

Laboratory Diagnosis

The Africa CDC recommends strict adherence to infection prevention and control guidelines during sample collection, handling, packaging, transportation, and testing in the laboratory[9]. National and international regulations for packaging and transport of infectious substances should be strictly followed. Samples taken from persons with suspected mpox should be safely handled by trained staff working in suitably equipped laboratories using proper IPC measures. Standard personal protective equipment (PPE) for the collection of mpox samples includes gloves, laboratory coats, masks, and eye protection. In certain situations, supplementary PPE, such as face shields or gowns, may be necessary.

Mpox specimen collection: Lesion specimens are preferred sample types for testing, this includes lesion fluid, lesion tissue, lesion crust or skin biopsy. Throat or nasopharyngeal swabs are also suitable specimens for patients with prodromal symptoms who present with no lesions, e.g., a contact who develops symptoms. It is advisable to collect samples from more than one lesion where possible and swabbed vigorously to ensure the collection of adequate samples for testing, however excessive sample collection should be discouraged to minimize risk to healthcare workers or laboratory personnel. Swabs can be transported dry in capped tubes or placed in viral transport media (VTM).

Specimen labelling and storage: Specimens which are suspected to contain mpox virus are handled at a different level of risk as confirmed specimens. Specimens suspected to contain mpox virus may be considered as category B infectious substances and should be labeled with the words 'Biological Substance, category B' on the outer package and must be labelled according to national and international guidelines such as guidelines from WHO and IATA. Although the preferred transport container for a mpox virus specimen is an empty, sterile container, formalin-fixed tissues and paraffin-embedded tissues can be sent for PCR testing. Specimens collected for mpox investigation should be refrigerated 2– 8°C within an hour after collection and for up to 7 days. If transport exceeds 7 days for the sample to be tested, specimens should be stored at -20°C or lower. Longer term specimen storage (>60 days from collection) is recommended at -70°C or lower.

Laboratory testing: Nucleic acid amplification testing (NAAT) is the primary diagnostic tool for mpox. Real-time or conventional PCR is used to detect unique sequences of viral DNA with high sensitivity and specificity. PCR can be used alone, or in combination with sequencing to characterize MPXV clades. Clinical and epidemiological data should be considered, and appropriate and sufficient specimens collection is important for testing.

Virus isolation by cell culture is not recommended as a routine diagnostic procedure and should only be performed in laboratories with appropriate experience and containment facilities. Currently, serology is not being used as a diagnostic modality. Antibody detection from plasma or serum can be used to evaluate exposure and immunity to orthopoxvirus but generally lack to differentiate between orthopoxvirus species reliably. However, IgM detection from acutely ill patients or IgG in paired serum samples, collected at least 21 days apart, with the first being collected during the first week of illness, can determine recent exposure. Recent vaccination may interfere with serological testing.

Genomic Sequencing: It provides a high-resolution view of pathogen evolution and is increasingly sought

after for outbreak investigation and surveillance. In addition to the potential use of sequencing for diagnosis, MPXV genome can provide valuable information to help understand the origins, epidemiology, and characteristics of the virus: for example, the origins of cases which are not part of the clade IIb B.1 lineage that gave rise to the 2022-2023 and ongoing multi-country outbreak or new strains emerging in countries where mpox is known to be endemic.

e. Countries are encouraged to systematically sample and sequence MPXV to characterize the spread and evolution of the virus. Member States with limited sequencing capacity are encouraged to contact AfricaPGI@africacdc.org to facilitate support for in-country or within region sequencing. Sequencing laboratories are encouraged to share all MPXV genome data with the respective Ministries of Health, Africa CDC, WHO, and the global scientific community to enhance national and regional genomic surveillance.

f. **Biosafety requirements:** Following basic biosafety protocols when managing Mpox specimens, which should be processed in biosafety level 2 laboratories is crucial. Furthermore, additional control measures must be established based on the local risk assessment. Specimens obtained from patients suspected of MPXV infection should be manipulated within a properly functioning class II biosafety cabinet. For more information on biosafety requirements please see the WHO Laboratory biosafety manual.

