

Summary of the situation

Globally, between January 2022 and 30 September 2024, 109,699 confirmed cases of mpox, including 273 deaths, were reported by 123 Member States across the six World Health Organization (WHO) Regions. In September 2024, the number of new cases reported monthly increased by 8% compared to August. Most of the cases reported in September occurred in the African Region (63.6%), and the Americas Region (15.5%) (1).

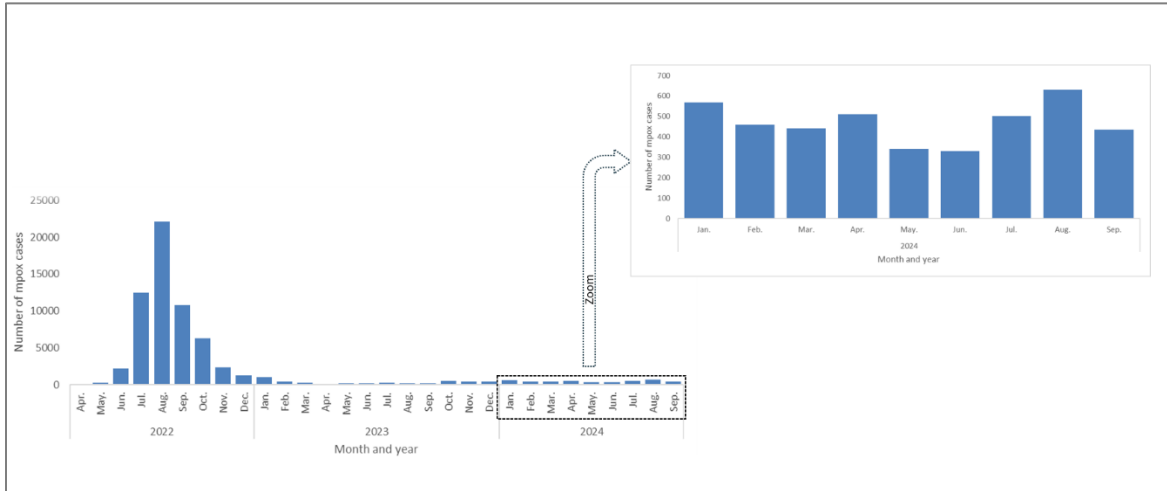
Between January and 6 October 2024, 7,535 confirmed cases, including 32 deaths, were reported by 16 countries in Africa (2). The most affected country remains the Democratic Republic of Congo, followed by Burundi and Nigeria. Sixteen countries in the WHO African Region have reported mpox cases in the past six weeks and there are outbreaks considered to be active and ongoing (2). Clade Ib was first reported in the Democratic Republic of the Congo, and cases have been identified in Burundi, Kenya, Rwanda, and Uganda. This clade was linked to the WHO Director-General's declaration of a public health emergency of international concern (PHEIC) on 14 August 2024 (3). Additionally, this clade has since been identified in confirmed cases outside the WHO African Region, in Germany (n=1 case), India (n=1 case), Sweden (n=1 case), and Thailand (n=1 case) (4-8).

Americas Region

From May 2022 through epidemiological week (EW) 40 of 2024, 65,876 confirmed cases of mpox, including 150 deaths, were reported in 31 countries and territories in the Americas Region. In total, 57,697 cases and 120 deaths were reported in 2022; 3,966 cases and 24 deaths in 2023; and 4,213 cases and six deaths so far in 2024 (9). Since the last PAHO/WHO mpox epidemiological update on 10 September 2024, an additional 1,207 cases of mpox have been reported in the Region (9-17).

The highest proportion of mpox cases was recorded during 2022 (88%), with the highest number of cases reported during the month of August 2022. Subsequently, a progressive decline in cases was observed and continued throughout 2023 and 2024 (**Figure 1**) (9). Genomic surveillance identified **clade IIb** in all mpox cases analyzed, which remains the only clade detected to date in the Americas Region (18).

Figure 1. Confirmed cases of mpox by month and year of symptom onset/notification. Americas Region, as of epidemiological week (EW) 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox case dashboard - Americas Region. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Available from: <https://shiny.paho-phe.org/mpox/> and Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (9, 19).

Regarding the distribution of cases by country and territory, the largest proportion of confirmed mpox cases between May 2022 and October 2024 corresponds to the United States of America (n= 34,067 cases, including 63 deaths), followed by Brazil (n= 12,724 cases, including 16 deaths), Colombia (n= 4,269 cases), Mexico (n= 4,178 cases, including 35 deaths), and Peru (n= 3,948 cases, including 23 deaths) (19).

Of the 61,093 cases of mpox reported between May 2022 and October 2024 in the Americas Region with available information on sex and age, 96% are male (n= 58,565 cases) and 39% of the cases are in the 30-39 age group (n= 24,148 cases) with a median age of 33 years and an age range between 0 and 95 years. In addition, there are 750 confirmed cases among children under 18 years of age in 16 countries of the Region (1.1% of cases). Of the 20,515 cases with available information on sexual practices, 72% identified as men who have sex with men (MSM). Of the 22,406 cases with available information on human immunodeficiency virus (HIV) status, 59% correspond to persons living with HIV (19).

Of the 51,782 cases of mpox for which information on hospitalization was available, 8% were hospitalized (n= 4,102 cases); 23% of these cases were hospitalized for clinical management (n= 944 cases). Among 61% of the cases, the cause of hospitalization was unknown (n= 2,497 cases) (9, 19).

