

Mpox

Multi-country external situation report no. 53 published 29 May 2025

KEY FIGURES				
Reporting period: 1 January 2022 – 30 April 2025				
Area	Number of reported confirmed cases		Number of deaths among confirmed cases	Number of reporting countries
Global	142 151		328	133
Reporting period: 1 January 2024 – 18 May 2025				
Area	Number of reported confirmed cases		Number of deaths among confirmed cases ¹	
	2024	2025	2024	2025
Africa	19 117	17 193	51	72
Democratic Republic of the Congo ²	14 176	8084	27	22
Uganda	1352	4972	13	28
Sierra Leone	0	2648	0	14
Burundi	2946	988	1	0
Reporting period: last six weeks, 7 April – 18 May 2025				
Africa	5618		16	
Democratic Republic of the Congo	1598		0	
Uganda	1171		1	
Sierra Leone	2511		12	
Burundi	183		0	

Highlights

- Ten countries in Africa have reported community transmission of mpox due to clade Ib monkeypox virus (MPXV) in the past six weeks.
- The Democratic Republic of the Congo continues to report the highest number of confirmed mpox cases in Africa in 2025, with important information and reporting gaps emerging partly due 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 been reported in Uganda in recent weeks. However, the country continues to experience a large outbreak, reporting close to 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 observed over the past six weeks, with over 600 new confirmed cases reported during the most recent week, highlighting the rising transmission in the country. Currently available data indicate that the outbreak is largely occurring among young

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.

adults in urban contexts, concentrated in and around Freetown. 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. A WHO mission is underway to bolster the outbreak response.

- Australia has reported its first case of mpox due to clade Ib MPXV, linked to travel to Thailand. Thailand has only reported travel-related cases of mpox due to clade Ib MPXV so far.
- This report provides an overview of mpox vaccination in countries in the African Region, where to date more than 720 000 doses of MVA-BN vaccines have been administered in seven countries. Of all doses, 81% have been administered in the Democratic Republic of the Congo, where microplanning is ongoing to optimize use of the limited vaccine supply with targeted vaccination strategies.

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Contextual description

This report provides an update on:

- the global epidemiological situation for mpox with data as of **30 April 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 **18 May 2025**;
- updates on imported cases of mpox due to clade I MPXV as of **21 May 2025**;
- operational response updates as of **23 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 the 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 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

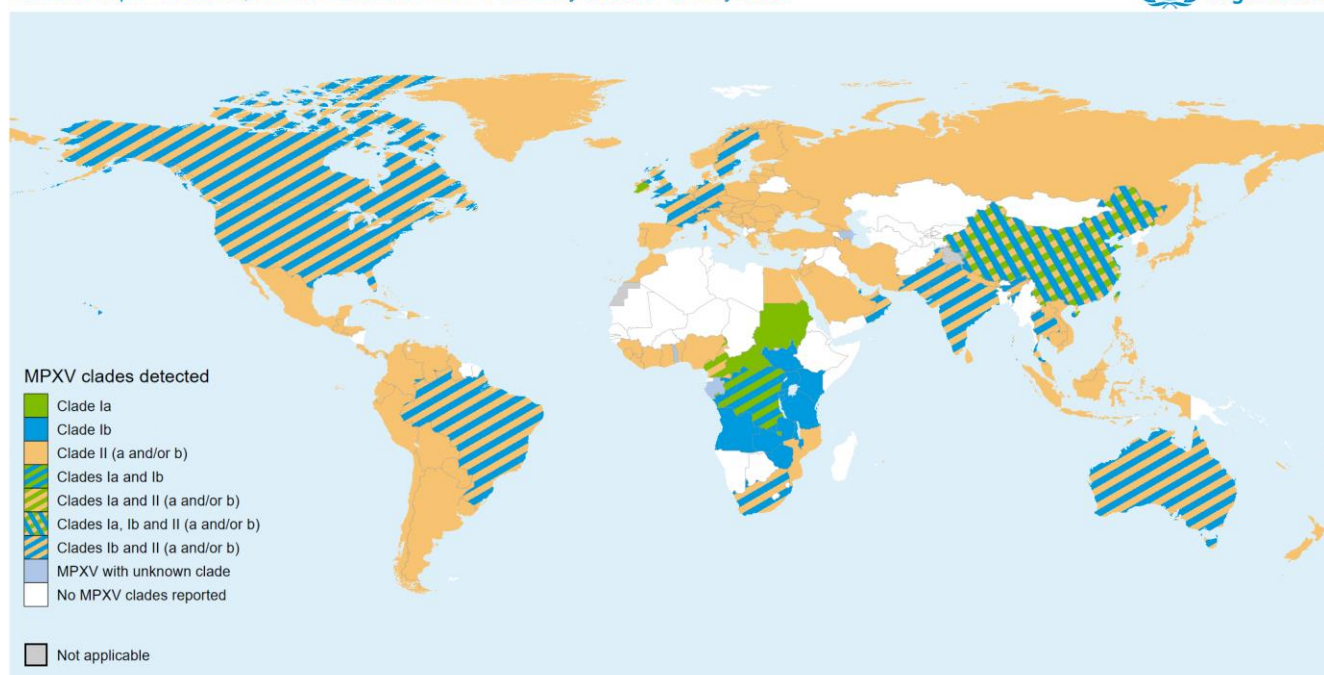
As of 18 May 2025, the distribution of reported MPXV clades by country of detection is shown in Figure 1. This information is compiled from genome sequencing conducted and reported via different sources, including open-access databases, peer-reviewed publications, reports and direct communication to 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 30 countries (Figure 1). Eighteen of these countries have only ever reported 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. Twelve countries have ever reported community transmission of this clade, 10 countries of which were still experiencing community transmission during the last six weeks.

Figure 1. Geographic distribution of MPXV clades reported to WHO, by country, 1 January 2022 to 18 May 2025⁵.