Table 3: Key data variables adapted by Member States for case-based reporting:

Variables	Variable description	Proposed values
1. Case ID:	A unique identifier for each case will be provided based on country preference.	Country specific
2. Demographic information:	Information about Age, gender and occupation	Age (day/month/year) Gender (Male/female) Occupation- in addition to country options include sex worker, unemployed, farmer, truck/long distance driver and students
3. Reporting Country	Country submitting the data.	Country name
4. Facility Name/ Health Area/2nd Subnational level (district)	Lowest administrative unit of occurrence and health facility of treatment	Name of second sub-national level And of health facility
5. Travel history	For countries with no cases, provide travel information outside home country	Yes/NO. If yes list countries within the last 21days
6. Date of Report	Date when the case was reported to health authorities.	Day month and year
7. Date of Onset	Date when symptoms first appeared.	Day month and year
8. Date of Diagnosis	Date when the case was confirmed or reported,	Day month and year
9. Type of test conducted	Type of diagnostic test used for confirmation.	PCR, genomic sequencing, RDT,
10. Testing Laboratory	Laboratory testing and confirming institution	Name of laboratory
11. Genomic sequencing outcome	Type of clade identified	Clade Ia, Clade Ib, Clade IIa or Clade IIb
12. Case Classification	Case category based on standard case definition	Suspected, probable, or confirmed case

13. Vaccination Status	Whether the patient was vaccinated against Mpox or similar diseases (smallpox),	YES/NO If YES, date of both doses
14. Infection Status	Indication of whether the case is new or a reinfection.	New/reinfection
15. Clinical information	Symptoms and complications from the disease	Fever, headache, body pain, back pain, weakness/fatigue, rash, swollen lymph nodes
16. hospitalization status	Indicate whether the case is in-patient or outpatient or selfcare	In patient / outpatient
17. Infection Outcome	(state if it's a community death), recovery, reinfection	Recovered, death in community, death in health facility
18. Co-morbidity	Any other known disease or condition	HIV-AIDs, malnutrition, diabetes, measles etc Viral load for HIV +cases

Table 4: Key data variables required for aggregate data reporting should include:

i. Number of new and cumulative suspected cases
ii. Number of new and cumulative probable cases
iii. Number of new and cumulative confirmed cases (disaggregated by clade)
iv. Number of cases hospitalized
v. Number of new and cumulative deaths (confirmed, probable and suspected)
vi. Number of new and cumulative healthcare workers affected
vii. Number of new and cumulative pregnant woman affected
viii. Number of new and cumulative recoveries
ix. Number of new and cumulative districts affected
x. Number of new and cumulative samples collected
xi. Number of new and cumulative samples tested
xii. Number of new and cumulative samples sequenced
xiii. Number of persons vaccinated
xiv. Number of new and cumulative Contacts identified
xv. Number of contacts lost to follow up
xvi. Number of contacts developed symptoms
xvii. Number of contacts completed 21 days

* The data should be disaggregated by age, sex, comorbidities and occupation

Reporting to Africa CDC

Countries are encouraged to share the case-based data with the African CDC and the WHO using the validated variables of the Member States **(Table 3 and Table 4).** Africa CDC will use this data to mobilize resources, guide

public health action, and establish a continental mpox dashboard to improve awareness and support real-time monitoring of the mpox situation on the continent.

A. Reporting Timelines

i. Non-Endemic Countries

Timely reporting: Probable and confirmed cases should be reported to Africa CDC within 24 hours of detection. Testing and sequencing data should be shared within a maximum of 7 days.

Data format: Agreed variables should be reported through the Africa CDC event management system (EMS) or email in excel format immediately.

ii. Endemic Countries

Timely reporting: Suspected, probable, and confirmed cases should be reported to Africa CDC weekly. Testing and sequencing data should be shared within a maximum of 7 days.

