MPOX, MULTI-COUNTRY

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Overall risk and confidence (based on information available at time of assessment, 17 August 2026)

Overall Public Health risk
Global
Moderate

Confidence in available information
Global
Moderate

Overall global public health risk *	
Individuals with multiple sexual partners	Moderate
All other individuals	Low

Confidence in available information
Moderate
Moderate

Overall local public health risk *	
Children in historically endemic areas	Moderate

Confidence in available information
Low

** All mpox outbreaks must be considered in their local context to gain a comprehensive understanding of the epidemiology, modes of transmission, risk factors for severe disease, viral origins and evolution, and relevance of strategies and countermeasures for prevention and control. For more detailed description of the risk groups, please refer to this section.*

Overall Global Risk statement

This global rapid risk assessment (RRA) assesses the current public health risk associated with the 2024 upsurge of mpox in Africa, in the context of the continuing global occurrence of mpox in all regions since 2022, with a focus on updates since the previous RRA in February 2026. **The overall public health risk posed by mpox remains unchanged from the last RRA.**

Global overview

As of 30 June 2026, the monkeypox virus (MPXV) continues to spread globally, causing both localized and extended mpox outbreaks driven by multiple MPXV clades (Ia, Ib, IIa, and IIb) in diverse settings. The recombination of MPXV clades has also been documented, with the two previously reported cases of a recombinant clade Ib/IIb MPXV strain detected in the United Kingdom of Great Britain and Northern Ireland in late 2025 and India in January 2026, and one additional case reported in Qatar since the last RRA.

Globally, from 1 January 2022 to 30 June 2026, 145 countries and territories across all WHO regions reported 188 847 confirmed cases of mpox, with 521 deaths [case fatality ratio (CFR) – 0.3%] and including two additional countries: Comoros and Guinea-Bissau. Since the last RRA, an additional 10 908 confirmed cases, 44 deaths, and an average of 420 new confirmed mpox cases per week have been reported across all affected countries.

As with the previous version, this RRA assesses the risk for three population groups; i) global risk for individuals with multiple sexual partners, ii) risk for children in mpox historically endemic areas where risk of zoonotic transmission continues, and iii) global risk for all other individuals. Updates in understanding of mpox epidemiology within these groups are described herein.

Individuals with multiple sexual partners – global risk

Since the start of the global mpox outbreak in 2022, sexual activity in linked sexual networks has been the primary driver of sustained transmission and geographic spread, particularly in newly affected areas. The major and

predominant contribution of sexual transmission, whether linked to heterosexual or same-sex contact, to the introduction, spread and establishment of mpox in communities has been recognized across all affected settings.

Outside the WHO African Region, over 87% of reported cases have been among men who have sex with men (MSM), with transmission driven by spread among individuals with multiple sexual partners in a short time span and/or frequent partner change. Outbreaks are commonly linked to a sex-on-premises location or event. In Africa, transmission has often been reported to involve sex workers and their clients, long-distance drivers and other sexual networks where people have multiple partners and/or frequent partner change. In Africa, most transmission appears to be heterosexual.

In networks characterized by multiple partners and/or frequent partner change over short periods (days to a few weeks), the secondary attack rate for sexual contact may be high (estimated at 73% in some settings), facilitating epidemic spread. This pattern was observed during the initial spread of clade IIb MPXV among MSM communities and more recently clade Ib and IIb MPXV outbreaks in Africa and elsewhere, with amplification in key populations such as female sex workers and their clients as well as others with multiple partners, often in different locations. The recently identified recombinant clade Ib/IIb strain of MPXV has also been identified in this group with similar risk factors related to sexual contact. This risk group therefore includes people with multiple or frequently changing sex partners, including those with higher-risk sexual behaviours.

Sexual contact transmission likely occurs during various stages of infection, including pre-symptomatic or less apparent stages, the duration of which can vary between individuals. People with few or mild genital lesions might not recognise the infection. Studies have shown that the virus can be present in genital and anal mucosae, as well as in seminal and vaginal fluids of symptomatic infected individuals. Emerging data suggests that viral shedding from the genitals may occur up to four days before symptom onset, potentially contributing to undetected sexual contact transmission. This could explain the persistence of the virus in communities and the challenges encountered in interrupting human-to-human transmission, while the contribution of asymptomatic viral carriage to transmission remains unclear.

In most healthy adults of this group, mpox is often self-limiting. However, severe disease, including disabling complications, secondary infections, long-term sequelae and death, continues to occur most particularly but not exclusively in people living with advanced HIV disease or uncontrolled HIV infection, as well as other immunocompromising conditions. While overall case fatality has remained below 1% in most settings, up to 15-fold or higher fatality has been observed among individuals with immunosuppression, as well as in vulnerable infants, and particularly neonates in some settings. Notably, recent data from the African setting support observations elsewhere that people living with HIV who have suppressed viral loads and preserved CD4 counts experience mortality equivalent to HIV-negative individuals, indicating that the HIV-associated mortality risk is largely modifiable and deaths are preventable through sustained viral suppression and immune reconstitution. Although most people living with HIV globally are on antiretroviral therapy, significant and growing gaps in diagnosis and treatment persist in several low- and middle-income settings, with 26.3 million people estimated to be living with HIV in Africa in 2025, of which over 20% either do not know their status, are not on antiretroviral therapy or are not successfully virally suppressed, a situation exacerbated by recent funding cuts to HIV control programmes in many countries. In many contexts, over half of mpox cases are reported among people living with HIV, adding more complexity to the convergence of risks faced by this group (risk of infection, risk of severe disease, and risk of poorer health service access).

Most countries globally have activated outbreak responses, including surveillance, case investigation, contact tracing, case management, and infection prevention and control. However, control efforts have been impeded when sexual contact transmission or other risk factors are not adequately recognized, or when risk communication and community engagement do not effectively reach key populations and other individuals within sexual networks. Furthermore, countries are increasingly tasking HIV/STI control programmes – themselves heavily constrained by recent funding cuts – with participating in or leading the response, as well as activating immunization policies and programme capacity.

While targeted mpox vaccination has been implemented for groups at higher risk of mpox exposure in many countries in high and low-income settings, including administration of more than two million doses in Africa, coverage remains uneven or partial and most individuals in this group remain susceptible to MPXV infection, particularly in countries outside Europe and North America. In addition, younger cohorts are continually entering sexually active age groups. The duration and level of protection conferred by prior infection and/or vaccination remains uncertain.

Overall, transmission in these groups at higher risk is ongoing and likely to continue to spread geographically, which can be expected to lead to severe outcomes among immunocompromised individuals, thus focusing risk of spread among individuals with multiple partners in interconnected sexual networks who may not be aware of risk, and the risk of complications and death among vulnerable individuals. **The overall public health risk for individuals with multiple sexual partners is, therefore, assessed as moderate**.

Children in historically endemic areas – local risk

In historically endemic areas in West and Central African countries, where viruses continue to circulate in animal hosts and zoonotic spillover continues to occur, particularly in the Democratic Republic of the Congo, the highest number of mpox cases and incidence of deaths has been documented among young children (<5 years). Surveillance and diagnostic capacities in these settings remain suboptimal and have continued to decline in 2026, making the interpretation of available data challenging.

Among individuals younger than 50 years in the Democratic Republic of the Congo, age-specific mpox incidence appears broadly comparable across age groups, largely reflecting the underlying age distribution of the population. However, case fatality among suspected mpox cases in children under five years of age (CFR 3.0%) is higher than that observed among individuals aged five to 15 years (CFR 1.9%), and almost twice that observed among individuals aged 15 years and older (1.7%). Of note, the case fatality ratio in historically endemic areas of the Democratic Republic of the Congo remains much higher across all age groups than elsewhere (about 7 to 20-fold higher). This may arise from specific vulnerabilities including delayed or limited access to appropriate health care, compounded by concomitant health risks, such as malaria, varicella, measles, malnutrition, and complications of mpox such as dehydration and secondary infections. This higher fatality is particularly observed in infants and young children, who are largely immunologically naïve. At present, mortality data from this setting are largely drawn from syndromic surveillance and multiple studies are underway to better describe the risks associated with mpox in these settings.

While targeted vaccination has supported outbreak response, in the absence of established vaccination programmes against mpox and limited access to early and appropriate healthcare, children and pregnant women in the affected settings are likely to continue experiencing elevated health risks from mpox and MPXV infection.

The risk of geographic spread associated with non-sexual contact transmission is predominantly local. Available data indicate secondary attack rates of less than 20% following non-sexual household contact, suggesting that while children are vulnerable to more severe disease, and outbreaks in schools have been documented, children generally appear to have a limited role in driving viral spread. In addition, children have not often been reported as a source of introduction of mpox in new areas, and their contribution to wider geographic or cross-border spread remains negligible, compared to spread among adults exposed through sexual contact.

Most historically endemic areas are rural forested territories, where there is a risk of insufficient control capacities of outbreak response, particularly now as countries transition from an acute outbreak response approach to a longer-term disease control programme. Mpox programmes in these settings have previously been greatly under-resourced and will increasingly need to rely on preventive strategies and routine care capacity.

Overall, in the absence of vaccination programmes for mpox in historically endemic areas, and resources for national programmes conducting outbreak response activities, the virus will likely continue to circulate, disproportionately affecting younger children. **The overall public health risk for children in historically endemic areas is, therefore, assessed as moderate**.

All other individuals – global risk

For individuals outside the above two risk groups, the overall risk of acquiring mpox is lower. While illness in the general population is typically mild and self-limiting, with most cases requiring only supportive care and no hospitalization, severe disease and death can also occur, albeit less commonly. While the risk of severe outcomes is much higher among individuals with underlying immunocompromising conditions, these persons generally represent a small proportion of cases reported in recent outbreaks, and thus the majority of cases with complications or deaths may actually occur in persons without immune suppression in some settings. As noted above, case fatality in historically endemic areas of the Democratic Republic of the Congo remains much higher across all age groups than elsewhere (about 7 to 20-fold higher). More research is needed to characterise less studied risk factors for severe disease.

Some data suggest that adults vaccinated before the cessation of routine smallpox vaccination worldwide, in 1980 or earlier in many countries, are likely to retain partial cross-protective immunity and present with lower disease severity. While breakthrough cases of mpox have been documented in some older previously vaccinated persons, epidemiological data indicate that few mpox deaths have been reported in this group. New cases of mpox with clade Ib MPXV in various regions have predominantly been associated with sexual contact in people with a history of travel to outbreak-affected areas who developed symptoms just prior to or upon return. Spread through sexual networks from some cases has ultimately led to the establishment of community transmission of clade Ib MPXV in several countries outside Africa.

Overall, the spread of clade Ib MPXV in newly affected areas has remained largely confined to groups at risk. Since the start of the global outbreak in 2022, the general population has not been widely affected by ongoing circulation of clade IIb MPXV in high income settings, nor has it been implicated in mpox introduction or establishment in new geographic areas. Secondary transmission to non-sexual contacts has remained limited. Thus, individuals in this risk group ("all other individuals") affected by clade IIb have mainly been infected through household or occupational contact, characterized by low secondary attack rates and limited onward transmission. Nonetheless, explosive outbreaks in West Africa have demonstrated that all age groups can be significantly affected such that continued vigilance is required for all mpox clade outbreaks in different settings. Within this broad group which includes most people, there are also other individuals in settings where there is a higher risk of onward mpox transmission, such as those in internally displaced person (IDP) and refugee camps and other congregate, overcrowded settings. Furthermore, some more vulnerable individuals are considered to face a higher risk of severe disease and poorer disease outcomes if they fall ill, particularly pregnant individuals, neonates, and infants. Poor outcomes have been documented among pregnant individuals and their unborn children, including spontaneous abortions, missed abortions, still births, congenital mpox and early neonatal death, with recent studies reporting these adverse outcomes in about half of pregnant individuals followed up. The healthcare-associated clade Ib mpox outbreak among neonates and infants in Pakistan in early 2026 which resulted in a CFR higher than 20% also demonstrated that mpox transmission can lead to severe consequences in highly vulnerable populations. In this instance, mpox in a neonatal intensive care setting resulted in rapid amplification and disproportionate impact in neonates and infants.

Public health control measures such as laboratory confirmation, rapid contact tracing and isolation have generally been sufficient to manage mpox in the general population, notably in high-income settings. Nonetheless, partner notification strategies should supplement classic contact-tracing to reach non-disclosed sexual partners. Vaccination has been prioritized for groups at higher risk of exposure with the intent to prevent and stop transmission. Where vaccines have, in some settings, been mainly offered to health workers for their individual protection, this strategy builds confidence and quality of care but cannot be expected to play a major role in stopping outbreaks.

In all settings therefore, the general population largely remains immunologically naïve to mpox, while the risk to health, contribution to international spread and burden of insufficient response capacities, remains low. Exceptions to this include where mpox is inadvertently introduced into high-risk settings, such as newborn and infant care units. **The overall public health risk for all other individuals without multiple sexual partners is, therefore, assessed as low**.

