MPOX, MULTI-COUNTRY

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Overall risk and confidence

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) aims to assess the current public health risk associated with the 2024 upsurge of mpox in in Africa, in the context of the continuing global reporting of mpox cases in other regions since 2022, with a focus on updates since the previous RRA in September 2025.

Global overview

As of 28 January 2026, the monkeypox virus (MPXV) continues to spread globally, causing both localized and extended mpox outbreaks driven by various MPXV clades (Ia, Ib, IIa, and IIb) in diverse settings. Furthermore, recombination of MPXV clades has been documented, with two cases of a recombinant clade Ib/IIb MPXV strain reported in recent months.

Globally, from 1 January 2022 to 31 December 2025 (latest global data available), 143 countries and territories across all WHO regions have reported 177 848 confirmed cases, including 477 deaths (case fatality ratio [CFR] – 0.3%). This marks an increase of five additional reporting countries (Kuwait, Mali, Madagascar, Namibia and Senegal), along with an additional 19 423 confirmed cases and 78 deaths since the last RRA in September 2025. Since the last RRA, an average of 616 new confirmed mpox cases per week have been reported across all affected countries.

In addition, in January 2026, the Comoros and the French departments of Mayotte and la Réunion have reported cases linked to travel to Madagascar.

Previous versions of this RRA have categorized risk based on MPXV clade. However, in absence of substantial data suggesting differences in the mode of transmission between different MPXV clades, and with relatively limited data suggesting higher case fatality for clade Ia MPXV compared to other clades, this version of the RRA assesses the risk for three population groups; global risk for individuals with multiple sexual partners, local risk for children in mpox historically endemic areas, and global risk for all other individuals.

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. In Europe and the Americas, up to 96% of cases were among men who have sex with men driven by spread among individuals with multiple sexual partners in a short space of time and frequent partner change. While sexual behavior data for cases in newly affected African countries remain limited, the contribution of sexual transmission to the introduction, spread and establishment of mpox in communities has been recognized across all affected settings, as in the most recent outbreak in Madagascar. In several countries, transmission has involved sex workers and their clients, and sexual networks with frequent and multiple partner change.

Sexual contact infection likely occurs during pre-symptomatic or less apparent stages of infection, the duration of which can vary between individuals. People with few or mild genital lesions might not even recognise the infection. Although the secondary attack rate for sexual contact is high (estimated at 16-73%), for the epidemic to spread it requires networks characterised by frequent partner change and high rates of partner turnover over short timeframe (days to few weeks). This pattern was observed during the initial spread of clade IIb among communities of men who have sex with men, as well as in more recent MPXV clade Ib oubtreaks driven – in part – by key populations such as female sex workers and their clients. We therefore consider within this group of multiple sexual partners, individuals with frequent partner change, and those who may engage in at-risk sexual behaviour, such as people who buy sex.

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 suggest 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 in interrupting human-to-human transmission. Furthermore, the contribution of asymptomatic viral carriage to transmission remains unclear.

In most healthy adults of this group, mpox infection is mild and self-limiting. However, severe disease and death have been documented in people living with uncontrolled HIV, as well as other immunocompromising conditions, including in countries such as Burundi, the Democratic Republic of the Congo, Sierra Leone and Uganda. While the overall case fatality ratio has remained below 1% in most settings, substantially higher fatality has been observed among individuals with immunosuppression. Although most people living with HIV globally are on antiretroviral therapy, gaps in diagnosis and treatment persist in several low- and middle-income settings, exacerbated by the cuts to HIV programmes in many countries.

Most countries have activated outbreak response mechanisms, including surveillance, case investigation, contact tracing, and infection prevention and control. However, control efforts have been impeded when sexual transmission is not adequately recognized and risk communication and community engagement do not effectively reach key populations and other individuals within sexual networks. A new recombinant clade Ib/IIb MPXV strain of MPXV has also been identified in this group at risk with, to date, apparently similar risk factors related to sexual contact.

While targeted mpox vaccination has been implemented for groups at higher risk of mpox exposure in several countries, coverage remains uneven and most individuals in this group, particularly in countries outside Europe and North America, remain susceptible to mpox infection. In addition, new cohorts of individuals entering sexually active age groups are continually added, and the duration and level of protection conferred by prior infection and/or vaccination remain uncertain.

Overall, while transmission in this population group is likely to continue and sustain geographic spread, severe outcomes most often occur among immunocompromised individuals and population-level health impact has remained limited. **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 countries of West and Central Africa, particularly in the Democratic Republic of the Congo, the highest number of mpox cases and and incidence of deaths has been documented among young children (<5 years). Surveillance and diagnostic capacities in these settings remain suboptimal and have decreased since the last

RRA, making the interpretation of available data more challenging. Children are less represented among mpox cases in surveillance data from other endemic countries outside of the Democratic Republic of the Congo.

Among individuals younger than 50 years in the Democratic Republic of the Congo, mpox incidence appears broadly comparable across age groups, however, case fatality among suspected mpox cases in children under five years of age (CFR 3.2%) is almost twice that observed among individuals aged 15 years and older (1.8%). Of note, the case fatality ratio in historically endemic areas of the DRC remains much higher across all age groups than elsewhere (about 5-10 fold higher), for reasons that remain poorly understood and may stem in part from surveillance (almost all data are syndromic) and in part from specific vulnerabilities. The higher fatality observed in infants and young children, who are largely immunologically naïve, is likely driven by delayed or limited access to appropriate healthcare and compounded by concomitant health risks, including malaria, varicella, malnutrition, and complications of mpox such as dehydration and secondary infections.

In the absence of established vaccination programmes against mpox and limited access to early and appropriate healthcare, children in these settings are likely to continue experiencing elevated health risks from mpox infection.

The risk of geographic spread associated with non-sexual contact transmission is most predominantly local . Available data indicate secondary attack rates of less than 20% following non-sexual household contact, suggesting children, while vulnerable to more severe disease, have a more limited role in driving viral spread. Children have also generally not been the source of introduction of the virus 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, especially 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 again increasingly need to rely on routine care capacity.

Evidence for this group is limited, as most available surveillance data are based on suspected cases and deaths. In addition, relatively few studies have been conducted in historically mpox-endemic areas, and many of these are outdated or have methodological limitations that restrict the generalizability of their findings.

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

All other individuals – global risk

For individuals outside the above two risk groups, mpox is typically mild and self-limiting, with most cases requiring only supportive care and no hospitalization. Severe disease and death are uncommon at the population level. While severe outcomes may occur among individuals with underlying immunocompromising conditions (including advanced HIV infection, malignancies under active treatment, immunosuppressive therapies, or poorly controlled chronic diseases), these individuals generally represent a small proportion of all cases in recent outbreaks. 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 lower disease severity. While breakthrough cases of mpox have been seen in some older previously vaccinated persons, epidemiological data indicate that few mpox deaths have been reported in this group. To date, there are no data regarding disease severity associated with the newly detected recombinant mpox virus strain beyond the two cases detected who experienced mild disease and recovered. The consequences for individuals in t are therefore considered minimal, resulting in an overall low risk to human health.

New cases of mpox with clade Ib MPXV in various regions have predominantly been associated with sexual contact involving people who have travelled to an outbreak area, and developed symptoms upon return. Secondary transmission from these cases to their non-sexual contacts have been limited, while spread through multiple sexual partners has ultimately led to community transmission of clade Ib MPXV in several countries outside Africa. Overall community spread of clade Ib MPXV in newly affected areas has generally remained within groups at risk. In addition, since the start of the global outbreak in 2022, this population group has also not been greatly affected by ongoing circulation of clade IIb MPXV, nor implicated in its introduction or establishment in new geographic areas. Individuals

in this group have mainly been infected through household or occupational contact, characterized by low secondary attack rates and limited onward transmission.

