Epidemiological Alert Mpox in the Americas Region

24 November 2026

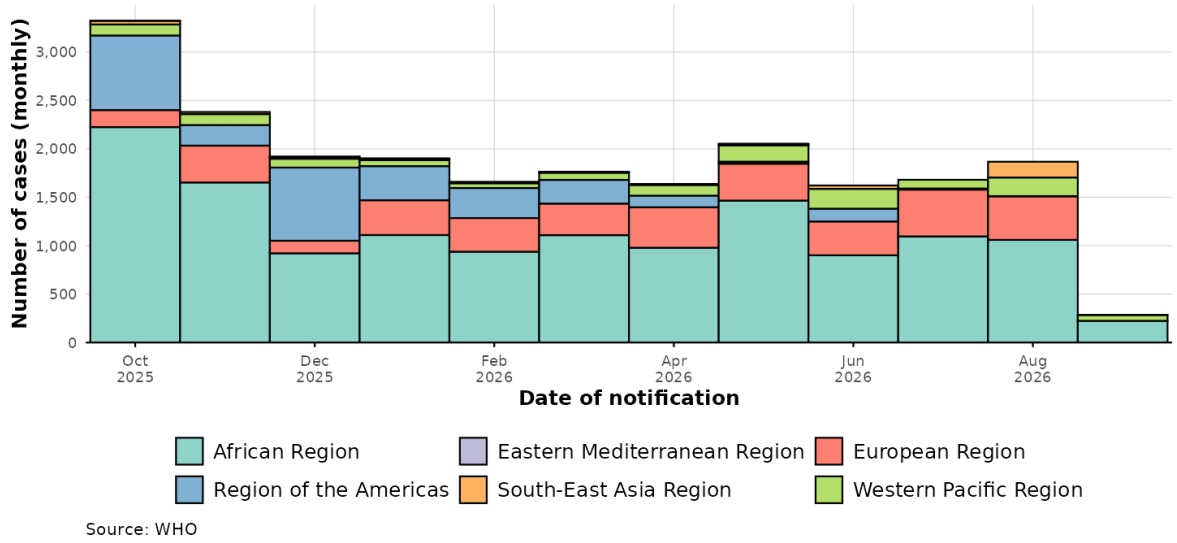
Given the increasing detection and geographic spread of mpox in several countries, the Pan American Health Organization (PAHO) / World Health Organization (WHO) urges Member States to strengthen epidemiological and genomic surveillance to ensure timely detection and investigation of cases, monitor changes in transmission patterns, and reinforce targeted prevention and control measures, particularly among populations at increased risk, including travelers heading to areas with active transmission.

Summary of the Situation

Globally, between 1 January 2022 and 30 September 2026, a total of 193,292 confirmed mpox cases, including 538 deaths, were reported in 146 Member States across the six regions of the World Health Organization (WHO). In 2025, 53,912 cases were confirmed, including 222 deaths. In 2026, as of 30 September 2026, 14,467 confirmed cases of mpox had been recorded, including 52 deaths *(1)*.

Over the past 12 months, a gradual decrease followed by a plateauing of the monthly number of reported mpox cases was observed at global level, primarily due to a decline in reported cases in the African and Americas regions, and a corresponding increase in reported cases in the European region (**Figures 1 and 2**) *(1)*.

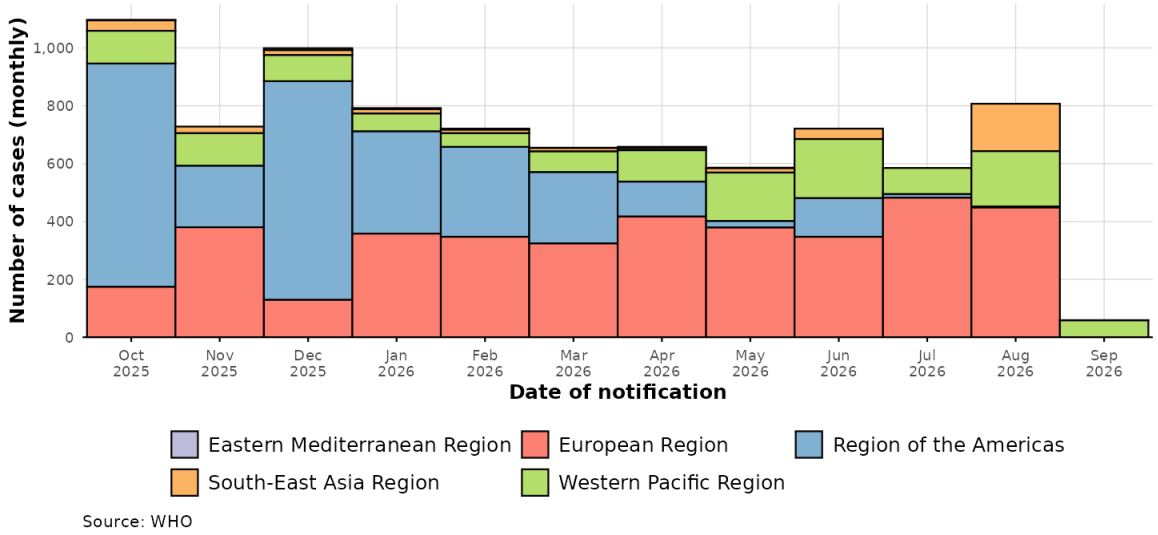
Figure 1. Trend in mpox cases across all WHO Regions over the past 12 months, as of 27 September 2026.



