MPOX, MULTI-COUNTRY

Date and version of current assessment: 02 September 2025, v5
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Overall risk and confidence

Overall Public Health risk
Global
Moderate

Confidence in available information
Global
Moderate

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

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 are epidemiologically distinct.*

Note: For MPXV naming conventions and a more detailed description of the risk groups, please refer to Annex 1.

Overall Global Risk statement

This global rapid risk assessment (RRA) aims to evaluate the current public health risk associated with the 2024 upsurge of mpox in the Democratic Republic of the Congo (DRC) and other countries in Africa, with a focus on updates since the previous RRA in June 2025.

Global Overview

As of 31 July 2025, the monkeypox virus (MPXV) continues to spread globally, causing both localized and extended outbreaks driven by various MPXV clades (Ia, Ib, IIa, and IIb) in diverse settings. From 1 January 2022 to 31 July 2025, 138 countries and territories across all WHO regions have reported 158 425 confirmed cases, including 399 deaths (Case Fatality Ratio [CFR] – 0.3%). This marks an increase of five additional reporting countries (Ethiopia, Gambia, Guinea Senegal, and Togo), along with an additional 16 274 confirmed cases and 71 deaths (as of 31 July 2025) since the last RRA.

Clade Ib MPXV

Since August 2024, when the public health emergency of international concern (PHEIC) was declared, and as of 24 August 2025, clade Ib MPXV has spread beyond Democratic Republic of the Congo (DRC), where it was first detected, to 33 other countries globally. Twelve countries, all located in central, eastern, and southern Africa, were reporting community transmission as of 24 August 2024, with DRC (29 070 confirmed cases, including 58 deaths; CFR – 0.2%), Uganda (7 905 confirmed cases, including 48 deaths; CFR – 0.6%), and Burundi (4 384 confirmed cases, including one death; CFR – 0.02%) still reporting the highest burden of confirmed cases, both since 1 January 2024 and in the last six weeks. Cases in DRC are a mix of clade Ia and clade Ib MPXV, and the CFR in the areas most affected by clade Ib MPXV is reported to be 0.2%.

All the three countries (DRC, Uganda, and Burundi) with the highest burden of confirmed cases have observed a sustained downward trend in confirmed cases in recent months. DRC is reporting about 200 confirmed cases per week, down from over 800 confirmed cases per week at the outbreak peak – with downward trends also reported in clade Ib MPXV-affected areas. Uganda is reporting under 100 confirmed cases per week, down from about 400 confirmed cases per week at the outbreak peak, and Burundi is reporting under 50 confirmed cases per week, down from 200 confirmed cases per week at the outbreak peak.

The characteristics of clade Ib MPXV outbreaks in these three high-burden countries have remained largely the same. DRC continues to observe most cases in young children and young adults in clade Ib MPXV-affected areas, and the emerging disproportionate burden in young children first reported in the previous RRA persists. The reasons for this are unclear. Burundi also continues to report most cases among young children and young adults. Uganda continues to report most cases among young adults, reflecting the continued importance of sexual contact as a driver of spread in that context.

Other countries reporting community transmission (Ethiopia, Kenya, Malawi, Mozambique, Republic of Congo, Rwanda, South Sudan, United Republic of Tanzania, and Zambia) have observed relatively smaller outbreaks. These countries have typically reported about 10 or less confirmed cases per week in recent weeks, except Kenya, which is of particular concern, reporting a consistent upward trend that has been sustained throughout 2025 and currently observing over 35 confirmed cases per week, up from less than 10 confirmed cases per week in June 2025. Sexual contact transmission continues to be implicated as a major amplifier of disease spread in these countries, with young adults remaining the most disproportionately affected group. Among the countries reporting community transmission, only Ethiopia and Mozambique have reported it for the first time since the last RRA.

A total of 109 confirmed cases linked to travel to clade Ib MPXV-affected countries have been cumulatively reported in 22 countries not currently reporting community transmission, an increase of 32 confirmed cases since the last RRA. Some of these importation events have led to onward transmission among household and/or sexual contacts, but the establishment of sustained community transmission has not been reported. In the six weeks ending 24 August 2025, six countries have reported travel-related cases including Australia (two confirmed cases), the United Kingdom (two confirmed cases), and China, Germany, South Africa and Türkiye with one case each.

Of note, recent reports of travel-related clade Ib MPXV clusters in China have raised concern. Since June 2025, China has reported 19 confirmed cases of mpox due to clade Ib MPXV among travelers and their contacts, bringing the

cumulative case count in the country to 29 confirmed cases. The country carried out in-depth investigations of all clusters to identify all cases, direct public health interventions, and interrupt transmission. Basing on the case investigation findings, the country's health authorities concluded that transmission was limited to these clusters and did not result in wider community transmission. That notwithstanding, the possibility of undetected transmission cannot be completely ruled out

The mortality associated with clade Ib MPXV outbreaks generally remains lower (less than 1% where large outbreaks have been reported) than what has been historically reported for clade Ia MPXV-endemic provinces in DRC, and broadly comparable to what has been observed during the global clade IIb MPXV outbreak. As observed with other subclades, MPXV can be particularly severe among immunocompromised individuals, such as those living with uncontrolled HIV infection, as observed in countries such as Uganda and Sierra Leone. This is especially concerning in sexual networks where HIV prevalence may be high and access to HIV prevention and care services remains limited, especially with reduced funding for HIV control programmes in some of the affected countries.

The healthcare systems in many affected countries in Africa continue to face challenges in scaling up diagnostic, surveillance, and treatment capacities in response to mpox. As such, case identification, testing, isolation and contact tracing remain largely insufficient. Furthermore, the involvement of sex workers, truck drivers and high-risk sexual networks in the transmission chains adds another layer of complexity, as these networks are often less visible and more difficult to reach with traditional outbreak response interventions. These key population groups are also vulnerable to severe disease and death, given an often-higher prevalence of HIV. As such, an effective mpox response requires close engagement through specific public health services, including HIV/AIDS and Sexually Transmitted Infections (STI) control programmes.

Given the sustained downward trajectory of clade Ib MPXV outbreaks in the most high-burden countries and limited geographic expansion of community transmission in recent months, the low overall mortality and a better understanding of drivers of transmission and key risk groups, the overall global public health risk associated with clade Ib MPXV is now considered **moderate**.

Clade Ia MPXV

Clade Ia MPXV epidemics in areas of DRC historically considered endemic for mpox continue to be driven by a complex mix of zoonotic spillover events and person-to-person transmission. These outbreaks affect both adults and children, with an incidence largely reflecting the underlying population distribution in these areas, though with proportionally lower incidence in individuals over 50 years of age, likely linked to pre-existing immunity from smallpox vaccination. The overall reported CFR from 1 January 2024 to 24 August 2025 in these areas (2.5%) has been higher than in non-endemic areas (0 – 0.2%), with mortality generally higher among children under five years of age than in older age groups. Nonetheless, there has been a steady improvement in mortality figures – with a CFR in 2025 at 1.6%, down from 3.6% in 2024. These estimates are largely based on syndromic surveillance, which is prone to biases due to potential misdiagnoses. In these endemic provinces, challenges in clinical management are compounded by factors such as malnutrition, co-infections, and barriers to accessing health services, among others. In the Central African Republic (CAR), only a few sporadic confirmed cases (25 confirmed cases) and one death in an infant have been reported in 2025.

Co-circulation of clade Ib MPXV and the strain of clade Ia MPXV associated with sustained human-to-human transmission continues in Kinshasa, with sequencing data suggesting that about 56.9% of confirmed cases are due to clade Ia MPXV, a small drop from 60.5% reported in the last RRA. In Kinshasa, both clades Ia and Ib MPXV appear to affect similar population groups, transmitting mostly among adults, high-risk sexual networks, and specific geographic clusters. No new travel-related cases of clade Ia MPXV linked to transmission in Kinshasa have been reported since the last RRA.

While the risk of international spread of this strain is considered higher than other clade Ia MPXV strains in endemic areas, with the downward trajectory of the epidemic in Kinshasa and vaccination underway, the risk of international spread is considered lower than that of clade Ib MPXV.

Given the declining mortality reported among cases due to clade Ia MPXV and the dropping clade Ia MPXV incidence, even among strains associated with sustained human-to-human transmission, the overall global public health risk posed by clade Ia MPXV is now considered **low**.

Clade II MPXV (historically endemic countries) overview

Mpox due to clade II MPXV (both clades IIa and IIb) has been endemic in West and Central Africa.

In 2025, Sierra Leone has experienced the largest clade II MPXV outbreak ever documented in West Africa, reporting over 600 confirmed cases per week at the outbreak peak in May 2025. However, since then, the outbreak trajectory has been on a consistent downward trend, with less than 50 confirmed cases reported in the most recent week (week ending 24 August 2025). The outbreak has remained largely concentrated in and around the capital, Freetown, predominantly affecting young adults. Although information about modes of transmission in the country has remained limited, available demographic data still suggest that sexual contact transmission among adults in urban settings has been the most likely driver of the outbreak. Genomic sequencing analysis data has revealed public circulation of primarily clade IIb MPXV lineage A.2.2.

Although smaller in scale, other countries in the region like Guinea, Liberia, and Ghana also reported unexpectedly large outbreaks following the surge in Sierra Leone. As seen with Sierra Leone, cases have been largely concentrated in and around the country capitals, predominantly among young adults, and clade IIb MPXV lineage A.2.2 has been reported, suggesting similar epidemic dynamics. As of 24 August 2025, the outbreak trajectories in Ghana, Guinea, and Liberia were showing early signs of slowing down.

Previously, clade IIa MPXV, historically reported in or linked to animals, had also emerged in human populations, with cases reported in Côte d'Ivoire, Ghana, Guinea and Liberia in 2024. In Liberia in particular, and to a much smaller extent in Côte d'Ivoire, Ghana and Sierra Leone, clade IIa MPXV and clade IIb MPXV were reported to be co-circulating earlier in 2025. More recent data, however, have identified only clade IIb MPXV in these countries. In these countries, the modes of transmission associated with clade IIa MPXV have still not been well elucidated but are thought to involve repeated zoonotic spillover events followed by limited secondary human-to-human transmission.

Given cross-border transmission links that triggered some of these outbreaks – both in historically endemic and newly reporting countries – and the rapid epidemic growth in several countries that quickly overwhelmed health systems, the global public health risk associated with clade II MPXV in historically endemic areas is considered **moderate**.

Clade IIb MPXV

Clade IIb MPXV continues to circulate globally as part of the 2022-2025 multi-country mpox outbreak, with the majority of cases continuing to occur within linked sexual networks, particularly among men who have sex with men. The 2022-2025 multi-country outbreak reached its peak around July-August 2022, and incidence declined sharply in most countries thereafter through a combination of factors including: a) behavior change in at-risk groups through effective risk communication and community engagement; b) immunity due to infection, particularly among individuals with multiple sexual partners who were at the highest risk of exposure and onward transmission; and c) immunity due to vaccination, in the countries where vaccines were available and accessible.

During 2025, clade IIb MPXV circulation has continued to be widely reported. The number of confirmed cases linked to clade IIb MPXV outbreaks globally averaged 871 cases per month over the past 12 months, peaking at close to 1500 cases per month in September 2024, followed by a downward trend in cases. Outbreaks continue to occur, and the virus is circulating in all WHO regions, including in areas that had previously achieved epidemic control, but they largely remain much smaller relative to outbreaks in previous years.

As such, the overall global public health risk associated with clade IIb MPXV is assessed as **Low.**

Overall public health risk

All countries remain at risk of importation and local transmission of **all** MPXV clades. While some countries have established robust response mechanisms, such as early detection and contact tracing that could help stop further spread, other countries are less prepared and are at a higher risk of missed chains of local transmission, especially where a low index of suspicion, stigma, and discrimination create barriers to access of diagnostic testing, clinical care services and implementation of prevention and control measures.

Despite significant progress in understanding human-to-human transmission of MPXV during the global outbreak since 2022 and to date in 2025, many knowledge gaps remain. The detailed epidemiology of the ongoing outbreaks in the DRC caused by the different clades, including in endemic areas, remains incompletely understood. Transmission dynamics and key drivers of transmission remain insufficiently studied and documented, including the role of

asymptomatic or pauci-symptomatic infections. Additionally, gaps in understanding risk factors for severe disease, immunity following infection, and potential risk of recurrence or reinfection, among others, limit our risk analysis. Furthermore, little is known about animal reservoirs, incidental hosts, risk factors for zoonotic transmission, or the contribution of spillover events, whether in DRC or elsewhere.

In recent months, there have been improvements in access to diagnostics and vaccines and delivery through coordinated efforts by WHO and its partners. Eight African countries have started mpox vaccination and more than 986 000 doses have been administered. However, funding for vaccine supply and deployment is increasingly limited, especially as countries are now expected to cover the rollout costs of donated vaccines. This highlights the importance of a targeted vaccination approach to ensure the greatest benefit for at-risk populations. Delays in vaccine introduction may limit their impact, and a low number of vaccinated individuals may not achieve the level of population-level protection necessary for vaccines to be effective. The current lack of evidence for the effectiveness of therapeutics, such as the antiviral tecovirimat, in treating mpox, limits their use in the countries reporting the highest number of cases.

The public health risk posed by mpox varies across different areas of the world. It is assessed based on four different categories, which differ in their geographic distribution, population groups affected, predominant modes of transmission, and the clades most commonly associated with infection in each group.

Notwithstanding, the **overall public health risk at the global level is assessed as Moderate.**

Risk questions

The below risk questions assess the global public health threat posed by mpox by evaluating its potential likelihood and consequences on human health, its spread, and the sufficiency of current control measures. For further details on the information provided in this table, please refer to the section on Supporting Information that follows.

Risk question Clade Ib MPXV		Assessment		Risk	Rationale
		Likelihood	Consequences		
Risk for human health	Global	Likely	Minor	Moderate	As of 24 August 2025, the main countries affected (those experiencing community transmission) include Burundi, Ethiopia, DRC, Kenya, Malawi, Mozambique, Republic of Congo, Rwanda, South Sudan, Uganda, United Republic of Tanzania, and Zambia. The clinical presentation of clade Ib MPXV still typically involves lesions on the face, palms of the hands, feet, and other parts of the body. Among adults, the spread through sexual contact remains more than historically documented for clade Ia MPXV, and consequently, there have been more reports of affected individuals presenting with more mucosal lesions, and/or exclusively genital lesions, a pattern not commonly historically seen for clade Ia MPXV. In DRC, Burundi and Zambia, the affected population predominantly includes young children and young adults, while in Kenya, Malawi, Mozambique, Republic of Congo, South Sudan, Uganda and United Republic of Tanzania, it primarily includes young adults. Clinical management is symptomatic, and only a small minority require hospitalization or intensive care. In DRC, specific mpox treatment centres offering free-of-charge treatment and isolation have been put in place, with variable provision for treatment at home based on capacity, or in special centres such as camps for internally displaced persons. In Burundi, all adult mpox cases are admitted for treatment and isolation, while children are admitted only if the illness is severe. In Uganda, initially, all cases were admitted for isolation and treatment. However, as admission capacities were overwhelmed when the outbreak in Uganda escalated, the country rolled out home-based care for mild cases and reserved health facility isolation for moderate, severe, and critical cases. In other countries in Africa, where outbreaks are still small, cases may be subjected to hospital isolation as part of a precautionary approach, but several countries that have initiated home-based care for mild cases, including Kenya, Malawi, Mozambique, South Sudan, and Zambia. The case fatality ratio (CFR) among suspected mpox cases due to clade Ib MPXV in South and North Kivu provinces of DRC is 0.1% based on data from 1 January 2024 to 24 August 2025 (40 027 suspected cases, including 55 deaths), somewhat comparable to the CFR (0.2%) reported at the time of the previous rapid risk assessment in June 2025. During the same period (1 January 2024 – 24 August 2025), the reported CFR (among confirmed cases) for other countries experiencing community transmission of clade Ib MPXV has been as follows: • Ethiopia: 3.6% (28 confirmed cases, including one death). Ethiopia had not reported experiencing community transmission by the beginning of June 2025; • Kenya: 1.5% (401 confirmed cases, including six deaths), down from 1.8% in June 2025; • Zambia: 1.4% (218 confirmed cases, including three deaths), down from 4.1% in June 2025; • Malawi: 1.2% (81 confirmed cases, including one death), up from 0% in June 2025 • Republic of Congo: 1.1% (93 confirmed cases, including one death), down from 1.7% in June 2025;

- Uganda: 0.6% (7 905 confirmed cases, including 48 deaths), comparable to 0.7% in June 2025;
- Burundi: 0.02% (4 384 confirmed cases, including one death), comparable to 0.03% in June 2025;
- Rwanda: 0% (127 confirmed cases; no deaths), same as in June 2025;
- United Republic of Tanzania: 0% (125 confirmed cases; no deaths), same as in June 2025;
- Mozambique: 0% (65 confirmed cases; no death). Mozambique had not reported experiencing community transmission by June 2025;
- Ethiopia: 0% (28 confirmed cases; no deaths). Ethiopia had not reported experiencing community transmission by the beginning of June 2025;
- South Sudan: 0% (20 confirmed cases; no deaths), same as in June 2025.

No deaths have been reported in any other countries, either in Africa or elsewhere, that have reported travel-related cases.