Public health control measures have generally been sufficient to manage mpox in the wider population. Vaccination has been prioritized for groups at higher risk of exposure, and vaccine has, in addition, been offered to mainly health workers in areas with cases primarily for their individual protection. In all settings therefore, the general population remains largely immunologically naïve for mpox, but the risk for their health, contribution to international spread and insufficient response capacities, is low. **The overall public health risk for all other individuals 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. While all countries remain at risk of importation and limited local transmission, recent outbreaks have confirmed observations, initially made since 2022, that sustained transmission and geographic spread are largely driven by sexual contacts in specific population groups and network dynamics, rather than in the general population.

While some countries have established robust response mechanisms, such as early detection and contact tracing that help in controlling viral spread, other countries are less prepared and are at a higher risk of missed chains of local transmission, especially where a low index of suspicion, stigma, and discrimination create barriers to access diagnostic testing, clinical care services and implementation of infection prevention and control measures.

Despite improvements since 2022 in understanding mpox transmission and risk groups, 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 (particularly for specific groups such as those with immunocompromising conditions), the need for periodic revaccinations, 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. Several cases and larger outbreaks have been reported in humanitarian emergency settings such as camps of displacement persons and other congregate, overcrowded settings, but the risk of spread and modes of transmission in these settings due to the living conditions or other factors is still poorly understood. Additionally, transmission between children outside of the household is also not fully understood and its potential to sustain the virus in the community has not been quantified.

In recent years, access to diagnostics, vaccines, and response tools has improved through coordinated efforts by WHO and partners, and several countries 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 due to limited mpox vaccine supply reduce the potential impact of vaccination, underscoring the importance of prioritization and timely deployment. In addition, evidence on the effectiveness of available therapeutics for mpox remains 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, two cases have been identified, genetically linked and implicating four countries in three WHO regions. The geographic areas where the recombination event occurred remains unknown and surveillance data suggest sustained undetected or unreported community transmission in several countries. While the current public health risk associated with this recombinant strain is considered low, ongoing genomic surveillance is essential given uncertainties related to viral evolution and recombination.

Overall, mpox continues to circulate in all WHO regions and pose distinct risks across different population groups and settings, with generally mild disease in most individuals. However sustained transmission of this still-emerging and evolving orthopoxvirus continues, posing health risks for vulnerable individuals in all settings. While response capacity improved since the declaration of the second public health emergency of international concern (PHEIC), it remains uneven and highly resource-dependent. Since transition to longer term disease prevention and control is still in the early stages and limited resources in several countries might hinder the gains of the last one-and-a-half years, **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 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 became clade I and the West African clade became clade II.[2] 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 DRC in 2023, and subclade Ia is currently considered to encompass all other strains of clade I that are not Ib. Two cases of a new recombinant clade Ib/IIb MPXV have been detected, one in the United Kingdom and one in India.

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.

Recent mpox outbreaks, particularly in newly affected areas, have been predominantly driven by sexual contact, followed by non-sexual contact within households. 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 paucisymptomaitc 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 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 (STIs), 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[3]:** 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. 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.

Risk questions

The below risk questions 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 Individuals with multiple sexual partners		Assessment		Risk	Rationale
		Likelihood	Consequences		
Risk for human health	Global	Likely	Minor	Moderate	In most healthy adults, mpox is a mild and self-limiting infection that can be managed with supportive care. However, infection may lead to severe disease and death among immunocompromised individuals. Individuals with multiple sexual partners have a higher incidence and prevalence of sexually transmitted infections, including 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 viral clades. Case fatality ratio in this risk group has been overall below 1%, and up to 15% among immunosuppressed individuals with CD4 count lower than 200 cells/mm^3. In many countries, the majority of people living with HIV are receiving antiretroviral therapy and HIV is virologically 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 higher risk of severe outcomes in case of MPXV infection. In addition, budget cuts in global health over the past year 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 suggests that viral shedding from the genital tract may occur up to approximately four days before symptom onset, potentially 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 cases of a new recombinant clade Ib/IIb MPXV have been detected globally in individuals belonging to this group. The first in the United Kingdom of Great Britain and Northern Ireland (hereafter “United Kingdom”) - with travel history to a country in South-East Asia - and the second in India (with travel history to a country in Middle East), but 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.
Risk of geographic spread	Global	Highly likely	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 mpox cases, 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. 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. During 2022 and 2023, men who have sex with men were the most affected group, but since 2024, sex workers and their clients have increasingly contributed to the geographic spread of mpox or specific mpox clades to new settings. 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 highly likely. There is insufficient information about the risk of spread represented by the recently detected recombinant Ib/IIb MPXV strain, since only two cases have been so far identified. Overall, secondary transmission (of any clade) through household or other non-sexual contact has been relatively limited, and sustained community transmission outside these networks has not been a major driver of spread. Consequently, at the global level, the overall consequences of geographic spread remain minor, and the overall risk of geographic spread is assessed as moderate.
Risk of insufficient control capacities	Global	Likely	Minor	Moderate	Most mpox outbreaks since 2022 have been limited in size, with the majority of reported cases 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, where surveillance, laboratory and response systems are often stretched. Limited and unpredictable funding, shortages of trained health workers, and competing outbreak priorities may delay case detection, contact tracing, 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 2025, 15 countries in Africa have implemented mpox vaccination for populations at the greatest risk, including healthcare workers, contacts of cases, sex workers, men who have sex with men, and other priority groups based on local epidemiology. While vaccination has strengthened prevention efforts in these settings, coverage remains heterogeneous and dependent on available resources and limited mpox vaccine doses. Globally, vaccination coverage among individuals with multiple sexual partners remains uneven, and most individuals in this group, particularly in countries outside Europe and North America, remain susceptible to mpox. In addition, new cohorts of individuals entering sexually active age groups are continually added, 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. Overall, it is likely that some countries will face insufficient control capacities for mpox; however, the consequences are assessed as minor given the relatively limited number of reported cases and the extent of mpox spread to date, resulting in an overall moderate risk.

Risk question Children in historically endemic areas		Assessment		Risk	Rationale
		Likelihood	Consequences		
Risk for human health	Local	Likely	Moderate	High	Mpox historically endemic areas include several countries in West and Central Africa, where transmission has predominantly occurred in rural forested settings, with subsequent 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 risk assessment, further complicating interpretation of available epidemiological data. Although children are disproportionately affected in the Democratic Republic of the Congo, they are less represented among reported mpox cases in other historically endemic countries outside the Democratic Republic of the Congo. Among individuals younger than 50 years who are unlikely to have vaccine-derived immunity from prior smallpox vaccination, mpox incidence appears broadly comparable across age groups. However, the case fatality ratio among suspected mpox cases in children under five years of age (3.2%) is almost twice that observed in individuals aged 15 years and older (1.8%).The higher fatality observed in young children, who are largely immunologically naïve, is likely driven by delayed or limited access to quality healthcare and compounded by concomitant health risks, including malaria, varicella (chickenpox), 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 pediatric care, these factors are expected to sustain a disproportionate disease burden among young children in historically endemic areas. Given the observed severity and fatality in young children, 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 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 drivers of wider geographic spread. Children have not been responsible for the introduction of 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 a 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 pediatric 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 very 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		Risk	Rationale
		Likelihood	Consequences		
Risk for human health	Global	Unlikely	Minimal	Low	For individuals outside of the other two risk groups assessed in this RRA, mpox infection is typically mild and self-limiting, with most cases requiring only supportive care. Hospitalization is uncommon, and severe disease and death are uncommon at the population level. While severe outcomes may occur in individuals with underlying immunocompromising conditions—such as advanced HIV infection, malignancies under active treatment, immunosuppressive therapies, poorly controlled diabetes, or other chronic conditions—these individuals represent a relatively small proportion of this population group and have not been not the primary drivers of mpox-associated morbidity and mortality in recent outbreaks. In addition, 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 it may wane over time, this residual immunity is expected to reduce disease severity and the risk of adverse outcomes in older age groups. While breakthrough mpox infections have been reported among some previously vaccinated individuals, epidemiological data suggest that disease severity in these cases is generally lower, and mpox-related deaths in this population group have been rare. Available epidemiological data indicate that the case fatality ratio in this population group has remained below 1% across recent outbreaks, with no data showing any increased severity associated with newly detected or recombinant mpox virus clades. Given the generally mild clinical course, 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 among all other individuals 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 within this risk category has not been a primary driver of the introduction or establishment of mpox in new geographic areas. Transmission in this 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, widespread community transmission. Secondary transmission from such cases to non-sexual contacts has generally been limited, and community transmission of clade Ib MPXV in newly affected areas has largely remained confined to higher-risk population groups. 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 evidence indicates low secondary attack rates associated with non-sexual contact, further limiting the potential for wider spread. To date, no sustained transmission chains or large outbreaks have been attributed to this population group, and no evidence suggests increased transmissibility associated with recently detected or recombinant mpox virus clades in this context.
Risk of insufficient control capacities	Global	Unlikely	Minimal	Low	Among individuals outside of the other two risk groups assessed in this RRA, existing public health control measures to manage mpox outbreaks vary across settings but have generally been sufficient. 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, the impact of these limitations on this population group 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 not recommended for the general population and has been prioritized for specific higher-risk groups, including healthcare workers, contacts of cases, men who have sex with men, sex workers, and other individuals with multiple sexual partners. 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. As a result, while gaps in funding or workforce capacity may occasionally delay response activities, the consequences for outbreak control in this population group are generally minimal, and the risk of insufficient control capacities for this group 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	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

