

# Mpox

Multi-country external situation report no. 51 published 29 April 2025

KEY FIGURES				
Reporting period: 1 January 2022 – 31 March 2025				
Area	Number of reported confirmed cases		Number of deaths among confirmed cases	Number of reporting countries
Global	137 892		317	132
Reporting period: 1 January 2024 – 20 April 2025				
Area	Number of reported confirmed cases		Number of deaths among confirmed cases <sup>1</sup>	
	2024	2025	2024	2025
Africa	20 009	10 944	45	63
Democratic Republic of the Congo <sup>2</sup>	15 067	5197	27	22
Uganda	1353	4033	7	33
Burundi	2946	866	1	0
Reporting period: last six weeks, 10 March – 20 April 2025				
Africa	2896		29	
Democratic Republic of the Congo	807		7	
Uganda	1343		18	
Burundi	198		0	

## Highlights

- Cases of mpox due to clade Ib monkeypox virus (MPXV) continue to be reported primarily in Africa, where eleven countries have reported community transmission of this strain in the past six weeks.
- Wherever mpox outbreaks are not quickly contained and human-to-human transmission is not stopped, they continue to represent a potential risk of sustained transmission in the community.
- Currently, Uganda is reporting the highest number of confirmed mpox cases globally, with 200 to 300 new cases reported per week<sup>3</sup>. To date, the country has detected only clade Ib MPXV.
- The Democratic Republic of the Congo continues to report the highest number of cumulative confirmed mpox cases in Africa in 2025, despite a decreasing number of confirmed cases reported in recent weeks likely due to a reduction in testing and confirmation capacity. Clades Ia and Ib MPXV continue to circulate in the country.
- Burundi continues to observe a declining trend of confirmed cases, with fewer than 50 new confirmed cases per week, down from over 200 confirmed cases per week at the peak of the outbreak.
- Sierra Leone has reported a rising number of confirmed mpox cases, with over 200 new confirmed cases reported during the most recent week, highlighting the increased transmission in the country. Details on the epidemiological characteristics are currently being gathered.

<sup>1</sup> A data review and harmonization process for data on deaths is in process, therefore, the way deaths are distributed over time may differ slightly from previous editions of this report.

<sup>2</sup> The national-level case counts for the Democratic Republic of the Congo indicated are based on the national laboratory database for mpox.

<sup>3</sup> Comparisons with other countries should be interpreted with caution, given the contextual differences between countries in elements of their respective mpox responses like diagnostic and disease surveillance reporting capacity.

- Malawi has reported its first cases of mpox due to clade Ib MPXV, with no known links with travel to other affected countries, suggesting that community transmission of the strain is already ongoing in the country.
- China reported a second case of mpox due to clade Ia MPXV, linked to travel from the Democratic Republic of the Congo.
- This report provides an overview of mpox vaccination in countries in the African Region, where to date more than 662 000 doses of MVA-BN vaccines have been administered in seven countries. From the total number of doses, 88% have been administered in the Democratic Republic of the Congo, where vaccination strategy is being revised in light of limited vaccine supply.

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## Contextual description

This report provides an update on:

- the global epidemiological situation for mpox with data as of **31 March 2025**;
- the epidemiological situation for mpox in Africa (including countries in the WHO African Region and some in the WHO Eastern Mediterranean Region), with data as of **20 April 2025**;
- updates on imported cases of mpox due to clade I MPXV as of **25 April 2025**;
- operational response updates as of **25 April 2025**.

The latest mpox updates can also be found in the [WHO mpox surveillance report](#).

The epidemiological content of the report is based on information from global mpox indicator-based surveillance set up in 2022. This surveillance system collects data on confirmed and probable mpox cases and deaths reported by Member States to WHO or reported publicly through official Member State resources (webpages, surveillance dashboards, as well as epidemiological and situation reports). Given limited access to Polymerase Chain Reaction (PCR) testing of suspected cases in some settings, particularly in the Democratic Republic of the Congo, WHO also reports suspected (clinically compatible) mpox cases which meet the country's national clinical case definition for suspected mpox since the declaration of the public health emergency of international concern (PHEIC) on 14 August 2024.

The indicator of suspected cases should nevertheless be interpreted with caution, as suspected cases that undergo testing are not removed from the overall count of suspected cases, independently from the test results. In the absence of more detailed information, it is currently not possible to correctly subtract confirmed cases from the total number of suspected cases reported; therefore, the confirmed cases represent a subset of suspected cases. The case definition for suspected mpox in the Democratic Republic of the Congo can be found [here](#).

Information on operational updates has been provided by the global mpox incident management support team at WHO headquarters, and the information on imported cases is based on notifications received by WHO from Member States under the provisions of the International Health Regulations (2005).

For reference purposes, a summary of the latest WHO global mpox rapid risk assessment conducted in February 2025 can be found in [Annex 1](#).

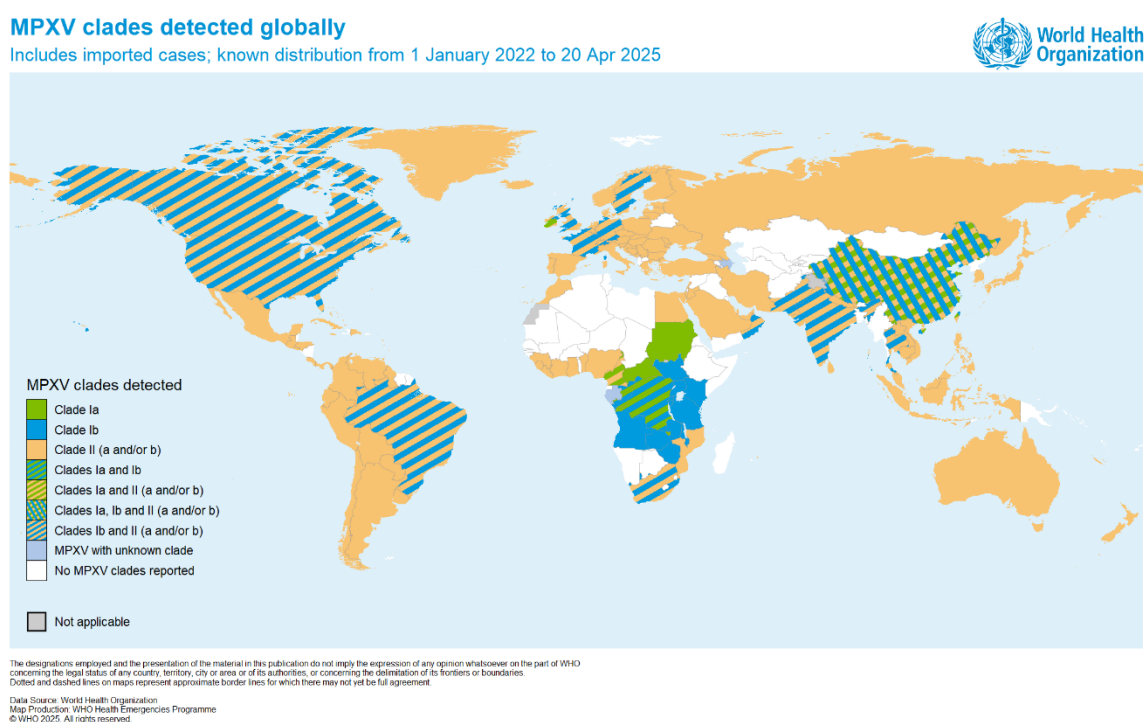
## Epidemiological update <sup>3, 4</sup>

### Global monkeypox virus (MPXV) distribution

As of 20 April 2025, the distribution of reported MPXV clades by country of detection is shown in Figure 1. This information is compiled from genome 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 29 countries (Figure 1). Most of these countries have reported only travel-related cases, 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.