Data format: Agreed variables should be reported through the Africa CDC EMS or on excel daily.

B. Data submission process

Submission of the case-based information should be done by the national surveillance or mpox focal point(s), who will compile the reports and upload into the EMS or forward it to the Africa CDC **ebs@africacdc.org**

C. Data Validation

Automated and manual checks during data collection and submission should be done at national, regional and continental levels to ensure accuracy and consistency

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D. Data Security

Data security and data sharing should adhere to the AU Health Information Guideline and Standards for Digital Health, and AU Member states policies, procedures, and best practices related to data sharing.

National, Regional Communication, Coordination and Feedback

The national focal person will oversee data collection and reporting, ensuring regional and continental guidelines are aligned. Additionally, robust feedback mechanisms will be established to facilitate continuous communication and coordination between national, regional, and continental levels, enhancing the effectiveness of data management and ensuring that guidelines are consistently applied across all levels.

Monitoring and Evaluation Indicators

Countries are encouraged to perform routine monitoring of their surveillance systems to evaluate performance and identify areas for improvement. See below (Table 5) a set of proposed indicators.

Table 5: Mpox surveillance monitoring and evaluation Indicators

- Timeliness of reporting
- Completeness of reporting
- Proportion of suspected cases investigated
- Proportion of suspected cases with laboratory testing performed
- Time from specimen collection to receipt of specimens in the laboratory
- Time from receipt of specimens in the laboratory to provision of results to appropriate authorities.
- Proportion of confirmed and probable cases with complete demographic information
- Proportion of confirmed and probable cases with complete clinical and risk factor information

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Annexes

ANNEX I: Example of Line list Variables for the Democratic Republic of Congo

Investigation

- Epidemiological Number
- Province
- Health Zone
- Health Area
- Date of investigation
- Notification Date

Case data

- Case Status (alive or dead)
- Date of birth
- Age
- Gender (female/male)
- Pregnancy or Breastfeeding (Yes/No)
- Profession (Student, Unemployed, Farmer, House-wife, Out-of-school child without work, Others, Sex worker, Resourceful/Independent, Fisherman, Trader, Teacher/Professor, Hunter, Biker, Military/ Policeman, Staff health, Portefaix, Small business, Civil servant/employee, Driver,
- Health professional (Yes/No)
- Professional Gender (Yes/No)
- Student or Pupil (Yes/No)
- Province of residence
- Residence health zone
- Residence health area
- Village or town of residence
- Avenue of residence

Symptoms that cases present

- Symptomatic (Yes/No)
- Symptom start date
- Rashes (Yes/No)
- Date rashes started
- Maculopapular eruptions (Yes/No)
- Genital Rashes (Yes/No)
- Genital edema (Yes/No)
- Oral Rashes/Ulcers (Yes/No)
- Fever (Yes/No)
- Fever start date
- Scabs/itchy lesions (Yes/No)
- Cough (Yes/No)
- Pruritus (Yes/No)
- Headaches (Yes/No)
- Muscle pain (Yes/No)
- Throat pain (Dysphagia) (Yes/No)
- Joint pain (Yes/No)
- Fatigue (Yes/No)
- Cervical lymphadenopathy (Yes/No)
- Inguinal Adenopathy (Yes/No)
- Axillary Lymphadenopathy (Yes/No)
- Cold Sweats (Yes/No)
- Diarrhea (Yes/No)
- Light sensitivity (Yes/No)
- The bedridden patient (Yes/No)
- Proctitis (Yes/No)
- Conjunctivitis (Yes/No)
- Keratitis (Yes/No)

Medical history

- HIV/AIDS (Yes/No)
- HIV/AIDS treatment (Yes/No)
- Tuberculosis (Yes/No)
- Diabetes (Yes/No)
- Syphilis (Yes/No)
- Other Immunodeficiencies (Yes/No)
- Malnutrition (Yes/No)
- MUAC (in mm)
- Suspected disease (Yes/No)
- History of vaccination for the suspected disease (Yes/No)