WHO Immediate Actions at Global level

- Convening of grading call to review findings of the rapid risk assessment, progress of the response, and the grading of the event.
- Continue to support countries in implementing the roadmap for the transition of the current acute emergency response approach to a routine programmatic approach.

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 DRC in 2023, and subclade Ia is currently considered to encompass all other strains of clade I that are not Ib.[4] In December 2025, the United Kingdom detected the first case of a clade Ib/IIb recombinant,[5] and after its classification as a novel MPXV recombinant strain, one case detected in India in September was retrospectively reclassified. To date, these are the only known cases of this recombinant.

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., hunting, trapping, or petting), 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).[7]

Since May 2022, a multi-country outbreak of mpox due to clade IIb MPXV has affected over 130 countries and territories worldwide, most of which had never reported mpox before.[8] This outbreak has been sustained by human-to human transmission, mainly through sexual contact.[9] 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 DRC, where in addition to zoonotic exposure, human-to-human transmission of clade Ib MPXV, including through sexual contact, has been ongoing since September 2023.[10]

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.[11] 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, with many of these lesions located in the genital or anorectal area, linked to sexual contact transmission.[12]

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[13] and parotitis[14] are now also recognized as rare complications.

Generally, most healthy individuals with mpox in the global outbreak have presented with mild 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 setting with access to quality healthcare.[15] Globally the case fatality ratio among confirmed mpox cases from 2022 to end of 2026 is around 0.3% (277/177 750), lower in Europe and the Americas, and higher in the African and South-East Asia Regions. The global outbreak, and the more recent cases in South Africa from May to August 2024, 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.[16] Over time the Democratic Republic of the Congo has reported one of the highest mpox case fatality, up to 4% in 2024 among suspected mpox cases. 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 endemic areas it is currently between 2-2.5% among suspected cases, while in provinces with better confirmation rates such as Kinshasa, North and South Kivu, it is below 1%. Higher case fatality ratio is observed among children, particularly those under the age of 5 years, which in endemic provinces have a case fatality ratio of around 3%. wherein the Democratic Republic of the Congo cases present 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 age and underlying health status of affected individuals. Moreover, limited surveillance capacity and resources in DRC 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 transmission of MPXV 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,[17] vaginal fluid[18] and anorectal swabs,[19] indicating that transmission through this type of contact may be multifaceted.[8,20,21] 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.[22]

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 UK 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.[23] Occasional detection of viral DNA in air samples suggests that airborne transmission is not the primary route but cannot be excluded in specific settings. These findings highlight the importance of implementing 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.[24]

Evidence from the Democratic Republic of the Congo, as well as the more recent outbreak in West African countries, have shown that transmission through sexual contact also occurs for all MPXV clades.[25,26]The presence of commercial sexual networks among mpox cases suggests 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-behavioral 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 varied across contexts and was shaped by individual and community characteristics, as well as direct exposure to people infected with mpox. While many people viewed mpox as a serious health threat, uncertainty persisted regarding symptoms, transmission routes, and who was most at risk. In several settings, key populations such as sex workers, truck drivers, and motor taxi drivers described themselves to be at risk. In Rwanda and Burundi, communities frequently identified children, pregnant women, and people with chronic illness as particularly vulnerable. Men who have sex with men (MSM) in these two countries were only identified as at-risk groups during discussions with key populations. In DRC and Liberia perceptions of risk extended beyond health outcomes to include fears of economic and social consequences, such as loss of income, isolation, or rejection within families and communities.[27] In both settings, mpox was often weighed against other pressing health threats such as malaria, cholera, diarrheal disease, and malnutrition and, while recognized as serious, was frequently considered less urgent.

Levels of community **mpox knowledge and awareness** shifted over the course of the outbreak. Early response data indicated gaps in understanding of symptoms and prevention, with lower levels of awareness observed among women and adolescents. Key populations including sex workers and truck drivers reportedly showed high levels of awareness compared to other groups. Rash and lesions were the most commonly cited symptoms, but they were noted to be non-specific and overlap with symptoms of other illnesses such as malaria, syphilis or leprosy was often reported. Preventive actions such as handwashing and avoiding close contact were commonly cited, with vaccination, avoiding sharing personal objects, and limiting sexual partners also cited.[28,29] Community volunteers reported good knowledge about mpox symptoms, transmission and prevention but noted recurring questions from community members about distinguishing mpox from other diseases and on transmission pathways. Findings from the rapid assessments highlight pluralistic understandings of disease causation, with biomedical explanations coexisting alongside beliefs linking mpox to contaminated water, unsafe remedies, or spiritual causes.[27] Circulating misinformation also influenced narratives linked mpox to contaminated water or unsafe remedies, or attributed it to supernatural causes, undermining biomedical explanations and affecting timely care-seeking.[30] Over time, information needs shifted across multiple settings: initial demands for clarity on symptoms and prevention, followed by confusion with chickenpox, and ongoing requests for plain-language advice on transmission and protective measures countries.[31]

Evidence on **isolation** emphasises social, economic, and structural barriers affecting uptake. Economic pressures, reliance on daily income, and social dimensions such as stigma, gender roles, and caregiving constrain the feasibility of home isolation in many contexts. In Rwanda, isolation requirements were reported as a major barrier to care-seeking, particularly among groups dependent on daily income such as sex workers and truck drivers, who feared losing their livelihoods during extended isolation. Findings from Liberia and DRC further underscore the role of caregiving norms and social obligations, with family members often continuing close contact with sick relatives despite recognising transmission risks. Insufficient social support, during isolation were commonly reported, with some describing children left unattended or lack of basic household assistance during isolation. In Burundi, fear of isolation and its indirect costs and insufficient knowledge about case management were commonly reported as reasons for delaying formal care. In South Africa, some opted for self-isolation and combined biomedical with traditional treatments, citing affordability and accessibility as key factors shaping their decisions. Self-reported intent to isolate after a positive diagnosis reportedly increased in DRC, the Central African Republic, and Rwanda, but declined in Burundi, suggesting shifting perceptions of feasibility and willingness to comply.[32] In dense urban setting such as Kinshasa, overcrowded housing and limited WASH infrastructure were found to further reduce the practicality of home isolation. Mental health impacts were also noted, particularly among MSM, who associated isolation with heightened stress and anxiety. WHO updated its recommendation with respect to home isolation accordingly in May 2025: " WHO suggests that persons with mild, uncomplicated mpox infection cared for at home are not required to isolate provided their lesions are covered and they wear a well fitting medical mask when in close proximity with others until all lesions are healed."