Overall public health risk

Mpox continues to pose a public health risk across all WHO regions, with the likelihood and impact varying by population group, transmission context, and local response capacity. The African Region will most likely continue observing sustained community transmission in several countries outside historically endemic areas, as well as recurrent outbreaks in countries where zoonotic transmission occurs. While all countries remain at risk of importation and limited local transmission, recent outbreaks (starting from 2022-2023) have confirmed observations that sustained transmission and geographic spread are largely driven by sexual contact in specific population groups and network dynamics, rather than in the general population, with some notable exceptions such as health facility-based outbreaks.

While most countries have established outbreak response mechanisms, such as early detection and contact tracing that help in controlling viral spread, the effectiveness of classic contact-tracing for a sexually transmissible infection remains very limited. Other countries are less prepared and at a higher risk of missing chains of local transmission, especially where low index of suspicion, stigma, and discrimination create barriers to access diagnostic testing, clinical care services and implementation of infection prevention and control measures, and where political and socio-cultural

contexts or other circumstances preclude timely information-sharing with communities, health sector partners and timely and complete reporting to WHO.

While improvements in understanding mpox transmission and risk have improved since the first mpox public health emergency of international concern (PHEIC) was declared in 2022, important knowledge gaps remain. These include uncertainties regarding the role of asymptomatic or pauci-symptomatic infections, the duration and extent of immunity following infection or vaccination (e.g., for immunocompromised individuals), risk factors for severe disease beyond known immunocompromising conditions, and the contribution of zoonotic spillover and potential human-to-animal transmission. Limited data regarding animal reservoirs and transmission at the human–animal–environmental interface further limits risk characterization in endemic settings. The lack of reporting by some countries further limits overall community awareness, appreciation of risk, and visibility on continuing evolution of the epidemic.

Several cases and larger outbreaks have been reported in humanitarian emergency settings such as IDP and refugee camps and other congregate, overcrowded settings, but the risk of spread and modes of transmission in these settings, including the role of living conditions among other factors, are still poorly understood. Additionally, transmission between children outside of the household setting is not fully understood, and its potential to sustain spread of the virus in the community context has not been quantified.

In recent years, access to diagnostics, vaccines, and response tools has improved through coordinated efforts by WHO and partners, and 19 countries in Africa have implemented vaccination for populations at highest risk. However, funding constraints, competing public health priorities, and reliance on limited resources for vaccine supply continue to challenge sustained response efforts, particularly in low- and middle-income countries. Delays in vaccine introduction and limited coverage reduce the potential impact of vaccination, underscoring the importance of prioritization and timely vaccine deployment. In addition, data on the effectiveness of available therapeutics for mpox remain limited, particularly in settings reporting the highest burden of disease.

The detection of a recombinant MPXV strain with genetic elements of both clade Ib and IIb MPXV warrants continued monitoring. To date, one additional case has been detected since the last RRA, bringing the cumulative case count to three. The geographic areas where the recombination event first occurred remain unknown. While the public health risk associated with this recombinant strain is currently considered low, ongoing genomic surveillance is essential given uncertainties related to viral evolution and recombination.

Overall, MPXV continues to circulate in all WHO regions and pose distinct risks across different population groups and settings. Sustained transmission of this still emerging and evolving orthopoxvirus continues, posing health risks for vulnerable individuals of all ages and in all settings. While response capacity continued to improve during the second PHEIC, it remains uneven with suboptimal reporting practices, and highly dependent on dwindling or non-existent resources as priorities shift. Transition to longer term disease prevention and control programmes and strategies is still in early stages in most settings and resources remain extremely limited as interest in mpox response wanes. Taken together, this context creates additional risk that the gains made over the past few years may erode. Thus, **the overall public health risk at the global level is assessed as moderate.**

Naming conventions for MPXV and definition of risk groups

After consultations with experts, countries, and the general public, WHO has adopted the name "mpox" for the disease, which in 2024 became the preferred term in English. "Monkeypox" remains a synonym, to match historic information, and the virus causing the disease is the *Orthopoxvirus monkeypox*, or monkeypox virus (MPXV). [1]

MPXV clades were also renamed in 2022, with nomenclature of a Roman numeral for each clade, with lowercase Latin characters for subclades; the Congo Basin clade was renamed clade I and the West African clade was renamed clade II.[1] Each of the clades has two subclades, Ia and Ib for clade I, and IIa and IIb for clade II. Subclades Ia and Ib were defined after the emergence of subclade Ib in the South Kivu province of the Democratic Republic of the Congo in 2023, and subclade Ia is currently considered to encompass all other strains of clade I that are not Ib. Three cases of a new recombinant clade Ib/IIb MPXV have been detected, one in the United Kingdom of Great Britain and Northern Ireland (hereafter "the United Kingdom"), one in India, and one in Qatar.

In this assessment, the population groups for which risk was assessed were selected based on known transmission dynamics, risk factors for infection and severe disease, as well as types of public health interventions and programmes for outbreak response and control. Within these groupings, additional risk groups are considered.

Recent mpox outbreaks, particularly in newly affected areas, have been predominantly driven by sexual contact, followed by non-sexual contact within households or, less commonly, community or congregate settings. Sexual contact with an mpox case results in more efficient transmission due to extensive skin and mucosal contact, the presence of virus on lesions, mucosae, and sexual fluids, the probable pre- and paucisymptomatic transmission, and the relatively long infectious period of the virus. These characteristics are further amplified in sexual networks characterized by multiple and concomitant partnerships, which facilitate repeated exposure events within a short time frame and can lead to sustained community transmission and geographic spread. Based on these considerations, the risk was assessed for the following population groups:

- **Individuals with multiple sexual partners** Individuals engaged in sexual networks characterized by multiple partners, frequent partner change, overlapping partnerships and/or anonymous sexual contacts. This group includes men who have sex with men (MSM) with multiple partners, sex workers and their clients, and anyone else who engages in sexual activity with multiple sex parters. These populations overlap with groups known to be at increased risk of other sexually transmitted infections, including HIV, which is relevant both for transmission dynamics and for the risk of severe mpox disease in individuals with untreated or advanced immunosuppression.

- **Children in mpox historically endemic areas[2]** This group is largely immunologically naïve to mpox and are considered as a distinct group due to different exposure pathways and health risks. In these settings, infection may result from zoonotic spillover or human-to-human contacts, particularly within the household. Risk of severe disease is highest in young children, declining among older children and adolescents. Combined with limited access to quality healthcare in many low-resource endemic settings, this places children at increased risk for adverse health outcomes, despite their limited role in driving wider geographic spread.

- **All other individuals** This group includes the general population not captured above. In the absence of close or prolonged contact with a confirmed case, the likelihood of infection in this group remains low, and sustained community transmission has not been a major driver of recent outbreaks. Outbreaks may nonetheless occur in health facilities or congregate settings, particularly affecting vulnerable individuals including health personnel or patients, infants or others when the virus is introduced from the community.

Risk questions

The risk questions below assess the global public health threat posed by mpox by evaluating its potential likelihood and consequences on human health, its spread, and the sufficiency of current control measures. For further details on the information provided in this table, please refer to the section on Supporting Information that follows.

Risk question		Assessment		Risk	Rationale
Individuals with multiple sexual partners		Likelihood	Consequences		
Risk for human health	Global	Likely	Minor	Moderate	In most healthy adults, mpox is a self-limiting viral infection. Associated clinical conditions are well described, including severe discomfort, pain and secondary infections, and can be managed with supportive care. Longer-term consequences and sequelae include disfigurement, blindness, and ongoing stigma after recovery. Mpox may also lead to severe disease and death, with much higher risk of these outcomes among immunocompromised individuals. People with multiple sex partners have a higher incidence and prevalence of sexually transmitted infections, including HIV, and adolescents or adults with mpox often have co-infections with syphilis, herpes or HIV. When HIV is untreated or poorly controlled, associated immunosuppression may increase the risk of severe mpox manifestations, including extensive lesions, secondary bacterial or pulmonary infections, organ failure, and death. These observations have been consistent across mpox virus clades. Case fatality in this risk group has largely been below 1% overall, and up to 15% or more among immunosuppressed individuals with CD4 count below 200 cells/mm^3. In many countries, the majority of people living with HIV are receiving antiretroviral therapy and their HIV viral loads have been suppressed. Nevertheless, according to UNAIDS 2024 estimates, around 9 million individuals in different settings, especially in low- and middle-income countries, remain unaware of their HIV status or are not on treatment, which places them at a higher risk of severe outcomes in case of MPXV infection. It is estimated that 600 000 new HIV infections occurred in Africa in 2025, raising the count of people living with HIV to 26.3 million (UI 22.2 to 30.9 million). In addition, budget cuts in global health over the past one-and-a-half years have affected HIV programmes in several low- and middle-income countries, which may further increase the vulnerability of people living with HIV. Studies have shown that MPXV can be detected in genital and anal mucosae, as well as in seminal and vaginal fluids of symptomatic infected individuals, providing biological evidence supporting sexual contact transmission. Emerging data further suggest that viral shedding from the genital tract may occur up to four days before symptom onset, contributing to undetected transmission through sexual contact. This pre-symptomatic infectious period may help explain the persistence of mpox within sexual networks and the challenges in interrupting human-to-human transmission. However, the contribution of asymptomatic viral carriage to transmission remains unclear. Two of three cases of a recombinant clade Ib/IIb MPXV strain have been detected globally in individuals in this group, one in the United Kingdom (with travel history to a country in WHO South-East Asia Region) and another in India (with travel history to the Arabian peninsula). Nonetheless, no difference in clinical manifestation and disease severity from other known clades has been observed. This risk group, especially those who are immunocompromised, represent the most likely host where co-infection with different strains could lead to viral recombination. While the risk of severe outcomes is much higher among individuals with underlying immunocompromising conditions, these persons generally represent a small proportion of cases reported in recent outbreaks. As such,

					while mpox infection is considered to result in moderate consequences for immunosuppressed individuals specifically, the consequences for the overall risk group are assessed as minor. The impact on human health for the overall risk group is, therefore, assessed as likely, and the consequences are considered minor beyond specific sub-groups with immune suppression, resulting in a moderate risk for human health overall in this group.
Risk of geographic spread	Global	Almost certain	Minor	Moderate	Since the start of the global outbreak in 2022, transmission within extended networks of individuals with multiple sexual partners has been the primary amplifier of the geographic spread of mpox to new locations. In many instances, individuals travelling to areas with ongoing transmission are exposed through sexual contact with a person with mpox, including during early or less apparent stages of infection, travel back during their incubation period, and develop symptoms upon return to their place of residence. Occasionally, pre-symptomatic individuals from areas with ongoing transmission have travelled to other places for work or tourism and have developed the disease in the country of destination. In several settings, sexual contact transmission has also been followed by secondary transmission within households, particularly when cases are not promptly detected and isolated. Conversely, when imported cases are promptly detected, diagnosed and isolated, further transmission in the destination setting has generally been limited. However, when initial cases are not detected in a timely manner and undetected transmission occurs within sexual networks, mpox becomes established in new geographic areas. Since 2024, sex workers, their clients and other individuals or settings where heterosexual transmission occurs have played a greater role in the geographic spread of mpox or specific mpox clades to new settings, while the previously most affected group of men who have sex with men continue to also be affected by circulating virus clades. Given the extent and interconnectedness of these sexual networks, and the potential for transmission through sexual contact during the pre-symptomatic phase, continued geographic spread through this population group remains almost certain. There is insufficient information about the recently detected recombinant Ib/IIb MPXV strain. The three cases identified so far, and their respective travel histories have implicated six countries in three WHO regions. Diagnostic escape was also documented for these cases, as one was first identified as one clade then reclassified as another and two were found to be recombinant strains through full genome sequencing which is not widely available and not used for all cases. The very limited available data therefore suggest much wider circulation of this recombinant strain occurred than the three cases detected. It is not known if this strain continues to circulate. Other recombinant strains may also emerge in future. Overall, secondary transmission (of any clade) through household or other non-sexual contact has been relatively limited, and sustained transmission outside these networks has not been a major driver of spread. Consequently, risk of global geographic spread is assessed as moderate.
Risk of insufficient control capacities	Global	Likely	Minor	Moderate	Since 2024, 114 countries have reported cases with most recent larger outbreaks occurring in countries in Africa. Almost all countries reporting cases have activated response capacities, including through implementation of an Incident Management System (IMS). However, several countries have faced challenges in securing adequate and sustained funding to maintain response activities over time. The risk of insufficient control capacities is higher in low- and middle-income countries facing multiple concurrent public health emergencies, including Bundibugyo virus disease, and where surveillance, laboratory and response systems are often stretched. Limited and unpredictable funding, shortages of trained health workers, and competing outbreak priorities delay case

					detection, contact tracing, risk communication, and implementation of targeted prevention and control measures. These constraints can reduce the timeliness and effectiveness of the response, increasing the likelihood of sustained transmission. Since late 2024, 19 countries in Africa have implemented mpox vaccination for populations at greatest risk, including for health workers, contacts of cases, sex workers, men who have sex with men, and other priority groups based on local epidemiology. Many countries vaccinated narrowly, prioritizing contacts and health workers which cannot stop onward transmission in the groups were mpox spreads. Others pivoted more quickly with innovative vaccination strategies to reach those most at risk in community settings and health services such as HIV/STI clinics. While vaccination has strengthened prevention efforts, coverage remains heterogeneous and dependent on available resources and mpox vaccine supply limited by the cost of the vaccine and voluntary donation of doses by countries with smallpox vaccine reserves. Globally, vaccination coverage among individuals with multiple sex partners remains uneven, and most individuals in this group, particularly in countries outside Europe and North America, remain susceptible to mpox. In addition, younger cohorts of individuals entering sexually active age groups are continually being added to this population, and the duration and level of protection conferred by prior infection and/or vaccination remain uncertain. The risk of insufficient control capacities is further increased when sexual transmission is not adequately recognized in outbreak response strategies, or when risk communication and community engagement activities do not effectively reach individuals with multiple sexual partners, resulting in delayed behaviour change, delayed health-seeking, and missed opportunities for early interruption of transmission. While full engagement of emergency response programmes with HIV/STI control programmes is absolutely critical, such engagement remains patchy, partial or time-limited in most countries and global partner organizations. Failing to initiate such coordination and integration represents a major risk for ongoing mpox prevention and control in the most affected and vulnerable populations. Overall, it is likely that some countries will have insufficient control capacities for mpox; however, the consequences are assessed as minor given the relatively limited number of reported cases in most countries currently despite the extent of global mpox spread to date. Risk is increasing due to lack of resources for prevention and response and therefore assessed as moderate.

