Mpox

Multi-country external situation report no. 46, published 28 January 2025

KEY FIGURES			
Reporting period: 1 January 2022 – 31 December 2024			
Area	**Number of reported confirmed cases**	**Number of deaths among confirmed cases**	**Number of reporting countries**
Global	**124 753**	**272**	**128**
Reporting period: 1 January 2024 – 19 January 2025			
Area	**Number of reported confirmed cases**	**Number of deaths among confirmed cases**	
Africa	**20 345**	**64**	
Democratic Republic of the Congo[1]	**14 530**	**43**	
Burundi	**3116**	**1**	
Uganda[2]	**2031**	**10**	
Reporting period: last six weeks, 9 December 2024 – 19 January 2025			
Africa	**2935**	**5**	
Democratic Republic of the Congo	**1316**	**0**	
Burundi	**570**	**0**	
Uganda	**984**	**5**	

Highlights

- The outbreak of mpox due to clade Ib monkeypox virus (MPXV) continues predominantly in the Democratic Republic of the Congo, Burundi and Uganda, with new travel-related cases identified in previously unaffected countries.
- The Democratic Republic of the Congo remains the most affected country, experiencing circulation of both clade I MPXV subclades. Despite many of the provinces reporting stable trends in cases, the situation in the country remains concerning, with continued sustained circulation of virus strains. The escalating violence in the eastern part of the country poses additional challenges for the mpox response.
- Burundi and Uganda continue to report the most cases outside of the Democratic Republic of the Congo.
- New travel-related cases of mpox due to clade Ib MPXV have been detected in countries that had already detected travel-related cases before, including China, Germany, Thailand, the United Kingdom of Great Britain and Northern Ireland and the United States of America.
- Azerbaijan has reported its first case of mpox. Information on the MPXV clade is not yet available.

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

[2] Following routine data verification activities carried out in-country since the last edition of this situation report, the number of deaths among confirmed cases reported in Uganda has been revised from 12 deaths to 10 deaths by the country for this reporting period. Accordingly, the total number of deaths among confirmed mpox cases in Africa for this reporting period has been revised from 66 deaths to 64 deaths.

In this edition:

Contextual description

This report provides an update on:

- The global mpox epidemiological situation, as of **31 December 2024**. Global surveillance data is collected monthly, and December 2024 is the last month for which complete data are available.
- The epidemiological situation for mpox in Africa (including countries in the WHO African Region and some in the WHO Eastern Mediterranean Region), with data as of **19 January 2025**.
- Operational response updates and updates on imported mpox cases as of **24 January 2025.**

The latest mpox updates can also be found in the WHO mpox surveillance report.

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

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

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

For reference purposes, a summary of the latest WHO global mpox rapid risk assessment conducted in November 2024 can be found in Annex 1.

Epidemiological update [3, 4]

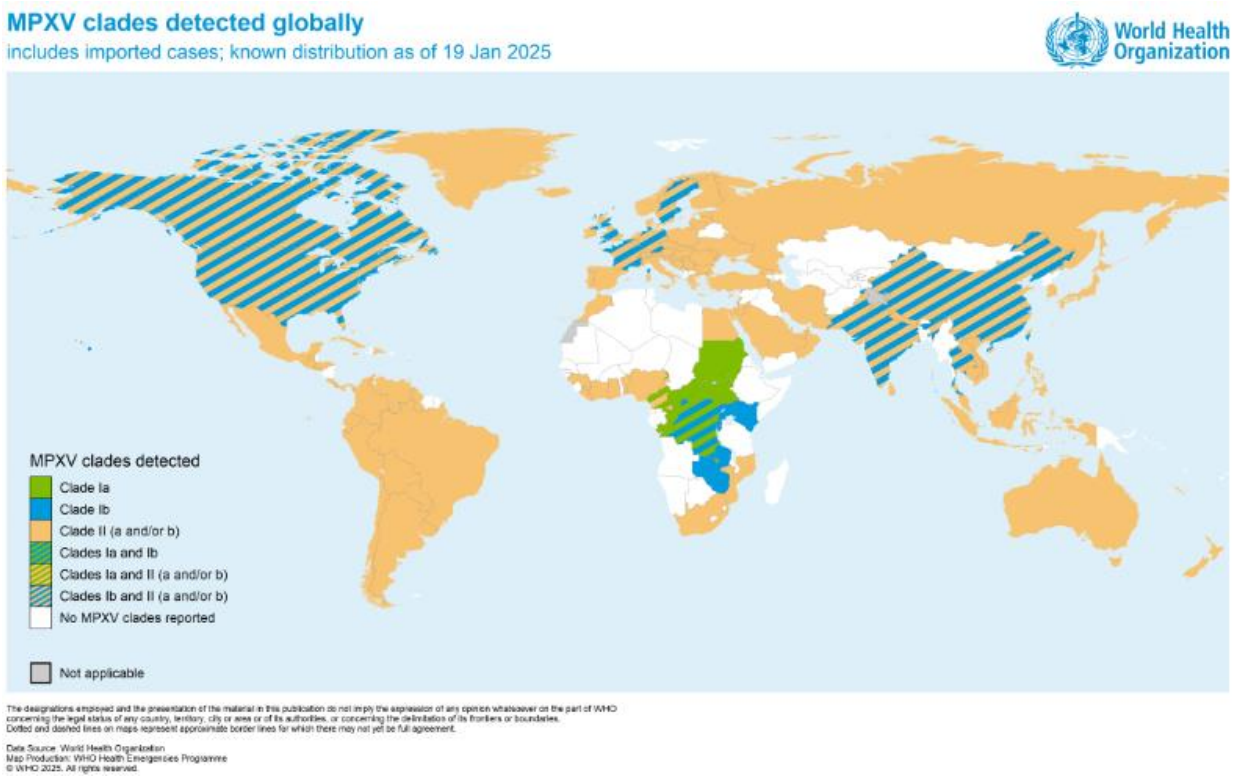
Global monkeypox virus (MPXV) distribution

As of 19 January 2025, the distribution of reported MPXV clades by country of detection is as shown in Figure 1. This information is compiled from sequencing activities conducted and reported on 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 eight provinces of the Democratic Republic of the Congo (in South Kivu, North Kivu, Kinshasa, Kasai, Tshopo, Tanganyika, Haut-Katanga, and Mai-Ndombe provinces). Within Africa, community transmission has been reported in Burundi, Kenya, Rwanda and Uganda; travel-related cases have been reported in Zambia, and Zimbabwe. In addition, while no cases have so far been confirmed in Tanzania, the identification of mpox cases in other countries who had traveled to Tanzania, together with information from affected communities in the country, suggests undetected transmission may be ongoing.

Outside Africa, 11 countries have detected clade Ib MPXV: China (7 cases), Germany (7 cases), the United Kingdom of Great Britain and Northern Ireland (6 cases), Thailand (3 cases), Belgium (2 cases), the United States of America (2 cases), Canada (1 case), France (1 case), India (1 case), Pakistan (1 case), and Sweden (1 case). No deaths associated with clade Ib MPXV have been reported in these countries. For more details, please refer to Table 2 in the section on Other countries reporting cases of mpox due to clade Ib MPXV.

Figure 1. Geographic distribution of MPXV clades reported to WHO, by country, as of 19 January 2025.



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

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

Overview of mpox outbreaks by virus clade

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

Clade Ia MPXV

Clade Ia MPXV is found primarily in the Democratic Republic of the Congo, where it affects endemic provinces and has increasingly been found in previously unaffected provinces in recent years, including the capital Kinshasa since 2023. Sporadic cases continue to be reported in neighbouring Central African Republic and in the Republic of Congo. The Democratic Republic of the Congo and the Central African Republic report a higher proportion of children among cases, while in the Republic of Congo, most cases are among adults.

Previously, genomic sequencing analysis had indicated that clade Ia MPXV typically emerged in human populations through zoonotic exposure, leading to human-to-human transmission. Current epidemiological data and phylogenetic analysis still suggest that many outbreaks of mpox due to clade Ia MPXV are the result of zoonotic spillover with secondary human-to-human transmission. There is emerging evidence of increasing sustained human-to-human transmission of clade Ia MPXV in sexual networks in Kinshasa following importation from endemic parts of the country. This has not yet been documented in the Central African Republic or in the Republic of Congo.