Intent to **seek formal care for mpox** was generally high, but care-seeking was shaped by accessibility, affordability, trust in services, perceived quality of care, perceived severity of symptoms and risk perceptions. .[32] In Burundi, uncertainty about where and when to seek care was identified as a barrier, compounded by transport challenges, indirect costs, and concerns about poor quality of care. In DRC, distrust in health facilities and long wait times were identified as factors affecting care-seeking.[28] In South Africa, decisions were reportedly influenced by affordability and accessibility, with some individuals combining biomedical care with traditional remedies or informal advice, while MSM preferred non-government organization (NGO) clinics over public health facilities due to fear of discrimination. Misinformation, including narratives promoting herbal cures discouraging biomedical care and reinforcing rejection of medical advice, further influenced care seeking.[30]

Intent to **vaccinate against mpox** was reportedly high in many countries, with increases observed over time,[32] despite the African region having the lowest mpox vaccine acceptance rates worldwide.[33] Drivers included awareness of vaccine availability, accurate information on its protective value, perceived severity of mpox, and trust in health providers. In Rwanda, vaccine awareness was initially low among sex workers and truck drivers, but once information was shared, acceptance reportedly increased. In South Africa, MSM and sex workers described vaccination as a preferred preventive measure but requested clearer information on eligibility, efficacy, and side effects. In eastern DRC, community members and health workers associated vaccination with visible benefits, reporting a reduction in cases where campaigns had taken place, while also expressing frustration over shortages and the prioritisation of health workers and contacts of cases.[34] Vaccine acceptance was also found to be higher among health workers and respondents in historic mpox-endemic regions, while lower among unemployed groups and urban populations.[29] Barriers to vaccine acceptance included lack of awareness, concerns about effectiveness and safety, risk perceptions, cultural beliefs, misinformation, and distrust.[28] Misinformation and rumours around mpox vaccines — including infertility, poisoning, corruption, and association with COVID-19 vaccines — were widely reported across the region, influencing vaccine hesitancy.[35]

Stigma was highlighted as a critical factor affecting timely care-seeking and reintegration of survivors. People with visible symptoms or survivors reportedly faced avoidance and rejection, including being shamed, evicted, or losing customers in their businesses, even after recovery.[27] Caregivers and family members also reported that they experienced stigma as a result of their association with patients. In Rwanda and Burundi, survivors were in some instances only accepted back once communities had official discharge certificates confirming they were no longer infectious. Mpox was also associated with underlying patterns of marginalisation: in South Africa and Uganda, it was framed as a “gay disease” or linked to sex work, HIV, or foreigners, fuelling discrimination and reinforcing barriers to care.

Viral genome sequencing

MPXV clade I has historically been spreading in Central and East Africa, and clade II mostly in West Africa, although in most recent years subclade IIb has spread to more than 140 countries and subclade Ib to 50 countries.

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,[36,37] and historically it has been observed that human cases due to clade I MPXV had higher severity and mortality compared to clade II.[38] The main limitation of these results is due to the spread of the different clades in different population, involving a different proportion of children and vulnerable individuals, which makes the comparison more challenging. Overall, the case fatality ratio of clade Ib has been comparable of that of clade IIb, and of that of clade Ia in urban settings such as Kinshasa, while in more rural areas of the Democratic Republic of the Congo, clade Ia cases have higher case fatality ratio.[39]

Clade Ia MPXV infections over time have been linked to zoonotic transmission[40] 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 clade Ia sequenced strains.[4140] 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 DRC.[25] 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.[42] This outbreak lineage has subsequently been detected in several other provinces within the DRC, including Kwilu, Kwango, and Kongo-Central.

Clade IIa 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 transmissions. 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[10] 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.[43]

Clade IIb has has the wider human-to-human transmission of any other MPXV strain, and since 2022 it has continued to genetically diversify. Its specific lineages and sublineages have spread in different geographical areas, where sometimes they have lead to clustering of cases with similar genetics, but as cases due to the movement of people continue to be reported the genetic diversity of viral strain also keeps moving.

Two cases of a new recombinant clade Ib/IIb MPXV have been detected, one in the United Kingdom (with recent travel to a country in South-East Asia) and another in India (with recent travel from a country in Middle East). In both 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 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).[44] 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.[44] 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.[45] 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 [46] to wild sooty mangabeys in Taï National Park in Côte d'Ivoire. A recent pre-print 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, DRC 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.[47] 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.[48] 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 with an overview of the mpox epidemiological situation across the world, highlighting Africa and 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 ***31 December 2025****. 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 31 December 2025, a total of 177 848 confirmed cases of mpox, including 477 deaths, were reported to WHO from 143 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 1176 new confirmed cases were reported in December 2025, reflecting a 47% decline from the previous month. This apparent decline should be interpreted with caution, given likely reporting delays for the most recent data. Furthermore, in the WHO European Region, data prior to December 2025 were 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 and the apparent decrease in cases might be overestimated.

The majority of cases in December 2025 were reported from the African Region (68.8%), followed by the Region of the Americas (11.1%) and the European Region (11.0%). Five regions reported a monthly decrease in cases for December 2025, compared to November 2025: the European Region (66%, 129 vs 380 confirmed cases), the Region of the Americas (64%, 130 vs 363 confirmed cases), the African Region (50%, 809 vs 1616 confirmed cases), the South-East Asian Region (41.7%, 14 vs 24 confirmed cases) and the Western Pacific Region, (20%, 90 vs 112 confirmed cases). The Eastern Mediterranean Region reported an increase in confirmed cases from zero cases in November 2025 to four cases in December 2025.

Table 1. Number of cumulative confirmed mpox cases and deaths reported to WHO, by WHO Region, from 1 January 2022 through 31 December 2025.

WHO Region	Total confirmed cases	Total deaths among confirmed cases	New cases reported in November 2025	New cases reported in December 2025	Monthly change in cases (%)
Region of the Americas	73 025	158	363	130	-64.0
African Region	64 015	271	1616	809	-50.0
European Region	31 680	10	380	129	-66.0
Western Pacific Region	7 015	21	112	90	-20.0
South-East Asia Region	1 185	14	24	14	-41.7
Eastern Mediterranean Region	928	3	0	4	
Total	177 848	477	2495	1176	-53.1

Figure 1 below shows that over the past 12 months (1 January – 31 December 2025), the number of confirmed mpox cases reported monthly in the WHO African Region have been declining from the peak reported in May 2025, attributed to decreasing trends in DRC, Sierra Leone, and Uganda, which had been accounting for the heaviest burden of confirmed mpox cases in 2025.

The Eastern Mediterranean and South-East Asia Regions have been reporting the lowest numbers of cases globally, with the Eastern Mediterranean region reporting sporadic cases in 2025, and South-East Asia observing an upward trend in confirmed cases until a peak in October 2025, which has since subsided, with Thailand reporting the majority of cases.

The Western Pacific and the Region of the Americas have observed an upward trend in reported confirmed cases until a peak in July 2025 and September 2025 respectively, which has since subsided.

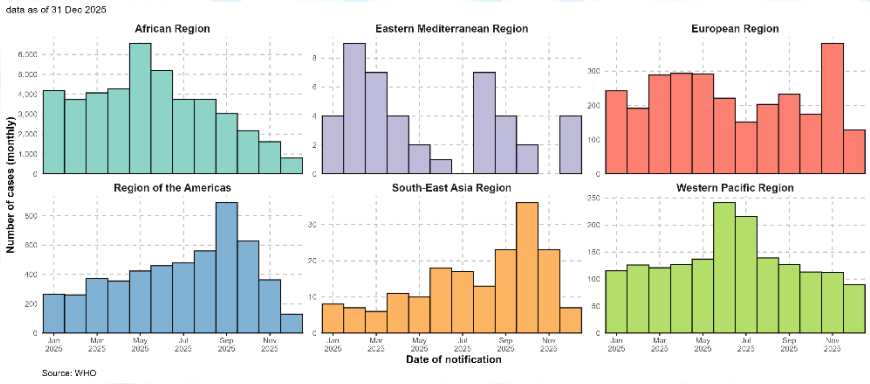
The European Region observed largely stable trends in 2025, with a spike in reported confirmed cases in November 2025 that was not sustained in December 2025. Trends in the European Region should be interpreted with caution given recent changes in reporting methods already described above.