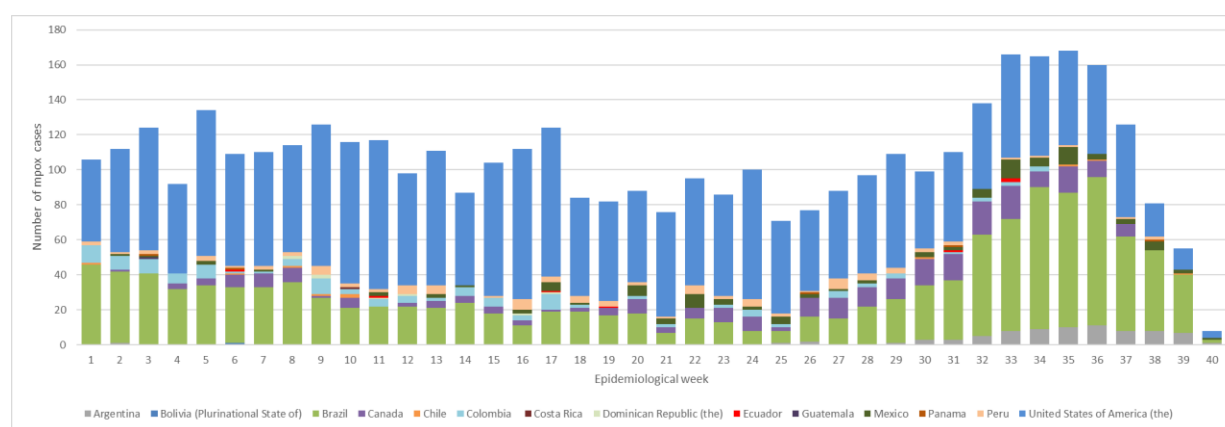
Situation in the Americas Region in 2024

In the Americas Region in 2024, 14 countries recorded a total of 4,213 confirmed cases of mpox, including six deaths: Argentina (n= 78 cases), Bolivia (n= 1 case), Brazil (n= 1,225 cases), Canada (n= 251 cases), Chile (n= 10 cases), Colombia (n= 121 cases), Costa Rica (n= 1 case), Ecuador (n= 7 cases), the Dominican Republic (n= 8 cases), Guatemala (n= 1 case), Mexico (n= 99 cases, including one death), Panama (n= 5 cases), Peru (n=89 cases, including two

deaths), and the United States of America (n= 2,317 cases, including three deaths) (Figure 2) (9-17, 19).

In 2024, of 3,767 mpox cases with available information on sex and age in the Americas Region, 96% of cases were reportedly male (3,622 cases), similar to the cases reported in 2022-2023, and 46% of cases are in the 30-39 age group (1,722 cases) with a median age of 34 years and an age range between 0 and 81 years (9-17, 19). In addition, there are 28 confirmed cases among children under 18 years old in five countries in the Region (0.6% of cases) (9-17, 19). Of 709 cases with information available on sexual practices, 75% identified as MSM. Of the 1,257 cases with available information on HIV status, 50% were persons living with HIV (19).

Figure 2. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification and country*. Americas Region, EW 1 to EW 40 of 2024.



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

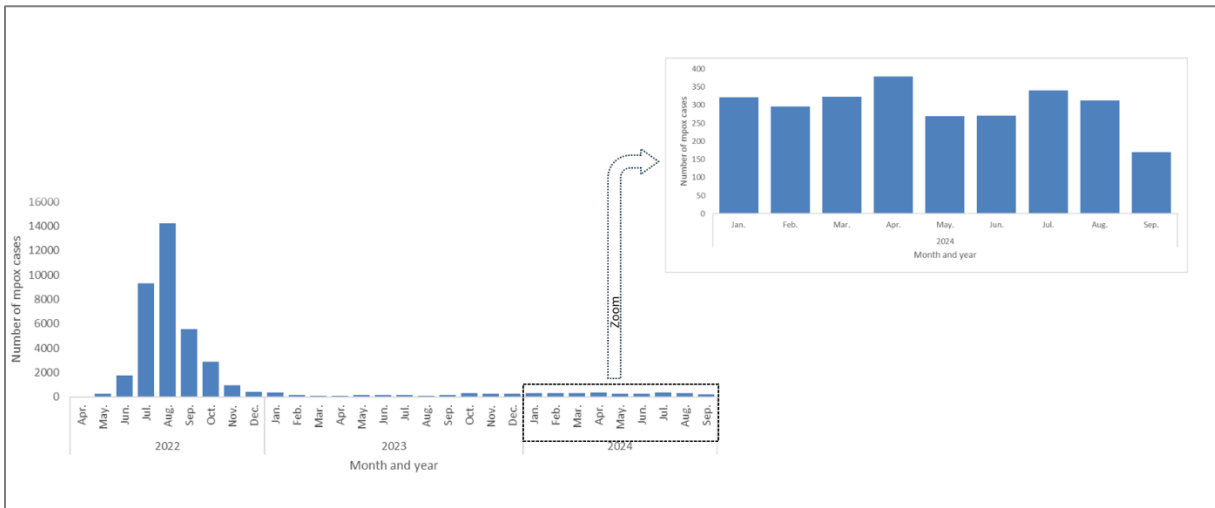
Source: Adapted from Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (5).