Clade Ib MPXV

Clade Ib MPXV is predominantly spreading in the Democratic Republic of the Congo, and neighbouring countries to the east, with community transmission reported in Burundi, Kenya, Rwanda, and Uganda, and mostly travel-related cases in other countries where it has been reported. No human case has yet been substantively linked to a suspected animal exposure for this clade, and current genomic sequencing data suggest that it is transmitted only through human-to-human contact. In the Democratic Republic of the Congo, it has been reported from eight provinces: South Kivu, North Kivu, Kinshasa, Kasai, Tshopo, Tanganyika, Haut-Katanga and Mai-Ndombe, and it is the fastest expanding outbreak of an MPXV strain. Other most affected countries in Africa are Burundi and Uganda, where widespread transmission has been ongoing in recent months, while more limited transmission has been reported in Kenya and Rwanda, where the extent of undetected transmission remains unclear. Zambia and Zimbabwe have reported travel-related cases and very limited secondary transmission. Outside Africa, imported travel-related cases have also been detected (in order of reporting) in Sweden, Thailand, India, Germany, the United Kingdom of Great Britain and Northern Ireland, the United States of America, Canada, Pakistan, Belgium, China, and France. Secondary transmission from these cases has been reported in the United Kingdom of Great Britain and Northern Ireland, Germany, Belgium, China and France.

Imported mpox cases have been among adults who travelled during their incubation periods or with early symptoms and were diagnosed once they arrived in the reporting country. Often, they reported prior sexual contact with a person with known mpox or someone with signs and symptoms suggestive of mpox.

Where initial clusters of mpox due to clade Ib MPXV expand and as the outbreak progresses, transmission patterns appear to evolve, with more spread within households, leading to a progressive shift in age and sex distribution, with a rising proportion of cases among children.

The multi-country outbreak of mpox driven by clade IIb MPXV that began in 2022 showed that sexual contact can sustain community transmission of MPXV. Likewise, subclades Ia and Ib are also spreading through sexual contact; much remains to be understood about transmissibility and sustainability of transmission through non-sexual direct physical contact for all clades. In settings where transmission persists, it is likely driven by a combination of sexual, household, and community contact.

Clade IIa MPXV

In 2024, Côte d'Ivoire, Guinea, and Liberia reported cases of mpox due to clade IIa MPXV. There is evidence of evidence of sustained community transmission of this strain in Côte d'Ivoire and Liberia, with cases dispersed over wide geographical areas. Outbreaks of clade IIa MPXV are a concerning new phenomenon as human-to-human transmission of this clade had not been reported before 2024. Furthermore, co-circulation of clade IIa and clade IIb MPXV has been reported for the first time, in both Côte d'Ivoire and Liberia.

Mpox linked to clade IIa MPXV has been reported in adults and children, with many lacking a known epidemiological link, suggesting ongoing, largely undetected community transmission. Limited epidemiological investigations have constrained our understanding of the modes of transmission in these outbreaks and clade IIa MPXV remains the least described MPXV strain in scientific literature. While there is no documented evidence of sexual contact transmission for this strain, it is likely that all forms of close contact contribute to its spread, as with other MPXV strains.

Clade IIb MPXV

Most mpox outbreaks in other parts of Western, Northern and Southern Africa and other parts of the world are due to clade IIb MPXV, a continuation of the multi-country outbreak that began in 2022. Most regions report circulation of clade IIb lineage B.1, while lineage A.1 continues to circulate in Nigeria and some countries in the WHO Eastern Mediterranean Region. The most affected population outside of Africa continues to be men who have sex with men, primarily exposed through sexual contact. In instances where others have been affected, such as women and children, it has not led to sustained transmission, unlike what is being observed for clade I MPXV in the African context. Australia had seen an unprecedented rising trend in cases in 2024 which has been subsiding in recent months while most other reporting countries have indicated ongoing low-level transmission mainly in the same population at risk.

Global trends

This section is a monthly update of the global epidemiological situation, based on the most recent complete information from the mpox global surveillance system, **as of the end of December 2024**. Further details on global trends can be found on the online WHO dashboard.

From 1 January 2022 through 31 December 2024, a total of 124 753 confirmed cases of mpox, including 272 deaths, were reported to WHO from 128 countries/territories/areas (hereafter 'countries') in all six WHO Regions (Table 1). The global Case Fatality Ratio (CFR) among confirmed cases in this period is 0.2%.

A total of 3831 new confirmed cases were reported in December 2024, a 5.6% decline from the preceding month. Most cases in December 2024 were reported from the African Region (86.2%), followed by the European Region (5.6%) and the Western Pacific Region (4.3%). The African Region was the only region to report a monthly rise in cases in December 2024, compared to November, at 6%. The Region of the Americas, the Western Pacific Region, the South-East Asian Region, and the European Region reported declines in cases in December 2024, at 62%, 40%, 29% and 23% respectively. The monthly number of cases in the Eastern Mediterranean Region remained the same in December 2024.

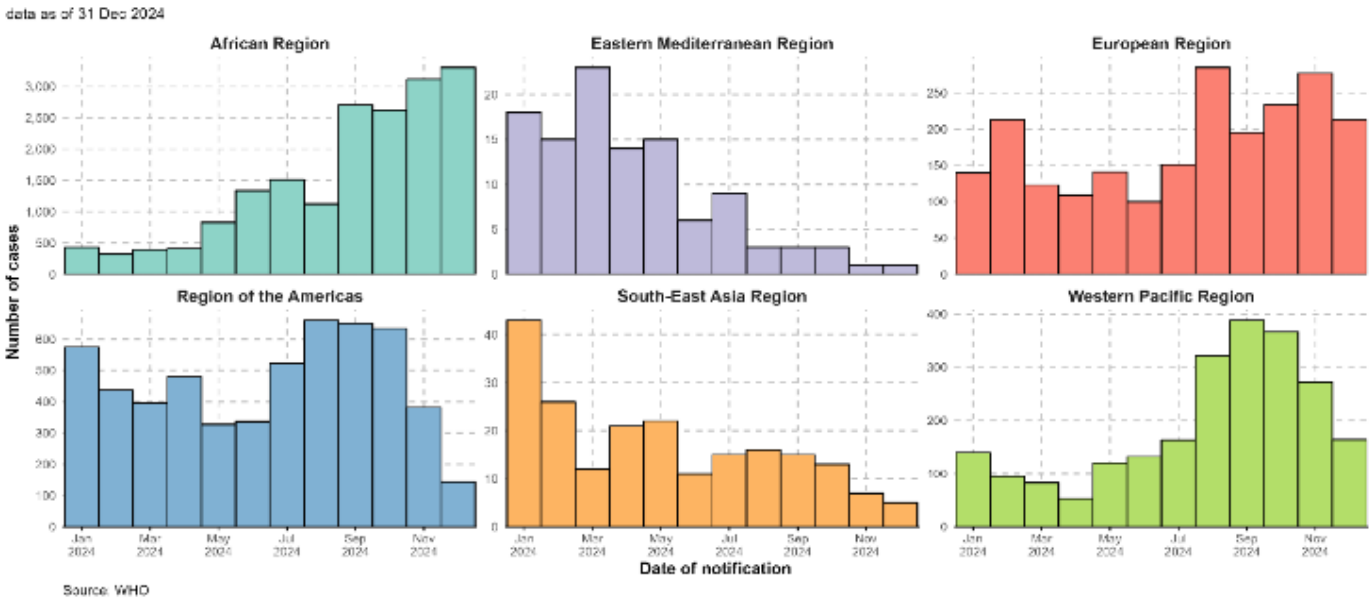
Table 1. Number of cumulative confirmed mpox cases and deaths reported to WHO, by WHO Region, from 1 January 2022 through 31 December 2024

WHO Region	Total confirmed cases	Total deaths among confirmed cases	New cases reported in November 2024	New cases reported in December 2024	Monthly change in cases (%)
Region of the Americas	67 219	151	382	144	-62.0
European Region	28 884	9	277	213	-23.0
African Region	21 556	86	3118	3304	6.0
Western Pacific Region	5219	12	272	164	-40.0
South-East Asia Region	996	11	7	5	-29.0
Eastern Mediterranean Region	879	3	1	1	0.0
Total	124 753	272	4057	3831	-5.6

Figure 2 shows that over the past 12 months (1 January – 31 December 2024), the number of confirmed mpox cases reported monthly in the WHO African Region has been steadily increasing, while the Eastern Mediterranean and Southeast-Asia Regions have seen a consistent decline in the monthly number of cases during the same period. In the European Region, the trend has been relatively stable, while in the Region of the Americas and the Western Pacific, there has been a drop in cases in recent months following a rising trend earlier in 2024.