Risk question Children in historically endemic areas		Assessment Likelihood	 Consequences	Risk	Rationale
Risk for human health	Local	Likely	Moderate	High	Historically endemic areas include several countries in West and Central Africa where zoonotic transmission has predominantly occurred in rural forested settings, with subsequent local outbreaks and further human-to-human transmission in peri-urban and urban areas. The highest burden has been reported in the Democratic Republic of the Congo, where surveillance and diagnostic capacities remain suboptimal for comprehensive investigation, sampling, and testing of all suspected mpox cases, and where surveillance performance has declined since the last RRA, further complicating interpretation of available epidemiological data. Although children are disproportionately affected in the Democratic Republic of the Congo, and they are less represented among reported mpox cases in some other historically endemic countries outside the Democratic Republic of the Congo, new outbreaks can be heralded by an index case in an infant or young child. Among individuals younger than 50 years who are unlikely to have vaccine-derived immunity from prior smallpox vaccination, age-specific mpox incidence appears broadly comparable across age groups. However, the case fatality ratio among suspected mpox cases in children under five years of age (3.0%) is almost twice that observed in individuals aged 15 years and older (1.7%).The higher fatality observed in young children, who are largely immunologically naïve, is likely driven by delayed or limited access to quality health care and compounded by concomitant health risks, including malaria, varicella (chickenpox), measles, varying degrees of malnutrition, and secondary bacterial or opportunistic infections. Immunity from potential prior mpox infection in older children and adults may also confer partial protection among individuals aged 15 years and older. In the absence of established vaccination programmes against mpox in these settings, children are likely to continue experiencing an elevated risk of adverse health outcomes following mpox infection. Combined with limited access to early diagnosis and quality paediatric care, these factors are expected to sustain a disproportionate disease burden among young children in historically endemic areas where zoonotic spillover events continue to occur. Given the observed severity and fatality in young children, the impact of human health is considered likely, and the consequences are assessed as moderate, resulting in an overall high risk to human health in this population group.
Risk of geographic spread	Local	Likely	Minor	Moderate	The risk of geographic spread associated with children in historically endemic areas is predominantly local, reflecting limited mobility and transmission occurring mainly through caregivers or other household contacts. While contact among children outside the household context has been hypothesized as a factor contributing to sustained community transmission, conclusive evidence supporting this mode of spread remains limited. Available data indicate low secondary attack rates following non-sexual household contact (generally below 20%), suggesting that children are unlikely to be major amplifiers of wider geographic spread. Children have not generally been reported to have introduced mpox into new geographic areas, and transmission is therefore expected to remain largely confined to households or local communities, with limited contribution to long-distance or cross-border spread. Based on likely occurrence of localized transmission and minor overall consequences at the regional and global levels, the risk of geographic spread associated with this population group is assessed as moderate.

Risk of insufficient control capacities	Local	Highly likely	Minor	Moderate	The likelihood of insufficient control capacities for mpox affecting children in historically endemic areas is high, particularly since these are mostly low-income countries facing concurrent public health emergencies. Surveillance, laboratory confirmation, and paediatric case management capacities are often constrained by limited funding, shortages of trained health workers, competing outbreak priorities, and weak referral and infection prevention and control systems at community and primary healthcare levels. As countries transition from acute outbreak response mechanisms to longer-term disease control approaches, mpox programmes, historically under-resourced in these settings, are increasingly reliant on routine health system capacity. These limitations may result in delayed outbreak control; however, transmission associated with children is predominantly local and limited, and children are unlikely to drive large-scale outbreaks. As a result, while insufficient control capacities are considered highly likely in this population group, the overall consequences at the population and geographic levels are assessed as minor, and the overall risk as moderate.

Risk question All other individuals		Assessment Likelihood	 Consequences	Risk	Rationale
Risk for human health	Global	Unlikely	Minimal	Low	For individuals outside of the other two risk groups assessed in this RRA, MPXV infection is typically self-limiting, with most cases requiring supportive care for acute illness, secondary infections or longer-term sequelae. Hospitalization is required in a minority of patients, and severe disease and death are uncommon in the general population. It is nonetheless important to note that in areas where zoonotic transmission continues, all age groups are at much higher risk of infection and severe disease, and at a seven to 20-fold higher risk of death compared to non-endemic areas. Studies to characterize the clinical progression of mpox continue in various African settings. Severe outcomes may occur in anyone, and most particularly in people with underlying immunocompromising conditions—such as advanced HIV infection, malignancies under active treatment, immunosuppressive therapies, poorly controlled diabetes, or other chronic conditions— as well as other vulnerable persons, including pregnant individuals, neonates, and infants. Poor outcomes have been documented among pregnant individuals and their unborn children, including spontaneous abortions, missed abortions, still births, congenital mpox and early neonatal death, with recent studies reporting these adverse outcomes in about half of pregnant individuals followed up. The healthcare-associated mpox outbreak with eight confirmed infant deaths among neonates and infants in Pakistan in early 2026 which resulted in a CFR higher than 20% also demonstrated that mpox transmission can lead to outbreaks with severe consequences in highly vulnerable populations. In this instance, mpox in a neonatal intensive care setting resulted in rapid amplification and disproportionate impact in neonates and infants, affecting ultimately at least six health facilities. While these individuals represent a relatively small proportion of the overall population in this group, these examples illustrate the ongoing risk of introduction of MPXV in settings and populations where outbreaks can take a greater toll. A proportion of adults, particularly those born before the cessation of routine smallpox vaccination, are likely to enjoy the cross-protective benefits of smallpox vaccination. Although protective immunity may wane over time, this residual immunity is expected to reduce disease severity and the risk of adverse outcomes in older age groups. Breakthrough mpox infections have been reported among some previously vaccinated individuals; epidemiological data suggest that the risk of severe disease in these cases is lower, and mpox-related deaths in vaccinated individuals have been rare. Available epidemiological data indicate that the CFR in the general population has remained below 1% in recent outbreaks. Given the generally self-limited clinical course of disease, low observed fatality, presence of residual orthopoxvirus immunity in parts of the population, and the limited size of subgroups with increased vulnerability, the consequences of mpox infection for human health in this population group are considered minimal. The overall risk to human health in the general population is therefore assessed as low.
Risk of geographic spread	Global	Unlikely	Minimal	Low	Among individuals outside of the other two risk groups assessed in this RRA, the risk of geographic spread of mpox remains low. Since the start of the global outbreak in 2022, transmission has not been amplified in the general population following introduction or establishment of mpox in new geographic areas. Transmission in the general population has largely occurred in the context of defined exposure events, such as household contact with a confirmed case or occupational exposure, rather than through sustained community transmission. Secondary transmission from such cases to non-sexual contacts has generally been limited, and transmission of

					mpox in newly affected areas has largely remained confined to higher-risk population groups, particularly in high-income settings. Some explosive or long-lasting outbreaks have all the same exhibited rapid or ongoing spread which includes members of the general population and for which ongoing modes of transmission remain poorly described, most notably in African settings including Sierra Leone, which brought the outbreak under control after several months, and Madagascar, where the largest and longest-lasting epidemic of mpox is still ongoing after nine months with no sign of remission. Thus, vigilance remains critical at the onset and throughout any mpox outbreak to monitor epidemiological trends, population groups most affected, and modes of transmission, to devise effective public health interventions to stop the outbreak. Although international travel by individuals from areas with ongoing transmission may occasionally result in imported cases, onward transmission in destination settings has generally been limited when cases are promptly detected and appropriate public health measures are implemented. Available data indicate low secondary attack rates associated with non-sexual contact, further limiting the potential for wider spread. Nevertheless, within this broad group, there are individuals considered to face a higher risk of onward mpox transmission if infected, like those in IDP and refugee camps and other congregate, overcrowded settings, or in health facilities with inadequate prevention and control practices. To date, few sustained transmission chains or large outbreaks have been attributed to the general population group, and no evidence suggests increased transmissibility associated with recently detected or recombinant mpox virus clades in this context. Specific conditions can create extended chains of transmission, such as during the 2026 outbreak in Pakistan when mpox was repeatedly introduced from the community into health facilities and back home to caregivers, transferred along with affected infants moved between health facilities, and spread between hospitalized infants due to inadequate IPC practices, leading to sequential outbreaks in hospitals and homes and multiple deaths. Thus, unreported ongoing transmission in the community can lead to unexpected outbreaks in a range of settings. Unreported ongoing transmission in countries that do not report cases also represents a significant risk of further spread in local communities and internationally, as has been reported on numerous occasions following travel to or from countries in the WHO Eastern Mediterranean region and most notably in the Arabian Peninsula. This phenomenon affects both travelers and migrant workers who return to their home countries for medical care. Beyond such specific circumstances, geographic spread in the general population is considered unlikely among individuals who do not have multiple sex partners, and the consequences are usually minimal. The risk of geographic spread is therefore assessed as low.
Risk of insufficient control capacities	Global	Unlikely	Minimal	Low	Public health control measures to manage mpox outbreaks vary across settings and have generally been sufficient to avert spread in the general population in most settings. In high-income countries, no major challenges in control capacities have been observed since the decline in cases during the second half of 2022. In low- and middle-income countries facing multiple public health priorities, while overall response capacities may be constrained, and with some exceptions, the impact of these constraints for the general population has remained limited.

					Transmission among all other individuals typically occurs through identifiable exposure events, such as household or occupational contact, which are more readily traced and managed through standard public health interventions, including case investigation, contact tracing, infection prevention and control measures, and risk communication and community engagement activities. Since 2022, most countries reporting mpox cases have activated response capacities, often through established Incident Management System (IMS) structures. Vaccination is currently recommended for specific higher-risk groups, including men who have sex with men, sex workers and other individuals with multiple sexual partners, as well as contacts of cases and health workers. Despite the absence of population-wide vaccination, the number of cases in this group has generally remained within the capacity of existing public health systems to manage. As a result, while gaps in funding or workforce capacity may delay response activities, the risk of insufficient control capacities for the general population is assessed as low.

Major actions recommended by the risk assessment team

	Action	Timeframe
☐	Refer the event for review by IHR Emergency Committee for consideration as a PHEIC by DG (Art 12, IHR)	Not applicable
☐	Immediate activation of WHO response mechanism as urgent public health response is required	Not applicable
☒	Recommend setting up of WHO grading call (funding can be accessed before grading completed)	Immediate
☐	Immediate support to response, but no WHO grading recommended at this point in time	Not applicable
☐	Rapidly seek further information and repeat RRA (including field risk assessment)	Not applicable
☒	Support Member State to undertake preparedness measures	Continuous
☒	Continue to closely monitor	Continuous
☐	No further risk assessment required for this event, return to routine activities	Not applicable

[+]If chosen, list actions and identify **persons responsible and due dates** for each action in section 2 (Supporting information)

Supporting information

Hazard assessment

Mpox is an infectious disease caused by the monkeypox virus (MPXV), which is part of the genus *Orthopoxvirus*, that includes the variola virus, the causative agent for smallpox. There are two known clades of MPXV: clade I (previously called the Congo Basin clade), which includes subclades Ia and Ib; and clade II (previously called the West Africa clade), which includes subclades IIa and clade IIb. Subclades Ia and Ib were defined after the emergence of subclade Ib in the South Kivu province of the Democratic Republic of the Congo in 2023, and subclade Ia is currently considered to encompass all other strains of clade I that are not Ib.[3] In December 2025, the United Kingdom detected the first case of a clade Ib/IIb recombinant.[4] After its classification as a novel MPXV recombinant strain, a second case detected in India in September 2025 was retrospectively reclassified, and more recently, a third case was detected in Qatar in March 2026. To date, these are the only known cases of this recombinant, each having reported travel from a different country or region than their own.

