Epidemiological Update
Mpox
Americas Region

17 August 2024

Summary of the situation

On 14 August 2024, the Director-General of the World Health Organization (WHO) determined that the resurgence of Mpox in the Democratic Republic of Congo (DRC) and a growing number of countries in Africa constitutes a Public Health Emergency of International Concern (PHEIC) *(1)*. Temporary recommendations are being developed with input from the International Health Regulations Emergency Committee and will be available in the coming days.

The emergence and rapid spread of a new virus strain in the Democratic Republic of the Congo, clade Ib, which appears to spread mainly through sexual networks, and its detection in neighboring countries of the Democratic Republic of the Congo are one of the main reasons for the declaration of PHEIC *(1)*. A summary of this situation was provided in the Epidemiological Alert issued on 8 August 2024 *(2)*.

This Epidemiological Update provides a summary of the situation in the Americas based on cases reported to the Pan American Health Organization / World Health Organization (PAHO / WHO) and published on the official websites of the Ministries and Health Agencies of the Americas. It is subject to change as data is retroactively adjusted.

Between 2022 and as of 17 August 2024, 63,270 confirmed cases of Mpox, including 141 deaths, were reported in 32 countries and territories in the Americas Region *(3)*. The highest proportion of cases was recorded during 2022 (90%), with the highest number of cases reported in epidemiological week (EW) 32. A progressive decrease in the number of cases was observed since then. Although a slight increase in cases was recorded during EW 48 of 2022, the downward trend continued during 2023 and 2024 (**Figure 1**) *(3)*.

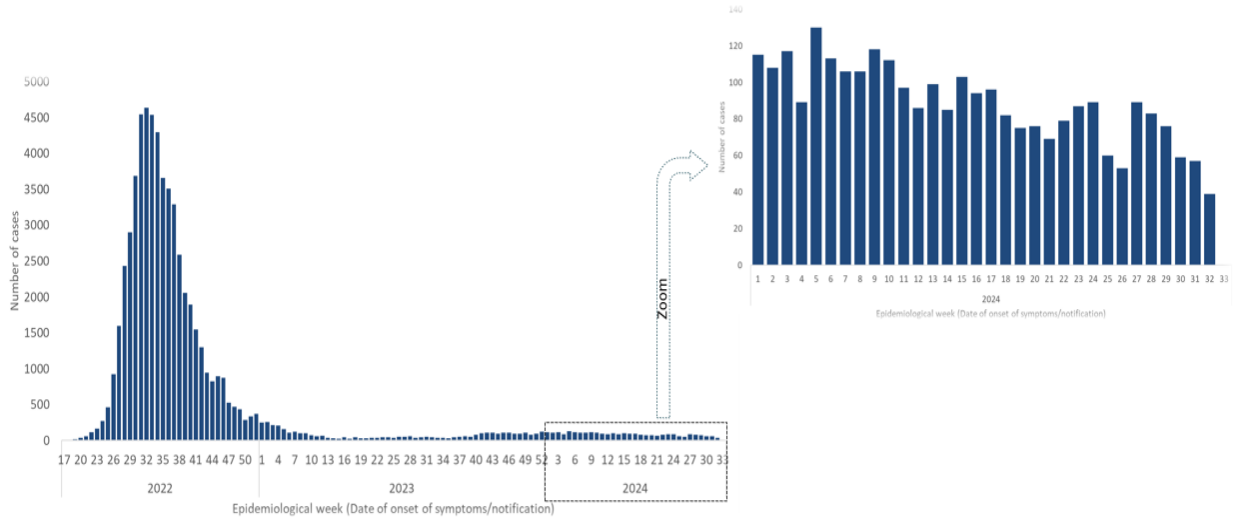
Of 59,729 cases with available information on sex and age, 80% were males aged 20-44 years and 777 cases were under 18 years in 15 countries of the Region. Of 18,948 cases with available information on sexual orientation, 70% were identified as men who have sex with men (MSM) *(3)*.

Between EW 1 of 2023 and EW 33 of 2024, 16 countries reported cases to PAHO/WHO: Argentina (n=132 cases), Bahamas (n=2 cases), Bolivia (n=5 cases), Brazil (n=1,541 cases), Canada (n=231 cases), Chile (n=60 cases including one death), Colombia (n=200 cases), Costa Rica (n=124 cases including one death), Ecuador (n= 267 cases), Guatemala (n=104 cases including one death), Honduras (n=30 cases), Mexico (n=392 cases including 13 deaths), Panama (n=152 cases including one death), Paraguay (n=73 cases), Peru (n=241 cases), and the United States of America (n=3,442 cases including 8 deaths)*(4 - 19)*.