In the last 12 months, an average of 2371 confirmed mpox cases per month has been reported. Most of them were reported by the African Region, followed by the Region of the Americas, and the Western Pacific. Outside Africa, the highest number of confirmed cases in December 2024 was reported by Australia. The country experienced an unprecedented outbreak of clade IIb MPXV in 2024, affecting mainly men who have sex with men infected through sexual contact. However, there has been a drop in the monthly number of reported cases in recent months.

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

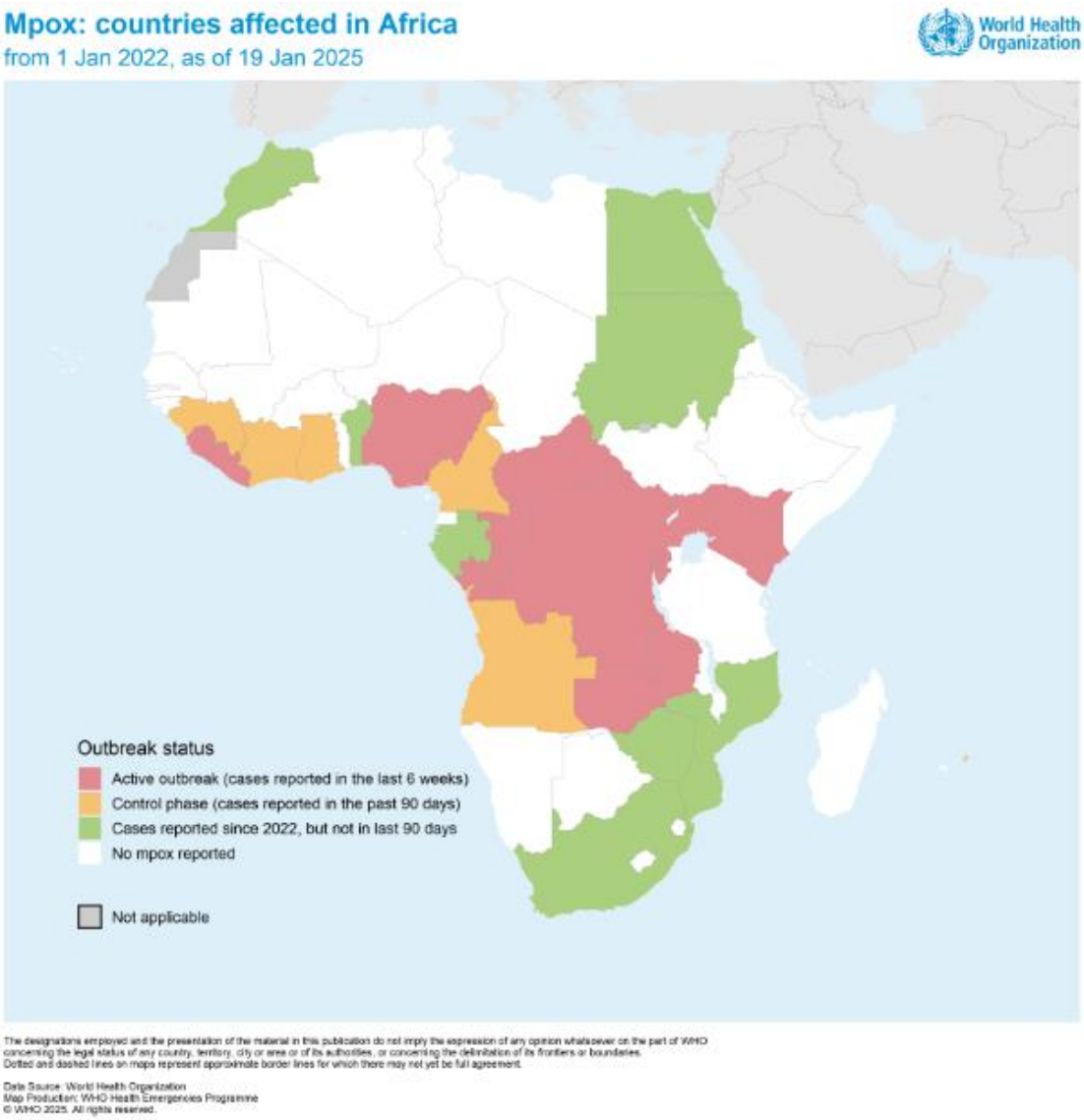


Please note the different Y axis of the regional epidemic curves, in order to allow a better overview of the trend in each region.

Confirmed cases reported in Africa

In Africa, from 1 January 2024 to 19 January 2025, 20 345 confirmed mpox cases, including 64 deaths[5] (CFR – 0.3%), have been reported by 21 countries. The most affected country continues to be the Democratic Republic of the Congo (14 530 confirmed cases, including 43 deaths)[6] followed by Burundi (3116 confirmed cases, including one death) and Uganda (2031 confirmed cases, including 10 deaths). Eleven countries in Africa have reported mpox cases in the last six weeks (two maximum incubation periods of 21 days) and are considered to have active, ongoing outbreaks (Figure 3). Five countries, Angola, Cameroon, Côte d'Ivoire, Ghana, and Guinea have not reported confirmed cases in the last six weeks and could be considered to have transitioned into the control phase of their mpox outbreak, as defined in the Strategic framework for enhancing prevention and control of mpox 2024-2027, if surveillance is deemed to be adequate.

Figure 3. Mpox outbreak status in Africa, by country (1 January 2022 – 19 January 2025).



[5] Following routine data verification activities carried out in-country since the last edition of this situation report, the number of deaths among confirmed cases reported in Uganda has been revised from 12 deaths to 10 deaths by the country for this reporting period. Accordingly, the total number of deaths among confirmed mpox cases in Africa for this reporting period has been revised from 66 deaths to 64 deaths.

