Epidemiological Update Mpox in the Americas Region

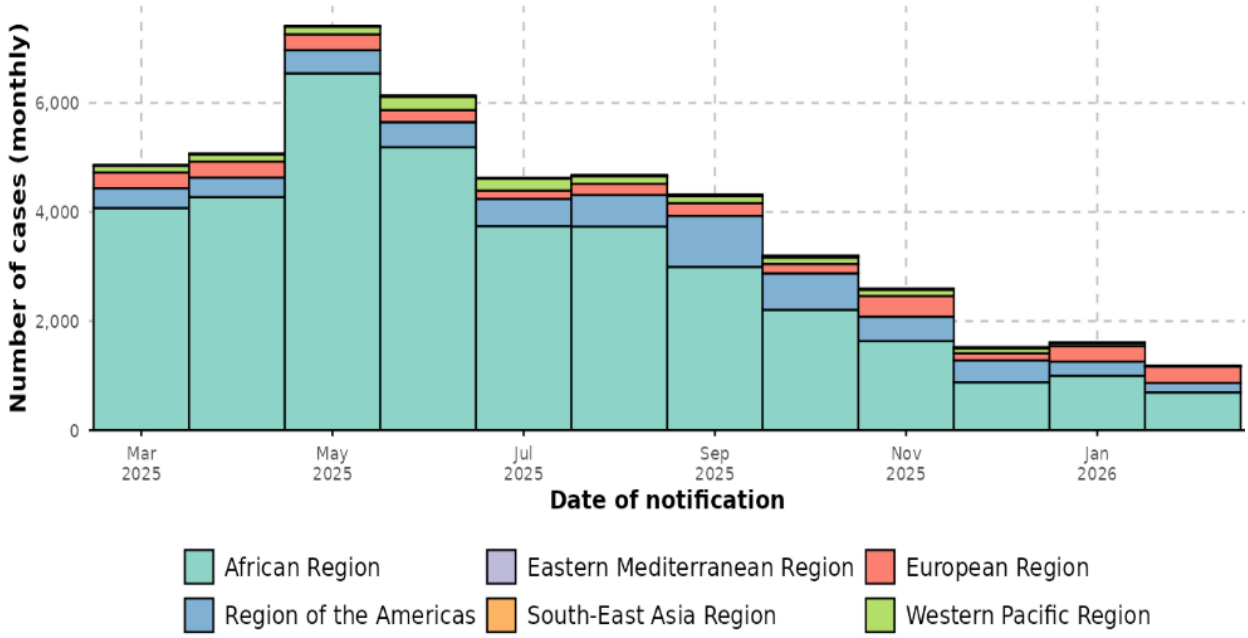
23 April 2026

Summary of the Situation

Globally, between January 2022 and as of 31 March 2026, a total of 181,164 confirmed mpox cases, including 492 deaths, were reported in 144 Member States across the six regions of the World Health Organization (WHO). In 2025, 53,562 cases were confirmed, including 219 deaths. In 2026, as of 28 February 2026, 2,794 confirmed cases of mpox had been recorded, including eight deaths *(1)*.

Over the past 12 months, a gradual decrease in the monthly number of reported mpox cases was observed, primarily due to a decline in reported cases in the African and Americas regions (**Figures 1 and 2**) *(1)*.

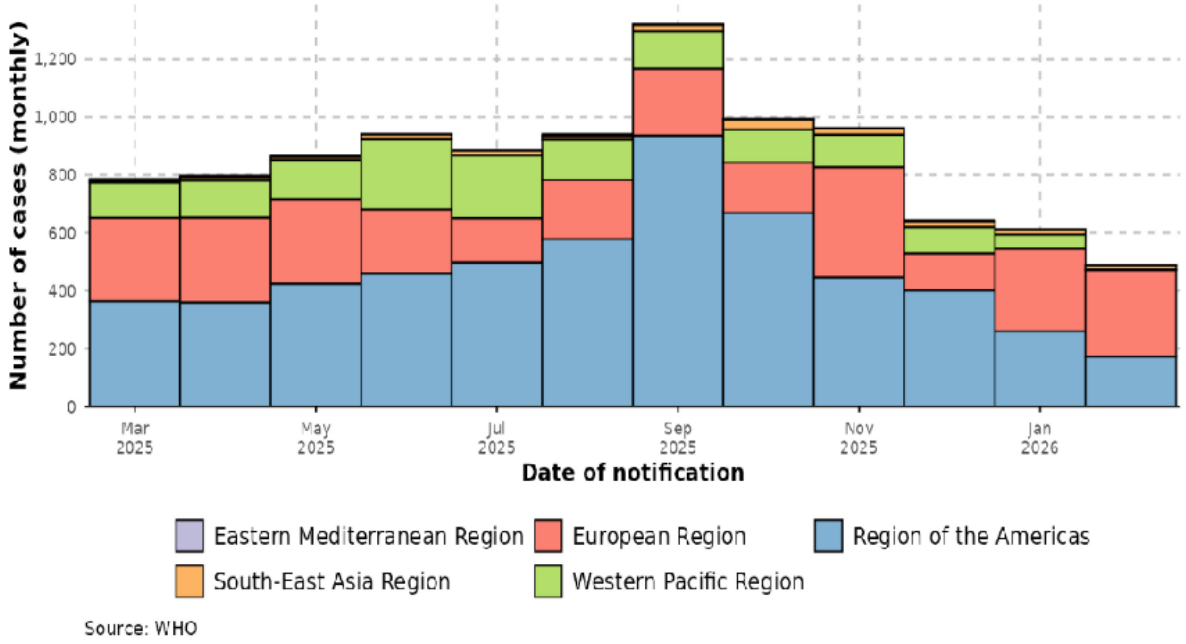
Figure 1. Trend in mpox cases across all WHO regions over the past 12 months, as of 28 February 2026.



Source: World Health Organization. Global Mpox Trends. Geneva: WHO; 2026 [cited 20 April 2026]. Available from: https://worldhealthorg.shinyapps.io/mpx_global/ *(1)*

Suggested citation: Pan American Health Organization/World Health Organization. Epidemiological Update: Mpox in the Americas Region, 23 April 2026. Washington, D.C.: PAHO/WHO; 2026.

Figure 2. Trend in mpox cases in WHO regions (excluding the African Region) over the past 12 months, through 28 February 2026.



Source: World Health Organization. Global Mpox Trends. Geneva: WHO; 2026 [cited 20 April 2026]. Available from: https://worldhealthorg.shinyapps.io/mpx_global/ *(1)*

