Mpox

Multi-country external situation report no. 48, published 10 March 2025

KEY FIGURES				
Reporting period: 1 January 2022 – 31 January 2025				
Area	**Number of reported confirmed cases**		**Number of deaths among confirmed cases**	**Number of reporting countries**
Global	**129 172**		**283**	**130**
Reporting period: 1 January 2024 – 2 March 2025				
Area	**Number of reported confirmed cases**		**Number of deaths among confirmed cases**	
	2024	**2025**	**2024**	**2025**
Africa	**19 924**	**5247**	**64**	**19**
Democratic Republic of the Congo[1]	**14 924**	**2415**	**43**	**4**
Uganda[2]	**1408**	**1983**	**10**	**13**
Burundi	**2946**	**640**	**1**	**0**
Reporting period: last six weeks, 20 January – 2 March 2025				
Africa	**2744**		**16**	
Democratic Republic of the Congo	**1080**		**4**	
Uganda[2]	**1157**		**10**	
Burundi	**350**		**0**	

Highlights

- Following the convening of the Emergency Committee under the International Health Regulations (2005) (IHR) on 25 February 2025, the WHO Director-General determined that the ongoing upsurge of mpox continues to be a public health emergency of international concern (PHEIC). The WHO Director-General issued a revised set of temporary recommendations to this effect.
- The rapid risk assessment of the overall public health risk posed by mpox was updated on 24 February 2025. The overall public health risk posed by mpox was assessed as moderate at the global level.
- The outbreak of mpox due to clade Ib monkeypox virus (MPXV) continues in the Democratic Republic of the Congo and in East and Southern Africa, with new travel-related cases identified in several WHO regions.
- In the last six weeks, Uganda has reported the highest number of confirmed cases, which constitute over 40% of all confirmed cases reported on the continent during this period.[3]
- The Democratic Republic of the Congo continues to experience a high burden of mpox, with circulation of both clade I MPXV subclades. Many provinces report steady case counts from week to week and the situation in the country remains concerning with many areas seeing sustained transmission. The violence in the eastern part of the country poses challenges for the mpox response.

[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] Data reported as of 23 February 2025.
[3] Comparisons with other countries should be interpreted with caution, given the contextual differences between countries in elements of their respective mpox responses like diagnostic and disease surveillance reporting capacity.

- Clade Ib MPXV has been detected in the Lomami province of the Democratic Republic of the Congo for the first time in February 2025, bringing the number of provinces in the country reporting circulation of the clade to ten provinces.
- Genomic sequencing indicates that one specific strain of clade Ia MPXV has persisted since July 2024 in the capital of the Democratic Republic of the Congo, Kinshasa, leading to sustained human-to-human transmission. There is currently no evidence that the clade Ia MPXV strain in Kinshasa is inherently more transmissible or more severe than other clade Ia or Ib MPXV strains.
- New travel-related cases of mpox due to clade Ib MPXV have been detected in countries that had previously detected travel-related cases, including Belgium, France, Germany, the United Kingdom of Great Britain and Northern Ireland, and the United States of America.
- South Africa has reported its first cluster of mpox cases due to clade Ib MPXV.

In this edition:

Contextual description

This report provides an update on:

- the global mpox epidemiological situation, as of **31 January 2025;** global surveillance data are summarized monthly; January 2025 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 **2 March 2025**.
- Operational response updates and updates on imported mpox cases as of **28 February 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 to WHO or reported publicly through official Member State resources (webpages, surveillance dashboards, as well as epidemiological and situation reports). Given limited access to Polymerase Chain Reaction (PCR) testing of suspected cases in some settings, particularly in the Democratic Republic of the Congo, WHO also reports suspected (clinically compatible) mpox cases which meet the country's national clinical case definition for 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 February 2025 can be found in Annex 1.

Third Emergency Committee meeting

On 25 February 2025, WHO convened the Emergency Committee under the provisions of the International Health Regulations 2005 (IHR, 2005) to advise the WHO Director-General on whether the upsurge of mpox continues to constitute a public health emergency of international concern (PHEIC) and, if so, on the proposed temporary recommendations to States Parties as they respond to the event.

Key aspects of the meeting proceedings included:

- An update, by the WHO Secretariat, on the global mpox epidemiological situation, the resulting public health risk, and the actions WHO has taken, with States Parties and partners, since the declaration of the PHEIC in August 2024;
- An update, by affected States Parties, on the mpox epidemiological situation in their countries and their current response efforts, needs and challenges;
- The deliberations by the Committee on whether the event still constitutes a PHEIC, and if so, the appropriate temporary recommendations to issue to States Parties.

Following deliberations, the Committee expressed the view that the ongoing upsurge of mpox still meets the criteria for a PHEIC and considered that the determination by the WHO Director-General that the upsurge of mpox still constitutes a PHEIC would be warranted.

The WHO Director-General concurred with the advice of the Committee that the situation remains a public health emergency of international concern and issued revised temporary recommendations to that effect.

The revised set of Temporary Recommendations can be accessed here.

Updated global rapid risk assessment

WHO conducted the latest global mpox rapid risk assessment in February 2025. Based on information available at the time of this risk assessment, the risk of geographical spread of mpox and potential impact on health were assessed as follows:

Overall Public Health risk
Global
Moderate

Confidence in available information
Global
Moderate

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

Confidence in available information
Moderate
Moderate
Moderate
Moderate

**All mpox outbreaks must be considered in their local context to gain a comprehensive understanding of the epidemiology, modes of transmission, risk factors for severe disease, viral origins and evolution, and relevance of strategies and countermeasures for prevention and control.*

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

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

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

Epidemiological update [4, 5]

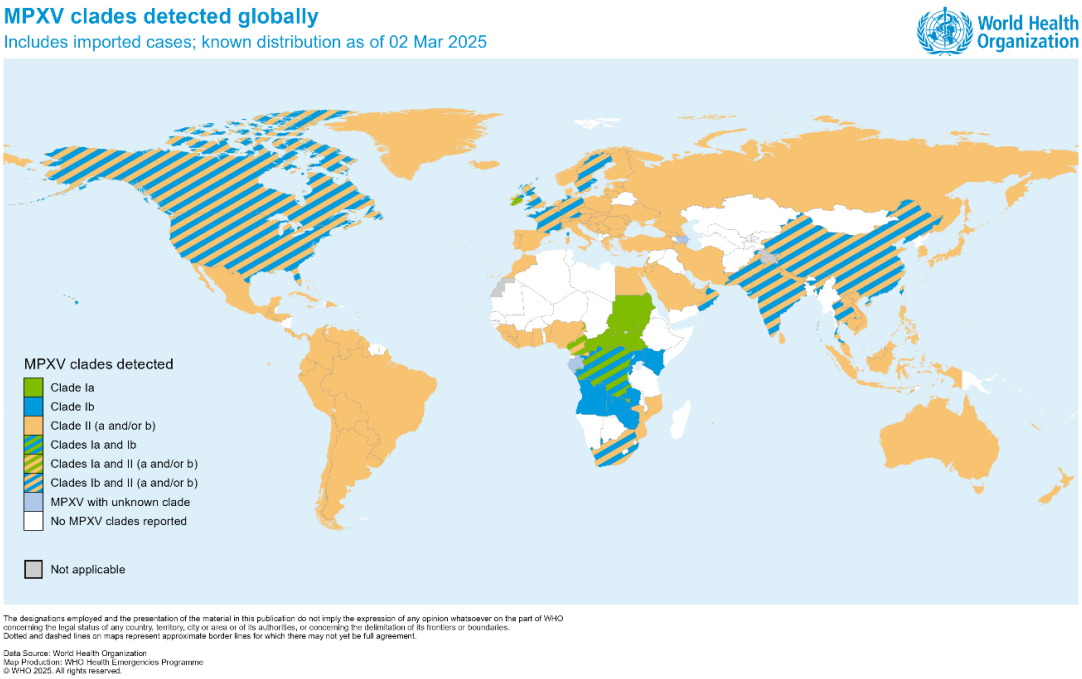
Global monkeypox virus (MPXV) distribution