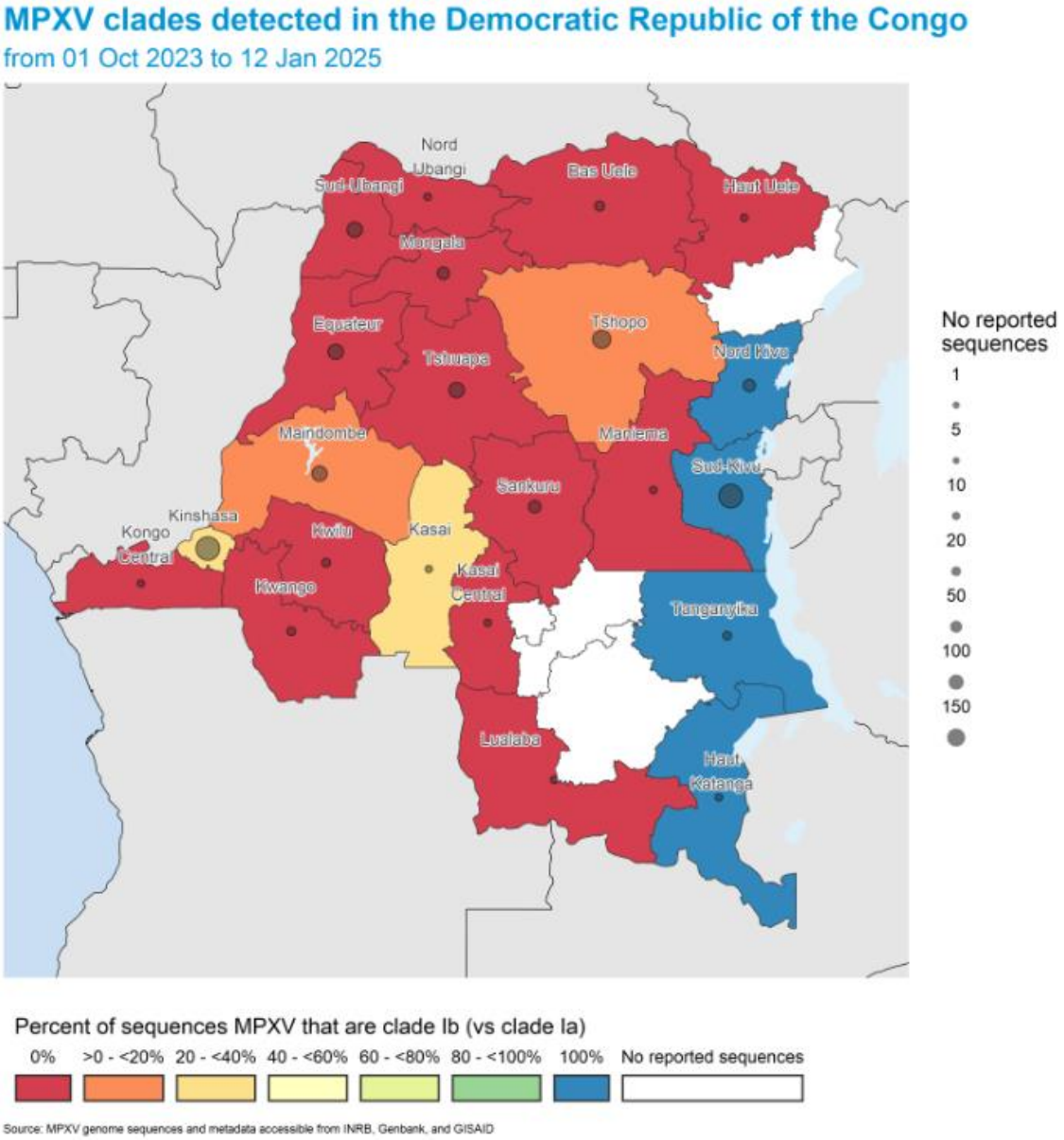
[6] The national-level case counts for the Democratic Republic of the Congo indicated here are based on the national laboratory database for mpox.

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

There is an ongoing process for review of mpox surveillance data in the Democratic Republic of the Congo and the Ministry of Health is currently harmonizing data from the different data sources in the country.

Mpox outbreaks in the Democratic Republic of the Congo continue to be driven by both clade Ia and Ib MPXV strains. Most sequenced samples from 1 October 2023 to 12 January 2025 are from the provinces of Kinshasa and South Kivu (Figure 4). Although all provinces in the country have reported confirmed mpox cases during this period, no sequencing has been done for samples from four provinces: Ituri, Kasai Oriental, Lomami and Haut-Lomami. So far, clade Ib MPXV has been detected in eight provinces, and in half of them, it is co-circulating with clade Ia MPXV. Sequencing data from the Kinshasa outbreak have revealed increasingly sustained human-to-human transmission of clade Ia MPXV with high rates of APOBEC3-driven mutations. However, no such indications have been reported so far in the other provinces where clade Ia MPXV is circulating.

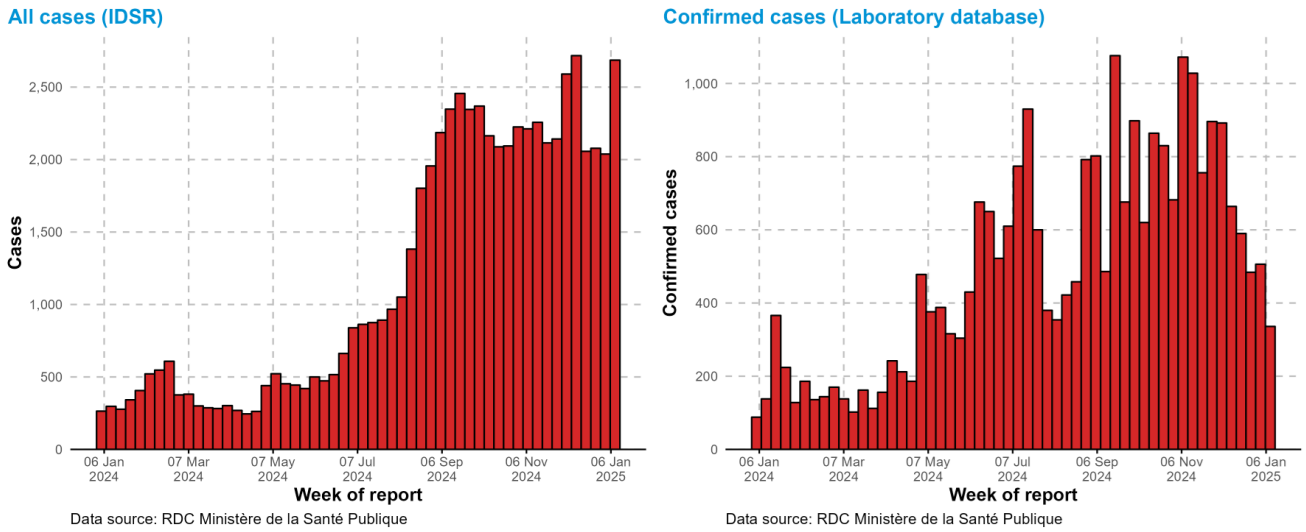
Figure 4. Geographic distribution of clade Ia and Ib MPXV in the Democratic Republic of the Congo, by province, from 1 October 2023 to 12 January 2025[7]



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

The analysis of the epidemic trend of reported suspected mpox cases (left, Figure 5) still shows that over 2000 new suspected mpox cases are reported per week. The trend in reported confirmed cases, (right panel, Figure 5) suggests an ongoing increase over time with very early indications of a downward trend in recent weeks. The trends in reported confirmed cases should be interpreted with caution, given challenges with testing capacities and the impact of the festive period at the end of 2024.

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



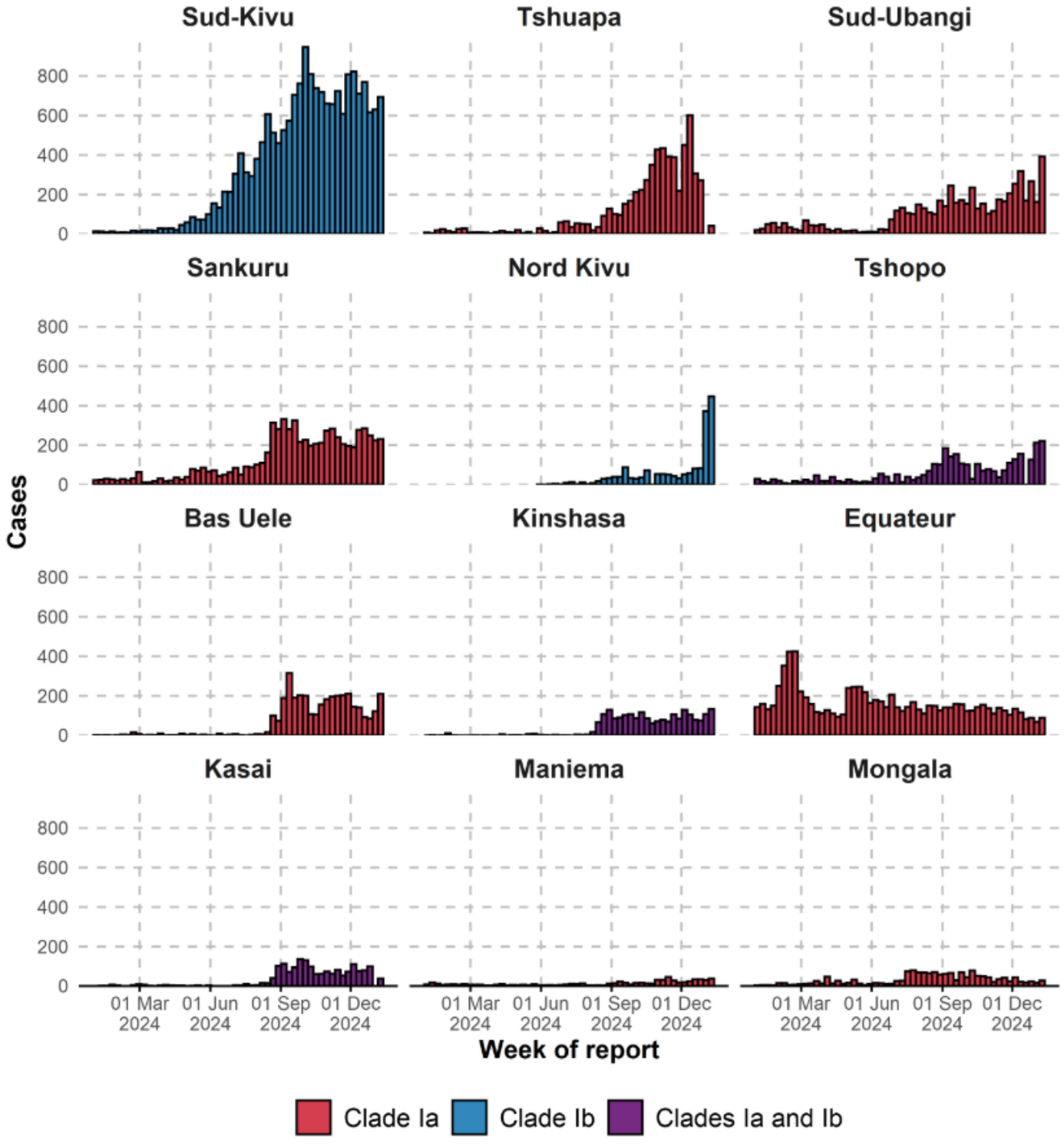
Furthermore, national trends should be interpreted in light of the varying epidemic dynamics at the subnational level. An analysis of the epidemic trend of reported suspected mpox cases in the 12 most affected provinces in the Democratic Republic of the Congo shows that these provinces have varying outbreak sizes, but for most of them, the trend in recent weeks appears to relatively stable (Figure 6).