Suggested citation: Pan American Health Organization / World Health Organization. Epidemiological Update. Mpox Americas Region, 17 August 2024. Washington, D.C.: PAHO/WHO; 2024.

In 2024, 13 countries reported cases: Argentina (n=8 cases), Bolivia (n=1 case), Brazil (n=702 cases), Canada (n=162 cases), Chile (n=7 cases), Colombia (n=111 cases), Costa Rica (n=1 case), Ecuador (n= 4 cases), Guatemala (1 case), Mexico (n=53 cases), Panama (n= 4 cases), Peru (n=77 cases), and the United States(n=1,716 cases and 1 death)*(4, 6 - 14, 16, 17, 19)*.

Figure 1. Confirmed cases of Mpox by epidemiological week of onset of symptoms/notification. Americas Region, as of 17 August 2024.



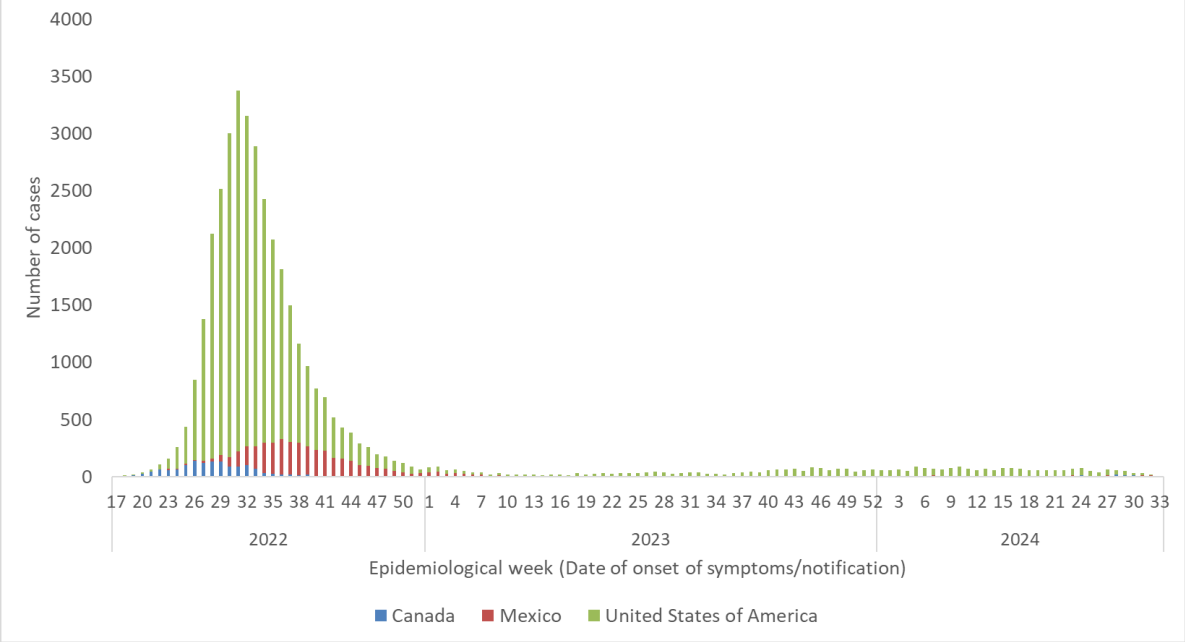
***Note:** Only countries and territories where information on cases by symptom onset is available are included.
Source: Adapted from Pan American Health Organization. Mpox case board – Americas Region. Washington, D.C.: PAHO; 2024 [cited 17 August 2024]. Available from: https://shiny.paho-phe.org/Mpox/ and from data reported by the IHR National Focal Points to PAHO/WHO *(4-19)*.

Most of the cases reported in the Americas Region were identified through human immunodeficiency virus (HIV) care services, sexual health services, or primary and/or secondary health care facilities, involving mainly but not exclusively, men who have sex with men (MSM) *(20)*. Genomic surveillance identified clade IIb in all cases tested, which remains the only one detected to date in the Region.

Summary of the current situation by Subregion

In the **North American** subregion, between 2022 and as of 17 August 2024, 39,149 cases of Mpox were reported, including 94 deaths. The highest proportion of cases was recorded in the **United States of America** with 85% of cases. During 2024, all three countries from this subregion have reported cases (**Figure 2**) *(3, 8, 15, 19)*.

