Mpox

Multi-country external situation report no. 52 published 13 May 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	**138 029**		**317**	**132**
Reporting period: 1 January 2024 – 4 May 2025				
Area	**Number of reported confirmed cases**		**Number of deaths among confirmed cases[1]**	
	2024	**2025**	**2024**	**2025**
Africa	**19 179**	**14 758**	**51**	**67**
Democratic Republic of the Congo[2]	**14 238**	**7411**	**27**	**22**
Uganda	**1352**	**4590**	**13**	**28**
Sierra Leone	**0**	**1387**	**0**	**10**
Burundi	**2946**	**937**	**1**	**0**
Reporting period: last six weeks, 10 March – 20 April 2025				
Africa	**4517**		**18**	
Democratic Republic of the Congo	**1610**		**2**	
Uganda	**1307**		**4**	
Sierra Leone	**1275**		**8**	
Burundi	**185**		**0**	

Highlights

- Cases of mpox due to clade Ib monkeypox virus (MPXV) continue to be reported primarily in Africa, where ten countries have reported community transmission of this strain in the past six weeks.
- The Democratic Republic of the Congo continues to report the highest number of cumulative confirmed mpox cases in Africa in 2025, with important reporting and other information gaps emerging due to in part to a reduction in testing and confirmation capacity. Clades Ia and Ib MPXV continue to circulate in the country.
- A downward trend in confirmed cases has also been reported in Uganda in recent weeks. However, the country continues to observe a large outbreak, reporting about 200 new confirmed cases per week.
- Burundi continues to observe fewer than 50 new confirmed cases per week, down from over 200 confirmed cases per week at the peak of the outbreak.
- Sierra Leone continues to report a surge in the number of confirmed mpox cases over the past four weeks, with over 500 new confirmed cases reported during the most recent week, highlighting the rising transmission in the

[1] Routine review and harmonization processes for data on deaths may alter the way deaths are distributed over time, resulting in slight differences from previous editions of this report.
[2] The national-level case counts for the Democratic Republic of the Congo indicated are based on the national laboratory database for mpox.

country. Investigations into the epidemiological characteristics of the outbreak continue and a joint WHO – Africa CDC mission has provided recommendations to enhance the outbreak response.

- This report provides an overview of mpox vaccination in countries in the African Region, where to date more than 668 000 doses of MVA-BN vaccines have been administered in seven countries. From the total number of doses, 87% have been administered in the Democratic Republic of the Congo, where microplanning is ongoing in different provinces with the aim to optimize use of the limited vaccine supply with targeted vaccination strategies.

In this edition:

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 **4 May 2025**;
- updates on imported cases of mpox due to clade I MPXV as of **8 May 2025**;
- operational response updates as of **8 May 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.

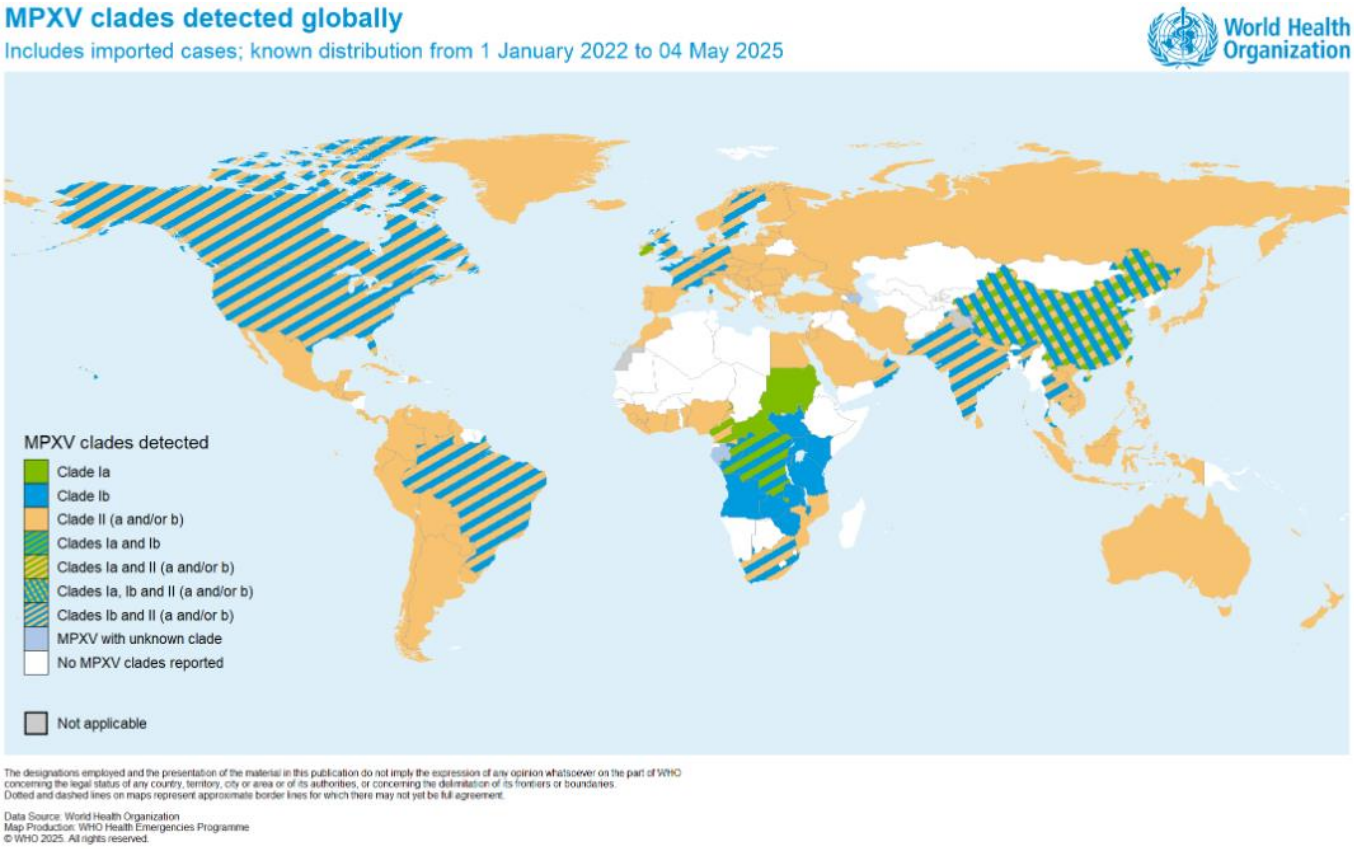
Epidemiological update [3, 4]

