NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

MPOX PREPAREDNESS

An update for healthcare workers

Outbreak Response Unit, Division of Public Health Surveillance and Response and Centre for Emerging Zoonotic and Parasitic Diseases

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(NICD) 24-hour hotline number for healthcare workers: 0800 212 552

As of 5 September 2025, the multi-country mpox outbreak was no longer considered a Public Health Emergency of International Concern by WHO due to sustained decline in cases in the Democratic Republic of Congo and other affected countries. On 22 January 2026 the Africa CDC lifted the Public Health Emergency of Continental Security declaration as a result of strengthened response capacity and reduction in cases.

Clade I, previously known as the Congo Basin clade, has two sub-clades, Ia and Ib. Clade Ib denotes the new strain discovered in September 2023 that has spread in the DRC and neighbouring countries. The mode of transmission and the high-risk populations distinguish the strains. In addition to sexual contact, Clade Ia is transmitted through household contact and contact with contaminated animals. Clade Ib, seems to spread more easily through routine close contact, as evidenced by the number of children affected by the outbreak. This outbreak is happening concurrently with the multi-national outbreak that started in 2022.

Clade II, previously known as the West African clade, has two sub-clades, IIa and IIb. Clade IIb is the strain that caused the 2022 global outbreak and is primarily transmitted through sexual contact. In this outbreak, the most at-risk group was identified as men who have sex with men.

South Africa reported five cases in 2022, 25 cases in 2024 and 15 cases in 2025. As of 29 October, twenty-six cases have been detected in 2026, with four active cases reported currently. The geographic distribution of all twenty-six cases to date is: KwaZulu-Natal (n=1), Free State (n=2) Eastern Cape (n=2), Gauteng (n=3; one case travelled to Belgium), Western Cape (n=18; the first two cases reported in the Western Cape were imported (one German and one Norwegian national, both visiting South Africa at the time of identification)). Most (25/26) cases were men, with ages ranging from 23 to 50 years. None of the cases received tecovirimat, while seven were hospitalized.

Transmission

Mpox can be transmitted to a person upon contact with the virus from an animal, human, or materials contaminated with the virus. Person-to-person transmission occurs through prolonged close contact (i.e. kissing, sex, cuddling). Entry of the virus is through broken skin, the respiratory tract, or the mucous membranes (eyes, nose, or mouth). Fomite (contaminated materials) transmission has not been documented, however is possible. Mpox scabs are infectious, thus a case is infectious until all lesions have healed, all scabs have fallen off and a new layer of skin has developed.

Signs and symptoms

The incubation period for mpox is on average 7–14 days but can range from 5–21 days.

Initial symptoms include fever, headache, muscle aches, backache, chills and exhaustion. Lymphadenopathy may also be noted. Skin lesions develop between 1-3 days following onset.

The lesions may be found spread over the body or localized, including in genital or peri-genital areas. The lesions progress through several stages before scabbing over and resolving. Lesions of the rash have been shown to progress through different stages at the same time.

More severe cases have been historically reported in children, pregnant women and individuals with untreated HIV disease. The case fatality rate is very low, and most cases will not require hospitalisation.

Response to a suspected case:

1. Establish that the patient meets the signs and symptoms for suspected mpox.
2. Observe appropriate infection control procedures (i.e. isolation with universal precautions). **As soon as the decision is made to proceed on the basis of a presumptive diagnosis of mpox, measures should be applied to minimize exposure of HCWs, other patients and other close contacts.**
3. Clinical management is supportive and will vary from case to case, but typically cases are self-resolving. Tecovirimat is an anti-viral agent that may be used for people with severe mpox disease.
4. Inform the NICD hotline (0800 212 552) and notify the local and provincial communicable disease control co-ordinator (CDCC) telephonically so that additional case finding and extensive contact tracing can be conducted.
5. Notify the case telephonically and through the NMC App – complete the Case Investigation Form (CIF-MPOX). Submit forms to provincial CDCC.
6. Submit samples to NICD for testing.

Differential diagnosis:

Other rash illnesses, some commonly found include chickenpox (caused by varicella virus), hand-foot-and-mouth disease, measles, bacterial and fungal skin infections, syphilis, molluscum contagiosum and drug-related rashes.

Lymphadenopathy in the prodromal phase of illness distinguishes mpox from chickenpox, if present.

Sample collection and testing for mpox:

Guidance on submission of samples (swab of lesions) for testing: Refer to lab guide mpox for instructions.

For more information, visit the NICD website, Mpox