MPXV clades detected globally

Includes imported cases; known distribution from 1 January 2022 to 18 May 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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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.

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.

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 phase⁶.

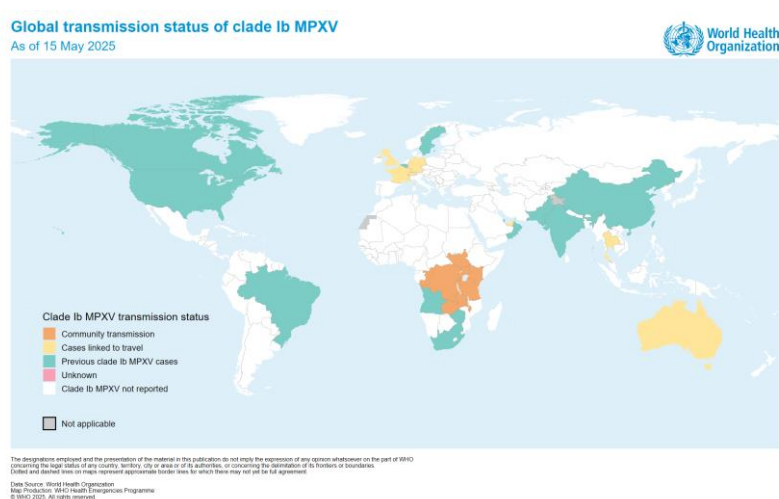
Unknown transmission dynamics, if insufficient information is available to determine if cases are due to community transmission or linked to travel.

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 have not reported any cases within the past six weeks include Angola, South Africa and Zimbabwe.

Outside Africa, 17 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), 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), Australia, 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, please refer to 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 15 May 2025.



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>

Overview of mpox outbreaks by virus clade⁷

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.

⁷ The geographical distribution of MPXV clades described in this overview is based on sequences from clinical samples of confirmed mpox cases. Sequences from wastewater and environmental samples are excluded from this overview.

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 Taï 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 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, neighbouring countries, 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 April 2025**. Further details on global trends can be found on the [online WHO dashboard](#).

From 1 January 2022 through 30 April 2025, a total of 142 151 confirmed cases of mpox, including 328 deaths, were reported to WHO from 133 countries/territories/areas (hereafter 'countries') in all six WHO Regions (Table 1). The global CFR among confirmed cases during this period is 0.2%.

A total of 3915 new confirmed cases were reported in April 2025, a 12.5% decline from the previous month. Most cases in April 2025 were reported from the African Region (88.7%), followed by the European Region (7.5%) and the Region of the Americas (2.3%). The South-East Asian Region and the European Region reported a monthly increase in cases for April 2025, compared to March 2025, with increases of 83% and 1.7% respectively. On the other hand, the Region of the Americas, the Eastern Mediterranean Region, Western Pacific Region, and the African Region reported declines in cases in April 2025, by 72%, 57%, 48%, and 7.7% respectively.

Table 1. Number of cumulative confirmed mpox cases and deaths reported to WHO, by WHO Region, from 1 January 2022 through 30 April 2025⁸.

WHO Region	Total confirmed cases	Total deaths among confirmed cases	New cases reported in March 2025	New cases reported in April 2025	Monthly change in cases (%)
Region of the Americas	68 840	152	322	90	-72.0
African Region	35 833	135	3758	3470	-7.7
European Region	29 898	9	288	293	1.7
Western Pacific Region	5645	15	93	48	-48.0
South-East Asia Region	1028	14	6	11	83.0
Eastern Mediterranean Region	907	3	7	3	-57.0
Total	142 151	328	4474	3915	-12.5

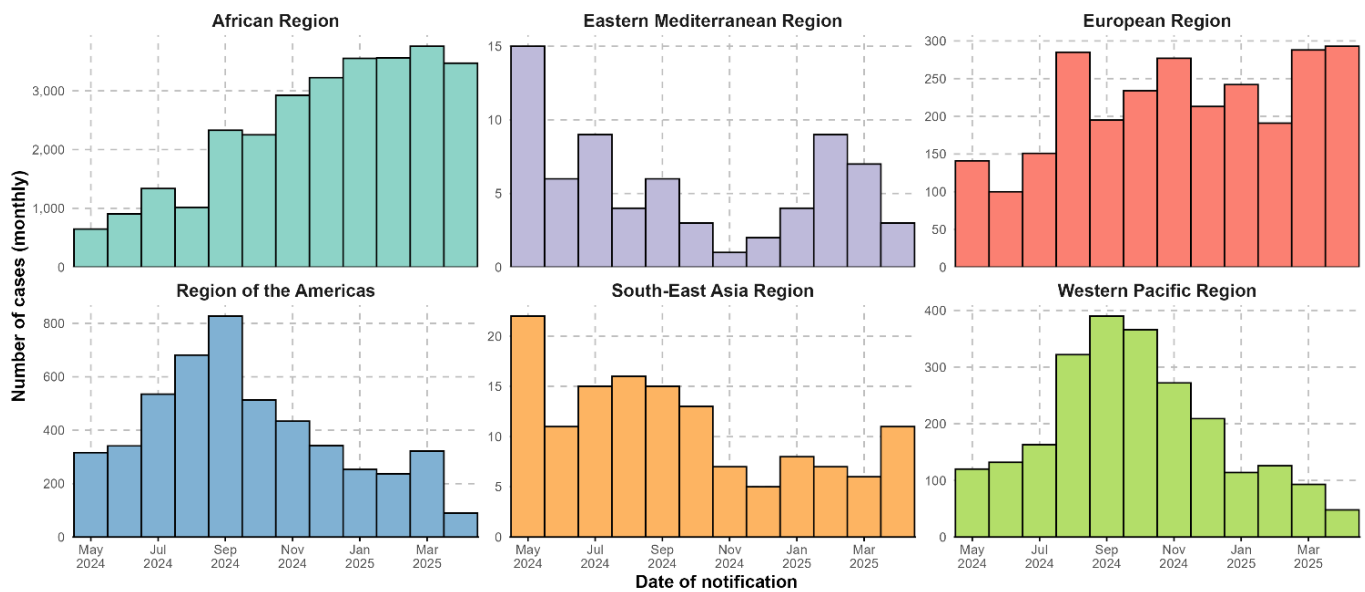
Figure 3 shows that over the past 12 months (1 May 2024 – 30 April 2025), the number of confirmed mpox cases reported monthly in the WHO African Region has steadily plateaued over the last six months. The Eastern Mediterranean and South-East Asia Regions have been reporting the lowest number of cases, with the former observing an upward trend earlier in 2025, 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 over the past two months. 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, a global average of about 3253 confirmed mpox cases per month has been reported. Most of them were reported by the African Region (28 973 confirmed cases), followed by the Region of the Americas (4891 confirmed cases), and the Western Pacific (2355 confirmed cases). Outside Africa, Spain reported the highest number of confirmed cases in April 2025 (93 confirmed cases).