Source: World Health Organization. Global Mpox Trends. Geneva: WHO; 2026 [cited 17 November 2026]. Available from: https://worldhealthorg.shinyapps.io/mpx_global/ *(1)*

Suggested citation: Pan American Health Organization/World Health Organization. Epidemiological Alert: Mpox in the Americas Region, 24 November 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 20 September 2026.



Source: World Health Organization. Global Mpox Trends. Geneva: WHO; 2026 [cited 17 November 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, initially detected in September 2023 in the Democratic Republic of 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 WHO regions, including active community transmission in six countries in the African region[1], while 51 other countries reported travel-associated cases *(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 multiple African countries. Additionally, recombination between mpox virus (MPXV) clades has been documented, with three cases associated with a recombinant strain of clade Ib/IIb, underscoring the need for continuous genomic surveillance *(1-2)*.

[1] Angola, Burundi, Kenya, Madagascar, the Democratic Republic of the Congo, South Sudan

Situation in the Americas Region

From 2022 through 20 November 2026, 76,084 confirmed mpox cases, including 202 deaths, were reported across 31 countries and territories in the Americas Region. Among the 114 deaths with available information on HIV status, 97.37% (111 of 114 deaths) occurred in people living with HIV *(3)*.

In 2026, between epidemiological week (EW) 1 and EW 43, in the Americas Region, 13 countries reported a total of 3,269 confirmed cases of mpox, including four deaths: Argentina (n= 24 cases), Bolivia (n= 16 cases), Brazil (n= 1,325 cases, including one death), Canada (n= 108 cases), Chile (n= 143 cases, including one death), Colombia (n= 64 cases), Costa Rica (n= 5 cases), Ecuador (n= 8 cases), Jamaica (n= 1 case), Mexico (n= 107 cases, including two deaths), Paraguay (n=1 case), Peru (n= 10 cases), and the United States of America (n= 1,457 cases) (**Figure 3**). The reporting rate in the first six months of 2026 remains comparable to that observed in the same period of 2025, but an increasing trend starting from EW 39 of 2026 onwards, primarily reported in Brazil indicates a localized resurgence of cases. A concomitant increase in the detection of mpox clade Ib suggest a shift in the epidemiology of that clade in Brazil, from travel related only cases to an apparent community transmission. Prevention and control interventions targeting key populations are still the primary means of management and must be maintained and strengthened *(3)*.

With regard to **clade Ib**, in the Americas Region, from EW 47 of 2024 to EW 46 of 2026, more than 380 cases have been reported in 11 countries in this Region, more than 360 of which were reported during 2026: Argentina (n= 14 cases), Brazil (n= 43 cases), Canada (n= 34 cases of clade I mpox, with 30 confirmed cases of clade Ib), Chile (n= 20 cases), Colombia (n= 23 cases), Costa Rica (n= 2 cases), Ecuador (n= 1 case), Mexico (n= 30 cases), Peru (n= 2 cases), Paraguay (n= 1 case), and the United States (n= >200 cases of clade I mpox) *(3–14)* (**Table 1**). 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) *(3-14)*.

The **United States** Centers for Disease Control and Prevention (CDC) reports more than 200 clade I cases in at least 31 states and Puerto Rico since November 2024, including travel-related cases. Since August 2026, cases with presumed domestic transmission have been reported in at least 16 jurisdictions, which indicates a transition to sustained clade Ib transmission *(14)*.

Brazil reports a total of 43 clade Ib cases in Rio de Janeiro, corresponding to the increasing trend in Brazil in the last eight weeks *(5,15)*.

Canada continues to report an increasing number of clade Ib cases, most related to international travel, but with recent patterns indicating ongoing community transmission of cases *(6)*.

Colombia reported 23 cases of confirmed clade Ib mpox in 2026, of which 18 cases were reported in the last three months. While initial cases had history suggestive of transmission linked to international travel, the most recent cases had no relevant travel history, suggesting community transmission in the country *(8)*.

Mexico also reports an increasing trend of clade Ib mpox detection, with 22 of 30 reported cases being identified in the last two months. Only 13 remain linked to international travel, while others are still under investigation for the source of transmission *(11)*.

Chile, Costa Rica, Ecuador, Paraguay, and Peru reported the first confirmed clade Ib cases in the country in the last six months, with almost all reported cases linked to international travel *(7,9,10,12,13)*.

