Mpox

Multi-country external situation report no. 50 published 11 April 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	**133 018**		**293[1]**	**131**
Reporting period: 1 January 2024 – 30 March 2025				
Area	**Number of reported confirmed cases**		**Number of deaths among confirmed cases**	
	2024	**2025**	**2024**	**2025**
Africa	**19 733**	**8647**	**52**	**49**
Democratic Republic of the Congo[2]	**14 789**	**3924**	**29[3]**	**18**
Uganda	**1353**	**3528**	**12**	**25**
Burundi	**2946**	**779**	**1**	**0**
Reporting period: last six weeks, 17 February – 30 March 2025				
Africa	**3339**		**26**	
Democratic Republic of the Congo	**1083**		**12**	
Uganda	**1753**		**10**	
Burundi	**258**		**0**	

Highlights

- Clade Ib monkeypox virus (MPXV) cases continue to be reported in the African Region, where nine countries have community transmission of this strain, as well as in countries outside of Africa among travelers returning from affected countries.
- Wherever mpox outbreaks are not quickly contained and human-to-human transmission is not limited, they continue to represent a potential risk of sustained transmission in the community.
- Currently Uganda is reporting the highest number of confirmed mpox cases globally, with 200 - 300 new cases reported per week.[4] So far, the country has detected only clade Ib MPXV.
- The Democratic Republic of the Congo continues to be the country most affected by mpox in the African Region. The number of suspected cases reported has stabilized while reported confirmed cases have declined in recent weeks, mainly due to a reduction in testing. Currently, approximately 2 out of every 10 suspected mpox cases

[1] The difference of global deaths compared with the previous situation report among confirmed cases is attributed to a retrospective adjustment of the data.

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

[3] Following routine data verification activities carried out since the last edition of this situation report, the number of deaths among confirmed cases reported in the Democratic Republic of the Congo during 2024 has been revised from 43 to 29 deaths. Accordingly, the total number of deaths among confirmed mpox cases in Africa and globally for this reporting period has been revised.

[4] 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.

are sampled, and among those two cases sampled, one is on average confirmed as mpox through laboratory testing. Clades Ia and Ib MPXV continue to circulate in the country. This report presents an overview of mpox testing and test positivity in the country.

- Burundi shows a consistent declining trend of confirmed cases with fewer than 50 new cases per week, down from over 200 cases per week at its peak.
- China has reported its first case of mpox due to clade Ia MPXV, linked to travel to the Democratic Republic of the Congo.
- The United Kingdom of Great Britain and Northern Ireland has reported the detection of its first case of mpox due to clade Ib MPXV without any known link to international travel.
- Switzerland reported its first clade Ib MPXV case, linked to travel to Uganda.
- This report provides an overview of the mpox vaccination in countries in the African Region, where to date more than 610 000 doses of MVA-VN vaccines have been administered in six countries. From the total number of doses, 95% have been administered in the Democratic Republic of the Congo, where vaccination is temporarily on hold as the strategy is being revised in light of limited supply.

In this edition:

Contextual description

This report provides an update on:

- 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 **30 March 2025**;
- updates on imported cases of mpox due to clade I MPXV as of **9 April 2025**;
- Operational response updates as of **4 April 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 suspected 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 caution, as suspected cases that undergo testing are not removed from the overall count of suspected cases, independently from the test results. In the absence of more detailed information, it is currently not possible to correctly subtract confirmed cases from the total number of suspected cases reported; therefore, the confirmed cases represent a subset of suspected cases. The case definition for suspected mpox in the Democratic Republic of the Congo can be found here.

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

For reference purposes, a summary of the latest WHO global mpox rapid risk assessment conducted in February 2025 can be found in Annex 1.