As of 2 March 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 10 provinces of the Democratic Republic of the Congo (in South Kivu, North Kivu, Kinshasa, Kasai, Tshopo, Tanganyika, Haut-Katanga, Mai-Ndombe, Lomami, and Kongo-Central provinces). Within Africa, community transmission has also been reported in Burundi, Kenya, Rwanda, Uganda, and Zambia; sporadic or travel-related cases have been reported in Angola, South Africa, and Zimbabwe. Clade Ib MPXV has also been reported in the Republic of Congo, and investigations are ongoing to ascertain further details. In addition, while no cases have so far been confirmed in Tanzania, the identification of mpox in other countries in persons who had travelled to Tanzania, along with information from affected communities in the country, suggest ongoing undetected transmission.

Outside Africa, 14 countries have reported clade Ib MPXV: the United Kingdom of Great Britain and Northern Ireland (ten cases), Germany (eight cases). China (seven cases), Belgium (five cases), Thailand (four cases), the United States of America (four cases), France (two cases), Qatar (two cases), Canada, India, Oman, Pakistan, Sweden, and the United Arab Emirates (one case each). In none of these countries has sustained community transmission been documented, nor have any deaths associated with clade Ib MPXV been reported. For more details, please refer to Table 1 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 2 March 2025.



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

[5] 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. While the Democratic Republic of the Congo and the Central African Republic report a higher proportion of children among cases, in the Republic of Congo, most cases are among adults.

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

Clade Ib MPXV

Clade Ib MPXV is predominantly spreading in the Democratic Republic of the Congo, and neighbouring countries to the east, with community transmission also reported in Burundi, Kenya, Rwanda, Uganda and Zambia, and primarily travel-related cases in other countries where it has been reported. Such cases are being reported among travellers and/or among their contacts in the reporting country. No human case has yet been substantively linked to a suspected animal exposure for this clade, and current genomic sequencing data suggest that the strain detected for the first time in 2023 in South Kivu is transmitted only through human-to-human contact. In the Democratic Republic of the Congo, it has been reported in 10 provinces: South Kivu, North Kivu, Kinshasa, Kasai, Tshopo, Tanganyika, Haut-Katanga, Mai-Ndombe, Lomami and Kongo Central, and it currently drives the fastest expanding outbreaks of any MPXV strain.

Other heavily 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, Rwanda, and Zambia, where the extent of undetected transmission remains unclear. Angola, South Africa, and Zimbabwe have reported primarily travel-related cases.

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, Oman, Belgium, China, France, the United Arab Emirates, and Qatar. Secondary transmission from these cases has been reported in Germany, the United Kingdom of Great Britain and Northern Ireland, Belgium, China and France. So far sustained human-to-human transmission of clade Ib has not been reported outside Africa.

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. In some cases, the index case had not travelled but reported contact with someone who had.

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. This results in a rising proportion of cases among children, and a bimodal distribution, with the highest incidence observed among young children and young adults.

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, Ghana, Guinea, and Liberia reported cases of mpox due to clade IIa MPXV. There is evidence of ongoing transmission of this strain in Côte d'Ivoire and Liberia, with cases dispersed over wide geographic areas. Outbreaks of clade IIa MPXV in human populations are a concerning new development, as this clade had over decades only rarely been detected, and even then, almost solely in animal populations. Furthermore, co-circulation of clade IIa and clade IIb MPXV was reported for the first time in 2024, in Côte d'Ivoire, Ghana, and Liberia.

Mpox linked to clade IIa MPXV has been reported in adults and children, with many lacking a known epidemiological link. 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. Nonetheless, preliminary indications from genomic sequencing analysis along with observations of a continued increase in the number of cases across different areas of the countries, affecting mostly adults, suggests repeated zoonotic spillover events followed by secondary human-to-human transmission. 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 West, 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 levels of 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 January 2025**. Further details on global trends can be found on the online WHO dashboard.

From 1 January 2022 through 31 January 2025, a total of 129 523 confirmed cases of mpox, including 283 deaths, were reported to WHO from 130 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 3656 new confirmed cases were reported in January 2025, a 17.9% decline from the preceding month. Most cases in January 2025 were reported from the African Region (86.2%), followed by the European Region (6.7%) and the Western Pacific Region (3.8%). The Eastern Mediterranean Region, South-East Asian Region, and the European Region reported a monthly increase in cases for January 2025, compared to December 2024, with increases of 200%, 60%, and 14% respectively. On the other hand, the Region of the Americas, the Western Pacific Region, and the African Region reported declines in cases in January 2025, by 65%, 22%, and 16% respectively.

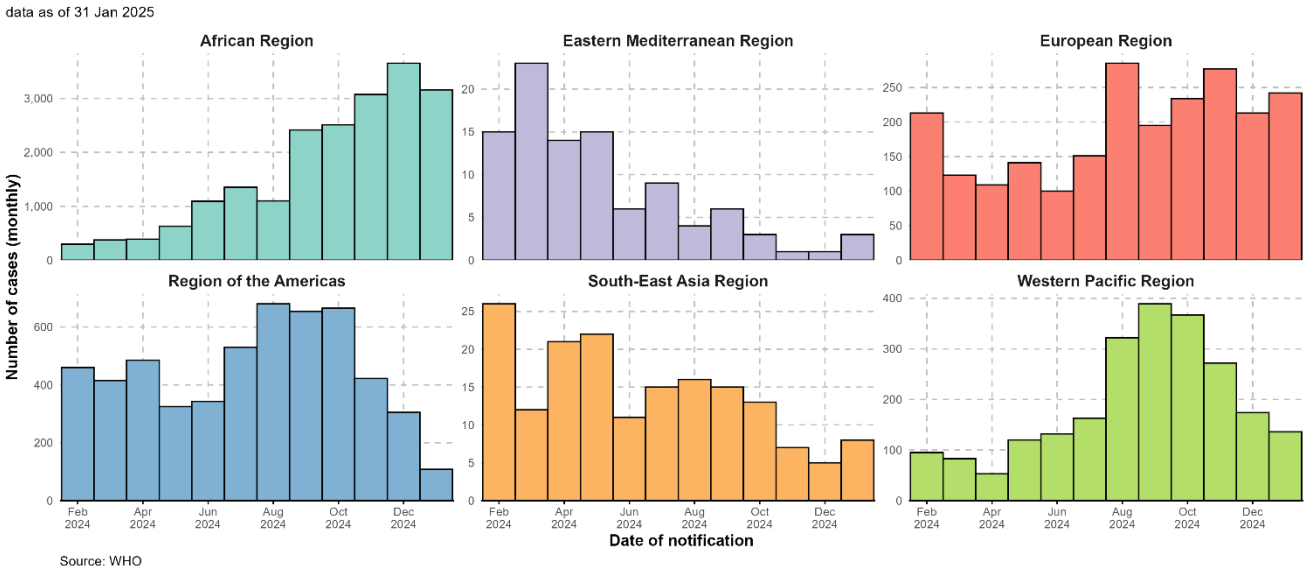
Table 1. Number of cumulative confirmed mpox cases and deaths reported to WHO, by WHO Region, from 1 January 2022 through 31 January 2025.