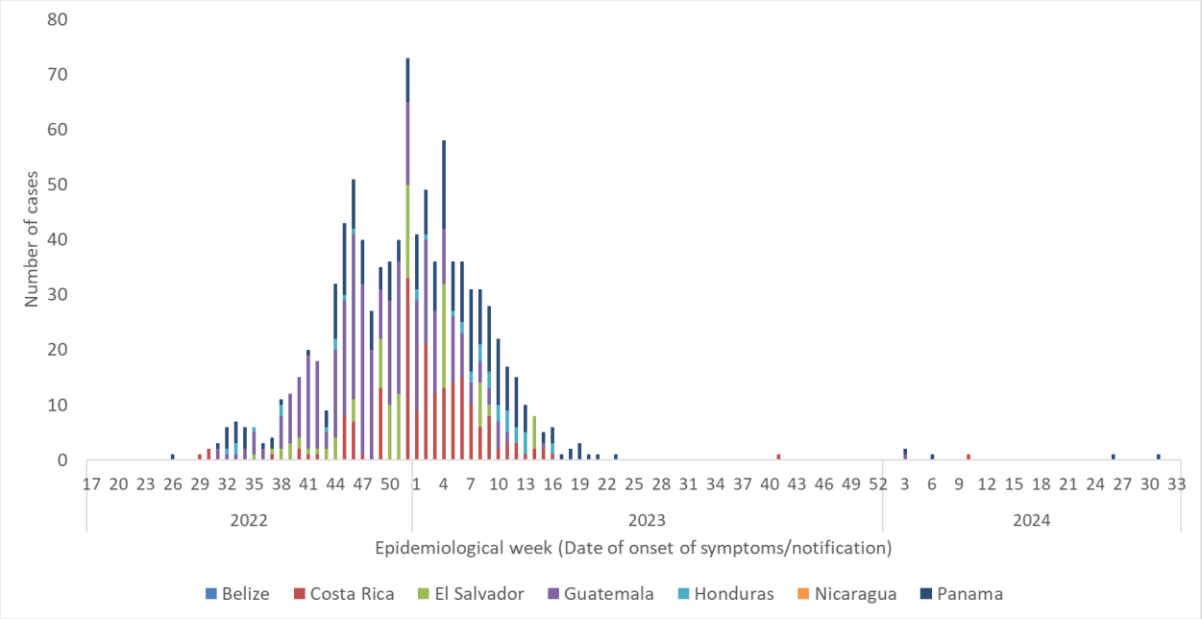
Figure 2. Confirmed cases of Mpox by epidemiological week of onset of symptoms/notification and country. Subregion North America, as of 17 August 2024.



Source: Adapted from Pan American Health Organization. Mpox case board – Americas Region. Washington, D.C.: PAHO; 2024 [cited 17 August 2024]. Available from: https://shiny.paho-phe.org/mpox/ and from data reported by the IHR National Focal Points to PAHO/WHO *(3, 8, 15, 19)*.

In the **Central American** subregion, between 2022 and as of 17 August 2024, 1,024 cases of Mpox were reported, including three deaths. The highest proportion of cases was recorded in **Guatemala**, with 40% of the cases. Among the countries from this subregion, **Costa Rica, Guatemala**, and **Panama** have reported cases in 2024 (**Figure 3**) *(3, 11, 13, 14, 16)*.