Most recent trends in all regions may be prone to surveillance and reporting biases.

In the last 12 months, a global average of about 4415 confirmed mpox cases per month has been reported. Most of them were reported by the African Region (43 106 confirmed cases), followed by the Region of the Americas (5185 confirmed cases), and the European Region (2796 confirmed cases).

Since the last grading call, the number of reported confirmed mpox cases has been decreasing in all WHO regions. However, 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 declining 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 January – 31 December 2025.



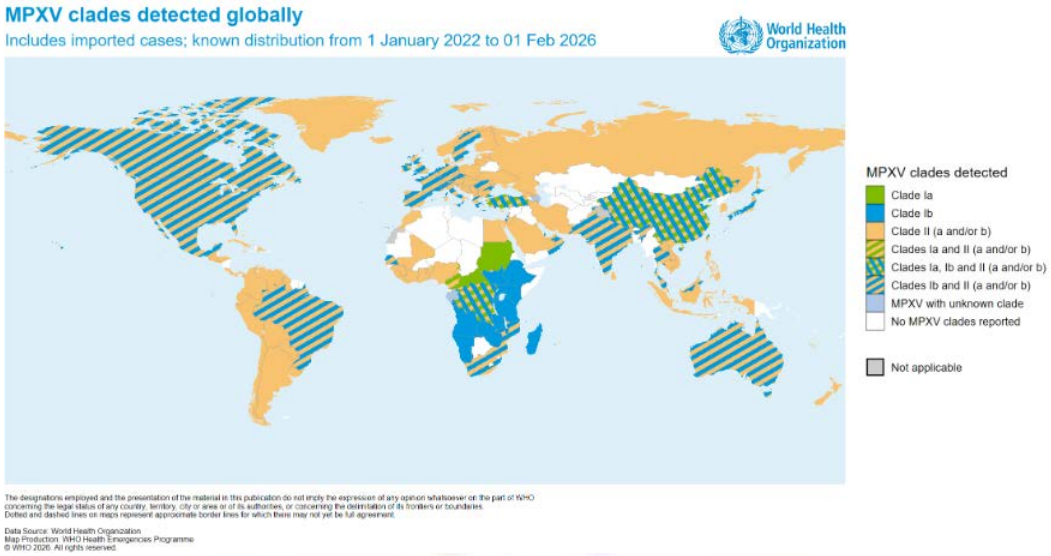
Please note that different Y axis scales have been used for the regional epidemic curves to allow a better overview of the trend in each region.

Global MPXV clade distribution

From January 2022 and as of 1 February 2026, the distribution of reported MPXV clades by country of detection is 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 52 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 clade Ib MPXV community transmission at some point, like the European Region (France, Italy, the Netherlands, Portugal and Spain), the Region of the Americas (the United States of America), and the Western Pacific Region. 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 who are currently not reporting cases highly suggests that some countries might 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 1 February 2026[a].



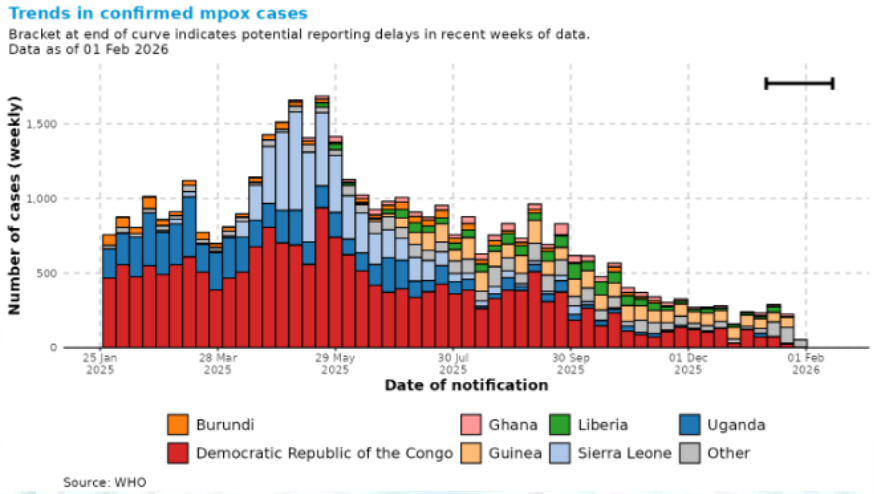
Epidemiological situation in Africa

Africa has been the region with the highest number of reported mpox confirmed cases in the last 12 months.

In Africa, since 2025, and as of **1 February 2026**, a total of 46 004 confirmed mpox cases, including 202 deaths (CFR 0.4%), have been reported across 30 countries. Overall, the downward trend in reported weekly confirmed cases that began mid-2025 continues (Figure 3). Around 100 new confirmed cases per week have been reported in recent weeks, a drop from over 1600 confirmed cases reported per week at the outbreak peak mid-2025. This drop has been driven by a sustained downward trend in case counts in high-burden countries, initially DRC, Sierra Leone, and Uganda, then Kenya and Liberia as well later in the year. An increase in reported cases has been seen in recent weeks in Madagascar.

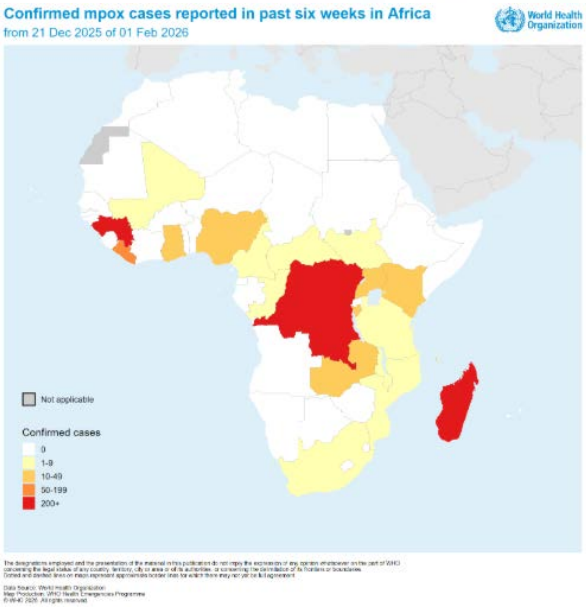
[a] The geographical distribution of MPXV clades shown is based on sequences from clinical samples of confirmed mpox cases. Sequences from wastewater and environmental samples are excluded from this analysis.

Figure 3. Epidemic curve of confirmed mpox cases in Africa, by country, in the past 12 months, 25 January 2025 – 1 February 2026.



In the last six weeks, 20 countries on the continent have reported active transmission of mpox (Figure 4), with 1191 confirmed cases, including four deaths (CFR 0.3%), reported during this period. Countries reporting the highest number of confirmed cases over the last six weeks are Guinea (354 confirmed cases), DRC (316 confirmed cases), Madagascar (224 confirmed cases), Liberia (82 confirmed cases) and Ghana (46 confirmed cases). DRC and Guinea have been observing a downward trend in cases, Liberia and Ghana have been observing a somewhat stable trend in confirmed cases, while Madagascar has been observing an upward trend in confirmed cases reported.

Figure 4. Geographic distribution of confirmed mpox cases in the past six weeks, Africa, 21 December 2025 – 1 February 2026.