⁸ 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 May 2024 – 30 April 2025.*

data as of 30 Apr 2025



Source: WHO

***Please note that different Y axis scales have been used for the regional epidemic curves to allow a better overview of the trend in each region.**

Laboratory-confirmed cases reported in Africa

In Africa, from 30 December 2024 to 18 May 2025, 17 193 confirmed mpox cases, including 72 deaths (CFR – 0.4%), have been reported by 19 countries. The most affected country continues to be the Democratic Republic of the Congo (8084 confirmed cases, including 22 deaths)⁹ followed by Uganda (4972 confirmed cases, including 28 deaths)¹⁰, Sierra Leone (2648 confirmed cases and 14 deaths), and Burundi (988 confirmed cases, including no deaths) (Figure 4).

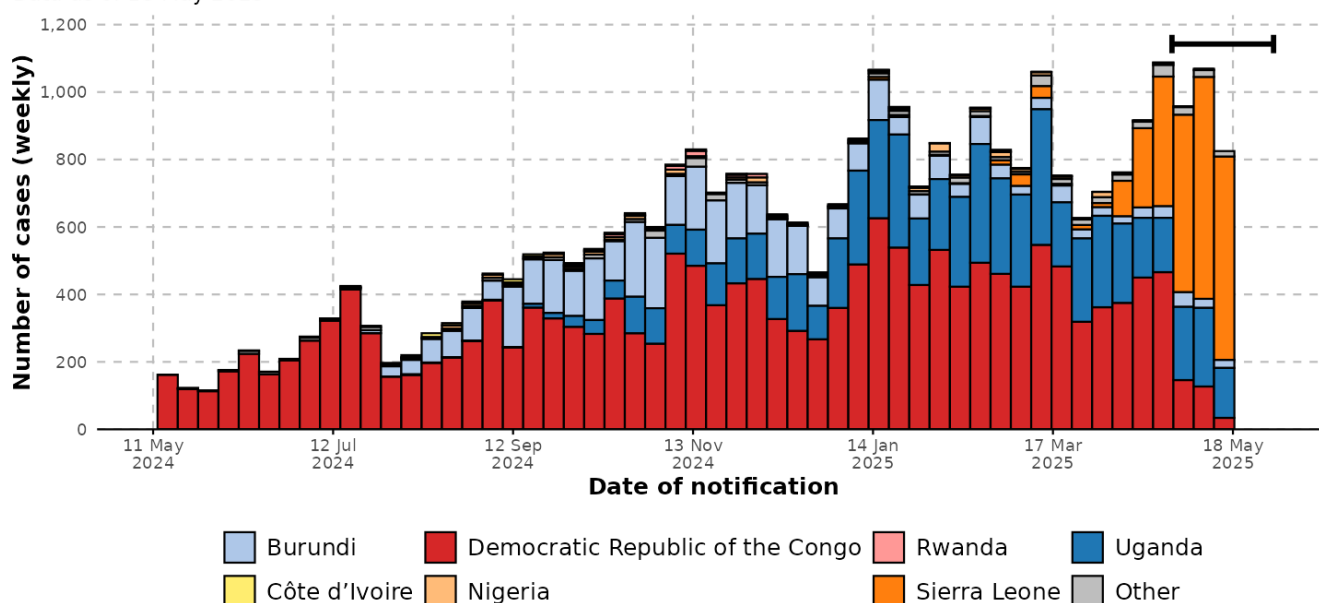
Over recent weeks and based on confirmed cases reported, Sierra Leone, the Democratic Republic of the Congo¹¹, and Uganda continue to experience large mpox outbreaks, with Sierra Leone reporting the highest number of confirmed cases during the last six weeks (2511 confirmed cases), followed by the Democratic Republic of Congo (1598 confirmed cases) and Uganda (1171 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.

This marks the first time Sierra Leone has reported the highest number of confirmed cases in the past six weeks. The abrupt surge in confirmed cases in the country reported in the last edition of this report has continued into its sixth week, with over 600 new confirmed cases 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. Currently available data indicate that the outbreak is largely occurring among young adults in urban contexts, concentrated in and around Freetown.

Figure 4. Confirmed mpox cases in Africa, by country, in the past 12 months, 11 May 2024 – 18 May 2025.

Trends in confirmed mpox cases

Bracket at end of curve indicates potential reporting delays in recent weeks of data.
Data as of 18 May 2025



Source: WHO

Note: The clade distribution is based on sequencing information available for the country/ies as of 18 May 2025

⁹ The national-level case counts for the Democratic Republic of the Congo indicated here are based on the national laboratory database for mpox.

¹⁰ 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.

