Mpox

Multi-country external situation report no. 49 published 28 March 2025

KEY FIGURES				
Reporting period: 1 January 2022 – 28 February 2025				
Area	**Number of reported confirmed cases**		**Number of deaths among confirmed cases**	**Number of reporting countries**
Global	**132 797**		**304**	**131**
Reporting period: 1 January 2024 – 16 March 2025				
Area	**Number of reported confirmed cases**		**Number of deaths among confirmed cases**	
	2024	**2025**	**2024**	**2025**
Africa	**19 737**	**7063**	**66**	**28**
Democratic Republic of the Congo[1]	**14 806**	**3207**	**43**	**4**
Uganda	**1339**	**2802**	**12**	**19**
Burundi	**2946**	**699**	**1**	**0**
Reporting period: last six weeks, 3 February – 16 March 2025				
Africa	**3170**		**15**	
Democratic Republic of the Congo	**1134**		**0**	
Uganda	**1504**		**10**	
Burundi	**286**		**0**	

Highlights

- Updated global surveillance data show that 3191 new confirmed mpox cases were reported globally to WHO for February 2025, an 18.2% decline from the preceding month, and most cases (88%) were detected in the African Region.
- In the last six weeks, Uganda has reported the highest number of confirmed mpox cases globally, with up to 300 new cases per week.[2]
- The Democratic Republic of the Congo continues to be cumulatively the most affected country in the Region since the beginning of the outbreak. The number of suspected cases is plateauing and confirmed cases have decreased in recent weeks, however it is unclear if this reflects a real decline given reductions in testing in recent weeks. Both clade Ia and Ib continue to circulate in the country.
- Burundi shows a consistent decreasing trend of confirmed cases with less than 50 new cases per week, down from over 200 cases per week at its peak, and an overall very low case fatality ratio with one death among 3645 reported cases.
- Brazil, the Republic of Congo and the United Republic of Tanzania have reported their first cases of mpox due to clade Ib MPXV.
- The Republic of Congo is the first country where co-circulation of clade Ia and Ib MPXV has been documented outside of the Democratic Republic of the Congo.

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

[2] 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.

- Epidemiological data on the number of cases detected in Tanzania and their broad geographic distribution suggests that community transmission is ongoing in the country.
- The full proceedings of the meeting of the Emergency Committee convened under the provisions of the International Health Regulations 2005 (IHR, 2005) on 25 February 2025 have been published.
- WHO has developed an interactive dashboard that offers a comprehensive overview of deployments by from WHO, GOARN, Standby and other partners in support of the mpox response.

In this edition:

Contextual description

This report provides an update on:

- the global mpox epidemiological situation, as of **28 February 2025;** global surveillance data are summarized monthly; February 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 **16 March 2025**;
- updates on imported cases of mpox due to clade I MPXV as of **17 March 2025**;
- Operational response updates as of **21 March 2025.**

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

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

Epidemiological update [3, 4]

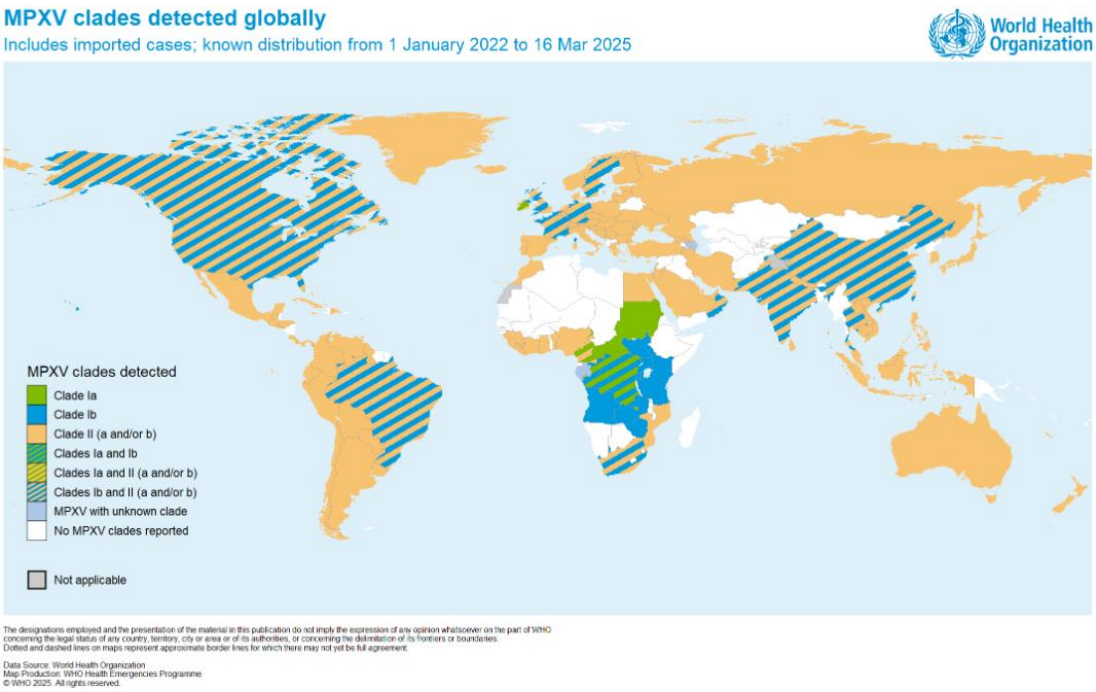
Global monkeypox virus (MPXV) distribution

As of 16 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, South Africa, Uganda, the United Republic of Tanzania, and Zambia; sporadic or travel-related cases have been reported in Angola, Republic of Congo, South Sudan, and Zimbabwe.

Outside Africa, 15 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), Qatar (three cases), France (two cases), Brazil, Canada, India, Oman, Pakistan, Sweden, and the United Arab Emirates (one case each). In none of these countries is there documented sustained community transmission, nor have any deaths associated with clade Ib MPXV been reported there. 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, from 1 January to 16 March 2025[5].