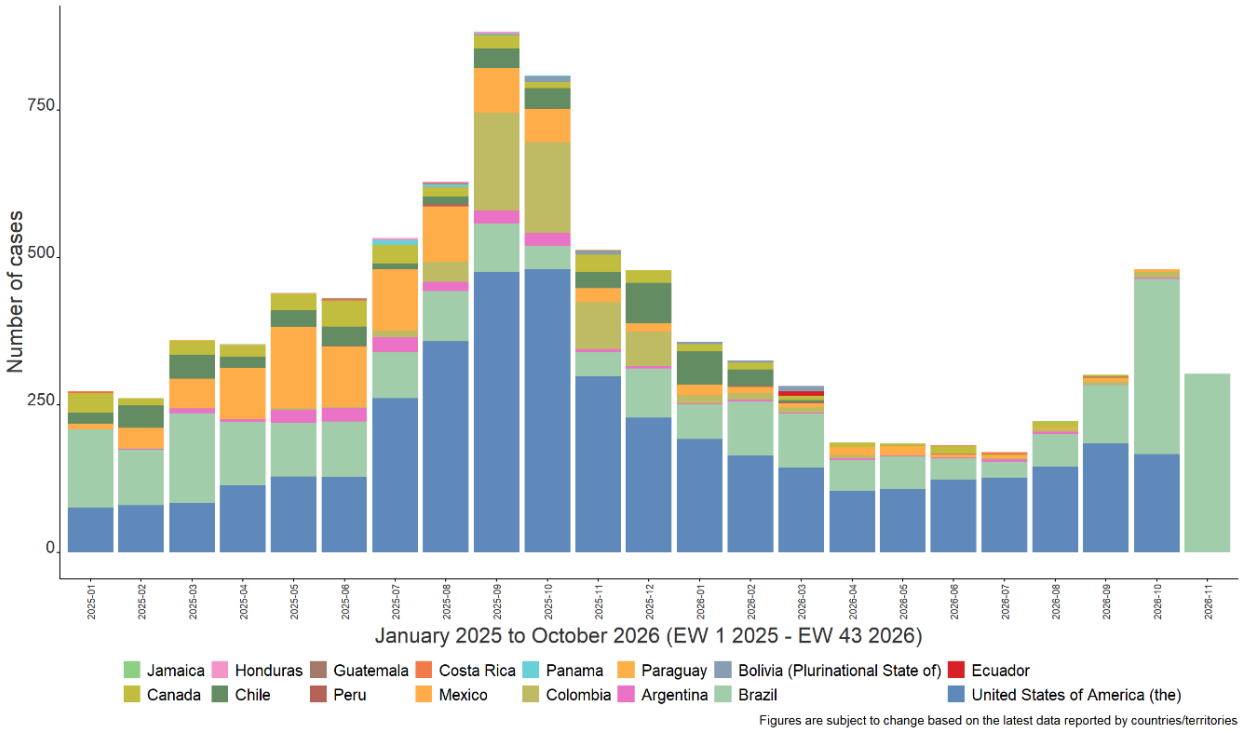
However, the detection of cases without a history of travel suggests episodes of sustained transmission in the United States and possible community transmission in Canada and Colombia that require thorough epidemiological investigation and enhanced genomic surveillance to detect any changes in the transmission pattern early.

Table 1. Reported mpox clade I and confirmed clade Ib cases by country, EW 47 of 2024 to EW 46 of 2026.

Country	**Reported Clade I cases**	**Confirmed Clade Ib cases**	**Transmission Status**
Argentina	14	14	Under Investigation
Brazil	43	43	Under Investigation
Canada	34	30	Emerging evidence of community transmission
Chile	20	20	Under Investigation
Colombia	23	23	Emerging evidence of community transmission
Costa Rica	5	5	Under Investigation
Ecuador	1	1	Under Investigation (imported)
Mexico	30	30	Under Investigation
Peru	2	2	Under Investigation
Paraguay	1	1	Under Investigation
United States of America	>200	Not published	Sustained Clade Ib transmission

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 18 November 2026]. Unpublished *(3-14)*

Figure 3. Confirmed mpox cases by country and month of symptom onset/notification in the Americas Region, January 2025 to October 2026 (EW 1 of 2025 to EW 43 of 2026) *.