Among the provinces reporting only clade Ib MPXV, South Kivu continues to account for most suspected cases in the country, reporting over 600 suspected cases per week. Despite having reported only one mpox case ever before this outbreak, South Kivu has reported the highest number of suspected mpox cases in 2024. The increase in reported cases observed in North Kivu 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.

Among the provinces in which only clade Ia MPXV has been detected, Tshuapa had been reporting an increasing trend with very early indications of a downward trend in recent weeks, while the other provinces have been observing more stable trends in recent months. In Equateur province, the province historically most affected by mpox in the country, the trend has been relatively stable since June 2024, with less than 200 suspected cases reported per week.

Among 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 also been relatively stable in the past months. Despite most of the trends appearing stable, the situation in the country remains concerning since circulation of the virus continues at a high level.

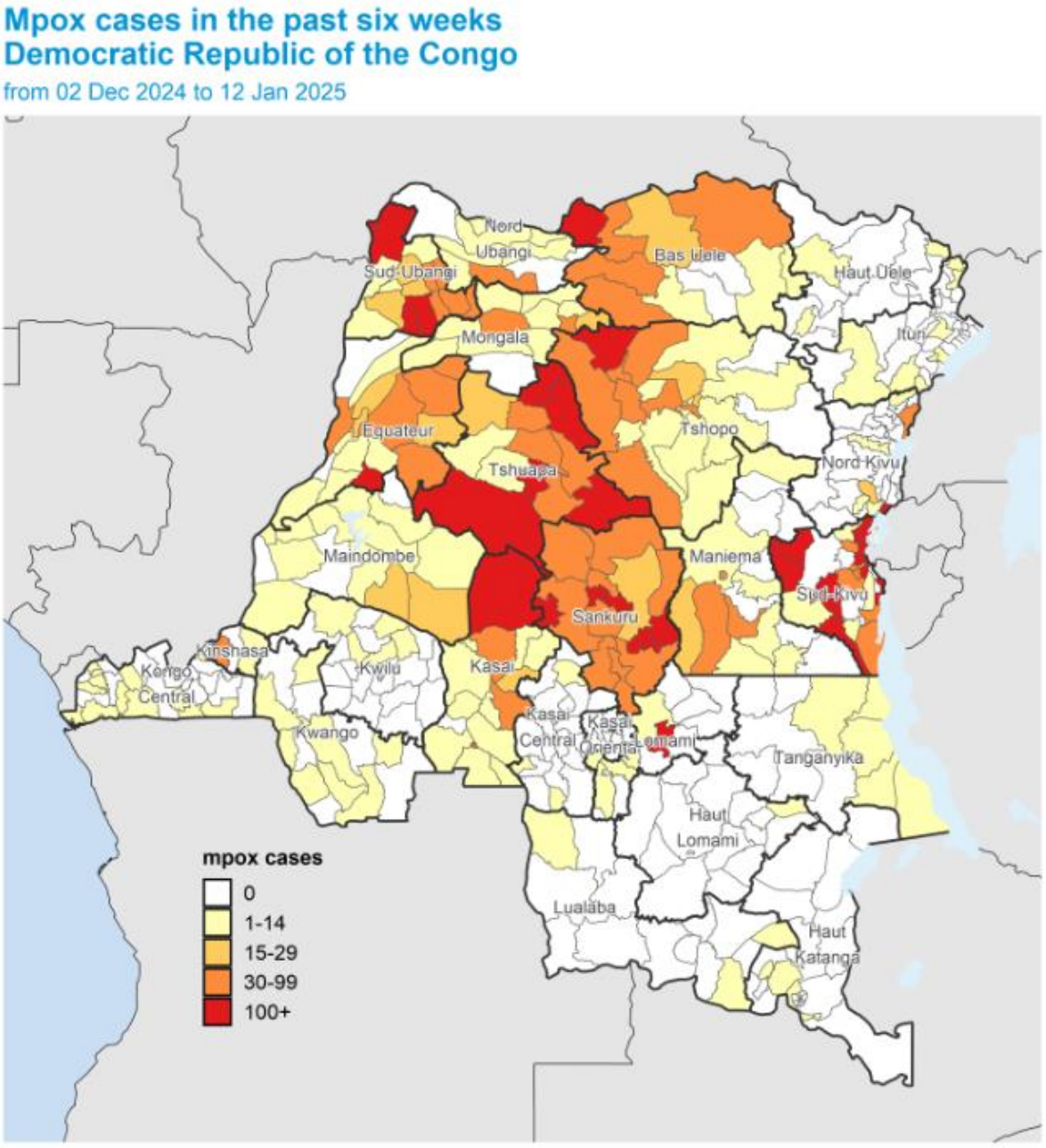
Figure 6. Epidemic curve of reported suspected mpox cases in the most affected provinces of the Democratic Republic of the Congo, 1 January 2024 – 12 January 2025.



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

An analysis of the sub-provincial geographic distribution of suspected mpox cases reported in the Democratic Republic of the Congo over the last six weeks (Figure 7) shows wide variation between different health zones. The highest number of affected health zones is the north-west part of the country, historically considered endemic for mpox, while new hotspots can also be observed in South Kivu, as well as Kinshasa. These provinces (South Kivu and Kinshasa) are particularly relevant for the international spread of mpox because they both have international airports, and South Kivu is also highly connected through land borders with Burundi and Rwanda.

Figure 7. Geographic distribution of suspected mpox cases in the past six weeks, by health zone, in the Democratic Republic of the Congo, 2 December 2024 – 12 January 2025[8].



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

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

Other countries reporting cases of mpox due to clade Ib MPXV

The clade Ib MPXV outbreak has been expanding from eastern Democratic Republic of the Congo into neighbouring countries, with community transmission reported in Burundi. Kenya, Rwanda, and Uganda, and travel-related cases in all other countries in which it has been reported so far, as summarized in Table 2 below. In some countries with travel-related cases, limited transmission linked to these first introductions of clade Ib MPXV has been documented, without widespread transmission reported.

Table 2. Confirmed mpox cases and deaths linked to clade Ib MPXV outbreaks reported to WHO, by country*, as of 24 January 2025.