Historically mpox has been primarily characterized by zoonotic transmission, with outbreaks occurring in tropical rainforest regions of East, Central and West Africa, with occasional exportations of cases to other areas. In the context of zoonotic transmission, MPXV is transmitted from animals to humans through direct contact with infected animals (e.g. bites, scratches, or direct contact with the animal's body fluids), and possibly through processing and consuming infected animals or their body parts and fluids.[6] Once the virus transmits from animals to humans, it can spread among humans through direct close physical contact with an infected person, indirect contact (contact with contaminated materials), transmission through infectious respiratory particles, and mother-to-child transmission (vertical transmission).[5]

Since May 2022, a multi-country outbreak of mpox due to clade IIb MPXV has affected over 140 countries and territories worldwide, most of which had never reported mpox before.[6] This outbreak has been sustained by human-to human transmission, mainly through sexual contact.[7] This global event has also brought to light the long-standing and continuing expansion of areas affected by clade I MPXV across Africa, particularly in the Democratic Republic of the Congo, where in addition to zoonotic exposure, human-to-human transmission of clade Ib MPXV, primarily through sexual contact, has been ongoing since September 2023.[8]

Symptoms of mpox in humans include swollen lymph nodes, fever, and a skin and/or mucosal rash that may initially be mistaken for other rash illnesses such as chickenpox (caused by the varicella virus), or sexually transmitted infections like herpes or syphilis, if the rash or lesions appear in the genital or anal region. The ongoing 2022-2026 outbreak has shown that mpox can also present with very few lesions, and there have been some reports of asymptomatic infection.[9] There is currently very limited documentation of asymptomatic infection for the other subclades. The contribution of asymptomatic infection to transmission remains poorly understood. Cases of mpox due to clade Ib MPXV and clade IIb MPXV have presented with relatively more mucosal lesions

than previously described for other subclades, with many of these lesions located in the genital or anorectal area, linked to sexual contact transmission.[10]

While ocular, genital and inguinal lesions had already been well described, newly recognized phenomena during the global outbreak include severe rectal pain and inflammation (proctitis), inflammation of the penile glans (balanitis) and urethra (urethritis) and urinary retention, and involvement of the colon, most likely related to contact transmission among men who have sex with men. In the Democratic Republic of the Congo in 2023 and 2024, ulcerative vulvo-vaginal lesions and peritonitis were seen in female patients with confirmed mpox due to clade I MPXV. While encephalitis and sepsis were known to occur, myocarditis[11] and parotitis[12] are now also recognized as rare complications.

Generally, most healthy individuals with mpox in the global outbreak have presented with self-limiting clinical manifestations, mostly not requiring hospitalization, often attributed to lower severity associated with clade IIb MPXV, but becoming more common as the spread of clade Ib expands to new settings with better access to quality healthcare.[13] Globally, the CFR among confirmed mpox cases from 2022 to June 2026 is around 0.3% (521/188 847), lower in Europe and the Americas, and higher in the African and South-East Asia Regions. The outbreak in South Africa from May to August 2024, which resulted in a CFR of 12.5%, illustrated that clade IIb MPXV infection can cause severe disease in nearly all patients when it spreads within networks of persons with weakened immune systems due to a high prevalence of uncontrolled HIV or advanced HIV disease.[14] The healthcare-associated mpox outbreak among infants in Pakistan in early 2026, which led to eight confirmed neonatal and young infant deaths due to mpox among 34 confirmed cases, resulted in a CFR higher than 20% also demonstrated that mpox transmission can lead to outbreaks with severe consequences in other highly vulnerable populations. In this instance, mpox in a neonatal intensive care setting resulted in rapid amplification, spread across at least six health facilities, and disproportionate impact in neonates and infants. Poor outcomes have also been documented among pregnant individuals and their unborn children, including spontaneous abortions, missed abortions, still births, congenital mpox and early neonatal death, with recent studies reporting these adverse outcomes in about half of pregnant individuals followed up. [15,16]

Over time, the Democratic Republic of the Congo has also reported one of the highest mpox case fatality estimates, up to 4% in 2024 among suspected mpox cases. However, due to improved surveillance and better confirmation rates among suspected cases case fatality ratio has also decreased for cases in the Democratic Republic of the Congo. In historically affected and/or endemic areas is the CFR is currently about 2.2% among suspected cases, while in provinces with better confirmation rates and a higher proportion of cases among adults such as Kinshasa, North and South Kivu, the CFR is below 1%. This observation of a higher CFR in endemic areas of the Democratic Republic of the Congo has been corroborated by the PALM007 study, which was conducted in two historically endemic areas of the Democratic Republic of the Congo where clade Ia was present, to investigate the effectiveness of tecovirimat against clade I MPXV infection, and reported an overall mortality of 1.7% across all ages and disease severity.[17] Higher case fatality is also observed among children, particularly those under the age of 5 years, which in endemic provinces experience a CFR of about 3%, presenting with more extensive body rashes, possibly linked to a multitude of factors such as potentially higher virulence of the virus, limited access to affordable quality health services, as well as young age and underlying health status of affected individuals. Moreover, limited surveillance capacity and resources in the Democratic Republic of the Congo hinder access to care in less severe cases until illness progresses or complications develop, potentially skewing observations towards more severe cases.

Exposure assessment

Modes of transmission and exposure settings

While human-to-human mpox transmission is possible through skin-to-skin contact, skin-to-mucosal contact, fomites, and infectious respiratory particles, epidemiological and surveillance data from the global 2022-2026 outbreak in newly affected countries, and more recently the spread of clade Ib MPXV, show that MPXV transmission is mainly driven by sexual contact, followed by transmission within households. Sexual contact includes skin-to-skin and skin-to-mucosal contact, as well as contact with semen or vaginal fluids during sex. Studies have detected the presence of virus in semen,[18] vaginal fluid[19] and anorectal swabs,[20] indicating that transmission through this type of contact may be multifaceted.[6,21,22] The presence of live virus in anal swabs up to four days before symptom onset suggests some contribution of asymptomatic and/or presymptomatic transmission which may in part explain the rapid spread of the virus through sexual contact. Animal models show an increased viral shedding and transmission of mpox via the genital mucosae.[23]

Exposure to MPXV can also occur through contact with infectious respiratory particles or contaminated surfaces, objects or fabrics, including clothing, bedding or towels used by someone with mpox. A recent hospital study (2024–2025) identified extensive environmental contamination in mpox isolation rooms, with MPXV DNA detected on most surfaces and viable virus recovered from a subset, indicating a potential risk of fomite-mediated transmission.[24] The healthcare-associated mpox outbreak among neonates and infants in Pakistan in early 2026 – in which 34 confirmed epidemiologically linked cases, including eight deaths, were reported – demonstrated that nosocomial transmission can be marked by rapid amplification, spread across multiple health facilities, and disproportionate impact in especially vulnerable populations, such as neonates and infants, even where the risk of transmission is perceived to be limited. In this setting, the risk associated with admission of infants with mpox to busy neonatal intensive care units had not been recognized and the subsequent relative contributions of fomite vs person-to-person have not been easy to discern. These instances nonetheless highlight the critical importance of early diagnosis of atypical infectious syndromes and rapid implementation of strict infection prevention and control measures, including environmental cleaning, frequent hand hygiene, appropriate use of PPE, and adequate isolation and ventilation. Health workers are also at risk when infection prevention and control measures – use of personal protective equipment (PPE), safe handling of sharps, and hand hygiene – are inadequate.[25]

Data from the Democratic Republic of the Congo, as well as the more recent outbreaks in West African countries, have shown that transmission through sexual contact also occurs for all MPXV clades.[26,27] The presence of commercial sexual networks among mpox cases suggests it is likely to be transmitted undetected in these key populations, including their clients, who may be harder to reach through traditional means, with fewer economic resources and social stigmatization. Notably, while sexual contact appears to be a major mode of transmission for clade Ib MPXV in the currently affected areas, transmission through all other types of contact continues to occur and as the outbreaks expand and the virus enters more households, there is a shift in transmission dynamics towards an increasing proportion of household transmission.

Most importations of mpox in new areas are linked to people who acquired mpox in an affected area, very often through sexual contact, and travelled during their incubation period, or even during the initial phase of the disease, to develop disease in the place of destination. When these imported cases are promptly detected, diagnosed and isolated, further transmission in the destination setting has generally been limited. However, when initial cases

are not detected in a timely manner and transmission occurs undetected within sexual networks, mpox has become established in new geographic areas.

Transmission in mpox endemic areas may additionally occur through contact with live or dead animals or consumption of insufficiently cooked contaminated meat, which can happen both in the open air and the household (more details in the section below Zoonotic transmission).

Socio-behavioural dimensions

Across countries and contexts, outbreak dynamics are influenced by multiple, intersecting factors including individual risk perception, social norms, stigma, structural inequality, access to care, security, and social protection.

Risk perceptions and knowledge have varied across settings, closely associated with direct exposure to mpox cases. Occupationally exposed groups such as sex workers, transport workers and truck drivers, as well as MSM and people living with HIV (PLHIV), reportedly considered themselves at higher risk, while wider community understanding of symptoms and transmission was often confused with other rash illnesses such as chickenpox, measles or malaria, and explained through a mix of biomedical, spiritual and moral beliefs.[28] Rapid assessments identified knowledge gaps, particularly among rural populations, caregivers, and women, alongside language barriers in some settings; sex workers and truck drivers reportedly showed high levels of awareness compared to other groups. In newly affected areas such as Sindh Province, Pakistan, trusted information channels were underused, while transgender people and sex workers received little or no information through relevant services.[12] Consulted communities had not previously heard of mpox and reportedly understood it only as a childhood rash or chickenpox, due to the outbreak among infants and their families in the province. **Isolation and care-seeking** remain constrained by economic pressures, caregiving norms, and housing conditions. Reliance on daily income, overcrowded housing, and limited water and sanitation infrastructure reduces the feasibility of home isolation. Data from Liberia and the Democratic Republic of the Congo further underscores the role of caregiving norms and social obligations, with family members often continuing close contact with sick relatives despite recognizing transmission risks. In Pakistan, shared multi-family compounds made home isolation impractical. Insufficient social support during isolation was commonly reported, with some describing children left unattended or a lack of basic household assistance during isolation. Findings from rapid assessments indicated that people began care at home with self-medication, prayer or traditional remedies and sought formal care only when symptoms worsened; transport costs, distance, drug shortages and indirect costs contributed to delays. Along the Kenya-Uganda border, factors such as mobility, alert fatigue, confusion between chickenpox and other illnesses, and the use of biomedical, traditional, and religious care all influenced how people sought treatment within dense family and trading networks.[29] In Madagascar, displacement into temporary shelters increased crowding, while shortages of protective equipment, medicines, vaccines and sanitation supplies were found to constrain protective measures. **Stigma** continued to drive concealment and delayed care-seeking among patients, reinforcing marginalization linked to sex work, HIV status, sexual orientation or foreign origin. Caregivers and family members also reported that they experienced stigma as a result of their association with patients.

Intent to **vaccinate against mpox** was reportedly high in many countries, with increases observed over time,[30] despite one study suggesting that the African region may have the low mpox vaccine acceptance rates compared to other regions.[31] Drivers included vaccine availability, clarity on eligibility criteria, access, service experience and perceived risk. [32] Barriers to vaccine acceptance included lack of awareness, concerns about effectiveness and safety, risk perceptions, cultural beliefs, misinformation, and distrust.[33] Misinformation, including claims linking vaccines to infertility, poisoning or COVID-19, continued to undermine confidence.[34] Limited visibility of response activities, weak feedback mechanisms and inconsistent inclusion reportedly reduced trust in response actors and communities' influence over response priorities and delivery. Women, youth, PLHIV and other marginalized groups were not consistently engaged.

Viral genome sequencing

No substantial differences in the modes of transmission of the different clades have been documented to date.

