

### Summary of the situation

Globally, between January 2022 and 30 November 2024, 117,663 confirmed mpox cases, including 263 deaths, were reported in 127 Member States in the six World Health Organization (WHO) Regions (1). In November 2024, the number of new cases reported monthly has decreased by 13% compared with October 2024. Most of the cases reported in November were from the WHO regions of Africa (71.2%) and the Western Pacific (10.8%) (1). According to the second meeting of the International Health Regulations (2005) Emergency Committee (IHR) on the resurgence of mpox in 2024, held in November 2024, this event continues to constitute a Public Health Emergency of International Importance (PHEIC) (2, 3).

Regarding the situation in Africa<sup>1</sup>, between January 2022 and as of 8 December 2024, 24 African Member States have notified WHO of mpox cases. As of 8 December 2024, a total of 15,661 laboratory-confirmed cases, including 83 deaths, have been reported to WHO (1).

During 2024 and as of 8 December 2024, 20 countries had reported 13,257 confirmed cases, including 60 deaths. The three countries with the most cases in 2024 are the Democratic Republic of Congo (n= 9,247 cases), Burundi (n= 2,523 cases), and Uganda (n= 925 cases) (1).

**Clade Ib**, has been identified outside Africa in: Germany (n= 1 case), Canada (n= 1 case), India (n= 1 case), the United States of America (n= 1 case), the United Kingdom (n= 4 cases), Sweden (n= 1 case), and Thailand (n= 1 case) (4 - 12). Outside Africa, secondary transmission of mpox due to the monkeypoxvirus (MPXV) clade Ib has been reported in the United Kingdom, where three secondary cases were confirmed among household contacts of the first case of mpox clade Ib in the United Kingdom in November 2024 (9).

### Situation in the Americas Region

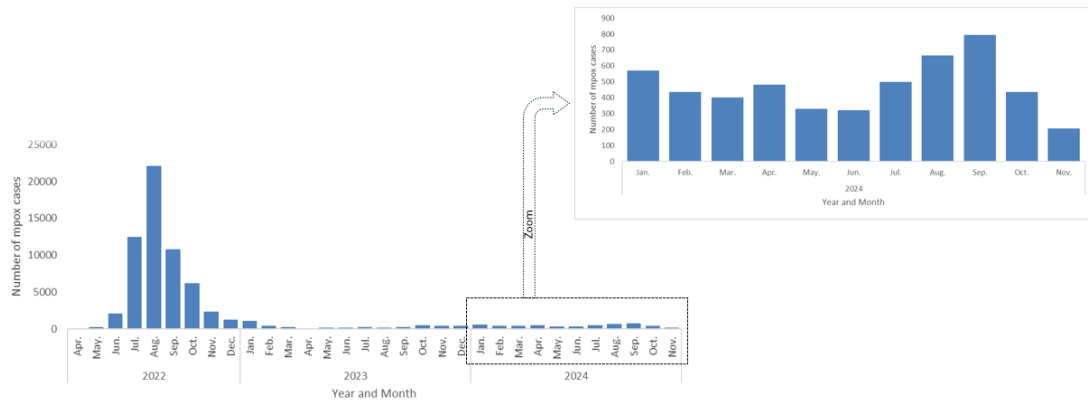
Since May 2022 and as of epidemiological week (EW) 48 of 2024, 66,824 confirmed mpox cases clade IIb, including 152 deaths, were reported in 31 countries and territories in the Americas Region (13-20, 22). In the Region, clade Ib has been identified in Canada (n= 1 case) and the United States (n= 1 case) (6, 8, 16, 18). Since the last PAHO/WHO mpox epidemiological alert on 19 November 2024, 534 additional mpox cases were reported, one death, **and clade Ib was identified for the first time in Canada** (6, 13-22).

In the Americas Region, the highest proportion of mpox clade IIb cases was recorded during 2022 (87%), with the highest number of cases reported in the month of August 2022. Subsequently, a progressive decline in cases was observed that continued during 2023 and 2024 (**Figure 1**) (13-20, 22).

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<sup>1</sup> Information from Member States of the WHO African and Eastern Mediterranean Regions is included.

**Figure 1.** Confirmed mpox cases clade Ib by month and year of symptom onset/notification. Americas Region, as of epidemiological week (EW) 48 of 2024.



**Source:** Adapted from Pan American Health Organization. Dashboard of mpox cases - Americas Region. Washington, D.C.: PAHO; 2024 [cited 18 December 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 National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (13, 22).

Regarding the distribution of cases by country and territory, the largest proportion of confirmed mpox cases clade Ib between May 2022 and as of EW 48 of 2024 corresponds to the United States (n= 34,362 cases, including 64 deaths), followed by Brazil (n= 13,236 cases, including 16 deaths), Colombia (n= 4,281 cases), Mexico (n= 4,195 cases, including 35 deaths), and Peru (n= 3,949 cases, including 23 deaths) (13-20, 22).

Of 61,824 mpox cases, registered between May 2022 and November 2024, with available information on sex and age, in the Americas Region, 96% correspond to males (n= 59,264 cases) and 40% of the cases are in the 30-39 age group (n= 24,462 cases) with a median age of 33 years, with an age range of 0-95 years. In addition, there are 768 confirmed cases among minors under 18 years of age in 16 countries of the Region (1.2% of cases). Of 22,560 cases with available information on human immunodeficiency virus (HIV) serostatus, 59% correspond to persons living with HIV (13-20, 22).