Epidemiological situation in key countries

Focus on DRC

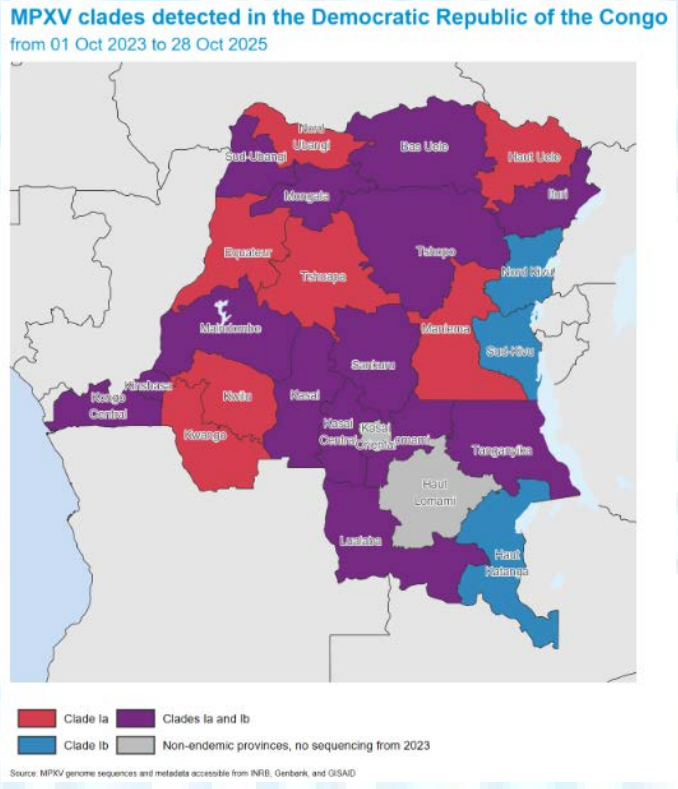
The country continues to face challenges in the laboratory diagnosis of mpox, with a decreasing number of laboratories testing and confirming mpox cases compared to the PHEIC period. The number of cases tested is dropping faster than the number of

*suspected cases. Since 2025, approximately a third of suspected mpox cases were tested, and among these, about half were found to be positive, as of **25 January 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.*

Mpox transmission continues across the DRC 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 DRC, by province, from 1 October 2023 to 28 October 2025[b].

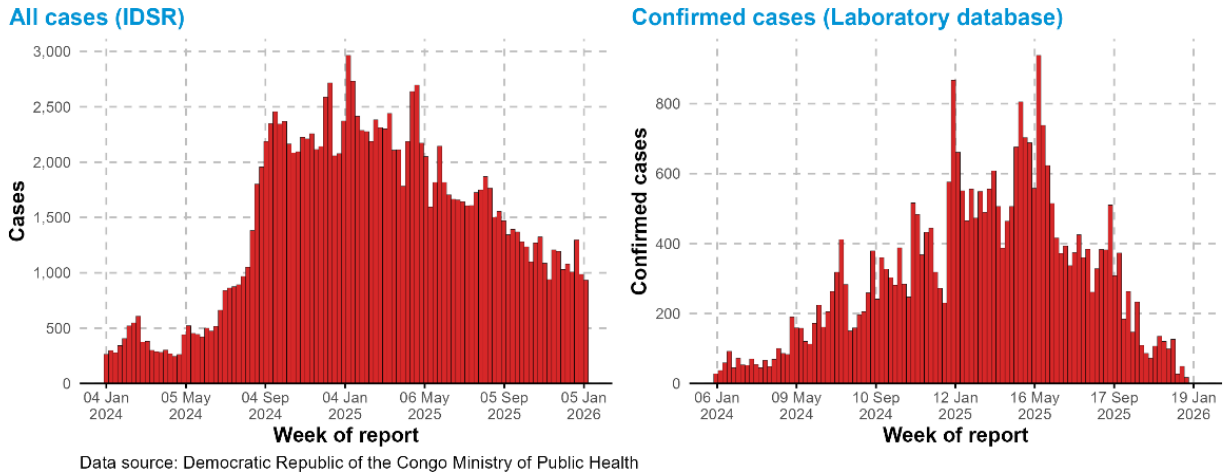


Since late 2024, the country has experienced a sustained high burden of reported suspected cases of mpox. Weekly notifications peaked in the second half of 2024, with up to 3000 new suspected cases per week, and remained elevated throughout most of 2025 (left, Figure 6). More recently, a gradual decline in the number of reported confirmed cases has been observed, with close to 1000 new suspected cases still reported per week in recent weeks. The trends in reported confirmed cases (right, Figure 6), suggest an overall rising trend in 2024 and

[b] This is the most recent complete epidemiological week for which subnational genomic sequencing data are available.

early 2025, reaching a peak in late May 2025, after which there has been an overall decline in weekly confirmed cases reported.

Figure 6. Epidemic curve of suspected (left) and confirmed (right) mpox cases reported in DRC, 1 January 2024 – 11 January 2026[c].

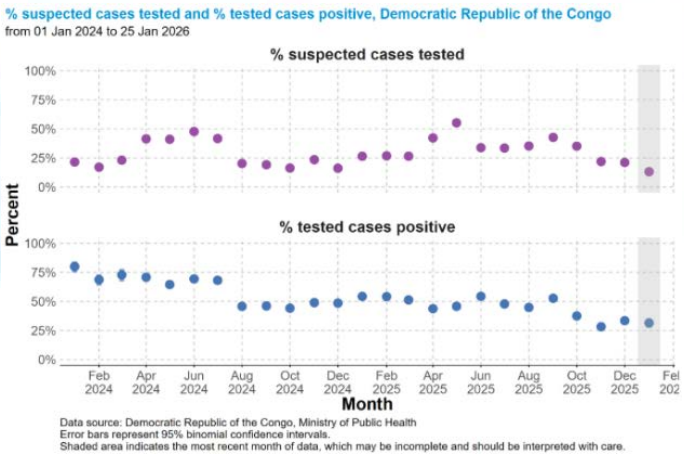


In 2024 and 2025, access to confirmatory testing for suspected cases remained variable over time, generally ranging from about 20% to just over 50% (Figure 7). Since October 2025, there has been a continuous decrease in the proportion of suspected cases tested to below 25%, making confirmed case counts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

During the same period, test positivity remained high overall, largely hovering about 50%, suggesting high levels of MPXV circulation. Since October 2025, however, test positivity has dropped as low as 25%, which could partially explain the declining trend of confirmed cases reported in the country (Figure 6).

The downward trend in suspected cases reported and lower test positivity may suggest diminishing MPXV circulation, but this should be interpreted with caution, given the reduced proportion of suspected cases currently being tested, which in turn reduces visibility on the epidemiology of mpox in provinces with limited access to testing.

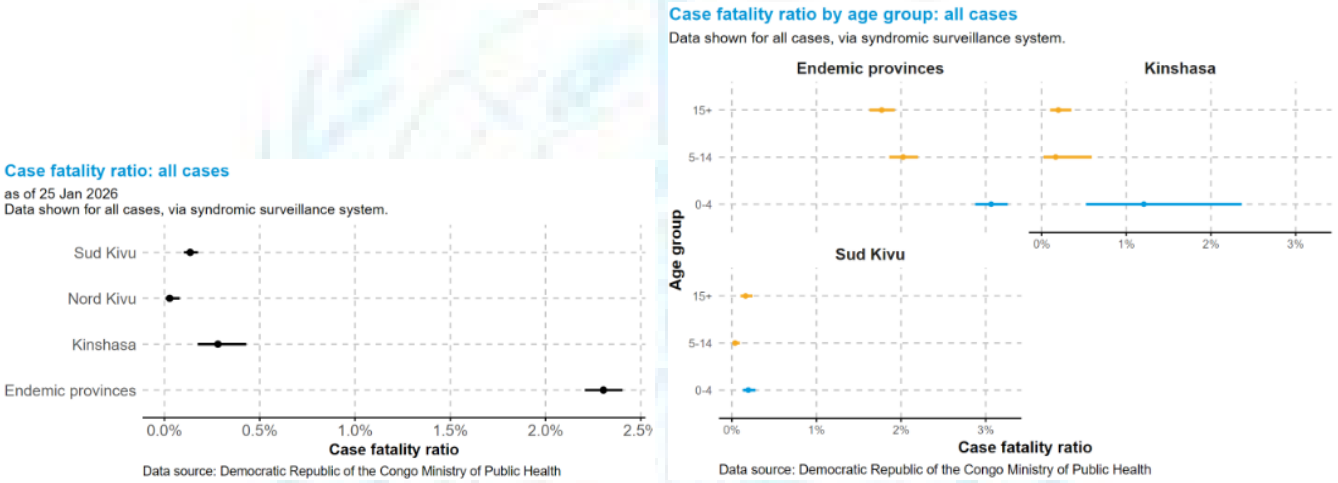
Figure 7. Proportion of suspected cases for whom a sample was collected (top) and proportion of confirmed cases among those that undergo laboratory testing (bottom), in the DRC, by month, 1 January 2024 – 25 January 2026[d].