Country	Confirmed cases	Confirmed deaths	Date of country notification to WHO	Distribution/Source
Burundi	3116	1	25 July 2024	Largely concentrated in and around the capitals, Bujumbura and Gitega
Uganda	2031	10	24 July 2024	Multiple districts, but largely concentrated in and around the capital, Kampala
Rwanda	82	0	24 July 2024	Multiple districts, including capital, Kigali
Kenya	36	1	30 July 2024	Multiple counties (including capital Nairobi) along the major transport corridor from the coast to Uganda and Tanzania
China	7	0	3 January 2025	One case with history of travel to the Democratic Republic of the Congo and five subsequent cases among close contacts
			21 January 2025	One case with a history of travel to the United Arab Emirates
Germany	7	0	18 October 2024	One case with history of travel to Rwanda in September 2024
			13 December 2024	One case with history of travel to East Africa in November 2024 and three subsequent cases among household contacts
			19 December 2024	One case with history of travel to East Africa in November 2024
			9 January 2025	One case with history of travel to East Africa from December 2024 to January 2025
United Kingdom and Northern Ireland	6	0	30 October 2024	One case with history of travel to East Africa in October 2024 and three subsequent cases among household contacts.
			29 November 2024	One case with history of travel to Uganda in November 2024
			19 January 2025	One case with a history of travel to Uganda in January 2025
Zambia	3	0	8 October 2024	One case with history of travel through multiple districts in Zambia over several weeks. Most time was spent in a district bordering the Democratic Republic of the Congo
			30 December 2024	One case with history of recent travel to an affected country in Central Africa and one subsequent case among family contacts
Thailand	3	0	22 August 2024	One case with history of travel to the Democratic Republic of the Congo
			18 January 2025	One case with a history of travel to the United Arab Emirates
			21 January 2025	One case with a history of travel to the United Arab Emirates and a link to the preceding notified case
Belgium	2	0	18 December 2024	One case with history of travel to Central Africa and one subsequent case among family contacts
United States of America	2	0	18 November 2024	One case with history of travel to East Africa
			14 January 2025	One case with a history of travel to East Africa
Zimbabwe	1	0	18 October 2024	One case with history of travel to Tanzania
Sweden	1	0	15 August 2024	One case with history of travel to East Africa
India	1	0	1 October 2024	One case with history of travel to the United Arab Emirates
Canada	1	0	22 November 2024	One case with history of travel to East Africa
Pakistan	1	0	1 December 2024	One case with history of travel to the United Arab Emirates

France	1	0	7 January 2025	One case linked to contact with travelers returning from an affected country in Central Africa

*The Democratic Republic of the Congo is not included in Table 2.

Sustained community transmission

Sporadic travel-related cases

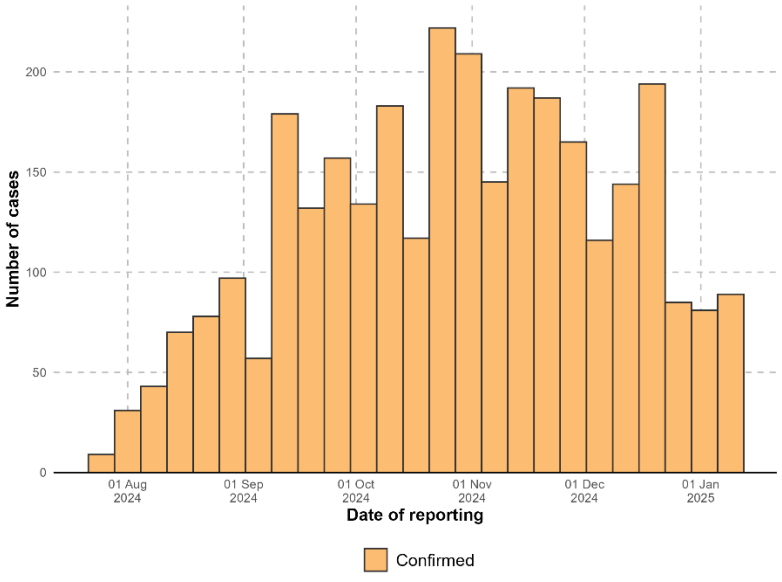
Note: No case of mpox due to clade Ib MPXV has been reported by the United Arab Emirates so far, suggesting likely undetected transmission in the country.

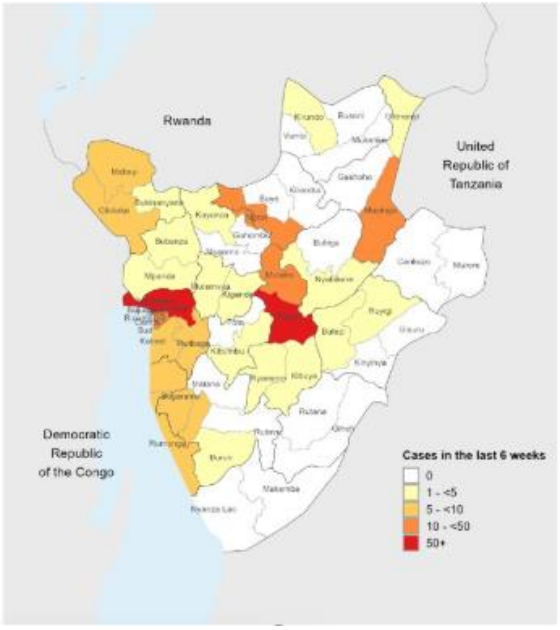
Burundi

From the start of the mpox outbreak in July 2024 to 19 January 2024, Burundi has reported 3116 confirmed mpox cases, including one death (CFR – 0.03%). The country is experiencing community transmission, and the national case count had been ranging between 100 and 200 new confirmed cases per week (left, Figure 8) before a recent drop to less than 100 cases per week. The downward trend in reported cases during the most recent weeks should be interpreted with caution since the apparent decline in cases could be due to the impact of the festive season at the end of 2024 that might have affected surveillance and reporting.

Cases have been reported in at least 94% (46 out of 49) of health districts, but the epidemic remains largely concentrated in and around the largest city of Bujumbura and the capital, Gitega. Almost all suspected mpox cases are tested, and the test positivity rate is approximately 51%. Only clade Ib MPXV, related to the strains circulating in South Kivu, has been detected in the country, and current evidence suggests exclusive human-to-human transmission of the virus.

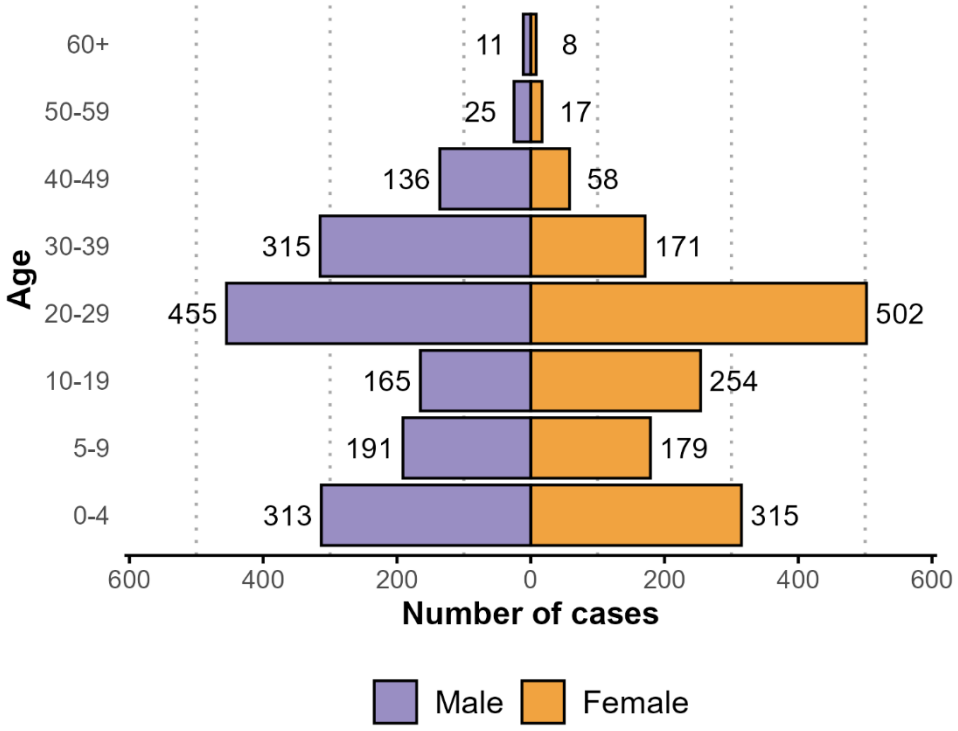
Figure 8. Epidemic curve of weekly number of confirmed mpox cases, by reporting epidemiological week (left), and geographic distribution of confirmed mpox cases by health district in the last six weeks (9 December 2024 – 12 January 2025) (right), in Burundi





Compared to the first month of the outbreak, more recent cases have a bimodal age distribution with higher incidence in young children under 5 years of age and among young adults 20-29 years old. Notably, in recent weeks, the 20 – 29 years age group has replaced the under 5 years age group as the most affected age group in the country (Figure 9). Household transmission, community transmission, and sexual contact transmission have all been reported to contribute to the spread of mpox in the country. However, the relative contributions of each to mpox spread are unclear.