Of the 52,299 mpox cases for which information was available, 8% were hospitalized (n= 4,057 cases), 24% of these cases being for clinical management (n= 962 cases). In 60% of the cases (n= 2,432 cases), the cause of hospitalization was unknown (13-20, 22).

### Summary of clade Ib mpox cases Americas Region

On 22 November 2024, **Canada** reported a laboratory-confirmed case of mpox associated with the Ib MPXV clade detected in the province of Manitoba (6, 16). The case is an adult with a history of travel to eastern Africa to regions where mpox caused by clade Ib MPXV continues to circulate (6, 16). The case left Africa on 17 November 2024 and sought medical attention in Canada on 20 November where mpox was suspected because of travel history and symptoms. Samples from the case's skin lesions were positive for MPXV clade Ib at the National Microbiology Laboratory (NML) in Canada on 22 November 2024. This is the first case of mpox clade Ib detected in Canada. The case was treated with tecovirimat, a targeted antiviral therapy, and has fully recovered since. Contacts of the case were actively followed up. Domestic contacts were offered and accepted MVA-BN (Imvamune™) vaccine on 22

November. All contacts identified in Canada reported being asymptomatic at the end of a 21-day follow-up period (6, 16).

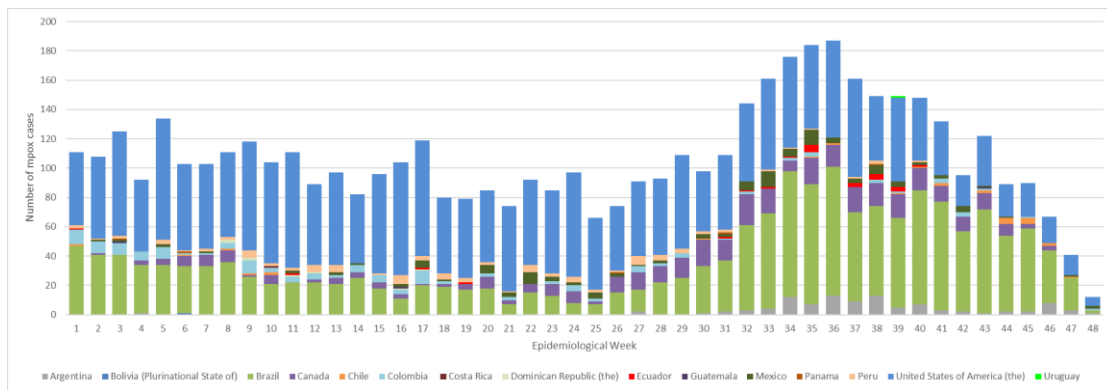
On 16 November, the **United States** reported the detection of a confirmed mpox case clade Ib. The case was diagnosed in a person who recently traveled to Central/East Africa (8, 18). The case was treated shortly after returning to the United States at a local medical center and was released (8, 18). Since then, the person isolated at home and recovered. Based on the patient's travel history and symptoms, samples from the patient were analyzed and the presence of mpox clade I was confirmed (8, 18). Samples were sent to United States Centers for Disease Control and Prevention (U.S. CDC) for further viral characterization and clade Ib was confirmed by the U.S. CDC and the state. In addition, U.S. CDC coordinated with the state and local health authorities to identify and follow up on potential contacts. All household, travel companion, and aircraft passenger contacts associated with this case have completed the 21-day monitoring period. No additional cases were detected (8, 18).

### Summary of clade Ib cases in the Americas Region in 2024

In 2024 in the Americas Region, 15 countries record a total of 5,156 confirmed mpox cases including eight deaths: Argentina (n= 101 cases), Bolivia (n= 1 case), Brazil (n= 1,740 cases), Canada (n= 365 cases), Chile (n= 26 cases), Colombia (n= 133 cases), Costa Rica (n= 1 case), Ecuador (n= 24 cases), the United States (n= 2,542 cases, including four deaths), Guatemala (n= 3 cases, including one death), Mexico (n= 116 cases, including one death), Panama (n= 5 cases), Peru (n= 90 cases, including two deaths), the Dominican Republic (n= 8 cases), and Uruguay (n= 1 case) (**Figure 2**) (13-20, 22).

In 2024, of 4,503 mpox cases with available information on sex and age, in the Americas Region, 96% of the cases correspond to males (n= 4,324 cases), being similar to the cases reported in 2022-2023, and 43% of cases are in the 30-39 year age group (n= 1,913 cases) with the median age being 34 years, and ranging between 0 and 76 years (9-17, 19). In addition, 42 confirmed cases were reported in minors under 18 years of age in seven countries of the Region (0.8% of cases) (13-20, 22). Of 1,521 cases with available information on HIV status, 49% were among persons living with HIV (13-20, 22).

**Figure 2.** Confirmed mpox cases by epidemiological week (EW) of symptom onset/notification and country\*. Americas Region, between EW 1 and EW 48 of 2024.