Factors that might explain the lower fatality in clade Ib MPXV – affected provinces in DRC compared to that reported in endemic areas with clade Ia MPXV circulation, include better surveillance in the affected provinces, resulting in the detection of milder cases and the capacity to confirm cases and deaths (unlike in endemic provinces, where most deaths remain among suspected cases and may be linked to other or concurrent illnesses). Other factors likely contributing to the lower fatality, include more timely access to care, better quality of care provided at mpox treatment centres, and the deletion (through sustained virus circulation) of a gene that expresses a complement control protein implicated as an MPXV virulence factor in clade Ia MPXV. Notably though, the escalation of conflict in the clade Ib MPXV-affected South and North Kivu provinces earlier in 2025 disrupted the mpox response in the region, introducing new surveillance and response limitations there as well. In Burundi, early diagnosis and the hospitalization of all cases among adults, as well as children with severe disease, might have contributed to the low fatality during the period under review. About 47.9% of deaths reported in Uganda and at least 83.3% of deaths in Kenya have been reported mostly among people living with HIV, many without adequate antiretroviral therapy. These deaths in Uganda and Kenya highlight the risk of poor health outcomes in people living with HIV, as was documented for other clades. In the affected countries, a proportion of cases are linked to sexual contact within connected networks, including sex workers. The HIV prevalence in this population group is higher than the general population, which if untreated, puts them at higher risk of severe disease.

Some mpox cases due to clade Ib MPXV have occurred in pregnant women, and although not well captured in the global mpox surveillance system, some have led to more severe disease and poor pregnancy outcomes, including fetal loss. This information has been documented through field and case reports.

Overall, limited and delayed access to quality healthcare increase morbidity and mortality among affected cases. Rapid access to and provision of high quality symptomatic clinical care remain essential to prevent complications and ensure prompt recovery.

The risk for human health associated with clade Ib MPXV is, therefore, considered Moderate.

For more information, please refer to the sections covering Epidemiological situation in DRC (clade Ia and clade Ib MPXV) and Epidemiological situation in other countries reporting cases of mpox due to clade Ib MPXV.

Risk of geographic spread	Global	Likely	Minor	Moderate	Clade Ib MPXV, estimated to have emerged in South Kivu in September 2023, continues to spread through human-to-human contact, without evidence of zoonotic exposure. As of 24 August 2025, clade Ib MPXV has been identified in 13 provinces of DRC (up from 10 provinces in June 2025): Haut-Katanga, North Kivu, and South Kivu – where it is the only strain detected, as well as in Ituri, Kasai, Kinshasa, Kongo Central, Lomami, Lualaba, Mai-Ndombe, Mongala, Tanganyika, and Tshopo – provinces where co-circulation of clade Ia and clade Ib MPXV has been reported. Community transmission has also been reported in: • Uganda: 7 905 confirmed cases, including 48 deaths, compared to 6 324 confirmed cases and 42 deaths in June 2025; • Burundi: 4 384 confirmed cases, including one death, compared to 3 934 confirmed cases and one death in June 2025; • Kenya: 401 confirmed cases, including six deaths, compared to 113 confirmed cases and one death in June 2025; • Zambia: 218 confirmed cases, including three deaths, compared to 76 confirmed cases and three deaths in June 2025; • Rwanda: 127 confirmed cases and no deaths, compared to 119 confirmed cases and no deaths in June 2025; • United Republic of Tanzania: 125 confirmed cases and no deaths, compared to 43 confirmed cases and no deaths in June 2025; • Republic of Congo: 93 confirmed cases, including one death, compared to 60 confirmed cases and one death in June 2025; • Malawi: 81 confirmed cases, including one death, compared to 10 confirmed cases and no deaths in June 2025; • Mozambique: 65 confirmed cases and no death. Mozambique had not reported experiencing community transmission by June 2025. • Ethiopia: 28 confirmed cases, including one death. Ethiopia had not reported experiencing community transmission by June 2025; • South Sudan: 20 confirmed cases and no deaths, compared to 14 cases and no deaths in June 2025. Altogether, community transmission has been reported in 12 countries, up from 10 countries in June 2025. Furthermore, during the six weeks ending 24 August 2025, six countries reported mpox cases among individuals with recent international travel history to clade Ib MPXV-affected countries, down from eight countries reported in the last RRA. These six countries include Australia (two confirmed cases), the United Kingdom (two confirmed cases), and China, Germany, South Africa and Türkiye with one case each. Cumulatively, 34 countries have ever reported clade Ib MPXV since it first emerged, up from 30 countries in June 2025. The four countries that have reported cases of mpox due to clade Ib MPXV for the first time during the period since the last rapid risk assessment include Mozambique (65 confirmed cases), Ethiopia (28 confirmed cases), Türkiye and Italy with one confirmed case each. Türkiye has also retrospectively reported three cases detected earlier in 2025. Overall, DRC has been continuously reporting a downward trend in suspected mpox cases, largely averaging 1500 suspected mpox cases per week since the last rapid risk assessment in June 2025, down from 2000 – 3000 suspected cases per week previously. Among clade Ib MPXV-affected provinces, only South Kivu continues to face a relatively large outbreak, reporting about 400 suspected cases per week. Furthermore, South Kivu also

					continues to report the highest number of mpox cases of any province in DRC regardless of clade. North Kivu and Tanganyika, which were still observing high caseloads by June 2025, have since reported a drop in weekly suspected cases. The initial outbreak in South and North Kivu occurred predominantly among adults, with rapid amplification through high-risk sexual networks, including sex workers. However, as clade Ib MPXV spread across South and North Kivu, transmission expanded beyond sexual networks, resulting in an increasing proportion of cases among children and a bimodal age distribution with the highest incidence in young children and young adults. Notably, since February 2025, a disproportionate burden has emerged in those aged under 10 years. The reasons for this age-shift remain unclear. However, transmission dynamics are heterogeneous, with variable age distribution across other clade Ib MPXV-affected provinces. Additionally, there have also been reports of transmission in hospital settings and Internally Displaced Persons' (IDP) camps. These trends remain somewhat challenging to interpret due to the lack of robust and consistent testing capacity. Burundi continues to report declining trends in mpox cases, first observed at the end of 2024, continuing to report under 50 confirmed cases per week, comparable to June 2025 and down from 200 confirmed cases per week at the outbreak's peak. Cumulatively, cases have been reported in at least 94% (46 out of 49) of health districts, but only 12 health districts were reported to have active outbreaks at the time of writing. The epidemic remains largely concentrated in and around the largest city, Bujumbura, and the capital, Gitega. The country also continues to observe a bimodal case distribution, with children under 10 years of age and young adults 20 – 29 years old disproportionally affected. Household, community, and sexual contact transmission have all been reported, but the contribution of each to the spread remains unclear. While Uganda is reporting the largest clade Ib MPXV outbreak outside DRC, the country continues to report an overall downward trend in weekly mpox cases, first observed in February 2025. Cumulatively, cases have been reported in at least 82% (120 out of 146) of districts and mpox cases remain widespread across the country. Although the epidemic was largely concentrated in and around the capital Kampala earlier in the outbreak, several regional cities (like Hoima, Masaka, and Mbarara cities) have also emerged as hotspots, reporting local resurgences in recent months. Household, community, and sexual contact transmission have all been reported to contribute to the spread of mpox in the country. While the relative contributions of each to mpox spread are unclear, sexual contact transmission continues to be implicated as a major amplifier of disease spread, especially in networks of sex workers and their clients. As such, young adults have remained the most disproportionately affected group. In Kenya, on the other hand, the situation is concerning. The country has reported a consistent upward trend that has been sustained throughout 2025 and is currently observing over 35 confirmed cases per week, up from less than 10 confirmed cases per week in June 2025. Sexual contact transmission continues to be implicated as a major amplifier of disease spread, with young adults remaining the most disproportionately affected group. Ethiopia, Malawi, Mozambique, Republic of Congo, Rwanda, South Sudan, United Republic of Tanzania and Zambia, while also experiencing community transmission, have had smaller outbreaks, each typically reporting under 30 confirmed cases per week. Initially, cases in Ethiopia, South Sudan, the United Republic of Tanzania, and Zambia emerged predominantly along the East African Northern transport corridor and the trans-African highway, at the interface of truck drivers, sex workers, and traders who were disproportionately affected, similar to the epidemiological profiles observed in the initial phases of the outbreak in eastern DRC, Burundi, Uganda,

					and Kenya. However, transmission patterns have become much more heterogenous in recent months, highlighting the risk that these epidemics may continue to spread if efforts to contain them are not scaled up, potentially leading to more widespread community transmission across various age groups. Outside Africa, recent reports of travel-related clade Ib MPXV clusters in China have raised concern. Since June 2025, China has reported 19 confirmed cases of mpox due to clade Ib MPXV among travelers and their contacts, bringing the cumulative case count in the country to 29 confirmed cases. The country carried out in-depth investigations of all clusters to identify all cases, direct public health interventions, and interrupt transmission. Basing on the case investigation findings, the country's health authorities concluded that transmission was limited to these clusters and did not result in wider community transmission. That notwithstanding, the possibility of undetected transmission cannot be completely ruled out. The relative contribution of each mode of transmission to the overall spread is not always clear and may vary in different settings based on the social interactions and demographics affected in each area. While new geographic clusters and international spread appear to be driven mainly by infection among adults – often with evidence of transmission through sexual contact – the extent to which outbreaks are sustained through different modes of direct or indirect (e.g., via fomites) person-to-person contact remains uncertain. Outbreaks have been on a sustained downward trajectory in high-burden countries (Burundi, DRC, and Uganda), remain relatively smaller in other countries, and have not led to sustained community transmission outside central and eastern Africa. However, with surveillance limitations and low disease severity, there remains a high probability of under-detection in many areas and among specific demographic groups, particularly high-risk sexual networks and sex workers, who may be a hard-to-reach population, with fewer economic means and at risk of social stigmatization. Due to limited resources and incomplete information shared by persons with mpox, contact tracing activities are sub-optimal, which hinders early case detection and interruption of chains of transmission. **As such, the risk of geographic spread associated with clade Ib MPXV is considered Moderate**. *For more information, please refer to the sections covering Epidemiological situation in DRC (clade Ia and clade Ib MPXV) and Epidemiological situation in other countries reporting cases of mpox due to clade Ib MPXV.*
Risk of insufficient control capacities	Global	Likely	Minor	Moderate	Earlier in the outbreak, the emergence and rapid spread of clade Ib MPXV in South Kivu and its subsequent expansion to neighbouring provinces and countries underscored the significant challenges these regions faced in curtailing the spread of the virus. The affected areas, which had little prior experience with mpox, struggled to implement effective containment measures. Nonetheless, the recent downward trajectory of cases in the areas most affected by clade Ib MPXV in DRC, as well as Burundi and Uganda, is easing the strain on health authorities and making it more feasible to implement public health interventions with greater success.

					Mpox outbreak response activities continue in all the other affected African countries with mixed success: while some countries like Ethiopia, Malawi, and South Sudan have not reported explosive outbreaks despite observing cases for months, other countries are reporting a rising incidence (Kenya) or the establishment of clade Ib MPXV community transmission for the first time (Ethiopia and Mozambique) since the last rapid risk assessment. **Given the factors outlined above, the risk of insufficient control capacities associated with clade Ib MPXV is considered Moderate.** *For more information, please refer to the sections covering Epidemiological situation in DRC (clade Ia and clade Ib MPXV) and Epidemiological situation in other countries reporting cases of mpox due to clade Ib MPXV.*

Risk question Clade Ia MPXV		Assessment		Risk	Rationale
		Likelihood	Consequences		
Risk for human health	Global	Likely	Minor	Moderate	**Historically clade Ia MPXV-endemic areas in DRC** Mpox-endemic provinces in the Democratic Republic of the Congo include Equateur, Sankuru, Tshuapa, Tshopo, Nord Ubangi, Bas Uele, Sud-Ubangi, Mongala, Kwilu, Mai-Ndombe and Maniema. In these mpox-endemic provinces of DRC, which account for the majority of mpox cases due to clade Ia MPXV reported globally, the overall CFR among suspected cases from 1 January 2024 to 10 August 2025 is 2.5% (70 102 suspected cases, including 1 765 deaths), a drop from the CFR (2.7%) reported during the previous RRA. There has been a steady improvement in mortality figures – with a CFR in 2025 at 1.6%, down from 3.6% in 2024. The CFR remains generally (though not consistently) higher among children under five years of age than in older age groups like those aged 5 – 14 years and those over 15 years of age. Nonetheless, since the last RRA, the CFR has dropped or remained unchanged across all age groups, now estimated at 3.3% (down from 3.6%) for children under five years of age, 2.2% (down from 2.4%) for those aged 5 – 14 years, and 1.9% (down from 2.0%) for those over 15 years of age. The clinical presentation of clade Ia MPXV is similar to that of clade Ib MPXV. Like in areas predominantly affected by clade Ib MPXV, the approach to case management is symptomatic and specific mpox treatment centres offering free-of-charge treatment and isolation have been established. Those with less severe clinical presentation may be treated at home given appropriate infection prevention measures. Tecovirimat (an antiviral) has been tested in the contact of a clinical trial, which reported no effect on mortality or lesion resolution; it is not used in routine clinical practice. Notably, endemic provinces currently have less diagnostic capacity than most areas predominantly affected by clade Ib MPXV. The majority of deaths of mpox cases are, therefore, among suspected cases, clinically compatible with mpox, but not confirmed by PCR testing. The limited testing and confirmation make it challenging to make mortality comparisons between areas and between circulating clades in DRC. The higher reported mortality, compared to what is reported from most areas with predominantly clade Ib MPXV

					circulation, may be due in part to the differences in affected demographic groups (with young children in the areas predominantly affected by clade Ia MPXV appearing to have a higher mortality than adults), differences in surveillance and case ascertainment in a context of more limited testing capacity, and challenges accessing health care, as well as potential compounding factors such as childhood malnutrition (which is a hypothesis as evidence for a link with malnutrition is lacking), and a higher prevalence of co-infections. Although not well captured in the global mpox surveillance system, severe outcomes have also been noted among pregnant women with mpox, including an increased risk of miscarriage and stillbirth. Challenges in early diagnosis along with barriers to accessing healthcare and medication further compound the risk. **Focus on Kinshasa** Since June 2025, a downward trend in cases has been observed, with less than 50 confirmed cases reported per week in recent weeks, a drop from about 200 confirmed cases per week in the last RRA. Co-circulation of clade Ia and Ib MPXV continues, with sequencing data indicating that approximately 56.9% of the cases are due to clade Ia MPXV, a small drop from 60.5% at the time of the last RRA, suggesting that clade Ib MPXV still has a growth advantage over clade Ia MPXV in Kinshasa. Although clade Ia MPXV still accounts for majority of cases, severity and mortality remain low, with 18 deaths reported among 5 807 suspected cases (CFR 0.3%), same as that reported during the previous RRA. Among cases of mpox due to clade Ia MPXV exported from Kinshasa to other countries (one case in Ireland in February 2025 and two cases in China in April 2025), no deaths have been reported. This epidemiology in Kinshasa suggests that the severity of mpox due to clade Ia MPXV may be similar to that of mpox due to clade Ib MPXV when transmission occurs in similar settings and population groups. This emphasizes the need for further investigation into the differences in mpox severity based on clade and populations affected. **Historically clade Ia MPXV-endemic countries outside DRC** Countries outside DRC considered to be endemic for clade Ia MPXV include Cameroon, the Central African Republic, Gabon and the Republic of Congo in Central Africa, as well as Sudan and South Sudan in East Africa. Mpox cases due to clade Ia MPXV in these countries continue to occur only sporadically, and in 2025, only the Republic of Congo – where there is now co-circulation of clade Ia and clade Ib MPXV (69 confirmed cases, including one death) – and the Central African Republic (25 confirmed cases, including one death) have reported clade Ia MPXV outbreaks. **Given the factors outlined above, the overall risk for human health associated with clade Ia MPXV is considered Moderate**
Risk of geographic spread	Global	Likely	Minimal	Low	**Historically clade Ia MPXV-endemic areas in DRC** In endemic parts of the country, clade Ia MPXV transmission has been thought to be linked to sporadic zoonotic events followed by secondary human-to-human transmission, which may not sustain the virus within the population. Recent clade Ia MPXV detections in a dog and in a squirrel reported in Equateur province appear to corroborate this narrative. The age and sex distribution of suspected and confirmed mpox cases generally reflects that of the broader population, except for older adults who are significantly less affected. This is, likely

due to prior smallpox vaccination or previous exposure to mpox. Since the cessation of smallpox vaccination in the 1980s, immunity in the population has waned over time, leading to a gradual increase in adult mpox cases in the decades since. With the rising number of cases in more recent years, there was also a geographical expansion of clade Ia MPXV from provinces considered mpox-endemic to other provinces in the country. This expansion is thought to have been partially driven by socio-economic change, including increased population movements across the country, as well as changes in the interaction with wildlife as wild game products also become more widely available through commerce, including by riverboat. However, many factors contributing to this geographic expansion remain poorly understood. Outbreaks occurring in remote rural areas may largely be self-limiting, but exact transmission dynamics are not fully elucidated, especially those following a zoonotic event.

However, in the most recent months, clade Ia MPXV-endemic provinces have largely observed a downward trajectory in reported suspected cases. In Equateur province, the province historically most affected by mpox in the country, the trend has been relatively stable since the last RRA, with about 50 suspected cases reported per week, down from over 200 suspected cases per week at the outbreak peak. Bas-Uele and Tsuapa have also been observing downward trends in recent weeks. Only Sankuru and Sud-Ubangi have observed a slight uptick in suspected cases reported in the most recent weeks, but it remains unclear if this will be sustained.