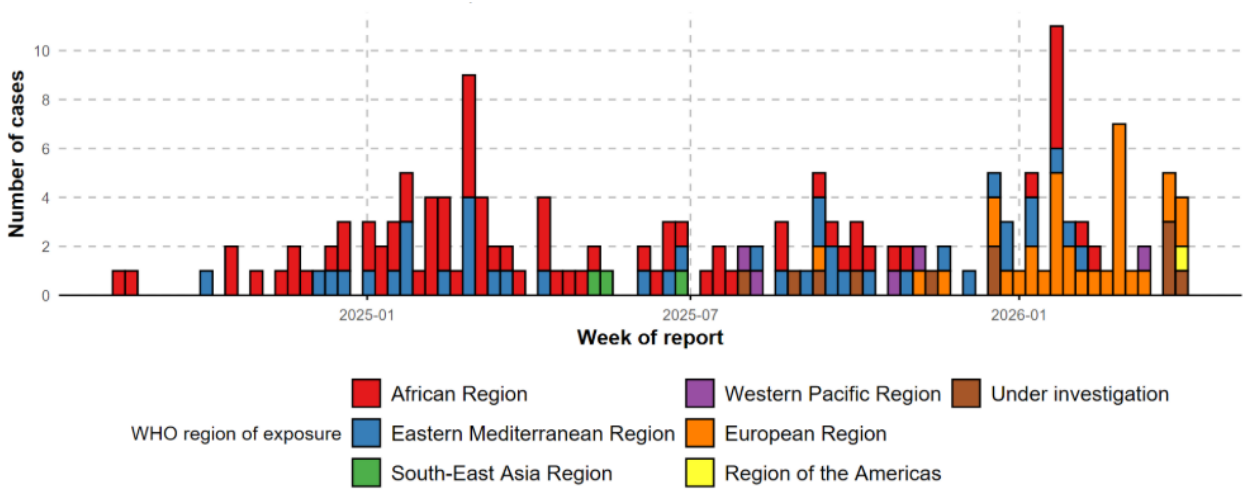
Mpox continues to spread globally, driven by the circulation of various virus clades (Ia, Ib, IIa, and IIb), each with distinct epidemiological characteristics. **Clade IIb** has been primarily responsible for global expansion since 2022, with sustained transmission predominantly through sexual contact, disproportionately affecting men who have sex with men (MSM). Clade IIb continues to account for the vast majority of cases reported outside Africa *(1)*.

Clade Ib, which emerged in 2024 in the Democratic Republic of the Congo, is characterized by a genomic deletion and additional mutations that distinguish it from the endemic clade Ia; its international spread has been driven primarily by the mobility of travelers from areas with active transmission in Africa and, more recently, from European countries with established community transmission *(1)*. Clade Ib has been reported in all regions, including community transmission in 15 countries globally[1], while six other countries reported travel-associated cases (**Figure 3**) *(1)*.

It is important to note that, although both clades can be transmitted through sexual contact, clade Ib has also shown transmission in broader household and community settings in endemic areas. Additionally, recombination between mpox virus (MPXV) clades has been documented, including the recent reporting of two cases associated with a recombinant strain of clade Ib/IIb, underscoring the need for continuous genomic surveillance *(2)*.

[1] Germany, Belgium, Burundi, Comoros, Spain, Kenya, Madagascar, Malawi, the Central African Republic, the Republic of the Congo, the Democratic Republic of the Congo, the United Kingdom of Great Britain and Northern Ireland, Singapore, South Sudan, and Uganda

Figure 3. Number of confirmed cases of travel-related mpox clade I as of 8 April 2026.



Source: World Health Organization. Global Mpox Trends. Geneva: WHO; 2026 [cited 20 April 2026]. Available from: https://worldhealthorg.shinyapps.io/mpx_global/ *(1)*

Situation in the Americas Region

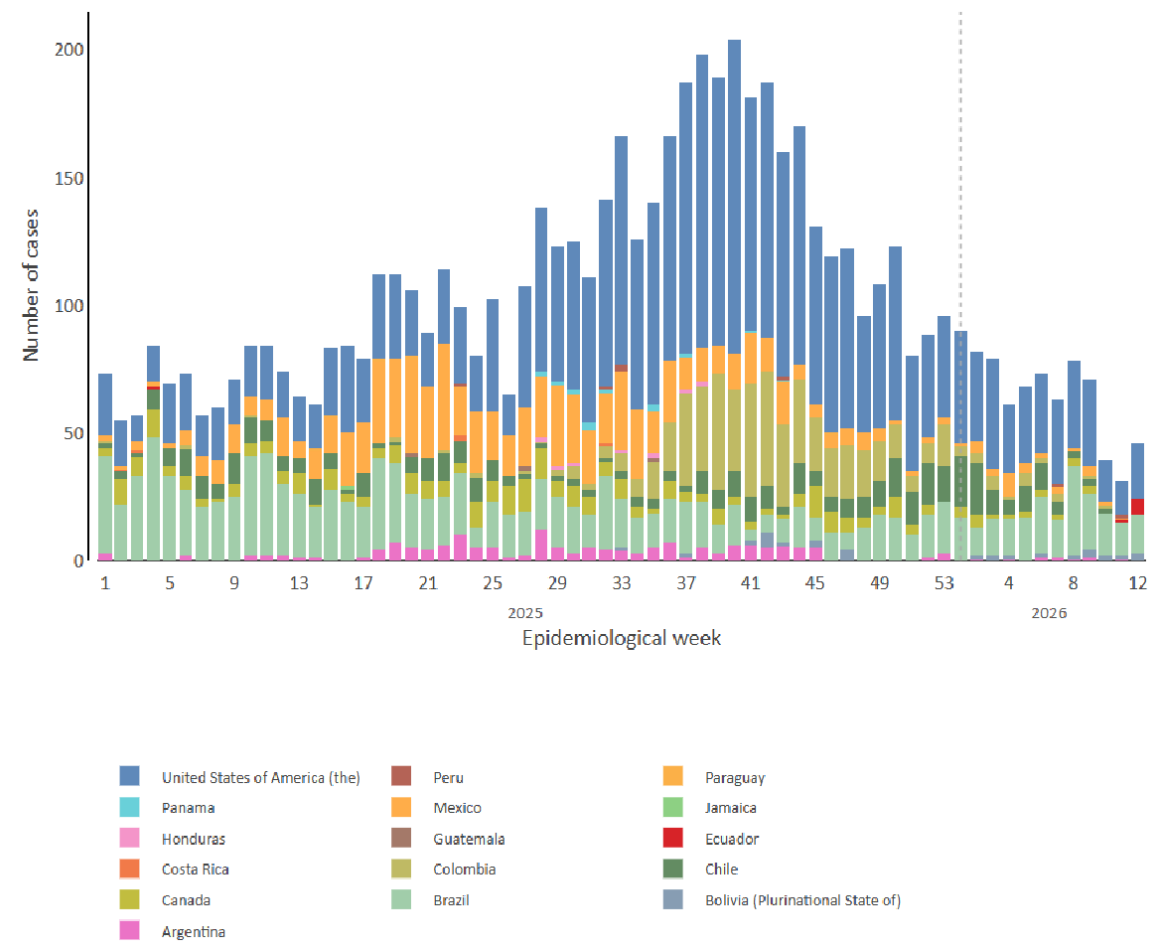
In 2025, between epidemiological weeks (EW) 1 and EW 53, 16 countries in the Americas Region reported a total of 5,774 confirmed cases of mpox, including nine deaths: Argentina (n= 154 cases), Bolivia (n= 19 cases), Brazil (n= 1,053 cases, including three deaths), Canada (n= 299 cases), Chile (n= 362 cases, including one death), Colombia (n= 509 cases), Costa Rica (n= 5 cases), Ecuador (n= 1 case), Guatemala (n= 4 cases), Honduras (n= 9 cases), Jamaica (n= 1 case), Mexico (n= 784 cases, including five deaths), Panama (n= 15 cases), Paraguay (n= 5 cases), Peru (n= 6 cases), and the United States (n= 2,548 cases) *(3–10)*. Almost all of these cases belong to clade IIb, confirming that sustained transmission of this clade — predominantly through sexual contact among MSM— remains the primary driver of the mpox disease burden in the Region. The concentration of cases in five countries (the United States, Brazil, Mexico, Colombia, and Chile, which together account for 91% of regional cases in 2025) reflects the persistence of active transmission chains in urban settings with extensive sexual networks.