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

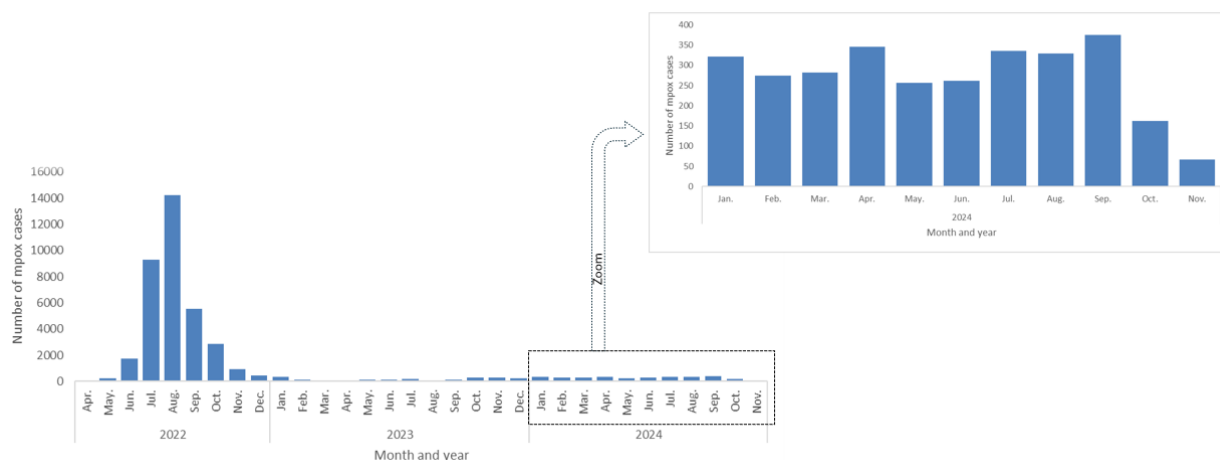
**Source:** Adapted from Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (22).

## Summary of the situation by subregion and selected countries

In the **North American** subregion<sup>2</sup>, between 2022 and as of EW 48 of 2024, 40,394 confirmed mpox cases were reported, including 99 deaths. The highest proportion of cases was reported in the **United States** with 85% of cases (16,18,19).

During 2024, as of EW 48, the three countries that make up this subregion have reported cases (n= 3,023 cases including five deaths), since the last PAHO/WHO mpox epidemiological update, 232 additional mpox cases were reported in this subregion (**Figure 3**) (16, 18, 19).

**Figure 3.** Confirmed mpox cases by month and year of symptom onset/notification. North American sub-region, as of epidemiologic week (EW) 48, 2024.

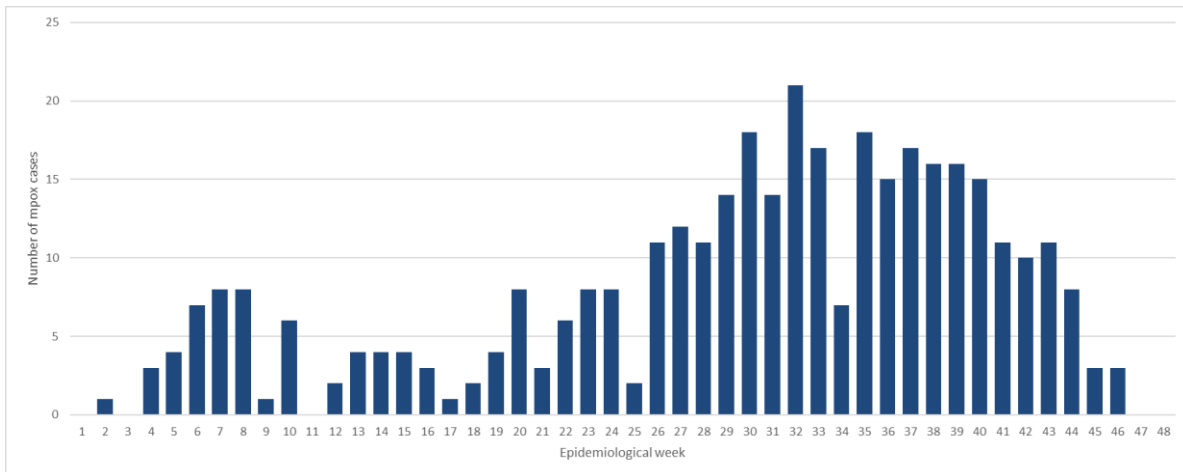


**Source:** Adapted from Pan American Health Organization. Dashboard of mpox cases - Americas Region. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Available from: <https://shiny.paho-phe.org/mpox/> and Pan American Health Organization. mpox dataset Americas Region 2022-2024; Information submitted by the International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (13, 22).

In **Canada**, between EW 1 and EW 48 of 2024, 365 confirmed mpox cases have been reported, with a weekly average of seven cases (**Figure 4**). Males accounted for 96% of cases (n= 349 cases) and 39% of cases were in the 30–39-year age group (n= 144 cases), with no cases reported in minors under 18 years of age. Of 336 cases with available information, 1.5% of the cases were hospitalized (16, 22).

<sup>2</sup> Canada, the United States, and Mexico.

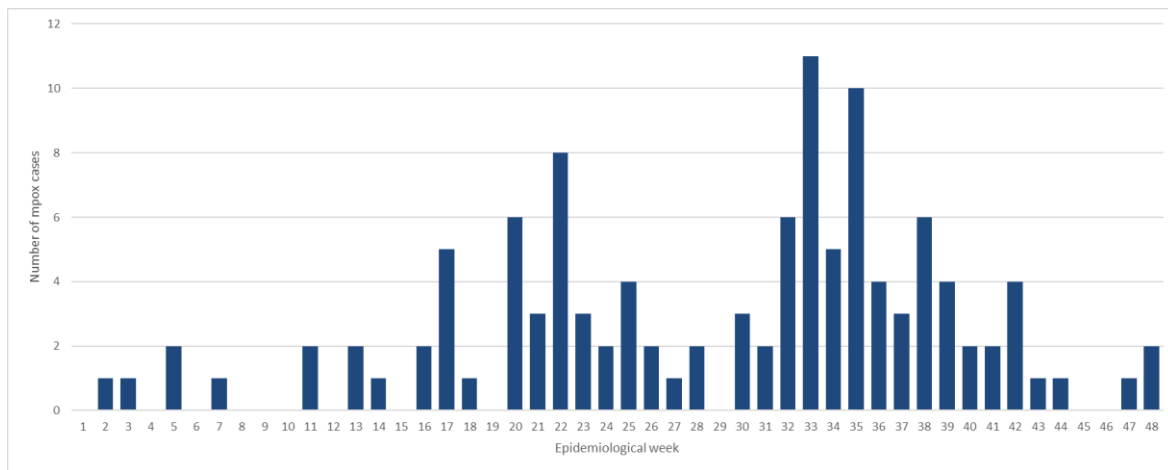
**Figure 4.** Confirmed mpox cases by epidemiological week (EW) of symptom onset/notification. Canada, between EW 1 and EW 48 of 2024.