Global monkeypox virus (MPXV) distribution

As of 4 May 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, 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.

Figure 1. Geographic distribution of MPXV clades reported to WHO, by country, 1 January 2022 to 4 May 2025[5].



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.

[3] On the African continent there are 47 Member States in the WHO African Region and seven in the Eastern Mediterranean Region.

[4] 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

[5] 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.

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.

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[6].

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.

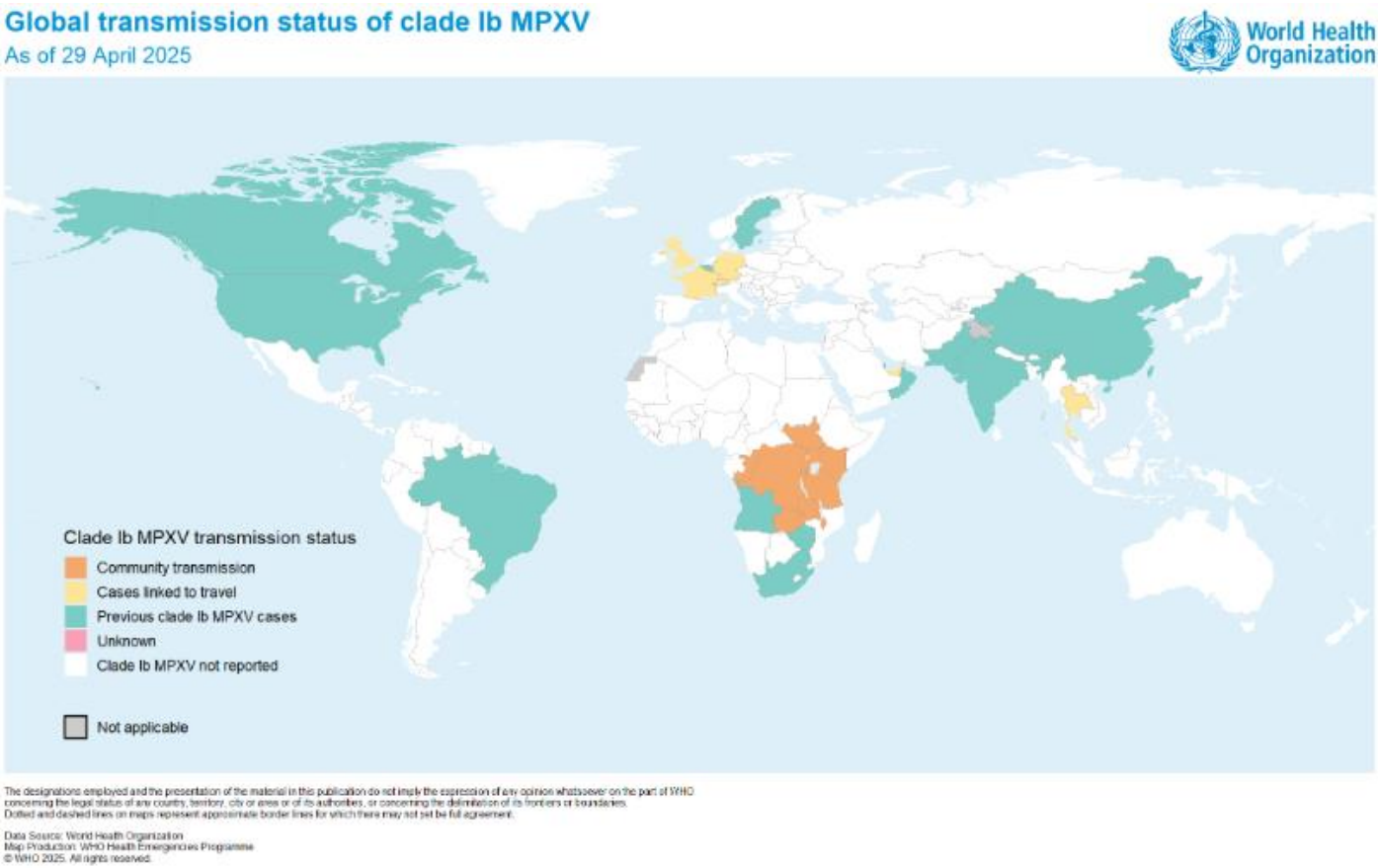
In the Democratic Republic of the Congo, where clade Ib MPXV originated, cases have been reported in 10 provinces: South Kivu, North Kivu, Kinshasa, Kasai, Tshopo, Tanganyika, Haut-Katanga, Mai-Ndombe, Lomami, and Kongo-Central. Within Africa, community transmission of clade Ib MPXV has also been reported in Burundi, Kenya, Malawi, Republic of Congo, Rwanda, South Sudan, Uganda, the United Republic of Tanzania, and Zambia during the last six weeks. Countries which have previously reported cases but not reported any cases within the past six weeks include Angola, South Africa 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), India (10 cases)[7], China (seven cases), Belgium (five cases), Qatar (five cases), Thailand (five cases), the United States of America (four cases), France (three cases) , United Arab Emirates (two cases), Brazil, Canada, Oman, Pakistan, Sweden, and Switzerland (one case each). Only travel-related cases have been reported outside Africa during the past six weeks. For more details on the rest of the countries, and the number of cases reported in each, please refer to Table 1 in the section on Other countries reporting cases of mpox due to clade Ib MPXV.