WHO Region	Total confirmed cases	Total deaths among confirmed cases	New cases reported in December 2024	New cases reported in January 2025	Monthly change in cases (%)
Region of the Americas	67 746	151	305	108	-65.0
European Region	29 126	9	213	242	14.0
African Region	25 396	94	3677	3097	-16.0
Western Pacific Region	5365	12	174	136	-22.0
South-East Asia Region	1004	14	5	8	60.0
Eastern Mediterranean Region	886	3	1	3	200.0
Total	129 523	283	4375	3594	-17.9

Figure 2 shows that over the past 12 months (1 February 2024 – 31 January 2025), the number of confirmed mpox cases reported monthly in the WHO African Region has been steadily rising, 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 2552 confirmed mpox cases per month have 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 January 2025 was reported by Brazil (147 confirmed cases).

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

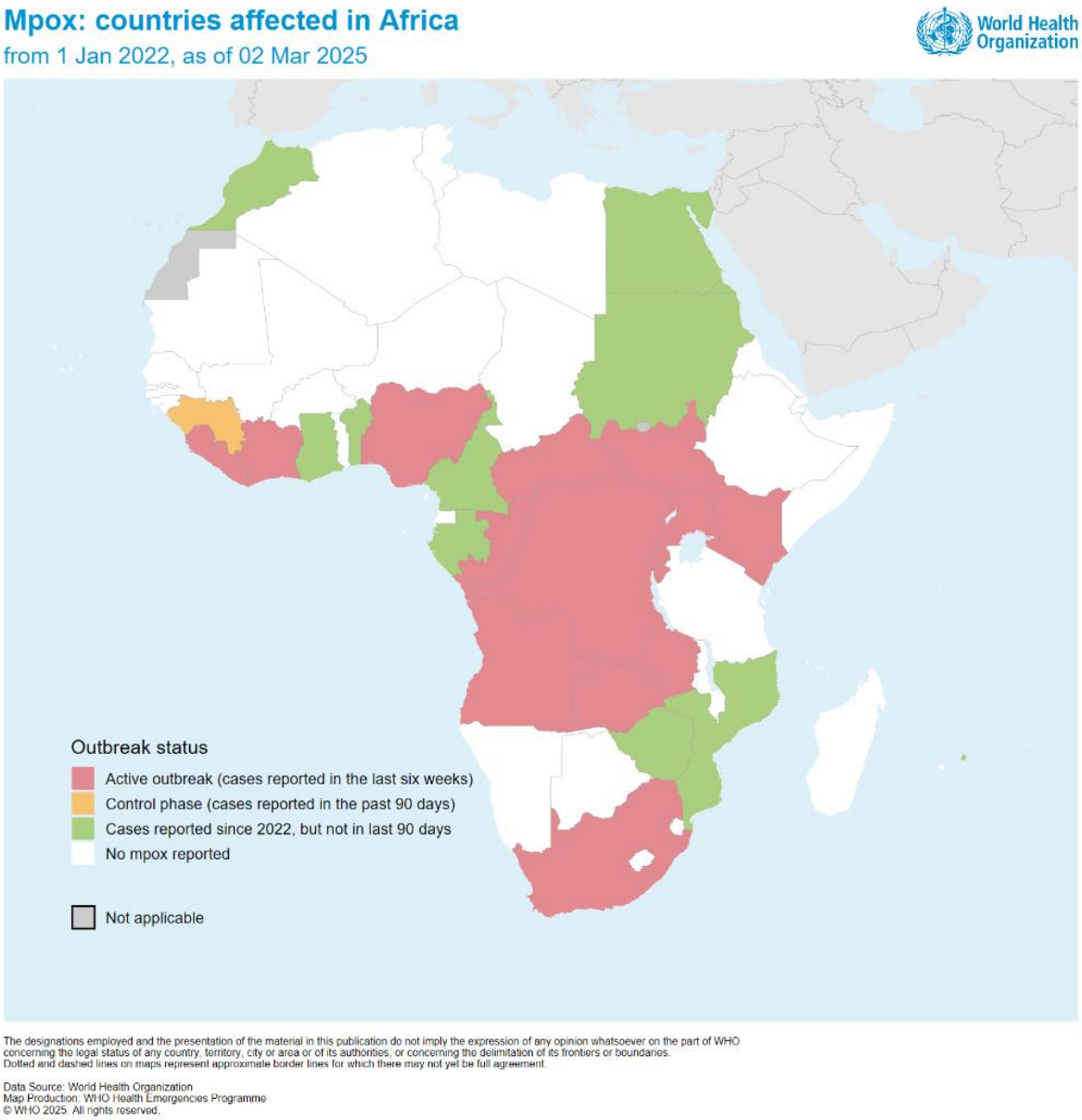


Please note the different Y axes for the regional epidemic curves, to allow an overview of trends in each region.

Confirmed cases reported in Africa

In Africa, from 30 December 2024 to 2 March 2025, 5247 confirmed mpox cases, including 19 deaths (CFR – 0.4%), have been reported by 15 countries. The most affected country continues to be the Democratic Republic of the Congo (2415 confirmed cases, including four deaths)[6] followed by Uganda (1983 confirmed cases, including 13 deaths)[2], and Burundi (640 confirmed cases and no deaths). Fifteen 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). One country, Guinea, has 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, should surveillance be deemed to be adequate.

Figure 3. Mpox outbreak status in Africa, by country (1 January 2022 – 2 March 2025).