**Source:** Adapted from Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (22).

In **Mexico**, between EW 1 and EW 48 of 2024, 116 confirmed mpox cases have been reported, including one death, with a weekly average of two cases (**Figure 5**). Males account for 91% of the cases (n= 106 cases) and 47% of the cases are in the 30-39 years age group (n= 55 cases). Three cases were reported in minors under 18 years of age. No hospitalized cases were reported (19, 22).

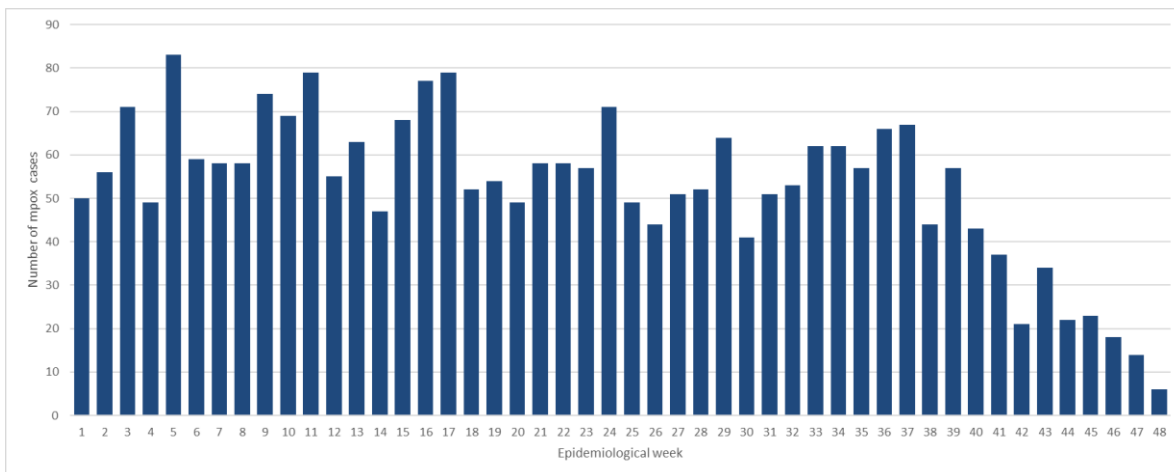
**Figure 5.** Confirmed mpox cases according to epidemiological week (EW) of symptom onset/notification. Mexico, between EW 1 and EW 48 of 2024.



**Source:** Adapted from Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024. [cited 18 December 2024]. Unpublished (22).

In the **United States**, between EW 1 and EW 48 of 2024, 2,542 confirmed mpox cases were reported, including four deaths, with a weekly average of 53 cases (**Figure 6**). Males accounted for 96% of cases (n= 2,324 cases) and 41% of cases were in the 30-39 age group (n= 990 cases). Eight cases are recorded in minors under 18 years of age. Of 2,081 cases with available information, 11% were hospitalized (18, 22).

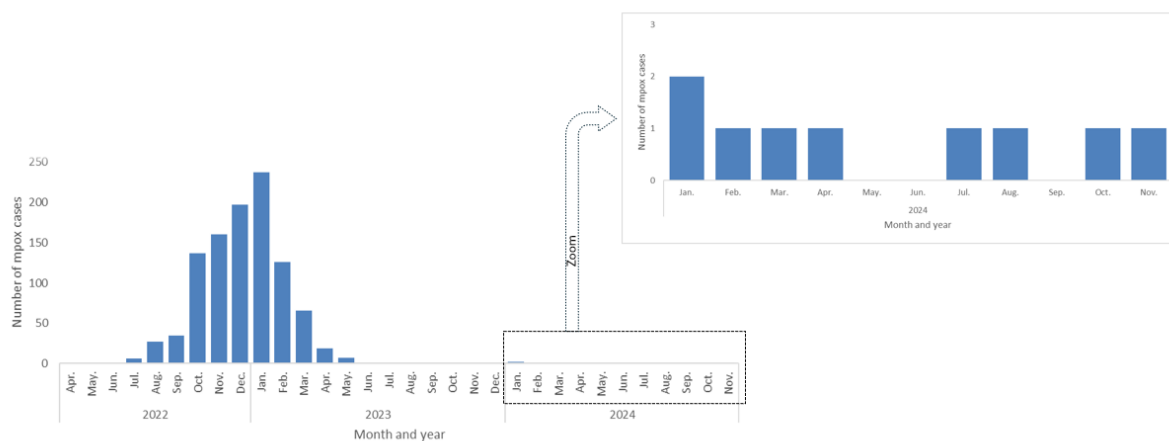
**Figure 6.** Confirmed mpox cases by epidemiologic week of symptom onset/notification. United States, between EW 1 and EW 48 of 2024.