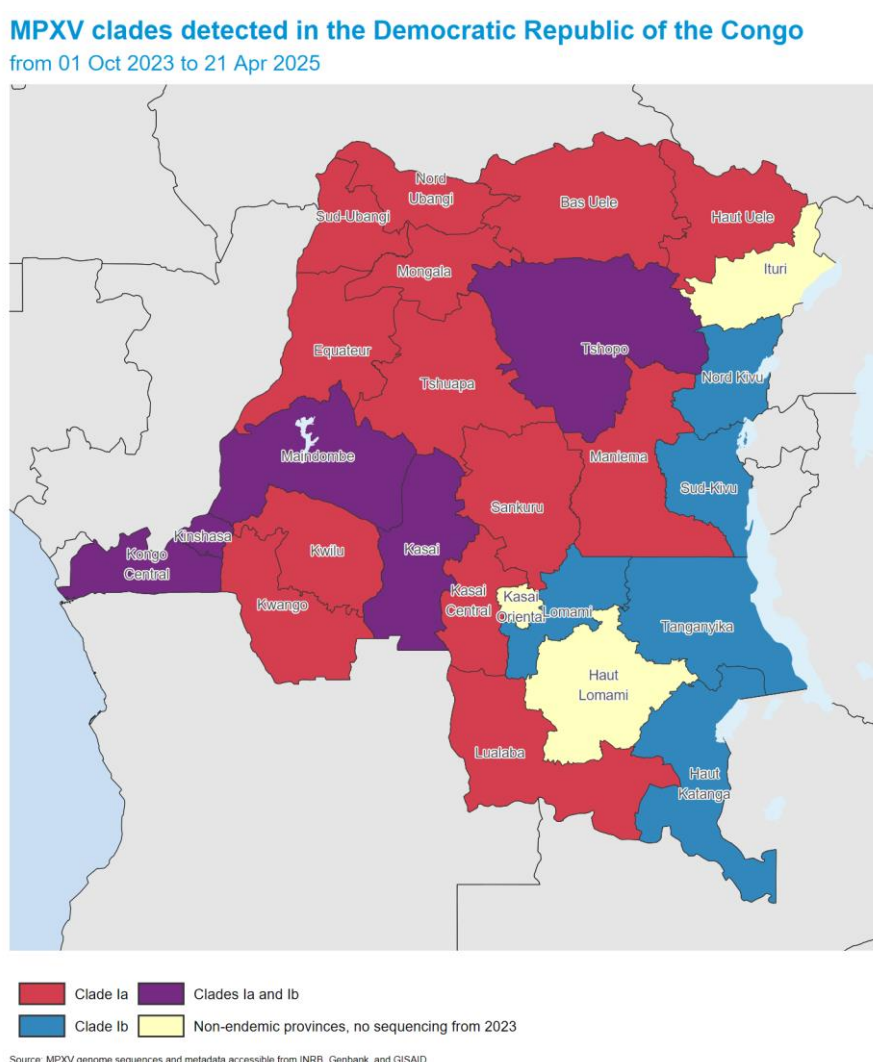
¹¹ This should be interpreted with caution given a reduction in testing and confirmation capacity in the country since the end of January 2025. This is explored further in the next section.

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 21 April 2025¹² 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 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 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 5. Geographic distribution of clade Ia and Ib MPXV in the Democratic Republic of the Congo, by province, from 1 October 2023 to 21 April 2025¹³

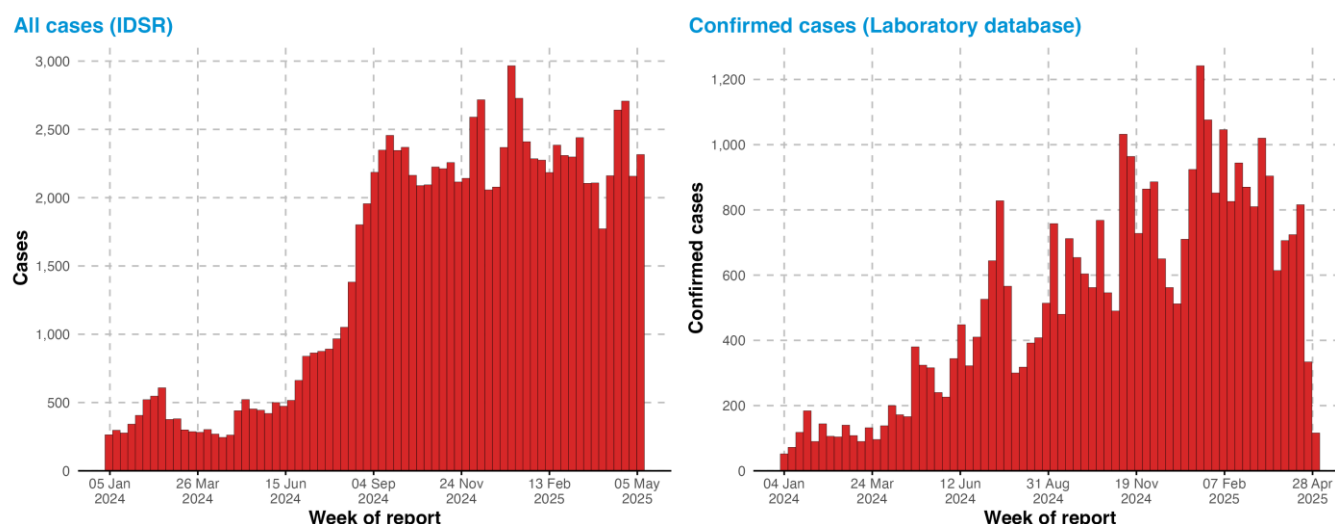


¹² This is the most recent complete epidemiological week for which subnational genomic sequencing data are available.

¹³ This is the most recent complete epidemiological week for which subnational genomic sequencing data are available.