Case management

- Mode (outpatient/referred to inpatient)
- Hospitalization(Yes/No)
- Date of hospitalization/Isolation
- Intensive care(Yes/No)
- Treatment Received
- Discharge date
- Discharge Mode
- Date of death
- Scar Smallpox vaccine(Yes/No)
- M Pox vaccine (Yes/No)
- Pox Vaccine Type
- Number of doses Pox vaccine
- Date Pox Vaccine

Risk factors

- Concept of travel within 21 days before the start of the signs (Yes/No)
- Epidemiological link (Yes/No)
- Sexual contact with someone with skin lesions/ Mpox(Yes/No)
- Contact with someone with skin lesions in the household(Yes/No)
- Contact with nursing staff during care (Yes/No)
- Contact with a Human with skin lesions(Yes/No)
- Specify, Other contact with a Human with skin lesions
- Contact with an animal(Yes/No)
- Contact with a squirrel(Yes/No)
- Contact with a Monkey(Yes/No)
- Contact with a Porcupine(Yes/No)
- Contact with wild rodent (Forest) (Yes/No)
- Contact with a pangolin(Yes/No)
- Contact with a bat(Yes/No)
- Contact with another Animal(Yes/No)
- Specify, Contact with another Animal
- Mode of transmission (contact direct/type1, contact sécrétions/type2, dormir/manger/sojourner avec un malade
- Number of Contacts listed
- Number of contacts that have become suspicious
- Investigation report available (Yes/No)

Laboratory

- Sampling taken (Yes/No)
- Blood Collected (Yes/No)
- Sampled Crusts(Yes/No)
- Swabs Collected
- Other sample
- Collection date
- Date the sample was sent to the laboratory
- Date the sample was received at the laboratory
- RDT Mpox
- Diagnostic Test (not known, PCR pox, PCR VZV
- Date of receipt of lab results at the ZS
- Date of feedback to the health facility
- Sequencing (yes/no)
- Clade (I/II/undetermined)
- Diagnostic Test Results (positive/negative)

Additional data

- Final classification (suspect/probable/confirmed by epi/confirmed)
- Symptom-Notification Time (in days)
- Notification-Investigation Time (in days)
- Age Range
- Age Group 2
- Epidemiological Notification Week
- Epidemiological week of onset of symptoms

ANNEX II : List of Member State Experts

No	NAME	COUNTRY
	Abdoulaye Annour Idriss	Chad
	Aden Hussein Ali	Somalia
	Alain Ngandu	DRC
	Alexander Goredema	Zimbabwe
	Ali Abderaman Abdoulaye	Chad
	Assimbo Batch Joseph	DRC
	Boly Diop	Senegal
	Bonface Muigai Waweru	Kenya
	Boubakar Traore	Mali
	Cris Kacita	DRC
	Daouda Chaibou	Niger
	Dr Mucowintore Evelyne	Burundi
	Dr Yacouba Kone	Mali
	Fatoumata Keita	Guniea
	Gahungu Christian	Burundi
	Hiba Abdalrahim Osman	Sudan
	Hunde Merga	Ethiopia
	Iayla Hamadelnile Abdalradi Hassan	Sudan
	Ilanga Mputu Sterlain	DRC
	Joyce Beyamu	Mali
	Kambou Frederic Firmin	Burkina Faso
	Kompguep Mipo Boris	Cameroon
	Mariame Ahmed Ali Said	Cameroon
	Mohamed Ahmed Nur	Somalia
	Mohammed Ahmed Ladan	Nigeria
	Ngbangaie Ngonzou Mermoz Thierry	CAR
	Noel Khunga	Malawi
	Nouhan Camaran	Guniea
	Nyuma Mbewe	Zambia
	Ohelo mulamba ghislain	DRC
	Okello Emmanuel Okunga	Kenya
	Roaa Suliman Musa mawlod	Sudan
	Solomon Kassahun Gelaw	Ethiopia
	Tewabe Manaye Adege	Ethiopia
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