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

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

[5] Unlike the previously published editions of the situation report, in this edition, Figure 1 is restricted to data from January 2022.

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. Reporting of sporadic cases in neighbouring Central African Republic and in the Republic of Congo continues. While the Democratic Republic of the Congo and the Central African Republic report a higher proportion of children among cases, in the Republic of Congo, most cases are among adults.

Previously, genomic sequencing analysis had indicated that clade Ia MPXV typically emerged in human populations through zoonotic exposure, leading to limited human-to-human transmission. 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 from 2024, 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 neighboring countries to the east, with community transmission also reported in Burundi, Kenya, Rwanda, South Africa, Uganda, the United Republic of Tanzania, and Zambia, and primarily travel-related cases in other countries where it has been reported. Such cases are being reported among travelers and/or among their contacts in the reporting country. No human case has 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 being transmitted only through human-to-human contact.

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 first reported 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.

Clade IIa MPXV

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. Since 2024, countries such as Côte d'Ivoire, Ghana, Guinea, and Liberia have reported human cases of mpox due to clade IIa MPXV in different locations, including their capitals.

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 limited 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.

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.

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. Most countries affected outside of western Africa have ongoing low levels of transmission mainly in the same population at risk. In western Africa, cases are reported in different age groups and include males and females, highlighting potentially different transmission dynamics, which are not fully understood.

The multi-country outbreak of mpox driven by clade IIb MPXV that began in 2022 showed that sexual contact can sustain community transmission of MPXV. 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 human-to-human transmission persists, it is likely driven by a combination of sexual, household, and community contact.

Global trends

This section is a monthly update of the global epidemiological situation, based on the most recent complete information from the mpox global surveillance system, **as of the end of February 2025**. Further details on global trends can be found on the online WHO dashboard.

From 1 January 2022 through 28 February 2025, a total of 132 797 confirmed cases of mpox, including 304 deaths, were reported to WHO from 131 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 3191 new confirmed cases were reported in February 2025, an 18.2% decline from the preceding month. Most cases in February 2025 were reported from the African Region (88.2%), followed by the European Region (6.0%) and the Region of the Americas (3.2%). The Eastern Mediterranean Region reported a monthly increase in cases of 50% for February 2025, compared to January 2025. On the other hand, the Region of the Americas, the Western Pacific Region, the European Region, the African Region, and the South-East Asian Region reported declines in cases in February 2025, by 50%, 39%, 21%, 15%, and 12% respectively.

Table 1. Number of cumulative confirmed mpox cases and deaths reported to WHO, by WHO Region, from 1 January 2022 through 28 February 2025[6].

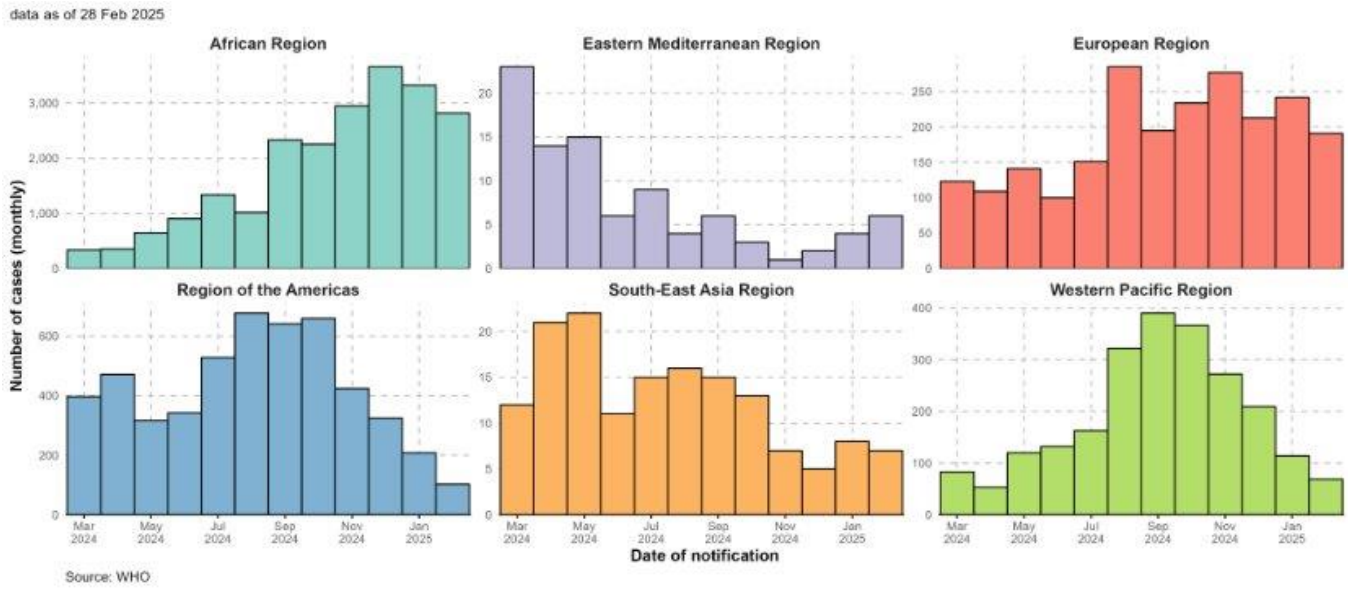
WHO Region	Total confirmed cases	Total deaths among confirmed cases	New cases reported in January 2025	New cases reported in February 2025	Monthly change in cases (%)
Region of the Americas	67 877	151	208	103	-50.0
European Region	29 317	9	242	191	-21.0
African Region	28 251	112	3324	2815	-15.0
Western Pacific Region	5447	15	114	69	-39.0
South-East Asia Region	1011	14	8	7	-12.0
Eastern Mediterranean Region	894	3	4	6	50.0
Total	132 797	304	3900	3191	-18.2

Figure 2 shows that over the past 12 months (1 March 2024 – 28 February 2025), the number of confirmed mpox cases reported monthly in the WHO African Region has been steadily rising, with a downward trend in the last two months. This decrease is likely due to the impact of lower levels of testing and case confirmation in the Democratic Republic of the Congo in recent weeks. The Eastern Mediterranean and Southeast-Asia Regions have been reporting the lowest number of cases, with the former observing an upward trend in recent months, driven mainly by Gulf countries. In the European Region, the trend has been relatively stable in recent months, 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. Trends in all regions may be prone to surveillance and reporting biases.