Situation summary by subregion and selected countries

In the **North America**¹ subregion, between 2022 and as of EW 40 of 2024, 40,045 confirmed cases of mpox were reported, including 98 deaths. The largest proportion of cases was reported in the **United States of America** with 85% of cases (19). During 2024, as of EW 40, all three countries in this subregion have reported cases (n= 2,667 cases including four deaths) (Figure 3) (12, 14, 15).

¹ Canada, the United States of America, and Mexico.

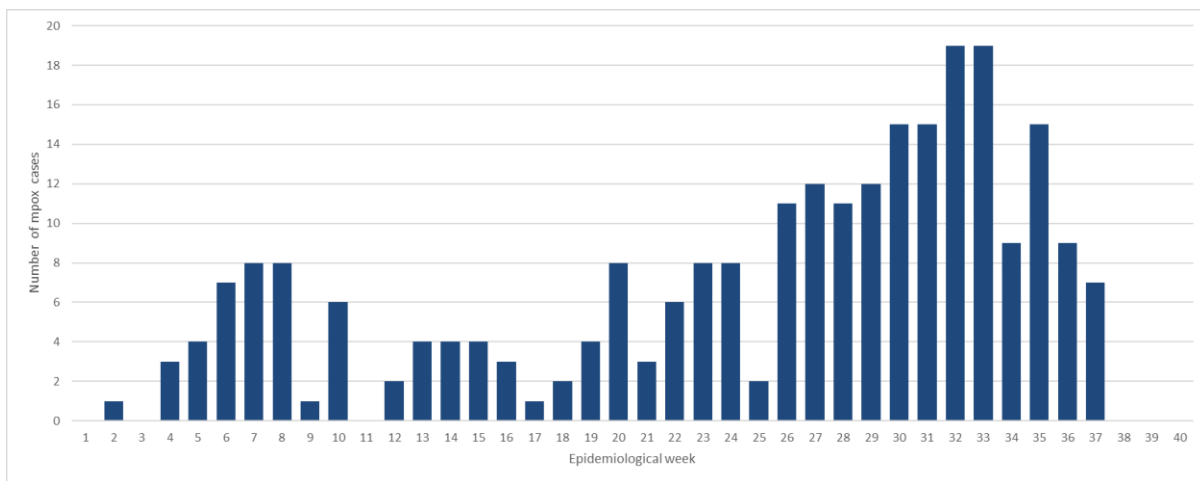
Figure 3. Confirmed cases of mpox by month and year of symptom onset/notification. North America subregion, as of epidemiological week (EW) 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox case dashboard - Americas Region. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Available from: <https://shiny.paho-phe.org/mpox/> and Pan American Health Organization. Mpox dataset Americas Region 2022-2024; Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (2, 5).

In **Canada**, between EW 1 and EW 40 of 2024, 251 confirmed cases of mpox were reported, with a weekly average of 6 cases (**Figure 4**). Males accounted for 96% of cases (n= 242 cases) and 38% of cases were in the 30-39 age group (n= 95 cases); no cases were reported among children under 18 years of age. Of the 245 cases with available information, 0.8% were hospitalized (12, 19).

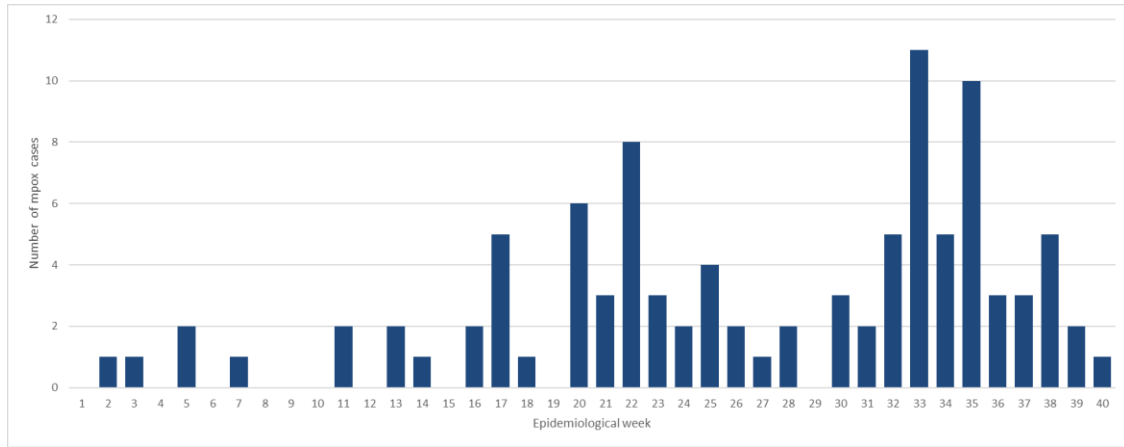
Figure 4. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification. Canada, EW 1 to EW 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (19).

In **Mexico**, between EW 1 and EW 40 of 2024, 99 confirmed cases of mpox have been reported, including one death, with a weekly average of two cases (**Figure 5**). Overall, 90% of cases are male (n= 89 cases) and 45% of cases are in the 30-39 age group (n= 47 cases). Three cases were reported among children under 18 years of age. No hospitalized cases were reported (15, 19).