**Figure 1.** Geographic distribution of MPXV clades reported to WHO, by country, 1 January 2022 to 20 April 2025.



Based on the status of clade Ib MPXV transmission during the past six weeks, a country is classified as having:

**Community transmission**, if at least one case reported during the last six weeks has no epidemiological link to travel or contact with a traveler from a country with known mpox transmission. This classification applies regardless of the total number of cases reported.

**Cases linked to travel**, if, within the last six weeks, all reported cases are either: individuals who traveled to a country with known mpox transmission, were likely exposed there, and were diagnosed upon return or arrival OR Individuals who did not travel themselves but had direct contact with someone who traveled to an affected country where the exposure likely occurred.

<sup>3</sup> On the African continent there are 47 Member States in the WHO African Region and seven in the Eastern Mediterranean Region.

<sup>4</sup> Slight discrepancies in epidemiological data are expected between this report and the WHO Africa Regional Office, Regional Mpox Bulletin due to different reporting dates. The Regional Mpox Bulletin is available in the following link: [Mpox \(monkeypox\) | WHO | Regional Office for Africa](#)

**Previously reporting cases**, if no new cases of mpox due to clade Ib MPXV have been reported for a period of more than six consecutive weeks since the last case, regardless of the previous transmission classification. Transmission is in control phase.<sup>5</sup>

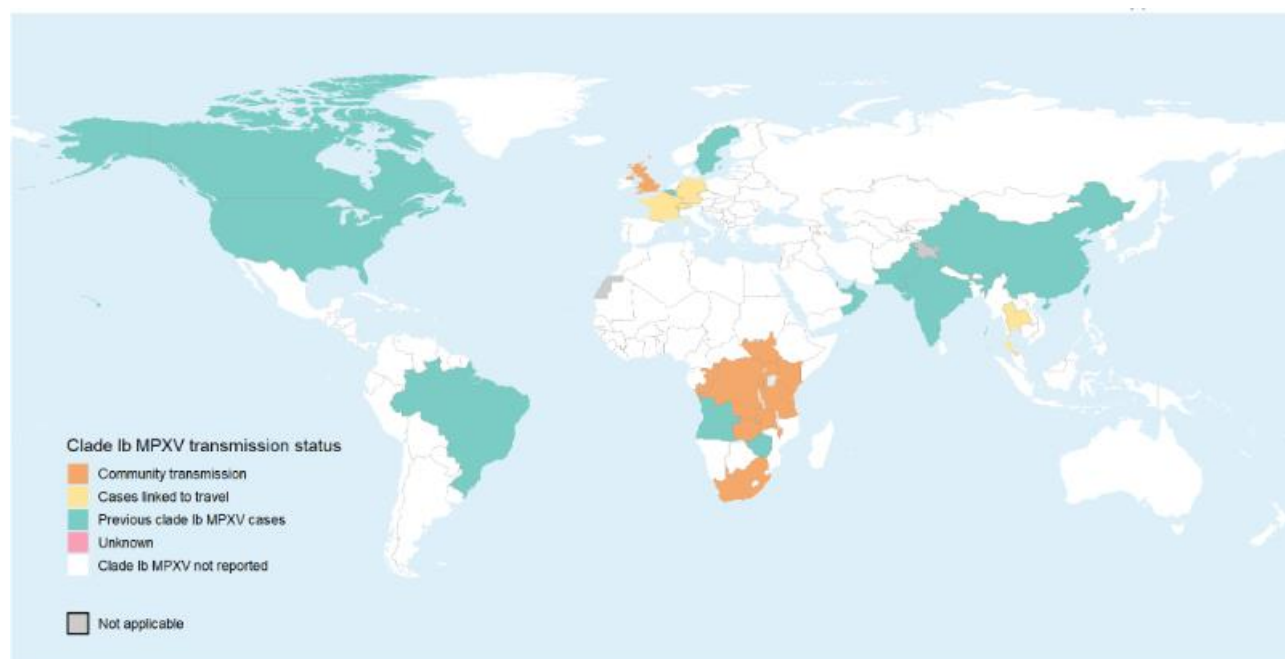
**Unknown** transmission dynamics, if insufficient information is available to determine if cases are due to community transmission or linked to travel.

Figure 2 provides an overview of the clade Ib MPXV transmission status across all countries that have reported cases of mpox due to clade Ib MPXV to date.

In the Democratic Republic of the Congo, where clade Ib MPXV originated, cases have been reported in 10 provinces: South Kivu, North Kivu, Kinshasa, Kasai, Tshopo, Tanganyika, Haut-Katanga, Mai-Ndombe, Lomami, and Kongo-Central. Within Africa, community transmission of clade Ib MPXV has also been reported in Burundi, Kenya, Malawi, Republic of Congo, Rwanda, South Africa, South Sudan, Uganda, the United Republic of Tanzania, and Zambia. Countries which have previously reported cases but not reported any cases within the past six weeks include Angola and Zimbabwe.

Outside Africa, 16 countries have reported cases of mpox due to clade Ib MPXV: the United Kingdom of Great Britain and Northern Ireland (12 cases), Germany (10 cases), China (seven cases), Belgium (five cases), Thailand (five cases), the United States of America (four cases), France (three cases), Qatar (three cases), Brazil, Canada, India, Oman, Pakistan, Sweden, Switzerland and the United Arab Emirates (one case each). Community transmission has only been documented in the United Kingdom, where the eleventh reported case had no known link to travel or to a confirmed case with travel history. For more details on the rest of the countries, and the number of cases reported in each, please refer to Table 2 in the section on [Other countries reporting cases of mpox due to clade Ib MPXV](#).

**Figure 2.** Clade Ib MPXV transmission status within the last six weeks, by country, as of 20 April 2025.



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization  
Map Production: WHO Health Emergencies Programme  
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<sup>5</sup> For more information, please refer to the Strategic framework for enhancing prevention and control of mpox – 2024-2027 (2024) Available at: <https://www.who.int/publications/i/item/9789240092907>

## Overview of mpox outbreaks by virus clade

This section provides an overview of mpox outbreaks by MPXV subclade. It is not intended to be an exhaustive list of outbreaks in all settings; rather, it highlights the main characteristics of some outbreaks and the affected populations. Although there is currently no documented difference in inherent transmissibility of different MPXV strains to date, they are affecting different populations in different settings, resulting in distinct outbreak dynamics.

### Clade Ia MPXV

Clade Ia MPXV is found primarily in the Democratic Republic of the Congo in provinces where mpox is endemic and has increasingly been found in previously unaffected provinces in recent years, including the capital Kinshasa since 2023. Reporting of sporadic cases in neighbouring Central African Republic and in the Republic of Congo also continues. While the Democratic Republic of the Congo and the Central African Republic report a higher proportion of children among cases, in the Republic of Congo, most cases are among adults.

Previously, genomic sequencing analysis had indicated that clade Ia MPXV typically emerged in human populations through zoonotic exposure, leading to limited human-to-human transmission. Epidemiological data and phylogenetic analyses still suggest that many outbreaks of mpox due to clade Ia MPXV in endemic areas result from zoonotic spillover with secondary human-to-human transmission. However, there is emerging evidence of increasing sustained human-to-human transmission of one lineage of clade Ia MPXV from 2024, mainly through sexual contact, in Kinshasa. At least three other provinces in the country (Kongo-Central, Kwilu, and Kwango) have detected this lineage, suggesting continuing spread in the country, and three imported cases have recently been found in Ireland (one case) and China (two cases). Sustained human-to-human transmission of clade Ia MPXV has not yet been documented in the Central African Republic or in the Republic of Congo.

### Clade Ib MPXV

Clade Ib MPXV is currently spreading predominantly in the Democratic Republic of the Congo, and its neighbouring countries to the east. In other countries where it has been reported, cases are primarily associated with international travel (Figure 1). To date, no human case of mpox due to clade Ib MPXV has been substantiated to result from animal exposure. Genomic sequencing data suggest that all cases detected to date are genomically linked to the strain detected for the first time in 2023 in South Kivu. Available evidence therefore suggests exclusive human-to-human contact transmission for this virus sub-clade.