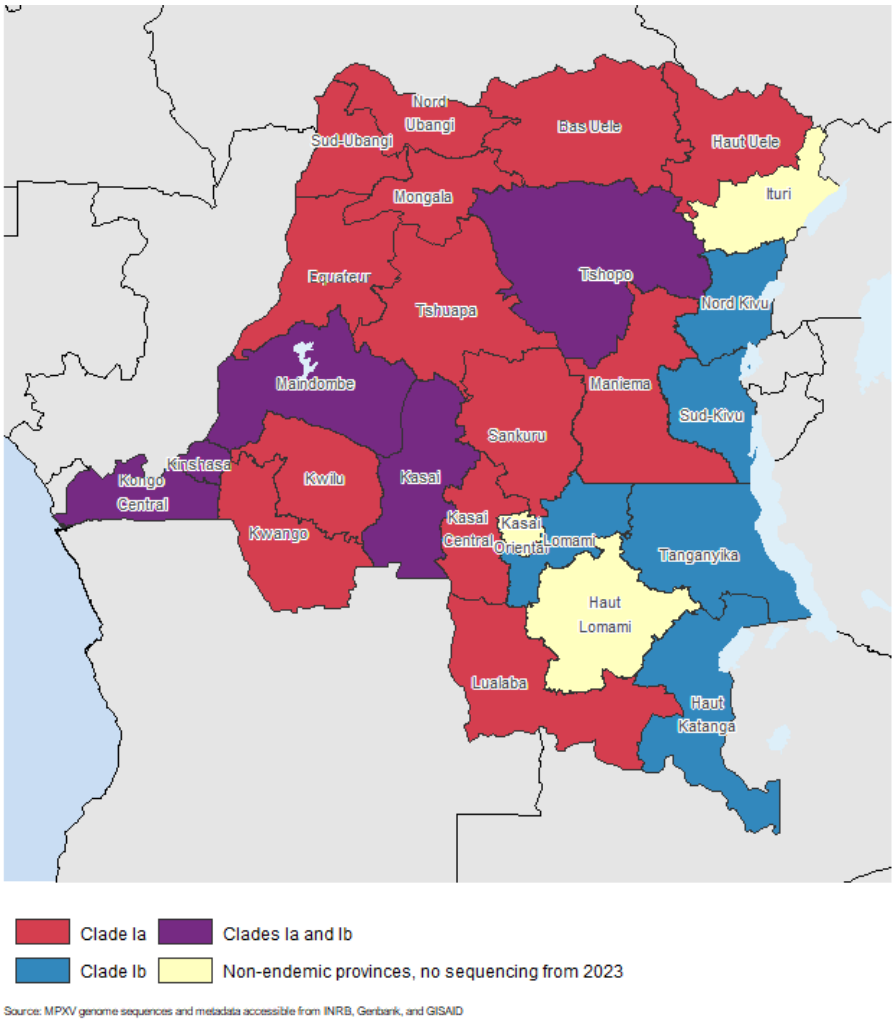


[6] The national-level case counts for the Democratic Republic of the Congo indicated here are based on the national laboratory database for mpox.

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

Mpox outbreaks in the Democratic Republic of the Congo continue to be driven by both clade Ia and Ib MPXV strains (Figure 4). Most sequenced samples from 1 October 2023 to 2 March 2025 are from the provinces of Kinshasa and South Kivu. Although all provinces in the country have reported confirmed mpox cases during this period, no sequencing has been done for samples from three provinces: Ituri, Kasai Oriental, and Haut-Lomami. So far, clade Ib MPXV has been detected in 10 provinces, and in five of them, it is co-circulating with clade Ia MPXV. Clade Ib MPXV was detected in the Ludimbi-Lukula health zone in Lomami province for the first time in February 2025. 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 8 February 2025[7].

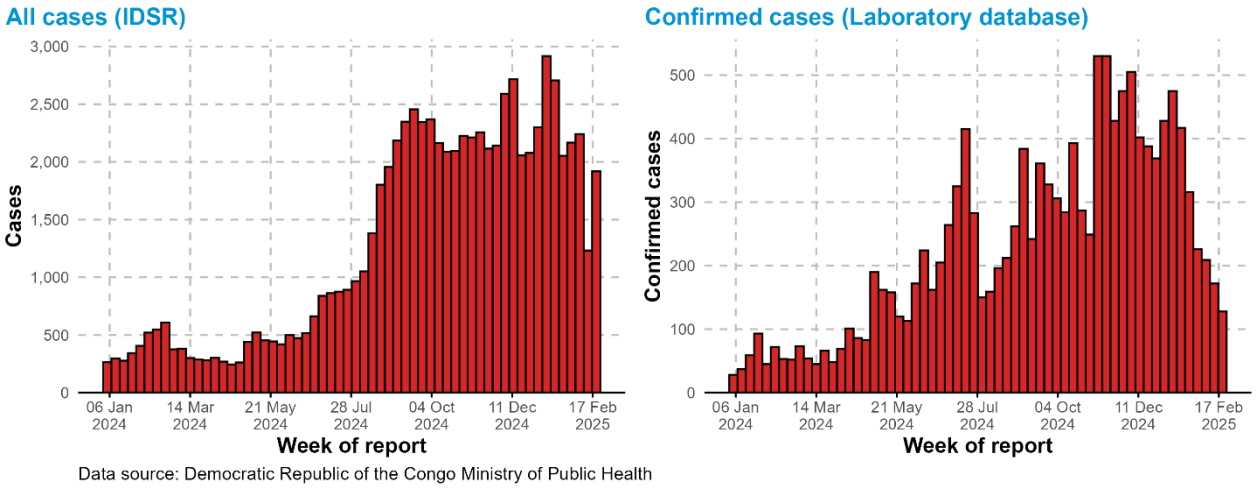


The analysis of the epidemic trend of reported suspected mpox cases (left, Figure 5) shows that there had been a notable rising trend through most of 2024 and that the number of suspected cases reported has remained at a high level, in the range of 2000 to 3000 cases per week, since September 2024.

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

The trend in reported confirmed cases, (right, Figure 5) suggests that there has been an ongoing increase in cases reported weekly over time, with a stable trend in recent weeks. The trends in reported confirmed cases should be interpreted with caution, given continuing challenges with testing capacities, reporting delays for confirmed cases in recent weeks and the recent escalation of conflict in the eastern part of the country.

Figure 5. Epidemic curve of suspected (left) and confirmed (right) mpox cases reported in the Democratic Republic of the Congo, 1 January 2024 – 23 February 2025[8].



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 number of cases reported in recent weeks appears to be relatively stable (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 approximately 600 suspected cases per week. Although there had been a notable upward trend through most of 2024, the reported number of weekly suspected cases has plateaued, largely stable within the range of 600 to 800 cases each week since September 2024. As regards to North Kivu, the sudden increase in reported cases observed in the province during the initial weeks of 2025 has been attributed to a change in the province's reporting practices, with both the tested and untested suspected cases now included in the overall count of suspected cases, unlike in 2024, when the overall count of suspected cases only included the untested suspected cases.