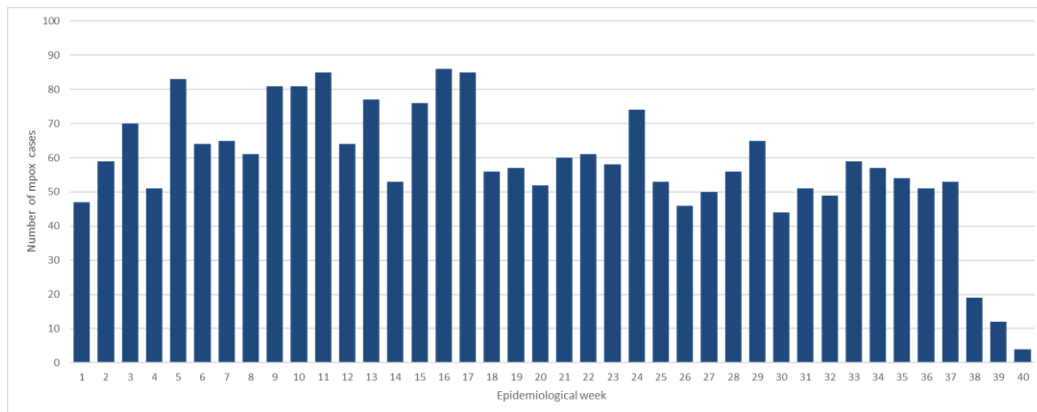
Figure 5. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification. Mexico, EW 1 to EW 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (19).

In the **United States of America**, between EW 1 and EW 40 of 2024, 2,317 confirmed cases of mpox were reported, including three deaths, with a weekly average of 58 cases (**Figure 6**). Overall, 96% of the cases are male (n= 2,105 cases) and 41% of the cases are in the 30-39 age group (n= 905 cases), with 8 cases among children under 18 years of age. Of the 1,841 cases with available information, 11% were hospitalized (14, 19).

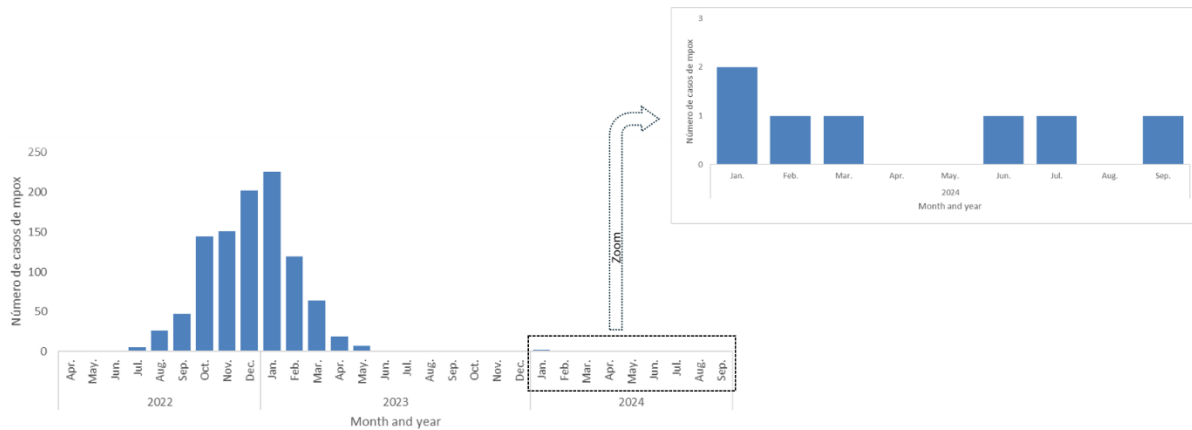
Figure 6. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification. United States of America, EW 1 to EW 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox data set Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (5).

In the **Central America**² subregion, between 2022 and EW 40 of 2024, 1,021 cases of mpox were reported, including three deaths. The highest proportion of cases was reported in **Guatemala** with 40% of these cases. Among the 7 countries in this subregion, **Costa Rica, Guatemala, and Panama** reported cases in 2024 (**Figure 7**) (9, 19).

Figure 7. Confirmed cases of mpox by month and year of symptom onset/notification. Central America subregion, as of epidemiological week (EW) 40 of 2024.



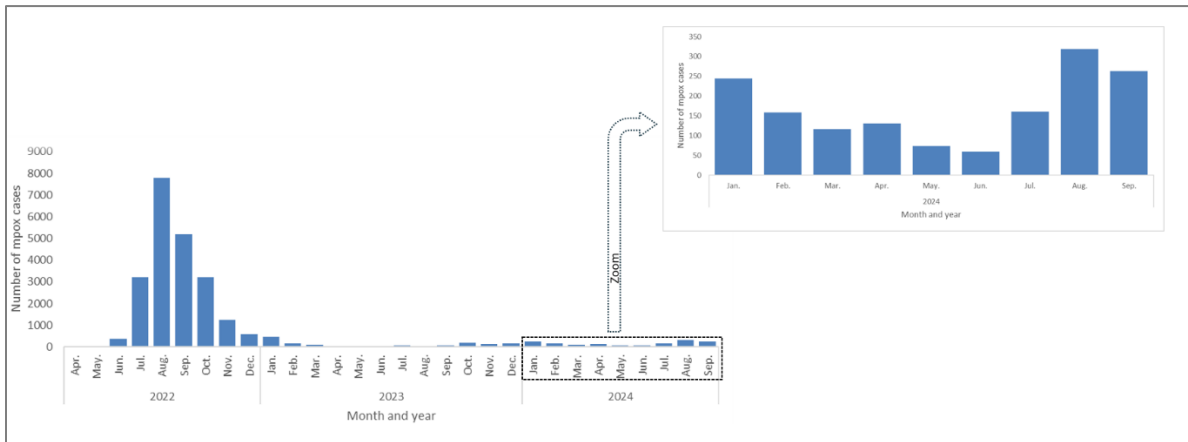
Source: Adapted from Pan American Health Organization. Mpox case dashboard - Americas Region. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Available from: <https://shiny.paho-phe.org/mpox/> and Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (9, 19).