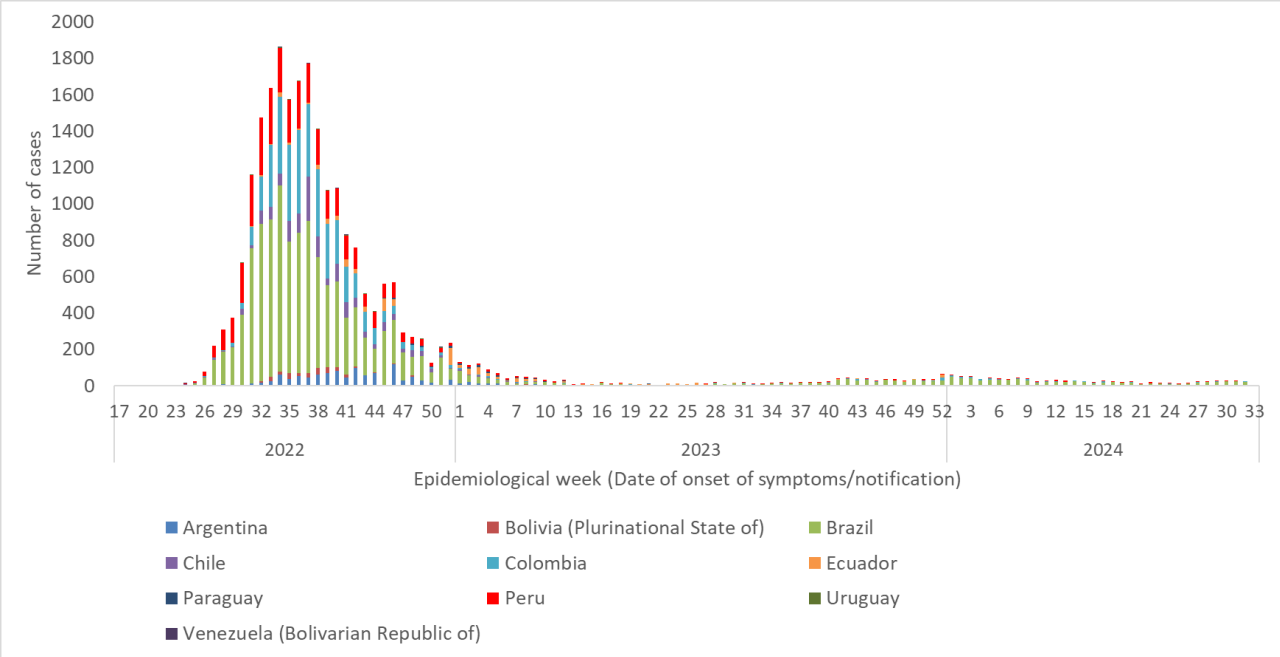
Figure 3. Confirmed cases of Mpox by epidemiological week of onset of symptoms/notification and country. Central American Subregion, as of 17 August 2024.



Source: Adapted from Pan American Health Organization. Mpox case board – Americas Region. Washington, D.C.: PAHO; 2024 [cited 17 August 2024]. Available from: https://shiny.paho-phe.org/Mpox/ and from data reported by the IHR National Focal Points to PAHO/WHO *(3, 11, 13, 14, 16)*.

In the **South American** subregion, ten countries have reported cases. Between 2022 and as of 17 August 2024, 22,990 cases of Mpox were reported, including 44 deaths. The highest proportion of cases was reported in **Brazil** with 49% of cases, followed by Colombia with 19% and Peru with 17%. Within the countries from this subregion, seven countries reported cases in 2024: **Argentina, Bolivia, Brazil, Chile, Colombia, and Peru** (**Figure 4**) *(3, 4, 6, 7, 9, 10, 12, 17, 18)*.

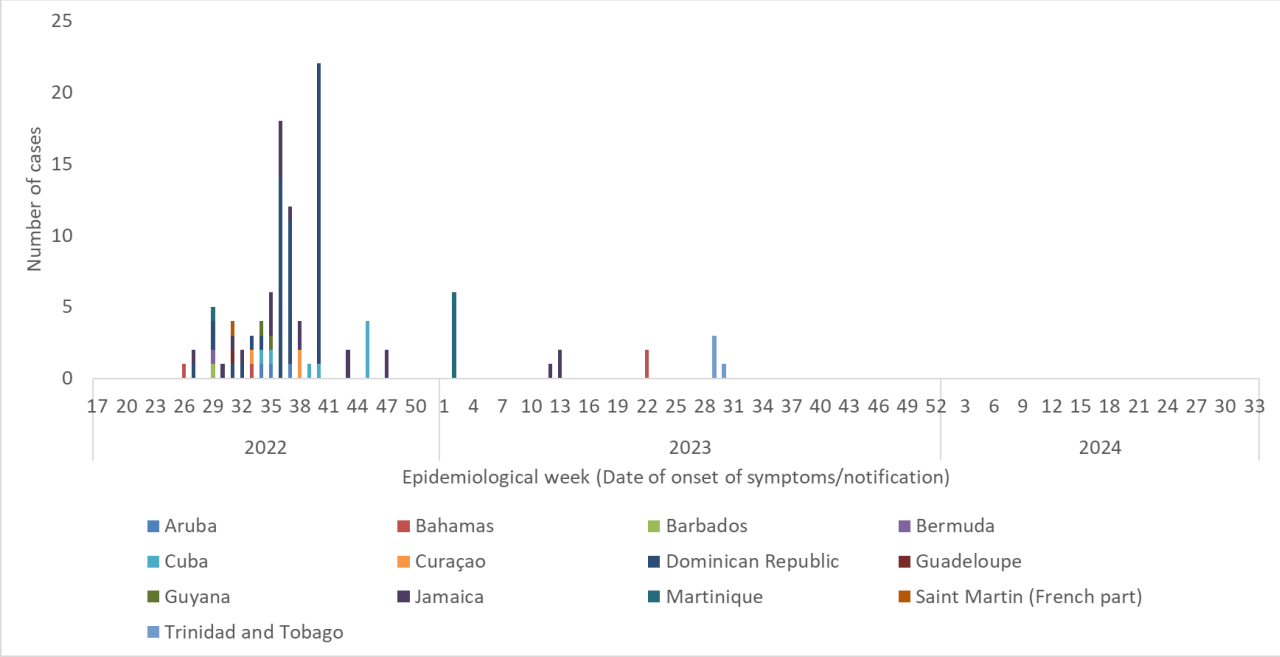
Figure 4. Confirmed cases of Mpox by epidemiological week of onset of symptoms/notification and country. Subregion South America, as of 17 August 2024.