[c] This is the most recent complete epidemiological week for which data are available.
[d] This is the most recent complete epidemiological week for which data are available.

The country continues to report one of the highest mpox case fatality ratio estimates, although it has decreased from the 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 (2.3%), and the provinces first 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 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 observing 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), January 2024 - January 2026.



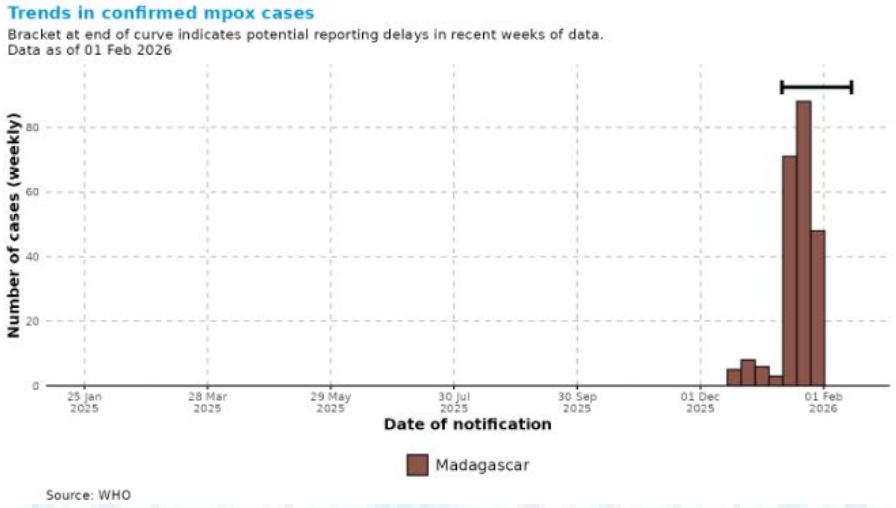
Focus on Madagascar

On 30 December 2025, the Ministry of Public Health of Madagascar declared an outbreak of mpox. The first case, who did not report recent travel, had symptom onset on 12 December 2025 and was confirmed on 17 December 2025.

Between 18 December 2025 and 1 February 2026, Madagascar reported a total of 617 suspected mpox cases, including 229 laboratory-confirmed cases (Figure 9). No mpox-related deaths have been reported to date. On 6 January 2026, the circulating strain was confirmed to be clade Ib MPXV. Currently the country is experiencing community transmission of this clade.

A total of 455 suspected cases has been tested, of which 229 cases have been confirmed, corresponding to a test positivity of 50.3% among tested individuals. Three laboratories are testing for mpox nationally, and work is ongoing to extend and decentralize testing capacity through GeneXpert machines.

Figure 9. Confirmed mpox cases reported in Madagascar over the past 12 months, 25 January 2025 – 1 February 2025



Suspected cases of mpox that meet the national case definition have been notified across 22 of the 24 regions, with laboratory-confirmed cases reported in 12 regions (Amoron'i Mania, Analamanga, Analanjirofo, Anosy, Atsimo Andrefana, Betsiboka, Boeny, Bongolava, Haute Matsiatra, Melaky, Vakinankaratra, and Vatovavy,). The epicenter of the outbreak is Boeny region, which accounts for approximately 49.9% of notified cases and 72.9% of confirmed cases.

An approximately equal distribution between males and females has been observed, and the median age is 23 years. Cases have been reported among key populations, including sex workers and people living with HIV, suggesting broader transmission and likely undetected circulation prior to the first laboratory confirmation.

The epidemiological characteristics of the outbreak in Madagascar are similar to those observed in countries in East Africa affected by clade Ib MPXV, where sexual contact plays an important role in transmission. As the outbreak expands, the risk of infection also rises in households and among other non-sexual contacts.

Emergence of inter-clade recombinant strains

Two countries, India and the United Kingdom of Great Britain and Northern Ireland (hereafter the United Kingdom) have reported the detection of inter-clade recombinant MPXV strains. The high similarity among these two strains indicate that they are part of the same chain of transmission and common ancestor.

Case in the United Kingdom of Great Britain and Northern Ireland

The case is a male aged 40-49 years, with symptom onset on 19 October 2025. The laboratory confirmation was obtained on 28 October 2025 and the individual was immediately isolated. The case reported recent travel to a country in South-East Asia in October 2025 and also reported a history of sexual contact with a transgender woman while in that country. No visible signs of infection were observed in the partner at the time of contact. The patient was reported to have presented with typical features of mpox and to have experienced mild illness. He is HIV-negative and had not received mpox vaccination. He self-isolated at home and has since been lost to follow-up. During laboratory confirmation, the virus was initially typed as clade Ib MPXV by qPCR. Subsequent whole genome sequencing revealed that the MPXV strain identified was unusual – distinct from other known clade Ib MPXV strains – with phylogenetic analysis indicating that the genome had regions similar to both clade Ib and clade IIb MPXV reference sequences, suggesting that it is an inter-clade recombinant. To confirm this unusual finding, sequencing was repeated on the original extract from the primary sample, a fresh extract from the same primary sample, a second swab collected from the patient at the same time, and a cultured isolate derived from

the initial swab. This repeat sequencing yielded identical viral genome sequences from both clinical swabs and the cultured isolate, supporting the initial findings of a new recombinant strain, and showing that it can replicate and presents the potential for onward transmission. This strain is a recombinant MPXV, containing genetic elements from both clade Ib and clade IIb MPXV. Three contacts, one household member and two healthcare workers, were identified and followed up in the United Kingdom; none developed any clinical features of mpox. The healthcare workers had worn full personal protective equipment (PPE) during provision of medical care to the patient. The authorities of the United Kingdom continue to investigate the biological significance of this recombinant MPXV strain.

Case in India

On 13 January 2026, India's IHR National Focal Point (NFP) submitted Case Reporting Forms to WHO, providing information on 16 laboratory-confirmed mpox cases, including one case with an inter-clade recombinant monkeypox virus (MPXV) with genomic elements of clades Ib and IIb MPXV. The recombinant virus was found in samples from a male individual in his 20s, detected in September 2025 in Southern India. The case reported recent travel from a country in Middle East, where he resides as an overseas worker, and sexual contact with an unknown female approximately one month before symptom onset, while in the country. He developed symptoms including fever and sore throat on 1 September 2025, while still in the country, followed by skin eruptions four days later affecting the trunk, genitalia, extremities and face. He returned to India on 10 September 2025, clinical specimens (including throat swab and lesion samples) were collected and tested at the state laboratory, and real-time PCR confirmed MPXV infection on 11 September 2025. Clade differentiation PCR performed at the Indian Council of Medical Research (ICMR)-National Institute of Virology (NIV), Pune, on 15 September 2025 initially identified this virus as clade II MPXV. Initial genomic sequencing analysis suggested features consistent with clade IIb MPXV, however following the update of the global Nextclade database on 16 December 2025 to include the recombinant clade Ib/IIb MPXV strain reported by the United Kingdom in December 2025, the virus was reclassified as belonging to this recombinant strain. Recombination analysis demonstrated mosaic patterns containing genomic regions derived from both parent clades. Following the initial diagnosis, the case was hospitalized, and did not experience any medical complications, and fully recovered, testing negative on 29 September 2025. The case did not report close contacts in India, and no known secondary cases were identified following this introduction of the recombinant clade Ib/IIb MPXV in India. This case currently represents the earliest known detection of this recombinant strain globally, having preceded the event reported in the United Kingdom. Full or near-full genome retrieval (>99%) from both the sample and a sample-derived virus isolate enabled phylogenetic analysis showing >99.9% similarity to the recombinant strain detected in the United Kingdom. A total of 34 recombinant tracts were observed in the sequence reported by India, while 28 recombinant tracts were observed in the sequence reported by the United Kingdom; 16 recombinant tracts were common to both strains. Nationwide, routine mpox surveillance in India continues to detect clade Ib and clade IIb viruses. To date, the recombinant strain has only been detected in this case. Samples from all confirmed mpox cases in India undergo whole genome sequencing. It should be noted that while clade differentiation PCR initially identified the recombinant MPXV detected in the United Kingdom as clade Ib MPXV and the recombinant MPXV detected in India as clade II MPXV, in both instances, whole genome sequencing confirmed the novel recombinant strain. Detection of recombinant MPXV strains depends on the availability, quality and completeness of genomic sequencing data. Consistent with the case reported in the United Kingdom, no apparent difference in clinical presentation from clade I and clade II MPXV (non-recombinant MPXV) infection were observed.