Focus on Kinshasa

The sustained outbreak predominantly among adults in Kinshasa which began in August 2024, peaking at over 300 confirmed cases per week in January 2025, has been on a downward trajectory in recent months, with less than 50 confirmed cases reported weekly over the last few weeks, a drop from about 200 confirmed cases per week in the last RRA. Co-circulation of clade Ia and Ib MPXV continues, and sequencing data suggest that about 56.9% of the cases are due to clade Ia MPXV, a small drop from 60.5% during the last rapid risk assessment, suggesting that clade Ib MPXV still has a growth advantage over clade Ia MPXV in these settings. Transmission patterns in Kinshasa continue to largely differ from rural areas and continue to involve sexual contact and sex workers, with proportionally more adults than children affected, similar to what was observed in new clade Ib MPXV outbreaks elsewhere. The new strain of clade Ia MPXV with a higher proportion of APOBEC3-type mutations first detected in 2024 has been implicated in this sustained human-to-human transmission of clade Ia MPXV in Kinshasa. While the epidemic in Kinshasa is still considered to present a risk of spread nationally and internationally, given that it is well connected relative to other parts of the country and is affecting populations linked through sexual networks, no clade Ia MPXV exportations have been reported to have occurred in the period since the last RRA.

Historically clade Ia MPXV-endemic countries outside DRC

Historically endemic countries in Central Africa are Cameroon, the Central African Republic, Gabon and the Republic of the Congo, while those in East Africa include Sudan and South Sudan.

In 2024, the Central African Republic reported the largest clade Ia MPXV outbreak (92 cases, including three deaths; CFR 3.3%) outside the DRC, followed by the Republic of Congo (24 cases; no deaths). However, in 2025, the Central African Republic has observed sporadic cases and small clusters, reporting only 25 cases, including one death. The only other country to report cases in 2025 is the Republic of Congo (69 cases, including one death; CFR 1.4%), but the escalation of the outbreak in 2025 has been attributed to the establishment of clade

					Ib MPXV circulation for the first time in the country, with clade Ib MPXV accounting for two-thirds of mpox cases reported in 2025. Mpox cases due to clade Ia MPXV in these countries have historically been reported to occur sporadically. Clusters often present with one or two initial cases who are ill, and further case investigations to identify additional cases tend to yield very limited data on the origin of the outbreak and likely transmission dynamics. Nonetheless, the available evidence suggests that in these countries, transmission is likely due to repeated zoonotic spillover events followed by limited human-to-human transmission. Recent outbreaks have been reported in urban areas, with clusters of cases in the capital of the Republic of Congo (Brazzaville). Sustained mpox outbreaks in such highly urban areas, which have international travel links, continue to pose a risk of spread of clade Ia MPXV internationally. Nevertheless, no clade Ia MPXV exportations have been reported to have occurred in the period since the last RRA. The decline of outbreaks within endemic areas in DRC and Kinshasa, as well as the small size of outbreaks in the Central African Republic and the Republic of Congo, suggest a lower risk of geographic spread than in previous assessments. **The overall risk of geographic spread associated with clade Ia MPXV is, therefore, considered Low.**
Risk of insufficient control capacities	Global	Likely	Minimal	Low	Initially, the gradual increase in mpox cases reported in DRC in the decades since the cessation of smallpox vaccination and the geographical expansion of clade Ia MPXV from provinces considered mpox-endemic to other provinces in the country underscored the significant challenges these provinces faced in curtailing the spread of the virus. The affected areas, despite having a longer history of mpox outbreaks, struggled to implement effective containment measures. Nonetheless, the recent downward trajectory of cases in these provinces, including Kinshasa, is easing the strain on the health system and lowering the risk of overwhelming the health system. The same has been observed in the Central African Republic, where the outbreak reported in 2025 has been much smaller than in 2024, with only sporadic cases and small clusters linked to zoonotic spillover events reported in recent weeks. Even in the Republic of Congo, which has reported a larger outbreak in 2025 than in 2024, most cases have been linked to the clade Ib MPXV outbreak. The decline of outbreaks within endemic areas in DRC and Kinshasa, as well as the small size of outbreaks in the Central African Republic and the Republic of Congo, suggests a lower risk of insufficient control capacities than in previous assessments. **The risk of insufficient control capacities associated with clade Ia MPXV is, therefore, considered Low.**

Risk question Clade II MPXV (historically endemic areas)		Assessment Likelihood	 Consequences	Risk	Rationale
Risk for human health	Global	Likely	Minor	Moderate	**Historically clade II MPXV-endemic countries in Africa** Countries considered clade II MPXV-endemic remain Cameroon in Central Africa, as well as Benin, Côte d'Ivoire, Ghana, Liberia, Nigeria and Sierra Leone in West Africa. All these historically endemic countries except Benin, as well as newly reporting countries in the region like Gambia, Guinea and Togo, reported cases from 1 January 2024 to 24 August 2025 as follows: Sierra Leone (5 197 confirmed cases, including 52 deaths; CFR 1%), Guinea (708 confirmed cases, including one death; CFR 0.1%), Liberia (600 confirmed cases and no deaths), Nigeria (472 confirmed cases, including four deaths; CFR 0.8%), Ghana (446 confirmed cases, including one death; CFR 0.2%), Côte d'Ivoire (167 confirmed, including two deaths; CFR – 1.2%), Cameroon (12 confirmed cases, including two deaths; CFR – 16.7%), and the Gambia (one case and no death). Historically, mpox cases due to clade II MPXV have been reported to be sporadic in most of these countries, except in Nigeria, where large outbreaks have been reported since 2017. Identified cases typically present with vesiculopustular skin and mucosal eruptions spread throughout the body, face, as well as genitalia, especially in countries with better epidemiological descriptions such as Nigeria. Treatment is mostly symptomatic, while more severe cases are hospitalized. Tecovirimat and other antiviral treatments are not in routine clinical use. Access and quality of care vary broadly between different settings, as do the case management and case isolation practices. In 2025 specifically, only Ghana, Guinea, Nigeria, and Sierra Leone have reported deaths among confirmed mpox cases. The reported CFR is about 1% or less for most countries, with Ghana (0.2%) and Guinea (0.1%) having CFRs comparable to areas outside the African Region (0.2%) – much lower than the historical CFR estimate (3.6%) reported in high-burden countries, like Nigeria, in the region. In these areas, as everywhere, mpox represents a higher risk for those with co-morbidities, especially those with compromised immune systems, such as people with uncontrolled HIV. Viral load testing for people living with HIV is not consistently available, and HIV services, including screening, are not routinely integrated in many countries. With the reduction of funding for HIV control programmes in some countries, there is a risk that more people will become vulnerable to mpox, potentially resulting in poorer health outcomes. **The overall risk for human health posed by clade II MPXV is, therefore, considered Moderate.** *For more information, please refer to the sections covering Focus on Sierra Leone and Focus on priority countries reporting clade II MPXV.*
Risk of geographic spread	Global	Likely	Minor	Moderate	**Historically clade II MPXV-endemic countries in Africa** Countries considered clade II MPXV-endemic remain Cameroon in Central Africa, as well as Benin, Côte d'Ivoire, Ghana, Liberia, Nigeria and Sierra Leone in West Africa. All these historically endemic countries, except Benin, as well as other newly reporting countries in the region like Gambia, Guinea and Togo, have reported cases from 1 January 2024 to 24 August 2025, as follows: Sierra Leone (5197 confirmed cases, including 52 deaths; CFR 1%),

					Guinea (708 confirmed cases, including one death; CFR 0.1%), Liberia (600 confirmed cases and no deaths), Nigeria (472 confirmed cases, including four deaths; CFR 0.8%), Ghana (446 confirmed cases, including one death; CFR 0.2%), Côte d'Ivoire (167 confirmed, including two deaths; CFR – 1.2%), Cameroon (12 confirmed cases, including two deaths; CFR – 16.7%), and the Gambia (one case and no death). Historical descriptions had linked the disease to sporadic zoonotic spillover events, but since the 2017 – 2018 clade IIb MPXV outbreak in Nigeria, human-to-human transmission, including sexual and non-sexual contact that led to international spread, has played a much more significant role in mpox spread. Although clade IIb MPXV is thought to have emerged from animal populations, it has only been detected in the human population to date. In 2025, Sierra Leone has experienced the largest clade II MPXV outbreak ever documented in West Africa, reporting over 600 confirmed cases per week at the outbreak peak in May 2025. However, since then, the outbreak trajectory has been on a consistent downward trend, with less than 50 confirmed cases reported in the most recent week (week ending 24 August 2025). The outbreak has remained largely concentrated in and around the capital, Freetown, predominantly affecting young adults. Although information about modes of transmission in the country has remained limited, available demographic data still suggest that sexual contact transmission among adults in urban settings has been the most likely driver of the outbreak. Genomic sequencing analysis data revealed circulation of primarily clade IIb MPXV lineage A.2.2. Although smaller in scale, other countries in the region like Guinea, Liberia, and Ghana also reported unexpectedly large outbreaks following the surge in Sierra Leone. As seen with Sierra Leone, cases have been largely concentrated in and around the country capitals, predominantly among young adults, and clade IIb MPXV lineage A.2.2 has been reported, suggesting similar epidemic dynamics. As of 24 August 2025, the outbreak trajectories in Ghana, Guinea and Liberia were showing early indications of slowing down. While the majority of cases in these countries had historically been linked to clade IIb MPXV, cases of mpox due to clade IIa MPXV, previously reported in or linked to animals, had also emerged in human populations, with cases were reported in Côte d'Ivoire, Ghana, Guinea and Liberia in 2024. In Liberia in particular, and to a much smaller extent in Côte d'Ivoire, Ghana and Sierra Leone, clade IIa MPXV and clade IIb MPXV were reported to be co-circulating earlier in 2025. More recent data, however, only identified clade IIb MPXV in these countries. In these countries, limited outbreak investigations still have not elucidated the modes of transmission associated with clade IIa MPXV, but preliminary indications from genomic sequencing analysis suggest repeated zoonotic spillover events followed by limited secondary human-to-human transmission. **The risk of geographic spread associated with clade II MPXV is, therefore, considered Moderate.** *For more information, please refer to the sections covering Focus on Sierra Leone and Focus on priority countries reporting clade II MPXV.*
Risk of insufficient control capacities	Global	Likely	Minor	Moderate	The capacity to control outbreaks is generally compromised by several challenges, such as limited healthcare infrastructure, underfunded public health systems, and insufficient access to diagnostic and treatment resources. Given the lower mortality of mpox compared to other epidemic-prone diseases in these areas, mpox has not been

					prioritized. Even though some of these areas have had a long history of mpox, the multiple competing public health priorities drain resources and overwhelm public health infrastructure. The lack of widespread access to vaccination and adequate resources for optimal clinical care further exacerbates the situation, as does the challenge of effectively isolating and treating cases in resource-limited settings. Additionally, the socio-economic conditions in some areas, including poverty and limited education, hinder public health messaging and community engagement efforts, making it difficult to achieve widespread behavioural change needed to control zoonotic as well as human-to-human transmission. As a result, while some control measures are in place, the risk remains moderate due to the potential for systems to be quickly overwhelmed, and the fact that several major urban areas in these countries have reported mpox cases, as demonstrated in Ghana, Guinea, Liberia, and Sierra Leone. Among these countries, Liberia, Nigeria, and Sierra Leone have received vaccine doses and vaccination has been ongoing. In Liberia and Sierra Leone, vaccination has mainly been targeting frontline workers, contacts of cases, sex workers and other high-risk groups. In Nigeria, vaccination has mainly been targeting frontline workers, contacts of cases, and those at high risk of severe disease. **The overall risk of insufficient control capacities associated with clade II MPXV is, therefore, considered Moderate.** *For more information, please refer to the sections covering Focus on Sierra Leone and Focus on priority countries reporting clade II MPXV.*

Risk question Clade IIb MPXV (global outbreak)		Assessment		Risk	Rationale
		Likelihood	Consequences		
Risk for human health	Global	Likely	Minor	Moderate	**Clade IIb MPXV global outbreak** During the ongoing 2022-2025 outbreak which affects many countries experiencing mpox for the first time, clinical manifestations of the disease have varied widely. Cases ranged from asymptomatic or pauci-symptomatic infections to presentation with few lesions (sometimes just one) in localized body areas, including mucosa and genitalia, or many lesions including confluent lesions or full-body rashes and, in some cases, severe multi-organ disease and death. The summary statistics describing these cases have remained largely unchanged from those reported in the last RRA. Overall, among confirmed cases for whom detailed data are available as of 31 July 2025, 87% identified as men who have sex with men and 51.2% reported living with HIV. Only 1% of cases have been reported in children under 18 years of age. Case management often includes symptomatic pain management, and for more severe cases the use of the antiviral tecovirimat, when available. Approximately 9% of affected cases required hospitalization, and overall mortality has been about 0.2%, among the lowest recorded CFR estimates for mpox. This may be due to differences in surveillance compared to historical surveillance data, with expanded surveillance and testing, as

					well as the demographics of the population affected, with most cases affecting young (including adolescents) and middle-aged men. As with other clades, studies and surveillance data analyses on the clade IIb MPXV outbreak have shown that the main risk factor for severe mpox disease and death is a compromised immune system, due either to uncontrolled or advanced HIV disease in key populations or other immunosuppressive conditions, such as advanced diabetes. The highest burden has been among men who have sex with men, particularly those in highly connected sexual networks, with severe cases occurring mostly among those with uncontrolled HIV infection. These population groups have a higher HIV prevalence and adherence to antiretroviral treatment varies between different areas. As such, outbreaks among people with uncontrolled HIV, can lead to high case fatality ratio (3 deaths among 25 cases, CFR 12%). Children and women have accounted for approximately 1% and 3% of the mpox outbreak in these settings, respectively, with very low morbidity and mortality observed overall. Among the 62 pregnant women for whom data were available in the global surveillance system, none have died or reported miscarriage as of July 2025, however, the extent of follow-up after initial diagnosis is unknown. Some of the affected countries have had access to antiviral treatment, through their national regulatory authorities, study protocols, or the compassionate use reserve managed by WHO and have used it for the management of more severe cases. However, tecovirimat and other antiviral treatments have not found a mainstream role in the response due to lack of research evidence of efficacy. Several high-income countries have acquired and distributed vaccines for the most affected group of men who have sex with men during the peak of the outbreak in 2022-2025, which has been shown in observational vaccine effectiveness studies to prevent infection and lower disease severity among breakthrough cases. **The risk for human health associated with clade IIb MPXV is considered Moderate.** *For more information, please refer to the section on Global clade IIb MPXV outbreak (clade IIb MPXV circulation outside Africa).*
Risk of geographic spread	Global	Likely	Minimal	Low	**The spread of clade IIb MPXV** in the 2022 – 2025 outbreak represents the largest recorded outbreak of mpox. During 2025, clade IIb MPXV circulation continued to be reported across the world. The number of confirmed cases linked to clade IIb MPXV outbreaks outside Africa averaged just over 871 cases per month over the past 12 months (a rise from 838 cases per month during the last rapid risk assessment), peaking at close to 1500 cases per month in September 2024, after which there has been a largely downward trend in cases since. This 2022 – 2025 outbreak continues to primarily affect adult men who have sex with men, who are part of sexual networks with multiple partners. This outbreak was also the first to document and describe the significant role of sexual contact in the transmission of MPXV. Initially thought to be unique to clade IIb MPXV, a growing body of evidence suggests that potentially all MPXV clades can be transmitted through sexual contact. Transmission through sexual contact continues to involve close skin and mucosal contact, as well as exposure to sexual fluids, which have been found to carry the virus.