**Source:** Adapted from Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (22).

In the **Central America** subregion<sup>3</sup>, between 2022 and as of EW 48 of 2024, 1,023 mpox cases were reported, including four deaths. The highest proportion of cases was reported in **Guatemala** with 40% of cases. Within the countries that make up this subregion, **Costa Rica** (n= 1 case), **Guatemala** (n= 3 cases, including one death) and **Panama** (n= 5 cases) reported cases in 2024 (**Figure 7**) (13, 22).

**Figure 7.** Confirmed mpox cases according to month and year of symptom onset/notification. Central America sub-region, as of epidemiological week (EW) 48 of 2024.



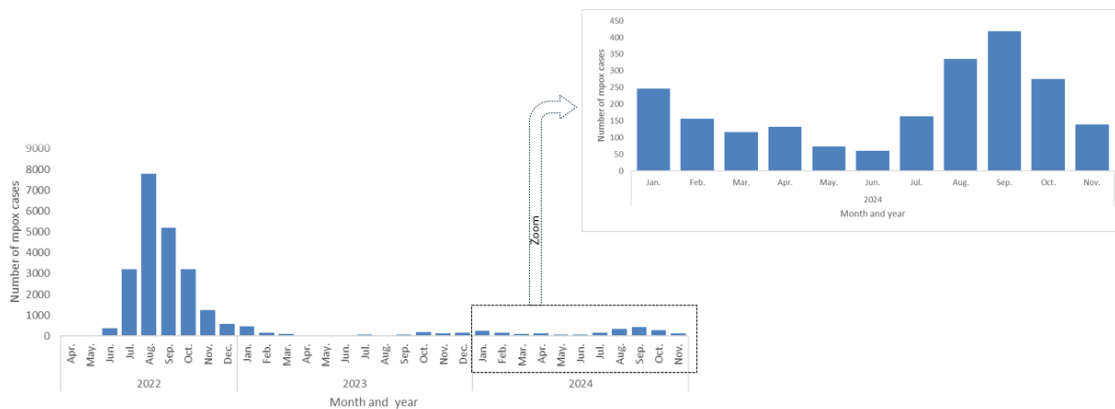
**Source:** Adapted from Pan American Health Organization. Mpox case dashboard - Americas Region. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Available from: <https://shiny.paho-phe.org/mpox/> and Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (13, 22).

<sup>3</sup> Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama.

In the **South American** subregion<sup>4</sup>, ten countries have reported cases between 2022 and as of EW 48 of 2024, 25,241 mpox cases were reported, including 47 deaths. The highest proportion of cases was reported in **Brazil** with 52% of cases, followed by **Colombia** with 17%, and **Peru** with 16%.

Within the countries that make up this subregion, eight countries reported cases in 2024 (n= 2,116 cases including two deaths): **Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Peru, and Uruguay**, since the last PAHO/WHO mpox epidemiological update, 277 additional mpox cases were reported in this subregion (**Figure 8**) (13-15, 17, 20-22).

**Figure 8.** Confirmed mpox cases according to month and year of symptom onset/notification. South America sub-region, as of epidemiological week (EW) 48 of 2024.

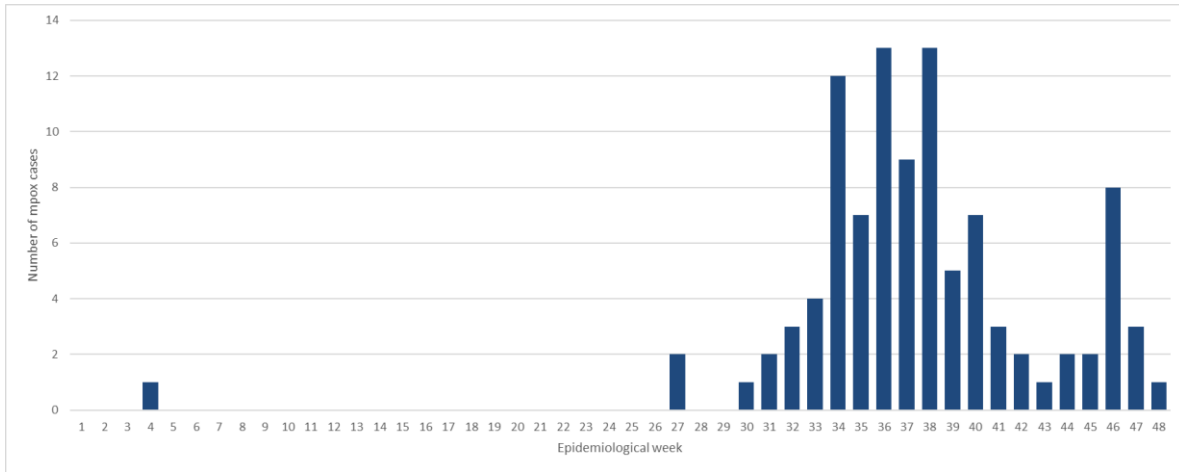


**Source:** Adapted from Pan American Health Organization. Dashboard of mpox cases - Americas Region. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Available from: <https://shiny.paho-phe.org/mpox/> and Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (13, 22).

In **Argentina**, between EW 1 and EW 48 of 2024, 101 confirmed mpox cases have been reported, with a weekly average of two cases, during the last four weeks (**Figure 9**). Males accounted for 98% of the cases (n= 99 cases) and 48% of the cases were in the 30-39 years age group (n= 48 cases). A single case in a minor under 18 years of age was reported. Of 91 cases with available information, 9% of the cases were hospitalized (14, 22).

<sup>4</sup> Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela (Bolivarian Republic of).