In vitro experiments have shown that clade I is more virulent than clade II,[35,36] and historically it has been observed that human cases due to clade I MPXV had higher severity and mortality compared to clade II.[37] The main limitation of these results is the spread of the different clades in different populations, involving different proportions of children and vulnerable individuals, which makes real-world comparisons more challenging. Overall, the case fatality ratio of clade Ib MPXV has been comparable to that of clade IIb MPXV, as well as that of clade Ia MPXV in urban settings such as Kinshasa. Conversely, in more rural areas of the Democratic Republic of the Congo, clade Ia MPXV infections have resulted in a higher case fatality ratio.[17]

Clade Ia MPXV infections over time have been linked to zoonotic transmission[38] with limited onward human-to-human transmission, predominantly in household settings. The lack of sustained human-to-human transmission of clade Ia MPXV is reflected in a low level of APOBEC3-like mutations in most sequenced clade Ia MPXV strains.[3938] However, human-to-human transmission of clade Ia MPXV through sexual contact was first reported in an isolated cluster in Kenge, Kwango Province, in the Democratic Republic of the Congo.[26] This was followed by the detection of a larger ongoing clade Ia MPXV outbreak within Kinshasa associated with human-to-human transmission, evidenced by the presence of an APOBEC3-like mutational signature.[40] This outbreak lineage has subsequently been detected in several other provinces in the Democratic Republic of the Congo, including Kwilu, Kwango, and Kongo-Central.

Clade IIa MPXV has historically also been linked to zoonotic transmission, and genome sequences collected in 2024 from Côte d'Ivoire, Liberia and Ghana, available in public databases, do not show a high proportion of APOBEC3 mutagenesis. This supports the hypothesis that majority of mpox cases due to clade IIa MPXV in West Africa continue to be acquired through independent zoonotic transmission. Although the clustering of the small number of genomes suggests some level of human-to-human transmission, evidence of broader sustained transmission in communities is lacking.

The current clade Ib MPXV outbreak likely originated from a single spillover from an unknown animal reservoir[8] and has spread through human-to-human transmission since at least September 2023. This is supported by the presence of an APOBEC3-like signature in the mutations seen in clade Ib MPXV sequences and supported by epidemiological analyses. Analysis of available genome sequencing data supports co-circulation of multiple, ongoing transmission chains of clade Ib MPXV.[41]

Clade IIb MPXV has the widest geographic distribution and greatest scale of human-to-human transmission of any MPXV subclade, and since 2022 it has continued to genetically diversify. Its specific lineages and sublineages have spread in different geographic areas, where sometimes they have led to clustering of cases affected by similar strains, but as cases due to the movement of people continue to be reported, the genetic diversity of viral strain also keeps evolving.

Three cases of a new recombinant clade Ib/IIb MPXV have been detected: one case in the United Kingdom of Great Britian and Northern Ireland (who reported recent travel from a country in WHO South-East Asia Region), one case in India (who reported recent travel from the Arabian Peninsula), and one case in Qatar (who reported recent travel to the Kingdom of Saudi Arabia), thus implicating six countries in three WHO regions. Recombinant virus has also been found in local condom studies in a country in WHO South-East Asia Region reporting cases (unpublished results), suggesting wider transmission. In all cases, genomic sequencing analysis indicates that the virus acquired alternating fragments from both clade Ib and clade IIb MPXV, resulting in a replication-competent recombinant. No secondary transmission from these cases or further cases of this recombinant strain in other parts of the world has been documented so far. There is also no indication to date that this recombinant strain is more transmissible or causes more severe disease.

Zoonotic transmission

Animal-to-human transmission can occur through direct contact with infected animals e.g. bites, scratches, or direct contact with the animal's body fluids) or through consumption of insufficiently cooked infected meat from wild animals (bushmeat).[42] Presumed zoonotic transmission has been occurring since the 1970s in parts of West, Central and East Africa. However, significant uncertainty remains around the natural history of the MPXV, and its circulation in wildlife.[42] A variety of mammals, including but not limited to rodent species such as rope or sun squirrels and dormice, as well as non-human primates are susceptible to the virus.[43] The unregulated wildlife trade, including the sale of live wildlife animals of meat and other products, can potentially lead to both domestic and international spread of zoonotic diseases such as mpox. Not all infected animals will display visible signs of MPXV infection, such as a rash.

Recent evidence documented likely cross-species transmission of clade IIa MPXV from fire-footed rope squirrels[44] to wild sooty mangabeys in Taï National Park in Côte d'Ivoire. A recent paper provided both direct and indirect evidence demonstrating that a clade IIa MPXV outbreak in fire-footed rope squirrels triggered a subsequent clade IIa MPXV outbreak in the wild sooty mangabey population of the national park. Furthermore, the Democratic Republic of the Congo recently notified WHO of detection of clade Ia MPXV in a squirrel and a dog in Equateur province (unpublished results), and in three rodent species in other provinces.[45] These reports strengthen the broader body of evidence implicating African rodents as likely reservoir hosts of MPXV, advancing our understanding of the animal reservoir and drivers for transmission.

Moreover, there is also a risk of viral spill-back from humans to animals, with the potential for the formation of a novel animal reservoir. Despite reports during the 2022 – 2026 multi-country outbreak of possible transmission from humans to animals concerning pet dogs in France and Brazil, spillover events have not been confirmed nor reported to result in sustained transmission in either species.[46] Further epidemiological investigation, research and studies at the human-animal-environmental interface are needed to better elucidate the sources and modes of interspecies spread of MPXV in different rural and urban contexts in countries in Africa and beyond.

Context assessment

This section provides an overview of the mpox epidemiological situation across the world, highlighting Africa and a few selected countries, as well as an update on the status of the global mpox response across the different response pillars.

Epidemiological overview

Global epidemiological situation

This section is based mainly on mpox global surveillance data, which includes information about confirmed and probable mpox cases and deaths since the beginning of 2022. Currently, global data is collected on a monthly basis, and the latest available and complete data are as of ***30 June 2026****. Reporting to the global surveillance system has varied over time and the lifting of the public health emergency of international concern (PHEIC) declaration in September 2025 might have had an impact on mpox awareness, surveillance and reporting to WHO.*

From 1 January 2022 through 30 June 2026, a total of 188 847 confirmed cases of mpox, including 521 deaths, were reported to WHO from 145 countries/territories/areas (hereafter 'countries') in all six WHO Regions (Table 1 and Figure 2). The overall global CFR among confirmed cases in this period is 0.3%.

A total of 1319 new confirmed cases were reported in June 2026, reflecting a 33.7% decline from the previous month. This apparent decline should be interpreted with caution, given reporting delays for the most recent data, especially in high-burden countries like the Democratic Republic of the Congo and in the context of concurrent outbreaks e.g., the ongoing Ebola outbreak there. Furthermore, in the WHO European Region, data prior to December 2025 was compiled from multiple sources, including the European Centre for Disease Prevention and

Control (ECDC) European Surveillance System (TESSy) report, country situation reports, and official IHR notifications. From December 2025 onward, data have been sourced exclusively from the TESSy report, which may have contributed to a reduction in the number of newly reported cases and deaths. Epidemiological trends for the European Region should, therefore, be interpreted with caution.

The majority of cases in June 2026 were reported from the African Region (54.7%), followed by the European (17.8%), and Western Pacific regions (15.8%). Three regions reported more confirmed cases in June 2026, compared to May 2026: the WHO Region of the Americas (594.1% increase, from 17 to 118 confirmed cases), the South-East Asia (140% increase, from 15 to 36 confirmed cases), and Western Pacific regions (24.6% increase, from 167 to 208 confirmed cases). Three WHO regions reported fewer confirmed cases in June 2026, compared to May 2026: the African (49.2% decrease, from 1422 to 722 confirmed cases), European (36% decrease, from 367 to 235 cases), and Eastern Mediterranean regions (from two cases to no cases).

Data for the most recent month must be interpreted with caution since reporting delays often lead to retrospective adjustments over time, and trends in all regions may be prone to surveillance and reporting biases.

Table 1. Number of cumulative confirmed mpox cases and deaths reported to WHO, by WHO Region, 1 January 2022 - 30 June 2026.

WHO Region	Total confirmed cases	Total deaths among confirmed cases	New cases reported in May 2026	New cases reported in June 2026	Monthly change in cases (%)
Region of the Americas	74 847	164	17	118	594.1
African Region	70 398	304	1422	722	-49.20
European Region	33 692	12	367	235	-36.0
Western Pacific Region	7680	21	167	208	24.6
South-East Asia Region	1282	16	15	36	140.0
Eastern Mediterranean Region	948	4	2	0	-
Total	188 847	521	1990	1319	-33.7

Since the last RRA (which assessed data as of end of 2025), the WHO Western Pacific Region has largely been observing a gradual upward trend in the number of monthly reported confirmed cases (Figure 1). This upward trend has been largely driven by an increase reported in Australia and China, with the latter associated with returning travellers from Thailand in mid-April 2026.

The WHO African, European, and South-East Asian Regions have reported more stable numbers of monthly confirmed mpox cases in 2026. The spike in the number of monthly confirmed cases observed in WHO South-East Asia Region in June 2026 is largely attributable to an increase of cases in Thailand, where expanding clade Ib MPXV community transmission has been reported.

Over the last six months, a gradual downward trend in the number of monthly reported cases has been observed in the WHO Region of the Americas, largely been driven by the decrease in mpox cases reported in the United States of America.

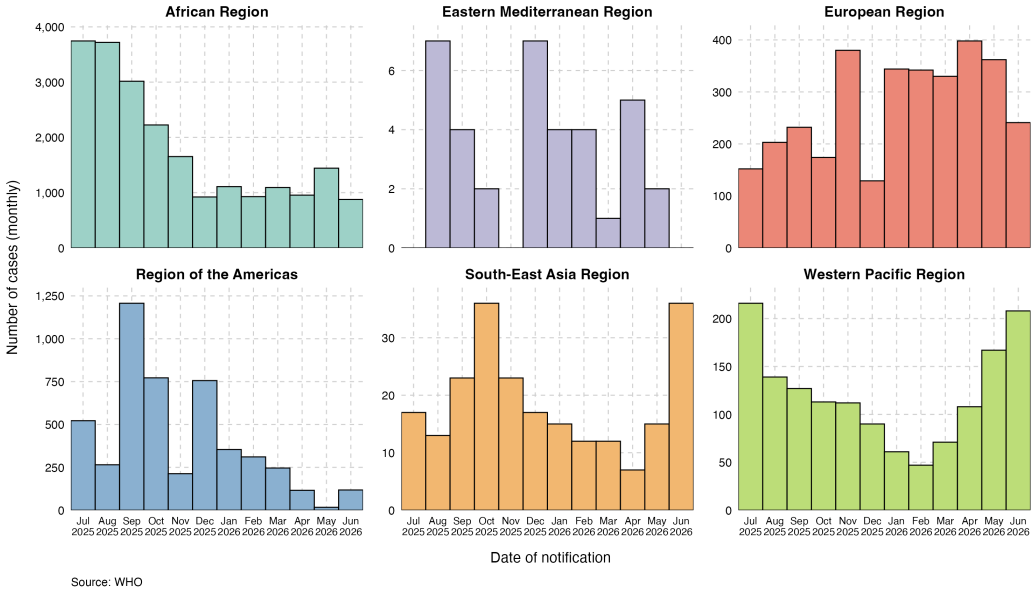
The Eastern Mediterranean Region has been reporting the lowest numbers of cases globally, with sporadic cases reported during 2026.

In the last 12 months, a total of 31 203 confirmed cases has been reported (a global average of about 2600 confirmed mpox cases per month). Most of the cases were reported by the African Region (21 304 confirmed cases), showing the ongoing disproportionate burden in Africa including outside historically affected areas,

followed by the Region of the Americas (4897 confirmed cases), and the European Region (3287 confirmed cases).

Reporting to the global surveillance system has varied over time and the lifting of the public health emergency of international concern (PHEIC) declaration in September 2025 might have had an impact on mpox awareness, surveillance and reporting to WHO. Given the limited visibility on the scale of testing and risk communication and community engagement in many contexts, these trends should be interpreted with caution.

Figure 1. Epidemic curves of monthly aggregated number of confirmed mpox cases reported to WHO, by WHO region, 1 July 2025 – 30 June 2026.



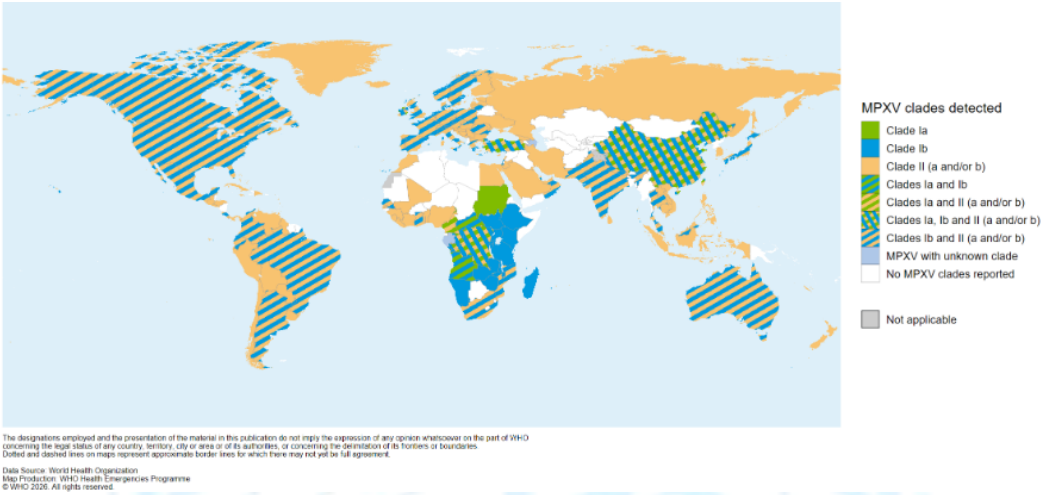
Please note that different Y axis scales have been used for the regional epidemic curves to allow a better overview of the trend in each region.