					While the clade IIb MPXV outbreak in newly affected countries included women and children, it did not lead to sustained transmission within these groups. The secondary attack rate has been reported to be below 10% for non-sexual contacts, but significantly higher for sexual contacts. Estimating the exact rate of sexual contact transmission has been challenging due to the nature of some multiple sexual partnerships, stigma and discrimination, or reluctance of some individuals to disclose complete information about their sexual contacts. Although outbreaks were eventually brought under control through the involvement of affected communities, behavioral changes (such as reducing the number of sexual partners), isolation of cases, early diagnosis, and preventive vaccination, where available, cases and local outbreaks continue to be reported in many countries, indicating that undetected community transmission is still occurring. It is unclear to what extent asymptomatic, presymptomatic or pauci-symptomatic transmission play a role in keeping the virus circulating among men who have sex with men. The route of transmission through anal sex is also thought to play a role in the persistence of transmission but the evidence is not conclusive. This ongoing transmission poses a continuing challenge to controlling and eliminating human-to-human clade IIb MPXV transmission outside Africa. While cases among men who have sex with men are likely to continue occurring, current data suggest that transmission is unlikely to spread extensively beyond this particular risk group. This population is nevertheless also at risk of infection with other clades circulating in Africa. Clade IIb MPXV importations have been reported in Kinshasa, DRC and Brazzaville, Republic of Congo, marking the first time this subclade has been documented among clinical cases in these countries. In Kinshasa, two cases were reported, in a traveler from Côte d'Ivoire and his contact. In Brazzaville, one case was reported in an individual with a recent history of travel to Côte d'Ivoire and France. Current surveillance data suggest that these importations have not led to widespread transmission of this subclade. **The overall risk of geographic spread associated with clade IIb MPXV is, therefore, considered Low.** *For more information, please refer to the section on Global clade IIb MPXV outbreak (clade IIb MPXV circulation outside Africa).*
Risk of insufficient control capacities	Global	Unlikely	Minor	Low	The ongoing 2022-2025 outbreak highlighted significant gaps in the preparedness and response capacities of countries newly affected by clade II MPXV. Many of these areas had never experienced MPXV before, including countries in Africa, leading to delays in recognition and response. Early in the outbreak, these regions struggled with limited diagnostic capabilities, insufficient contact tracing, and a lack of familiarity with the disease, which allowed the virus to spread rapidly before adequate measures were implemented. Currently, most countries have diagnostic capacities to detect mpox, nevertheless, disease incidence in most settings remains very low and case detection is not always timely. Contact tracing efforts were not always effective in these settings, where most cases were among men who have sex with men who were reluctant to share information about their sexual contacts. While the provision of vaccines and public health guidance helped bring the peak of outbreak under control, several countries still face challenges in maintaining adequate surveillance and eliminating human-to-human transmission of clade IIb MPXV. The continual reports of new cases suggest that undetected community

					transmission continues to occur, indicating that control capacities are not preventing further spread as interest in mpox has waned. Nonetheless, although not homogenous across regions, the risk of insufficient capacity to control outbreaks of clade IIb MPXV appears to be low for most regions with low case numbers, controlled outbreaks and good response capacity, The global probability of lacking control capacity is therefore considered as unlikely and the risk of having new uncontrolled outbreaks is assessed as low. *For more information, please refer to the section on Global clade IIb MPXV outbreak (clade IIb MPXV circulation outside Africa).*

Major actions recommended by the risk assessment team

	Action	Timeframe
☒	Refer the event for review by IHR Emergency Committee for consideration as a PHEIC by DG (Art 12, IHR)	Immediate
☐	Immediate activation of WHO response mechanism as urgent public health response is required	Not applicable
☐	Recommend setting up of WHO grading call	Not applicable
☐	Immediate support to response, but no WHO grading recommended at this point in time	Not applicable
☐	Rapidly seek further information and repeat RRA (including field risk assessment)	Not applicable
☒	Support Member State to undertake preparedness measures	Continuous
☒	Continue to closely monitor	Continuous
☐	No further risk assessment required for this event, return to routine activities	Not applicable

WHO Immediate Actions at Global level

WHO Immediate actions at Global level *(not a detailed response plan, state if no action required)*

- Convening of the IHR (2005) Emergency Committee to review findings of the rapid risk assessment and progress of the response to advise the WHO Director-General on whether this event still constitutes a public health emergency of international concern.
- Issuing of Temporary Recommendations by the WHO Director-General, if applicable.
- Continue to support countries in implementing the roadmap for the transition of the current acute emergency response approach to a routine programmatic approach, in line with the updated mpox global strategic preparedness and response plan, the mpox continental response plan 2.0, and the strategic framework for prevention and control of mpox 2024 - 2027.

Supporting information

Hazard assessment

Mpox is an infectious disease caused by the monkeypox virus (MPXV), which is part of the genus *Orthopoxvirus*, that includes the variola virus, the causative agent for smallpox. There are two known clades of MPXV: clade I (previously called the Congo Basin clade), which includes subclades Ia and Ib; and clade II (previously called the West Africa clade), which includes subclades IIa and clade IIb. Subclades Ia and Ib were defined after the emergence of subclade Ib in the South Kivu province of DRC in 2023, and subclade Ia is currently considered to encompass all other strains of clade I that are not Ib.[1]

Historically mpox has been primarily characterized by zoonotic transmission, with outbreaks occurring in tropical rainforest regions of East, Central and West Africa, with occasional exportations of cases to other areas. In the context of zoonotic transmission, MPXV is transmitted from animals to humans through direct contact with infected animals (e.g., hunting, trapping, or petting), and possibly through processing and consuming infected animals or their body parts and fluids.[2] Once the virus has transmitted from animals to humans, it can spread among humans through direct close physical contact with an infected person, indirect contact (contact with contaminated materials), respiratory contact through infectious respiratory particles, and mother-to-child transmission (vertical transmission).[3]

Since May 2022, a multi-country outbreak of mpox due to clade IIb MPXV has affected over 130 countries and territories worldwide, most of which had never reported mpox before.[4] This outbreak has been sustained by human-to human transmission, mainly through sexual contact.[5] This global event has also brought to light the long-standing and continuing expansion of areas affected by clade I MPXV across Africa, particularly in DRC, where in addition to zoonotic exposure, human-to-human transmission of clade Ib MPXV, including through sexual contact, has been ongoing since September 2023.[6]

Symptoms of mpox in humans include swollen lymph nodes, fever, and a skin and/or mucosal rash that may initially be mistaken for other rash illnesses such as chickenpox (caused by the varicella virus), or sexually transmitted infections like herpes or syphilis, if the rash or lesions appear in the genital or anal region. The ongoing 2022-2025 outbreak has shown that mpox can also present with very few lesions, and there have been some reports of asymptomatic infection.[7] There is currently very limited documentation of asymptomatic infection for the other subclades. The contribution of asymptomatic infection to transmission remains poorly understood. Cases of mpox due to clade Ib MPXV and clade IIb MPXV have presented with relatively more mucosal lesions than previously described, with many of these lesions located in the genital or anorectal area, linked to sexual contact transmission.[8]

While ocular, genital and inguinal lesions had already been well described, newly recognized phenomena during the global outbreak include severe rectal pain and inflammation (proctitis), inflammation of the penile glans (balanitis) and urethra (urethritis) and urinary retention, and involvement of the colon, most likely related to contact transmission among men who have sex with men. In the Democratic Republic of the Congo in 2023 and 2024, ulcerative vulvo-vaginal lesions and peritonitis were seen in female patients with confirmed mpox due to clade I MPXV. While encephalitis and sepsis were known to occur, myocarditis[9] and parotitis[10] are now also recognized as rare complications.

Generally, most individuals with mpox in the global outbreak have presented with mild clinical manifestations, often attributed to lower severity associated with clade IIb MPXV. However, the outbreak in South Africa from May to August 2024 illustrated that clade IIb MPXV infection can cause severe disease in nearly all patients when it spreads within networks of persons with weakened immune systems due to a high prevalence of uncontrolled

HIV or advanced HIV disease.[11] At the same time, clade I MPXV continues to lead to a more extensive rash and death in DRC, where cases present with more extensive body rashes and higher case fatality ratio compared to those with clade IIb MPXV infection, possibly linked to a multitude of factors such as potentially higher virulence of the virus, limited access to affordable good quality health services, as well as age and underlying health status of affected individuals. Moreover, limited surveillance capacity and resources in DRC hinder access to care in less severe cases until illness progresses or complications develop.

For an overview of mpox outbreaks by virus clade, please refer to the previous rapid risk assessment (page 23).

Exposure assessment

Modes of transmission and exposure settings

While human-to-human mpox transmission is possible through skin-to-skin contact, skin-to-mucosal contact, fomites, and infectious respiratory particles, epidemiological and surveillance data from the global 2022-2025 outbreak in newly affected countries show that transmission of clade IIb MPXV has been sustained mainly through sexual contact.[4] From 1 January 2022 to 31 January 2025, sexual contact was the most reported route of transmission (88.0%; 20 095 of 22 839 cases) for cases where information was available. Sexual contact includes skin-to-skin and skin-to-mucosal contact, as well as contact with semen or vaginal fluids during sex. Studies have detected the presence of virus in semen,[12] vaginal fluid[13] and anorectal swabs,[14] indicating that transmission through this type of contact may be multifaceted.[4,15,16] This pattern of transmission has been consistent since the beginning of this outbreak. The presence of live virus in anal swabs up to four days before symptom onset suggests some contribution of asymptomatic and/or presymptomatic transmission which may in part explain the rapid spread of the global outbreak in the second and third quarters of 2022.[17]

Exposure to clade II MPXV can also occur through contact with infectious respiratory particles or contaminated surfaces, objects or fabrics, including clothing, bedding or towels used by someone with mpox. Transmission via infectious respiratory particles appears to typically require prolonged face-to-face interactions, which may place household members and other individuals in close physical contact or in the same confined space at higher risk. Health workers are also at risk when infection prevention and control measures – use of personal protective equipment (PPE), safe handling of sharps, and hand hygiene – are inadequate.[18] Gatherings and events can facilitate the transmission of the MPXV, especially in settings with high attendee density and mobility, or close physical interactions such as in sex-on-premises venues. Although not previously described, these events highly contributed to the distribution of the virus especially at the beginning of the multi-country outbreak in 2022.[19]

Evidence from the Democratic Republic of the Congo has demonstrated that transmission through sexual contact also occurs for clade I MPXV.[20] More recently, this type of contact has been the driver of sustained community transmission in the absence of zoonotic exposure in the eastern part of the country, in South and North Kivu,[21] where clade Ib MPXV has been circulating in the human population since late 2023.[6] This includes transmission in newly described locations, such as bars, where the clients of sex workers have been documented to have acquired mpox. The risk of exposure to this strain through heterosexual or same sex contact is currently high in this highly connected border area with frequent cross-border exchanges and population movements. The inclusion of heterosexual commercial sexual networks suggests cases may be more likely to go undetected in these key populations, including sex workers and their clients, who may be harder to reach through traditional means, with fewer economic resources and social stigmatization. Notably, while sexual contact appears to be a major mode of transmission for clade Ib MPXV in the currently affected areas, transmission through all other types of contact

continues to occur and as the outbreaks expand and the virus enters more households, there is a shift in transmission dynamics towards an increasing proportion of household transmission.

The eastern part of the Democratic Republic of the Congo is highly connected through land with neighbouring countries and through an international airport to other countries. There is evidence of people who acquired mpox and travelled during their incubation period, or even during the initial phase of the disease, including through air travel or across land borders, as has occurred for Burundi, Kenya, Rwanda, Uganda and a rising number of countries in Africa and around the world.

Transmission settings in the countries with historical mpox transmission (parts of the Democratic Republic of the Congo and other countries in East, West and Central Africa where mpox is endemic) have historically included community (e.g. household, Internally Displaced Persons (IDP) camps, prisons), and healthcare settings. Additionally, in these settings, transmission may occur through contact with live or dead animals or consumption of insufficiently cooked contaminated meat, which can happen both in the open air and the household.

Concerningly, there have been some indications from 2024 – 2025 data of Kinshasa that show that clade Ia MPXV transmission there also appears to involve sexual contact, including with sex workers, with proportionally more adults than children affected in recent weeks, similar to what was seen in new clade Ib MPXV outbreaks elsewhere.

Socio-behavioral dimensions

This section draws on analysis from joint community data and programs of WHO and key partners in the mpox response in the African Region: Africa Centres for Disease Control and Prevention (Africa CDC), International Federation of the Red Cross and Red Crescent Societies (IFRC), United Nations Children's Fund (UNICEF), implementing partners, independent survey providers and academic research. Several parameters influence the reporting of results, including limited available data, some datasets using small or opportunistic sampling, and limited comparability across datasets. Results should be interpreted considering these limitations.

Social and behavioural factors continue to shape both community risk exposure and response to interventions. Across countries and contexts, outbreak dynamics are influenced by multiple, intersecting factors including individual risk perception, social norms, stigma, structural inequality, access to care, security, and social protection.

Data on **risk perceptions** in the mpox response are limited but show variation across contexts, influenced by individual and community characteristics. For instance, early response data indicated that many people viewed mpox as a serious health threat but were unsure about who was most at risk. In several settings, key populations such as sex workers, truck drivers, and motor taxi drivers described themselves as highly exposed, while in other contexts, men reported lower personal risk. In Rwanda and Burundi, communities frequently identified children, pregnant women, and people with chronic illness as particularly vulnerable. Men who have sex with men (MSM) were only identified as at-risk groups during discussions with key populations. In DRC, perceptions of risk extended beyond health outcomes to include fears of economic and social consequences, such as loss of income, isolation, or rejection within families and communities. Public narratives also shifted: early concerns focused on uncertainty about how mpox spread, later narratives focused on group-specific risks, and more recent debates centred on transmission following recovery.[22]

Levels of community **mpox knowledge and awareness** shifted over the course of the outbreak. In Uganda and Rwanda, mpox awareness reportedly increased over time, while in the DRC, awareness declined, and in the Central African Republic, low levels persisted. Early response data indicated that a high proportion of people in various countries lacked understanding of symptoms and prevention. Notably, differences by sex and age were

observed, with women and adolescents showing a lower level of awareness. In Rwanda, key populations including sex workers and truck drivers reportedly showed high levels of awareness compared to other groups. Knowledge of mpox symptoms varied across settings and data collection points; however, rash and lesions were the most commonly cited symptoms. Confusion with malaria, syphilis or leprosy was often reported and understanding of sexual transmission and transmission after recovery was limited and inconsistent. Preventive actions such as handwashing and avoiding close contact were commonly cited, with vaccination, avoiding sharing personal objects, and limiting sexual partners also mentioned in some contexts.[23,24] Community volunteers reported good knowledge about mpox symptoms, transmission and prevention but noted recurring community questions on distinguishing mpox from other diseases and on transmission pathways. Socio-cultural factors and circulating misinformation also influenced knowledge levels, with narratives that confused mpox with other illnesses, linked it to contaminated water or unsafe remedies, or attributed it to supernatural causes, undermining biomedical explanations and affecting timely care-seeking.[25] Over time, information needs shifted across multiple settings: initial demands for clarity on symptoms and prevention, followed by confusion with chickenpox, and ongoing requests for plain-language advice on transmission and protective measures countries.[26]

Limited documentation exists on **isolation** practices in the mpox response. However, available evidence emphasises several factors affecting its uptake, including economic pressures, structural constraints, and social dimensions such as stigma, gender roles, and caregiving. In Rwanda, isolation requirements were reported as a major barrier to care-seeking, particularly among groups dependent on daily income such as sex workers and truck drivers, who feared losing their livelihoods during extended isolation. Survivors and patients also highlighted a lack of adequate support, with some describing children left unattended or insufficient household assistance during isolation. In Burundi, fear of isolation and its indirect costs and insufficient knowledge about case management were commonly reported as reasons for delaying formal care. In South Africa, some opted for self-isolation and combined biomedical with traditional treatments, citing affordability and accessibility as key factors shaping their decisions. Self-reported intent to isolate after a positive diagnosis reportedly increased in DRC, the Central African Republic, and Rwanda, but declined in Burundi, suggesting shifting perceptions of feasibility and willingness to comply.[27] In dense urban settlements such as Kinshasa, overcrowded housing and limited WASH infrastructure were found to further reduce the practicality of home isolation. Mental health impacts were also noted, particularly among MSM, who associated isolation with heightened stress and anxiety.

The intention to **seek formal care for mpox** remained high across the region, with increases observed in some countries.[27] Care-seeking behaviour was reportedly influenced by factors such as accessibility and affordability of services, trust and perceived quality of care, perceived severity of symptoms and risk perceptions. In Burundi, uncertainty about where and when to seek care was identified as a barrier, compounded by transport challenges, indirect costs, and concerns about poor quality of care. In DRC, distrust in health facilities and long wait times were identified as factors affecting care-seeking.[23] In South Africa, decisions were reportedly influenced by affordability and accessibility, with some individuals combining biomedical care with traditional remedies or informal advice, while MSM preferred non-government organization (NGO) clinics over public health facilities due to fear of discrimination. Misinformation also played a role: narratives promoting herbal cures were identified as potentially discouraging treatment-seeking behaviour and reinforcing rejection of medical advice.[25]

The intent to **vaccinate against mpox** was reportedly high in many countries, with increases observed over time,[27] despite the African region having the lowest mpox vaccine acceptance rates worldwide.[28] Drivers of vaccination intent included awareness of vaccine availability, accurate information on its protective value, perceived severity of mpox, and trust in health providers. In Rwanda, vaccine awareness was initially low among sex workers and truck drivers, but once information was shared, acceptance reportedly increased. In South Africa, MSM and sex workers described vaccination as a preferred preventive measure but requested clearer information on eligibility,

efficacy, and side effects. In eastern DRC, community members and health workers associated vaccination with visible benefits, reporting a reduction in cases where campaigns had taken place, while also expressing frustration over shortages and the prioritisation of health workers and contacts of cases.[29] Vaccine acceptance was also found to be higher among health workers and respondents in historic mpox-endemic regions, while lower among unemployed groups and urban populations.[30] Barriers to vaccine acceptance included lack of awareness, concerns about effectiveness and safety, risk perceptions, cultural beliefs, misinformation, and distrust.[23] Misinformation and rumours around mpox vaccines — including infertility, poisoning, corruption, and association with COVID-19 vaccines — were widely reported across the region, influencing vaccine hesitancy.[31]

Evidence on **stigma** is limited; however, available data from several countries highlight it as a recurring challenge in the mpox response affecting timely care-seeking and reintegration of survivors. People with visible symptoms or survivors reportedly faced avoidance and rejection, including being shamed, evicted, or losing customers in their businesses. In Rwanda and Burundi, survivors were in some instances only accepted back once communities had official discharge certificates confirming they were no longer infectious. Mpox was also associated with underlying patterns of marginalisation: in South Africa and Uganda, it was framed as a "gay disease" or linked to sex work, HIV, or foreigners, fuelling discrimination and reinforcing barriers to care. Anticipated stigma affected isolation and care-seeking behaviour, with some individuals reportedly hiding symptoms or delaying seeking care to avoid being labelled.[90,91,92] Widespread stigmatising public narratives also linked mpox to marginalised groups, particular racial or national backgrounds, or conspiracy theories.