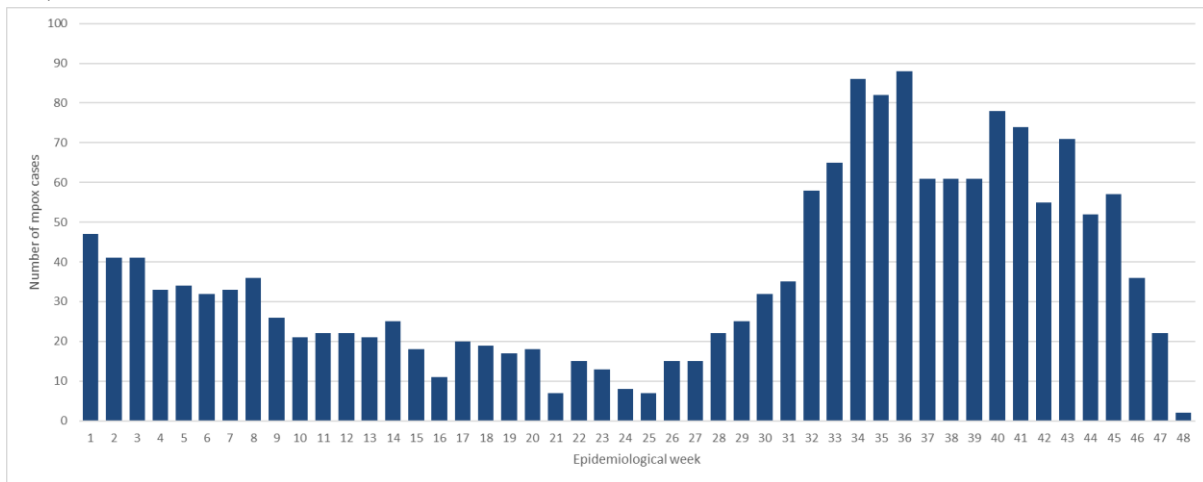
**Figure 9.** Confirmed mpox cases according to epidemiological week (EW) of symptom onset/notification. Argentina, between EW 1 and EW 48 of 2024.



**Source:** Adapted from Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (22).

In **Brazil**, between EW 1 and EW 48 of 2024, 1,740 confirmed mpox cases have been reported, with a weekly average of 36 cases (**Figure 10**), with an upward trend starting in EW 30 of 2024. Males accounted for 94% of the cases (n= 1,636 cases) and 44% were in the 30-39 age group (n= 790 cases). There are 23 cases among minors under 18 years of age. Of 1,413 cases with available information, 9% of cases were hospitalized (15, 22).

**Figure 10.** Confirmed mpox cases according to epidemiological week (EW) of symptom onset. Brazil, between EW 1 and EW 48 of 2024.



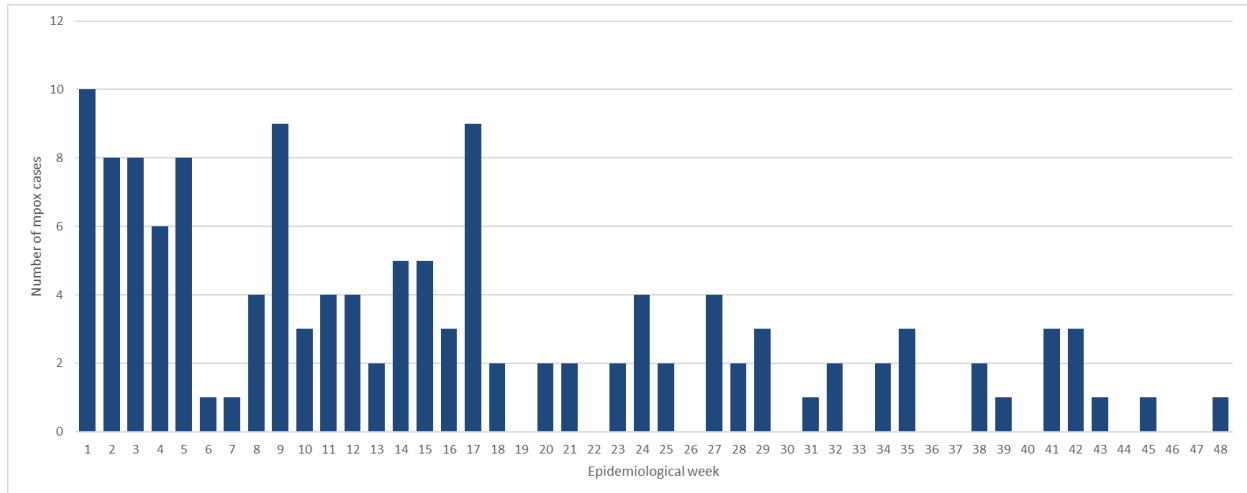
**Source:** Adapted from Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (22).

In **Colombia**, between EW 1 and EW 48 of 2024, 133 confirmed mpox cases have been reported, with a weekly average of three cases (**Figure 11**). Of 133 cases with available information, 99% of the cases correspond to males (n= 132 cases) and 51% of the cases are in



the 30-39 years age group (n= 68 cases). There are no cases reported in minors under 18 years of age. Of 133 confirmed cases, 26% of the cases were hospitalized (17, 22).