In the **South America**³ subregion, all ten countries have reported cases. Between 2022 and as of EW 40 of 2024, 24,652 cases of mpox were reported, including 47 deaths. The highest proportion of cases was reported in **Brazil**, with 52% of cases, followed by **Colombia** with 17% of cases and **Peru** with 16% of cases. Seven countries in this subregion have reported cases in 2024: **Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, and Peru** (**Figure 8**) (19).

² Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

³ Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela (Bolivarian Republic of).

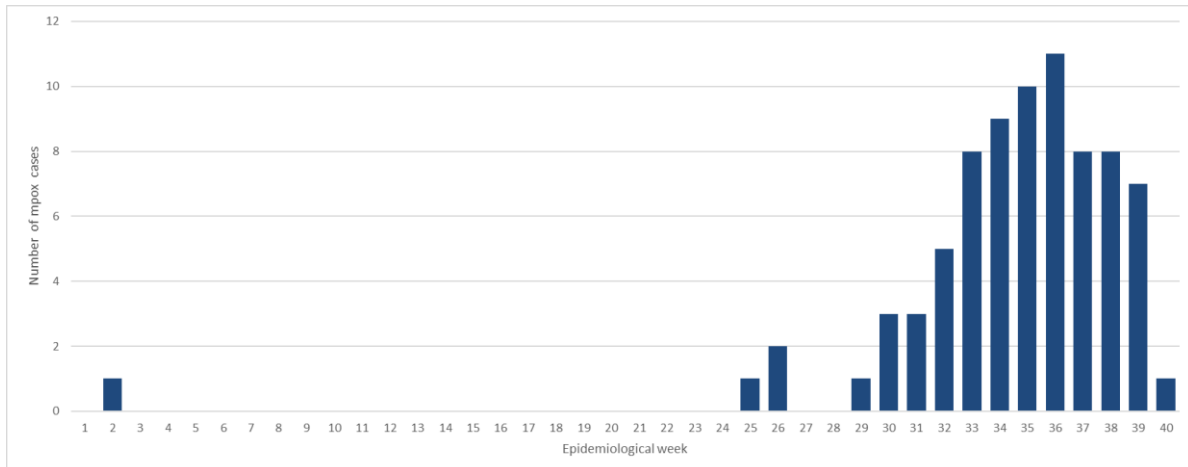
Figure 8. Confirmed cases of mpox by month and year of symptom onset/notification. South America subregion, as of epidemiological week (EW) 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox case dashboard - Americas Region. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Available from: <https://shiny.paho-phe.org/mpox/> and Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (9, 19).

In **Argentina**, between EW 1 and EW 40 of 2024, 78 confirmed cases of mpox have been reported, with a weekly average of seven cases (**Figure 9**). The highest proportion of cases were reported during EW 36 of 2024, with 11 cases. Overall, 99% of the cases were male (n= 77 cases) and 49% of the cases were in the 30-39 age group (n= 38 cases). One case in a child under 18 years of age was reported. Of the 73 cases with available information, 7% of the cases were hospitalized (10, 19).

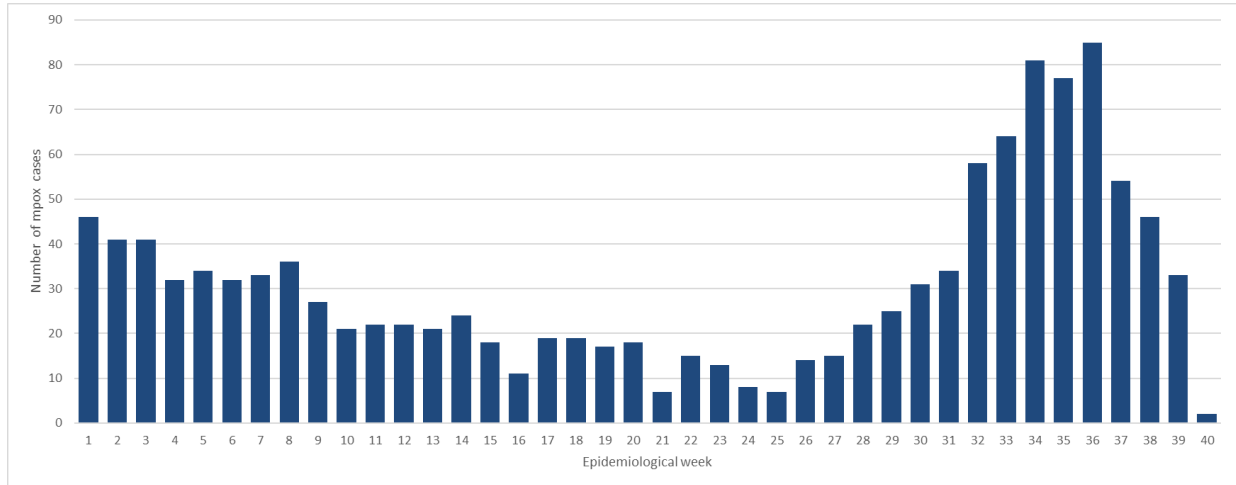
Figure 9. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification. Argentina, EW 1 to EW 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (19).