Viral genome sequencing

Whereas most clade Ia MPXV sequences have come from human specimens, clade Ia MPXV infections appear to have been initially mainly acquired through zoonotic transmission[32] with limited onward human-to-human transmission occurring predominantly in close-contact household settings. The lack of sustained human-to-human transmission of clade Ia MPXV is reflected in a low level of APOBEC3-like mutations.[33] Furthermore, the repeated spillover from animals results in genetic diversity amongst clade Ia MPXV viruses in human cases, with multiple co-circulating phylogenetic branches in individual provinces of DRC, including within the same timeframe.[32] However, human-to-human transmission of clade Ia MPXV through sexual contact was first reported in an isolated cluster in Kenge, Kwango Province, in the DRC.[20] This was followed by the detection of a larger ongoing clade Ia MPXV outbreak within Kinshasa associated with human-to-human transmission, evidenced by the presence of an APOBEC3-like mutational signature.[34] This outbreak lineage has subsequently been detected in several other provinces within the DRC, including Kwilu, Kwango, and Kongo-Central, although sustained human-to-human transmission of clade Ia MPXV has not been reported there.

Clade IIa genome sequences collected in 2024 from Côte d'Ivoire, Liberia and Ghana are available in public databases. These sequences cluster within the clade IIa MPXV phylogenetic tree, and even amongst more closely related sequences, there is no evidence of APOBEC3 mutagenesis. This supports the hypothesis that majority of mpox cases due to clade IIa MPXV in West Africa during 2024 were acquired through independent zoonotic transmissions. The clustering of a small number of clade IIa MPXV genomes may suggest human-to-human transmission. However, there is no evidence of sustained human-to-human transmission of clade IIa MPXV within these genome sequences.

The current clade Ib MPXV outbreak likely originated from a single spillover from an unknown animal reservoir.[6] Clade Ib MPXV has undergone sustained human-to-human transmission since at least September 2023.[1] This is supported by the presence of an APOBEC3-like signature in the mutations seen in clade Ib MPXV sequences and supported by epidemiological analyses. Analysis of available genome sequencing data supports co-circulation of multiple, ongoing transmission chains of clade Ib MPXV.[35] Similar to clade Ia MPXV, there are clade Ib MPXV genomes from Kasaï, Tanganyika and Tshopo provinces linked to Kinshasa.

In April 2025, MPXV sequences from wastewater samples collected in Fragile, Conflict, and Vulnerable (FCV) settings across the world during December 2024 were uploaded in GISAID and Pathoplexus.[36] These sequences were distributed widely across the MPXV phylogeny, clustering with clade I, clade IIa and clade IIb MPXV sequences. Preliminary analyses of these sequences suggest a wider geographic distribution of clade IIa, and clade IIb MPXV outside west Africa, compared to what had previously been reported through MPXV genomic surveillance data derived from clinical samples. However, given that wastewater sampling yields only fragments of MPXV genetic material, WHO and partners are still exploring the utility of genomic sequencing analyses of wastewater samples for mapping the geographic distribution of MPXV clades, therefore, these data have not been used for this rapid risk assessment.

Furthermore, although there had been reports of clade I MPXV (subclade not differentiated) detections in wastewater samples in the United States of America earlier in 2025,[37] no detections have been reported since the last rapid risk assessment. States which had reported these detections earlier in2025 include Alabama, California, Iowa, and North Carolina. Enhanced surveillance activities were carried out in these states following these detections, but no suspected or confirmed cases of mpox due to clade I MPXV were reported. WHO continues to work with partners to explore the utility of wastewater surveillance for tracking MPXV circulation.

Zoonotic transmission

Animal-to-human transmission can occur through various modes, such as direct contact with infected animals, via bites, scratches, or direct contact with the animal's body fluids, or consumption of insufficiently cooked infected meat from wild animals (bushmeat) leading to new outbreaks in some locations.[38] Presumed zoonotic transmission has been occurring at least since the 1970s in areas of West, Central and East Africa. However, there remains uncertainty about the natural history of the MPXV, and further research are needed to identify reservoirs and better understand how the virus circulates in nature.[38] A variety of mammals, including but not limited to rodent species such as rope or sun squirrels and dormice, as well as non-human primates are known to be susceptible to the virus.[39] The unregulated wildlife trade, including the sale of live wildlife animals of meat and other products, can potentially lead to both domestic and international spread of zoonotic diseases such as mpox. Not all infected animals will display visible signs of MPXV infection, such as a rash.

Recent evidence[40] documented likely cross-species transmission of clade IIa MPXV from fire-footed rope squirrels to wild sooty mangabeys in Taï National Park in Côte d'Ivoire. A recent pre-print provided both direct and indirect evidence demonstrating that a clade IIa MPXV outbreak in fire-footed rope squirrels triggered a subsequent clade IIa MPXV outbreak in the wild sooty mangabey population of the national park. Furthermore, DRC recently notified WHO of detection of clade Ia MPXV in a squirrel and a dog in Equateur province. These reports strengthen the broader body of evidence implicating African rodents as likely reservoir hosts of MPXV, advancing our understanding of the animal reservoir and drivers for transmission.

In general, there is a risk of viral spill-back from humans to animals, with the potential for the formation of a novel animal reservoir. Despite reports during the 2022 – 2025 multi-country outbreak of possible transmission from humans to animals concerning pet dogs in France and Brazil, spillover events have not been confirmed nor reported to result in sustained transmission in either species.[41] Further epidemiological investigation, research and studies at the human-animal-environmental interface are needed to better elucidate the sources and modes of interspecies spread of MPXV in different rural and urban contexts in countries in Africa and beyond.

Context assessment

This section provides with an overview of the mpox epidemiological situation across the world, as well as an update on the status of the global mpox response across the different response pillars.

Epidemiological overview

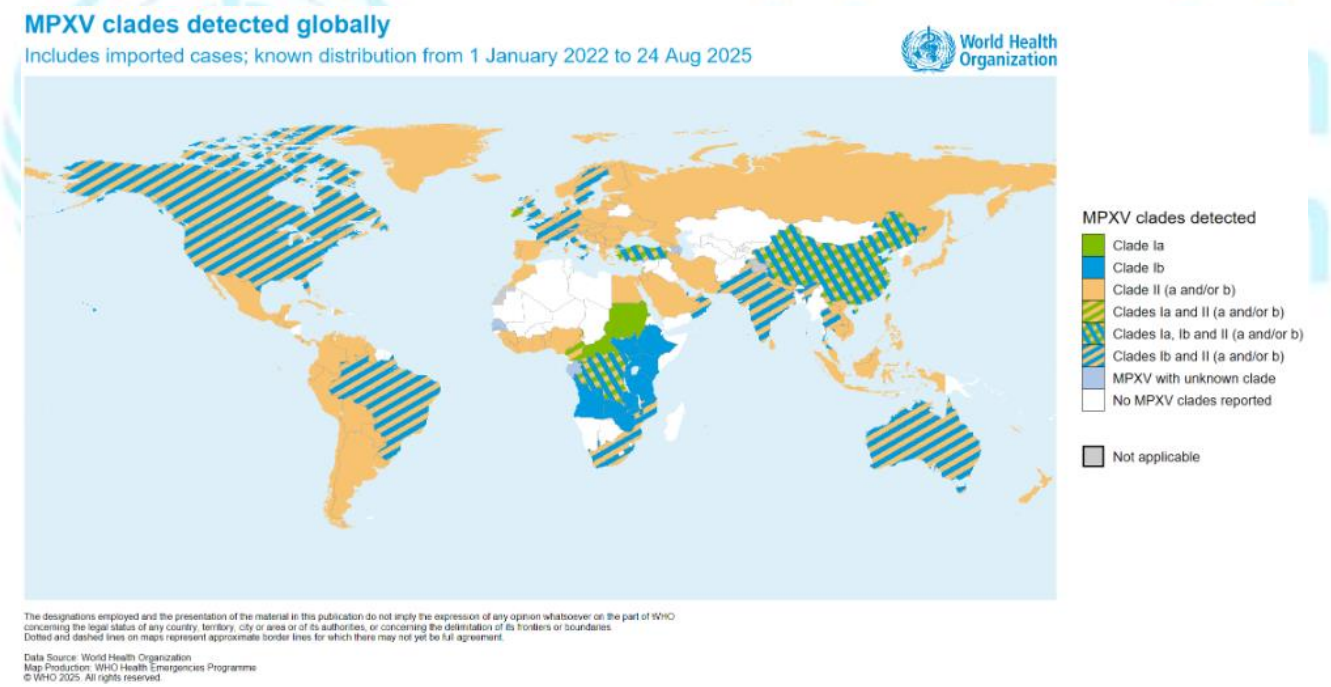
Global epidemiological situation

*This section is based mainly on mpox global surveillance data, which includes information about confirmed and probable mpox cases and deaths since the beginning of 2022. Currently, this information is collected on a monthly basis and the latest available and complete data are as of **31 July 2025**. Reporting to the global surveillance system has varied over time and the public health emergency of international concern (PHEIC) declaration in August 2024 might have increased mpox awareness, surveillance and reporting to WHO.*

As of 24 August 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 34 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 in human cases reported to WHO, by country, as of 24 August 2025[1].



From 1 January 2022 through 31 July 2025, a total of 158 425 confirmed cases of mpox, including 399 deaths, were reported to WHO from 138 countries/territories/areas (hereafter 'countries') in all six WHO Regions (Table 1 and Figure 1). The global CFR among confirmed cases in this period is 0.3%.

A total of 3924 new confirmed cases were reported in July 2025, reflecting a 24.2% decline from the previous month. This apparent decline should be interpreted with caution, given likely reporting delays for the most recent data. The majority of cases in July 2025 were reported from the African Region (82.2%), followed by the Western

[1] 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.

Pacific Region (7.6%) and the Region of the Americas (5.6%). The Western Pacific Region and the South-East Asian Region reported a monthly increase in cases for July 2025, compared to June 2025, with increases of 160% and 5.9% respectively. On the other hand, the European Region, Region of the Americas, and African Region reported declines in cases in July 2025 of 31%, 31%, and 28% respectively.

Table 1. Number of cumulative confirmed mpox cases and deaths reported to WHO, by WHO Region, from 1 January 2022 through 31 July 2025.

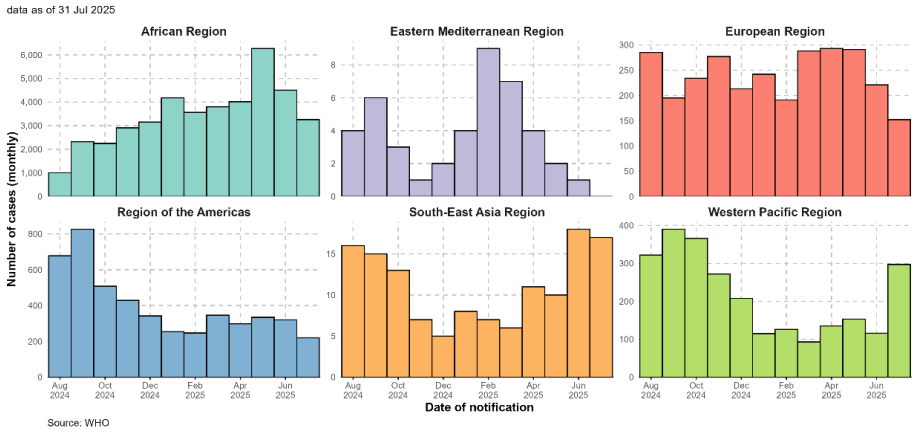
WHO Region	Total confirmed cases	Total deaths among confirmed cases	New cases reported in June 2025	New cases reported in July 2025	Monthly change in cases (%)
Region of the Americas	69 886	153	320	220	-31.0
African Region	49 695	201	4 503	3 225	-28.0
European Region	30 562	10	221	152	-31.0
Western Pacific Region	6 298	18	116	297	160.0
South-East Asia Region	1 073	14	17	18	5.9
Eastern Mediterranean Region	911	3	1	0	-100.0
Total	158 425	399	5 178	3 924	-24.2

Figure 2 below shows that over the past 12 months (1 August 2024 – 31 July 2025), the number of confirmed mpox cases reported monthly in the WHO African Region have been declining from the peak reported in May 2025, attributed to decreasing trends in DRC, Sierra Leone, and Uganda. The Eastern Mediterranean and South-East Asia Regions have been reporting the lowest numbers of cases globally, with the Eastern Mediterranean region observing an upward trend earlier in 2025, driven mainly by Gulf countries, which has since subsided, and South-East Asia observing largely stable trends since late 2024.

In the European Region, the Region of the Americas and the Western Pacific, the trend has been relatively stable in recent months, with the European Region showing early signs of a decrease in the number of cases reported over the past two months and the Western Pacific observing an increase attributed to batch reporting in one of the reporting countries.. Most recent trends in all regions may be prone to surveillance and reporting biases.

In the last 12 months, a global average of about 4302 confirmed mpox cases per month has been reported. Most of them were reported by the African Region (41 178 confirmed cases), followed by the Region of the Americas (4802 confirmed cases), and the European Region (2882 confirmed cases).

Figure 2. Epidemic curves of monthly aggregated number of confirmed mpox cases reported to WHO, by WHO region, 1 August 2024 – 31 July 2025.



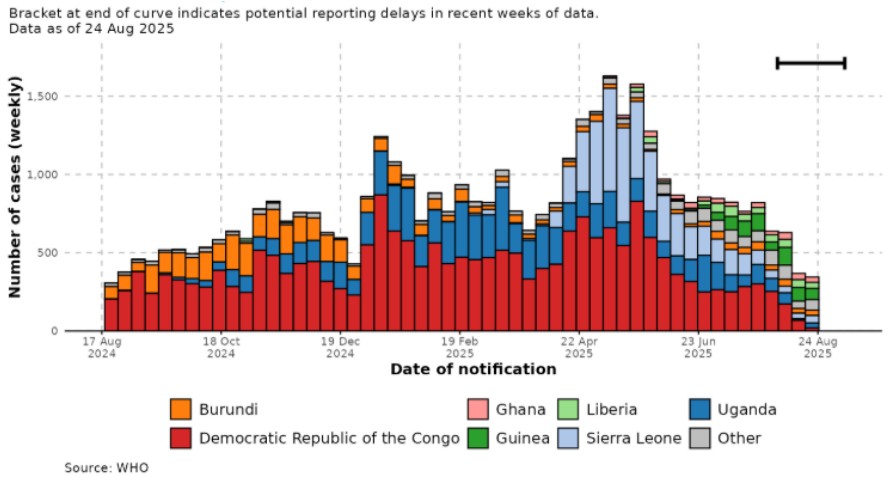
Please note that different Y axis scales have been used for the regional epidemic curves to allow a better overview of the trend in each region.

Epidemiological situation in Africa

In Africa, from 30 December 2024 to **24 August 2025**, a total of 31 913 confirmed mpox cases, including 137 deaths (CFR 0.4%), have been reported across 25 countries. Overall, DRC remains the most affected country this year, with 15 573 confirmed cases, including 31 deaths[2] ,followed by Uganda (6 553 confirmed cases, including 35 deaths), and Sierra Leone (5 197 cases, including 52 deaths).

However, in recent months, a declining epidemic trend has been observed on the continent, largely driven by a sustained downward trend in confirmed cases reported in the DRC, Uganda, and Sierra Leone (Figure 3), with DRC reporting about 200 confirmed cases per week (down from over 800 confirmed cases per week at outbreak peak), Uganda reporting under 100 confirmed cases per week (down from about 400 confirmed cases per week at outbreak peak), and Sierra Leone reporting under 50 confirmed cases a week (down from over 600 confirmed cases per week at outbreak peak) in recent weeks.

Figure 3. Epidemic curve of confirmed mpox cases in Africa, by country, in the past 12 months, 3 August 2024 – 24 August 2025.



[2] The national-level case counts for DRC indicated here are based on the national laboratory database (cases) and the national clinical line list (deaths).