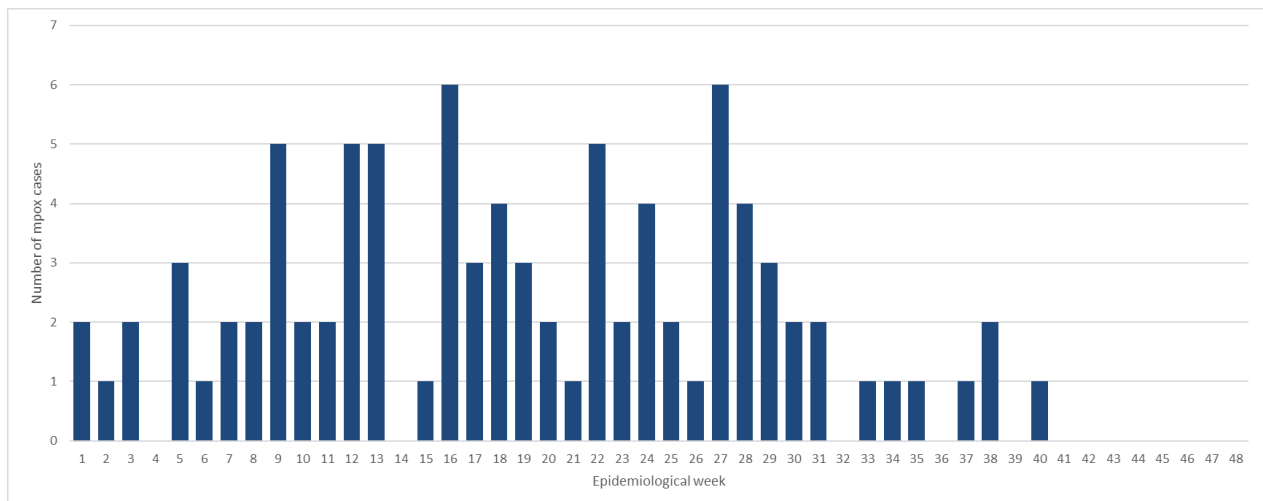
**Figure 11.** Confirmed mpox cases according to epidemiological week of symptom onset/notification Colombia, between EW 1 and EW 48 of 2024.



**Source:** Adapted from Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (22).

In **Peru**, between EW 1 and EW 48 of 2024, 90 confirmed mpox cases have been reported, including two deaths, with a weekly average of two cases (**Figure 12**). Ninety-six percent of the cases correspond to males (n= 86 cases) and 51% of the cases are in the 30-39 years age group (n= 46 cases). One case is recorded in a child under 18 years of age (20, 22).

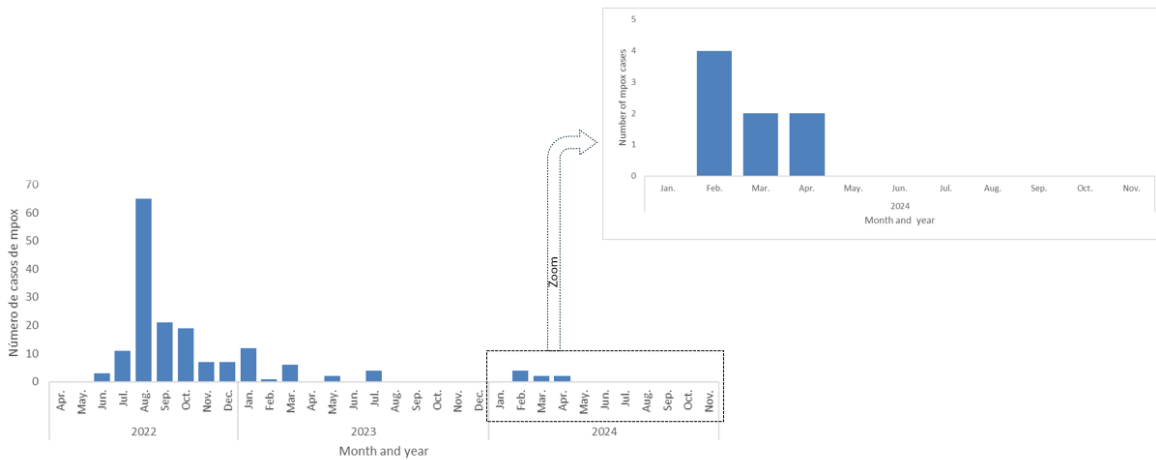
**Figure 12.** Confirmed mpox cases according to epidemiological week (EW) of symptom onset/notification. Peru, between EW 1 and EW 48 of 2024.



**Source:** Adapted from Pan American Health Organization. mpox dataset Americas Region 2022-2024, Information submitted by International Health Regulations National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 18 December 2024]. Unpublished (22).

In the **Caribbean and Atlantic Ocean Islands** subregion<sup>5</sup>, thirteen countries and territories have reported cases. Between 2022 and as of EW 48 of 2024, 166 mpox cases 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** (n= 8 cases) is the only country in this subregion to report cases during 2024 (**Figure 13**) (13, 22).

**Figure 13.** Confirmed mpox cases according to month and year of symptom onset/notification. Subregion of the Caribbean and Atlantic Ocean Islands, as of epidemiological week (EW) 48 of 2024.



**Source:** Adapted from Pan American Health Organization. mpox case dashboard - Americas Region. Washington, D.C.: PAHO; 2024 [ cited 13 December 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 National Focal Points (IHR NFPs) or extracted from publicly available official sources. Washington, D.C.: PAHO; 2024 [cited 13 December 2024]. Unpublished (13, 22).

## Guidance to Member States

Since the declaration of the Public Health Emergency of International Concern (PHEIC) on 14 August 2024, WHO has issued the temporary recommendations and maintains for an additional 12 months the current standing recommendations on mpox (all clades) (2, 23).