Imported mpox has been confirmed among adults who travelled during their incubation period or with early symptoms and were diagnosed upon arrival in the reporting country. These individuals frequently reported sexual contact during their travels, with persons known or suspected to have mpox.

Often introduced in new settings through sexual contact among connected sexual networks, clade Ib MPXV introductions can lead to broader outbreaks and evolving transmission patterns, including spread within households. This has resulted in a progressive shift in age and sex distribution of cases, with an increasing proportion occurring among children, and a bimodal distribution, with the highest incidence observed among young children and young adults.

### Clade IIa MPXV

Outbreaks of mpox linked to clade IIa MPXV in human populations are a concerning development, as this clade had previously mainly been detected in or linked to animals, including a recent outbreak among monkeys in Thai national park in Côte d'Ivoire and the 2003 outbreak among pet prairie dog owners in the United States of America linked to small mammals imported from Ghana. Since 2024, Côte d'Ivoire, Ghana, Guinea, and Liberia have reported human mpox due to clade IIa MPXV in different locations, including their capital cities.

In these countries, mpox linked to clade IIa MPXV has been reported in adults and children, with many lacking a known epidemiological link. Limited epidemiological investigation has constrained understanding of the modes of



transmission in these outbreaks. Clade IIa MPXV infection in humans remains the least described in the scientific literature. Nonetheless, preliminary indications from genomic sequencing analysis along with a continued rise in the number of cases across different geographic areas in the affected countries, mostly among adults, suggest the occurrence of repeated zoonotic spillover events followed by limited secondary human-to-human transmission. While sexual contact transmission for this strain has not been documented, it is likely that all forms of close contact contribute to its spread, as with other MPXV strains.

Co-circulation of clade IIa and clade IIb MPXV was first reported in 2024, in Côte d'Ivoire, Ghana, and Liberia.

### **Clade IIb MPXV**

Most mpox outbreaks in other parts of Africa and on other continents are due to clade IIb MPXV, a continuation of the multi-country outbreak that began in 2022. Most regions report circulation of clade IIb lineage B.1, while lineage A.1 continues to circulate in Nigeria and some countries in the WHO Eastern Mediterranean Region. The most affected population outside of Africa, where low levels of transmission are reported, continues to be men who have sex with men, primarily exposed through sexual contact. In instances where others have been affected, such as women and children, it has not led to sustained transmission. In western Africa, cases are reported in different age groups and include males and females, highlighting potentially different transmission dynamics, which are not fully understood.

The multi-country outbreak of mpox driven by clade IIb MPXV that began in 2022 showed that sexual contact can sustain community transmission of MPXV for long periods of time. Likewise, subclades Ia and Ib have also been shown to be spreading through sexual contact, and their transmission is being sustained in different settings. Much remains to be understood about transmissibility and sustainability of transmission through non-sexual direct physical contact for all clades. In settings where human-to-human transmission persists, it is likely driven by a combination of sexual, household, and community contact.



## Global trends

This section is a monthly update of the global epidemiological situation, based on the most recent complete information from the mpox global surveillance system, **as of the end of March 2025**. Further details on global trends can be found on the [online WHO dashboard](#).

From 1 January 2022 through 31 March 2025, a total of 137 892 confirmed cases of mpox, including 317 deaths, were reported to WHO from 132 countries/territories/areas (hereafter 'countries') in all six WHO Regions (Table 1). The global Case Fatality Ratio (CFR) among confirmed cases during this period is 0.2%.

A total of 3353 new confirmed cases were reported in March 2025, an 12.7% decline from the preceding month. Most cases in March 2025 were reported from the African Region (84.8%), followed by the European Region (8.6%) and the Region of the Americas (5.6%). The European Region reported a monthly increase in cases of 51% for March 2025, compared to February 2025. On the other hand, the Western Pacific Region, the Eastern Mediterranean Region, the African Region, the South-East Asian Region, and the Region of the Americas reported declines in cases in March 2025, by 83%, 22%, 14%, 14%, and 12% respectively.

**Table 1.** Number of cumulative confirmed mpox cases and deaths reported to WHO, by WHO Region, from 1 January 2022 through 31 March 2025<sup>6</sup>.

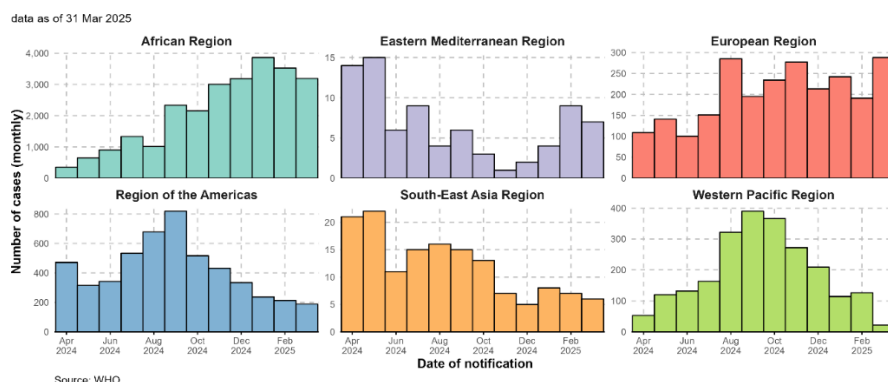
WHO Region	Total confirmed cases	Total deaths among confirmed cases	New cases reported in February 2025	New cases reported in March 2025	Monthly change in cases (%)
Region of the Americas	68 553	151	213	188	-12.0
European Region	29 605	9	191	288	51.0
African Region	32 287	125	3294	2842	-14.0
Western Pacific Region	5526	15	126	22	-83.0
South-East Asia Region	1017	14	7	6	-14.0
Eastern Mediterranean Region	904	3	9	7	-22.0
<b>Total</b>	<b>137 892</b>	<b>317</b>	<b>3840</b>	<b>3353</b>	<b>-12.7</b>

Figure 3 shows that over the past 12 months (1 April 2024 – 31 March 2025), the number of confirmed mpox cases reported monthly in the WHO African Region rose steadily, with a downward trend in the last three months. This decline is likely due to the lower proportion of suspected cases being tested in the Democratic Republic of the Congo in recent weeks. The Eastern Mediterranean and Southeast-Asia Regions have been reporting the lowest number of cases, with the former largely observing an upward trend in recent months, driven mainly by Gulf countries. In the European Region, the trend has been relatively stable in recent months, with an increase in the number of cases reported in March 2025. In the Region of the Americas and the Western Pacific, rising trends earlier in 2024 have been followed by a drop in cases in recent months. Trends in all regions may be prone to surveillance and reporting biases.

In the last 12 months, an average of 2971 confirmed mpox cases per month have been reported. Most of them were reported by the African Region (25 637 cases), followed by the Region of the Americas (5078 cases), and the European Region (2426 cases). Outside Africa, the highest number of confirmed cases in March 2025 was reported by Germany (77 cases).

<sup>6</sup> The monthly reported data may be prone to delays and incompleteness and are therefore subject to retrospective adjustments over time as more data become available.

**Figure 3.** Epidemic curves of monthly aggregated number of confirmed mpox cases reported to WHO, by WHO region, 1 April 2024 – 31 March 2025.