Global MPXV clade distribution

From January 2022 and as of 19 July 2026, the distribution of reported MPXV clades by country of detection is as shown in Figure 2. This information is compiled from genomic sequencing conducted and reported via different sources, including open-access databases, peer-reviewed publications, reports and direct communication to WHO, including through its Technical Advisory Group on Virus Evolution (TAG-VE).

Since its first detection in September 2023, clade Ib MPXV has been detected in 65 countries (Figure 2). Initially, most of these cases were travel-related, that is, infections in individuals who were exposed in countries with community transmission of clade Ib MPXV in Central or Eastern Africa, or who were contacts of travelers returning from these regions. Since the lifting of the PHEIC declaration on 5 September 2025, several regions outside the African Region have reported occurrences of clade Ib MPXV community transmission, such as Region of the Americas and the European, South-East Asia and Western Pacific Regions. Reporting of MPXV specific data depends on mpox surveillance and sequencing capacities, as well as sharing of data with WHO. Information about cases with travel history to countries that are currently not reporting cases highly suggests that countries in the Eastern Mediterranean Region might also have ongoing sustained human-to-human transmission of clade Ib MPXV, despite cases not being detected or data not being shared with WHO.

Figure 2. Geographic distribution of MPXV clades in human cases reported to WHO, by country, as of 19 July 2026[a].

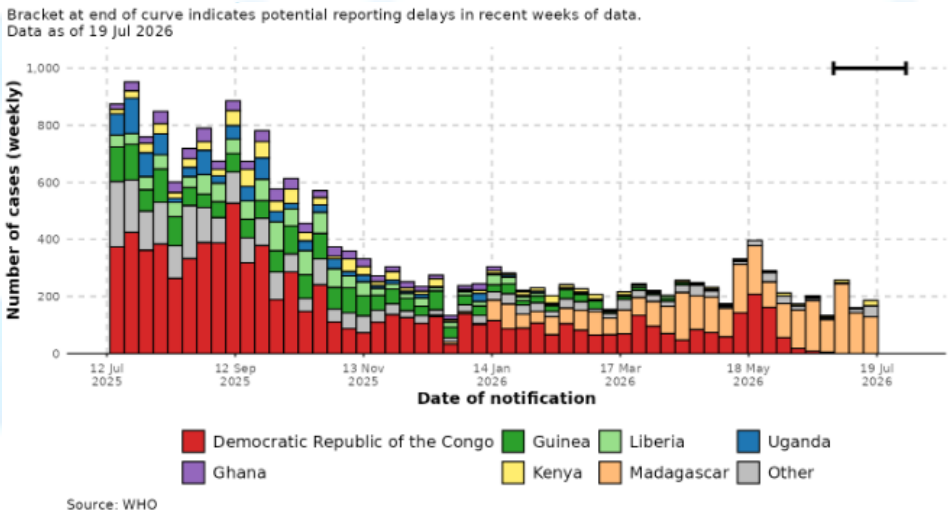


Epidemiological situation in Africa

The WHO African Region has reported the highest number of confirmed mpox cases in the last 12 months.

In Africa, since 2025, as of **19 July 2026**, a total of 51 159 confirmed mpox cases, including 235 deaths (CFR 0.5%), have been reported in 32 countries. The downward trend in the number of reported weekly confirmed cases continues since mid-2025, with stable case counts reported in 2026, about 200 new confirmed cases per week. As mentioned, data for recent weeks should be interpreted with caution, as reporting delays have been noted which will likely lead to retrospective adjustments. Furthermore, with a reduction in surveillance activities, notably in the presence of concurrent outbreaks and competing priorities, the case counts may be underestimated.

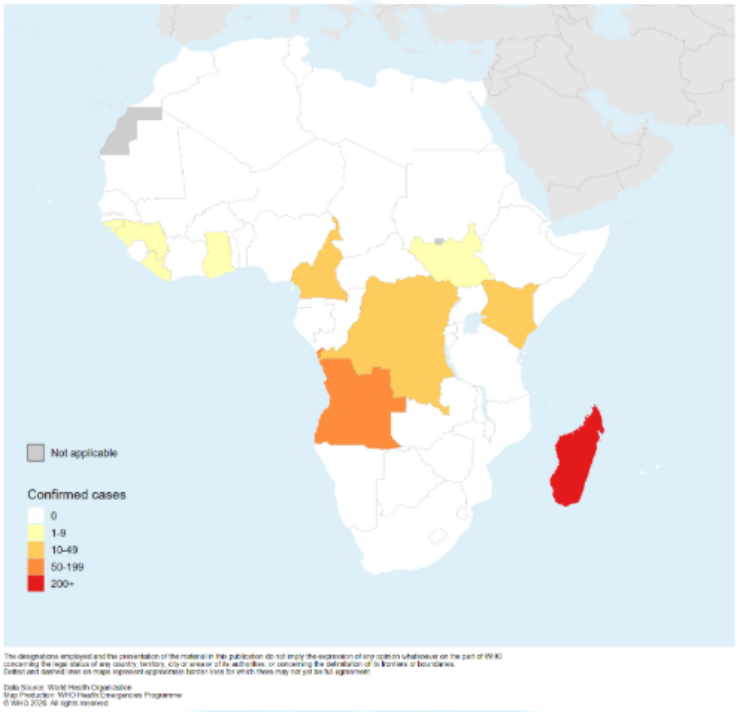
Figure 3. Epidemic curve of confirmed mpox cases in Africa, by country, in the past 12 months, 12 July 2025 – 19 July 2026.



[a] The geographical distribution of MPXV clades shown is based on sequences from clinical samples of confirmed mpox cases. Sequences from wastewater and environmental samples are excluded from this analysis.

In the last six weeks, 10 countries on the continent have reported active transmission of mpox (Figure 4), with 1112 confirmed cases, including 12 deaths (CFR 1.1%), reported during this period. Countries reporting the highest number of confirmed cases over the last six weeks are Madagascar (940 confirmed cases), Angola (57), Kenya (48), Democratic Republic of the Congo (30), and Cameroon (24). Interpretation of data from the Democratic Republic of the Congo should consider delays in reporting of mpox data owing to the country's current focus on the response to the Bundibugyo virus disease outbreak.

Figure 4. Geographic distribution of confirmed mpox cases in the past six weeks, Africa, 7 June – 19 July 2026.



Epidemiological situation in key countries

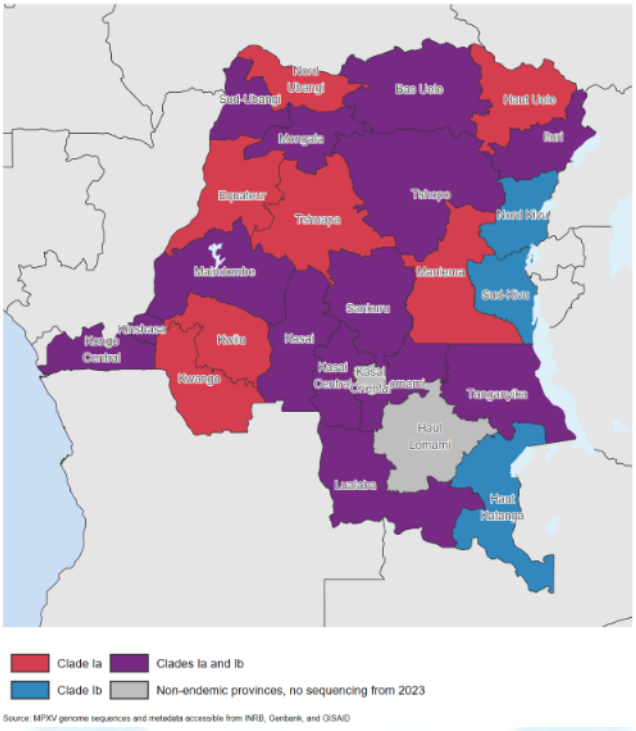
Focus on the Democratic Republic of the Congo

The country continues to face challenges in the laboratory diagnosis of mpox, with a decreasing number of laboratories testing and confirming mpox cases compared to the PHEIC period. **Since 2025, approximately a third of suspected mpox cases have been tested, and among these, about half have been found to be positive, as of 19 July 2026.** Given the low testing coverage and the variability in testing rates between areas, information about suspected cases is presented in this section to further inform the understanding the evolution of the outbreak in the country. Furthermore, with the reduction in surveillance activities in the context of competing activities given the country's focus on the response to the ongoing Bundibugyo virus disease outbreak, data presented here should be interpreted with caution.

Mpox transmission continues across the Democratic Republic of the Congo with circulation of clades Ia and Ib MPXV in different parts of the country, and co-circulation of both clades in at least 14 provinces (Figure 5). Genomic sequencing data from October 2023 to October 2025 show that clade Ib MPXV has been detected in several provinces, while clade Ia MPXV continues to be reported predominantly in historically endemic provinces in the central and north-western parts of the country. Genomic sequencing remains unevenly distributed geographically, with some provinces reporting confirmed cases but no available genomic data, reflecting a convenience sampling strategy that prioritizes provinces with better sample transport capacity.

In July 2025, an imported case of mpox caused by clade IIb MPXV was detected, followed by one secondary case involving the spouse of the index case. Following a rapid public health response, including case isolation, contact tracing, and vaccination of contacts, no further cases of mpox due to clade IIb MPXV were detected. To date, no further cases of mpox due to clade IIb MPXV have been reported in the country.

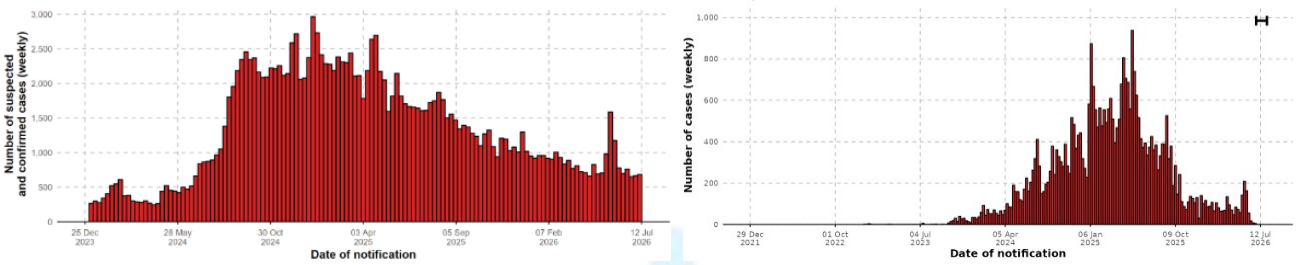
Figure 5. Geographic distribution of clade Ia and Ib MPXV in the Democratic Republic of the Congo, by province, from 1 October 2023 to 28 October 2025.



Since late 2024, the country has experienced a sustained high burden of reported suspected mpox cases. The number of weekly notifications peaked in the second half of 2024, with up to 3000 new suspected cases per week (left, Figure 6), and the gradual decline in the number of reported confirmed cases that followed that peak has largely continued, with weekly suspected case counts dropping below the 1000-case mark in 2026. The spike in the number of suspected cases observed in May 2026 was largely driven by a scale-up of surveillance activities in Sankuru province, suggesting that there has likely been an under ascertainment of suspected mpox cases due to resource restraints, and if more resources are available for the mpox response, more suspected cases would be identified.

The trends in the numbers of reported confirmed cases (right, Figure 6), suggest an overall increasing trend in 2024 and early 2025, reaching a peak in late May 2025, after which there was an overall decline in the number of weekly confirmed cases reported until November 2025, followed by largely stable weekly confirmed case counts to date.