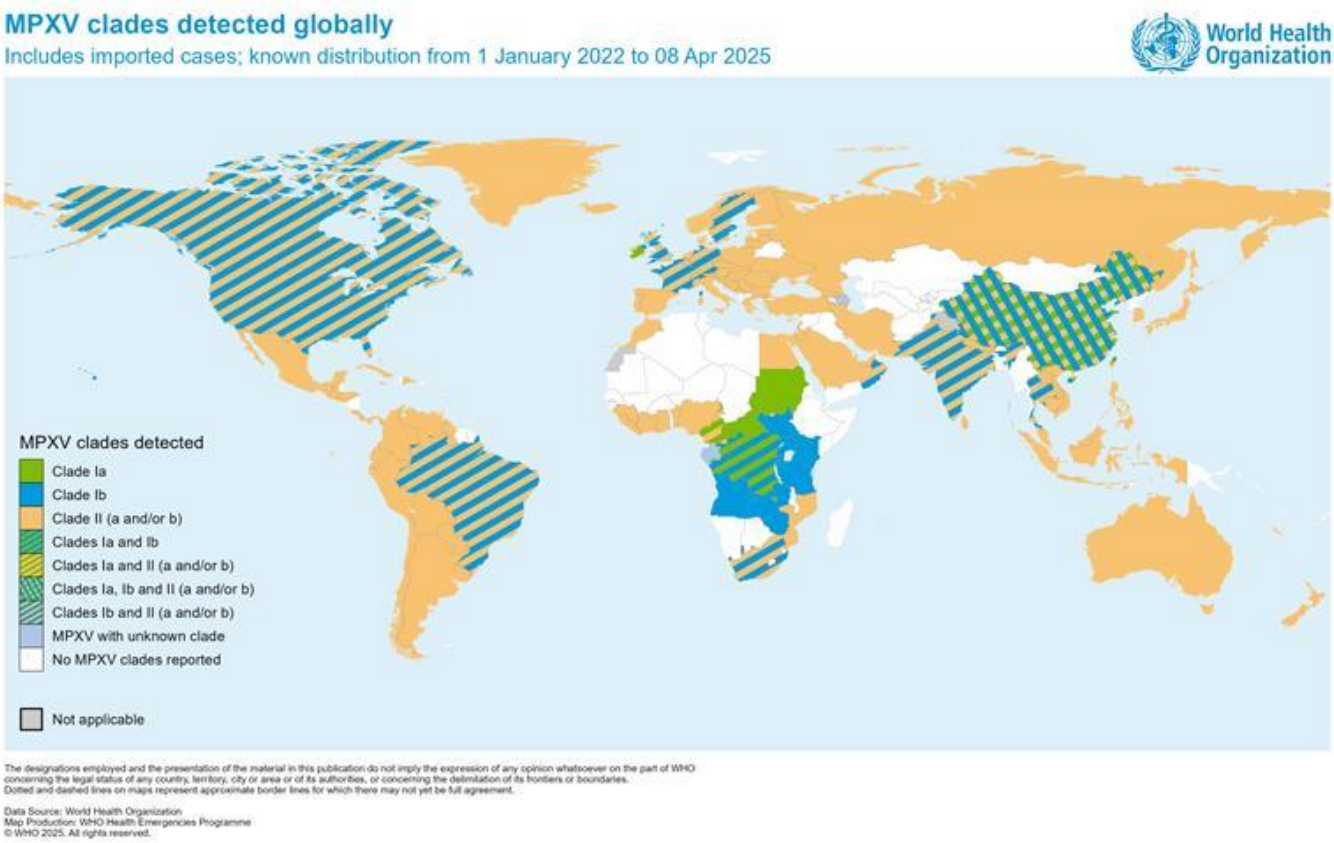
Epidemiological update [5, 6]

Global monkeypox virus (MPXV) distribution

As of 9 April 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 initial detection in September 2023, clade Ib MPXV has been detected in 28 countries (Figure 1). Most of these countries have reported only travel related cases, infections in individuals who were exposed in countries with community transmission of clade Ib MPXV in Central or Eastern Africa, or who were contacts of travelers returning from these regions.

Figure 1. Geographic distribution of MPXV clades reported to WHO, by country, from 1 January 2022 to 8 April 2025[7].



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

[6] 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.