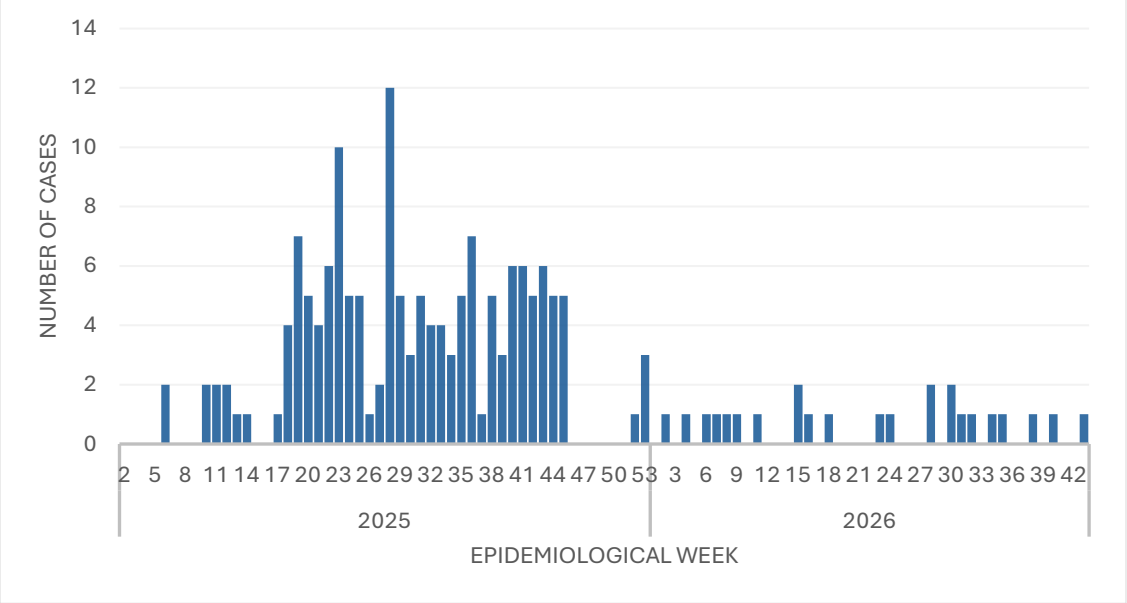
***Note**: Includes only countries for which information is available by epidemiological week of symptom onset or notification. The United States changed its public reporting of mpox cases from epidemiological week–based reporting to monthly reporting. To maintain consistency with the weekly database, monthly case counts have been assigned to the last epidemiological week of each corresponding month. Data for Brazil includes EW 44 to EW 46 of 2026

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 18 November 2026]. Unpublished *(3)*.

Summary of the situation in selected countries

In **Argentina**, between EW 1 and EW 43 of 2026, 24 confirmed cases of mpox (22 clade IIb and 2 clade Ib) have been reported (**Figure 4**). Of the cases with available information, 96% were male between the ages of 24 to 53 years. Of the 18 cases with available information, three were hospitalized. In 2026, 14 cases of mpox clade Ib were reported in the country *(3,4)*.

Figure 4. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/reporting, Argentina, between EW 1 of 2025 and EW 43 of 2026.



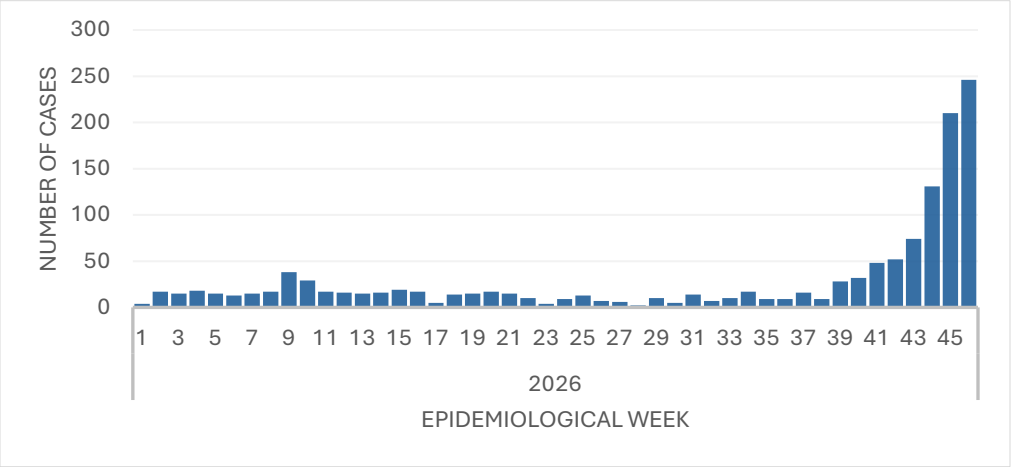
Source: Adapted from the Pan American Health Organization. Mpox dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 18 November 2026]. Unpublished *(3)*.

In **Brazil,** between EW 1 and EW 46 of 2026, 1,325 confirmed cases of mpox have been reported, along with one death (**Figure 5**). An upward trend of cases has been observed since EW 39, with 246 cases being reported in EW 46. This increase is primarily driven by a significant rise in cases in Rio de Janeiro, accompanied by a moderate increase in Ceará, the Federal District, and São Paulo, compared to the same period in 2025. Additionally, after two years with no recorded cases, one case was identified in EW 46 in the state of Roraima, which borders Venezuela *(5)*.

A total of 96% of cases occurred in males, and 50% of cases were recorded in the 30–39 age group. Of the 1,306 cases with available information, 11.5% were hospitalized *(5)*.

Regarding the clade, specifically in Rio de Janeiro, among 62 individuals for whom information was available between September and October—43 were infected with mpox clade Ib and 19 with mpox clade IIb *(5, 15)*.