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 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 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).

Figure 6. Epidemic curves of suspected (left) and confirmed (right) mpox cases reported in the Democratic Republic of the Congo, 1 January 2024 – 11 May 2025¹⁴.



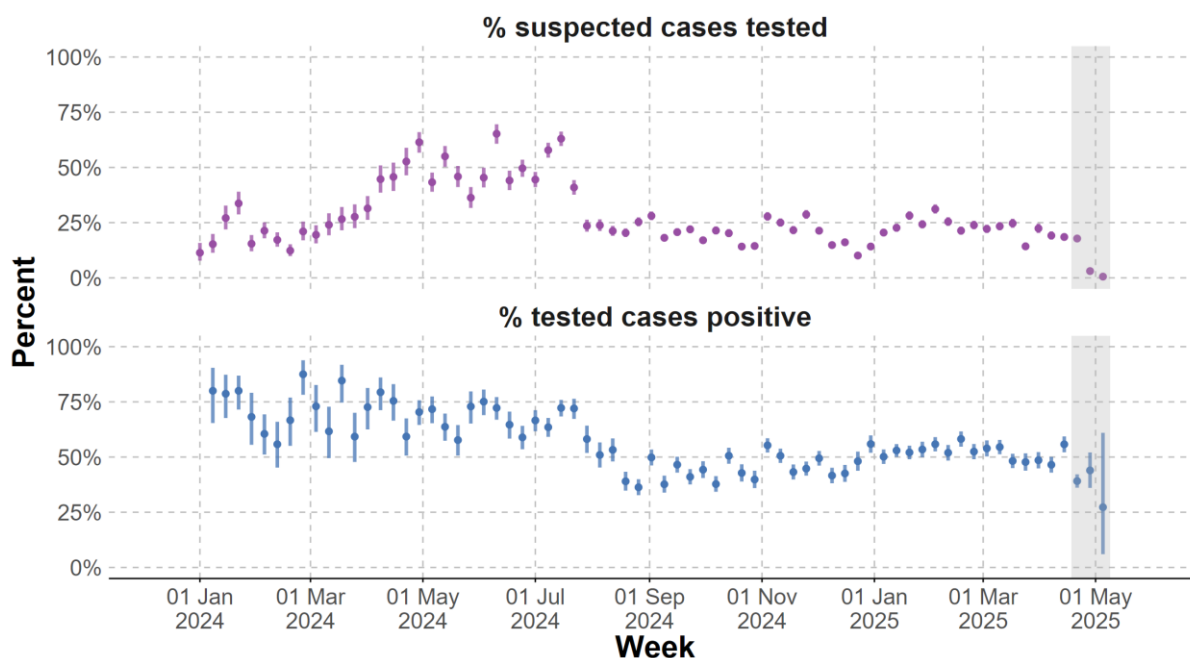
In Figure 7 the sampling proportion is calculated by dividing the number of cases from whom clinical specimens were taken (as recorded in the national laboratory line list) by the number of suspected cases reported through the syndromic surveillance system. This metric combines data from two distinct 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 6), the test positivity has remained stable at about 50% during the same period (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 (with a true decline in cases, it would be expected that a higher proportion of suspected cases would be discarded following a negative test). 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.

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

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 – 11 May 2025^{15, 16}

% suspected cases tested and % tested cases positive, Democratic Republic of the Congo

from 01 Jan 2024 to 11 May 2025



Data source: Democratic Republic of the Congo, Ministry of Public Health

Error bars represent 95% binomial confidence intervals.

Shaded area indicates the most recent 3 weeks of data, which may be incomplete and should be interpreted with care.

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 about 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 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 surge in the number of suspected cases reported, attributed to an influx of displaced persons fleeing conflict in North and South Kivu.

Among the provinces in which only clade Ia MPXV has been detected, Sankuru has been reporting a rising number of cases in recent weeks. In Sankuru, 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 prior to these activities. In Equateur province, the province historically most affected by mpox in the country, the trend

¹⁵ Test positivity estimates are based solely on national laboratory line list data. Wider confidence intervals indicate smaller sample sizes or more variable positivity.

¹⁶ This is the most recent complete epidemiological week for which subnational data are available.

has been slowly declining over time since a significant outbreak in January 2024, with fewer than 100 suspected cases reported weekly in recent weeks.