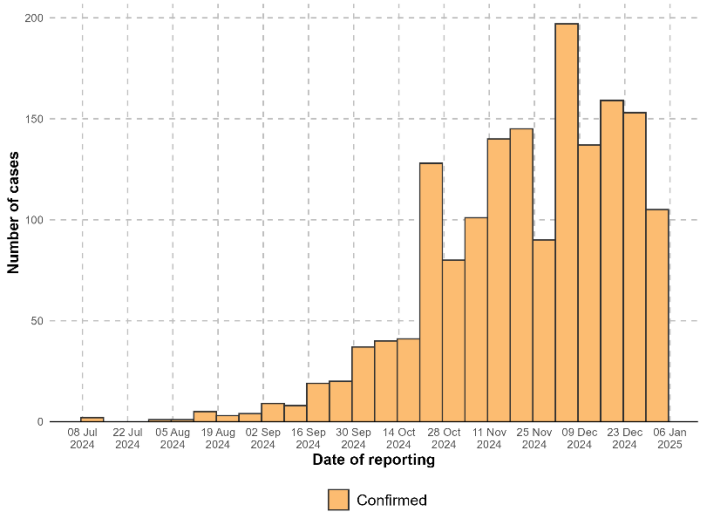
Figure 9. Age and sex distribution of confirmed mpox cases, Burundi, as of 12 January 2025.

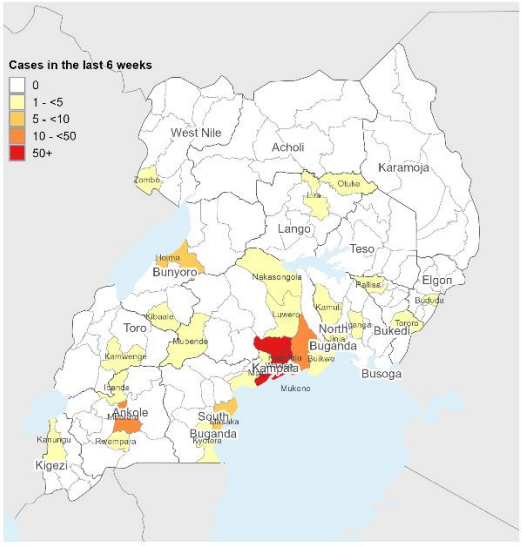


Uganda

From the start of the outbreak in July to 19 January 2025, the country has reported 2031 confirmed mpox cases, including 10 deaths (CFR 0.5%).[9] The country is experiencing community transmission, and the national case count has been increasing over time, with indications of a plateauing in recent weeks (left, Figure 10). Data from most recent weeks need to be interpreted with caution since the apparent decline in cases could be due tothe impact of the scaling down of response activities during the impact of the festive season, which might have affected surveillance and reporting. Data from most recent weeks need to be interpreted with caution since the apparent decline in cases could be due to the impact ofestiveimpact of the impact of the festive season, which might have affected surveillance and reporting.

Figure 10. Epidemic curve of weekly number of confirmed mpox cases, by reporting epidemiological week (left) and geographic distribution of confirmed mpox cases in the last six weeks (right), Uganda, 23 November 2024 – 4 January 2025





Cases have been reported in at least 53% (78 out of 146) of districts in the country, but the epidemic remains largely concentrated in and around Kampala, the capital (right, Figure 10). So far, only clade Ib MPXV, linked to the outbreak in eastern Democratic Republic of the Congo, has been detected in the country, and current evidence indicates that transmission of the virus is occurring exclusively through close, physical human-to-human contact.

First mpox case reported in Azerbaijan (clade not yet determined)

On 18 January 2025, WHO received reports of the first case of mpox to be detected in Azerbaijan. The case is an adult male who reported a history of recent international travel to the WHO Eastern Mediterranean Region. Following his return, he developed signs and symptoms suggestive of mpox and sought medical attention. He was diagnosed with mpox, managed in hospital isolation, and was receiving treatment at the time of reporting. Genomic sequencing information was still pending at the time of reporting.

[9] Following routine data verification activities carried out in-country since the last edition of this situation report, the number of deaths among confirmed cases reported in Uganda has been revised from 12 deaths to 10 deaths by the country for this reporting period.

Global operational updates

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

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

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

This section provides updates on the WHO global mpox response **as of 24 January 2025.**

1. Emergency coordination

- WHO is providing strategic and technical support for Intra-Action Reviews of the response in some high-burden countries like Uganda.

2. Collaborative surveillance

- Epidemiological data on mpox in Africa are updated weekly and can be accessed on the WHO surveillance report here. The monthly global surveillance update can be found here.
- WHO published risk evaluations of clade Ia and clade Ib MPXV on 24 January 2025. These risk evaluations consider the comparative characteristics of these subclades, such as transmissibility, immune escape, severity, and clinical/diagnostic considerations in a broader and more general context[10].

3. Community protection

- Continued coordination across multiple technical areas, including risk communication, community engagement and infodemic management, Water, sanitation and hygiene (WASH) and infection prevention and control (IPC) in community settings, community-based surveillance, and border health.
- WHO published general information for the public on mpox vaccines on 22 January 2025 which can be accessed here.
- WHO convened an expert technical working group on 13 January 2025 to advance interim guidance for social and behavioural research for mpox community protection.
- WHO convened its informal community reference group for the first time this year on 24 January 2025. The focus of the session was on framing how social and behavioural research can support efforts to achieve the targets of the global mpox response.

4. Safe and scalable care

- Continued strengthening of treatment facilities ongoing in all affected countries, ensuring required medicines and essential supplies, including for IPC/WASH and care, are available.

[10] The way the risk estimates are presented in these risk evaluations may differ from the rapid risk assessment completed in November 2024, in which public health risk is estimated based on the combination of the risk for human health, the risk for further spread and the risk of insufficient response capacities, in and from the affected areas.

5. Access to and delivery of countermeasures

Access and Allocation Mechanism (AAM)

Vaccines

- WHO has continued to provide technical support to accelerate implementation and uptake of mpox vaccination in affected countries in at-risk groups, in support of controlling the surge in mpox cases on the African continent.
- Efforts are underway to advance delivery of remaining vaccine doses that were allocated during the first allocation round, to finalize the outstanding shipment arrangements and documentation. Nine countries have been allocated vaccine doses and six countries have fully accepted their allocation (Democratic Republic of the Congo, Rwanda, Kenya, Liberia, South Africa, and Uganda)
- To date, 465 760 vaccines have been delivered to six countries and vaccination has started in four countries (Central African Republic, Democratic Republic of the Congo, Nigeria, and Rwanda).
- Over 4.83 million vaccine doses are expected to be available in 2025. The vaccine supply includes contributions from multiple nations and organizations, including 1.73 million dose donations of MVA-BN vaccine (150 000 doses from the European Union, 696 200 doses from the United States, 876 300 doses procured through UNICEF/Gavi), 50 000 doses of ACAM2000 vaccine from Emergent BioSolutions, as well as a further 3.05 million doses of LC16m8 vaccine from Japan.
- The AAM partners have continued to work together to ensure countries receive guidance to get operational funds for implementation of the national vaccination plans.