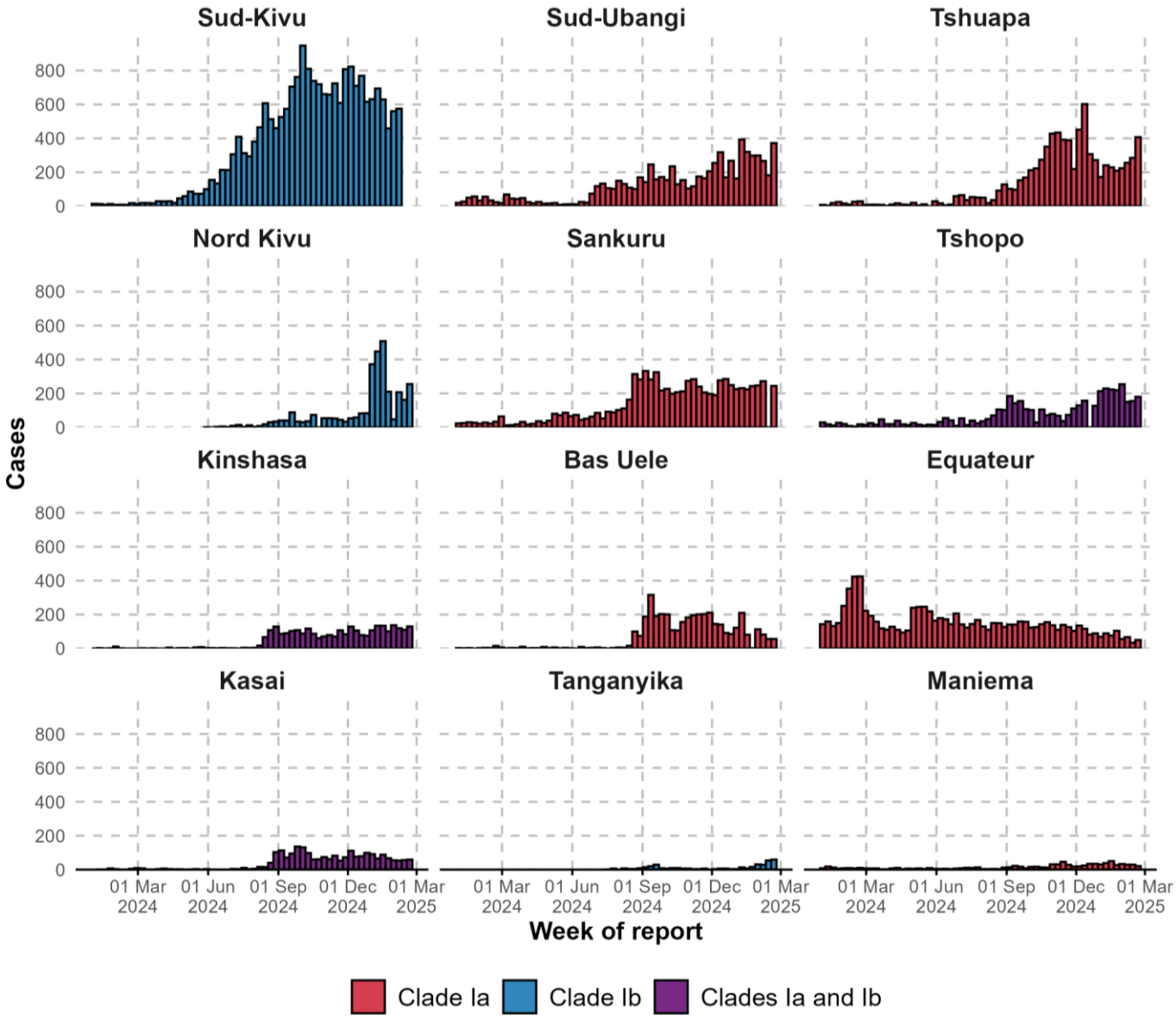
Among the provinces in which only clade Ia MPXV has been detected, Tshuapa has been reporting an increasing trend in recent weeks, while the other provinces have been observing more stable trends in recent months. In Equateur province, the province historically most affected by mpox in the country, the 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 number of suspected cases reported each week has also been relatively stable in recent months.

The epidemiological situation in the country remains concerning since circulation of the virus continues at a high level. Furthermore, the recent escalation of armed conflict in the eastern part of the country has drastically affected the mpox response, resulting in under-ascertainment and underreporting of mpox cases. Any interpretations of the recent trends should take this limitation into account.

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

Figure 6. Epidemic curve of reported suspected mpox cases in the most affected provinces of the Democratic Republic of the Congo, 1 January 2024 – 23 February 2025[9].

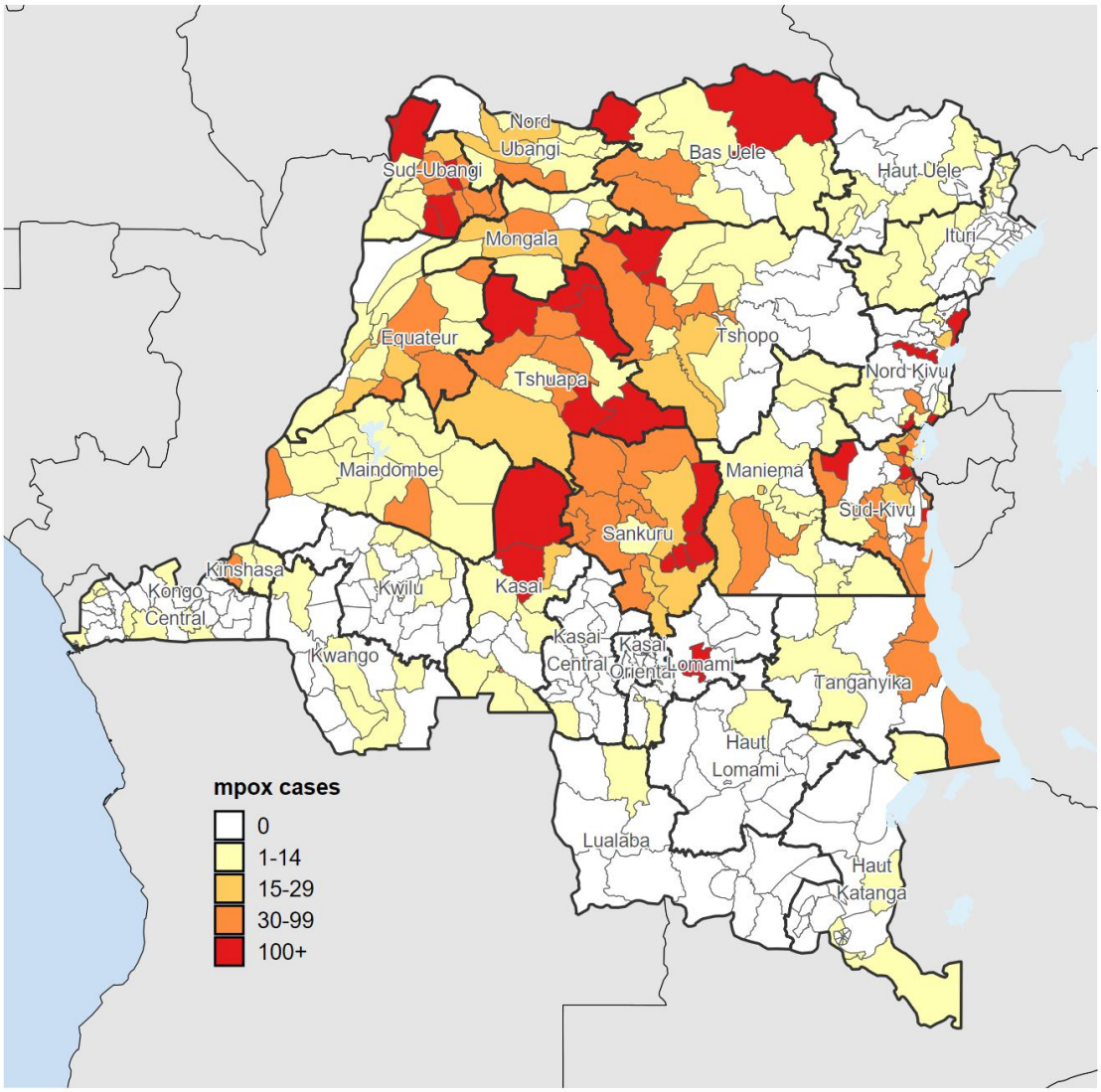


Data source: Democratic Republic of the Congo Ministry of Public Health
Data shown for all cases, via syndromic surveillance system.