In **Brazil**, between EW 1 and EW 40 of 2024, 1,225 confirmed cases of mpox have been reported, with a weekly average of 31 cases (**Figure 10**), and an upward trend starting in EW 30 of 2024. Males accounted for 93.5% of cases (n= 1,145 cases) and 47.2% were in the 30-39 age group (n= 540 cases). There were 15 cases among children under 18 years of age. Of the 987 cases with available information, 9.2% were hospitalized (11, 19).

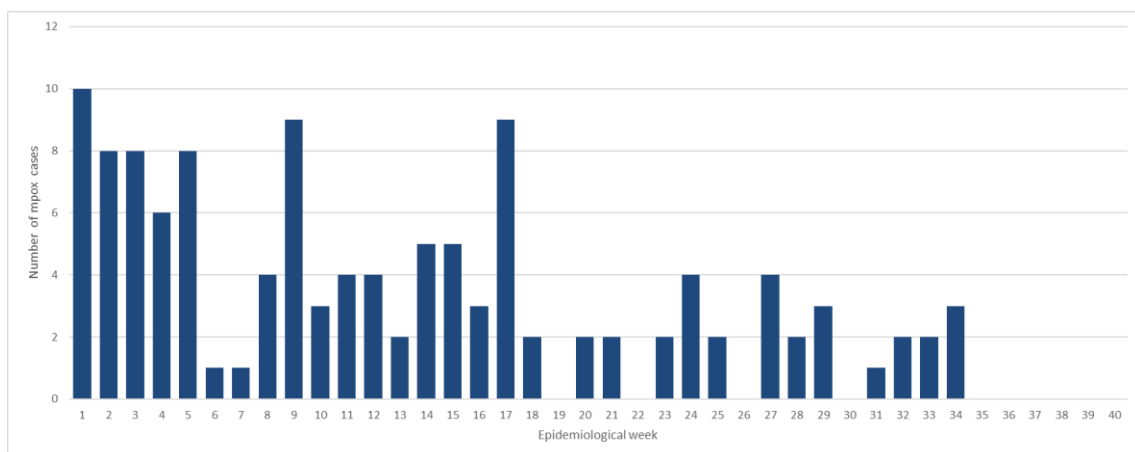
Figure 10. Confirmed cases of mpox by epidemiological week (EW) of symptom onset. Brazil, EW 1 to EW 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox data set Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (19).

In **Colombia**, between EW 1 and EW 40 of 2024, 121 confirmed cases of mpox have been reported, with a weekly average of three cases (**Figure 11**). Overall, 99% of cases correspond to males (n= 118 cases) and 44% of the cases are in the 30-39 years age group (n= 52 cases). There have been no cases among children under 18 years of age. Of 119 cases with available information, 23% of cases were hospitalized (13, 19).

Figure 11. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification. Colombia, EW 1 to EW 40 of 2024.

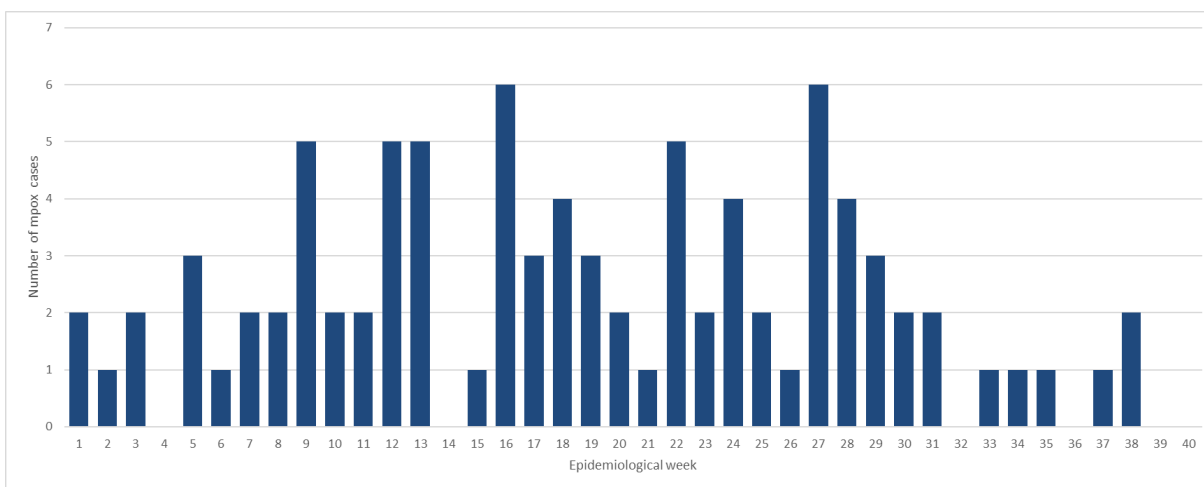


Source: Adapted from Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from

publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (19).

In **Peru**, between EW 1 and EW 40 of 2024, 89 confirmed cases of mpox have been reported, including two deaths, with a weekly average of two cases (**Figure 12**). Overall, 95% of the cases are male (n= 85 cases) and 44% of the cases are in the 30-39 age group (n= 45 cases). One case was reported in a child under 18 years of age (16, 19).

Figure 12. Confirmed cases of mpox by epidemiological week (EW) of symptom onset/notification. Peru, EW 1 to EW 40 of 2024.