In 2026, between EW 1 and EW 12, in the Americas Region, ten countries reported a total of 801 confirmed cases of mpox, including one death: Argentina (n= 7 cases), Bolivia (n= 9 cases), Brazil (n= 214 cases), Canada (n= 24 cases), Chile (n= 88 cases), Colombia (n= 27 cases), Ecuador (n= 7 cases), the United States (n= 390 cases), Mexico (n= 34 cases, including one death), and Peru (n= 1 case) (**Figure 4**). The reporting rate in the first 12 weeks of 2026 (weekly average of 53 cases) remains comparable to that observed in the same period of 2025, indicating that transmission of clade IIb does not show a sustained downward trend and that prevention and control interventions targeting key populations must be maintained and strengthened.

With regard to **clade Ib**, in the Region of the Americas, from epidemiological week (EW) 47 of 2024 to EW 14 of 2026, a total of 29 cases have been reported in six countries in the Region, 15 of which were reported during 2026: Argentina (n= 2 cases), Brazil (n= 4 cases), Canada (n= 4 cases), Ecuador (n= 1 case), the United States (n= 15 cases), and Mexico (n= 3 cases) (3–10). These cases represent less than 0.5% of the regional total, and most have been linked

to a history of travel to areas with active transmission of clade Ib (Africa and, more recently, Europe). However, the detection of cases without a history of travel in the United States and Argentina suggests episodes of limited local transmission that require thorough epidemiological investigation and enhanced genomic surveillance to detect any changes in the transmission pattern early.

Figure 4. Confirmed mpox cases by country and epidemiological week (EW) of symptom onset/notification in the Americas Region*, EW 1 of 2025 to EW 12 of 2026.



***Note**: Includes only countries for which information is available by epidemiological week of symptom onset or notification.

Source: Pan American Health Organization. Mpox Data Set for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 8 April 2026]. Unpublished *(3)*.

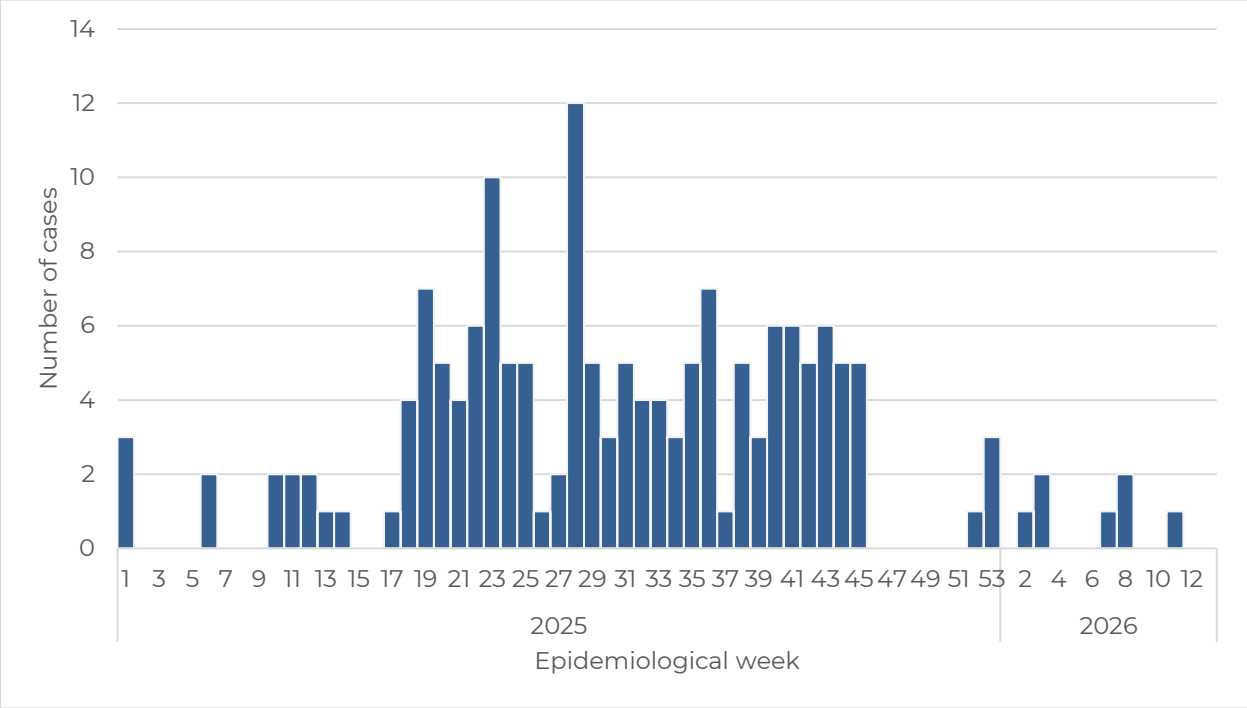
Summary of the situation in selected countries

In **Argentina,** between EW 1 and EW 53 of 2025, 157 confirmed cases of mpox have been reported, with a weekly average of four cases, and no deaths have been recorded (**Figure 5**). Ninety-seven percent of the cases were in males (n= 152 cases), and 83% of the cases were in the 25–49 age group (n= 131 cases). Of the 132 cases with available information, 6% were hospitalized (n= 8 cases) *(4)*.

In 2026, between EW 1 and EW 12, seven confirmed cases of mpox have been reported (**Figure 5**). 100% of the cases were male aged 29 to 39 years. Of the 6 cases with available information, none were hospitalized.

Regarding mpox cases of clade Ib, during EW 8 of 2026, a case was detected with no travel history, no history of mpox vaccination, and no relevant comorbidities. The case reported multiple new and casual sexual partners, including individuals with a history of travel, in the period prior to the onset of symptoms. Management was outpatient, and the case has since recovered. Subsequently, in EW 11 of 2026, a second case of clade Ib was identified, and the case has recovered with outpatient management. The epidemiological investigations for both cases are ongoing *(4)*.

Figure 5. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/reporting. Argentina, between EW 1 of 2025 and EW 12 of 2026.



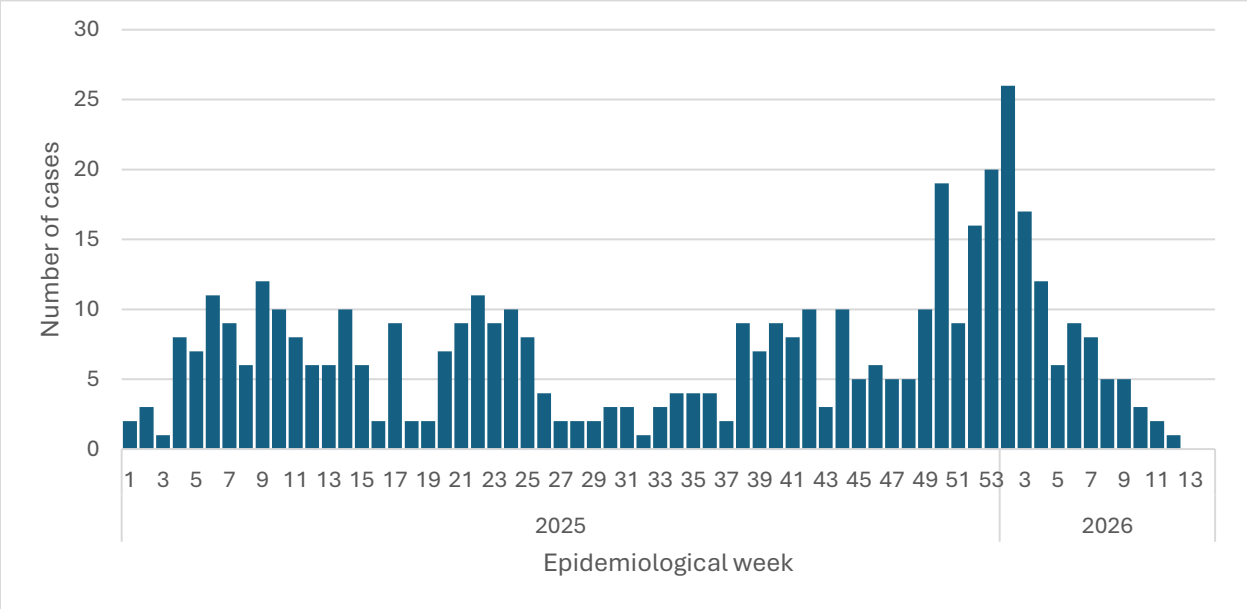
Source: Adapted from the Pan American Health Organization. Mpox dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 6 April 2026]. Unpublished *(3)*.