Given the recent identification of clade I in the Americas Region, 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 then reminded of the main recommendations for surveillance, clinical management, prophylaxis, and risk communication (24).

<sup>5</sup> Anguilla, Antigua and Barbuda, Aruba, Bahamas (the), Barbados, Bermuda, Bonaire, Cayman Islands, British Virgin Islands, Cuba, Curaçao, Dominica, Dominican Republic (the), Falkland Islands (Malvinas), French Guiana, Grenada, Guadeloupe, Guyana, Haiti, Jamaica, Martinique, Montserrat, Puerto Rico, Saba, Saint Barthelemy, 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.

## Surveillance

The main objective of mpox surveillance and case investigation is the rapid detection of cases and clusters in order to provide appropriate clinical care; isolation of cases to prevent onward transmission; identification, management, and follow-up of contacts to recognize early signs or symptoms of infection; identification of groups at higher risk of infection and severe disease; protection of front-line health care workers; and adoption of effective control and prevention measures (25).

It is crucial to maintain epidemiological surveillance based on laboratory testing and timely reporting of probable and confirmed cases. This includes the follow-up of clinical pictures compatible with mpox through existing surveillance programs and the implementation of clear case definitions for suspected, probable, confirmed, and reinfection according to current guidelines (25, 26).

Integrating mpox surveillance, detection, prevention, care, and research into HIV and other sexually transmitted infection (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 (27).

We reiterate the need for laboratory confirmation and the implementation of genomic surveillance to determine the circulating clades and their evolution, and at the same time contribute to knowledge by sharing genetic sequence data for pertinent public health actions.

## Laboratory diagnosis

**With the emergence of MPXV clade Ib, the previous guidelines for molecular detection and confirmation of suspected mpox cases should be maintained. However, it is recommended that the proposed algorithms for differentiation of circulating clades and proper identification of clade Ib be carefully followed.**

Detection of viral DNA by polymerase chain reaction (PCR) is the laboratory test of choice for mpox. The best specimens for diagnosis are those taken directly from the eruptive lesion including: vigorous swabbing of the surface and/or exudate of the lesion, upper edges of lesions, or crusts (28). Swabs of lesions are usually sufficient for diagnosis; in case upper edges or crusts of lesions are taken, sharps injury prevention measures should be strictly followed. In the absence of skin lesions and in the presence of mucosal lesions, oropharyngeal, anal or rectal swabs can be performed (28). However, while a positive oropharyngeal, anal or rectal swab result is indicative of mpox, a negative result is not sufficient to exclude MPXV infection. Attempted blood screening is not recommended. On the other hand, 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 (28).

MPXV clade I, which is currently increasing transmission in Africa, has been documented to have a deletion in the genome and additional mutations that have not been identified in clade II, leading to its classification as clade Ib (29). Although molecular detection using the recommended generic PCR protocol (only to detect MPXV) still works well, clade I-specific

PCR (previously recommended) does not detect the new clade (Ib) of the virus (29). **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 (28).** Currently, there are PCR protocols for the specific detection of clade Ib, which can support the confirmation of a positive suspect case for the generic MPXV detection assay; however, validation data for these protocols are still lacking, so sequencing is always recommended, especially when it is the index case or the first cases detected in an outbreak (28).

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 (30).

All decisions on immunization with mpox vaccines should be based on a case-by-case assessment of risks and benefits through shared clinical decision-making. The implementation of vaccination should be accompanied by robust pharmacovigilance measures, and conducting vaccine efficacy studies following clinical trial protocols is highly recommended. (30).

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 (29)**, 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 individuals at substantially higher risk of exposure than in the general population. Identification of populations at risk of exposure should be based on epidemiologic data (31).

Between May 2022 and as of December 2024, nine countries administered 32,474 complete mpox vaccine series: Chile (n= 13,926), Brazil (n= 12,302), Ecuador (n= 3,761), Panama (n= 1,669), Peru (n= 650), El Salvador (n= 112), the Dominican Republic (n= 29), the Bahamas (n= 14), and Honduras (n= 11). Of these doses, 12,308 (38%) were administered to persons between 30 and 39 years of age. Among the other age groups, persons aged 40-49 years received 7,915 (24%) doses, while persons aged 20-29 years received 6,881 (21%) doses. All countries administered Modified Vaccinia Ankara-Bavarian Nordic (MVA-BN) vaccine (32).

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 mpox cases can be challenging given the similarity to other infections and conditions (33, 34). 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 (34).

People with HIV without antiretroviral therapy, particularly when they have advanced disease (CD4 cell count below 200/mm<sup>3</sup>) 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 (35). Therefore, it is recommended to offer an HIV serology test to all suspected mpox cases, 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 mpox cases, 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 (34, 36).

Patients with mpox with mild or moderate clinical presentation who are able to receive home care require careful assessment of ability to safely isolate themselves and maintain required PCI precautions at 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 (34, 36). WHO has recently published a guideline for home care of mpox cases (37).

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 (36). 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) (36). 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 assessment (33, 38).

## **Risk communication**

Promote the dissemination of public health messages aimed at health personnel, the general population and in particular populations at higher 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 prompt initiation of treatment of these cases. Continue 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 mpox cases (39).

Disseminate simple information, education, and communication (IEC) materials on transmission, symptoms, prevention, and treatment through various media (including social

networks, dating apps, or CCTV in health care facilities with services for populations with higher prevalence of HIV and other STIs).

Among the key messages, the 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, to reduce the potential transmission of mpox by this route, considering that this risk is still unknown (40).

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 (40).

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 (40).

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