

Position Statement

28 July 2026

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Mpox

Summary

Human mpox (formerly known as monkeypox) is a zoonotic disease caused by the monkeypox virus (MPXV) and which is endemic in some regions of Central and West Africa. There are two major genetic groups (clades) of MPXV, clade I (formerly known as Central African or Congo basin clade) and clade II (formerly known as West African clade). Since 2022, outbreaks have occurred outside of the African continent, emerging from animal reservoirs and evolving to sustained human-to-human contact, including sexual contact. In 2022/23, there was a global outbreak of clade IIb, predominantly amongst gay, bisexual and other men who have sex with men (GBMSM). A small number of cases continue to be reported, including in the UK. Since August 2024, clade I MPXV has also been reported outside of African endemic countries.

Current information on the global mpox epidemiological situation, including affected countries and case numbers, can be found on the [World Health Organization \(WHO\) global mpox trends dashboard](#).

Epidemiology, pathogenesis, infection dynamics and clinical characteristics relevant to SoHO safety

Since 2022, mpox clade II has been circulating globally outside the African continent, primarily among GBMSM, and most European Union (EU)/European Economic Area (EEA) countries have reported clusters of locally acquired cases. In 2022, there were 3732 confirmed and highly probable mpox clade IIb cases reported in the UK.

MPXV clade II

There is continued circulation of mpox clade II at low levels in the UK; 700 cases reported between 2023 and 2025. Since January 2023, mpox clade II is no longer considered a high consequence infectious disease (HCID) within the UK, and the current UK risk is level 2 (transmission within a defined population group) with flat or negative growth.

MPXV clade I

To January 2025, clade Ib mpox cases have been reported in small numbers in many countries including Germany (11), Thailand (10), France (9), China (9), Belgium (6), the USA (5), Italy (4) and Ireland (3).

Nineteen clade Ib mpox cases have been reported in the UK, with most cases reporting direct or indirect links to travel to countries where mpox clade Ib is circulating. Some of these cases were in GBMSM, indicating a change in the epidemiology of clade Ib; given the global outbreak in 2022/23, this requires monitoring. The probability of importation into the UK has increased from medium to high.

Clinical presentation

Mpox begins with fever, headache, muscle aches, chills, swollen lymph nodes and exhaustion. The incubation period is between 5 and 21 days (but typically 6 to 13 days) following exposure. A rash generally appears within 1 to 5 days after the appearance of fever; the rash often begins on the face then spreads to other parts of the body. Lesions progress through macules, papules, vesicles and pustules before the scabs fall off between 2 and 4 weeks later. Most people who catch mpox will recover within several weeks without any treatment. However, severe illness can occur in some individuals.

Transmission routes

Unlike respiratory viruses (e.g. severe acute respiratory syndrome coronavirus 2, SARS-CoV-2), MPXV does not spread easily between individuals. Human-to-human transmission occurs through close physical contact, including both sexual and non-sexual contact, from infectious material, skin lesions of an infected person, through respiratory droplets in prolonged face-to-face contact, and through virus-contaminated fomites such as bedding or clothing.

In infected individuals, MPXV DNA has been detected in blood, including detection after the clearance of rash. There are limited data on viraemia in asymptomatic individuals (most, if not all, cases are thought to develop symptoms) or pre-symptomatic individuals, and the role of asymptomatic cases in transmission is currently unclear.

The survival of MPXV in blood components, tissues and cells is unknown although the virus is known to be robust. No cases of MPXV transmission through substances of human origin (SoHO) have been documented, although transmission from mother to baby during pregnancy has been documented. Transmission of MPXV through SoHO is considered possible, although currently the overall likelihood of MPXV being present in a donation with onward risk of transmission to recipients is low due to the low case numbers in the population, the defined groups of individuals currently affected with this infection, and the risk mitigation processes that are already in place in UK Blood and Tissue Establishments.

Risk mitigation

(as applicable, e.g. measures adopted by UK blood, haematopoietic stem cells and tissue establishments, if any; availability of efficacious preventative measures, prophylaxis or treatment)

The risk for recipients of SoHO, including blood, tissues and cells, is considered low. Donor selection criteria already in use before the recent mpox outbreaks by UK blood, haematopoietic stem cells and tissue establishments offer some level of risk mitigation.

The JPAC [Donor Selection Guidelines](#) ensure safe and consistent donor selection processes. These guidelines include information on the identification and deferral of donors with acute infections. Questions regarding illness, infection or fever in the preceding 2 weeks, asked to all UK donors at each donation, should screen out symptomatic individuals; a question regarding contact with anyone with an infectious disease in the last 4 weeks should screen out known contacts. It is unlikely that symptomatic donors would attend to donate, but there is the potential for a live tissue donor who is symptom-free but with virus circulating in the bloodstream, or a deceased tissue donor who had mild unidentified symptoms antemortem, to donate. However, this is considered an unlikely event and the existing measures currently in place in UK Blood and Tissue Establishments are currently thought sufficient to the point at which any risk of donations from mpox infected individuals is negligible. The identification of a potential exposure to an mpox case is the important factor when obtaining history and assessing the donor. Current epidemiology indicates exposure in endemic areas or increased risk amongst the GBMSM community.

Contacts of an mpox case should be deferred from blood, organ or bone marrow donations for a minimum of 21 days from the last day of exposure. Public health management of known contacts of mpox infected individuals for 21 days (which includes isolation for contacts) will also prevent this group of individuals from presenting as donors. UK Public Health Agencies are working closely with colleagues across the wider health service to spread awareness and ensure clinicians are available to identify possible cases and associated contacts. All donors are asked to think about any recent behaviours such as travel or new sexual partners that might affect their eligibility to donate blood.

Post-donation reporting of illnesses enables the discard of donations from potentially infected donors.

Travel deferrals for imported cases of mpox are mitigated in blood and tissue donation by a 4-month malaria deferral for visitors to countries where mpox is endemic. This does not apply to hematopoietic stem cell transplantation. As the main event in the current outbreak relates to spread of infection amongst the GBMSM community outside endemic areas, detailed history is in place for identification of exposure risk.

UK Blood and Tissue Establishments have a mechanism in place, through JPAC's Standing Advisory Committee on Transfusion Transmitted Infections (SACTTI), to identify infectious outbreaks/cases and new and emerging pathogens which may threaten the safety of donated components/products, and to ensure that appropriate actions are taken to mitigate any risk identified.

Vaccination

A routine mpox vaccination programme has been introduced in the UK for GBMSM at higher risk. In 2022, the third-generation non-replicating smallpox vaccine Imvanex® (Modified Vaccinia Ankara – produced by Bavarian Nordic, MVA-BN) was authorised in the EU for protection against mpox in adults. [UK mpox vaccination indication advice](#) (pre- and post-exposure) is available from GOV.UK. Individuals receiving the vaccine will have been assessed as high-risk; these donors should not present for donation, and if they did, current donor selection criteria would identify these individuals.

Other relevant information

Key facts and guidance for mpox are available from the [WHO](#) and [GOV.UK](#).

Conclusion and recommendations

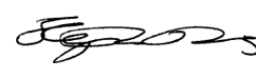
Current epidemiology of MPXV infection allows identification of potentially infected donors; this, together with existing donor selection criteria, is considered sufficient to mitigate the low risk of transmission via SoHO. Changes in epidemiology that would lead to the expansion of affected groups are monitored and will lead to a review of safety measures accordingly.

Awareness of the infection and the characteristics that put an individual at risk of being infected are the important tools to observe.



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