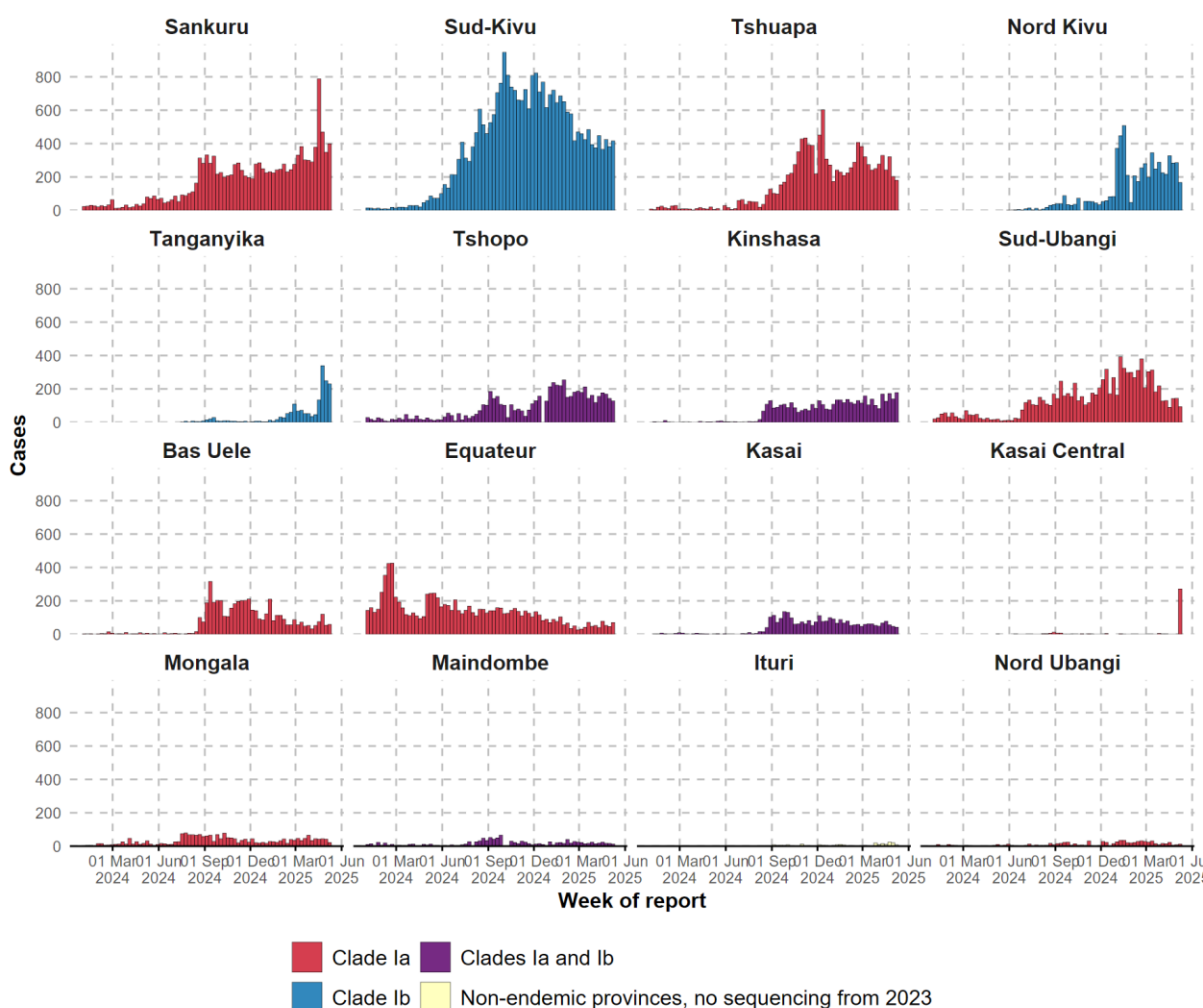
Among provinces in which clades Ia and clade Ib MPXV have been detected, including Kinshasa province, the number of suspected cases reported each week has been relatively stable in recent weeks.