***\*Please note the different Y axes for the regional epidemic curves, to allow an overview of trends in each region.***

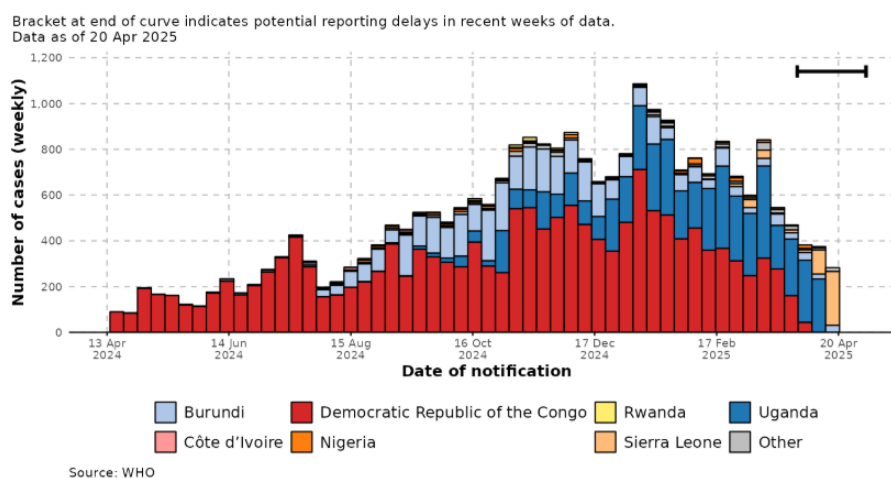
### Laboratory-confirmed cases reported in Africa

In Africa, from 30 December 2024 to 20 April 2025, 10 944 confirmed mpox cases, including 63 deaths (CFR – 0.6%), have been reported by 18 countries. The most affected country continues to be the Democratic Republic of the Congo (5197 confirmed cases, including 22 deaths)<sup>7</sup> followed by Uganda (4033 confirmed cases, including 33 deaths), and Burundi (866 confirmed cases and no deaths) (Figure 4).

In more recent weeks, the highest number of confirmed mpox cases in the Region has been reported by Uganda, with more than 200 new confirmed cases per week since December 2024, while Burundi has shown a stable decrease over recent months, with fewer than 50 new confirmed cases per week since February 2025.

The most recent new development is an abrupt spike in cases reported in Sierra Leone in recent weeks, with over 200 new confirmed cases reported in the most recent week. In 2025 alone, the country has reported 477 mpox confirmed cases, including four deaths (CFR 0.8%). The majority of cases (96%) are adults and most of the country's districts have reported cases. Approximately 60% of cases are male, but detailed epidemiological descriptions of the outbreak dynamics in the country are not yet available.

**Figure 4.** Epidemic curve of confirmed mpox cases in Africa, by country, in the past 12 months, 13 April 2024 – 20 April 2025.



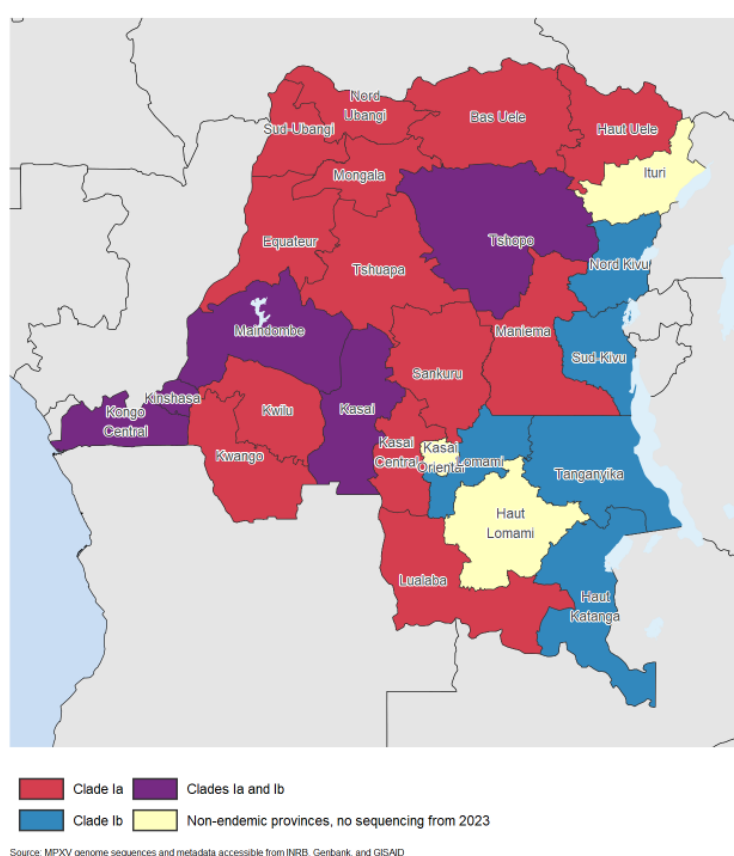
<sup>7</sup> The national-level case counts for the Democratic Republic of the Congo indicated here are based on the national laboratory database for mpox.

### Focus on the Democratic Republic of the Congo (clade Ia & Ib MPXV)

Mpox outbreaks in the Democratic Republic of the Congo continue to be driven by both clade Ia and Ib MPXV strains (Figure 5). Most sequenced samples from 1 October 2023 to 3 March 2025 are from the provinces of Kinshasa and South Kivu. Although all provinces in the country have reported confirmed mpox cases during this period, no sequencing has been done for samples from three provinces: Ituri, Kasai Oriental, and Haut-Lomami. So far, clade Ib MPXV has been detected in 10 provinces, and in five of them, it is co-circulating with clade Ia MPXV (Figure 5). Sequencing data from the Kinshasa outbreak have revealed increasingly sustained human-to-human transmission of clade Ia MPXV with high rates of APOBEC3-driven mutations. However, no such indications have been documented so far in the other provinces where clade Ia MPXV is circulating.

The current strategy for sequencing follows a convenience sampling approach, where positive samples reaching Kinshasa are prioritized. This allows good visibility of the situation in Kinshasa and provinces with better sample transportation systems but might bias the observed distribution of the virus strains by province.

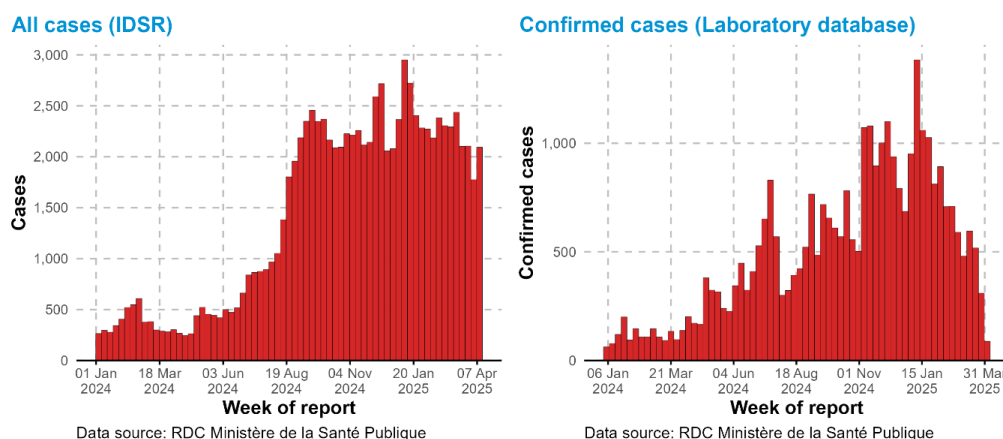
**Figure 5.** Geographic distribution of clade Ia and Ib MPXV in the Democratic Republic of the Congo, by province, from 1 October 2023 to 3 March 2025<sup>8</sup>.



The analysis of the epidemic trend of reported suspected mpox cases (left, Figure 6) shows that there was a notable rising trend in the second half of 2024, and the number of suspected cases reported has remained at a high level, around 2000-3000 cases per week, since then. The trends in reported confirmed cases, (right, Figure 6) suggest a rising trend in 2024 followed by a decline since the start of 2025. The latter needs to be interpreted with caution, since it is heavily influenced by access to testing and confirmation in the country (top, Figure 7) in the face of ongoing mpox transmission.