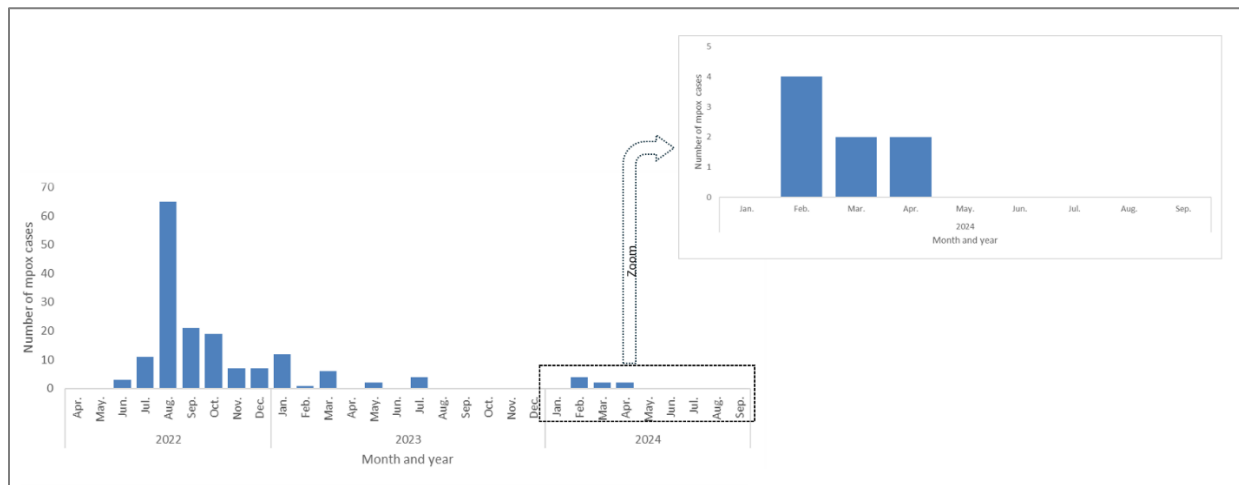


Source: Adapted from Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (19).

In the **Caribbean and Atlantic Ocean Islands**⁴ subregion, 13 countries and territories have reported cases. Between 2022 and EW 40 of 2024, 166 cases of mpox were reported, including two deaths. The highest proportion of cases was reported in the **Dominican Republic** with 66% of cases, followed by **Jamaica** with 13%, and **Cuba** with 5%. The **Dominican Republic** is the only country in this subregion that reported cases during 2024 (**Figure 13**) (9, 19).

⁴ Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Bermuda, Bonaire, Cayman Islands, British Virgin Islands, Cuba, Curaçao, Dominica, Dominican Republic (the), Falklands Islands, French Guiana, Grenada, Guadeloupe, Guyana, Haiti, Jamaica, Martinique, Montserrat, Puerto Rico, Saba, Saint Barthélemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Pierre and Miquelon, Saint Vincent and the Grenadines, Saint Eustatius, Sint Maarten, Suriname, Trinidad and Tobago, Turks and Caicos, and the U.S. Virgin Islands.

Figure 13. Confirmed mpox cases by month and year of symptom onset/notification, Caribbean and Atlantic Ocean Islands subregion, as of epidemiological week (EW) 40 of 2024.



Source: Adapted from Pan American Health Organization. Mpox case dashboard - Americas Region. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Available from: <https://shiny.paho-phe.org/mpox/> and Pan American Health Organization. Mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations (IHR) National Focal Points (NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [accessed 21 October 2024]. Unpublished (9, 19).

Guidance to Member States

Since the declaration of the public health emergency of international concern (PHEIC) on 14 August 2024, WHO has issued temporary recommendations and maintains the current standing recommendations for mpox (all clades) for an additional 12 months (3, 20).

Although no cases of mpox belonging to the new variant of clade Ib have yet to be detected in the Americas Region, the risk of introduction cannot be ruled out, and therefore health authorities are encouraged to continue their surveillance efforts to characterize the situation and respond rapidly in the event of an introduction of this or any other variant of the virus (MPXV).

Member States are reminded of the key recommendations for surveillance, clinical management, prophylaxis, and risk communication (21).

Surveillance

The main objective of mpox surveillance and case investigations is the rapid detection of cases and clusters in order to provide appropriate clinical care; isolation of cases to prevent onward transmission; the identification, management, and follow-up of contacts in order to recognize early signs or symptoms of infection; determining the groups at highest risk of infection and severe illness; protection of frontline healthcare workers; and the adoption of effective control and prevention measures (22).

It is crucial to maintain epidemiological surveillance based on laboratory testing and timely notification of probable and confirmed cases. This includes the follow-up of clinical characteristics compatible with mpox through existing surveillance programs and the implementation of clear case definitions for suspected, probable, confirmed, and reinfection cases according to current guidelines (22, 23).

Integrating mpox surveillance, detection, prevention, care, and research into HIV and other sexually transmitted infections (STI) prevention and control programs and services will facilitate early detection of outbreaks, reduce barriers to health services, and improve the response to HIV- MPXV co-infection (24).

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

Diagnosis and laboratory.