In the last 12 months, an average of 2650 confirmed mpox cases per month have been reported. Most of them were reported by the African Region (21 915 cases), followed by the Region of the Americas (5091 cases), and the Western Pacific (2293 cases). Outside Africa, the highest number of confirmed cases in January 2025 was reported by Spain (71 cases).

[6] The monthly reported data may be prone to delays and incompleteness and are therefore subject to retrospective adjustments over time as more data become available.

Figure 2. Epidemic curves of monthly aggregated number of confirmed mpox cases reported to WHO, by WHO region, 1 March 2024 – 28 February 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 16 March 2025, 7063 confirmed mpox cases, including 28 deaths (CFR – 0.4%), have been reported by 16 countries. The most affected country continues to be the Democratic Republic of the Congo (3207 confirmed cases, including four deaths)[7] followed by Uganda (2802 confirmed cases, including 19 deaths), and Burundi (699 confirmed cases and no deaths) (Figure 3). Fifteen countries 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 4). One country, the Central African Republic, 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 adequate.

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

Figure 3. Epidemic curve of confirmed mpox cases in Africa, by country, 1 January 2022 – 16 March 2025.

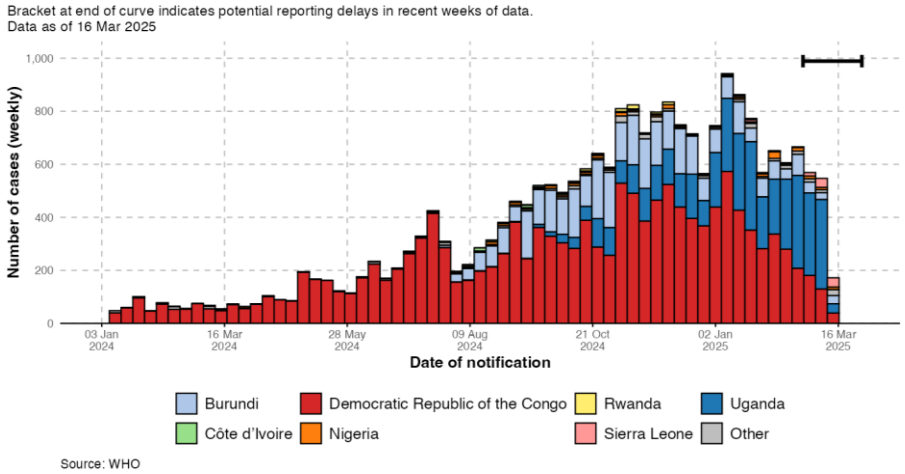
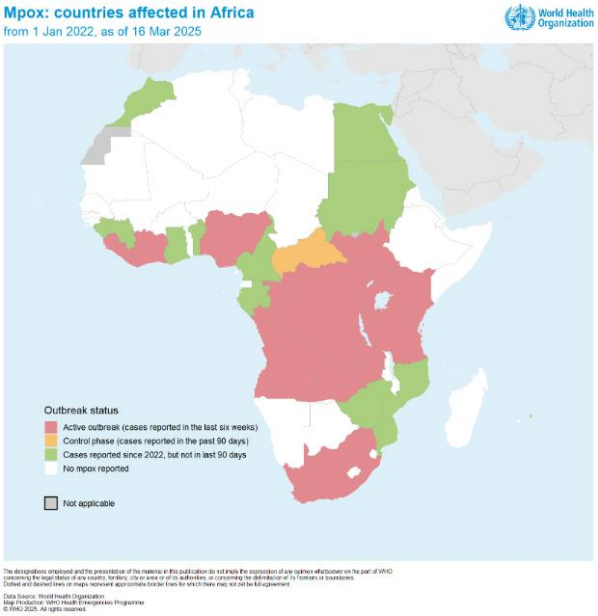


Figure 4. Mpox outbreak status in Africa, by country, 1 January 2022 – 16 March 2025.

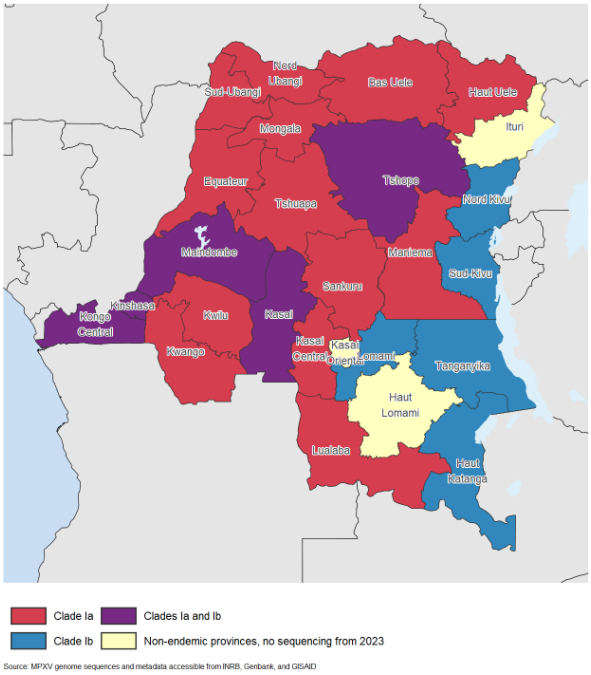


Focus on the Democratic Republic of the Congo (clade Ia & Ib MPXV)

Mpox outbreaks in the Democratic Republic of the Congo continue to be driven by both clade Ia and Ib MPXV strains (Figure 5). 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. Sequencing data from the Kinshasa outbreak have revealed increasingly sustained human-to-human transmission of clade Ia MPXV with high rates of APOBEC3-driven mutations. However, no such indications have been documented so far in the other provinces where clade Ia MPXV is circulating.