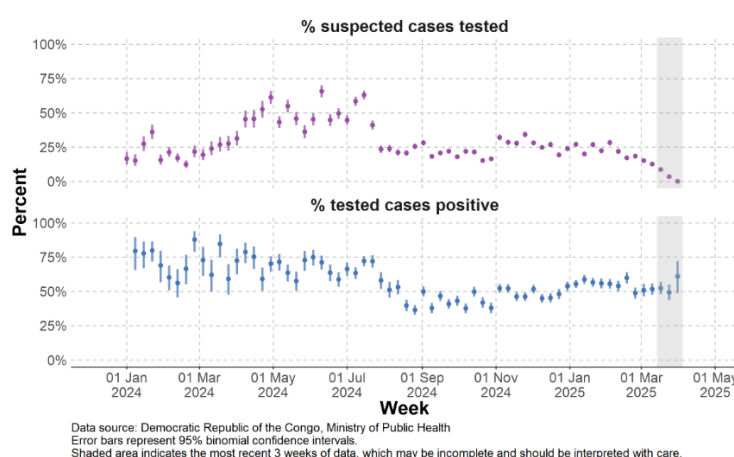
<sup>8</sup> This is the most recent complete epidemiological week for which subnational genomic sequencing data are available.

**Figure 6.** Epidemic curve of suspected (left) and confirmed (right) mpox cases reported in the Democratic Republic of the Congo, 1 January 2024 – 13 April 2025<sup>9</sup>.



In Figure 7 the sampling proportion is calculated by dividing the number of cases sampled (as recorded in the national laboratory line list) by the number of suspected cases reported through the syndromic surveillance system. This metric combines data from two distinct sources and is used solely to estimate testing activity. Due to potential date misalignments and other discrepancies between the two databases, these estimates may vary from week to week and should be interpreted with caution. Test positivity is calculated as the proportion of positive PCR results among the total number of tests conducted for each geographic area. Although the number of confirmed cases has been decreasing over recent weeks (right, Figure 6), the test positivity has remained stable at just over 50% during recent months (bottom, Figure 7). This suggests that the observed declining trend in confirmed cases reported in recent weeks is likely to be a result of decreased access to testing, rather than a true decline in mpox incidence which would have resulted in a decline in test positivity. This is corroborated by the decline in the proportion of suspected cases tested in recent weeks (top, Figure 7). Interpretation of trends in confirmed cases over time should therefore take into account trends in suspected cases, proportion of suspected cases tested, and test positivity over time.

**Figure 7.** Proportion of suspected cases for whom a sample was collected (top) and proportion of confirmed cases among those that undergo laboratory testing (bottom), in the Democratic Republic of the Congo, by week, 1 January 2024 – 6 April 2025<sup>10</sup>.



<sup>9</sup> This is the most recent complete epidemiological week for which subnational data are available.

<sup>10</sup> Test positivity estimates are based solely on national laboratory line list data. Wider confidence intervals indicate smaller sample sizes or more variable positivity.

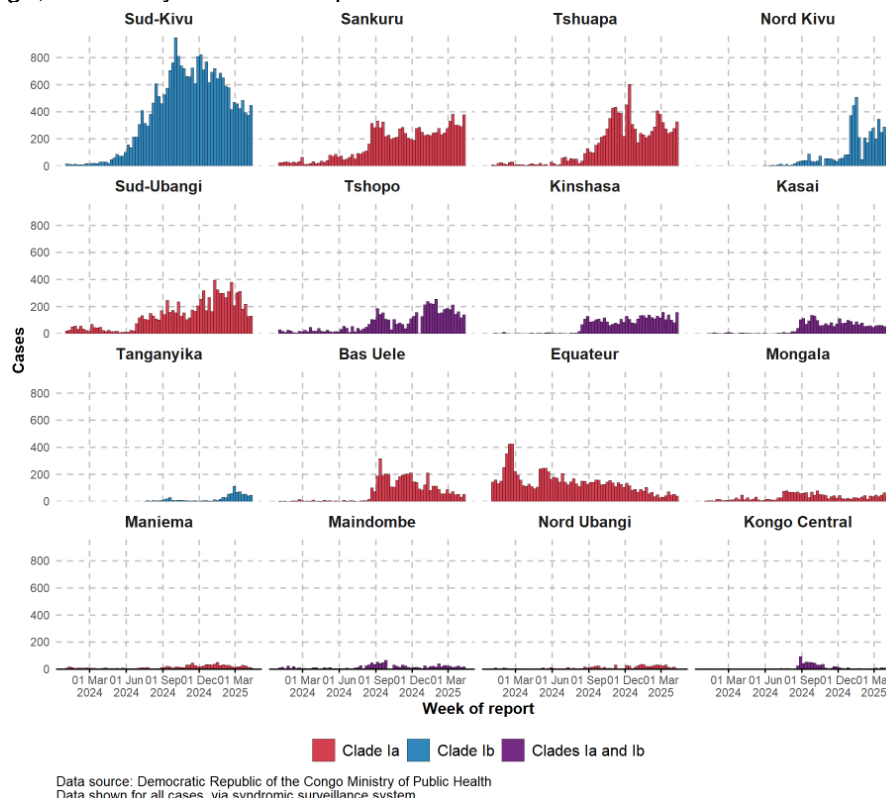
Furthermore, national trends should be interpreted in light of the varying epidemic dynamics at the subnational level. An analysis of the epidemic trend of reported suspected mpox cases in the 16 most affected provinces in the Democratic Republic of the Congo shows that these provinces have varying outbreak sizes, but for most of them, the number of cases reported in recent weeks appears to be relatively stable (Figure 8).

Among the provinces reporting only clade Ib MPXV, South Kivu continues to account for most suspected cases in the country, still typically reporting over 400 suspected cases per week. The reported number of weekly suspected cases has continued to decline in South Kivu since mid-October 2024, although the decline in reported cases after February should be interpreted with caution given the impact of the escalation of conflict in the province during this time on surveillance and response activities. As regards North Kivu, the sudden increase in reported cases observed in the province during the initial weeks of 2025 has been attributed to a change in the province's reporting practices, with both the tested and untested suspected cases now included in the overall count of suspected cases, unlike in 2024, when the overall count of suspected cases only included the untested suspected cases. This makes the syndromic surveillance in North Kivu more comparable to that of other provinces in 2025. This notwithstanding, the trends in suspected cases in North Kivu have remained relatively stable in recent weeks. Tanganyika province continues to report cases each week.

Among the provinces in which only clade Ia MPXV has been detected, Sankuru and Tshuapa have been reporting a rising number of cases in recent weeks. In Equateur province, the province historically most affected by mpox in the country, the trend has been slowly declining over time since a significant outbreak in January 2024, with fewer than 100 suspected cases reported weekly in recent weeks.

Among provinces in which clades Ia and clade Ib MPXV have been detected, including Kinshasa province, the number of suspected cases reported each week has also been relatively stable in recent weeks. The epidemiological situation in the country remains concerning since circulation of the virus continues countrywide, with several local flare ups of transmission.

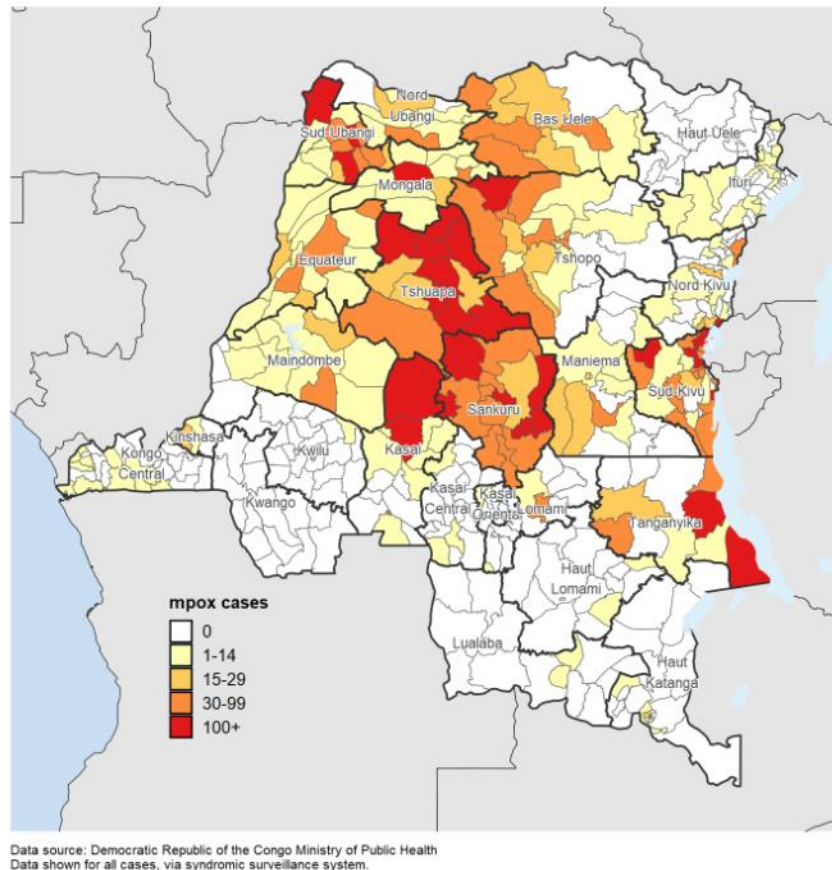
**Figure 8.** Epidemic curve of reported suspected mpox cases in the most affected provinces of the Democratic Republic of the Congo, 1 January 2024 – 13 April 2025<sup>11</sup>.