Figure 5. Confirmed mpox cases by epidemiological week (EW) of symptom onset, Brazil, between EW 1 and EW 46 of 2026.

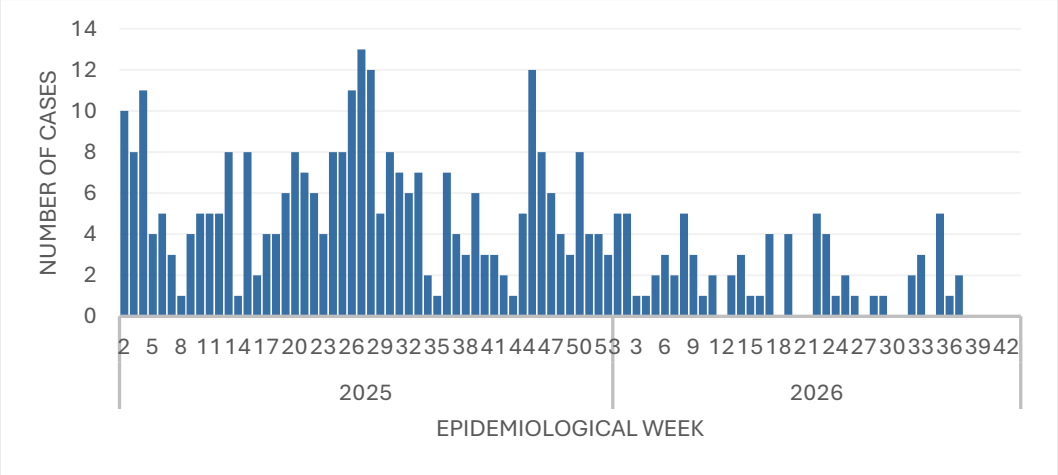


Source: Adapted from the Pan American Health Organization. Mpox dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 18 November 2026]. Unpublished *(3)*.

In **Canada**, between EW 1 and EW 41 of 2026, 108 confirmed cases of mpox have been reported (**Figure 6**). Almost all reported cases (95.4%) were male, and 93.5% of the cases were in the 18–49 age group (n= 101 cases). Of the 106 cases with available information, 5.7% were hospitalized (n= 6 cases) *(6)*.

Most cases had a history of international travel or epidemiological link to travelers, while others indicate history suggestive of community transmission of the clade Ib virus *(6)*.

Figure 6. Confirmed mpox cases by epidemiological week (EW) of symptom onset/notification, Canada, between EW 1 of 2025 and EW 43 of 2026.

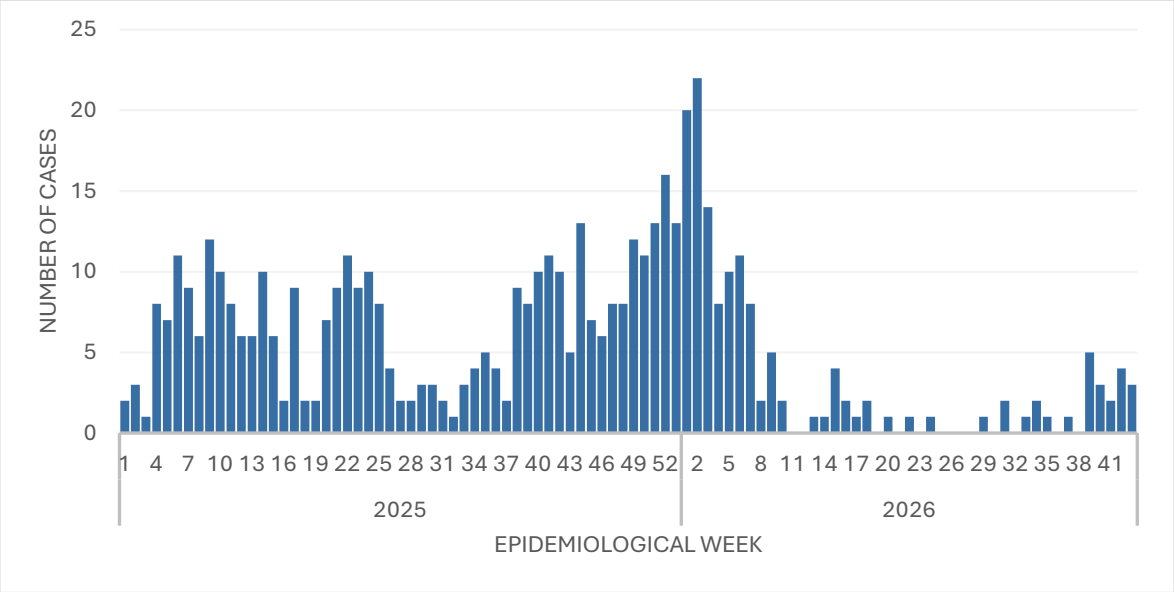


Source: Adapted from the Pan American Health Organization. Mpox dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 18 November 2026]. Unpublished *(3)*.