The current strategy for sequencing follows a convenience sampling approach, where positive samples reaching Kinshasa are prioritized. This allows good visibility of the situation in Kinshasa and nearby provinces but might bias the observed distribution of the virus strains by province.

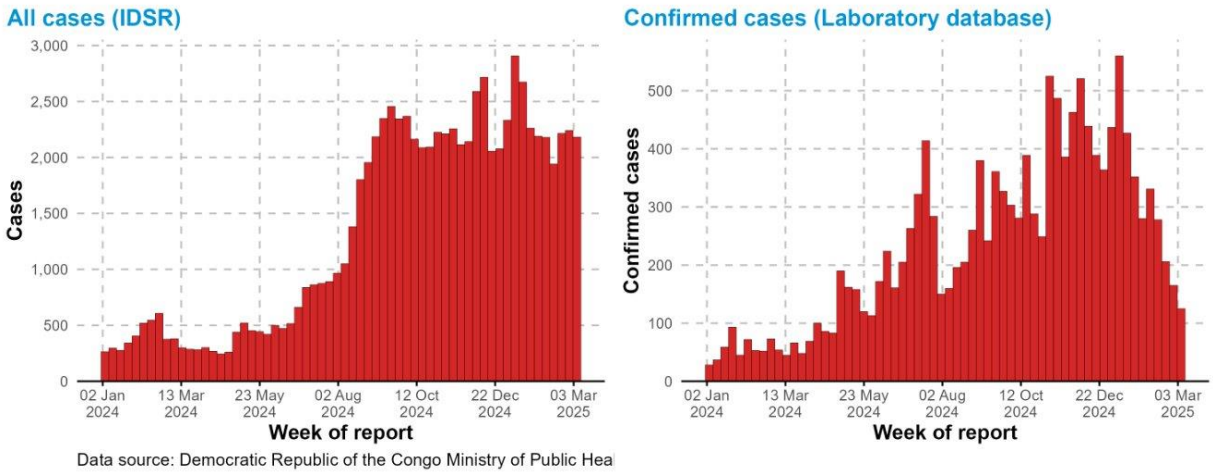
Figure 5. Geographic distribution of clade Ia and Ib MPXV in the Democratic Republic of the Congo, by province, from 1 October 2023 to 8 February 2025[8].



The analysis of the epidemic trend of reported suspected mpox cases (left, Figure 6) shows that there had been a notable rising trend in the second part of 2024, likely impacted also by the PHEIC declaration, and the number of suspected cases reported has remained at a high level, largely in the range of 2000 to 3000 cases per week, since September 2024.

The trend in reported confirmed cases, (right, Figure 6) suggests that there has been an ongoing increase in cases reported weekly over time, with a downward 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.

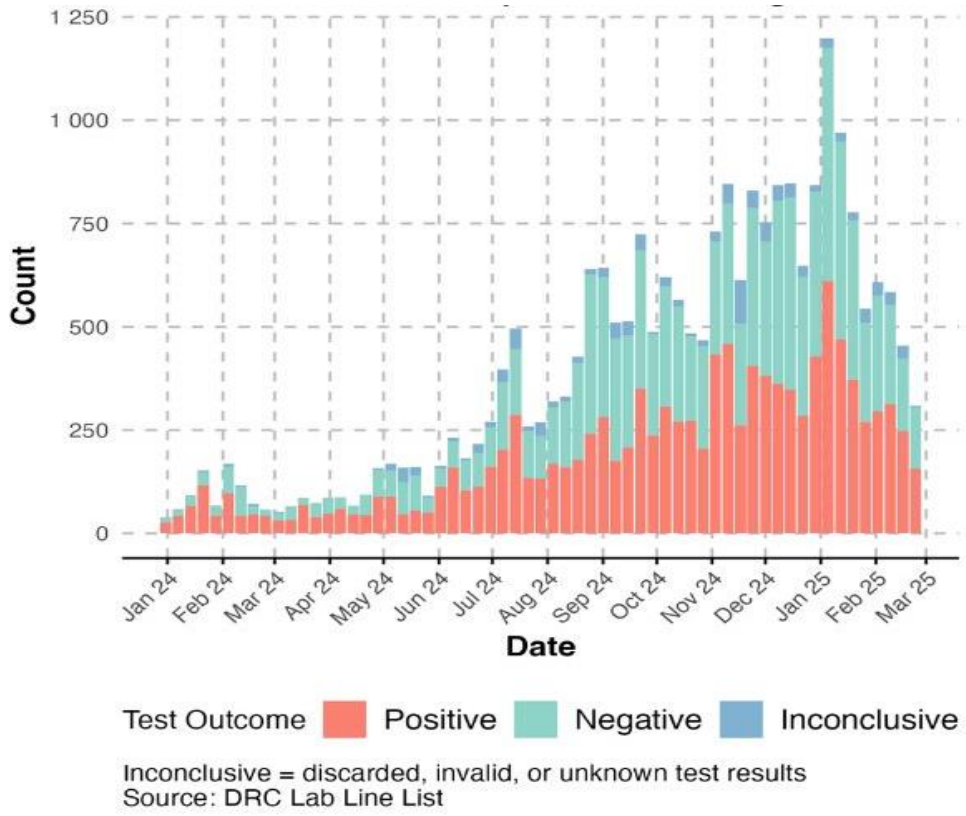
Figure 6. Epidemic curve of suspected (left) and confirmed (right) mpox cases reported in the Democratic Republic of the Congo, 1 January 2024 – 9 March 2025[9].



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

As shown in the figure below, the trend of confirmed cases in the country closely approximates that of samples tested in the country, with a positivity rate of around 50% in recent weeks. The decrease in the number of confirmed cases is due to both disruption of response activities in the eastern part of the country, linked to insecurity, as well as resource constraints following the freeze on U.S. foreign aid that was supporting sample transportation.