Source: Adapted from Pan American Health Organization. Mpox case board – Americas Region. Washington, D.C.: PAHO; 2024 [cited 17 August 2024]. Available from: https://shiny.paho-phe.org/Mpox/ and from data reported by the IHR National Focal Points to PAHO/WHO *(3, 4, 6, 7, 9, 10, 12, 17, 18)*.

In the **Caribbean and Atlantic Ocean Islands** subregion, thirteen countries and territories have reported cases. Between 2022 and as of 17 August 2024, 107 cases of Mpox were reported, including one death. The highest proportion of cases was reported by the Dominican Republic with 49% of cases, followed by Jamaica with 20% and Cuba 7%. None of the countries and territories from this subregion have reported cases during 2024 (**Figure 5**) *(3, 5)*.

Figure 5. Confirmed cases of Mpox by epidemiological week of onset of symptoms/notification and country. Subregion of the Caribbean and Atlantic Ocean Islands, as of 17 August 2024.



Source: Adapted from Pan American Health Organization. Mpox case board – Americas Region. Washington, D.C.: PAHO; 2024 [cited 17 August 2024]. Available from: https://shiny.paho-phe.org/Mpox/ and from data reported by the IHR National Focal Points to PAHO/WHO *(3, 5)*.

Guidance to Member States

Although no cases of Mpox belonging to the new variant of clade I have been reported to date in the Americas Region, sporadic introduction cannot be ruled out, and health authorities are encouraged to continue their surveillance efforts to characterize the situation and respond rapidly in the event of an introduction of this or a new variant of Monkeypoxvirus (MPXV).

Member States are reminded of the main recommendations for surveillance, clinical management, prophylaxis, and risk communication.

Surveillance

The main objectives of Mpox surveillance and case investigation are the rapid detection of cases and clusters of cases in order to provide appropriate clinical care; isolation of cases to prevent onward transmission; identification, management, and follow-up of contacts to recognize early signs or symptoms of infection; identification of groups at risk of infection and severe disease; protection of front-line health care workers; and adoption of effective control and prevention measures *(21)*.

It is crucial to maintain epidemiological surveillance based on laboratory testing and timely reporting of confirmed and probable cases. This includes the follow-up of clinical pictures

compatible with Mpox in existing surveillance programs, and the implementation of clear case definitions for suspected, probable, confirmed, and reinfected cases according to the ongoing guidance *(21, 22)*.

Integration of Mpox surveillance, detection, prevention, care, and research into HIV and other sexually transmitted infections (STI) prevention and control programs and services will facilitate early detection of outbreaks, reduce barriers to health services, and improve the response to HIV-MPXV coinfection *(23)*.

The implementation of genomic surveillance is key to determine the circulating clades and their evolution, and at the same time contribute to knowledge by sharing genetic sequence data for relevant public health actions.

Diagnosis and laboratory.

Detection of viral DNA by polymerase chain reaction (PCR) is the laboratory test of choice for Mpox. The best diagnostic samples are taken directly from the rash (skin, fluid or crusts) collected by vigorous swabs *(24)*. In the absence of skin lesions, testing can be performed with oropharyngeal, anal or rectal swabs *(24)*. However, while a positive oropharyngeal, anal, or rectal swab result is indicative of Mpox, a negative result is not sufficient to exclude MPXV infection. Blood testing is not recommended. Antibody detection methods can be used for retrospective case classification, but not for diagnosis. It should be restricted to reference laboratories and may not be useful, as it often does not distinguish between different orthopoxviruses *(24)*.