In **Chile**, between EW 1 and EW 43 of 2026, 143 cases of mpox have been reported (**Figure 7**). A total of 99% of the cases were men (n= 142 cases), and 46% were in the 30–39 age group (n= 66 cases). Of the total reported cases, one hospitalization has been recorded to date *(7)*.

Chile has reported 20 cases of clade Ib mpox, of which seven cases have a history of travel to Europe and America, indicative of travel-acquired infection *(7)*.

Figure 7. Confirmed mpox cases by epidemiological week (EW) of symptom onset/notification, Chile, between EW 1 of 2025 and EW 43 of 2026.

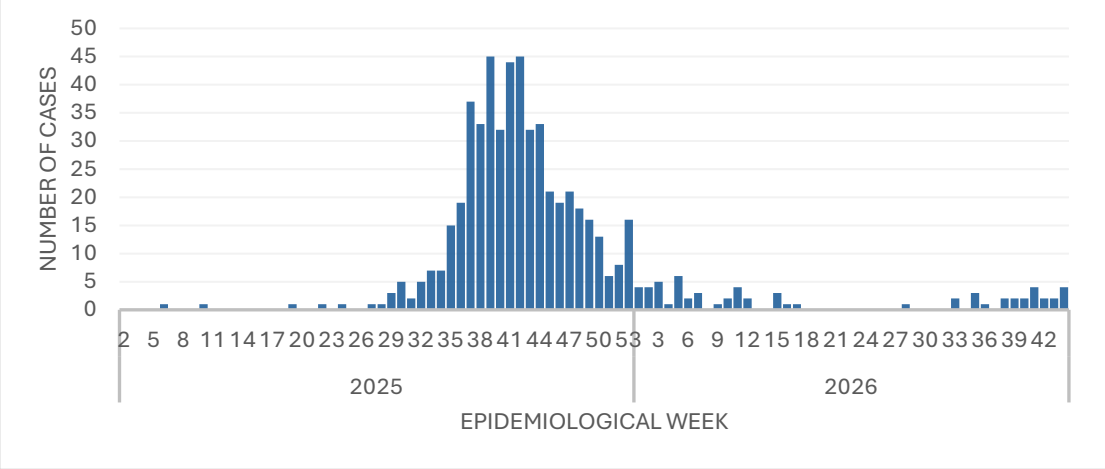


Source: Adapted from the Pan American Health Organization. Mpox dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 18 November 2026]. Unpublished *(3)*.

In **Colombia**, between EW 1 and EW 44 of 2026, 64 confirmed cases of mpox have been reported (**Figure 8**). All reported cases in 2026 were male (n= 64 cases), and 50% of the cases are in the 30–39 age group (n= 32). Of the total number of cases, 12 were hospitalized *(8)*.

Colombia has confirmed 23 cases of clade Ib mpox, of which 18 cases were reported in the last eight weeks. Regarding the geographic distribution, cases were reported in Bogotá (n = 18), Antioquia (n = 3), Cundinamarca (n = 1), and Risaralda (n = 1). While the initial cases had a history of travel, the most recent cases had no relevant travel history, suggesting community transmission of clade Ib *(8)*.

Figure 8. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification, Colombia, between EW 1 of 2025 and EW 44 of 2026.

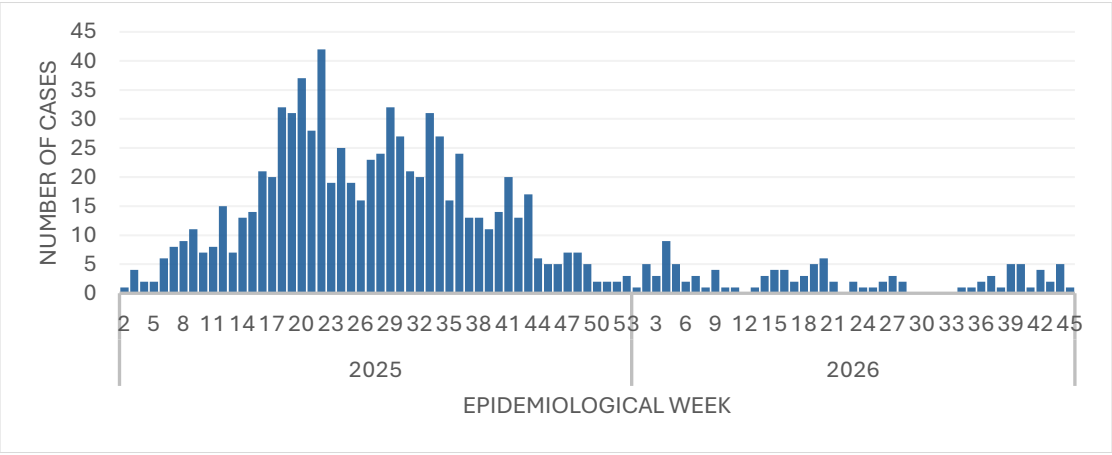


Source: Adapted from the Pan American Health Organization. Mpox dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 18 November 2026]. Unpublished *(3)*.