<sup>11</sup> This is the most recent complete epidemiological week for which subnational data are available.

An analysis of the sub-provincial geographic distribution of suspected mpox cases reported in the Democratic Republic of the Congo over the last six weeks (Figure 9) shows wide distribution of suspected mpox cases and variation between different health zones. Provinces in the north-west of the country where mpox has historically been endemic continue to report a high number of cases, although the virus is also affecting large areas in eastern and south-eastern provinces.

**Figure 9.** Geographic distribution of suspected mpox cases in the past six weeks, by health zone, in the Democratic Republic of the Congo, 3 March – 13 April 2025<sup>12</sup>.



<sup>12</sup> This is the most recent complete epidemiological week for which subnational data are available.



## Other countries reporting active clade Ib MPXV transmission

This section of the report includes countries that report outbreaks of clade Ib MPXV or travel-related cases of mpox due to clade Ib MPXV in the last six weeks and are therefore considered to have active clade Ib MPXV transmission (Table 2). The remaining 13 countries of a total of 29 countries that have reported cases of mpox due to clade Ib MPXV, are not included and are currently considered to be in control phase for clade Ib MPXV transmission.

**Table 2.** Countries reporting active clade Ib MPXV outbreaks, according to confirmed cases reported to WHO, as of 25 April 2025.

Country	Cases since January 2024	Cases in past six weeks	Transmission status	Additional notes
Democratic Republic of the Congo	20 264	807	Community transmission	
Uganda	5386	1343	Community transmission	
Burundi	3812	198	Community transmission	
Rwanda	114	4	Community transmission	
Kenya	80	27	Community transmission	
Congo	54	8	Community transmission	
United Republic of Tanzania	39	37	Community transmission	
Zambia	36	12	Community transmission	
The United Kingdom	12	2	Community transmission	One case with no reported travel or links to travelers
South Sudan	8	1	Community transmission	One case with no reported travel or links to travelers
South Africa	6	3	Community transmission	
Malawi	3	3	Community transmission	None of the three cases is linked to travel
Germany	10	2	Cases linked to travel	
Thailand	5	1	Cases linked to travel	
France	3	1	Cases linked to travel	
Switzerland	1	1	Cases linked to travel	

Note:

- Imported cases are updated as of 25 April 2025 whereas case counts for countries classified as community transmission are updated as of 20 April 2025.
- For countries classified as having cases linked to travel, only cases of mpox due to clade Ib MPXV are included. Cases in these countries for which clade and subclade classification is not determined or pending are not included.
- Countries with cases linked to travel also include instances where one to two generations of onward transmission have been reported and linked to index cases.
- Cases reported in the Republic of Congo and the Democratic Republic of the Congo are known to be a mix of clade Ia and clade Ib MPXV.



### **First cases of mpox due to clade Ib MPXV without any international travel link reported in Malawi**

On 18 April 2025, Malawi notified its first cases of mpox due to clade Ib MPXV. The cases are three male individuals, aged 30 - 40 years old, in Lilongwe District, and the Ministry of Health officially declared an mpox outbreak on 17 April 2025.

The first case involved a 30-year-old male who presented with symptoms consistent with mpox on 20 March 2025. A second case, a 33-year-old male, was identified on 9 April 2025 and the third case is a 38-year-old man identified on 18 April. Clinical specimens were collected from all individuals for laboratory investigations at the National Reference Laboratory in Lilongwe and PCR results were positive for mpox. All cases are stable and under care. The first two cases are among people living with HIV.

None of the three cases reported any recent travel outside of Malawi, suggesting local transmission. Epidemiological investigations are ongoing and contact tracing is underway, with 34 contacts identified so far and under follow-up.

The Ministry of Health has activated incident management including the main pillars of the response focusing on coordination, surveillance, laboratory, case management, risk communication and community engagement as capacity building.

### **Second case of mpox due to clade Ia MPXV reported in China**

On 16 April 2025, China notified WHO of the second confirmed case of mpox due to clade Ia MPXV detected in the country. The case is an adult male who reported recent travel from the Democratic Republic of the Congo. He developed symptoms on 25 March, while still in the Democratic Republic of the Congo, where he sought care locally but was not diagnosed as mpox. On 12 April, while still symptomatic, he departed for China, where he arrived on 13 April and voluntarily declared his signs and symptoms. After testing, clade Ia MPXV infection was confirmed. The patient was hospitalized and is in stable clinical condition. Further local and international spread of infection related to this case are considered unlikely.

Overall, this case represents the third documented importation of clade Ia MPXV from an endemic country, showing the epidemic potential of this subclade previously known predominantly for local transmission in endemic contexts.

The two cases of mpox due to clade Ia MPXV previously reported, one case each in Ireland and China respectively, belonged to the lineage now causing sustained human-to-human transmission of clade Ia MPXV in the Democratic Republic of the Congo [reported in a previous edition of this report](#). Information on whether this third case also falls within the same lineage is not yet available, pending the results of genomic sequencing analysis.

### **Detection of clade I MPXV in wastewater in the United States of America**

While carrying out routine event-based surveillance, WHO found two reports of clade I MPXV in wastewater in the United States of America. The first detection was in wastewater samples collected in California from 23 February to 22 March 2025. The second detection was in wastewater samples collected in North Carolina from 23 March and 19 April. Efforts are underway to verify these reports.

The United States of America has reported four cases of mpox due to clade Ib MPXV so far, all among travelers from affected countries in East and Central Africa. The first case was reported in California in November 2024, the second case was reported in Georgia in January 2025, and the third and fourth cases were reported in early to mid-February 2025, in New Hampshire and New York respectively. There were no reported active cases in California and North Carolina during the periods in which the wastewater samples were collected in these states.

## Mpox vaccination in the African Region

As of 22 April 2025, seven African countries have initiated mpox vaccination, all using MVA-BN vaccine. A total of 662 740 doses have been administered during the current outbreak response. Notably, 88% of these doses have been administered in the Democratic Republic of the Congo, the country reporting the highest number of cases.

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. At its March 2025 meeting, the WHO Strategic Advisory Group of Experts on Immunization (SAGE) re-emphasized the importance of dose sparing strategies during times of vaccine shortages in outbreak response situations. This approach is also reflected in the recently updated [Strategic Preparedness and Response Plan \(SPRP\) for mpox](#).