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 – 11 May 2025¹⁷

Trends in all mpox cases by province in the Democratic Republic of the Congo

Includes the 16 provinces reporting the highest numbers in past six weeks

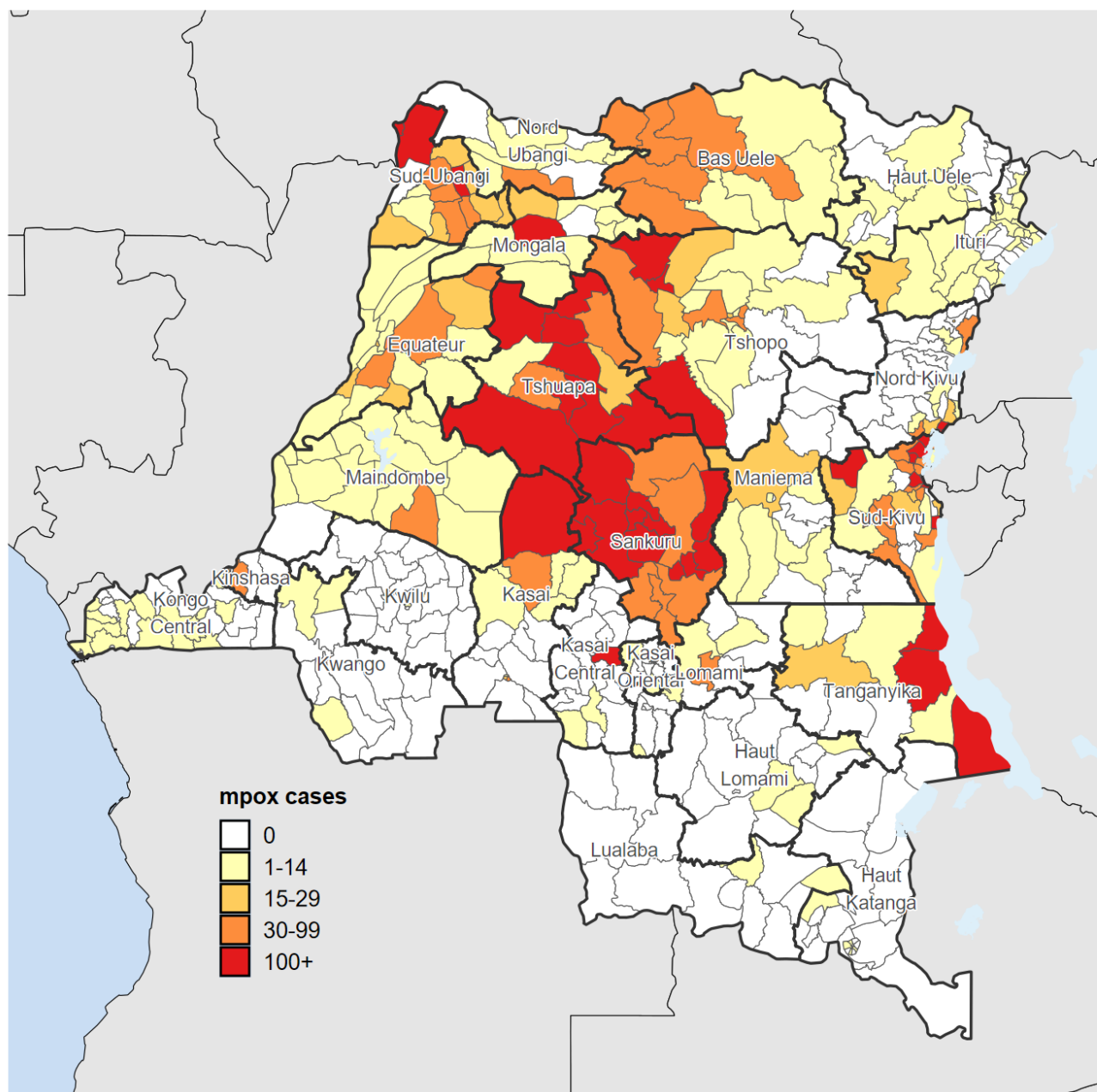


Data source: Democratic Republic of the Congo Ministry of Public Health
Data shown for all cases, via syndromic surveillance system.

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 a wide distribution of 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, and the virus is also affecting large areas in eastern and south-eastern provinces.

¹⁷ This is the most recent complete epidemiological week for which subnational data are available.

Figure 9. Geographic distribution of suspected mpox cases in the past six weeks, by health zone, in the Democratic Republic of the Congo, 31 March – 11 May 2025¹⁸



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

¹⁸ 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 2). 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 2. Countries reporting active clade Ib MPXV outbreaks, according to confirmed cases reported to WHO, as of 21 May 2025

Country	Cases since January 2024	Cases in past six weeks	Transmission status	Additional notes
Democratic Republic of the Congo	22 260	1598	Community transmission	-
Uganda	6324	1171	Community transmission	-
Burundi	3934	183	Community transmission	-
Rwanda	119	5	Community transmission	-
Kenya	113	43	Community transmission	-
Zambia	76	40	Community transmission	-
Congo	60	3	Community transmission	-
United Republic of Tanzania	43	9	Community transmission	-
South Sudan	14	6	Community transmission	-
Malawi	10	10	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	-
Australia	1	1	Cases linked to travel	-

Note:

- Imported cases are updated as of 21 May 2025 whereas case counts for countries classified as community transmission are updated as of 18 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.

First case of mpox due to clade Ib MPXV reported in Australia

On 15 May 2025, Australia notified WHO of the first confirmed case of mpox due to clade Ib MPXV detected in the country. The case is an adult male with a recent history of travel to Thailand, where he reported having had high-risk sexual exposure that likely led to infection.

After his return to Australia, he developed symptoms consistent with mpox and sought medical attention. Testing of laboratory samples collected confirmed MPXV infection, and genomic sequencing analysis revealed clade Ib MPXV.

Upon confirmation, the local public health authorities advised the patient to isolate at home and maintained regular follow-up and monitoring. The case investigation which followed identified no close contacts in Australia. Considering the rapidly initiated surveillance and response measures and findings of the case investigations, further local and international spread in relation to this case are considered unlikely.

However, since all five confirmed cases reported in Thailand have so far been travel-related, this suggests potential undetected clade Ib MPXV transmission in high-risk sexual networks in Thailand. The Australia public health authorities have notified the Thailand public health authorities and investigations are underway in Thailand to identify the source of infection.

Mpox vaccination in the African Region

As of 20 May 2025, seven African countries have initiated mpox vaccination using MVA-BN vaccine. have been administered during the current outbreak response. Notably, 81% 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 586 199 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 72 060 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, 12 518 doses have been administered. 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, 39 655 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 (such as people living with HIV).
- **Liberia:** Since 16 April 2025, 2155 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. 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 23 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 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) were presented to the [Seventy-eighth World Health Assembly](#), which ran from 19 – 27 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](#).
- 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

- Coordination across multiple technical areas including risk communication and community engagement, infodemic management, community-based infection prevention and control is ongoing. Community service delivery, public health and social measures, border health and mass gatherings, animal human interface and multisectoral action for social and economic protection are key areas of work.
- WHO held a second community of practice call, engaging Member States, operational partners, civil society and academia to explore the use of community data and evidence in health-decision making in mpox public health response.

4. Safe and scalable care

- 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, and writing and finalization of cascade training materials.
- WHO and Africa CDC jointly held a webinar on 20 May 2025 focused on shaping the future of mpox supportive care. The webinar provided insights on what's working and what's not working with regard to supportive care for mpox patients and explored what should be done to close the gaps in evidence for optimized mpox supportive care. Webinar participants provided feedback on what should be prioritized for the next phase of the clinical management guidelines for mpox.
- 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.

5. Access to and delivery of countermeasures

Access and Allocation Mechanism (AAM)

Diagnostics:

- As of 21 May 2025, [two additional MPXV diagnostics, namely EasyNAT Monkeypox Virus Assay and PortNAT Monkeypox Virus Test manufactured by UStar Biotechnologies Ltd](#), have been included in the [Emergency Use Listing](#) for monkeypox virus in vitro diagnostics / nucleic acid amplification test. Since the call for expressions of interest under the WHO Emergency Use Listing procedure for MPXV diagnostics on 28 August 2024, 71 manufacturers have contacted WHO and 41 pre-submission calls have been scheduled. A total of 14 manufacturers were invited to submit their applications for 16 nucleic acid amplification assays.
- To date, the WHO has listed [six products under the Emergency Use Listing](#) procedure, and [nine products are currently under assessment](#). One application is expected in July 2025.
- WHO held a webinar on 19 May 2025 to inform new guidance on WHO post-prequalification and post-Emergency Use Listing listing change applications for in vitro diagnostics. Revised guidance, the application form for reporting changes and the webinar recording have been made [available](#) at [PQ IVD webpage](#).