In **Mexico**, between EW 1 and EW 45 of 2026, 107 confirmed cases of mpox and two deaths have been reported (**Figure 9**). All the cases reported in 2026 were male , and 61% of the cases were among the 25–39 age group (n= 65 cases) *(11)*.

Regarding mpox cases identified as clade Ib, between EW 1 of 2025 and EW 45 of 2026, 30 cases were detected in the states of Aguascalientes (n= 2 cases), Baja California (n= 2 cases), Coahuila (n= 1 case), Guerrero (n= 1 case), Mexico City (n= 11cases), Jalisco (n= 1 case), Nuevo León (n= 10 cases), Puebla (n= 1 case), and Sonora (n= 1 case). Of these, 22 cases were identified within the last eight weeks *(11)*.

Figure 9. Confirmed cases of mpox by epidemiological week (EW) of rash onset, Mexico, EW 1 of 2025 to EW 43 of 2026.

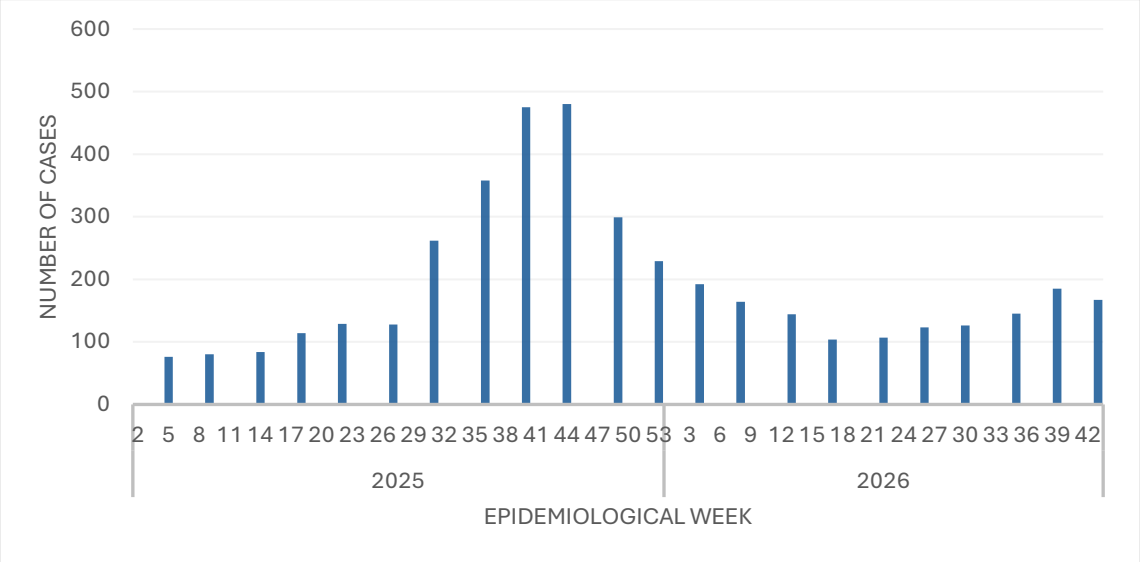


Source: Adapted from the Pan American Health Organization. Mpox dataset for the Americas Region 2022–2026, information submitted by the International Health Regulations (IHR) National Focal Point (NFP) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2026 [cited 18 November 2026]. Unpublished *(3)*.

In the **United States**, between EW 1 and EW 43 of 2026, 1,457 confirmed cases of mpox have been reported, with no deaths recorded (**Figure 10**) *(14)*.

The United States first detected a clade Ib case in November 2024, and since then more than 200 clade Ib cases have been confirmed in at least 31 states in the country, and Puerto Rico. While initial sporadic cases in 2024 and 2025 were associated with travel from East or Central Africa, the majority of recent cases with a reported travel history have been from Western Europe, or had contact with travelers from that region. Since August 2026, an increasing proportion of cases of clade Ib without recent international travel history have been detected in at least 16 jurisdictions, indicating sustained clade Ib mpox transmission in the country *(14)*.

Figure 10. Confirmed mpox cases by epidemiological week (EW)* of symptom onset/reporting, United States, between EW 1 of 2025 and as of EW 43 of 2026.



***The United States changed its public reporting of mpox cases from epidemiological week–based reporting to monthly reporting. To maintain consistency with the weekly database, monthly case counts have been assigned to the last epidemiological week of each corresponding month.**

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 18 November 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) *(16)* 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 2025 *(17)*. 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 *(18)*.

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 *(19)*.

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 *(19, 20)*.

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-MPXV coinfection *(21)*.

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 *(22)*. 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 *(22)*. 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 *(22)*.

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 Ia, leading to its classification as clade Ib *(23)*. 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 *(23)*. **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** *(22)*. 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 *(22)*.

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 *(22)*.

Contact tracing

Mpox cases should be interviewed promptly to identify potential contacts and exposure settings. Identified contacts should be notified within 24 hours and advised to monitor for symptoms and seek medical care if symptoms develop. Contact identification and tracing should begin as soon as a suspected mpox case is detected, without waiting for confirmation. If the case is subsequently discarded, contact tracing should be adapted or discontinued as appropriate.