Figure 7. Epidemic curve of tested mpox cases by week and test results in the Democratic Republic of the Congo, 01 January 2024-16 March 2025.



Furthermore, national trends should be interpreted in light of the varying epidemic dynamics at the subnational level. An analysis of the epidemic trend of reported suspected mpox cases in the 16 most affected provinces in the Democratic Republic of the Congo shows that these provinces have varying outbreak sizes, but for most of them, the number of cases reported in recent weeks appears to be relatively stable (Figure 8).

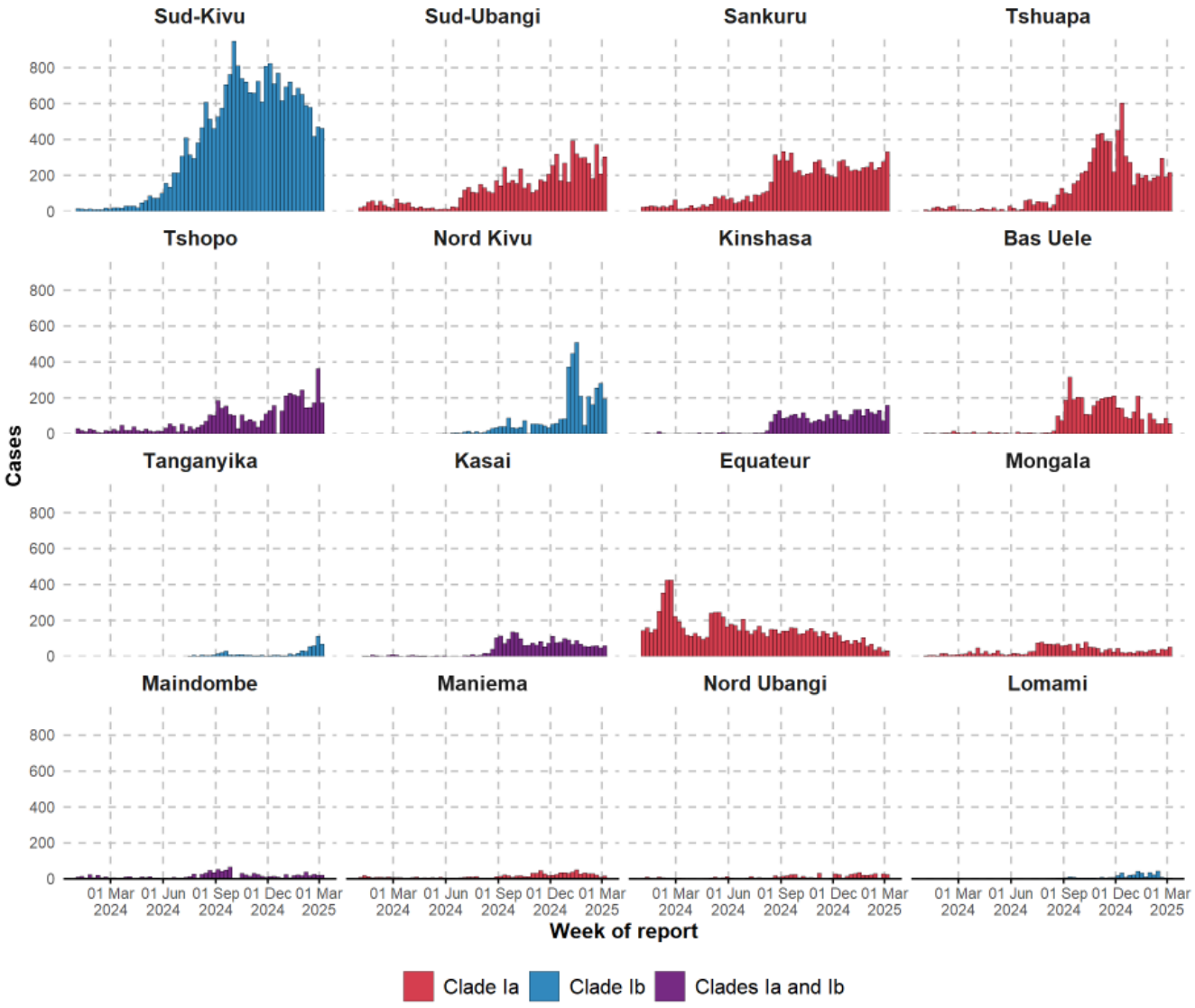
Among the provinces reporting only clade Ib MPXV, South Kivu continues to account for most suspected cases in the country, still typically reporting over 400 suspected cases per week. Although there had been a notable upward trend through most of 2024, the reported number of weekly suspected cases plateaued, within the range of 600 to 800 cases per week and a decrease since end of 2024. The apparent drop in cases in the most recent weeks should be interpreted with caution, given the recent escalation of conflict in the province, which has impacted surveillance and response activities. As regards North Kivu, the sudden increase in reported cases observed in the province during the initial weeks of 2025 has been attributed to a change in the province's reporting practices, with both the tested and untested suspected cases now included in the overall count of suspected cases, unlike in 2024, when the overall count of suspected cases only included the untested suspected cases. This makes the syndromic surveillance in North Kivu more comparable to that of other provinces.

Among the provinces in which only clade Ia MPXV has been detected, Sankuru, Tshuapa, and Sud Ubangi have been reporting a slight 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 countrywide.

Figure 8. Epidemic curve of reported suspected mpox cases in the most affected provinces of the Democratic Republic of the Congo, 1 January 2024 – 9 March 2025[10].