In **Brazil,** between EW 1 and EW 53 of 2025, 1,071 confirmed cases of mpox have been reported, including three deaths, with a weekly average of 20 cases (**Figure 6**). A total of 95% of the cases were male (n= 1,013 cases), and 45.6% of the cases were in the 30–39 age group (n= 462 cases). Of 954 cases with available information, 7% were hospitalized *(5)*.

In 2026, between EW 1 and EW 12, 214 confirmed cases of mpox have been reported (**Figure 6**). A total of 93.6% of cases were male (n= 201 cases), and 46.3% of cases were in the 30–39 age group (n= 93 cases). Of the 188 cases with available information, 8.5% were hospitalized *(5)*.

Regarding cases of mpox of clade Ib, between EW 1 of 2025 and EW 12 of 2026, four cases were detected, distributed across the states of São Paulo (n= 2 cases) and Rio de Janeiro (n= 2 cases). Of the four cases, one had a history of travel. None of the cases had a history of mpox vaccination, and all have recovered *(5)*.

Figure 6. Confirmed mpox cases by epidemiological week (EW) of symptom onset. Brazil, between EW 1 of 2025 and EW 12 of 2026.



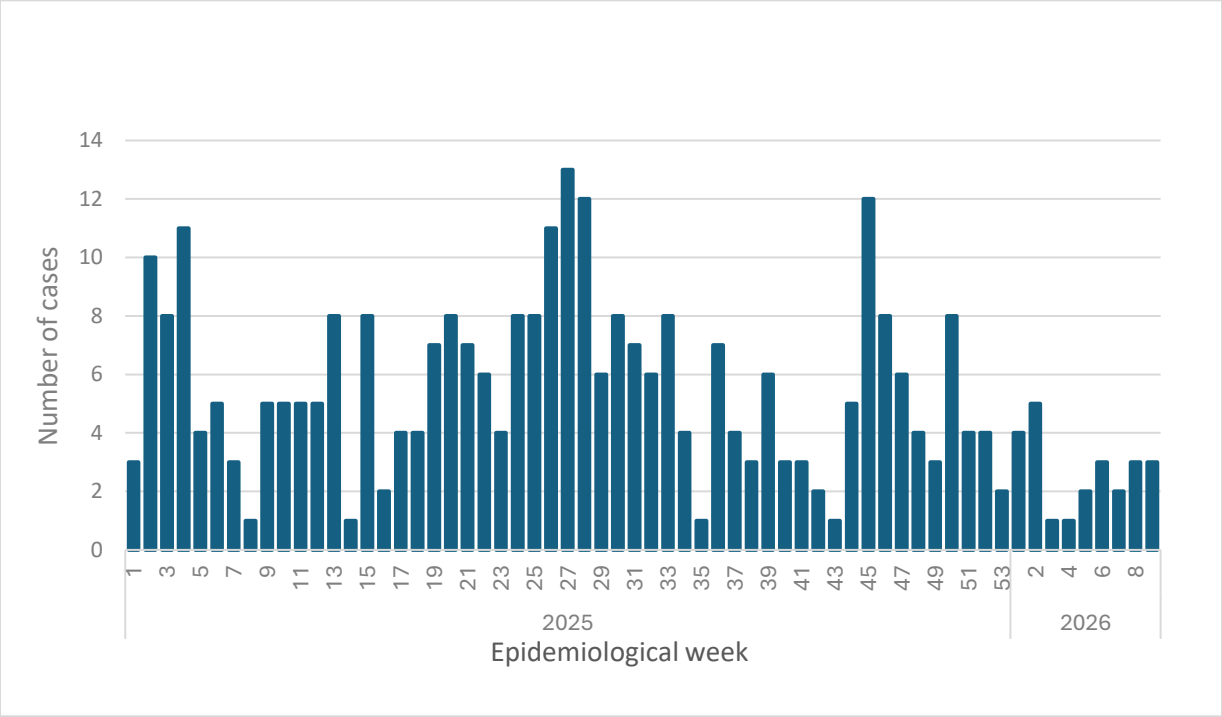
Source: Adapted from the Pan American Health Organization. Mpox Dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 6 April 2026]. Unpublished *(3)*.

In **Canada,** between EW 1 and EW 53 of 2025, 296 confirmed cases of mpox were reported, with a weekly average of six cases (**Figure 7**). Males accounted for 97% of cases (n= 287 cases), and 86% of cases were in the 18–49 age group (n= 247 cases). Of the 295 cases with available information, 1% were hospitalized (n= 3 cases) *(6)*.

In 2026, between EW 1 and EW 12, 24 confirmed cases of mpox have been reported (**Figure 7**). All the reported cases were male (n= 24 cases), and 92% of the cases were in the 18–49 age group (n= 22 cases). Of the 24 cases with available information, 4% were hospitalized (n= 1 case) *(6)*.

Regarding mpox cases of clade Ib, between EW 1 of 2024 and EW 12 of 2026, four cases were detected: two cases in Ontario, one case in Nova Scotia, and one case in Manitoba. Of the four cases, three had a history of travel, and three had a history of vaccination. All cases have recovered *(6)*.

Figure 7. Confirmed mpox cases by epidemiological week (EW) of symptom onset/notification. Canada, between EW 1 of 2025 and EW 12 of 2026.