Definition of a contact

A contact is defined as a person who has been exposed to a suspected, probable or confirmed mpox case during the infectious period of the latter. Exposure can happen through:

1. Direct contact
    - skin-to-skin, skin-to-mucosal or mouth-to-mucosal physical contact
    - Examples: touching, hugging, kissing, intimate oral or other sexual contact
2. Indirect contact
    - contact with items contaminated by the case, such as clothing or bedding
    - This includes handling contaminated materials like laundry and cleaning rooms
3. Non-physical contact
    - close and prolonged conversation with a symptomatic mpox case, especially if they have visible mpox ulcers
    - talking near such a person increases the risk of exposure to infectious respiratory particles (IRP) expelled through the mouth

4. Mother-to-child contact (vertical transmission)
    - Transmission can occur during pregnancy through the placenta or during delivery

The above also apply for health workers potentially exposed in the absence of proper use of appropriate personal protective equipment (PPE) *(19, 24)*. Household members living with a mpox case may present multiple potential exposures (direct, indirect, non-physical).

The infectious period for mpox begins at symptom onset (or up to two days before, when relevant) and ends when all lesions have healed and new skin has formed. Asymptomatic individuals with a positive mpox PCR test should also be considered infectious, and contact tracing should be initiated.

The full recommendations on Contact tracing are available at: Surveillance, case investigation and contact tracing for mpox: interim guidance, 27 November 2024 *(19)*

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 *(25)*.

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 *(26)*. 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.

In the context of the current resurgence of mpox in the Americas Region, travelers belonging to groups at high risk are advised to seek vaccination prior to the trip to areas with active transmission.

Clinical Management

Identifying mpox cases can be challenging given the similarity to other infections and conditions *(27, 28)*. 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 *(28)*.

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 *(29)*. 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 *(27, 29)*.

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 *(27,29,30)*. The WHO has recently published guidance for home care of mpox cases *(24)*.

Treatment focuses on wound care, pain management, and prevention of complications. At the start of the 2022 multi-country outbreak, 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 *(30)*. 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 *(31-33)*.

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 *(34)*.

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 *(34)*.

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 *(34)*.

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 *(34)*.

References

1. World Health Organization. Global Mpox Trends. Geneva: WHO; 2026 [cited 17 November 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 17 November 2026]. Available from: https://shiny.paho-phe.org/mpox/
4. Argentina International Health Regulations (IHR) National Focal Point (NFP). Communication received on 11 November 2026, via email. Buenos Aires; 2026. Unpublished.
5. Brazil International Health Regulations (IHR) National Focal Point (NFP). Communication received on 17 November 2026, via email. Brasília; 2026. Unpublished.
6. Canada International Health Regulations (IHR) National Focal Point (NFP). Communication received on 30 October 2026, via email. Ottawa; 2026. Unpublished.
7. Chile International Health Regulations (IHR) National Focal Point (NFP). Communication received on 4 September 2026, via email. Santiago, Chile; 2026. Unpublished.
8. Colombia International Health Regulations (IHR) National Focal Point (NFP). Communication received on 17 November 2026, via email. Bogotá; 2026. Unpublished.
9. Costa Rica International Health Regulations (IHR) National Focal Point (NFP). Communication received on 23 July 2026, via email. San José; 2026. Unpublished.
10. Ecuador International Health Regulations (IHR) National Focal Point (NFP). Communication received on 23 November 2026, via email. Quito; 2026. Unpublished.
11. Mexico International Health Regulations (IHR) National Focal Point (NFP). Communication received on 6 November 2026, via email. Mexico City; 2026. Unpublished.
12. Paraguay International Health Regulations (IHR) National Focal Point (NFP). Communication received on 5 November 2026, via email. Asunción; 2026. Unpublished.
13. Peru International Health Regulations (IHR) National Focal Point (NFP). Communication received on 5 November 2026, via email. Lima; 2026. Unpublished.
14. United States of America Centers for Disease Control and Prevention. Global Monkeypox: Current Situation. Atlanta: CDC; 16 November 2026 [cited 18 November 2026]. Available from: https://www.cdc.gov/monkeypox/situation-summary/index.html.
15. Fiocruz. INI/Fiocruz É a Unidade de Referência Para Atendimento de Casos de Mpox. Rio de Janeiro; 2026. Available from: https://fiocruz.br/noticia/2026/11/ini-fiocruz-e-unidade-de-referencia-para-atendimento-de-casos-de-mpox
16. 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.

17. 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.

18. 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.

19. World Health Organization. Surveillance, case investigation and contact tracing for mpox (monkeypox): Interim guidance, 27 November 2024. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/B09169.

20. 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).

21. 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).

22. 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

23. 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

24. 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

25. 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.

26. 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

27. 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

28. 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.

29. 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/

30. 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.

31. 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

32. 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

33. 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

34. 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