[6] 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

[7] Nine confirmed cases of mpox due to clade Ib MPXV detected over the period from December 2024 to March 2025 were retrospectively reported by India in the time since the last edition of this report.

Figure 2. Clade Ib MPXV transmission status within the last six weeks, by country, as of 4 May 2025.



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. In other countries where it has been reported, cases are primarily associated with international travel (Figure 2). 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 and 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.

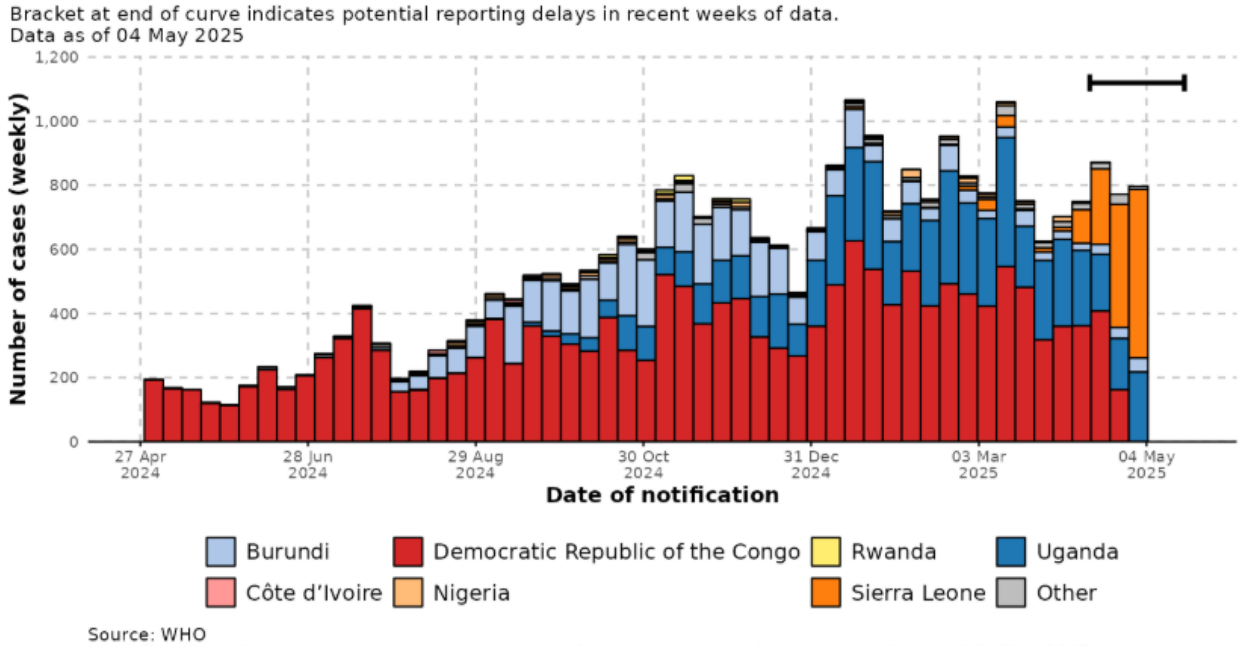
Laboratory-confirmed cases reported in Africa

In Africa, from 30 December 2024 to 4 May 2025, 14 758 confirmed mpox cases, including 67 deaths (CFR – 0.5%), have been reported by 18 countries. The most affected country continues to be the Democratic Republic of the Congo (7411 confirmed cases, including 22 deaths)[8] followed by Uganda (4590 confirmed cases, including 28 deaths)[9], Sierra Leone (1387 confirmed cases and 10 deaths), and Burundi (937 confirmed cases, including no deaths) (Figure 3).

Over recent weeks and based on confirmed cases reported the Democratic Republic of the Congo[10] and Uganda continue to experience large mpox outbreaks, with the Democratic Republic of Congo reporting the highest number of confirmed cases during the last six weeks (1610 confirmed cases), followed by Uganda (1307 confirmed cases). On the other hand, Burundi, which experienced a large mpox outbreak during the first half of 2024 and early 2025, has been reporting fewer than 50 cases per week since February 2025, down from 200 cases per week at the peak of its outbreak.

Conversely, for Sierra Leone, this marks the first time the country has emerged among the top three countries in Africa reporting the highest number of confirmed cases in 2025. This new development follows an abrupt surge in cases reported in Sierra Leone over the past four weeks, with over 500 new confirmed cases per week reported during the last week alone. Prior to this surge, only clade IIb MPXV had been detected, but efforts are underway to carry out genomic sequencing analysis for more recent samples.

Figure 3. Epidemic curve of confirmed mpox cases in Africa, by country, in the past 12 months, 27 April 2024 – 4 May 2025.



[8] The national-level case counts for the Democratic Republic of the Congo indicated here are based on the national laboratory database for mpox.

[9] Routine review and harmonization processes for data on deaths may alter the way deaths are distributed over time, resulting in slight differences from previous editions of this report.