Based on the presence of ongoing clade Ib MPXV transmission, a country is classified as having:

Community transmission, if: at least one reported case has no epidemiological link to travel or contact with a traveler from a country with known mpox transmission. This classification applies regardless of the total number of cases reported.

Cases linked to travel, if all reported cases are either: individuals who traveled to a country with known mpox transmission, were likely exposed there, and were diagnosed upon return or arrival OR Individuals who did not travel themselves but had direct contact with someone who traveled to an affected country where the exposure occurred.

Previously reporting cases, if: no new clade Ib MPXV cases have been reported for a period of more than six consecutive weeks since the last case, regardless of the previous transmission classification. Transmission is in control phase.[8]

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

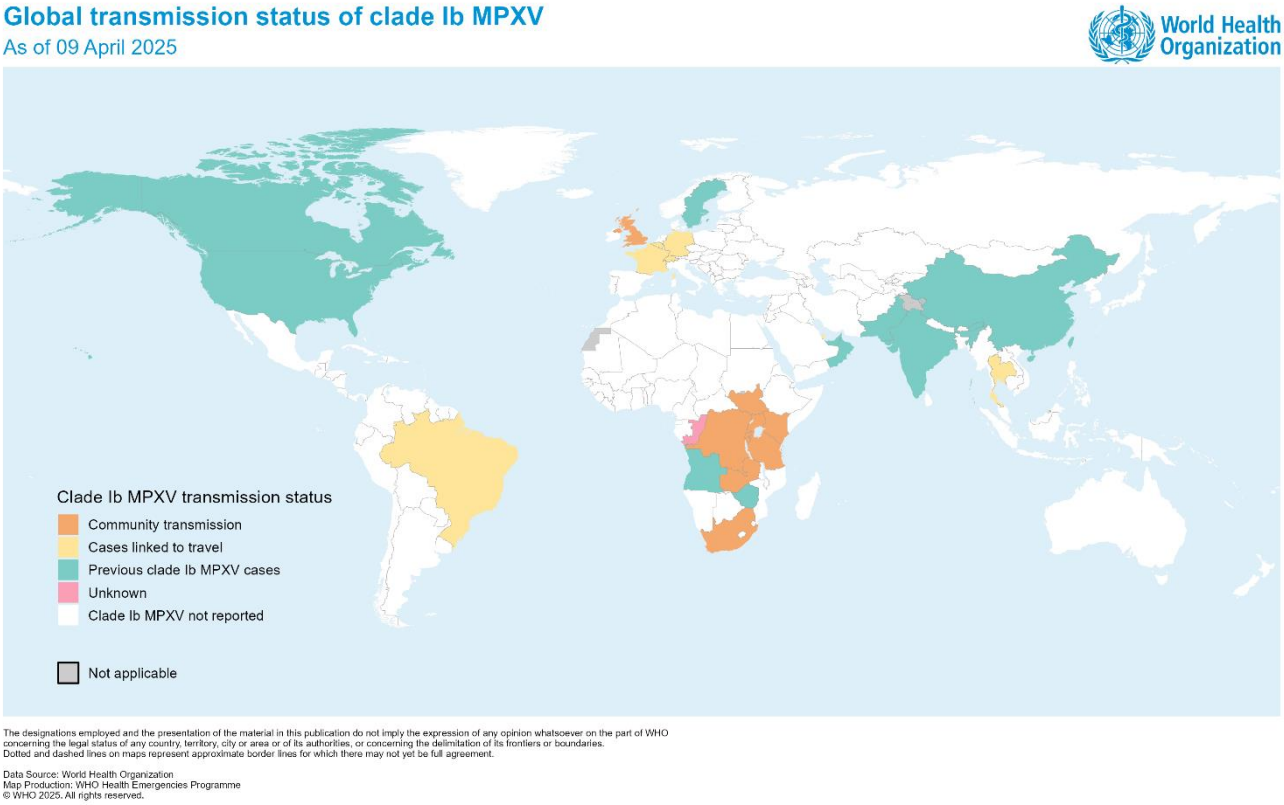
Figure 2 provides an overview of the clade Ib MPXV transmission status across all countries that have reported clade Ib MPXV cases to date.