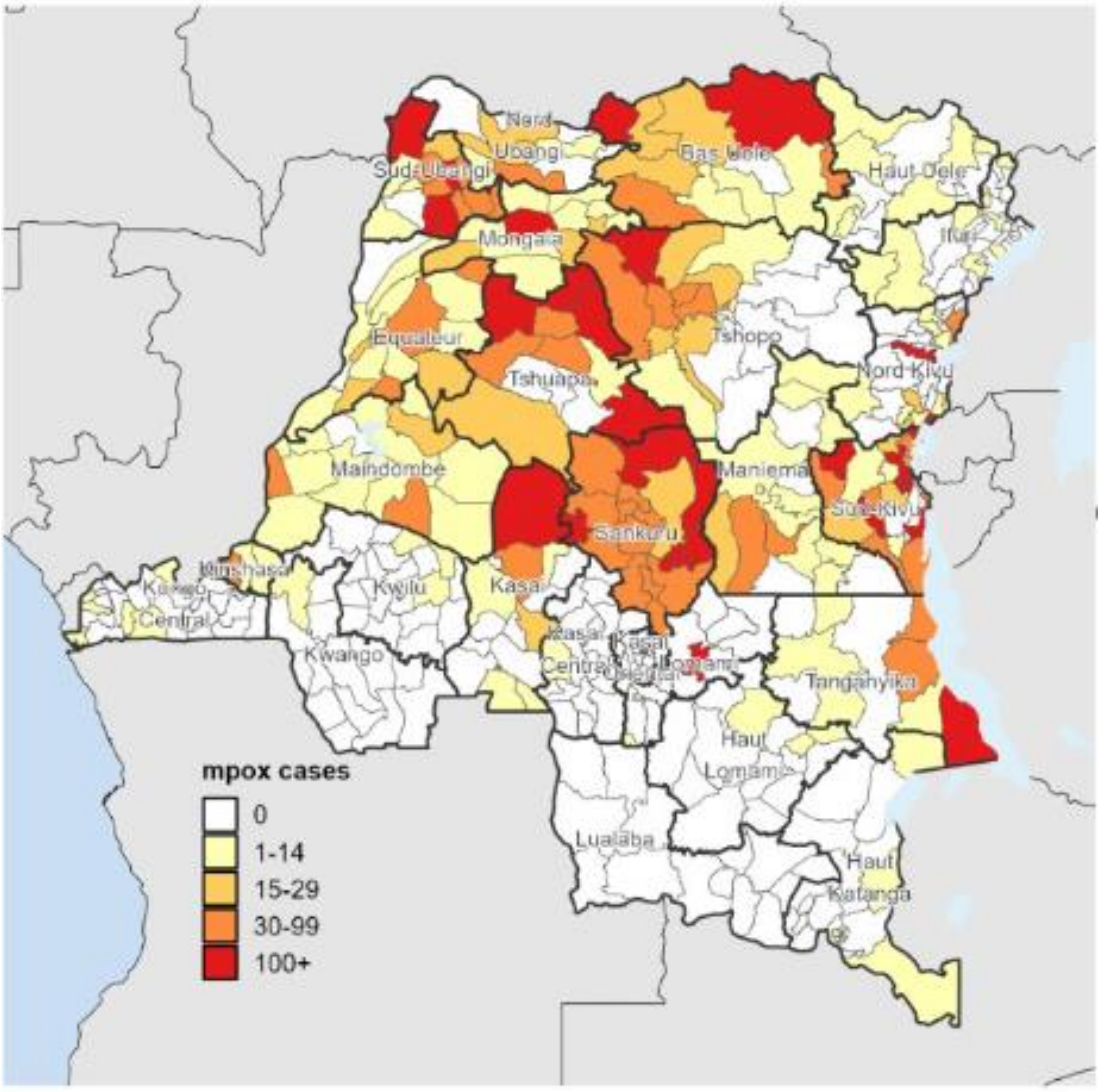


Data source: Democratic Republic of the Congo Ministry of Public Health
Data shown for all cases, via syndromic surveillance system.

[10] 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 9) shows wide geographical distribution of cases and variation between different health zones.

Figure 9. Geographic distribution of suspected mpox cases in the past six weeks, by health zone, in the Democratic Republic of the Congo, 27 January 2025 – 9 March 2025[11].



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

[11] 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, South Africa, Uganda, the United Republic of Tanzania, and Zambia, and primarily sporadic or 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 sustained chains of a transmission reported.

Table 2. Confirmed mpox cases and deaths linked to clade Ib MPXV outbreaks reported to WHO, by country*, as of 17 March 2025.

N.	Country	Confirmed cases	Confirmed deaths	Date of country notification to WHO	Distribution/Source
1	**Uganda**	4141	31	24 July 2024	Multiple districts, but largely concentrated in and around the capital, Kampala
2	**Burundi**	3645	1	25 July 2024	Largely concentrated in and around the capitals, Bujumbura and Gitega
3	**Rwanda**	104	0	24 July 2024	Multiple districts, including capital, Kigali
4	**Kenya**	55	1	30 July 2024	Multiple counties (including capital Nairobi) along the major transport corridor from the coast to Uganda and Tanzania
5	**Zambia**	31	0	8 October 2024	Multiple provinces, including the capital Lusaka
6	**United Republic of Tanzania**	22	0	10 March 2025	Multiple regions across the country
7	**South Africa**	6	0	25 February 2025	Last three cases form a cluster with no known links to international travel. All cases have been detected in one province so far
8	**United Kingdom and Northern Ireland**	10	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
				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
9	**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
10	**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
11	**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 Rwanda

12	**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
13	**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
14	**Qatar**	3	0	17 February 2025	One case with a history of travel to an affected country and two other cases with links to travelers from affected countries
15	**South Sudan**[12]	3	0	7 February 2025	Three cases with history of travel to Uganda
16	**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
17	**Angola**[11]	2	0	15 November 2024	One case linked to a traveler from the Democratic Republic of the Congo and one case among household contacts
18	**Zimbabwe**[11]	1	0	18 October 2024	One case with history of travel to Tanzania
19	**Sweden**	1	0	15 August 2024	One case with history of travel to East Africa
20	**India**	1	0	1 October 2024	One case with history of travel to the United Arab Emirates
21	**Canada**	1	0	22 November 2024	One case with history of travel to East Africa
22	**Pakistan**	1	0	1 December 2024	One case with history of travel to the United Arab Emirates
23	**Oman**	1	0	10 December 2024	One case with history of travel to the United Arab Emirates
24	**United Arab Emirates**	1	0	7 February 2025	One case with history of travel to Uganda
25	**Brazil**	1	0	7 March 2025	One case linked to travelers from the Democratic Republic of the Congo