Mpox resources

Strategic planning and global support

- WHO mpox global strategic preparedness and response plan. Updated 6 September 2024. Available at: https://www.who.int/publications/m/item/mpox-global-strategic-preparedness-and-response-plan
- Mpox continental preparedness and response plan for Africa. 5 September 2024. Available at: https://africacdc.org/download/mpox-continental-preparedness-and-response-plan-for-africa/
- WHO appeal: mpox public health emergency 2024, 27 August 2024. Available at: https://www.who.int/publications/m/item/who-appeal--mpox-public-health-emergency-2024
- Strategic framework for enhancing prevention and control of mpox (2024-2027). May 2024. Available at: https://www.who.int/publications/i/item/9789240092907

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

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Regional information products

- WHO Africa Regional Office, Regional Mpox Bulletin: https://www.afro.who.int/health-topics/mpox-monkeypox
- Joint Continental Situation Report on the Mpox Epidemic in Africa (23 September- 03 November 2024), 6 December 2024. https://africacdc.org/download/joint-continental-situation-report-on-the-mpox-epidemic-in-africa-23-september-03-november-2024/

Surveillance

- Surveillance, case investigation and contact tracing for mpox: Interim guidance, 6 December 2024. https://www.who.int/publications/i/item/B09169
- Considerations for wastewater and environmental surveillance for monkeypox virus: Interim guidance, 25 November 2024. https://www.who.int/publications/i/item/B09178
- Mpox Case Investigation Form (CIF) and minimum dataset Case Reporting Form (CRF), 5 September 2024. https://www.who.int/publications/m/item/monkeypox-minimum-dataset-case-reporting-form-(crf)
- WHO Go.Data: Managing complex data in outbreaks. https://www.who.int/tools/godata
- Technical Guidelines for Integrated Disease Surveillance and Response in the African Region: Third edition, March 2019. https://www.afro.who.int/publications/technical-guidelines-integrated-disease-surveillance-and-response-african-region-third

Laboratory and diagnostics

- Risk evaluation of clade Ia monkeypox virus: Review of evidence as of 10 December 2024. https://www.who.int/publications/m/item/risk-evaluation-of-clade-1a-monkeypox-virus-review-of-evidence-as-of-10-december-2024
- Risk evaluation of clade Ib monkeypox virus: Review of evidence as of 10 December 2024. https://www.who.int/publications/m/item/risk-evaluation-of-clade-1b-monkeypox-virus-review-of-evidence-as-of-10-december-2024
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- Mpox disease Emergency Use Listing Procedure (EUL) for IVDs Product: Alinity m MPXV AMP Kit and Alinity m MPXV CTRL Kit Public Report: https://extranet.who.int/prequal/sites/default/files/document_files/alinity-m-mpxv-amp-kit-and-alinity-m-mpxv-ctrl-kit-public-report.pdf
- WHO Guidance on regulations for the transport of infectious substances 2023 – 2024, 13 June 2024. https://www.who.int/publications/i/item/789240089525
- Diagnostic testing for the monkeypox virus (MPXV): interim guidance, 10 May 2024. https://www.who.int/publications/i/item/WHO-MPX-Laboratory-2024.1
- Genomic epidemiology of mpox viruses across clades. https://nextstrain.org/mpox/all-clades
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- Mpox Q&A on mpox testing for health workers, 11 December 2023. https://www.who.int/news-room/questions-and-answers/item/testing-for-mpox--health-workers

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- Mpox screening tool for health workers. 27 November 2024. https://www.who.int/multi-media/details/mpox-screening-tool-for-health-workers-poster
- Mpox lesions differential diagnosis, 27 November 2024. https://www.who.int/multi-media/details/mpox-lesions-differential-diagnosis-poster
- Mpox triage and clinical assessment for suspected and confirmed cases, 27 November 2024. https://www.who.int/multi-media/details/mpox-triage-and-clinical-assessment-for-suspected-and-confirmed-cases-poster
- Infection prevention and control and water, sanitation and hygiene measures for home care and isolation for mpox in resource-limited settings. Interim operational guide, 18 October 2024. https://www.who.int/publications/i/item/infection-prevention-and-control-and-water--sanitation-and-hygiene-measures-for-home-care-and-isolation-for-mpox-in-resource-limited-settings
- WHO mpox screening form for healthcare facilities entrance https://cdn.who.int/media/docs/default-source/ipc---wash/mpox-screening-form-for-healthcare-facility-entrances.pdf
    - Posters on screening ?sfvrsn=3893b9b2_3&download=true
- Posters for health and care workers.

  - Steps to put on PPE for mpox (16 August 2024)
  - Steps to remove PPE for mpox (16 August 2024)
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- Atlas of mpox lesions: a tool for clinical researchers, 28 April 2023. https://apps.who.int/iris/bitstream/handle/10665/366569/WHO-MPX-Clinical-Lesions-2023.1-eng.pdf
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- MVA-BN (Modified Vaccinia Ankara – Bavarian Nordic) smallpox and mpox vaccine: interim guidance, 27 November 2024. https://iris.who.int/handle/10665/379882
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- Report of the WHO Prequalification Vaccine Technical Advisory Group on LC16m8, 19 November 2024. https://extranet.who.int/prequal/sites/default/files/document_files/mpox-lc16m8_tag-report-19-11-2024-final.pdf
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- WHO AFRO Mpox Vaccination Preparation Roadmap. 27 September 2024. https://www.afro.who.int/publications/mpox-vaccination-preparation-roadmap-27-september-2024#:~:text=The%20Mpox%20Vaccination%20Preparation%20Roadmap,efficiently%20once%20they%20are%20accessed.
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- Package insert of MVA-BN (Imvanex) following WHO prequalification. https://extranet.who.int/prequal/vaccines/p/imvanexr
  Smallpox and mpox vaccine patient information leaflet: fvp-p-479_mpox_1dose_bn_pi-2024_1.pdf (who.int)
- Safety monitoring of mpox vaccines using cohort event monitoring: a WHO protocol, 03 December 2024. https://www.who.int/publications/i/item/9789240104068
- Smallpox and mpox (orthopoxviruses): WHO position paper. 23 August 2024. https://www.who.int/publications/i/item/who-wer-9934-429-456

- Meeting of the Strategic Advisory Group of Experts on Immunization (SAGE), 11 – 13 March 2024: conclusions and recommendations. https://iris.who.int/handle/10665/376934
- WHO Vaccines and immunization for monkeypox: Interim guidance, 16 November 2022. https://apps.who.int/iris/bitstream/handle/10665/364527/WHO-MPX-Immunization-2022.3-eng.pdf

Community protection public health advice and risk communication and community engagement (RCCE) resources

- Public health advice for people recovering from or caring for someone with mpox at home in low-resource settings, 19 December 2024. https://www.who.int/publications/m/item/public-health-advice-for-people-recovering-from-or-caring-for-someone-with-mpox-at-home-in-low-resource-settings
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- Risk communication and community engagement readiness and response toolkit: mpox, 23 April 2024. https://www.who.int/publications/i/item/9789240091559
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- Infographic on getting tested for mpox, 27 February 2023. https://www.who.int/multi-media/details/getting-tested-for-mpox--what-you-need-to-know
- Gatherings in the context of the 2024 mpox outbreak: Public health guidance, 15 October 2024. https://iris.who.int/handle/10665/379242
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Training and education

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- Mpox Q&A, 16 October 2024. https://www.who.int/news-room/questions-and-answers/item/mpox
- Mpox “What we know”: infographics: English: https://www.who.int/multi-media/details/mpox-what-we-know French: https://cdn.who.int/media/docs/default-source/documents/emergencies/outbreak-toolkit/mpox-infographic-fr-v03.pdf?sfvrsn=a4dac1d_1
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- VigiMobile training video: https://www.youtube.com/watch?v=UBfnBKRkAu0
- Adverse Event Following Immunization (AEFI) causality assessment methodology: https://www.who.int/publications/i/item/9789241516990
- Adverse Event Following Immunization (AEFI) causality assessment software: https://gvsi-aefi-tools.org/
- eLearning courses on vaccine safety monitoring https://who.csod.com/selfreg/register.aspx?c=aefi%20causality%20assessment
  - Vaccines safety basics
  - Adverse Event Following Immunization (AEFI) data management
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  - AEFI causality assessment

Other resources

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

Annex 1. Latest Rapid Risk Assessment of November 2024

WHO conducted the latest global mpox rapid risk assessment in November 2024. Based on information available at the time of that risk assessment, the mpox risk of geographical spread and potential impact on health were assessed as follows:

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

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

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

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