In the Democratic Republic of the Congo, where clade Ib originated from, cases have been reported in 10 provinces: South Kivu, North Kivu, Kinshasa, Kasai, Tshopo, Tanganyika, Haut-Katanga, Mai-Ndombe, Lomami, and Kongo-Central provinces. Within Africa, community transmission of clade Ib has also been reported in Burundi, Kenya, Rwanda, South Africa, South Sudan, Uganda, the United Republic of Tanzania, and Zambia; sporadic or travel-related cases have been reported in Angola, Republic of Congo, and Zimbabwe.

Outside Africa, 16 countries have reported clade Ib MPXV cases: the United Kingdom of Great Britain and Northern Ireland (11 cases), Germany (nine cases), China (seven cases), Belgium (five cases), Thailand (five cases), the United States of America (four cases), Qatar (three cases), France (two cases), Brazil, Canada, India, Oman, Pakistan, Sweden, Switzerland and the United Arab Emirates (one case each). Community transmission has only been documented in the United Kingdom, where the most recent reported case had no known link to travel or to a confirmed case with travel history. Further details about this case are provided below. For more details on the rest of the countries, please refer to Table 1 in the section on Other countries reporting cases of mpox due to clade Ib MPXV.

[8] For more information, please refer to the Strategic framework for enhancing prevention and control of mpox – 2024-2027 (2024) Available at: https://www.who.int/publications/i/item/9789240092907

Figure 2. Clade Ib monkeypox virus transmission status by country, as of 9 April 2025



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 currently no documented difference in inherent transmissibility of different MPXV strains to date, they are affecting different populations in different settings, resulting in distinct outbreak dynamics.

Clade Ia MPXV

Clade Ia MPXV is found primarily in the Democratic Republic of the Congo, 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 also continues. While the Democratic Republic of the Congo and the Central African Republic report a higher proportion of children among cases, in the Republic of Congo, most cases are among adults.

Previously, genomic sequencing analysis had indicated that clade Ia MPXV typically emerged in human populations through zoonotic exposure, leading to limited human-to-human transmission. 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. At least three other provinces in the country (Congo Central, Kwilu, and Kwango) have detected this lineage, and two imported cases have recently been found in Ireland and China, one respectively. 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, and primarily travel-related cases in other countries where it has been reported (Figure 1). No human case of clade Ib has been substantively linked to an animal exposure, and current genomic sequencing data suggest that all cases detected so far are genomically linked to the strain detected for the first time in 2023 in South Kivu. So far it 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 in the visiting country with person with known or unknown mpox diagnosis.

Often introduced in new settings through sexual contact among connected sexual networks, clade Ib MPXV outbreaks can expand and transmission patterns change, including spread within households and 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 development, as this clade had mainly been detected in animals, including the 2003 outbreak in the United States of America linked to imported small mammals and a more recent outbreak among monkeys in Thai national park in Cote d'Ivoire. 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 capital cities.

Mpox linked to clade IIa MPXV has been reported in adults and children, with many lacking a known epidemiological link. Limited epidemiological investigations constrained understanding of the modes of transmission in these outbreaks. Clade IIa MPXV remains the least described strain in the 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 Africa and outside of it 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, where low level transmission is reported, continues to be men who have sex with men, primarily exposed through sexual contact. In instances where others have been affected, such as women and children, it has not led to sustained transmission. In western Africa, cases are reported in different age groups and include males and females, highlighting potentially different transmission dynamics, which are not fully understood.