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

Community transmission

Cases linked to travel

Note:

- *Although the United Arab Emirates has reported one case, at least seven cases have been reported in other countries among travelers from the United Arab Emirates, 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.*

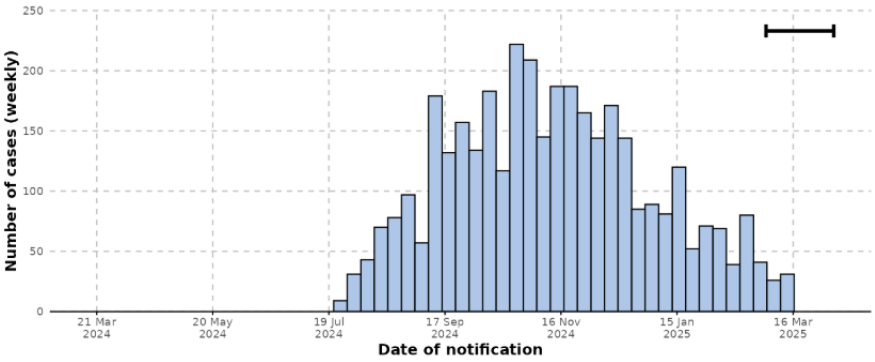
[12] For Angola, South Sudan, and Zimbabwe, only cases which have been confirmed to be due to clade Ib MPXV have been included in Table 2. Cases with unavailable genomic sequencing information have been excluded.

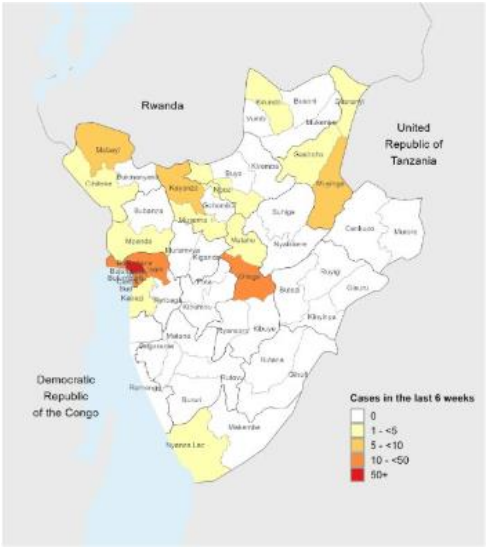
Burundi

From the start of the mpox outbreak in July 2024 to 2 March 2025, Burundi has reported 3645 confirmed mpox cases, including one death (CFR 0.03%). The country is experiencing community transmission, and the national case count peaked in October 2024 with more than 200 new confirmed cases per week (left, Figure 10) and a steady decrease since then. In recent weeks the number of cases reported has been fewer than 50 cases per week in the context of some gaps in surveillance.

Cases have been reported in at least 94% (46 out of 49) of health districts, but since the beginning 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 10. 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 (3 February 2025 – 16 March 2025) (right), in Burundi.





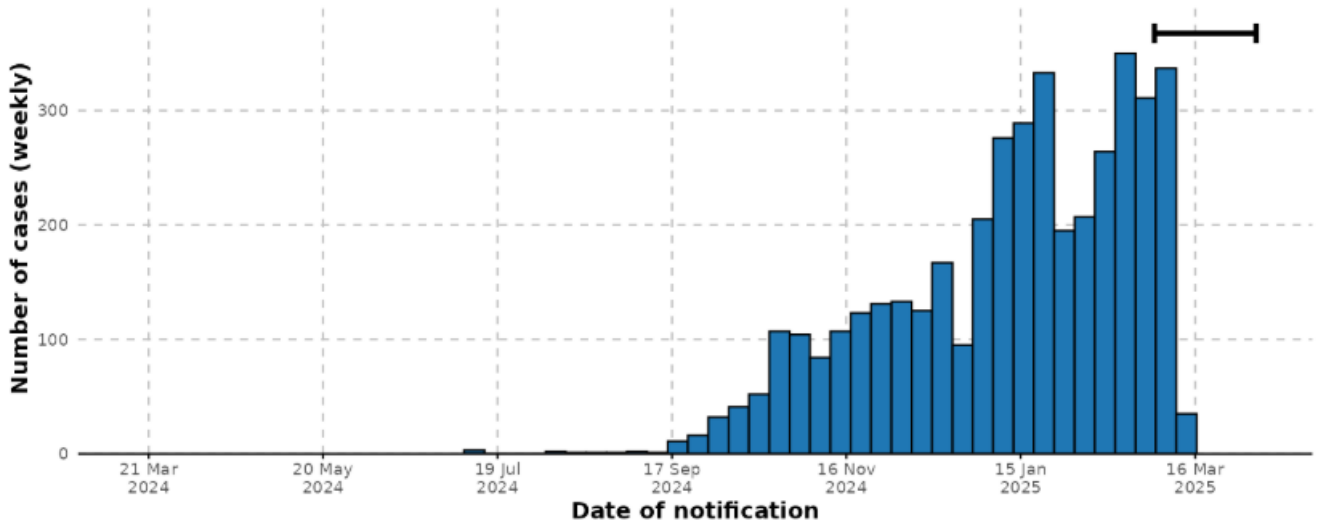
Uganda

From the start of the outbreak in July to 16 March 2025, the country has reported 4141 confirmed mpox cases, including 31 deaths (CFR 0.7%). The country is experiencing community transmission, and the weekly national case count has been increasing steadily over time (Figure 11). Uganda is the country that has reported the highest number of laboratory-confirmed cases in the past six weeks (1504 confirmed cases) in Africa.

Cases have been reported in at least 65.1% (95 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.