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

An analysis of the sub-provincial geographic distribution of suspected mpox cases reported in the Democratic Republic of the Congo over the last six weeks (Figure 7) shows wide variation between different health zones.

Figure 7. Geographic distribution of suspected mpox cases in the past six weeks, by health zone, in the Democratic Republic of the Congo, 13 January 2025 – 23 February 2025[10].



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

Clade Ia MPXV in Kinshasa, Democratic Republic of the Congo

Genomic sequencing indicates that while there have been multiple introductions of clade Ia MPXV from endemic provinces to Kinshasa, one specific strain has persisted since around July 2024.

Prolonged circulation of the virus increases the likelihood of APOBEC3 mutations, changes in the viral DNA of MPXV induced by the human immune system. Clade Ib MPXV is marked by sustained human-to-human transmission and a significant number of APOBEC3 target-site mutations, and the clade Ia MPXV circulating in Kinshasa also shows a higher level of APOBEC3 mutations than in strains circulating in endemic areas, linked to ongoing human-to-human spread of clade Ia MPXV. This specific strain has now led to sustained transmission in Kinshasa, with related cases identified in Kongo Central, Kwilu, and Kwango, as well as one imported case in Ireland. In contrast, phylogenomic analysis suggests that past mpox outbreaks of clade Ia MPXV and ongoing

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

clade Ia MPXV epidemics in endemic areas are primarily driven by multiple zoonotic events, followed by limited secondary human-to-human transmission.

There is currently no evidence that the clade Ia MPXV strain in Kinshasa is inherently more transmissible or more severe than other clade Ia or Ib MPXV strains. Preliminary analysis of available genomic sequences in areas in Kinshasa where clade Ia and clade Ib MPXV co-circulate suggests a potentially higher growth rate for clade Ib MPXV compared to Ia MPXV in some areas; however, further work is needed to understand and quantify potential differences.

The overall mortality reported in Kinshasa from 1 January 2024 to 23 February 2025 (11 deaths among 2895 suspected cases, CFR 0.4%) is similar to that reported in North and South Kivu (42 deaths among 24 079 suspected cases, CFR 0.2%) during the same period, suggesting no difference in mortality (confidence intervals for these CFR estimates overlap) between clades in the Kinshasa urban setting.

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, Uganda, and Zambia, 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 secondary 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 6 March 2025.

N.	Country	Confirmed cases	Confirmed deaths	Date of country notification to WHO	Distribution/Source
1	**Burundi**	3586	1	25 July 2024	Largely concentrated in and around the capitals, Bujumbura and Gitega
2	**Uganda**	3391	23	24 July 2024	Multiple districts, but largely concentrated in and around the capital, Kampala
3	**Rwanda**	104	0	24 July 2024	Multiple districts, including capital, Kigali
4	**Kenya**	52	1	30 July 2024	Multiple counties (including capital Nairobi) along the major transport corridor from the coast to Uganda and Tanzania
5	**Zambia**	23	0	8 October 2024	Multiple provinces, including the capital Lusaka
6	**United Kingdom and Northern Ireland**	10	0	30 0ctober 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
				25 January 2025	One case with a history of travel to Uganda in January 2025
				30 January 2025	One case with a history of travel to Uganda from December 2024 to January 2025
				5 February 2025	One case with a history of travel to Uganda from December 2024 to January 2025
				24 February 2025	One case with a history of travel to Uganda from January to February 2025
7	**Germany**	8	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

				21 February 2025	Case investigation underway and details pending
8	**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
9	**Belgium**	5	0	18 December 2024	One case with history of travel to Central Africa and three subsequent cases among family contacts
				3 March 2025	One case with a history of travel to East Africa
10	**Thailand**	4	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
				25 January 2025	One case with a history of travel to the United Arab Emirates
11	**United States of America**	4	0	18 November 2024	One case with history of travel to East Africa
				14 January 2025	One case with history of travel to East Africa
				7 February 2025	One case with a history of travel to East Africa
				12 February 2025	One case with a history of travel to East Africa
12	**South Africa**	3	0	25 February 2025	One case with history of travel to Uganda and two subsequent cases among close contacts
13	**Qatar**	2	0	17 February 2025	One case with a history of travel to an affected country One case with a link to a traveller from an affected country
14	**France**	2	0	7 January 2025	One case linked to contact with travelers returning from an affected country in Central Africa
				3 March 2025	One case with history of travel to East Africa
15	**Zimbabwe**	1	0	18 October 2024	One case with history of travel to Tanzania
16	**Sweden**	1	0	15 August 2024	One case with history of travel to East Africa
17	**India**	1	0	1 October 2024	One case with history of travel to the United Arab Emirates
18	**Canada**	1	0	22 November 2024	One case with history of travel to East Africa
19	**Pakistan**	1	0	1 December 2024	One case with history of travel to the United Arab Emirates
20	**Oman**	1	0	10 December 2024	One case with history of travel to the United Arab Emirates
21	**United Arab Emirates**	1	0	7 February 2025	One case with history of travel to Uganda

*The Democratic Republic of the Congo is not included in Table 1.

Sustained community transmission

Sporadic travel-related cases

Note:

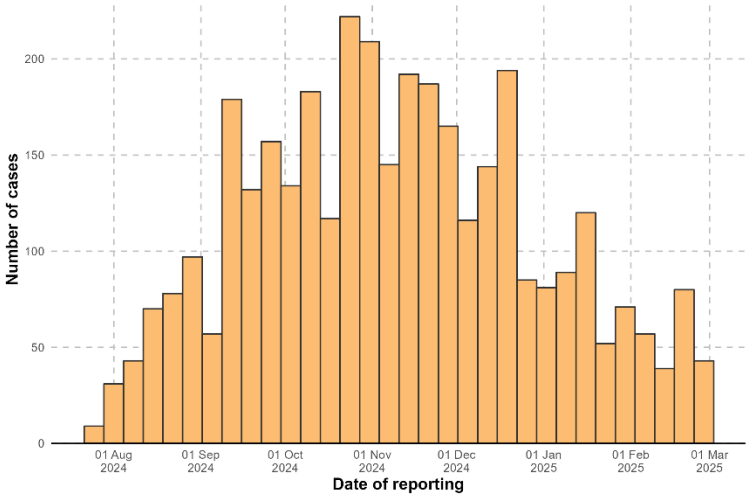
- *Although the United Arab Emirates has reported only one case, at least seven cases have been reported in other countries among travellers from the United Arab Emirates, suggesting likely community transmission in-country.*
- *No cases of mpox due to clade Ib MPXV have been reported by Tanzania, despite reports of mpox cases among individuals travelling from there and reports from persons affected in Tanzania, suggesting likely community transmission in-country.*
- *Although clade Ib MPXV has been reported in the Republic of Congo, case investigations are still ongoing, and the details will be reflected in this table once they become available.*