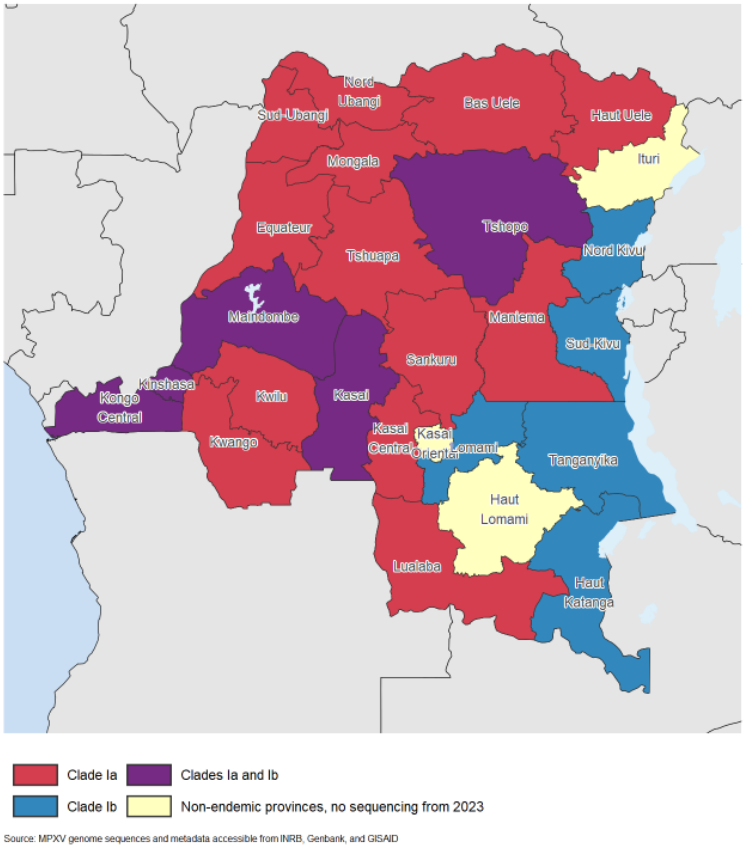
[10] This should be interpreted with caution given a reduction in testing and confirmation capacity in the country since the end of January 2025. This is explored further in the next section.

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 4). Most sequenced samples from 1 October 2023 to 3 March 2025[11] 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: Haut-Lomami, Ituri, and Kasai Oriental. 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 4). 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 PCR-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.

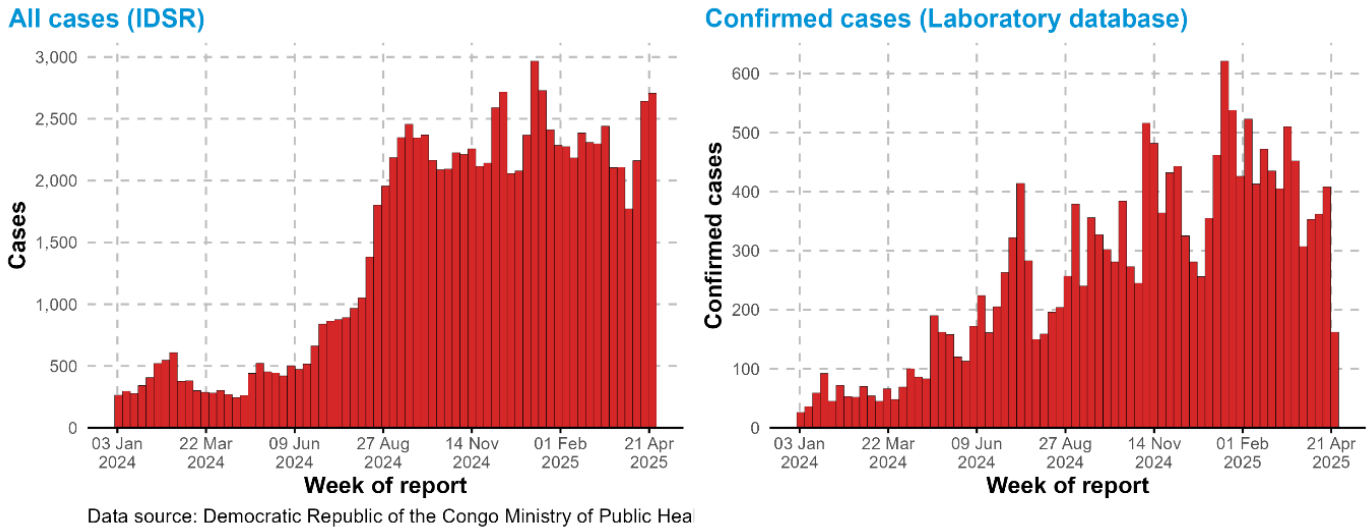
Figure 4. Geographic distribution of clade Ia and Ib MPXV in the Democratic Republic of the Congo, by province, from 1 October 2023 to 3 March 2025[12]



The analysis of the epidemic trend of reported suspected mpox cases (left, Figure 5) shows that there was a notable rising trend in the second half of 2024, and the number of suspected cases reported per week has remained at a high level, ranging from 2000 – 3000 cases per week since then. The trends in reported confirmed cases (right, Figure 5) 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 6).

[11,12] This is the most recent complete epidemiological week for which subnational genomic sequencing data are available.