Detection of viral DNA by polymerase chain reaction (PCR) is the laboratory test of choice for mpox. The best diagnostic samples are taken directly from the rash (skin, fluid, or scabs) collected by vigorous swabbing (18). In the absence of skin lesions and in the presence of mucosal lesions, oropharyngeal, anal, or rectal swabs can be performed (18). However, while a positive oropharyngeal, anal, or rectal swab result is indicative of mpox, a negative result is not sufficient to exclude MPXV infection. Blood tests are not recommended. Antibody detection methods can be used for retrospective case classification, but not for diagnosis. It should be restricted to reference laboratories and may not be useful, as it often does not distinguish between different orthopoxviruses (18).

Clade I, which is currently increasing transmission in Africa, has been reported to have a deletion in the genome and additional mutations that have not been reported in clade II, leading to its classification as clade Ib (25). Although molecular detection using the recommended generic PCR protocol (only to detect orthopoxvirus OPXV) still works well, clade I-specific PCR does not detect the virus (25). Therefore, after initial detection with the (generic) detection protocol, if the clade identification PCR is negative for both clade I and clade II, samples should be sequenced (25).

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>.

Vaccination

PAHO reminds Member States that mass vaccination against mpox in the population is neither required nor recommended. Every effort should be made to control the person-to-person spread of mpox through early detection and diagnosis of cases, isolation, and contact tracing (26).

All decisions on immunization with mpox vaccines should be on a case-by-case basis of the assessed risks and benefits through shared clinical decision-making. Vaccination implementation should be accompanied by robust pharmacovigilance, and vaccine efficacy studies under clinical trial protocols are recommended (26).

In May 2022, the PAHO Technical Advisory Group on Vaccine Preventable Diseases recommended that vaccination should only be offered to high-risk close contacts of a confirmed case of mpox (26). In this case, the vaccine should ideally be administered within four days of exposure.

Following the declaration of the public health emergency of international concern (PHEIC) on 14 August 2024, WHO published the **Mpox global strategic preparedness and response plan** (27), which states that in response to the mpox outbreak, it is critical to improve control strategies through strategic vaccination. The implementation of targeted vaccination strategies can help reduce the spread of the virus by focusing on those at highest risk of infection, thereby reducing overall transmission. This vaccination strategy prioritizes people at substantially higher risk of exposure. Identification of populations at risk of exposure should be based on epidemiologic data (27).

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

Clinical management

Identifying cases of mpox can be challenging given the similarity to other infections and conditions (28, 29). It is important to distinguish mpox from chickenpox, measles, bacterial skin infections, scabies, herpes, syphilis, other sexually transmitted infections, and drug-associated 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 getting people into appropriate care as soon as possible and to prevent further spread (29).

People with HIV without antiretroviral therapy, particularly when they have advanced disease (CD4 cell count below 200/mm³), have a disproportionate burden of disease and increased mortality. Chronic necrotizing lesions, proctitis and severe perianal pain, ocular lesions and other infrequent manifestations have been described in these patients (30). Therefore, it is recommended to offer an HIV serology test 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, persons at risk of HIV exposure should be identified and linked to prevention services.

During the care of suspected, probable, and/or confirmed cases of mpox, early identification is required through screening protocols adapted to local settings. These cases should be isolated immediately and require prompt implementation of appropriate infection prevention and control (IPC) measures, testing to confirm the diagnosis, symptomatic management of patients with mild or uncomplicated mpox, and follow-up and treatment of severe complications and conditions (29, 31).

Patients with mpox with mild to moderate clinical presentation who are able to receive home care require careful assessment of the ability to safely isolate themselves and maintain the required IPC precautions in their home to prevent transmission to other household and community members. Precautions (isolation and IPC measures) should be maintained until a new layer of skin has formed under the scabs (29, 31). WHO has recently published guidelines for home-based care of mpox cases (32).

Treatment is based on lesion care, pain control, and prevention of complications. The use of specific antiviral drugs, such as tecovirimat, has been proposed, particularly for severe cases or people at higher risk of complications, but there is still no evidence of its effectiveness (31). WHO recommends the use of tecovirimat in randomized clinical trials (RCTs) in order to contribute to the generation of evidence, and if this is not possible, to use it in the framework of monitored emergency use of unregistered and experimental interventions (MEURI) (31). WHO recently issued a call for countries to express interest in receiving a donation of tecovirimat for use under the revised WHO MEURI protocol (interested countries can contact the PAHO/WHO Country Office). In addition, the mpox clinical platform is offered as a tool for data collection and the mpox lesion atlas to harmonize lesion assessments (28, 33).

Risk communication

Promoting the dissemination of public health messages aimed at health personnel, the general population, and in particular, populations 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 is key in order to inform and educate the target population about prevention measures and improve early detection, reporting, and prompt initiation of treatment of these cases. Continued efforts to raise awareness among authorities and health personnel about the ongoing outbreak in the Democratic Republic of the Congo and the possibility of travel-associated cases of mpox are also needed (34).

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

Among the key messages, WHO suggests the constant use of condoms during sexual activity (oral/anal/receptive and insertive vaginal) during the 12 weeks following recovery from a confirmed case, in order to reduce the potential transmission of mpox by this route, considering that this risk is still unknown (35).

Avoid the spread of rumors and false, inaccurate or incorrect information about mpox. It is important that public health authorities systematically listen to and analyze information shared through social media to identify key questions and information gaps and develop communication strategies based on this. The public should be encouraged to obtain information only from official sources (35).

Continue risk communication and community engagement activities and work with civil society organizations to engage with key affected populations such as gay, bisexual and other MSM, including those living with HIV (35).

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