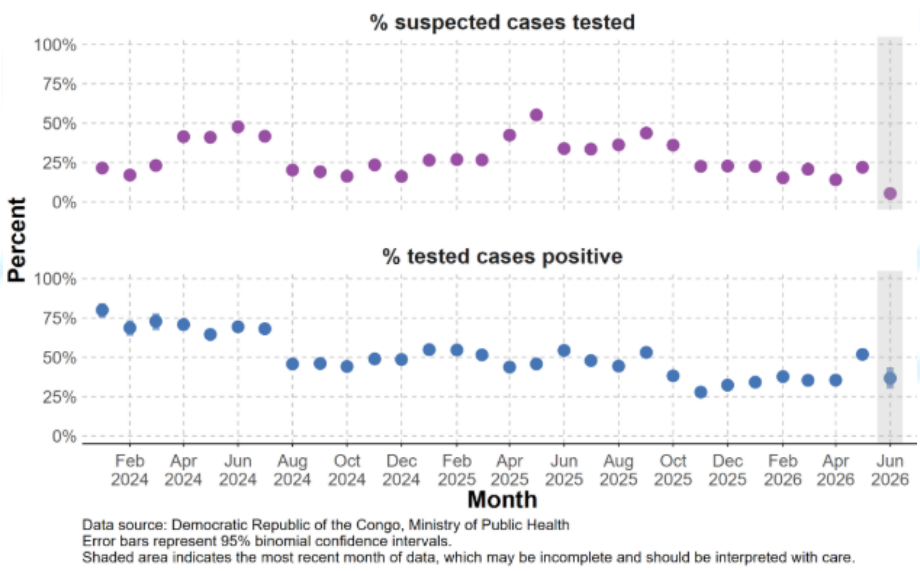
Figure 6. Epidemic curve of suspected (left) and confirmed (right) mpox cases reported in the Democratic Republic of the Congo, 1 January 2024 – 19 July 2026.



In 2024 and 2025, access to confirmatory testing for suspected cases remained variable over time, generally ranging from about 20% to just over 50% (Figure 7). Since October 2025, there has been a continuous decrease in the proportion of suspected cases tested to below 25%, making confirmed case counts an unreliable proxy of MPXV circulation in the country.

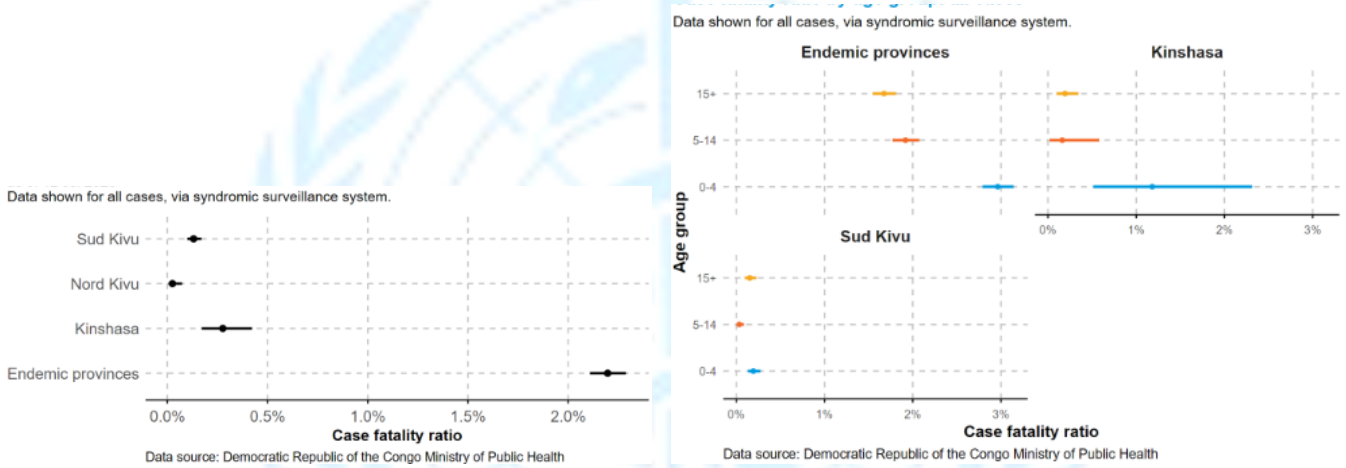
During the same period, test positivity initially remained high overall, hovering about 50%, suggesting high levels of MPXV circulation. Since October 2025, however, test positivity has remained between 30% and 40%, even dropping as low as 25%. While this drop in test positivity could potentially suggest a drop in the level of MPXV circulation, since it is occurring in the context of reduced diagnostic capacity, the extent to which it can be attributed to reduced MPXV circulation, compared to reduction in testing capacity, remains unclear. This uncertainty is demonstrated by the spike in test positivity in May 2026. The spike in proportion of suspected cases tested and test positivity in May 2026 was largely driven by a scale-up of surveillance activities in Sankuru province, suggesting that there has likely been an underestimation due to resource restraints, and if more resources are available for the mpox response, more confirmed cases will be identified.

Figure 7. Proportion of suspected cases for whom a sample was collected (top) and proportion of confirmed cases among those that undergo laboratory testing (bottom), in the Democratic Republic of the Congo, by month, 1 January 2024 – 19 July 2026.



The country continues to report one of the highest mpox case fatality ratio estimates, although it has decreased from CFR of 4% reported in 2024. There has been a notable difference in CFR between the historically endemic provinces (mostly poor rural areas), which have been reporting a higher CFR (2.2%), and the provinces initially affected in 2023-24 (Figure 8, left), which have been reporting a lower CFR (0.0 – 0.3%). The latter provinces have better access to care and have actively carried out expansive mpox response activities in the last two years. Within each setting, differences in the CFR between the different age groups have also been observed, with children under five years of age consistently reporting higher mortality across different settings (Figure 8, right).

Figure 8. Case fatality ratio among mpox suspected cases in the Democratic Republic of the Congo, nationally (left) and by age group for main provinces (right), 1 January 2024 – 12 July 2026.



Focus on Madagascar

Since December 2025, Madagascar has been experiencing the largest mpox outbreak in the WHO African Region and globally, with ongoing sustained community transmission and high weekly case counts. Genomic sequencing analysis identified clade Ib MPXV as the circulating strain.

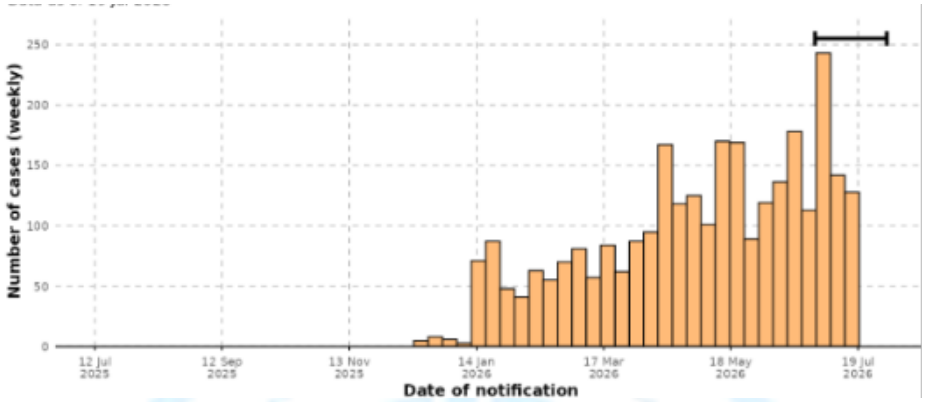
As of 19 July 2026, Madagascar has reported a total of 2921 confirmed cases, including 18 deaths (CFR 0.6%) (Figure 9). In the last week, Madagascar reported 128 confirmed cases, with a test positivity of 74%, indicating ongoing transmission and insufficiently sensitive surveillance.

With 61% of districts (70 of 115 districts) affected to date, widespread geographic dissemination continues. Cases have been reported across all age groups and both sexes, with individuals aged 15-49 years most affected.

Response activities have been scaled up, including vaccination, with 89 723 individuals having received one dose of MVA-BN vaccine, including 19 514 health workers, 5112 contacts, 1736 sex workers, and 1151 people living with HIV, with 62 210 doses administered to other individuals not otherwise described. Most confirmed cases (95%) receive either home-based care or care in dedicated treatment centres.

The outbreak is not yet under control, and the situation remains concerning due to continuing high case counts, high test positivity, operational challenges and gaps related to logistics, health-care capacity, vaccine stockouts and cold chain, and further needs for ongoing risk communication and community engagement for populations at risk. The country has conducted an Intra-Action Review (IAR) of the mpox response, identifying key strengths, operational challenges, and priority actions that should be taken to strengthen the response.

Figure 9. Confirmed mpox cases reported in Madagascar over the past 12 months, 12 July 2025 – 19 July 2026



Emergence of inter-clade recombinant strains

At the time of the last RRA, two detections of an interclade recombinant MPXV strain had been reported for the first time: in the United Kingdom of Great Britain and Northern Ireland (hereafter the United Kingdom) in December 2025 and India in January 2026. Since then, the third known detection of an interclade recombinant MPXV strain was reported in Qatar in March 2026.

Situation update- Qatar case

On 24 March 2026, Qatar's National IHR Focal Point (NFP) notified WHO of a laboratory confirmed mpox case, that was subsequently identified as an interclade recombinant MPXV, containing genomic elements of clade Ib and IIb MPXV. The recombinant virus was detected in samples from an adult male resident of Qatar. On 10 March, he developed fever, night sweats, dysuria, and myalgia followed by a generalized rash evolving from maculopapular to vesicular lesions. He had multiple healthcare encounters prior to diagnosis and on 21 March 2026, the samples tested positive for MPXV by Polymerase Chain Reaction (PCR), and on 2 April, genomic sequencing confirmed infection with a recombinant clade Ib/IIb MPXV. The case did not present with any known underlying health condition.

During epidemiological investigation, the case reported travel to Saudi Arabia from 28 February to 2 March 2026. While there, he reported shaving his head and contact with surfaces in public settings. He denied any sexual or other known high-risk exposures in either Saudi Arabia or Qatar during the incubation period. To date, the source of infection for this case remains unknown.

Following the initial diagnosis, the case was isolated in a designated facility where he recovered fully. Contact tracing was initiated, all contacts have completed monitoring, and no known secondary cases have been identified to date. Two travel contacts developed transient febrile illness but were asymptomatic on follow-up.

Consistent with earlier detections, no apparent differences in clinical presentation have been observed compared with non-recombinant clade I and clade II MPXV infections.

Surveillance and reporting

WHO global mpox surveillance continues, with cases reported weekly by countries in the African region and monthly for the other Regions.[5] This surveillance has allowed the WHO to monitor the spread of the virus and to describe the main epidemiological, clinical, and outcome characteristics of mpox cases.

All the analyzed surveillance data are shared publicly through the global mpox trends report, currently updated biweekly for countries in Africa and monthly for countries in other regions.[6] However, the quality of information is not homogenous. The aggregate number of cases and deaths is complete for most countries, but case-based

information coverage has been lower for the WHO Western Pacific (45.5%), Eastern Mediterranean (16%), and African (1%) regions. Since the lifting of the PHEIC in September 2025, there has been a further decrease in case reporting from most regions.

Laboratory and diagnostics

PCR testing for MPXV is now available in all affected countries. Testing continues to be restricted to symptomatic patients presenting with typical lesions and to contacts of confirmed cases with compatible prodromal symptoms.[47] The availability of PCR testing, including point-of-care testing (POCT) devices and sequencing for mpox, remains heterogeneous across regions and countries.

In several African countries, testing coverage has improved over time, however, notable gaps persist. There is a need for continued support to keep the laboratories functional and sustain the supplies for sampling and testing available. The Democratic Republic of the Congo, which had increased its testing capacity to 28 laboratories testing for mpox, is also facing challenges in maintaining and supplying them. From more recent data, around 8 laboratories are currently testing and reporting data for mpox in the country. In all countries, decentralization efforts through GeneXpert testing have improved testing coverage and timeliness of results.

WHO has continued to support equitable access to mpox diagnostics throughout the response, including advocacy for the development, evaluation, and deployment of fit-for-purpose diagnostic tools. It convened expert consultations to develop two target product profiles (TPPs) for MPXV diagnostics: TPP1 for use in health care facilities and laboratories, and TPP2 for detection of orthopoxvirus antigens in decentralised and community-based settings. Laboratory-based validation studies of five rapid antigen tests have been completed, and the results have been published.[48] Findings indicate high positive predictive values in high-prevalence settings, suggesting potential use cases for antigen-based rapid diagnostic tests (RDTs) as adjuncts to existing RT-PCR and point-of-care molecular platforms, particularly in high-burden settings with limited testing coverage. As part of efforts to expand access to quality-assured diagnostics, WHO has listed 12 MPXV in vitro diagnostics under its Emergency Use Listing (EUL) procedure (EUL MPXV_List of MPXV IVDs_5.pdf)

Regarding genomic surveillance, WHO interim guidance on mpox diagnostic testing and testing strategies recommends that sequencing approaches combine targeted characterization of samples of interest with representative sampling, aiming to sequence approximately 10% of confirmed cases to reflect viral circulation in a defined area.[47] WHO and partners continue to support Member States in strengthening sequencing capacity; however, this target remains unmet in several settings. Such heterogeneity in sequencing capacity may bias interpretations of MPXV clade distribution and should be carefully considered when inferring the clade driving outbreaks. In light of the detection of a clade Ib/IIb recombinant strain in the United Kingdom, India, and Qatar in cases with travel history to Asia and Middle East, there is a need to strengthen surveillance efforts to better understand the extent of circulation of this recombinant strain and its public health implications. So far, there is no indication that this recombinant strain is more transmissible or causes more severe disease.