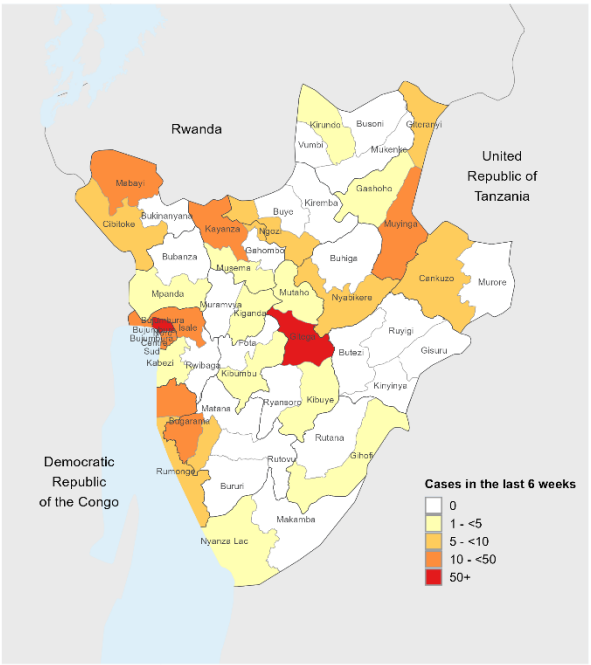
Burundi

From the start of the mpox outbreak in July 2024 to 2 March 2025, Burundi has reported 3586 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 at the end of 2024.

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, Bujumbura, and the capital, Gitega. Almost all suspected mpox cases are tested, and test positivity is approximately 50%. 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.

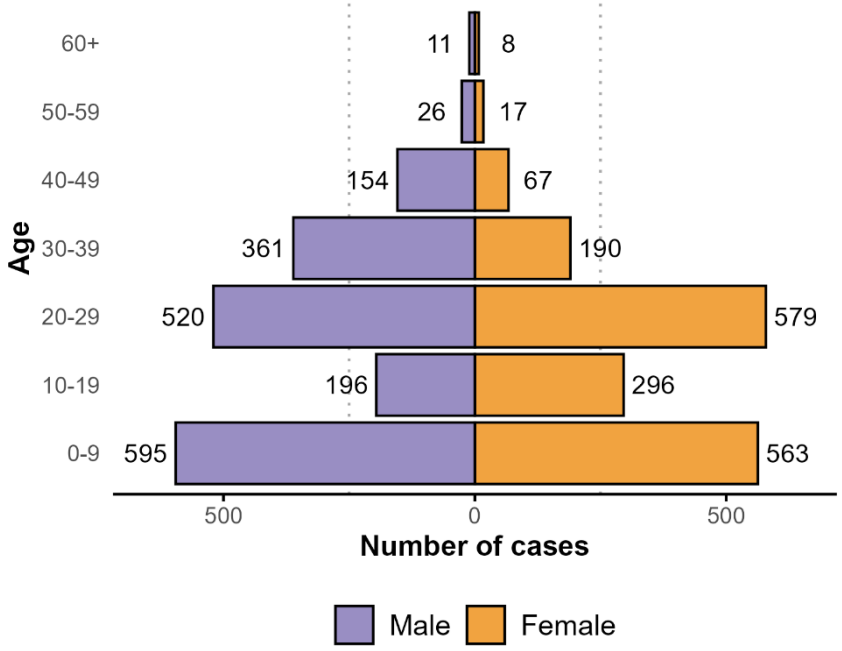
Figure 8. Epidemic curve of weekly number of confirmed mpox cases, by reporting epidemiological week (left), and geographic distribution of confirmed mpox cases by health district in the last six weeks (20 January 2025 – 2 March 2025) (right), in Burundi.





The age and sex distribution shows a bimodal age distribution with higher incidence in children under ten years of age and among young adults 20-29 years old (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 2 March 2025.



Uganda

From the start of the outbreak in July to 23 February 2025 (data were not yet available for the period from 24 February to 2 March 2025 at the time this report was being prepared), the country has reported 3391 confirmed mpox cases, including 23 deaths (CFR 0.7%). The country is experiencing community transmission, and the weekly national case count has been increasing steadily over time. Uganda has reported the highest number of laboratory-confirmed cases in the past six weeks (1157 confirmed cases), despite the reporting delay. The country continues to observe an escalation in the outbreak as the Democratic Republic of the Congo and Burundi report more stable trends in recent months.[11]

Cases have been reported in at least 62.3% (91 out of 146) of districts in the country, but the epidemic remains largely concentrated in and around Kampala, the capital. 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.

Many cases of mpox due to clade Ib MPXV notified outside Africa have reported travel links with Uganda in the days or weeks preceding the onset of their illness.

First cases of mpox due to clade Ib MPXV reported in South Africa

On 25 February 2025, South Africa notified WHO of the first case of mpox due to clade Ib MPXV detected in the country. The case is an adult with a recent history of travel to Uganda in January 2025. Symptom onset was on 27 January 2025 and disease confirmation was on 21 February 2025.

Contact tracing by the provincial health authorities identified two symptomatic contacts who have tested positive for mpox. Genomic sequencing analysis of the samples from these contacts is ongoing. Contact tracing for these two latest cases is also ongoing, along with other response measures.

[11] Comparisons with other countries should be interpreted with caution, given the contextual differences between countries in elements of their respective mpox responses like diagnostic and disease surveillance reporting capacity.

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 28 February 2025.**

1. Emergency coordination

- On 25 February 2025, the Emergency Committee convened under the provisions of the International Health Regulations 2005 (IHR, 2005) expressed the view that the ongoing upsurge of mpox still meets the criteria for a PHEIC and advised the WHO Director-General accordingly. The WHO Director-General concurred with the advice of the committee that the event continues to constitute a PHEIC and issued revised temporary recommendations to this effect which can be found here.
- WHO has begun a review of the WHO global mpox strategic preparedness and response plan.

2. Collaborative surveillance

- The rapid risk assessment of the overall public health risk posed by mpox was updated on 24 February 2025. The overall public health risk posed by mpox was assessed as moderate at the global level. More details can be found in Annex 1.
- Updates to epidemiological data on mpox in Africa continue weekly, updates to global epidemiological data continue monthly, and both can be accessed in the surveillance report.

3. Community protection

- Continued coordination across multiple technical areas, including risk communication, community engagement (RCCE) and infodemic management, water, sanitation, and hygiene (WASH) and infection prevention and control (IPC) in community settings, community-based surveillance, and border health.
- WHO and the International Federation of Red Cross and Red Crescent Societies published interim guidance on strengthening community detection and response during the mpox outbreak. This technical product provides national, subnational and local health authorities and surveillance officers with guidance to enhance community detection and reporting capacities by leveraging local and community structures and mobilizing community health volunteers and other workforces through enhanced community partnerships.
- On 5 and 20 February 2025, WHO convened an expert technical working group to finalize interim guidance on social and behavioural research for mpox community protection. The guidance covers many kinds of research, including rapid, operational studies and assessments to bring much needed evidence that can inform mpox public health responses for community protection.
- On 12 February 2025, WHO convened the first in a series of meetings for the mpox social and behavioural research community of practice bringing together public health practitioners, researchers, operational

partners, and civil society groups to exchange expertise and to share experience and findings for the mpox public health response.