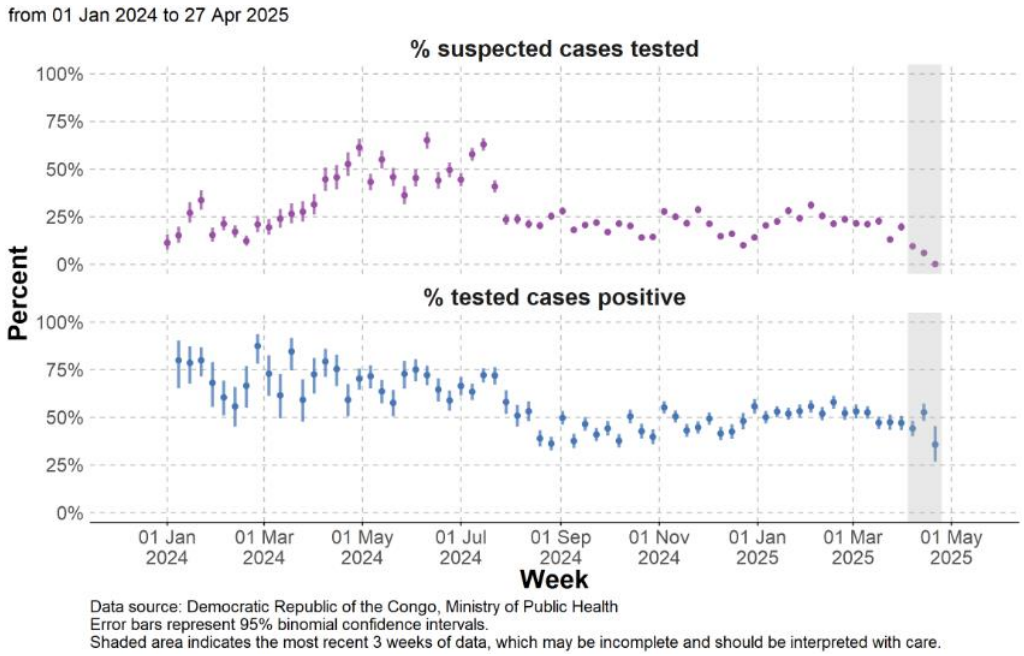
Figure 5. Epidemic curve of suspected (left) and confirmed (right) mpox cases reported in the Democratic Republic of the Congo, 1 January 2024 – 27 April 2025[12].



In Figure 6 the sampling proportion is calculated by dividing the number of cases from whom clinical specimens were taken (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 on an overall downward trajectory during 2025 (right, Figure 5), the test positivity has remained stable at about 50% during the same period (bottom, Figure 6). 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 (with a true decline in cases, it would be expected that a higher proportion of suspected cases would be discarded following a negative test). This is also corroborated by the decline in the proportion of suspected cases tested since mid-2024 (top, Figure 6) followed by a steady 25% of suspected cases tested since then, suggesting that field based clinical surveillance and laboratory testing were both accelerated with greater expansion of field surveillance compared to testing capacity. 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.

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

Figure 6. 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 – 27 April 2025[13, 14]



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 7).

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 2025 should be interpreted with caution given the impact of the escalation of conflict in the province during this time on surveillance and response activities. With regards to 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. That notwithstanding, the trends in suspected cases in North Kivu have remained relatively stable in recent weeks. In Tanganyika province, there has been a recent surge in the number of suspected cases reported, attributed to intensified surveillance and active case search activities carried out over the past few weeks.

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 Sankuru, like in Tanganyika, the recent spike in suspected cases occurred in the context of intensified surveillance and active case search activities, suggesting that there has likely been under-detection of cases in both provinces. 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.

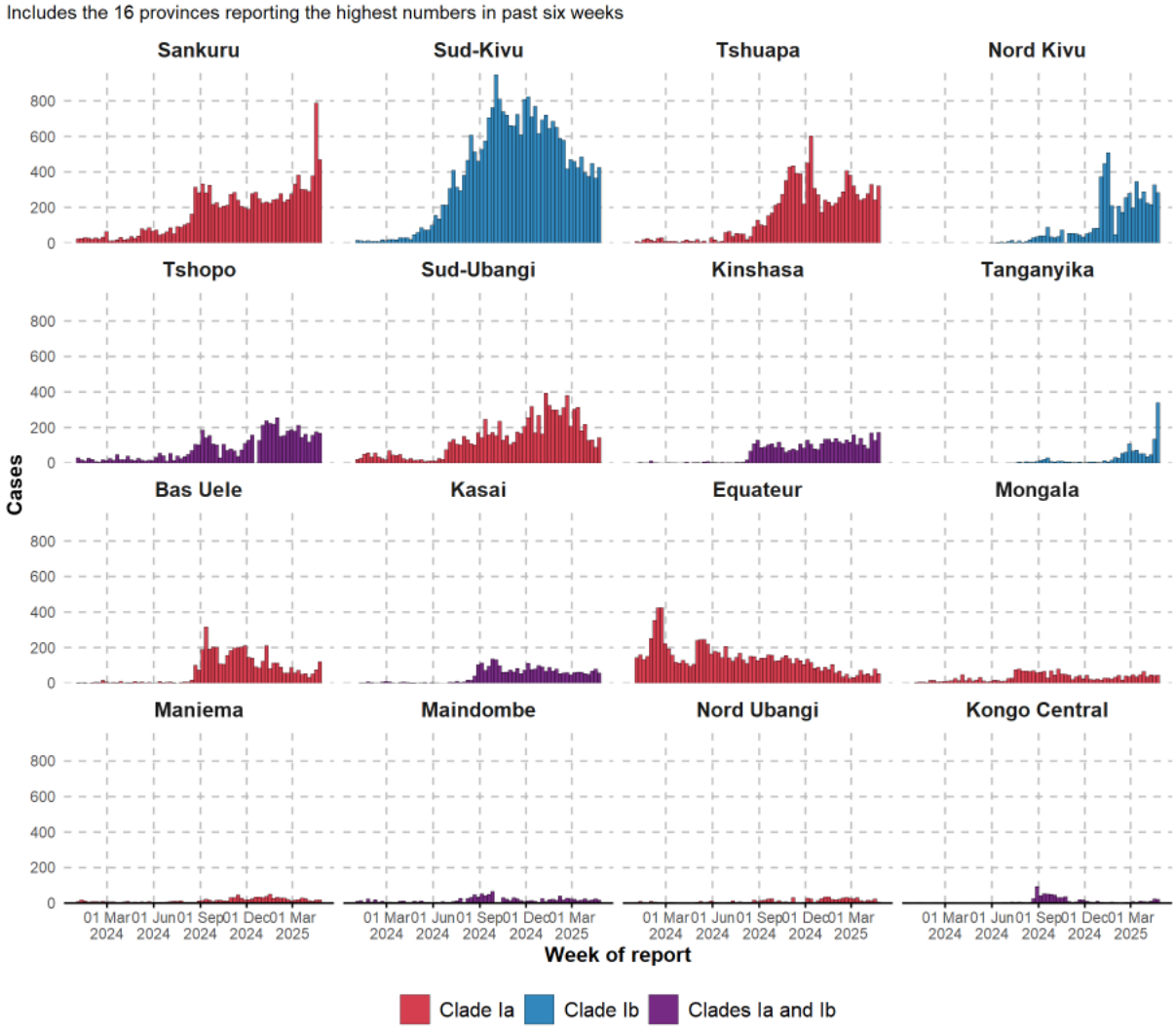
[13] Test positivity estimates are based solely on national laboratory line list data. Wider confidence intervals indicate smaller sample sizes or more variable positivity.