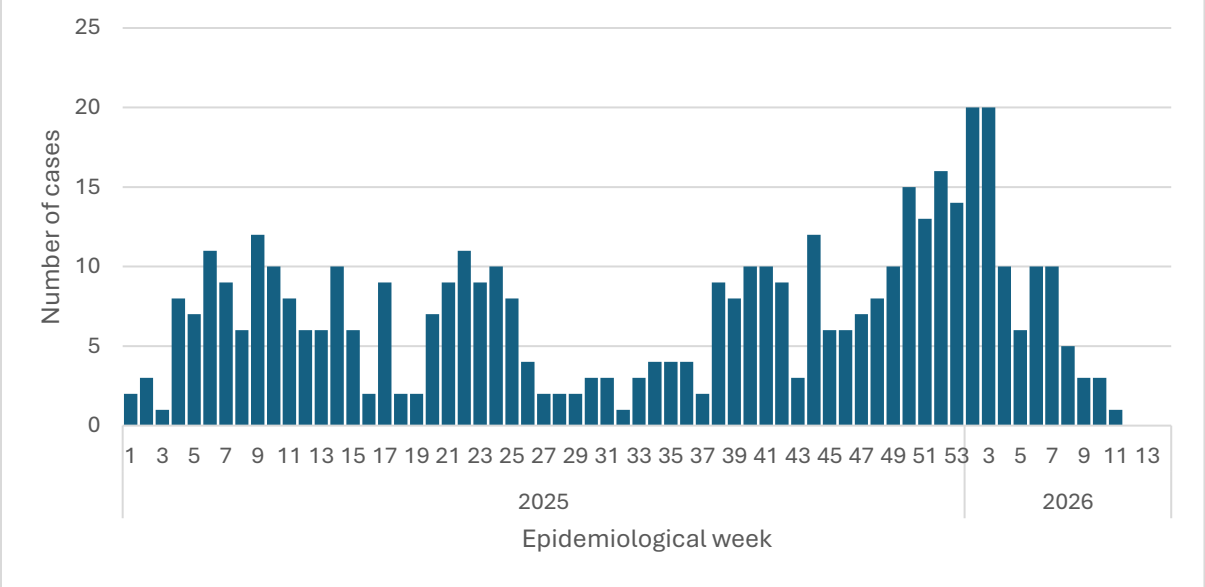


Source: Adapted from the Pan American Health Organization. Mpox Dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 6 April 2026]. Unpublished *(3)*.

In **Chile,** between EW 1 and EW 53 of 2025, 368 cases of mpox have been reported (364 confirmed and four probable), including one death, with a weekly average of seven cases (**Figure 8**). Ninety-nine percent of the cases were male (n= 365 cases), and 49% of the cases were in the 30–39 age group (n= 181 cases). Of 108 cases with available information, 7% were hospitalized for isolation or clinical management of lesions *(7)*.

In 2026, between EW 1 and EW 12, 89 cases of mpox have been reported (88 confirmed and one probable) (**Figure 8**). A total of 99% of the cases were men (n= 88 cases), and of the 85 cases with available information, 45% were in the 30–39 age group (n= 38 cases). Of the total reported cases, no hospitalizations have been recorded to date *(7)*.

Figure 8. Confirmed mpox cases by epidemiological week (EW) of symptom onset/notification*. Chile, between EW 1 of 2025 and EW 12 of 2026.



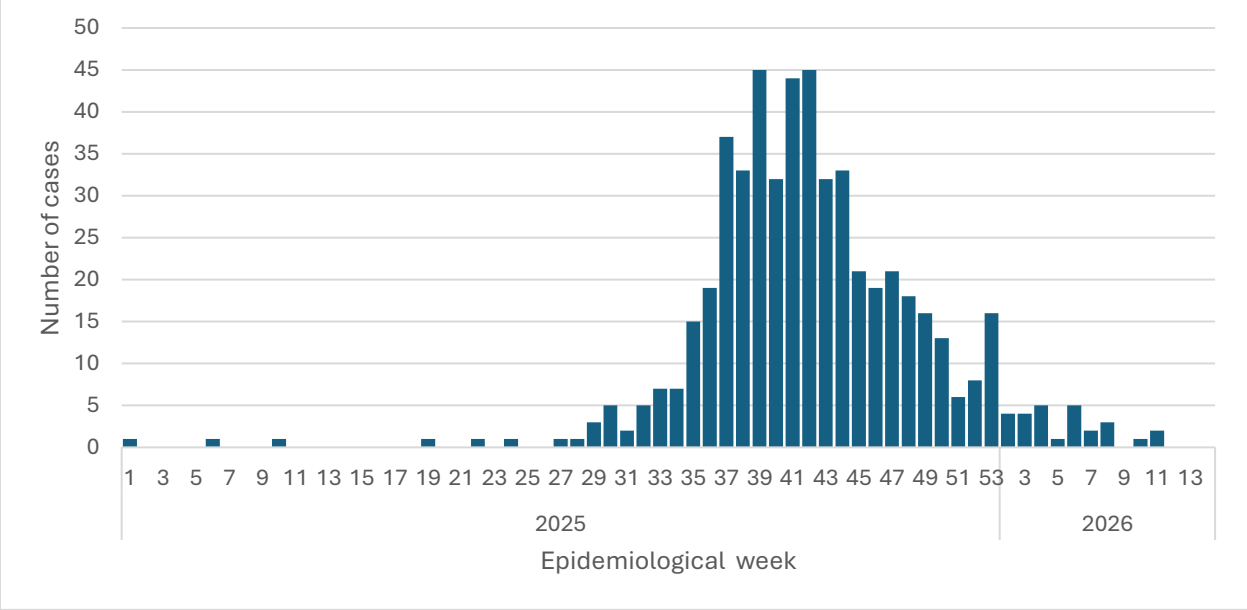
***Identified probable cases are excluded from the graph.**

Source: Adapted from the Pan American Health Organization. Mpox Data Set for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 6 April 2026]. Unpublished *(3)*.

In **Colombia,** between EW 1 and EW 53 of 2025, 510 confirmed cases of mpox were reported, with a weekly average of 10 cases (**Figure 9**). A total of 99% of the cases were male (n= 503 cases), and 45% of the cases were in the 30–39 age group (n= 232 cases). 21% of the cases were hospitalized (n= 107 cases) *(8)*.

In 2026, between EW 1 and EW 13, 29 confirmed cases of mpox have been reported (**Figure 9**). All of the reported cases in 2026 were male (n= 29 cases), and 55% of the cases are in the 30–39 age group (n= 16 cases). Twenty-four percent of the cases were hospitalized (n= 7 cases) *(8)*.

Figure 9. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification. Colombia, between EW 1 of 2025 and EW 13 of 2026.



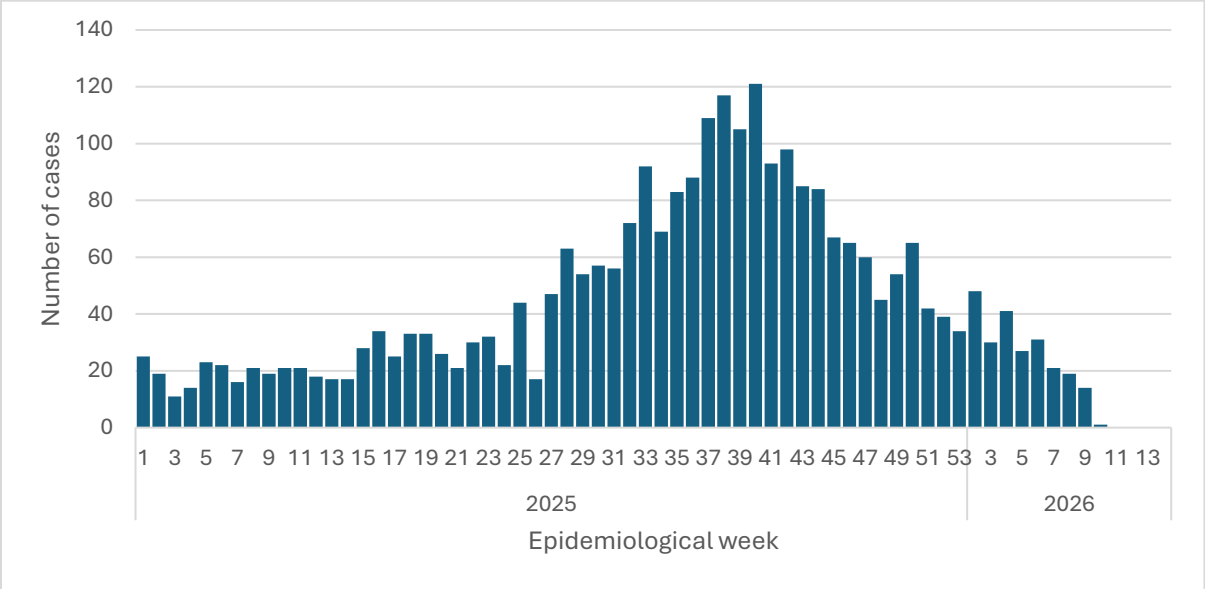
Source: Adapted from the Pan American Health Organization. Mpox Data Set for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 6 April 2026]. Unpublished *(3)*.