- WHO published the Community Conversation Kits Guidance in French and public advice on mpox vaccination.
- WHO Provided technical support to affected countries on implementation of the operational recommendations on IPC and WASH measures for safe isolation and home care.

4. Safe and scalable care

- Continued strengthening of treatment facilities is ongoing in all affected countries, ensuring required medicines and essential supplies are available and reach patients, including for IPC/WASH.
- Technical support to the Democratic Republic of the Congo in clinical care, including the design, set-up, and linkage of treatment centres.
- Continued support for the uptake of data collection tools to facilitate mpox clinical characterization using the WHO Global Clinical Platform. These include openly available tools developed in Research Electronic Data Capture (REDCap) and Open Data Kit (ODK) data platforms. These are currently in use to understand the epidemic in Africa, particularly in the Democratic Republic of the Congo, Sierra Leone and Uganda.
- Provision of accessible advice to healthcare workers through job-aids (mpox care of skin lesions, mpox screening, mpox lesions differential diagnosis, and mpox triage and clinical assessment), webinars, and technical support for refining clinical protocols (manuals) and the training and dissemination required to enact them in the Democratic Republic of the Congo.
- WHO published the Infection prevention and control and water, sanitation and hygiene measures during mpox vaccination activities, the accompanying summary document and the Infection prevention and control and water sanitation and hygiene in health facilities during mpox disease outbreaks; rapid assessment tool user guide.
- Technical support to IPC focal points in affected countries for improvement activities in health facilities and treatment centres continues.

5. Access to and delivery of countermeasures

Access and Allocation Mechanism (AAM)

Vaccines

- WHO continues 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.
- A total of 1 137 300 doses have been allocated in two rounds to 12 countries (Angola, the Central African Republic, Côte d'Ivoire, the Democratic Republic of the Congo, Guinea, Kenya, Liberia, Nigeria, Rwanda, Sierra Leone, South Africa, and Uganda)
- To date, 816 580 vaccine doses have been delivered to eight countries, including 50 000 doses of LC16m8 vaccine from Japan to the Democratic Republic of the Congo in January 2025.
- Vaccination activities have started in four countries (, Democratic Republic of the Congo, Nigeria, Rwanda, and Uganda).
- On 22 February 2025, the Democratic Republic of the Congo launched their accelerated mpox vaccination activities for 10 days in Kinshasa, aligned with the revised vaccination strategy, targeting more than 660 000 people including 337 000 children aged one to 17 years old.
- Bavarian Nordic's position on product liability: When national regulatory authorities allow age indications which are not on the label of the product (e.g. 1 year and above, or 12 years and above) in the Marketing Authorization (MA) or Emergency Use Authorization (EUA)., Bavarian Nordic covers the product liability as per the authorized indicated age groups.

- The AAM partners continue to work together to ensure countries receive guidance to get operational funds for implementation of the national vaccination plans.

Diagnostics:

- Since the call for Expressions of Interest under the WHO Emergency Use Listing procedure for MPXV diagnostics on 28 August 2024, 68 manufacturers have contacted WHO and 41 pre-submission calls had been scheduled as of 07 March 2025. A total of 12 manufacturers were invited to submit their applications for 13 Nucleic Acid Amplification assays. To date, the WHO has listed four products under the Emergency Use Listing procedure, and seven products are currently under assessment.
- A Mpox diagnostics consortium including all main partners engaged in this work was established in September 2024 and is meeting monthly. Within that initiative, a number of test evaluations (antigen rapid diagnostic tests and commercial PCR kits) are ongoing, and results are expected for in the coming months. This includes considerations on access allocation mechanisms which, for the moment, are not required for diagnostics tools.
- Decentralisation of testing continues in key countries, including in the Democratic Republic of the Congo.

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

- Third meeting of the International Health Regulations (2005) Emergency Committee regarding the upsurge of mpox 2024 – Temporary recommendations, 27 February 2025. https://www.who.int/news/item/27-02-2025-third-meeting-of-the-international-health-regulations-2005-emmergency-committee-regarding-the-upsurge-of-mpox-2024-temporary-recommendations
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- Extension of the standing recommendations for mpox issued by the Director-General of the World health organization (WHO) in accordance with the International Health Regulations (2005) (IHR), 21 August 2024. Extension of the standing recommendations for mpox issued by the Director-General of the World health organization (WHO) in accordance with the International Health Regulations (2005) (IHR)
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Regional information products

- WHO Africa Regional Office, Regional Mpox Bulletin: https://www.afro.who.int/health-topics/mpox-monkeypox
- 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
- Diagnostic testing and testing strategies for mpox: interim guidance, 12 November 2024. B09166-eng.pdf
- WHO issues Emergency Use Authorization for Xpert Mpox, a near-point-of-care real-time PCR test, 30 October 2024. https://www.who.int/news/item/30-10-2024-who-lists-additional-mpox-diagnostic-tests-for-emergency-use
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- 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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- Infection prevention and control and water sanitation and hygiene in health facilities during mpox disease outbreaks: rapid assessment tool user guide, 19 February 2025. https://www.who.int/publications/i/item/9789240105324
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- 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
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  Smallpox and mpox vaccine patient information leaflet: fvp-p-479_mpox_1dose_bn_pi-2024_1.pdf (who.int)
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One Health and animal health

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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
- OpenWHO. Online training module. Monkeypox: Introduction in English and French: https://openwho.org/infectiousdiseases/503162/Mpox
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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
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  - AEFI causality assessment

Other resources

- WHO mpox outbreak toolbox, July 2024. https://www.who.int/emergencies/outbreak-toolkit/disease-outbreak-toolboxes/mpox-outbreak-toolbox
- Responding to the global mpox outbreak: ethics issues and considerations: a policy brief, 19 July 2023. https://www.who.int/publications/i/item/WHO-Mpox-Outbreak_response-Ethics-2023.1
- WHO AFRO Weekly Bulletin on Outbreaks and Other Emergencies. https://www.afro.who.int/health-topics/disease-outbreaks/outbreaks-and-other-emergencies-updates

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

Annex 1. Latest Rapid Risk Assessment of February 2025

WHO conducted the latest global mpox rapid risk assessment in February 2025. Based on information available at the time of that risk assessment, the 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: **moderate**.
- Clade II MPXV (historically endemic areas) - Nigeria and countries of West and Central Africa where mpox is endemic, affecting children and adults, and is linked to zoonotic spillover events, as well as human-to-human transmission mainly through close physical contact, including sexual contact: **moderate**.
- Clade IIb MPXV* - Global risk, where outbreaks predominantly affect adult men who have sex with men and spread predominantly through sexual contact: **moderate.**

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

**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.