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, 1 332 280 vaccine doses have been delivered to eleven 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 recently 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

Mpox outbreak toolkit

- WHO mpox outbreak toolbox, Updated May 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>
- Mpox Continental Response Plan 2.0. Updated 15 April 2025. <https://africacdc.org/download/mpox-continental-response-plan-2-0/>
- Mpox response deployments by WHO, GOARN, and standby partners, 12 March 2025. <https://mpox-who-goarn-deployment-dashboard-who.hub.arcgis.com/>
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- Strategic framework for enhancing prevention and control of mpox (2024-2027). May 2024. Available at: <https://www.who.int/publications/i/item/9789240092907>
- Accountability to affected people: handbook on implementation in emergency response, 2025. <https://iris.who.int/handle/10665/380478>
- Responding to the global mpox outbreak: ethics issues and considerations: a policy brief, 19 July 2023. https://www.who.int/publications/i/item/WHO-Mpox-Outbreak_response-Ethics-2023.1

International Health Regulations Emergency Committee, Review Committee and recommendations of the Director-General

- Statement of the third meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox 2024, 17 March 2025. [https://www.who.int/news/item/17-03-2025-third-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-upsurge-of-mpox-2024](https://www.who.int/news/item/17-03-2025-third-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-upsurge-of-mpox-2024)
 - 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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[general-of-the-world-health-organization-\(who\)-in-accordance-with-the-international-health-regulations-\(2005\)-\(ihr\)](#)

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

- Surveillance, case investigation and contact tracing for mpox: Interim guidance, 6 December 2024. <https://www.who.int/publications/i/item/B09169>
- 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))
- WHO Go.Data: Managing complex data in outbreaks. <https://www.who.int/tools/godata>
- Technical Guidelines for Integrated Disease Surveillance and Response in the African Region: Third edition, March 2019. <https://www.afro.who.int/publications/technical-guidelines-integrated-disease-surveillance-and-response-african-region-third>

Laboratory and diagnostics

- Reportable changes to WHO prequalified and emergency use listed in vitro diagnostics: Application guidance https://extranet.who.int/prequal/sites/default/files/document_files/In%20draft_PQDx_121_v01_Changes%20to%20PQ-ed%20IVDs%20Guidance_vfinal.pdf, 19 May 2025
- Reportable changes application form for WHO prequalification and emergency use listed in vitro diagnostics: <https://extranet.who.int/prequal/key-resources/documents/change-request-form-reportable-changes-who-pq-and-eul-ivds-pqdx119-march>, 19 May 2025
- Webinar recording of the new guidance on WHO post-prequalification and post-EUL listing change applications for IVDs, (Passcode: **7YK=s?3=**) https://who.zoom.us/rec/share/omC-19wYnD1iXMZtP_qbYNmvfEMNBzsMLxL4cuSqEhpVrgoksqf2nLfrUw1IZhKS.VcSuOwaoh6vk1Iir, 19 May 2025
- Two additional MPXV tests listed by WHO under the Emergency Use Listing procedure, 14 May 2025. <https://extranet.who.int/prequal/news/two-additional-mpxv-tests-listed-who-under-emergency-use-listing-procedure>
- Integration of HIV and syphilis testing services as part of mpox response: standard operating procedures, 11 March 2025. <https://www.who.int/publications/i/item/9789240107229>
- Risk evaluation of clade Ia monkeypox virus: Review of evidence as of 10 December 2024. <https://www.who.int/publications/m/item/risk-evaluation-of-clade-1a-monkeypox-virus-review-of-evidence-as-of-10-december-2024>
- Risk evaluation of clade Ib monkeypox virus: Review of evidence as of 10 December 2024. <https://www.who.int/publications/m/item/risk-evaluation-of-clade-1b-monkeypox-virus-review-of-evidence-as-of-10-december-2024>
- Diagnostic testing and testing strategies for mpox: interim guidance, 12 November 2024. [B09166-eng.pdf](#)

- 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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https://extranet.who.int/prequal/sites/default/files/document_files/RADIONE%20Mpox%20Detection%20Kit%20%28MPXV-13227-214-00%20%29%20Public%20Report.pdf
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- Mpox Q&A on mpox testing for health workers, 11 December 2023. <https://www.who.int/news-room/questions-and-answers/item/testing-for-mpox--health-workers>

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- Strengthening hand hygiene practices in community settings and health-care facilities in the context of mpox, 1 May 2025. <https://www.who.int/publications/i/item/B09396>
- Health Emergencies – Infection prevention and control and water, sanitation and hygiene. <https://www.who.int/teams/health-care-readiness/infection-prevention-and-control>
- Infection prevention and control and water sanitation and hygiene in health facilities during mpox disease outbreaks: rapid assessment tool user guide, 19 February 2025. <https://www.who.int/publications/i/item/9789240105324>
- Risk assessment tool for identifying and managing health and care workers with a potential occupational exposure to monkeypox virus, 30 January 2025. <https://www.who.int/publications/m/item/risk-assessment-health-workers-mpox>
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 - Posters on screening [?sfvrsn=3893b9b2_3&download=true](https://cdn.who.int/media/docs/default-source/ipc---wash/mpox-screening-form-for-healthcare-facility-entrances.pdf?sfvrsn=3893b9b2_3&download=true)
- Posters for health and care workers.
 - [Steps to put on PPE for mpox](#) (16 August 2024)
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Vaccination

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- Infection prevention and control and water, sanitation and hygiene measures during mpox vaccination activities, 19 February 2025. <https://www.who.int/publications/i/item/B09203>

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Training and education

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- OpenWHO. Mpox and the 2022-2023 global outbreak (2023)
 - English: <https://openwho.org/infectiousdiseases/503162/Mpox>
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- Adverse Event Following Immunization (AEFI) causality assessment software: <https://gvsi-aeftools.org/>
- eLearning courses on vaccine safety monitoring <https://who.csod.com/selfreg/register.aspx?c=aeft%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
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 context¹⁹ 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**.

¹⁹ 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.