Below is a summary of countries that have started mpox vaccination, the number of doses administered to date, and the target populations:

- **Democratic Republic of the Congo:** Vaccination began on 5 October 2024, with 582 196 doses administered to date. During phase 1 (October 2024 – 21 February 2025) a two-dose regimen was administered to individuals aged 18 years and older targeting healthcare and frontline workers, contacts of mpox cases, and key populations including sex workers, men who have sex with men, hunters, and eco-guards/wildlife-rangers. In phase 2 (from 22 February 2025), the country shifted to a single-dose strategy for individuals aged 1 year and above; this strategy was deployed in the 15 most affected health areas (of 422) across five of 35 health zones in Kinshasa, while contacts of cases were also vaccinated outside of these areas. In view of the currently limited availability of vaccines in the country, the mpox vaccination strategy is again being adapted to the context. In April 2025, the Congo National Pharmacovigilance Center (CNPV) conducted training of enrollers who will conduct MVA-BN vaccine safety monitoring studies using a country-tailored [WHO cohort event monitoring protocol](#).
- **Uganda:** Since 2 February 2025, a total of 61 453 vaccine doses have been administered in two of the most affected divisions in the capital, Kampala. Vaccination with single-dose MVA-BN focused on individuals aged 12 years or more from the following groups: key populations (sex workers, men who have sex with men, people who inject drugs, bisexual, transgender, queer individuals), long-distance drivers, fishermen, health workers, and contacts of cases.
- **Rwanda:** Since 17 September 2024, 9577 doses have been administered (7737 first doses and 1840 second doses). Target populations included individuals aged 18 years and older among health workers, contacts of cases, and other high-risk groups.
- **Nigeria:** Since 25 November 2024, 7959 doses have been administered (4329 first doses and 3630 second doses) across six states. Vaccination targets individuals 18 years and older, including health workers, contacts of cases, and groups at risk of severe disease such as immunocompromised individuals. Currently, vaccination is on hold, pending availability of funds to continue activities.
- **Sierra Leone:** Since 27 March 2025, 887 doses have been administered using a single-dose strategy. Target groups include individuals 12 years and older among health and frontline workers, sex workers, contacts of cases, and other high-risk populations.
- **Liberia:** Since 16 April 2025, 631 doses have been administered. Target groups include individuals 18 years and older, including health workers, contacts of cases, and other high-risk key populations.
- **Central African Republic:** Since 18 January 2025, 100 doses have been administered, primarily to contacts of confirmed cases. Plans to expand vaccination to other provinces are underway.

Other countries in the African Region are expected to start mpox vaccination in the coming weeks.

## Global operational updates

The WHO health emergency prevention, preparedness, response and resilience (HEPR) framework underpins both the [Strategic Framework for enhancing prevention and control of mpox \(2024-2027\)](#) and the ongoing emergency response to the mpox public health emergency of international concern (PHEIC).

Aligned with the HEPR framework, the updated WHO [Global Strategic Preparedness and Response Plan](#) (SPRP) for mpox focuses on strengthening five core components—the **5Cs**:

1. **Emergency coordination:** Efficient coordination for timely crisis response.
2. **Collaborative surveillance:** Real-time data integration for early threat detection.
3. **Community protection:** Engaging communities in prevention and resilience-building measures.
4. **Safe and scalable care:** Equipping health systems to provide essential care with scalable capacity.
5. **Access to and delivery of countermeasures:** Ensuring equitable distribution of medical countermeasures.

This section provides updates on the WHO global mpox response **as of 25 April 2025**.

### 1. Emergency coordination

- WHO has revised and extended the [mpox global strategic preparedness and response plan](#) for six months, to August 2025, updating it to introduce adaptations to scale up and refine the global response.
- WHO also worked with Africa Centers for Disease Control and Prevention (CDC) and partners to launch the [mpox continental response plan 2.0](#) for Africa. It is an extension to the continental response plan first launched in September 2024, covering the next period to August 2025, which serves as a roadmap to complete the response phase and transition to routine programmes by strengthening the resilience of health systems for this ongoing and future public health emergencies.

### 2. Collaborative surveillance

- Updates to [epidemiological data on mpox in Africa](#) continue weekly, updates to [global epidemiological data](#) continue monthly, and both can be accessed in the [online WHO dashboard](#).
- Coordination for laboratory diagnostics continues, with all partners supporting countries and across three levels of the WHO through weekly lab pillar continental and monthly diagnostic consortium meetings.
- WHO held an EPI-WIN webinar on 16 April 2025: [The utility of pathogen genomics: Spotlight mpox](#). The objective of the seminar was to spotlight the use of genomics in expanding our understanding of mpox transmission dynamics and its role in strengthening surveillance for public health interventions.
- To ensure compliance with quality assurance in testing, WHO facilitated an External Quality Assurance programme for mpox testing, in which 145 laboratories participated.
- Field evaluation of six antigen rapid diagnostic tests (RDTs) for mpox is ongoing in the Democratic Republic of Congo with the support of WHO. Participant recruitment will end in the coming weeks, and testing of the RDTs is expected to commence on 18 May 2025.
- Performance evaluation of selected PCR kits is planned to commence at the Robert Koch Institute (Berlin), WHO Collaborating Centre for emerging infections and biological threats in May 2025 to determine their limit of detection and assess ability to identify all clades currently circulating in different parts of the globe.

### 3. Community protection

- WHO held an EPI-WIN webinar on 9 April 2025: Evidence for impact – advancing a community centred [response to mpox](#) to launch [Interim guidance on social and behavioural research for the mpox public health response, March 2025](#). This interim guidance is the first of its kind and was developed to strengthen the quality, ethics and impact of producing such evidence in an emergency response. The guidance is now

available in [English](#) and [French](#). Operational support tools for implementing the guidance were field tested in the week that followed.

- A HIVE community of [practice](#) is active for community protection partners. On HIVE, a broad multidisciplinary range of partners, including public health practitioners, researchers, operational partners and civil society groups collaborate and share information and expertise to strengthen the generation and use of evidence for the mpox public health response.

#### 4. Safe and scalable care

- Continued strengthening of treatment facilities is ongoing in all affected countries, endeavouring to ensure that essential medicines and supplies are available and reach patients, including for IPC/WASH.
- Technical support to the Democratic Republic of the Congo in clinical care, including the design, set-up, and linkage of treatment centres.
- Continued support for the uptake of data collection tools to facilitate mpox clinical characterization using the [WHO Global Clinical Platform](#). These include openly available tools developed in Research Electronic Data Capture (REDCap) and Open Data Kit (ODK) data platforms. These are in use to understand the epidemic in Africa, particularly in the Democratic Republic of the Congo, Sierra Leone and Uganda.
- Continued technical support to IPC focal points in affected countries regarding implementation of IPC measures.

#### 5. Access to and delivery of countermeasures

##### Access and Allocation Mechanism (AAM)

##### Diagnostics:

- Since the call for Expressions of Interest under the WHO Emergency Use Listing procedure for MPXV diagnostics on 28 August 2024, 69 manufacturers have contacted WHO and 41 pre-submission calls had been scheduled as of 23 April 2025. A total of 14 manufacturers were invited to submit their applications for 14 Nucleic Acid Amplification assays.
- To date, the WHO has listed [four products under the Emergency Use Listing](#) procedure, and [nine products are currently under assessment](#). One application is expected in July 2025.

##### Vaccines

- WHO continues to provide strategic, guidance, and technical support to accelerate implementation and uptake of mpox vaccination in affected countries for people at risk, in support of controlling the surge in mpox cases on the African continent.
- To date, 1 045 180 vaccine doses have been delivered to ten countries, including 50 000 doses of LC16m8 vaccine from Japan to the Democratic Republic of the Congo in January 2025.
- Vaccination activities have started in seven countries (the Central African Republic, Democratic Republic of the Congo, Liberia, Nigeria, Rwanda, Sierra Leone, and Uganda). Other countries seeking vaccine allocations are preparing national mpox vaccination plans.
- The position of the vaccine manufacturer Bavarian Nordic on product liability for MVA-BN mpox vaccine: When national regulatory authorities allow age indications which are not on the label of the product (e.g. one year and above, or 12 years and above) in their Marketing Authorization (MA) or Emergency Use Authorization (EUA), Bavarian Nordic covers the product liability for these age groups.
- WHO, UNICEF and the International Federation of Red Cross and Red Crescent Societies (IFRC) have produced a resource on [“How to achieve and sustain high uptake of mpox vaccination in outbreak settings”](#). April 2025.
- The AAM partners continue to work together to ensure countries receive guidance to get operational funds for implementation of the national vaccination plans.