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

Laboratory Guidelines for the Detection and Diagnosis of Mpox Virus Infection are available from: https://www.paho.org/en/documents/laboratory-guidelines-detection-and-diagnosis-monkeypox-virus-infection.

Vaccination

PAHO/WHO reminds Member States that mass vaccination against Mpox in the population is neither required nor recommended. Efforts should be directed to control the spread of Mpox from person to person through early detection and diagnosis of cases, isolation, and contact tracing *(20)*.

The PAHO Technical Advisory Group on Vaccine Preventable Diseases has adapted WHO recommendations, advising that vaccination be administered exclusively to close contacts of confirmed Mpox cases. *(20, 26)*.

Post-exposure vaccination with locally available vaccine may be considered for high-risk close contacts *(26)*. In this case, the vaccine should ideally be administered within four days after exposure.

All Mpox vaccines can have adverse effects. Therefore, when vaccination is proposed to a close contact, it is recommended to inform the person of the possible sequelae of vaccination and offer alternative infection control measures when feasible *(26)*.

All decisions on immunization with Mpox vaccines should be based on a case-by-case assessment of risks and benefits through shared clinical decision making. Implementation of vaccination should be accompanied by robust pharmacovigilance, and vaccine efficacy studies under clinical trial protocols are recommended *(26)*.

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

Clinical management

Identifying Mpox cases can be challenging given the similarity to other infections and conditions. It is important to distinguish Mpox from chickenpox, measles, bacterial skin infections, scabies, herpes, syphilis, other sexually transmitted infections, and drug-associated allergies. A person with Mpox may also simultaneously have another sexually transmitted infection, particularly syphilis, or having an undiagnosed HIV infection. Alternatively, a child or adult with suspected Mpox may also have chickenpox. For these reasons, testing is key to getting people treated as soon as possible and to prevent further spread *(27)*.

Treatment is based on lesion care, pain control and prevention of complications. Specific antiviral drugs, such as tecovirimat, has been proposed for the treatment of Mpox, particularly for severe cases or persons at increased risk of complications. However, sufficient evidence of its effectiveness is still lacking *(28)*.

People living with HIV who are not receiving antiretroviral treatment, especially those with advanced disease (CD4 cell count below 200/mm³), bear a disproportionate burden of morbidity and higher mortality. Therefore, it is recommended to offer an HIV serology test to all suspected cases of Mpox.

During the care of suspected, probable and/or confirmed cases of Mpox, early identification is required through screening protocols adapted to local settings. These cases should be isolated immediately and require prompt implementation of appropriate infection prevention and control (IPC) measures, testing to confirm the diagnosis, symptomatic management of patients with mild or uncomplicated Mpox, as well as follow-up and treatment of severe complications and conditions *(27, 28)*.

Patients with Mpox with mild or moderate clinical presentation who can be treated at home require careful assessment of the ability to safely isolate themselves and maintain the required PCI precautions at home to prevent transmission to other household and community members. Precautions (isolation and PCI measures) should be maintained until a new layer of skin has formed under the scabs *(27, 28)*.

Risk communication

- Promote the dissemination of public health messages aimed at health personnel, the general population, in particular the population with the highest prevalence of HIV and other STIs and those in antiretroviral treatment or pre-exposure prophylaxis programs, in order to inform and educate the target population on prevention measures and improve early recognition, reporting, and prompt initiation of treatment of these cases. Continue efforts to raise awareness among authorities and health personnel about the ongoing outbreak in the Democratic Republic of the Congo and the possibility of travel-associated cases of Mpox *(29)*.

- Disseminate simple information, education and communication (IEC) materials on transmission, symptoms, prevention and treatment through various media (including social networks, dating apps, or CCTV in health care facilities with services for populations with higher prevalence of HIV and other STIs).

- Among the key messages, the WHO suggests the constant use of condoms during sexual activity (oral/anal/receptive, and insertive vaginal) during the 12 weeks following recovery from a confirmed case, in order to reduce the potential transmission of Mpox by this route, considering that this risk is still unknown *(30)*.

- Prevent the spread of rumors and false or incorrect misinformation about Mpox. It is important that public health authorities systematically listen to and analyze information shared through social media to identify key questions and information gaps and develop communication strategies based on this. The public should be encouraged to obtain information only from official sources *(30)*.

- Continue risk communication and community engagement activities and work with civil society organizations to engage with key affected populations such as gay, bisexual, and other MSM *(30)*.

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