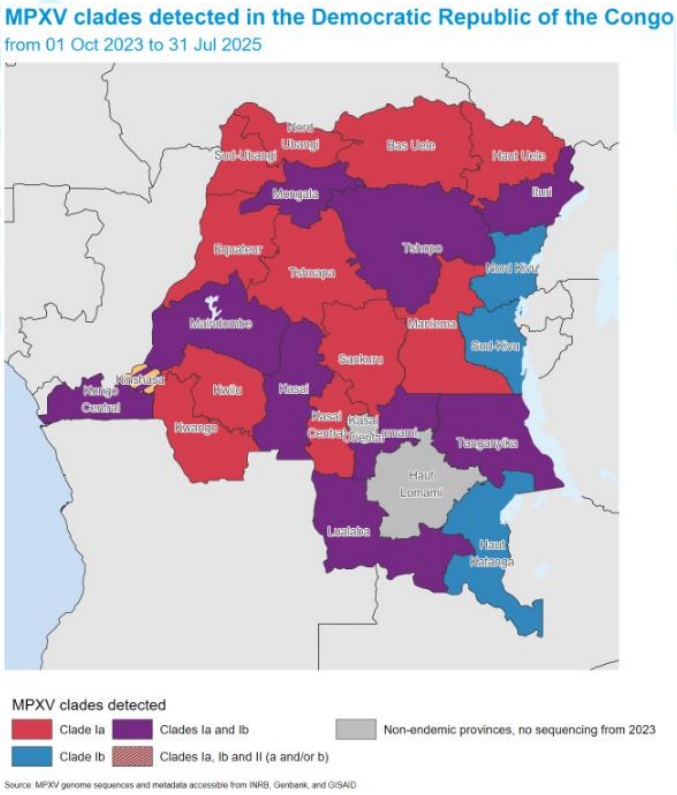
Epidemiological situation in DRC (clade Ia and clade Ib MPXV)

*The country continues to face challenges in the laboratory diagnosis of mpox, with only a limited number of testing sites and supplies available to serve the wide geographical area affected. In 2025, approximately a third of suspected mpox cases were tested, and among these, about half were found to be positive, as at **24 August 2025**. Given the low testing coverage and the variability in testing rates in between areas, information about suspected cases will be presented in this section to further inform our understanding the evolution of the outbreak in the country.*

Mpox outbreaks in DRC continue to be driven by both clade Ia and Ib MPXV strains (Figure 4). Most sequenced samples from 1 October 2023 to 31 July 2025[3] 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 two provinces: Haut-Lomami and Kasai Oriental. So far, clade Ib MPXV has been detected in 13 provinces, and in 10 of them, it is co-circulating with clade Ia MPXV (Figure 4). In Kinshasa in particular, sequencing data from the outbreak have revealed sustained human-to-human transmission of clade Ia MPXV with high rates of APOBEC3-driven mutations. However, no such indications have been reported 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 DRC, by province, from 1 October 2023 to 31 July 2025

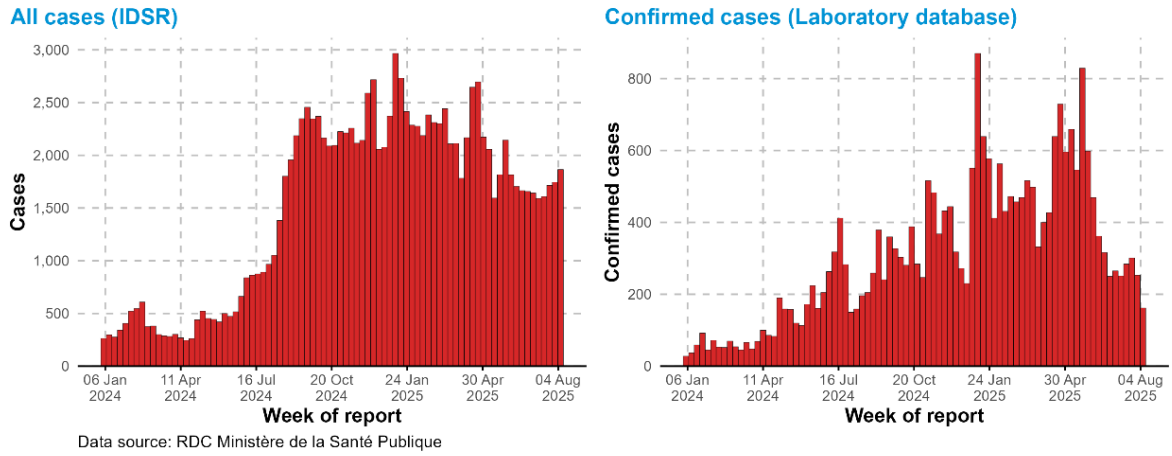


The analysis of the epidemic trend of reported suspected mpox cases (left, Figure 5) shows that while there was a notable rising trend in the second half of 2024, there has been an overall downward trend in suspected cases reported during 2025, averaging about 1500 suspected cases per week in recent weeks, down from 3000 suspected cases per week at the outbreak peak, albeit with a slight uptick in the most recent weeks. The trends

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

in reported confirmed cases, (right, Figure 5) suggest an overall rising trend in 2024 and early 2025, followed by a sustained decline since late May 2025.

Figure 5. Epidemic curve of suspected (left) and confirmed (right) mpox cases reported in DRC, 1 January 2024 – 17 August 2025



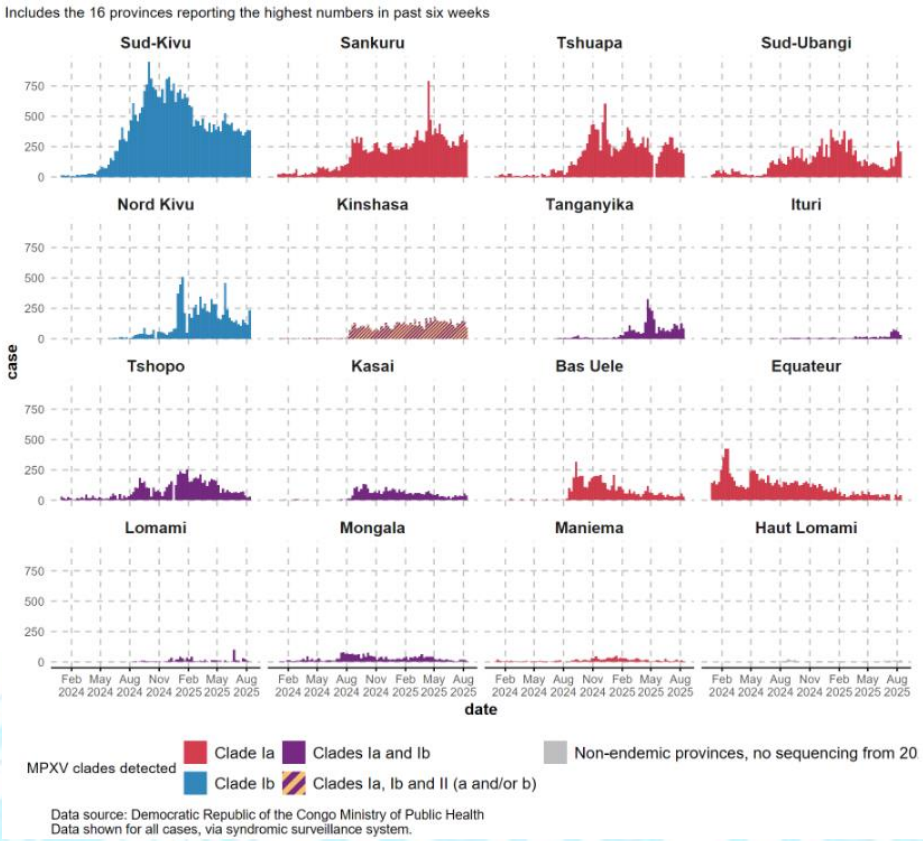
Furthermore, national trends should be interpreted in light of the varying epidemic dynamics at the subnational level. An analysis of the epidemic trend of reported suspected mpox cases in the 16 most affected provinces in DRC shows that these provinces have varying outbreak sizes, but for most of them, the trend in recent weeks appears to be relatively stable or declining (Figure 6).

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. As regards North Kivu, the sudden increase in reported cases observed in the province during the initial weeks of 2025 has been attributed to a change in the province's reporting practices, with both the tested and untested suspected cases now included in the overall count of suspected cases, unlike in 2024, when the overall count of suspected cases only included the untested suspected cases. This makes the syndromic surveillance in North Kivu more comparable to that of other provinces in 2025. That notwithstanding, the trends in suspected cases in North Kivu have remained relatively stable in recent weeks

Among the provinces in which only clade Ia MPXV has been detected, Sankuru and Sud-Ubangi have observed a slight uptick in suspected cases reported in the most recent weeks, but it remains unclear if this will be sustained. Bas-Uele and Tsuapa have been observing downward trends in recent weeks. In Equateur province, the province historically most affected by mpox in the country, the trend has been the trend has been slowly declining over time since a significant outbreak in January 2024, with less than 100 suspected cases reported per week.

Among most provinces in which clade Ia and clade Ib MPXV are known to be co-circulating, including the capital Kinshasa, the trend of reported suspected cases has been relatively stable in the past months. Ituri has observed a slight increase in suspected cases reported in the most recent weeks, but it remains unclear if this will be sustained.

Figure 6. Epidemic curve of reported suspected mpox cases in the most affected provinces of DRC, 1 January 2024 – 17 August 2025

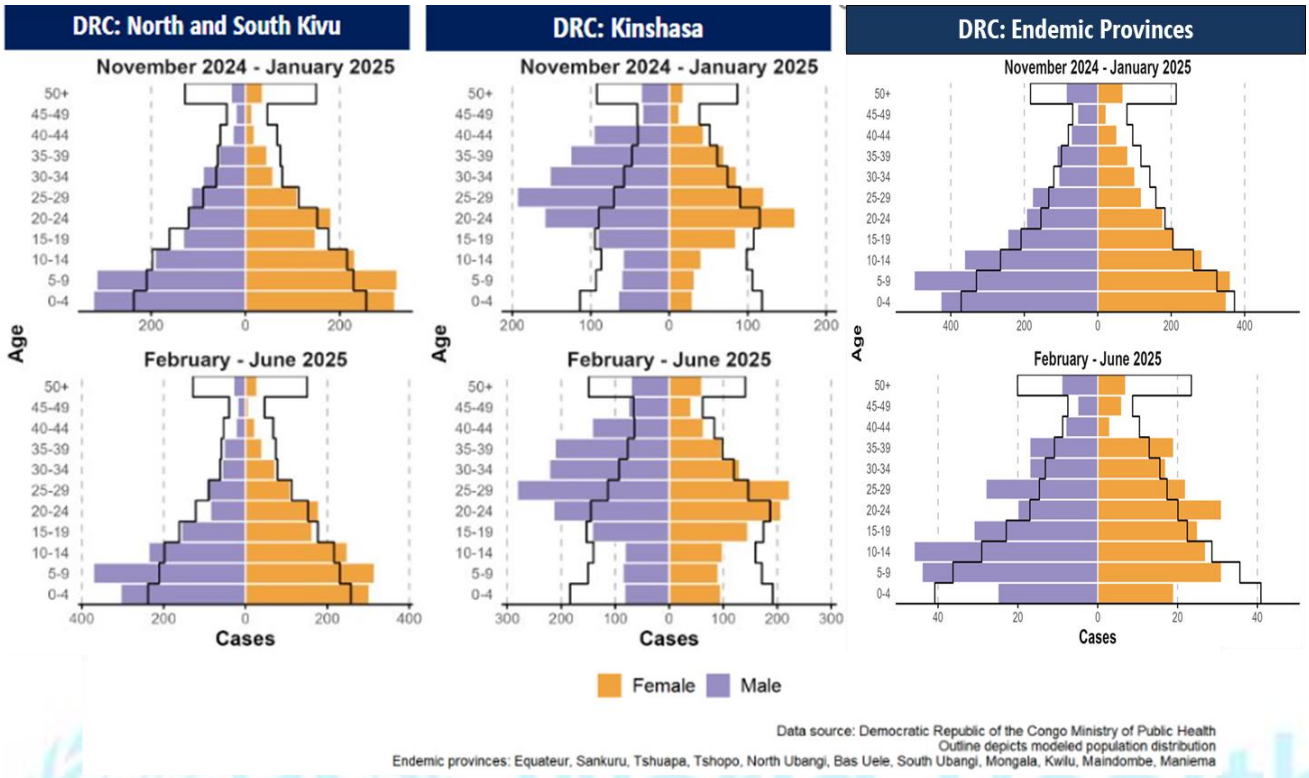


While the initial phase of the clade Ib MPXV epidemic in the eastern part of the country was mostly affecting adults and spreading primarily through sexual contact, as clusters expand in the community and the virus spreads in households, the epidemic is now affecting both adults and children, reflecting wider community transmission through close physical contact. Notably, younger age groups have been disproportionately affected in late 2024 and throughout 2025 (Figure 7-left side). The reason for this disproportionate burden among younger age groups remains unclear.

The age and sex distribution of confirmed mpox cases in mpox-endemic provinces (reporting mpox cases for five consecutive years) in DRC, where outbreaks are predominantly driven by clade Ia MPXV, has more closely approximated the age-sex distribution of the general population over time (Figure 7- right side). While children have historically been reported to be the most affected in these provinces, this has largely reflected the underlying population structure. Notably, there is a proportionally lower incidence in those over 50 years of age, likely linked to pre-existing immunity from smallpox vaccination.

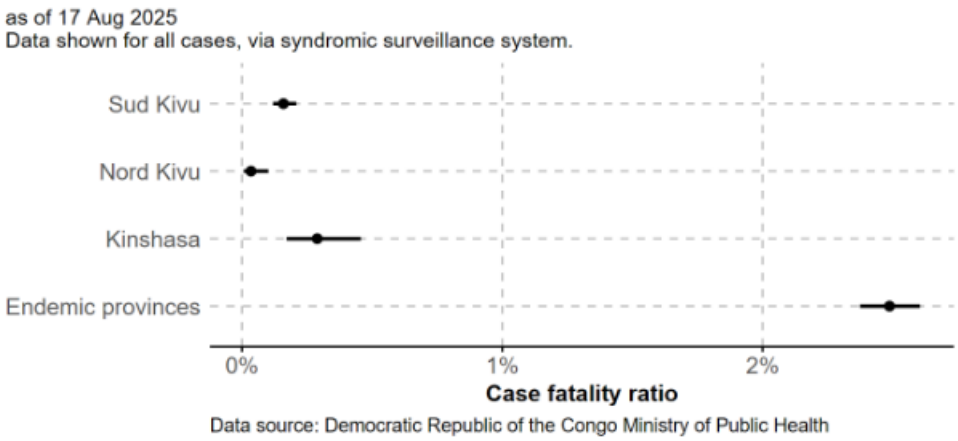
In Kinshasa, where clade Ia and Ib MPXV are co-circulating, the majority of cases remain among young adults (Figure 7- center), reflecting the continued spread mpox primarily through sexual contact.

Figure 7. Age and sex distribution of confirmed mpox cases in the endemic provinces, South and North Kivu provinces, and Kinshasa, in DRC, earlier in the outbreak (upper) and in more recent months (lower), as of 30 June 2025.



Data on the CFR of all suspected cases reported in the country suggest a difference in the CFR estimate for endemic provinces (2.5%) affected mainly by clade Ia MPXV, and the CFR estimate for Kinshasa (0.3%) where both subclades are circulating, and South Kivu (0.2%) and North Kivu (0.0%) where only clade Ib MPXV has been detected (Figure 8)[4]. It is currently unclear if this difference in case fatality ratio is due to the viral clade or differences in factors such as population vulnerability, healthcare access, demographic characteristics, and case reporting, among others. Of note, the majority of deaths in endemic provinces are reported among suspected (clinically compatible) cases, owing to limited access to diagnostic testing in some remote areas.

Figure 8. Mpox case fatality ratio estimates for suspected mpox cases in South and North Kivu provinces, Kinshasa, and the endemic provinces, in DRC, 1 January 2024 – 17 August



[4] Please note the overlapping confidence intervals of the CFR estimates for Kinshasa, North Kivu and South Kivu

Epidemiological situation in other countries reporting cases of mpox due to clade Ib MPXV

The clade Ib MPXV outbreak continues to expand. During the last six weeks (ending 24 August 2025), community transmission reported in Burundi, DRC, Ethiopia, Kenya, Malawi, Mozambique, Republic of Congo, Rwanda, South Sudan, United Republic of Tanzania, Uganda, and Zambia. Travel-related cases have been reported in six other countries in the African, European and Western Pacific regions during the same period (Table 2). The remaining 16 countries of a total of 34 countries that have ever reported cases of mpox due to clade Ib MPXV but have not reported any cases in the last six weeks are not included and can be considered to be in the control phase of their outbreaks, if surveillance is deemed to be adequate.

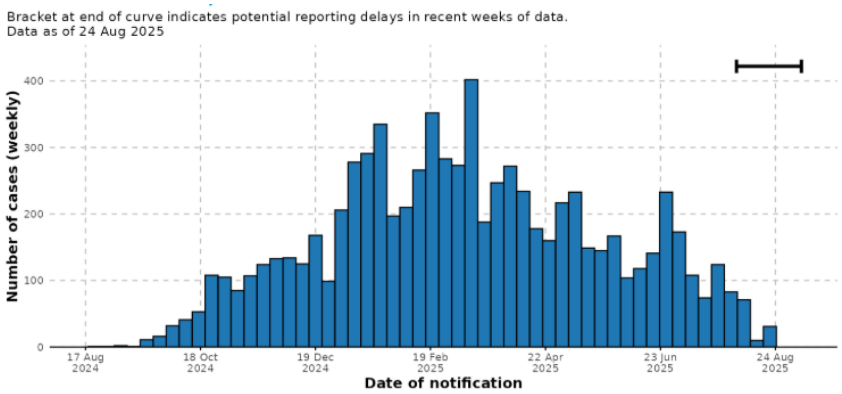
Table 2. Countries reporting active clade Ib MPXV outbreaks and travel-related cases, according to confirmed cases reported to WHO, during the last six weeks ending 24 August 2025.

Country	Cases since January 2024	Cases in past six weeks	Transmission status
Democratic Republic of the Congo	29 070	1 100	Community transmission
Uganda	7905	393	Community transmission
Burundi	4384	236	Community transmission
Kenya	401	161	Community transmission
Zambia	218	63	Community transmission
Rwanda	127	3	Community transmission
United Republic of Tanzania	125	25	Community transmission
Congo	93	9	Community transmission
Malawi	81	31	Community transmission
Mozambique	65	61	Community transmission
Ethiopia	28	1	Community transmission
South Sudan	20	3	Community transmission
China	29	7	Cases linked to travel
The United Kingdom	16	2	Cases linked to travel
Germany	11	1	Cases linked to travel
South Africa	9	1	Cases linked to travel
Türkiye	4	1	Cases linked to travel
Australia	3	2	Cases linked to travel

Focus on Uganda

From the start of the outbreak in July 2024 to 10 August 2025, the country has reported 7 905 confirmed mpox cases, including 48 deaths (CFR 0.6%). So far, only clade Ib MPXV has been detected in the country. The country continues to experience community transmission but has been observing a downward trend in confirmed cases reported since mid-March 2025 (Figure 9).

Figure 9. Epidemic curve of weekly number of confirmed mpox cases by reporting epidemiological week, in Uganda, 1 January 2024 – 24 August 2025.