## Mpox resources

### Mpox outbreak toolkit

- WHO mpox outbreak toolbox, Updated February 2025. <https://www.who.int/emergencies/outbreak-toolkit/disease-outbreak-toolboxes/mpox-outbreak-toolbox>

### Strategic planning and global support

- WHO mpox global strategic preparedness and response plan. Updated 17 April 2025. <https://www.who.int/publications/m/item/mpox-global-strategic-preparedness-and-response-plan-april-2025>
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### International Health Regulations Emergency Committee, Review Committee and recommendations of the Director-General

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- Third meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox 2024 – Temporary recommendations, 27 February 2025. <https://www.who.int/news/item/27-02-2025-third-meeting-of-the-international-health-regulations-2005-emergency-committee-regarding-the-upsurge-of-mpox-2024-temporary-recommendations>
- Second meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox 2024, 28 November 2024. <https://www.who.int/news/item/27-02-2025-third-meeting-of-the-international-health-regulations-2005-emergency-committee-regarding-the-upsurge-of-mpox-2024-temporary-recommendations>

First meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox 2024, 19 August 2024. [https://www.who.int/news/item/19-08-2024-first-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-upsurge-of-mpox-2024](https://www.who.int/news/item/19-08-2024-first-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-upsurge-of-mpox-2024)

- Extension of the standing recommendations for mpox issued by the Director-General of the World health organization (WHO) in accordance with the International Health Regulations (2005) (IHR), 21 August 2024. [Extension of the standing recommendations for mpox issued by the Director-General of the World health organization \(WHO\) in accordance with the International Health Regulations \(2005\) \(IHR\)](#)
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## Regional information products

- WHO Africa Regional Office, Regional Mpox Bulletin: <https://www.afro.who.int/health-topics/mpox-monkeypox>
- WHO AFRO Weekly Bulletin on Outbreaks and Other Emergencies. <https://www.afro.who.int/health-topics/disease-outbreaks/outbreaks-and-other-emergencies-updates>
- Joint Continental Situation Report on the Mpox Epidemic in Africa (23 September- 03 November 2024), 6 December 2024. <https://africacdc.org/download/joint-continental-situation-report-on-the-mpox-epidemic-in-africa-23-september-03-november-2024/>

## Surveillance

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- Considerations for wastewater and environmental surveillance for monkeypox virus: Interim guidance, 25 November 2024. <https://www.who.int/publications/i/item/B09178>
- Mpox Case Investigation Form (CIF) and minimum dataset Case Reporting Form (CRF), 5 September 2024. [https://www.who.int/publications/m/item/monkeypox-minimum-dataset-case-reporting-form-\(crf\)](https://www.who.int/publications/m/item/monkeypox-minimum-dataset-case-reporting-form-(crf))
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## Laboratory and diagnostics

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- WHO issues Emergency Use Authorization for Xpert Mpox, a near-point-of-care real-time PCR test, 30 October 2024. <https://www.who.int/news/item/30-10-2024-who-lists-additional-mpox-diagnostic-tests-for-emergency-use>
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- Mpox Factsheet, 26 August 2024. <https://www.who.int/news-room/fact-sheets/detail/mpox>

- Risk communication and community engagement readiness and response toolkit: mpox, 23 April 2024. <https://www.who.int/publications/i/item/9789240091559>
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- OpenWHO. Ten things you should know about mpox (2025). Quick videos online. <https://openwho.org/infectiousdiseases/503162/Mpox>
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- OpenWHO. Mpox and the 2022-2023 global outbreak (2023)

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- AVigiMobile AEFI reporting training video: <https://www.youtube.com/watch?v=UBfnBKRkAu0>
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- eLearning courses on vaccine safety monitoring  
<https://who.csod.com/selfreg/register.aspx?c=aefi%20causality%20assessment>
  - Vaccines safety basics
  - Adverse Event Following Immunization (AEFI) data management
  - AEFI investigation
  - AEFI causality assessment

**Disclaimer:** Caution must be taken when interpreting all data presented, and differences between information products published by WHO, national public health authorities, and other sources using different inclusion criteria and different data cut-off times are to be expected. While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change. All counts are subject to variations in case detection, definitions, laboratory testing, and reporting strategies between countries, states and territories.

## Annex 1. Latest Rapid Risk Assessment of February 2025

WHO conducted the latest global mpox rapid risk assessment in February 2025. Based on information available at the time of that risk assessment, the overall public health risk posed by mpox was assessed as follows:

Overall Public Health risk
<b>Global</b>
<b>Moderate</b>

Confidence in available information
<b>Global</b>
<b>Moderate</b>

Overall global public health risk *	
<b>Clade Ib MPXV</b>	<b>High</b>
<b>Clade Ia MPXV**</b>	<b>Moderate</b>
<b>Clade II MPXV (historically endemic areas)</b>	<b>Moderate</b>
<b>Clade IIb MPXV***</b>	<b>Moderate</b>

Confidence in available information
<b>Moderate</b>
<b>Moderate</b>
<b>Moderate</b>
<b>Moderate</b>

*\*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.*

*\*\*The situation in **Kinshasa**, however, requires particular attention. The risk associated with the clade Ia MPXV outbreak there is deemed higher than in clade Ia MPXV-endemic areas, with currently no evidence to suggest that clade Ia MPXV and clade Ib MPXV in the Kinshasa context<sup>13</sup> are epidemiologically distinct.*

*\*\*\* This group represents a very broad geographic area, encompassing countries and regions with diverse health systems and varying response capacities. In certain countries or regional blocs within this group, the risk may vary and/or be assessed as low.*

For a more detailed description of the risk groups:

- Clade Ib MPXV - Mostly affecting non-endemic areas for mpox in the Democratic Republic of the Congo and neighbouring countries, where mpox is spreading mainly through human-to-human close physical contact, including sexual contact. International spread is predominantly linked to sexual contact: **high**.
- Clade Ia MPXV - Mostly affecting mpox-endemic areas in the Democratic Republic of the Congo, with sporadic cases reported in other Central and East African countries, where mpox is linked to zoonotic spillover events, as well as human-to-human transmission mainly through close physical contact, including sexual contact: **moderate**.
- Clade II MPXV (historically endemic areas) - Nigeria and countries of West and Central Africa where mpox is endemic, affecting children and adults, and is linked to zoonotic spillover events, as well as human-to-human transmission mainly through close physical contact, including sexual contact: **moderate**.
- Clade IIb MPXV\*\*\*\* - Global risk, where outbreaks predominantly affect adult men who have sex with men and spread predominantly through sexual contact: **moderate**.

Given the high likelihood that existing and new MPXV strains will continue to emerge and spread within human populations, and the potential consequences, the **overall public health risk at the global level is assessed as moderate**.

<sup>13</sup> For more details, please refer to the [Multi-country outbreak of mpox, External situation report #48](#)

*\*\*\*\* This group represents a very broad geographical area, with countries and regions that have very diverse health systems and response capacities, and, in selected countries or regional blocs in this group, the risk may vary and/or be assessed as low.*

Individual-level risk is largely dependent on individual factors such as exposure risk and immune status, regardless of geographic area, epidemiological context, biological sex, gender identity or sexual orientation.

In this rapid risk assessment, public health risk is estimated based on the combination of the risk for human health, the risk for further spread and the risk of insufficient response capacities, in and from the affected areas. The way these risk estimates are presented may differ from the risk evaluations for [clade Ia](#) and clade Ib [MPXV](#) published in January 2025, which consider comparative characteristics of viruses, such as transmissibility, immune escape, severity and clinical/diagnostic considerations in a broader and more general context.