In the **United States,** between EW 1 and EW 53 of 2025, 2,559 confirmed cases of mpox have been reported, including one death, with a weekly average of 48 cases (**Figure 10**). Males accounted for 98% of cases (n= 2,111 of 2,159 cases with available information), and 63% of cases were in the 25–40 age group (n= 1,583 of 2,499 cases with available information). Of 2,093 cases with available information, 10% were hospitalized *(9)*.

In 2026, between EW 1 and EW 12, 390 confirmed cases of mpox have been reported, with no recorded deaths (**Figure 10**). A total of 97% of the cases are male, and 58% of the cases are in the 25–40 age group (n= 224 cases out of 387 cases with available information). Of the 284 cases with available information, 8% were hospitalized *(9)*.

Regarding Clade Ib mpox cases, a total of 15 cases were reported in the country. Between November 2024 and February 2026, 11 cases of Clade Ib mpox were reported in the United States. This figure includes three cases of Clade Ib mpox reported in October 2025 in individuals with no history of recent travel. Genomic data indicate that these three cases were linked to a separate case in the United States reported in August 2025 following travel to an area with a known Clade Ib mpox outbreak. In March 2026, four additional cases were reported. These cases are not related to one another. All four cases had a history of travel to an area with active Clade Ib transmission *(9)*.

Figure 10. Confirmed mpox cases by epidemiological week (EW) of symptom onset/reporting. United States, between EW 1 of 2025 and as of EW 12 of 2026.



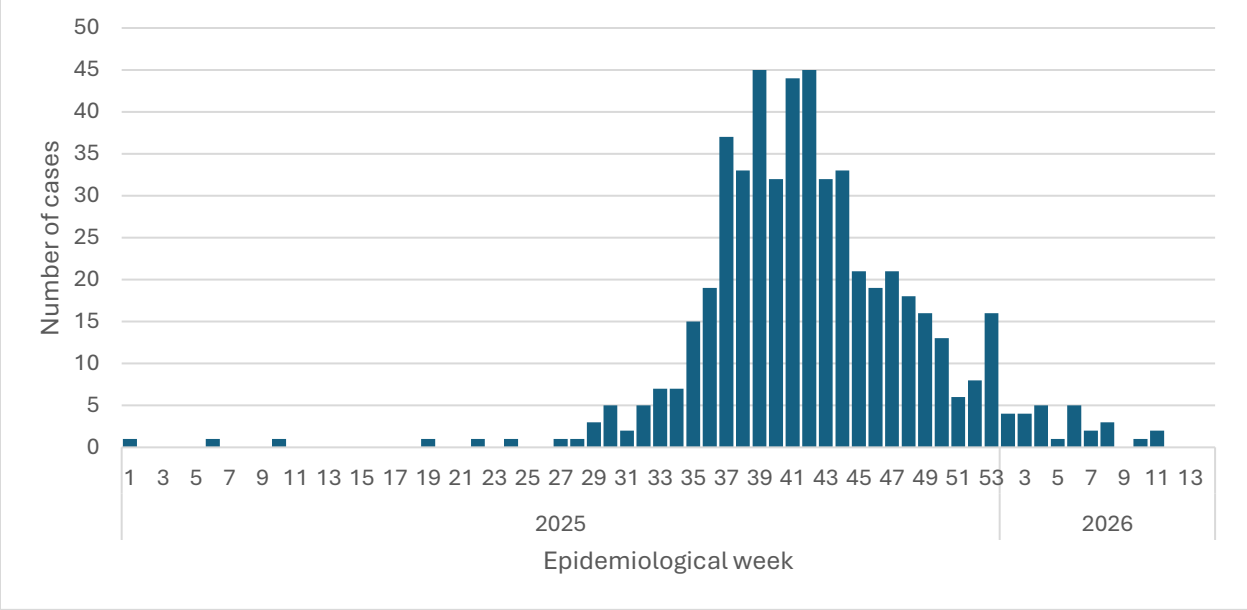
Source: Adapted from the Pan American Health Organization. Mpox Dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 6 April 2026]. Unpublished *(3)*.

In **Mexico,** between EW 1 and EW 53 of 2025 (based on the onset date of the rash), 781 confirmed cases of mpox have been reported, including five deaths, with a weekly average of 15 cases (**Figure 11**). Ninety-nine percent of the cases were in male (n= 776 cases), and 64% of the cases were in the 25–39 age group (n= 502 cases). Of the total confirmed cases, 6% were hospitalized (n= 47 cases) *(10)*.

In 2026, between EW 1 and EW 13, 34 confirmed cases of mpox and one death have been reported (**Figure 11**). All the cases reported in 2026 were male, and 65% of the cases were in the 25–39 age group (n= 22 cases). Of the total confirmed cases, 6% were hospitalized (n= 2 cases) *(10)*.

Regarding mpox cases identified as clade Ib, between EW 1 of 2025 and Ew 13 of 2026, three cases were detected in the states of Guerrero (n= 1 case), Mexico City (n= 1 case), and Puebla (n= 1 case). Of the three cases, only one had a history of travel to Germany, and all three cases had a favorable clinical course, with no criteria for hospitalization, and no secondary cases were identified *(10)*.

Figure 11. Confirmed cases of mpox by epidemiological week (EW) of rash onset. Mexico, EW 1 of 2025 to EW 13 of 2026.



Source: Adapted from the Pan American Health Organization. Mpox Data Set for the Americas Region 2022–2024, information submitted by the International Health Regulations (IHR) National Focal Point (NFP)or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024. [cited 6 April 2026]. Unpublished *(3)*.

Guidance for Member States

On 14 August 2024, the World Health Organization (WHO) declared a Public Health Emergency of International Concern (PHEIC) *(11)* in response to the international spread of mpox cases and the risk of sustained transmission in multiple regions. After observing a reduction in the global impact and the strengthening of surveillance, prevention, and response capacities in affected countries, the end of the PHEIC was announced on 5 September *(12)*. The end of the PHEIC does not eliminate the associated health risk, particularly in a context of continued virus circulation, detection of new clades, and persistence of cases in several regions, making it necessary to maintain surveillance and preparedness measures.

Given the increase in cases of clade I in the Americas Region, health authorities are advised to continue their surveillance efforts to characterize the situation and respond rapidly in the event of the introduction of this or another variant of the virus (MPXV).

Member States are reminded of the key recommendations for surveillance, clinical management, prophylaxis, and risk communication *(13)*.

Surveillance

The primary objective of mpox surveillance and case investigation is the rapid detection of cases and clusters in order to provide appropriate clinical care, isolate cases to prevent further transmission; identify, manage, and follow up with contacts to recognize early signs or symptoms of infection; determine which groups are at highest risk of infection and severe disease; protect frontline health workers; and implement effective control and prevention measures *(14)*.

It is crucial to maintain epidemiological surveillance based on laboratory testing and timely reporting of probable and confirmed cases. This includes monitoring clinical presentations consistent with mpox through existing surveillance programs and implementing clear definitions of suspected, probable, confirmed, and reinfection cases in accordance with current guidelines *(14, 15)*.