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

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.

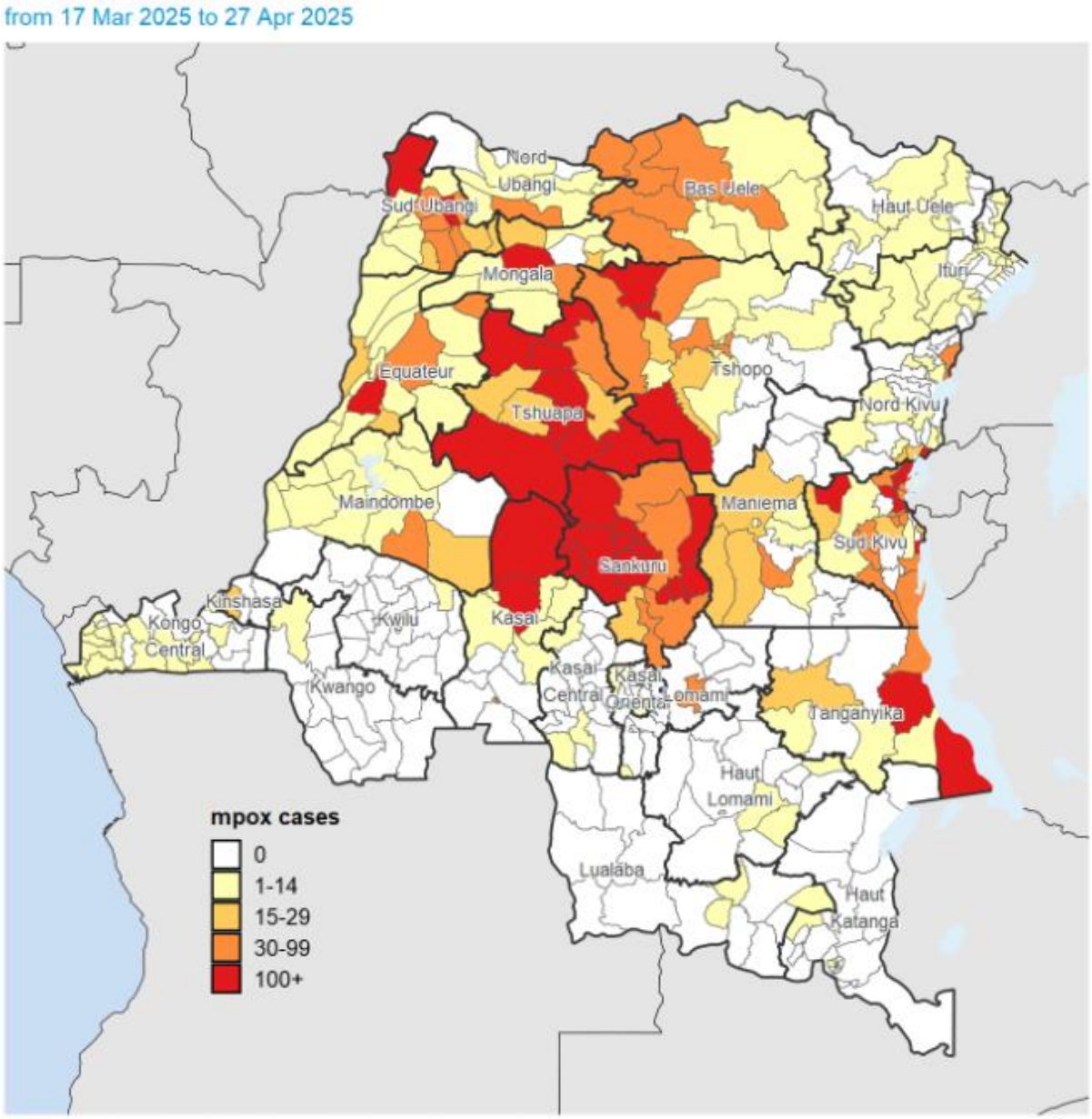
Figure 7. Epidemic curve of reported suspected mpox cases in the most affected provinces of the Democratic Republic of the Congo, 1 January 2024 – 27 April 2025[15]



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 8) shows a 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 suspected cases, although the virus is also affecting large areas in eastern and south-eastern provinces.