Surveillance and reporting

WHO global mpox surveillance continues, with cases reported weekly by countries in the African region and monthly for the other Regions.[7] Clade I cases (a & b) are being reported through timely IHR notifications. Additionally tracking systems have been put in place for clade detection monitoring as well as recording of imported cases reported through IHR. 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 weekly for countries in Africa and monthly for countries in other regions.[8] 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 is has been low for regions outside of Europe. Since the lifting of the PHEIC in Septemer 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.[49] The availability of PCT testing and sequencing for mpox remains heterogeneous across regions and countries.

In several African countries, testing coverage has improved over time, however, notable gaps persist and without continued support there is a risk of insufficient resources to keep the laboratories active and the supplies for sampling and testing available. The Democratic Republic of the Congo that increased its testing capacity to 28 laboratories testing for mpox in 2025 si 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 time for results. Similar decentralised GeneXpert-based testing approaches are now ongoing in Comoros and Madagascar, further strengthening sub-regional diagnostic capacity and reducing reliance on cross-border sample referral.

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 submitted for peer review publication.[50] Preliminary 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 mpox 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.[49] 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 UK and India from cases with travel history to Asia and Middle East, respectively, 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.[51] 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 released the new living guideline *Clinical Management and Infection Prevention and Control for Mpox*, incorporating the latest evidence to update recommendations.[15] 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 in Feb 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 randomised clinical trials indicate that tecovirimat is safe when used after 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, STOMP, and UNITY).

WHO continues to support data collection through the Global Clinical Platform,[52] 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.[53] 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 region 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 more recent outbreaks in 2024 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 internally displaced persons (IDP) in DRC, 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 Infection prevention and control 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.[54] As transmission patterns and affected populations have evolved, risk communication and community engagement (RCCE) approaches have been adapted to ensure that those most affected have access to timely, credible, and actionable information to reduce risk.

Since the declaration of the second mpox PHEIC in August 2024, WHO has strengthened support to countries through an integrated package for community protection,[54] prioritizing populations disproportionally affected by mpox, including sex workers[55] those living in IDP camps and camp-like settings,[56] and mpox-affected households , including children.[57] 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 in both rural and high-density urban areas. Due to limited funding in the last 3 month, the number of acitivites has been reduced and support has focused on few selected countries.

Community protection also expanded to support targeted vaccination efforts particularly among key populations. Engagement with HIV networks and civil-society organisations has been further strengthened including in newly affected countries and those continuing to experience large outbreaks. Informal community reference groups representing communities at high risk of mpox have continued to shape RCCE strategies, tools and approaches.

While significant steps have been made to inform and engage the disparate groups most at risk from mpox disease, there remain several associated risks for different groups in different settings. These include low risk perception in the context of multiple emergencies, lack of access to trusted and reliable information, knowledge gaps, mis- and disinformation, traditional beliefs, a lack of trust in health authorities among some populations and a risk of non-compliance with protective behaviours, including isolation recommendations. Stigma, particularly linked to sexual transmission, continues to deter care-seeking and isolation. In many mpox affected communities, this is compounded by structural barriers, such as overcrowded housing, poverty, and limited access to WASH services, which make it difficult to adopt recommended behaviours and are among the primary barriers to effective community-based interventions. In various regions and countries, particularly where foreign or migrant workers are present, additional barriers—such as fear of legal repercussions, deportation, or social stigma—may prevent individuals from reporting symptoms, undergoing testing, or seeking care.

Operational and contextual challenges—such as insecurity, limited access to affected populations, funding shortfalls, human resource constraints, gaps in local RCCE and infodemic management capacity, and coordination difficulties at district and sub-national levels—further affect the reach and effectiveness of RCCE implementation efforts. In various contexts, message fatigue has also contributed to a decline in public concern and risk perception, lowering engagement with and adoption of public health interventions.

Since the second PHEIC declaration, RCCE and infodemic management capacity has expanded, particularly in the African region, with thousands of personnel trained and several countries updating RCCE strategies. Progress has also been made in generating social and behavioural evidence to inform response activities, although gaps persist due to delays in approvals, fragmented research efforts, and limited understanding of behavioural drivers in specific high-risk populations.

To sustain impact, community protection must be further strengthened and institutionalized as a core function of national public health systems. This includes sustained investment in RCCE, community-based surveillance, and the community health workforce, as well as 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.[58] On 7 August 2024, the Director-General of the WHO announced that he had triggered the process towards Emergency Use Listing (EUL)[59] for mpox vaccines in light of the escalating mpox situation in DRC 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 and 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.[60] Mass vaccination is not currently recommended for mpox. Given the supply-constrained context of current outbreaks in Africa, WHO recommends the off-label use of a single dose or intradermal fractional dosing of MVA-BN vaccine.

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 has published operational interim guidance for MVA-BN[58] and LC16m8 vaccines[61] in addition to technical assistance for country readiness, implementation resources (such as WHO FAQ on MVA-BN mpox vaccine intradermal fractional dosing),[62] and training material[63] 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).[64] No real-world effectiveness data are yet available for the LC16m8 vaccine. Information on vaccine effectiveness in specific groups, such as people living with HIV, and duration of immunity due to vaccination, are currently unknown. 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, fifteen African countries have initiated mpox vaccination, all using MVA-BN vaccine. More than 2.1 million doses have been administered during the current outbreak response (more than 1.3 million doses of MVA-BN vaccine (most of them as single dose) in 15 countries and more than 775 000 doses of LC16m8 vaccine in DRC).[65]

To improve access, the interim Medical Countermeasures Network (i-MCM-Net) initiative coordinated by WHO has operationalized the multi-partners 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 DRC. In the seven allocation rounds, through the AAM, 2 358 190 mpox MVA-BN vaccine doses were allocated and delivered to 16 countries from the African region (Angola, Central African Republic, Côte d'Ivoire, DRC, Ghana, Guinea, Kenya, Liberia, 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 (DRC, Nigeria, Rwanda) through bilateral agreements. The access to vaccines by affected countries using the AAM mechanism is a significant step towards a coordinated and targeted use of vaccines in response to mpox outbreaks and with the lessons from other past efforts such as COVAX, provides a blueprint for coordinating the medical countermeasures value chain to be ready for future epidemic responses. While some MVA-BN vaccine doses remain available to address new country requests, funding is urgently needed to secure additional supply from manufacturers. 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 geographical areas with people at risk of exposure, and to strengthen capacity to monitor and adjust vaccination strategies as 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's work in these areas of work has been very limited. Independent research projects from academic institutions continue to be active, and their results are communicated through peer review publications which take normally long period of time.

Colleagues working on One health have contributed to the most recent FAO guidance on the animal investigations for mpox, which contributes in standardizing methods and approaches.[66]

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