Cumulatively, cases have been reported in at least 82% (120 out of 146) of districts in the country. Mpox cases remain widely distributed across the country. While initially, the epidemic was largely concentrated in and around Kampala, the capital, several regional cities (like Hoima, Mbarara, and Masaka cities) have reported a high incidence of cases in recent months. Household, community, and sexual contact transmission have all been reported to contribute to the spread of mpox in the country. While the relative contributions of each to mpox spread are unclear, sexual contact transmission continues to be implicated as a major amplifier of disease spread, especially in networks of sex workers and their clients.

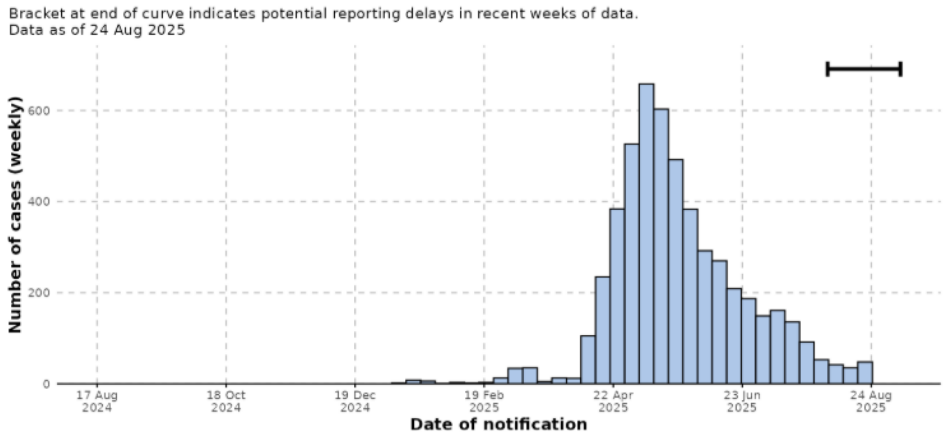
As of 24 August 2025, the country had reported the third-highest number of deaths among confirmed mpox cases, after DRC (58 deaths) and Sierra Leone (52 deaths). Reports from the country indicate that the majority (47.9%) of the deaths have been reported among persons living with HIV, highlighting the risk of poor health outcomes in this key population.

Epidemiological situation in priority countries in West Africa (where clade II MPXV is circulating)

Focus on Sierra Leone

In 2025, Sierra Leone has experienced the largest clade II MPXV outbreak ever documented in West Africa, with a cumulative total of 5197 confirmed cases, including 52 deaths (CFR: 1%), reported since the first case was identified in mid-January 2025 However, since the peak of over 600 confirmed cases per week in May 2025, the outbreak trajectory has been on a consistent downward trend, with less than 50 confirmed cases reported in the most recent week ending 24 August 2025 (Figure 10).

Figure 10. Epidemic curve of weekly number of confirmed mpox cases, by reporting epidemiological week, in Sierra Leone, as of 24 August 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 about 76% 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 25 – 29 years old, followed by those aged 30 – 34 years old, and those aged 20 – 24 years old. 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 analysis data revealed circulation of predominantly clade IIb MPXV lineage A.2.2.

For detailed descriptions of other MPXV outbreaks in other priority countries West Africa, please refer to Annex 2.

Global clade IIb MPXV outbreak (clade IIb MPXV circulation outside Africa)

The summary statistics for cases of mpox due to clade IIb MPXV outside Africa remain largely unchanged from those reported in the rapid risk assessment of July 2025.

As of 31 July 2025, among confirmed cases, with detailed data available, 87% identified as men who have sex with men and 51.2% reported living with HIV. Only 1% of cases have been reported in children under 18 years.

Approximately 9% of affected cases required hospitalization, and overall mortality has been about 0.2%, which is among the lowest CFR estimates recorded for mpox. This may be due to differences in surveillance compared to historical surveillance data, with expanded surveillance and testing, as well as the demographics of the population affected, with most cases affecting young (including adolescents) and middle-aged men.

As with other clades, studies and surveillance data analyses on the clade IIb MPXV outbreak have shown that the main risk factor for severe mpox disease and death is a compromised immune system, due either to uncontrolled or advanced HIV disease in key populations or other immunosuppressive conditions, such as advanced diabetes. The highest burden has been among men who have sex with men, particularly those in highly connected sexual networks, with severe cases occurring mostly among those with uncontrolled HIV infection. These population groups have a higher HIV prevalence and adherence to antiretroviral treatment varies between different areas. As such, outbreaks among people with uncontrolled HIV, such as sees in South Africa in 2024, can lead to high case fatality ratio (3 deaths among 25 cases, CFR 12.0%).

About 1% of mpox cases have been children, 3% have been women, and overall, they have shown very low morbidity and mortality. As of July 2025, none of the 63 pregnant women in the global surveillance system had died or reported a miscarriage. However, the extent of follow-up after their initial diagnosis is unknown.

Surveillance and reporting

At the beginning of the outbreak in May 2022, WHO, in collaboration with national and international partners set up a global mpox surveillance system, used by Member States (MS) to report probable and confirmed mpox cases and deaths. After the PHEIC declaration on 14 August 2024, it was extended to collect information about suspected cases for countries in Africa. The system has two components to collect information in a standardized manner: i) aggregated number of cases by country over time, which aims to be complete and timely; and ii) detailed case-based data for each reported case, which can be less timely and complete. This surveillance has allowed the WHO to monitor the spread of the virus and to describe the main epidemiological, clinical, and outcome characteristics of mpox cases. All the analyzed surveillance data are shared publicly through the Global mpox trends report, currently updated weekly for countries in Africa and monthly for countries in other regions.[7] However, the quality of information is not homogenous. The aggregate number of cases and deaths is complete for most countries, but case-based information coverage is very low for the African and Eastern-Mediterranean regions.

The PHEIC declaration has once again increased attention and awareness about mpox and had an impact on surveillance data reporting to the global level through the WHO regional offices. Additionally, the joint WHO – Africa Centres for Disease Control and Prevention (Africa CDC) continental response in Africa, has supported several countries in improving their surveillance capacities, including case detection and reporting, and this is likely to have contributed to the increase in number of reported mpox cases and reporting countries on the continent.

Laboratory and diagnostics

PCR for MPXV is now available in most countries, and where not available, sample referral mechanisms have been established. Testing has been largely restricted to symptomatic patients with typical lesions and contacts of confirmed cases with prodromal symptoms. Although many countries have worked to decentralise testing, the number of tests available and access to PCR testing for suspected cases remains heterogenous. In Africa, the testing coverage has been high (above 80%) except in DRC, where only 30-50% of suspected cases are tested. In the DRC, testing using GeneXpert machines began in early 2024, in an effort to increase the number of suspected cases being tested and improve access to patient care. The decentralization strategy in DRC has brought the number of laboratories capable of testing for mpox from two laboratories in December 2023, to 12 laboratories in mid-2024 and 26 laboratories in mid-2025. Implementation of the strategy continues with the aim to extend laboratory capacity for mpox diagnosis to all 26 provinces in the country. WHO has supported equitable access to testing throughout the mpox response and has advocated for the development and evaluation of much-needed tests for MPXV detection. WHO has released a publication from an expert consultation to develop two target product profiles (TPPs) for MPXV diagnostics within health care settings and laboratories (TPP1) and detecting orthopoxvirus antigen(s), that are amenable to decentralized use, including in the community (TPP2).[42] Currently, lab-based validation studies of five rapid antigen tests have been concluded, and the analysis is ongoing in Kinshasa, DRC.-Preliminary data show high positive predictive values in high prevalence settings, which indicate some use cases for antigen RDTs. An accurate rapid antigen test will serve as an adjunct to the existing diagnostic platforms such as point-of-care devices and RT-PCR tests and will significantly improve access to diagnostic testing especially for countries with high prevalence and low testing coverage, such as DRC. In the meantime, as part of ongoing efforts to expand quality-assured testing options available for countries, the WHO has listed six mpox in vitro diagnostics under its Emergency Use Listing (EUL) procedure: the *Alinity m MPXV assay* manufactured by Abbott Molecular Inc., *the cobas MPXV assay* developed by Roche Molecular Systems, Inc., and *Xpert Mpox*

manufactured by Cepheid were initially listed. Recently three additional tests *RADIONE Mpox detection kit* from KH Medical company as well as the *EasyNAT Mpox Virus assay* and *PortNAT Mpox Virus Test*, both manufactured by UStar Biotechnologies limited achieved EUL status. All the in vitro diagnostic tests currently listed for emergency use by WHO can be found in the EUL MPXV_List of MPXV IVDs_0.pdf

In the WHO interim guidance on diagnostic testing and testing strategies for mpox, it is stated that depending on the epidemiological context, sequencing strategies should adopt targeted sample characterization (i.e. sequence any sample of interest) and representative approaches (i.e. sequence around 10% of positive specimens, representative of the virus circulation in a defined area of interest). WHO has been working with partners to build sequencing capacity of Member States requiring that support, but despite their efforts, this 10% threshold remains unattained in some settings. For instance, in Sierra Leone, 33 sequences have been shared publicly to date, representing only 1% of the case count at the time this document was being finalized. This heterogeneity in genomic sequencing capacity may bias our understanding of MPXV clade distribution and should be taken into account when inferring the MPXV clade driving an outbreak.

Clinical management

In June 2025, WHO released the new living guideline *Clinical Management and Infection Prevention and Control for Mpox*, incorporating the latest evidence to update recommendations (PDF | MAGICapp). Complementing this guidance, the Global Meeting on the Development of Optimized Standard of Care Guidelines for Mpox was held in Nairobi from 10–12 June 2025, bringing together clinicians, researchers, public health experts, and policymakers from high-burden countries. Convened by WHO and Africa CDC with support from FCDO and GIZ, the meeting reviewed new evidence, including findings from the PALM 007 trial, and applied a guideline development group process to refine recommendations on key clinical issues such as pain management, wound care, ocular disease, and care for high-risk groups. New guidance will be published in the near future. Mild, uncomplicated cases can be managed safely at home with good symptom control, skin and lesion hygiene, hydration, and nutrition, alongside clear advice for when to seek further care. In health facilities, early risk assessment is essential to identify those needing escalation, particularly in the presence of airway or ocular involvement, severe proctitis, bacterial superinfection, encephalitis, dehydration, uncontrolled pain, pregnancy, young age, or advanced immunosuppression. Antibiotics are used only when there is clear evidence of bacterial infection, while HIV and other co-infections should be promptly diagnosed and treated without interrupting ART.

Infection prevention remains critical, with appropriate precautions in healthcare settings and at home until lesions have fully healed. Special populations, including pregnant people, children, and the immunocompromised, require closer monitoring and a lower threshold for admission. Good communication, clear home-care guidance, and attention to the mental health and social impacts of the disease are all part of providing high-quality, patient-centred care. Above all, clear communication, practical home-care guidance, and attention to mental health turn clinical care into patient-centred care.

In June 2025, the Data Monitoring Committee reviewed the MEURI results, with no further data to be submitted to WHO. Tecovirimat within the MEURI programme is now less than 12 months from expiry and cannot be shipped. The STOMP trial was stopped early, showing no signal of clinical benefit, and across PALM 007, STOMP, and UNITY, findings indicate that tecovirimat is safe when used after mpox infection but does not significantly shorten time to lesion resolution in any randomised trial.

WHO continues to support data collection through the Global Clinical Platform, and the openly available data models have been used to collect and understand data within national programs, and individual patient level data meta-analysis is planned.

Infection prevention and control (IPC)

Most MPXV transmission in the global outbreak has occurred through close person-to-person contact, including sexual contact. Transmission through contact with contaminated objects, linens, and surfaces has also been reported.[43] Close and prolonged conversational contact with a symptomatic mpox case, (particularly where there are visible mouth ulcers) presents risks for transmission.

A 2024 systematic review of non-comparative studies (covering 270 studies published between 2022-2024, with data from 32 318 mpox cases with reported transmission routes – not yet published but available) identified contact as the primary mode of transmission, accounting for 98.2% of cases with known transmission routes. This includes sexual contact, suspected sexual contact, close non-sexual contact, fomite/environmental contact, transplacental transmission, and percutaneous injury. Transmission through percutaneous injury with contaminated objects, fomite, transplacental route and animal products were rare, accounting for approximately 0.1% of cases. Notably, there was only one case of self-reported droplet exposure out of the 32 318 cases that reported route of transmission data. The review found 25 studies reporting 1712 health and care worker exposures of whom 13 developed mpox infection. Percutaneous exposure was reported for 10 of these cases, while the remaining three reported unspecified occupational exposures.

Challenges in implementing IPC practices have been noted in several countries in the African region experiencing outbreaks, including a lack of national IPC guidelines, lack of subnational and facility-level IPC practitioners with IPC expertise and gaps in water sanitation and hygiene (WASH) services within health facilities. Assessments have also identified gaps in training health and care workers, lack of screening for mpox in health facilities and inadequate isolation capacity, insufficient PPE access, insufficient resources and low compliance with hand hygiene standards.

Over the course of the more recent outbreaks in 2024 there are new challenges with transmission in the community, such as in overcrowded household and congregate settings (e.g. prisons, camps), especially in the camps for internally displaced persons (IDP) in DRC, elevating the importance of, and challenges with, implementing IPC measures and WASH services in these settings to mitigate transmission.

WHO has published the clinical management and IPC living guidelines for mpox 2025, which recommends that in health care settings health workers caring for mpox patients should use gloves, gowns, medical mask and eye protection based on risk assessment. In the community setting Infection prevention and control measures including hand hygiene, dedicated personal items, appropriate handling of linens and laundry, cleaning and disinfection of the environment, and waste management should be followed for persons with mpox in the community until all lesions are healed. Individuals with mild and uncomplicated mpox may be cared for at home, provided certain criteria are met. Isolation of mild mpox patients for homecare is not required if the person consistently covers the lesions, wears a well-fitting medical mask when around others, and avoids sharing personal items until all lesions are healed. When these measures can't be followed, persons with mild mpox should isolate in separate room or dedicated space.

Community protection

Community protection strategies and interventions remain critical in slowing transmission and stopping outbreaks in several countries. They are essential for creating more community-centred and equitable programmes that foster trust and help reduce the stigma and discrimination associated with mpox.[44]

As mpox transmission and the virus itself have evolved, affecting new populations and countries, RCCE strategies and interventions have been adapted to ensure those most affected have the information and means to take protective action.

Since the declaration of the second mpox PHEIC in August 2024, WHO has further strengthened its support to regions and countries through a comprehensive and integrated package for community protection.[45] Community protection emphasizes prioritizing support for those disproportionally affected by mpox transmission, such as sex workers[46] and those living in IDP camps and camp-like settings,[47] and mpox-affected households of those with mpox, including children. Activities also support affected communities in implementing home-based care where appropriate, providing culturally sensitive guidance to manage mild cases and reduce the risk of household transmission and enhancing community-based surveillance in identified hotspots.[48] Coordinated efforts have focused on supporting community health workers, volunteers and peer educators to enhance public trust, reinforce prevention behaviours, counter misinformation, detect and report cases, and strengthen community coordination and response in both rural and high-density urban areas. In DRC, over 500 community health workers were trained using an integrated community protection training package,[49] covering modules on risk communication and community engagement, early detection, community-based infection, prevention and control, home-based care, stigma reduction and mental health support. Delivered through a train-the-trainer approach for mpox detection and response and conducted in collaboration with the DRC Ministry of Health, Africa CDC and other key partners, the rollout has laid groundwork for further implementation including upcoming plans in Zambia.

Community protection also expanded to support targeted vaccination efforts particularly among key populations. Engagement with HIV networks and civil-society organisations has been further strengthened including in newly affected countries and those continuing to experience large outbreaks. Ensuring that we continue to listen to and work with those most affected by mpox, including those with lived experience of the disease, remains a priority. Informal community reference groups representing communities at high risk of mpox have continued to shape RCCE strategies, tools and approaches. Community leadership and participation have been crucial in delivering effective RCCE strategies that have provided timely, consistent, credible, and actionable messaging to at-risk and affected populations throughout the course of the response, especially within the last three months.

While significant steps have been made to inform and engage the disparate groups most at risk from mpox disease, there remain several associated risks for different groups in different settings. These include low risk perception in the context of multiple emergencies, lack of access to trusted and reliable information, knowledge gaps, mis- and disinformation, traditional beliefs, a lack of trust in health authorities among some populations and a risk of non-compliance with protective behaviours, including isolation recommendations. Stigma, particularly linked to sexual transmission, continues to deter care-seeking and isolation. In many mpox affected communities, this is compounded by structural barriers, such as overcrowded housing, poverty, and limited access to WASH services, which make it difficult to adopt recommended behaviours and are among the primary barriers to effective community-based interventions. In various regions and countries, particularly where foreign or migrant workers are present, additional barriers—such as fear of legal repercussions, deportation, or social stigma—may prevent individuals from reporting symptoms, undergoing testing, or seeking care.

Operational and contextual challenges—such as insecurity, limited access to affected populations, funding shortfalls, human resource constraints, gaps in local RCCE and infodemic management capacity, and coordination difficulties at district and sub-national levels—further affect the reach and effectiveness of RCCE implementation efforts. In various contexts, message fatigue has also contributed to a decline in public concern and risk perception, lowering engagement with and adoption of public health interventions.