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

Figure 8. Geographic distribution of suspected mpox cases in the past six weeks, by health zone, in the Democratic Republic of the Congo, 3 March – 27 April 2025[16]



Data source: Democratic Republic of the Congo Ministry of Public Health
Data shown for all cases, via syndromic surveillance system.

[16] 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 have reported community transmission 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 1). The remaining 13 countries of a total of 29 countries that have ever reported cases of mpox due to clade Ib MPXV are not included and can be considered to be in the control phase of their outbreaks, if surveillance is deemed to be adequate.

Table 1. Countries reporting active clade Ib MPXV outbreaks, according to confirmed cases reported to WHO, as of 8 May 2025

Country	Cases since January 2024	Cases in past six weeks	Transmission status	Additional notes
Democratic Republic of the Congo	21 649	1610	Community transmission	
Uganda	5942	1307	Community transmission	
Burundi	3883	185	Community transmission	
Rwanda	114	1	Community transmission	
Kenya	97	36	Community transmission	
Zambia	64	37	Community transmission	
Congo	59	9	Community transmission	
United Republic of Tanzania	41	14	Community transmission	
South Sudan	11	4	Community transmission	
Malawi	6	6	Community transmission	
The United Kingdom	12	1	Cases linked to travel	
Germany	10	2	Cases linked to travel	
Thailand	5	1	Cases linked to travel	
France	3	1	Cases linked to travel	
United Arab Emirates	2	1	Cases linked to travel	
Switzerland	1	1	Cases linked to travel	

Note:

- *Imported cases are updated as of 8 May 2025 whereas case counts for countries classified as community transmission are updated as of 4 May 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.*

Additional cases of mpox due to clade Ib MPXV reported in India

On 4 May 2025, India retrospectively reported nine additional cases of mpox due to clade Ib MPXV to WHO, detected during the period from December 2024 to March 2025. These additional cases reported brought the country's cumulative case count to 10 cases.

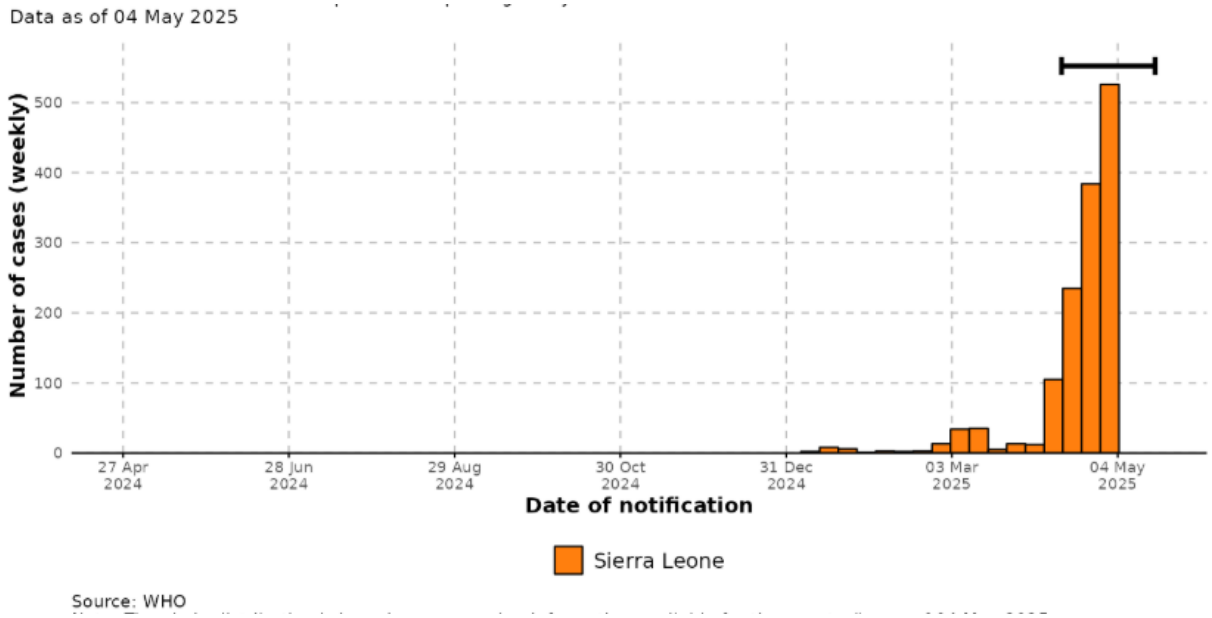
All these nine cases either reported a recent history of travel to countries in the Gulf or reported high-risk contact with travellers from those countries. All cases were adults, and eight out of nine cases were males. No epidemiological links have been reported among these cases.

Since the last of these cases was detected in March 2025, over six weeks before the publication of this edition of the situation report, the country is not considered to be experiencing active clade Ib MPXV transmission and is regarded as being in the control phase of its outbreak.

Epidemiological situation in Sierra Leone

Sierra Leone is facing a large mpox outbreak, with a cumulative total of 1387 confirmed cases, including 10 deaths (CFR: 0.7%), reported since the first case was identified in early January 2025. Over the last four weeks, there has been an unprecedented surge in cases in the country, with more than 500 new confirmed cases reported during last week alone (Figure 9),

Figure 9. Epidemic curve of confirmed mpox cases in Sierra Leone, 27 April 2024 – 4 May 2025



All regions of the country have reported at least one confirmed case, with the Western Area Urban and Western Area Rural regions (including the capital Freetown) being the most affected, reporting 90% of confirmed cases. The distribution of cases by sex is even, with 52% of confirmed cases reported among males. Most cases have been reported among those aged 35 – 39 years, followed by those aged 25 – 29 years and those aged 30 – 34 years. Although limited information is available about modes of transmission in the country, available demographic data suggest that sexual contact transmission among adults in urban settings is the most likely driver of the outbreak.