Figure 11. Epidemic curve of weekly number of confirmed mpox cases, by reporting epidemiological week, in Uganda



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

On 7 March 2025, Brazil notified WHO of the first confirmed case of mpox due to clade Ib MPXV detected in the country. The case is an adult female living in the Sao Paulo state, without any recent history of travel, but who has been linked to a relative who had traveled from the Democratic Republic of the Congo to visit Brazil. Case investigation and contact tracing were initiated immediately following the detection of the case and the Ministry of Health is working to reinforce of the epidemiological surveillance network. No secondary cases have been detected so far.

First cases of mpox due to clade Ib MPXV reported in the Republic of Congo

On 17 March 2025, the Republic of Congo notified WHO of two confirmed cases of mpox due to clade Ib MPXV detected in the country. Genomic sequencing analysis of samples collected from mpox patients during 2024 had also revealed that two patients had mpox due to clade Ib MPXV.

Among the 20 confirmed cases reported in 2025, five were sequenced and found to be due to clade Ia MPXV. Taken together these reports thus reflect that the Republic of Congo is the first country with documented clade Ia-Ib MPXV co-circulation outside the Democratic Republic of the Congo.

First cases of mpox due to clade Ib MPXV reported in the United Republic of Tanzania

On 10 March 2025, the United Republic of Tanzania notified WHO of two confirmed cases of mpox due to clade Ib MPXV. One case is adult male who had recently traveled to an affected neighbouring country and the other case is an adult male who reported no history of recent travel. These two cases are not linked.

As of 12 March 2025, the country had reported 22 confirmed cases from 10 regions across the country, with 122 contacts under follow-up by the time of reporting. Despite the only recent report of clade Ib MPXV cases in the country, the identification of so many cases dispersed across the country support the hypothesis of community transmission of mpox in Tanzania.

Deployments in support of the global mpox response

Since the declaration of the public health emergency of international concern (PHEIC) in August 2024, the Global Outbreak Alert and Response Network (GOARN) has played an important role in deploying specialized experts worldwide to support national and regional mpox response efforts. GOARN's coordinated approach has facilitated the rapid mobilization of professionals with expertise in epidemiology and surveillance, risk communication and community engagement, infection prevention and control, as well as coordination and other response areas. By leveraging established partnerships, GOARN has ensured that technical expertise reaches affected areas in a timely manner, thereby enhancing the overall effectiveness of the response in Africa.

WHO has developed an interactive dashboard that offers a comprehensive overview of deployments by WHO, GOARN, Standby and other partners to in support of the mpox response. This dashboard includes details on the number of experts deployed, the countries they have been sent to, the roles they have assumed, and the specific deployment mechanisms utilized. This transparent approach highlights the operational aspects of the global response but also underscores the commitment to accountability and continuous improvement.

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 21 March 2025.**

1. Emergency coordination

- The full proceedings of the meeting of the Emergency Committee convened under the provisions of the International Health Regulations 2005 (IHR, 2005) on 25 February 2025 have been published.
- WHO is finalizing the update of the global mpox strategic preparedness and response plan.

2. Collaborative surveillance

- Updates to epidemiological data on mpox in Africa continue weekly, updates to global epidemiological data continue monthly, and both can be accessed in the online WHO dashboard.

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 IPC and WASH tools and resources for mpox can be found here, including recent guidance on IPC and WASH measures during vaccination activities.

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.
- Continued technical support to IPC focal points in affected countries regarding implementation of IPC measures.

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 for people at risk, 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, 935 480 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 five countries (the Central African Republic, Democratic Republic of the Congo, Nigeria, Rwanda, and Uganda), with Sierra Leone and Liberia due to begin this week. On 22 February 2025, the Democratic Republic of the Congo intensified vaccination activities targeting those older than one year of age in the five most affected health zones of Kinshasa. A total of 407 816 persons were vaccinated with one dose of the MVA-BN vaccine and among those vaccinated, 158 493 (39%) were children and adolescents aged one to 17 years of age. Vaccination was planned for 15 (out of 422) health areas in five (out of 35) health zones In Kinshasa.
- South Sudan, the United Republic of Tanzania, and Zambia are preparing national response plans and are likely to submit vaccine requests to the AAM soon.
- From 10 – 13 March 2025, WHO convened the Strategic Advisory Group of Experts on immunization (SAGE). During this meeting, SAGE members re-emphasized strategies of dose sparing (single dose schedule, or fractional dosing with intradermal administration) during times of supply constraints in outbreak response situations. Highlights of discussions held during the meeting can be found here.
- 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. one 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 indicated authorized age groups.
- The Democratic Republic of the Congo and Japan are working to re-establish the supply of LC16m8 vaccine to the country following a period of disruption due to insecurity.
- 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 21 March 2025. A total of 13 manufacturers were invited to submit their applications for 14 Nucleic Acid Amplification assays. To date, the WHO has listed four products under the Emergency Use Listing procedure, and seven products are currently under assessment. Two other applications are expected in late April and July 2025.
- An 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.

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One Health and animal health

- World Organization for animal health (WOAH) statement on novel mpox, 23 August 2024. https://www.woah.org/en/woah-statement-on-novel-mpox/
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Training and education

- Health topics – mpox: https://www.who.int/health-topics/monkeypox
- Mpox Fact Sheet, 26 August 2024. https://www.who.int/news-room/fact-sheets/detail/mpox
- 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
  - Vaccines safety basics
  - Adverse Event Following Immunization (AEFI) data management
  - AEFI investigation
  - 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 overall public health risk posed by mpox was assessed as follows:

Overall Public Health risk
Global
Moderate

Confidence in available information
Global
Moderate

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

Confidence in available information
Moderate
Moderate
Moderate
Moderate

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

***The situation in **Kinshasa,** however, requires particular attention. The risk associated with the clade Ia MPXV outbreak there is deemed higher than in clade Ia MPXV-endemic areas, with currently no evidence to suggest that clade Ia MPXV and clade Ib MPXV in the* Kinshasa context[13] *are epidemiologically distinct.*

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

For a more detailed description of the risk groups:

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

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

[13] For more details, please refer to the Multi-country outbreak of mpox, External situation report #48

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

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

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