In parallel, a WHO Guideline Development Group (GDG) process on mpox testing is currently underway to update global recommendations, including the role of decentralised and point-of-care testing modalities.[49] The outcomes of this process are expected to inform future guidance on optimal testing strategies across diverse epidemiological and resource settings.

Clinical management

In June 2025, WHO published the living guideline *Clinical Management and Infection Prevention and Control for Mpox*, incorporating the latest evidence to update recommendations.[13] An updated guideline proposes new recommendations on pain management, wound care, ocular disease, and care for high-risk groups. This is expected to be published later in 2026. Mild, uncomplicated cases can be managed safely at home with good

symptom control, skin and lesion hygiene, hydration, and nutrition, alongside clear advice for when to seek further care. In health facilities, early risk assessment is essential to identify those needing escalation, particularly in the presence of airway or ocular involvement, severe proctitis, bacterial superinfection, encephalitis, dehydration, uncontrolled pain, pregnancy, young age, or advanced immunosuppression. HIV and other co-infections should be promptly diagnosed and treated without interrupting ART.

Special populations, including pregnant people, children, and the immunocompromised, require closer monitoring and a lower threshold for admission. Good communication, clear home-care guidance, and attention to the mental health and social impacts of the disease are all part of providing high-quality, patient-centred care. Above all, clear communication, practical home-care guidance, and attention to mental health turn clinical care into patient-centred care.

In November 2025, the Data Monitoring Committee reviewed data on patient outcomes given tecovirimat under the MEURI programme; results will be made public in due course. Openly available data from randomized clinical trials indicate that tecovirimat is safe when used for mpox infection but does not significantly shorten time to lesion resolution: the STOMP trial was stopped early, showing no signal of clinical benefit, a pattern which is consistent across others (PALM 007 and UNITY). These studies were not powered to assess benefit stratified by age or disease severity. Studies of use of tecovirimat for post-exposure prophylaxis are underway.

WHO continues to support data collection through the Global Clinical Platform,[50] and the openly available data models have been used to collect and understand data within national programs, and individual patient level data meta-analysis is planned.

Infection prevention and control (IPC)

Most MPXV transmission in the global outbreak has occurred through close person-to-person contact, including sexual contact. Transmission through contact with contaminated objects, linens, and surfaces has also been reported.[51] Close and prolonged conversational contact with a symptomatic mpox case, (particularly where there are visible mouth ulcers) presents risks for transmission.

Challenges in implementing IPC practices have been noted in several countries in the African and Eastern Mediterranean regions experiencing outbreaks, including a lack of national IPC guidelines, lack of subnational and facility-level IPC practitioners with IPC expertise and gaps in water sanitation and hygiene (WASH) services within health facilities. Assessments have also identified gaps in training health and care workers, lack of screening for mpox in health facilities, inadequate isolation capacity, insufficient PPE access, insufficient resources and low compliance with hand hygiene standards.

Over the course of the outbreaks in 2024 and 2025 there are new challenges with transmission in the community, such as in overcrowded household and congregate settings (e.g. prisons, camps), especially in the camps for IDPs in the Democratic Republic of the Congo, elevating the importance of, and challenges with, implementing IPC measures and WASH services in these settings to mitigate transmission.

WHO has published the clinical management and IPC living guidelines for mpox 2025, which recommends that in health care settings health workers caring for mpox patients should use gloves, gowns, medical mask and eye protection based on risk assessment. In the community setting IPC measures including hand hygiene, dedicated personal items, appropriate handling of linens and laundry, cleaning and disinfection of the environment, and waste management should be followed for persons with mpox in the community until all lesions are healed. Individuals with mild and uncomplicated mpox may be cared for at home, provided certain criteria are met. Isolation of mild mpox patients for homecare is not required if the person consistently covers the lesions, wears a well-fitting medical mask when around others, and avoids sharing personal items until all lesions are healed.

When these measures can't be followed, persons with mild mpox should isolate in separate room or dedicated space.

Community protection

Community protection strategies and interventions remain critical in slowing mpox transmission and stopping outbreaks.[52] Since the 2024-2025 PHEIC ended, the focus has increasingly shifted from response efforts towards integrated programming including sustaining community protection functions within routine services and preparedness systems.[53]

Over the course of the response, WHO has strengthened support to countries through an integrated package for community protection,[52] prioritizing populations disproportionately affected by mpox, including sex workers[54,] those living in IDP camps and camp-like settings,[55] and members of mpox-affected households, including children.[56] Coordinated efforts have focused on supporting community health workers, volunteers and peer educators to enhance public trust, reinforce prevention behaviours, counter misinformation, detect and report cases, and strengthen community coordination and response. Due to reduced funding and ongoing integration of mpox emergency-specific activities into routine programming, support has been concentrated on a few selected countries.

Community protection also expanded to support targeted vaccination efforts particularly among key populations. Engagement with HIV networks and civil-society organisations (CSOs) has been further strengthened, including in newly affected countries. Rapid community evidence highlighted the importance of trusted peer networks and CSOs in reaching key populations and providing a critical link to testing, referral and care. Where these actors were well resourced, they significantly extended the reach and credibility of the response. Vaccination delivery was also adapted to more effective strategies. For example, in Kenya, campaigns shifted outreach to evening hours at truck stops and border crossings to align with the availability of truck drivers and sex workers, reaching over 10,600 people.

While significant steps have been made, behavioural and structural drivers, including low risk perception, mis- and disinformation, stigma linked to sexual transmission, overcrowded housing, poverty, limited access to WASH infrastructure, as well as fear of legal repercussions among migrant populations, continue to constrain care-seeking, isolation and engagement with the response. Operational and contextual challenges, including insecurity, limited access to affected populations, funding shortfalls, human resource constraints, gaps in local RCCE capacity, and coordination challenges at sub-national levels further affected implementation, compounded in various contexts by message fatigue and declining public concern.

Over the course of the mpox response, RCCE capacity has expanded, particularly in the African region, with thousands of personnel trained. WHO has also published guidance on evidence for community protection and continues to support countries in generating rapid community evidence to inform response actions.[57,58]

Sustaining this impact will require institutionalizing community protection as a core function of national public health systems, with continued investment in RCCE, community-based surveillance, and the community health workforce, alongside coordinated, cross-border approaches in settings with high population mobility.

Vaccines and immunization

During this outbreak, there have been important advancements in regulatory approval of mpox vaccines, related acceleration of work from vaccine manufacturers towards further approvals from regulatory agencies and further assessment by WHO. Concerted efforts took place to improve access and provide WHO strategic, policy recommendations and programmatic guidance on outbreak response mpox vaccination, support country readiness, and delivery of mpox vaccines. Robust guidance was issued by SAGE in March 2024 for use of mpox vaccines during outbreaks, accompanied by a call to action for research in Africa. WHO SAGE advice endorsed by

the Director-General was published as a WHO vaccine position paper on 23 August 2024.[59] On 7 August 2024, the Director-General of the WHO announced that he had triggered the process towards Emergency Use Listing (EUL)[60] for mpox vaccines in light of the escalating mpox situation in the Democratic Republic of the Congo and mpox outbreak expansion in the African Region. WHO issued a notice of prequalification for the MVA-BN vaccine in September 2024 (with age extension for use from 12 years of age in October 2024), and this was followed by Emergency Use Listing for the LC16m8 vaccine on 18 November 2024.

There are two licensed vaccines that have been used in response to the current mpox outbreak: MVA-BN and LC16m8. These vaccines differ significantly in terms of dose-scheduling, route of administration, precautions, warnings, and contraindications. MVA-BN, a non-replicating live vaccine, administered subcutaneously (full dose) or intradermal (fractional dose), has the least safety-related use constraints and can be used for pregnant women(off-label), children under 12 years of age (off-label) and immunocompromised. LC16m8, a minimally replicating vaccine administered using the multiple puncture technique directly through the skin, i.e. percutaneous scarification, of the deltoid area on the upper arm with a sterile bifurcated needle is contraindicated for pregnant women and immunocompromised individuals. In the context of an outbreak, WHO recommends vaccination for: individuals at high risk of exposure, based on local epidemiology; members of a geographically defined area or community (e.g. village), including children, with a documented high risk of exposure to mpox; health workers and frontline workers at risk of repeated exposure; sex workers, gay, bisexual or other men who have sex with men; other individuals with multiple sexual partners.[61] Mass vaccination is not currently recommended for mpox. Where MVA-BN vaccine is used in contexts where vaccine supply is constrained, WHO supports the off-label use of a single dose or intradermal fractional dosing of a fifth of a dose, with the immunization schedule to be completed as soon as possible.

WHO published a revised mpox vaccination strategy for outbreak response in April 2025, focusing on targeting geographical areas with the highest numbers of newly reported mpox cases and, within those areas, the high-risk groups described above. In addition, WHO published operational interim guidance for MVA-BN[59] and LC16m8 vaccines[62] in addition to technical assistance for country readiness, implementation resources (such as WHO FAQ on MVA-BN mpox vaccine intradermal fractional dosing),[63] and training material[64] to support countries in their national policy recommendations, implementation, and monitoring of mpox vaccination. Results from the use of the MVA-BN vaccine during the 2022 global outbreak estimate: the effectiveness of pre-exposure vaccination was 76% (95% CI: 64–88) for a one-dose schedule and 82% (95%CI: 72–92) for a two-dose schedule; for post-exposure vaccination, effectiveness was estimated to be 20% (95%CI: -24–65).[65] No real-world effectiveness data are yet available for the LC16m8 vaccine. Vaccine effectiveness in specific groups, such as people living with HIV, and duration of immunity due to vaccination, are the subject of ongoing studies in Africa and elsewhere. Stakeholders are strongly encouraged to conduct studies with standardized data collection to assess the effectiveness of these vaccines during the implementation of vaccination programs.

In the context of the current outbreak response, 19 African countries have initiated mpox vaccination, all using MVA-BN vaccine, with the Democratic Republic of the Congo using both MVA-BN and LC16m8 vaccines. Nearly 3 million doses have been administered during the current outbreak response (1.5 million doses of MVA-BN vaccine (most of them as single dose) in 19 countries and over 1.3 million doses of LC16m8 vaccine in the Democratic Republic of the Congo).[66]

To improve access, the interim Medical Countermeasures Network (i-MCM-Net) initiative coordinated by WHO operationalized the multi-partner Access and Allocation Mechanism (AAM) for mpox medical countermeasures, to secure and coordinate available donations and supplies and strategically allocate them to affected countries to help them control the mpox outbreak. In 2024 and 2025, almost 6 million doses of mpox vaccine were mobilized globally, of which nearly 2.5 million doses of MVA-BN vaccine through the AAM and 3 million doses of LC16m8 through a bilateral donation from Japan to Democratic Republic of the Congo. In the nine allocation rounds,

through the AAM, 2 438 190 MVA-BN vaccine doses were allocated and delivered to 19 countries from the African region (Angola, Cameroon, Central African Republic, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, South Africa, Uganda and Zambia). In addition, 3 414 400 doses (311 400 MVA-BN doses and 3 050 000 LC16m8 doses) were delivered to three countries (Democratic Republic of the Congo, Nigeria, Rwanda) through bilateral agreements. The access to vaccines by affected countries using the AAM mechanism was a significant step towards a coordinated and targeted use of vaccines in response to mpox outbreaks in Africa. Some MVA-BN vaccine doses remain available to address new country requests. The International Coordinating Group for vaccine provision mpox vaccine stockpile to be launched in August 2026 with startup funding from Gavi, the vaccine alliance will ensure access to both MVA-BN and LC16m8 vaccines following. In the interim, countries are encouraged to consider adopting intradermal fractional dosing of MVA-BN vaccine, a proven strategy to maximize reach and widen access during supply constraints. Sustained efforts need to continue to support vaccination at the country level focusing on geographic areas with people at risk of exposure, and to strengthen capacity to monitor and adjust vaccination strategies are needed.

One Health

There are significant knowledge gaps in our understanding of the MPXV animal reservoirs, interspecies transmission patterns (including in wildlife and domestic mammals), and behavioural risk factors for zoonotic transmission. Addressing these gaps is crucial for directing preventive measures better.

WHO work in these areas of work has been carried out in partnership with the Food and Agriculture Organization (FAO) and the World Organisation for Animal Health (WOAH) to publish FAO-led guidance on the animal investigations for mpox, standardizing methods and approaches.[67] Independent research projects from academic institutions continue and limited inter-disciplinary response continues in countries where zoonotic transmission remains a continuing risk.

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