Genomic sequencing of samples collected earlier in the outbreak identified clade IIb MPXV and efforts are underway to carry out genomic sequencing for more recent samples collected during this surge.

From 28 April to 5 May, the Africa continental mpox Incident Management Support Team (IMST) jointly led by WHO and the Africa Centres for Disease Control and Prevention (CDC) deployed a mission team

to Sierra Leone to provide on-the-ground technical support, assess effectiveness of the national response and support planning for the next phase of outbreak response.

The mission team observed that the country is implementing a full-scale response, activating Incident Management Teams (IMTs) at the national and district levels to coordinate the response to the mpox emergency. The affected districts report on the outbreak situation daily and the situation reports are being disseminated. Most clinical specimens collected are tested within 48 hours, and the country is expanding sequencing capacity. Vaccination of at-risk groups, as reported in the next section, is ongoing.

The mission team also observed several major challenges, some of which included the high test positivity in suspected cases tested of above 70% – suggesting limited surveillance sensitivity, the high number of active cases isolated at home due to limited isolation capacity in health facilities, and the low level of mpox transmission investigation and contact tracing. With the high number of reported and active cases and challenges with adequate isolation and infection prevention and control (IPC) measures, in health facilities as well as in the community, the country is facing the most rapidly growing mpox epidemic and is among the top three countries with the highest number of confirmed cases globally in recent weeks.

Having assessed the status of mpox response operations and identified the key gaps and challenges, the mission team supported the national authorities in refining strategies to align them with the updated Mpox Continental Response Plan 2.0, provided technical support in the identification and prioritization of interventions to address the challenges faced, and supported planning for resource mobilization to facilitate these interventions.

Mpox vaccination in the African Region

As of 5 May 2025, seven African countries have initiated mpox vaccination, all using MVA-BN vaccine. A total of 668 039 doses have been administered during the current outbreak response. Notably, 87% 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 onwards), 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 being adapted to the context even further and microplanning is ongoing in several provinces. 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 62 021 vaccine doses have been administered. 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, 11 061 doses have been administered (9921 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, 2807 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 (like people living with HIV).
- **Liberia:** Since 16 April 2025, 1 895doses 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. Vaccination activities have been paused since no cases have been reported in the last weeks.

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 8 May 2025.**

1. Emergency coordination

- WHO and Africa CDC coordination for mpox response in Africa continues through the Continental Incident Management Support Team.
- Preparations are underway for the fourth meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox, scheduled for 5 June 2025.
- WHO work in health emergencies and a report on the implementation of the IHR (including the Director-General's standing recommendations on mpox) will be discussed at the Seventy-eighth World Health Assembly, scheduled to run from 19 – 29 May 2025.

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.
- Provision of technical support to the ongoing mpox transmission study being conducted in the Democratic Republic of the Congo.
- Coordination for laboratory diagnostics continues, with all partners supporting countries and across the three levels of the WHO, through the laboratory response pillar of the Africa continental Incident Management Support Team and monthly diagnostic consortium meetings.
- Field evaluation of six antigen rapid diagnostic tests (RDTs) for mpox is ongoing in the Democratic Republic of Congo with the support of WHO. Once participant recruitment is completed, testing of the RDTs will commence.
- 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

- Ongoing coordination across multiple technical areas including risk communication and community engagement, infodemic management, community-based infection prevention and control. Community service delivery, public health and social measures, border health and mass gatherings, animal human interface and multisectoral action for social and economic protection.

- Operational support tools for implementing Interim guidance on social and behavioural research for the mpox public health response, March 2025 have been field-tested and are being updated based on the results from the field-testing process.
- WHO has supported the enrolment and engagement of new members in the HIVE community of practice for community protection partners, following the EPI-WIN webinar on Evidence for impact: advancing community-centered responses to mpox held in April 2025.
- An EPI-WIN webinar – Empowering Community Health Workers (CHWs) through capacity strengthening for outbreak detection and response: lessons from the field – was held on 30 April 2025, highlighting an innovative training package for community health workers (CHWs) that integrated outbreak detection and response with risk communication, mental health and psychosocial support, infection prevention and control, and community coordination. The package is unique in integrating multiple areas of health emergency response for community health workers.

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/Water, sanitation and hygiene (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.
- WHO has published a document on strengthening hand hygiene practices in community settings and health-care facilities in the context of mpox. It serves as a call to action for member states to prioritize hand hygiene across communities and healthcare facilities, protect public health, and break the chain of mpox transmission.

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, 70 manufacturers have contacted WHO and 41 pre-submission calls had been scheduled as of 7 May 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, 1 265 280 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), several of which are implementing a

single-dose strategy. Other countries seeking vaccine allocations are preparing national mpox vaccination plans.

- WHO published interim guidance on the use of LC16m8 vaccine and training modules with the aim to support the Democratic Republic of the Congo in planning the deployment of LC16m8 vaccine doses.
- WHO, UNICEF and the International Federation of Red Cross and Red Crescent Societies (IFRC) have published guidance on how to achieve and sustain high uptake of mpox vaccination in outbreak settings.
- 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

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  - 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
Global
Moderate

Confidence in available information
Global
Moderate

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

Confidence in available information
Moderate
Moderate
Moderate
Moderate

**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[17] *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.**

[17] 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.