Integrating mpox surveillance, detection, prevention, care, and research into programs and services for the prevention and control of HIV and other sexually transmitted infections (STIs) will facilitate early detection of outbreaks, reduce barriers to health services, and improve the response to HIV- r MPXV coinfection *(16)*.

The need for laboratory confirmation and the implementation of genomic surveillance to determine circulating clades and their evolution is reiterated, while also contributing to knowledge by sharing genetic sequence data for relevant public health actions.

Laboratory Diagnosis

In light of the MPXV clade Ib outbreak, previous guidelines for molecular detection and confirmation of suspected mpox cases should remain in place. However, it is recommended to carefully follow the proposed algorithms for differentiating circulating clades and the appropriate identification of clade Ib.

Detection of viral DNA by polymerase chain reaction (PCR) is the laboratory test of choice for mpox. The best samples for diagnosis are those taken directly from the eruptive lesion, including vigorous swabbing of the lesion surface and/or exudate, the upper edges of the lesions, or scabs *(17)*. Lesion swabs are usually sufficient for diagnosis; if swabs are taken from the upper edges or scabs of lesions, sharps injury prevention measures must be strictly followed. In the absence of skin lesions and in the presence of mucosal lesions, oropharyngeal, anal, or rectal swabs may be performed *(17)*. However, while a positive result from an oropharyngeal, anal, or rectal sample is indicative of mpox, a negative result is not sufficient to rule out MPXV infection. Attempting detection in blood is not recommended. On the other hand, antibody detection methods can be used for retrospective case classification, but not for diagnosis. They should be restricted to reference laboratories and may not be useful, as they often do not distinguish between different orthopoxviruses *(17)*.

It has been documented that MPXV clade I, which is currently driving increased transmission in Africa, has a genomic deletion and additional mutations not identified in clade II, leading to its classification as clade Ib *(18)*. Although molecular detection using the recommended generic PCR protocol (for detecting MPXV only) continues to work correctly, the clade I-specific PCR (previously recommended) does not detect the new clade (Ib) of the virus *(18)*. **Therefore, following initial detection using the (generic) detection protocol, if the clade-specific PCR is negative for both clade I and clade II, the samples should be sequenced** *(17)*.

Currently, PCR protocols exist for the specific detection of clade Ib, which can support confirmation in the event of a suspected case that tests positive on the generic MPXV detection assay; however, validation data for these protocols are still lacking, so sequencing is always recommended, particularly for the index case or the first cases detected in an outbreak *(17)*.

Furthermore, the identification of recombinant MPXV can only be confirmed through sequencing; therefore, it is recommended to establish and maintain genomic surveillance for the timely detection of potential changes and evolutionary patterns that may be associated with changes in severity and transmission.

Laboratory guidelines for the detection and diagnosis of mpox virus infection are Available from: https://www.paho.org/en/documents/laboratory-guidelines-detection-and-diagnosis-monkeypox-virus-infection-27-august-2024. *(17)*.

Vaccination

In accordance with the guidelines of the Strategic Advisory Group of Experts on Immunization (SAGE), the use of the mpox vaccine is recommended for groups at high risk of infection. The decision regarding the use of the mpox vaccine and for which specific groups should be determined by each country based on the epidemiology of the disease within its jurisdiction *(19)*.

In May 2022, PAHO's Technical Advisory Group on Vaccine-Preventable Diseases recommended that vaccination should only be offered to close contacts at high risk of exposure to a confirmed case of mpox *(20)*. In this case, the vaccine should ideally be administered within four days of exposure.

In managing the outbreak response, vaccination should be considered an additional measure to complement primary public health interventions. At the individual level, vaccination should not replace other protective measures.

Clinical Management

Identifying mpox cases can be challenging given the similarity to other infections and conditions *(21, 22)*. It is important to distinguish mpox from chickenpox, measles, bacterial skin infections, scabies, herpes, syphilis, other sexually transmitted infections, and drug-related allergies. A person with mpox may also simultaneously have another sexually transmitted infection, particularly syphilis, or have an undiagnosed HIV infection. Alternatively, a child or adult with suspected mpox may also have chickenpox. For these reasons, testing is key to ensuring that people receive appropriate care as soon as possible and to preventing further spread *(22)*.

In cases of sexual transmission, the clinical presentation may be limited to proctitis, urethritis, or pharyngitis, which can sometimes be severe. People with HIV who are not receiving antiretroviral therapy, particularly those with advanced disease (CD4 lymphocyte count below$^{200/mm^3}$), bear a disproportionate burden of morbidity and experience higher mortality. In these patients, chronic necrotizing lesions, proctitis, and severe perianal pain, ocular lesions, and other rare manifestations have been reported *(23)*. Therefore, it is recommended to offer HIV serology testing to all suspected cases of mpox, and if positive, to confirm the diagnosis and initiate antiretroviral treatment as soon as possible. If the HIV test is negative,

individuals at risk of HIV exposure should be identified and referred to services that provide pre- and post-exposure HIV prophylaxis.

During the management of suspected, probable, and/or confirmed mpox cases, early identification is required through screening protocols adapted to local settings. These cases should be isolated immediately, and the rapid implementation of appropriate infection prevention and control (IPC) measures, testing to confirm the diagnosis, symptomatic management of patients with mild or uncomplicated mpox, and monitoring and treatment of complications and severe conditions are required *(22, 24)*.

Patients with mpox presenting with mild or moderate symptoms who can be cared for at home require careful assessment of their ability to safely isolate themselves and maintain the necessary IPC precautions in their home to prevent transmission to other household members and the community. Precautions (isolation and IPC measures) should be maintained until a new layer of skin has formed beneath the scabs *(22, 24)*. The WHO has recently published guidance for home care of mpox cases *(25)*.

Treatment focuses on wound care, pain management, and prevention of complications. At the start of the pandemic, the use of specific antiviral medications, such as tecovirimat, was proposed for severe cases or individuals at higher risk of complications. Based on the limited available information, the WHO had recommended the use of tecovirimat in randomized controlled trials (RCTs) to help generate evidence, and if this is not possible, to use it under the Monitored Emergency Use of Unregistered and Experimental Interventions (MEURI) framework *(24)*. The results of the three main studies (STOMP, PALM007, UNITY) established that tecovirimat is safe, but no clinical benefit from its use has been demonstrated *(27, 28, and 29)*.

Risk communication

Promote the dissemination of public health messages targeting healthcare workers, the general population, and in particular the population at highest risk (men who have sex with men, including those with HIV, as well as people with extensive sexual networks), and those in antiretroviral treatment or pre-exposure prophylaxis (PrEP) programs, in order to inform and educate the target population about prevention measures and improve early recognition, reporting, and rapid initiation of treatment for these cases *(26)*.

Distribute simple information, education, and communication (IEC) materials on transmission, symptoms, prevention, and treatment through various channels (including social media, dating apps, or closed-circuit television in healthcare facilities serving populations with higher prevalence of HIV and other STIs).

Emphasize in key messages that the WHO recommends consistent condom use during sexual activity (oral/anal/vaginal receptive and insertive) for 12 weeks following recovery from a confirmed case, to reduce the potential transmission of mpox through this route, given that this risk is still unknown *(26)*.

Prevent the spread of rumors and false, inaccurate, or incorrect information about mpox. It is important for public health authorities to systematically monitor and analyze information shared on social media to identify key questions and information gaps, and to develop communication strategies based on this analysis. The public should be encouraged to obtain information only from official sources *(26)*.