Despite these challenges, RCCE and Infodemic Management systems have continued to advance. Since the declaration of the second mpox PHEIC, RCCE-IM capacity has been significantly strengthened in the African region, with support from WHO and partners through the continental RCCE-IM coordination platform. Over 2000 RCCE-IM staff and experts across 21 countries have been trained on mpox readiness and response. In parallel, 13

countries in the African region have reviewed and updated their mpox RCCE and infodemic strategies to better align with emerging needs. In DRC, WHO initially led the development and piloting of an interactive RCCE data platform to track key indicators. The platform, which supports real-time reporting and coordination, is now being advanced as an interagency tool under the leadership of the Ministry of Health.

Sixteen countries in the African region have also expanded efforts to generate and use social, behavioural and community data and evidence. Several countries are collecting and using community evidence through research and rapid assessments, and funded interdisciplinary projects include social and behavioural science work streams.[50] Progress has also been made to establish norms and standards for ethics, quality and useful data and evidence through the first of its kind guidance on social and behavioural research for mpox,[51] along with operational support tools. However, despite significant efforts to improve the quality of evidence, gaps persist, with delays in ethics and other approvals hindering the timely generation of community data and evidence, fragmented research activity, and limited sharing of findings prior to publication. There are still critical gaps in understanding behavioural drivers of transmission particularly for different populations, such as sex workers, truck drivers, those living in camps and camp-like settings, immunocompromised individuals, local health workers, indigenous populations, and children. Further, co-design and co-implementation of interventions with target communities at identified hotspots, including camps for migrants, refugees and IDPs, needs to be scaled up, building on and strengthening existing community structures and systems and moving beyond one-way communication.

A key enabling factor would be to ensure the systematic flow of tailored and localised information. This is especially important in regions with high cross-border movement or migration. Cross-border mpox transmission requires coordinated RCCE efforts across countries, which can be complex due to differing health policies, languages, communication strategies and levels of RCCE resource allocation. Enhancing the skills of community health workers in community protection work including RCCE, home-based care, community IPC, and community-based surveillance needs to be further expanded in both critical humanitarian contexts and challenging urban hotspots. This will support community action and ownership of behavior change efforts and help to address the shortage of trained RCCE personnel on the ground.

Finally, to ensure long-term impact, community protection must be strengthened and institutionalized as a core function of national public health systems. A dedicated sustainability framework for community protection has been developed to guide this shift, outlining key actions to support Member States in sustaining and institutionalizing community protection functions into national health systems, policies, and preparedness plans. This includes sustaining RCCE-IM, surveillance, and community workforce support through integrated programming, policy alignment, and sustained investment in public health systems.

Vaccines and Immunization

During this outbreak, there have been important advancements in regulatory approval of mpox vaccines, related acceleration of work from vaccine manufacturers towards further approvals from regulatory agencies and further assessment by WHO, and concerted efforts to improve access, provide WHO policy recommendations, support country readiness, and delivery of mpox vaccines. Robust guidance was issued by SAGE in March 2024 for use of mpox vaccines during outbreaks, accompanied by a call to action for research in Africa. WHO SAGE advice endorsed by the Director-General was published as a WHO vaccine position paper on 23 August 2024.[52] On 7 August 2024, the Director-General of the WHO announced that he had triggered the process towards Emergency Use Listing (EUL) for mpox vaccines in light of the escalating mpox situation in DRC and mpox outbreak expansion in the African Region. The EUL is an emergency use authorization process, specifically developed to expedite the availability of medical products like vaccines that are needed in public health emergency situations. Granting of an EUL accelerates vaccine access for low-income countries which have not yet issued their own national regulatory approval and has the potential to result in scale up of supply through third party procurement by

partners such as Gavi and UNICEF. WHO issued a notice of prequalification for the MVA-BN vaccine in September 2024 (with age extension in October 2024), and this was followed by Emergency Use Listing for the LC16m8 vaccine on 18 November 2024.

There are two licensed vaccines for use in response to the current mpox outbreak: MVA-BN and LC16m8. These vaccines differ significantly in terms of dose-scheduling, route of administration, precautions, warnings, and contraindications. MVA-BN, a non-replicating live vaccine, has the least safety-related use constraints. In the context of an outbreak, WHO recommends vaccination for individuals at high risk of exposure, based on local epidemiology, members of a geographically defined area or community (e.g. village), including children, with a documented high risk of exposure to mpox; health workers and frontline workers at risk of repeated exposure; sex workers, gay, bisexual or other men who have sex with men, other individuals with multiple sexual partners.[52] Mass vaccination is not currently recommended for mpox. 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.

WHO has published operational interim guidance for MVA-BN[53] and LC16m8 vaccines[54] in addition to technical assistance for country readiness and training material[55] to support countries in their national policy recommendations, implementation, and monitoring of mpox vaccination. Results from the use of the MVA-BN vaccine during the 2022 global outbreak estimate: the effectiveness of pre-exposure vaccination was 76% (95% CI: 64–88) for a one-dose schedule and 82% (95%CI: 72–92) for a two-dose schedule; for post-exposure vaccination, effectiveness was estimated to be 20% (95%CI: -24–65).[56] No real-world effectiveness data are yet available for the LC16m8 vaccine. Information on vaccine effectiveness in specific groups, such as people living with HIV, and duration of immunity due to vaccination, are currently unknown. Stakeholders are strongly encouraged to conduct studies with standardized data collection to assess the effectiveness of these vaccines during the implementation of vaccination programs.

In the context of the current outbreak, seven African countries have initiated mpox vaccination, all using MVA-BN vaccine. More than 950 000 doses have been administered during the current outbreak response. Notably, 69% of these doses have been administered in DRC, the country reporting the highest number of cases.

Furthermore, to improve access, the interim Medical Countermeasures Network (i-MCM-Net) initiative coordinated by WHO has operationalized the multi-partners Access and Allocation Mechanism (AAM) for mpox medical countermeasures, to secure and coordinate available donations and supplies and strategically allocate them to affected countries to help them control the mpox outbreak. In 2024, almost 6 million doses of mpox vaccine were mobilized globally, of which nearly 2.5 million doses through the AAM. In the five allocation rounds, through the AAM, 2 181 200 mpox doses were allocated to 14 countries from the African region (Angola, Central African Republic, Côte d'Ivoire, DRC, Guinea, Kenya, Liberia, Malawi, Nigeria, Rwanda, Sierra Leone, South Africa, Uganda and Zambia). To date, more than 1.3 million vaccines have been delivered to twelve countries (Angola, Central African Republic, Côte d'Ivoire, DRC, Kenya, Liberia, Nigeria, Rwanda, Sierra Leone, South Africa,Uganda and Zambia), among which more than 980 000 doses delivered to the DRC. In addition, 1 861 400 doses (311 400 MVA-BN doses and 1 550 000 LC16m8 doses) were delivered to three countries (DRC, Nigeria, Rwanda) through bilateral agreements. The access to vaccines by affected countries using the AAM mechanism is a significant step towards a coordinated and targeted use of vaccines in response to mpox outbreaks and provides a blueprint for coordinating the medical countermeasures value chain to be ready for future epidemic responses. While some vaccine doses remain available to address new country requests, funding is urgently needed to secure additional supply from manufacturers. In the interim, countries are encouraged to consider adopting intradermal fractional dosing of MVA-BN vaccine, a proven strategy to maximize coverage and widen access during supply constraints.

Sustained efforts need to continue to support vaccination at the country level for people at risk, and to strengthen capacity to monitor and adjust vaccination strategies as needed.

One Health

There are significant knowledge gaps in our understanding of the MPXV animal reservoirs, interspecies transmission patterns (including in wildlife and domestic mammals), and behavioural risk factors for zoonotic transmission. Addressing these gaps is crucial for directing preventive measures better. While some epidemiological and ecological investigations are underway, particularly in central African countries and in Nigeria, research on animal infections remains underfunded and limited. Due to the time lag between exposure to a potentially infected animal and the onset of mpox symptoms, the identification and sampling of the animal remain extremely difficult. In addition, collaboration at the local levels between the human, animal, and environment sectors is not well-established in many countries, but essential for a comprehensive response. The communication and speed of information sharing is suboptimal with significant delay in publicly sharing findings of MPXV within other sectors.

DRC has a passive animal surveillance system in place, which includes mpox as a notifiable disease, and collects data on suspected and confirmed MPXV in animals, in line with national surveillance guidelines From the start of the response, several suspected animal cases have been reported, but none of those sampled has tested positive for MPXV. Linking animal and human mpox cases has proven to be very challenging, but genomic sequencing is adding valuable insights for a better understanding of the role of zoonotic spillover events in the evolving epidemiology of mpox.

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ANNEXES

Annex 1: Naming conventions for MPXV and description of risk groups

After consultations with experts, countries, and the general public, WHO has adopted the name "mpox" for the disease, which in 2024 became the preferred term in English. "Monkeypox" remains a synonym, to match historic information, and the virus causing the disease is the monkeypox virus (MPXV).[e]

MPXV clades were also renamed in 2022, with nomenclature of a Roman numeral for each clade, with lowercase Latin characters for subclades; the Congo Basin clade became clade I and the West African clade became clade II.[63]. Each of the clades has two subclades, Ia and Ib for clade I, and IIa and IIb for clade II. Subclades Ia and Ib were defined after the emergence of subclade Ib in the South Kivu province of DRC in 2023, and subclade Ia is currently considered to encompass all other strains of clade I that are not Ib.[f]

In this assessment, based on transmission dynamics (population affected, modes of transmission, spillover to other groups), geographical spread (clade distribution, incidence, potential zoonotic spillover), risk factors for infection and severe disease, as well as public health infrastructure for response strategies needed to control outbreaks, the risk has been assessed for the following groups:

- **Clade Ib MPXV: Currently mostly affecting non-endemic areas for mpox in DRC and neighbouring countries,** affecting all adults and children, and spreading through close physical contact, including sexual contact. For clade Ib MPXV, international spread is predominantly linked to sexual contact. The geographic expansion of clade Ib MPXV outbreaks in East Africa and beyond, with several countries outside East Africa and in other regions of the world increasingly reporting cases linked to travel to the region, illustrates the still-rising risk of spread of clade Ib MPXV across the globe.
- **Clade Ia MPXV: Currently mostly affecting mpox-endemic areas in DRC[12]**, with sporadic cases reported in other Central and Eastern[13] African countries, where the outbreak is linked to zoonotic spillover events as well as human-to-human transmission through close physical contact, including sexual contact.
- **Clade II MPXV in historically endemic areas: Currently mostly affecting Nigeria and countries of West and Central Africa where mpox is endemic**, with outbreaks often characterized by low incidence and low mortality, affecting adults and children, and linked to zoonotic spillover events as well as human-to-human transmission through close physical contact, including sexual contact.
- **Clade IIb MPXV global epidemic** in which outbreaks continue to spread primarily among adult men who have sex with men in connected sexual networks. This population is also at risk should clade I MPXV enter and transmit in these networks.

[e] World Health Organization (WHO), "WHO recommends new name for monkeypox disease," *accessed Dec 27, 2023*, https://www.who.int/news/item/28-11-2022-who-recommends-new-name-for-monkeypox-disease.
[f] World Health Organization (WHO).

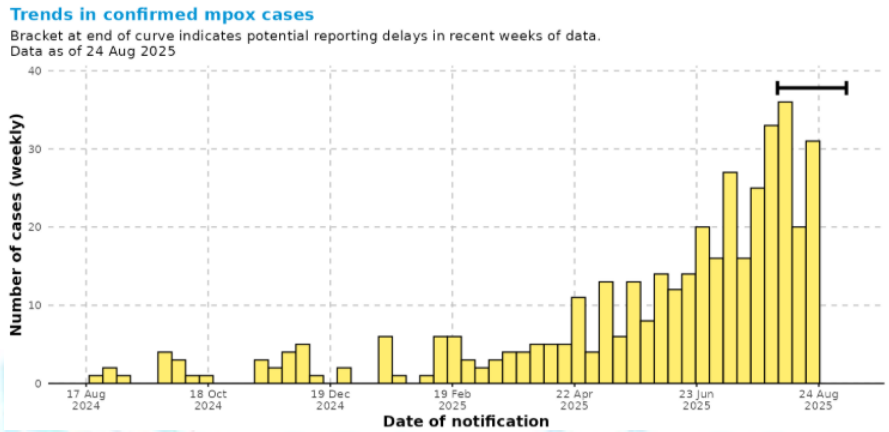
Annex 2: Descriptions of other mpox outbreaks in Africa

Focus on other priority countries reporting clade Ib MPXV co-circulation

Kenya

From 1 January 2024 to 24 August 2025, 401 confirmed mpox cases, including six deaths (CFR – 1.5%), have been reported in Kenya. So far, only clade Ib MPXV has been detected in the country. The country continues to experience community transmission and has been observing a gradual upward trend in confirmed cases reported throughout 2025 (Figure 11).

Figure 11. Epidemic curve of weekly number of confirmed mpox cases by reporting epidemiological week, in Kenya, 1 January 2024 – 24 August 2025.



Cumulatively, confirmed cases have been reported in 45% (21 out of 47) of counties in the country, up from just the 12 counties along the major A104 transport corridor at the beginning of 2025. Household, community, and sexual contact transmission have all been reported to contribute to the spread of mpox in the country. While the relative contributions of each to mpox spread are unclear, sexual contact transmission continues to be implicated as a major amplifier of disease spread, especially at the nexus of truck drivers, sex workers and traders along the major East African transnational highway.

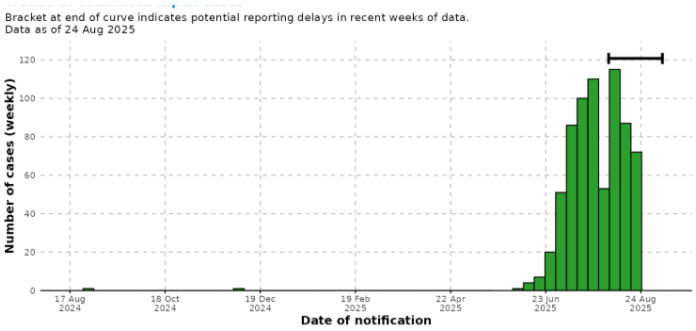
As of 24 August 2025, the country had reported six deaths among confirmed mpox cases. All but one of the deaths has been reported among persons living with HIV, highlighting the risk of poor health outcomes in this key population.

Focus on priority countries reporting clade II MPXV

Guinea

Guinea has not historically been considered endemic for mpox, but it hosts part of a tropical forest belt that extends across mpox-endemic countries in western and central Africa, and the virus could potentially be present in wild fauna in these areas. From 1 January 2024 to 24 August 2025, Guinea reported 708 confirmed cases, including one death (CFR 0.1%). As of 24 August 2025, Guinea is experiencing a fast-growing mpox outbreak, with a marked increase in confirmed cases reported since June 2025, reaching over 110 confirmed cases for the most recent peak (Figure 12). Only clade IIb MPXV has been reported in the country during this surge in cases.

Figure 12. Epidemic curve of weekly number of confirmed mpox cases by reporting epidemiological week, in Guinea, 1 January 2024 – 10 August 2025.



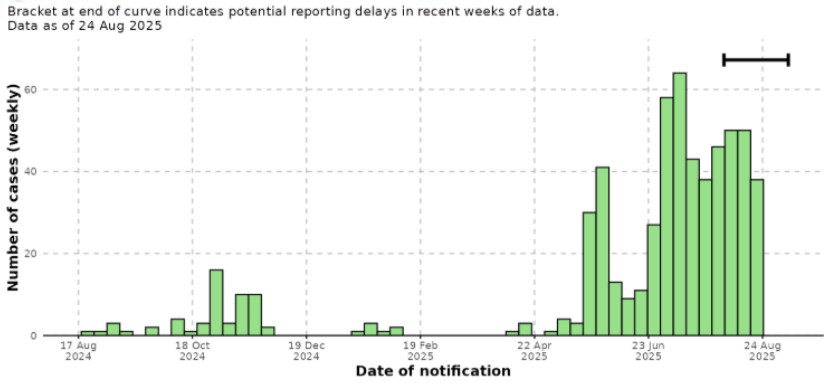
Prior to this surge, only sporadic cases had been recorded, with isolated detections in late 2024. While initial cases were reported to be linked to travel to Sierra Leone, most cases are now being reported in and around the capital, Conakry, among adults with no travel history. About two-thirds of cases are male and the majority of cases has been reported among those aged 20 – 29 years old, followed by those 30 – 39 years old.

Liberia

Liberia had previously reported four confirmed cases of mpox in 1970 and later, two additional confirmed cases and two deaths in 2017, at the time of the large 2017 – 2028 outbreak in Nigeria. The origin and modes of transmission of those two clusters of cases remain unknown.

From 1 January 2024 to 24 August 2025, Liberia has reported 600 confirmed mpox cases and no deaths. An outbreak was reported in late 2024 and sporadic cases were reported in early 2025, but in May 2025, there was a sharp increase in reported weekly confirmed cases, with more than 50 confirmed cases reported in recent weeks (Figure 13).

Figure 13. Epidemic curve of weekly number of confirmed mpox cases by reporting epidemiological week, in Liberia, 1 January 2024 – 24 August 2025.



Early in this surge, initial cases were linked to cross-border spread from neighbouring Sierra Leone, with initial cases reported to have had high-risk sexual exposure during a short stay in Sierra Leone before returning to Liberia where symptoms began. Since then, however, most cases have been reported among individuals with no travel history, signalling sustained local transmission. Most cases have been reported in Montserrado, which hosts the capital Monrovia. Although limited information is available on transmission patterns and most affected groups, epidemic dynamics are thought to be similar to other clade IIb MPXV outbreaks in the region where sexual contact has been implicated as a major driver of spread.