Continue risk communication and community engagement activities and work with civil society organizations to engage with the most affected key population groups, such as gay, bisexual, and other men who have sex with men, including those living with HIV *(26)*.

References

1. World Health Organization. Global Mpox Trends. Geneva: WHO; 2026 [cited 1 April 2026]. Available from: https://worldhealthorg.shinyapps.io/mpx_global/#1_Overview.
2. World Health Organization. WHO Rapid Risk Assessment - Mpox, Global v.6. Geneva: WHO; 2026. Available from: https://www.who.int/publications/m/item/who-rapid-risk-assessment---mpox--global-v.6
3. Pan American Health Organization. Mpox Case Dashboard - Americas Region. Washington, D.C.: PAHO; 2024 [cited 8 April 2026]. Available from: https://shiny.paho-phe.org/mpox/
4. Argentina International Health Regulations (IHR) National Focal Point (NFP). Communication received on 10 April 2026, via email. Buenos Aires; 2026. Unpublished.
5. Brazil International Health Regulations (IHR) National Focal Point (NFP). Communication received on 9 April 2026, via email. Brasília; 2026. Unpublished.
6. Canada International Health Regulations (IHR) National Focal Point (NFP). Communication received on 10 April 2026, via email. Ottawa; 2026. Unpublished.
7. Chile International Health Regulations (IHR) National Focal Point (NFP). Communication received on 9 April 2026, via email. Santiago, Chile; 2026. Unpublished.
8. Colombia International Health Regulations (IHR) National Focal Point (NFP). Communication received on 10 April 2026, via email. Bogotá; 2026. Unpublished.
9. United States of America International Health Regulations (IHR) National Focal Point (NFP). Communication received on 9 April 2026, via email. Washington, D.C.; 2026. Unpublished.
10. Mexico International Health Regulations (IHR) National Focal Point (NFP). Communication received on 10 April 2026, via email. Mexico City; 2026. Unpublished.
11. World Health Organization. First meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox 2024. Available from: https://www.who.int/news/item/19-08-2024-first-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-upsurge-of-mpox-2024.
12. World Health Organization. Fifth meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox 2024. Available from: https://www.who.int/news/item/30-10-2025-fifth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-upsurge-of-mpox-2024.
13. Pan American Health Organization / World Health Organization. Epidemiological Update Mpox in the Americas Region - 20 December 2024. Washington, D.C.: PAHO/WHO; 2024. Available from: https://www.paho.org/en/documents/epidemiological-update-mpox-americas-region-20-december-2024.
14. World Health Organization. Surveillance, case investigation and contact tracing for mpox (monkeypox): Interim guidance, 20 March 2024. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/WHO-MPX-Surveillance-2024.1.

15. World Health Organization. Fifth Meeting of the International Health Regulations (2005) (IHR) Emergency Committee on the Multi-Country Outbreak of mpox (monkeypox). Geneva: WHO; 2023. Available from: https://www.who.int/news/item/11-05-2023-fifth-meeting-of-the-international-health-regulations-(2005)-(ihr)-emergency-committee-on-the-multi-country-outbreak-of-monkeypox-(mpox).

16. World Health Organization. Fourth meeting of the International Health Regulations (2005) (IHR) Emergency Committee on the Multi-Country Outbreak of monkeypox (mpox). Geneva: WHO; 2023. Available from: https://www.who.int/news/item/15-02-2023-fourth-meeting-of-the-international-health-regulations-(2005)-(ihr)-emergency-committee-on-the-multi-country-outbreak-of-monkeypox-(mpox).

17. Pan American Health Organization. Laboratory guidelines for the detection and diagnosis of mpox virus infection. 27 August 2024. Washington, D.C.: PAHO; 2024. Available from: https://www.paho.org/en/documents/laboratory-guidelines-detection-and-diagnosis-monkeypox-virus-infection-27-august-2024

18. McQuiston JH, Luce R, Kazadi DM, Bwangandu CN, Mbala-Kingebeni P, Anderson M, et al. U.S. preparedness and response to increasing clade I mpox cases in the Democratic Republic of the Congo — United States, 2024. Morbidity and Mortality Weekly Report / May 16, 2024 / 73 (19); 435–440; Atlanta: CDC; 2024. Available from: https://www.cdc.gov/mmwr/volumes/73/wr/mm7319a3.htm

19. Pan American Health Organization. Recommendations for the use of mpox vaccine. 6 October 2025. Washington, D.C.: PAHO; 2025. Available from: https://www.paho.org/en/documents/recommendations-use-mpox-vaccine.

20. Pan American Health Organization. VIII Ad Hoc Meeting of PAHO's Technical Advisory Group (TAG) On Vaccine-Preventable Diseases: Technical Briefing on the Multi-Country Monkeypox Outbreak, 31 May 2022 (virtual). Washington, D.C.: PAHO; 2022. Available from: https://iris.paho.org/handle/10665.2/56116

21. World Health Organization. Atlas of mpox lesions: a tool for clinical researchers, version 28 April 2023. Geneva: WHO; 2023. Available from: https://www.who.int/publications/i/item/WHO-MPX-Clinical-Lesions-2023.1

22. Pan American Health Organization. Guidance on Clinical Suspicion and Differential Diagnosis of Monkeypox. Provisional Technical Note, June 2022. Washington, D.C.: PAHO; 2022. Available from: https://iris.paho.org/items/511325ee-e7ad-478b-bf49-5e1fd3744890.

23. Mitjà O, Alemany A, Marks M, Lezama J, Rodríguez J, Torres M, et al. Mpox in people with advanced HIV infection: a global case series. Lancet. 2023 Mar 18;401(10380):939-949. doi: 10.1016/S0140-6736(23)00273-8. Epub 2023 Feb 21. Erratum in: Lancet. 2023 Apr 8;401(10383):1158. doi: 10.1016/S0140-6736(23)00584-6. PMID: 36828001. Available from: https://pubmed.ncbi.nlm.nih.gov/36828001/

24. World Health Organization. Clinical management and infection prevention and control for monkeypox: Interim rapid response guidance, 10 June 2022. Geneva: WHO; 2022. Available from: https://www.who.int/publications/i/item/WHO-MPX-Clinical-and-IPC-2022.1.

25. World Health Organization. Infection prevention and control and water, sanitation, and hygiene measures for home care and isolation for mpox in resource-limited settings. Geneva: WHO; 2025. Available from: https://www.who.int/publications/i/item/9789240101654

26. World Health Organization. Risk communication and community engagement readiness and response toolkit: mpox, 23 April 2024. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/9789240091559

27. Zucker J, Fischer WA II, Zheng L, McCarthy C, Saha PT, Javan AC, et al. Tecovirimat for the treatment of mpox. N Engl J Med. 2026;394(9):884–895. doi:10.1056/NEJMoa2506495. Available from: https://www.nejm.org/doi/full/10.1056/NEJMoa2506495

28. PALM007 Writing Group. Tecovirimat for clade I MPXV infection in the Democratic Republic of the Congo. N Engl J Med. 2025;392(15):1484–1496. doi:10.1056/NEJMoa2412439. Available from: https://www.nejm.org/doi/full/10.1056/NEJMoa2412439

29. Grinsztejn B. Tecovirimat for mpox – primary clinical outcome results from the randomized part of the Unity clinical trial. Oral presentation given at: Making impact with mpox: Epidemiology and medical countermeasures; IAS 2025. Available from: https://plus.iasociety.org/webcasts/making-impact-mpox-epidemiology-and-medical-countermeasures