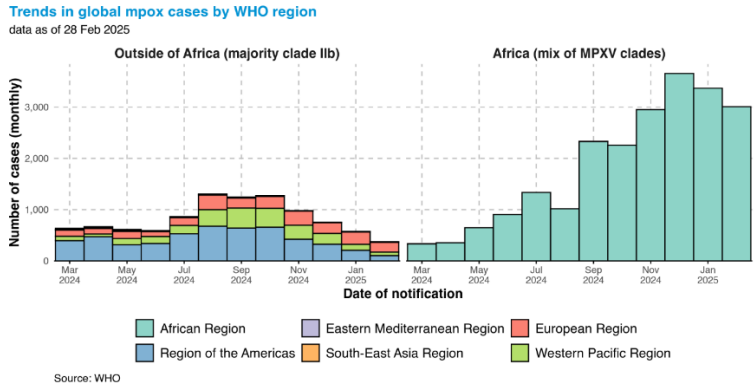
The multi-country outbreak of mpox driven by clade IIb MPXV that began in 2022 showed that sexual contact can sustain community transmission of MPXV for long periods of time. Likewise, subclades Ia and Ib have also been shown to be spreading through sexual contact, and their transmission is being sustained in different settings. Much remains to be understood about transmissibility and sustainability of transmission through non-sexual direct physical contact for all clades. In settings where human-to-human transmission persists, it is likely driven by a combination of sexual, household, and community contact.

Global trends

This section of the report offers an overview of the global epidemiological situation, based on data **at the end of February 2025,** as presented in the previous situation report.

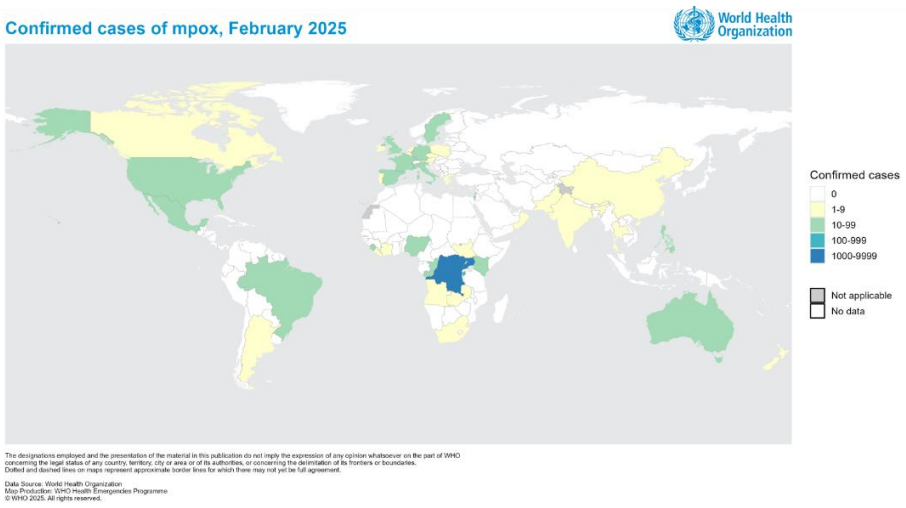
In the last 12 months the majority of mpox cases have globally been reported in the WHO African Region, with a peak of around 3 thousand new cases a month in recent months (Figure 3). While most other regions continue to experience low level MPXV circulation, the African Region has been recording its highest number of confirmed cases ever reported. This trend reflects the continuing spread of the disease in the Democratic Republic of the Congo and its bordering countries on the east and, in some measure, improved surveillance put in place before and since the declaration in August 2024 of a Public Health Emergency of International Concern (PHEIC) under the International Health Regulations. The slight decline in cases reported since December is linked to reduced capacity for testing and confirmation of cases in the Democratic Republic of the Congo, and it does not necessarily indicate a drop in mpox transmission at this time.

Figure 3. Epidemic curves of monthly aggregated number of confirmed mpox cases reported to WHO, by WHO regions outside Africa (left) and in the African region (right), 1 March 2024 – 28 February 2025.



Although most cases are now being reported to WHO by African countries, the geographic distribution of cases in February 2025 shows how mpox is still occurring in all WHO Regions (Figure 4), reflecting continuing circulation of clade IIb MPXV together with increasingly frequent reports of clade Ib MPXV outside of Africa. Given high population susceptibility at the global level, wherever mpox outbreaks are not quickly contained and human-to-human transmission is not limited, they continue to represent a potential risk of sustained transmission in the community and a continuing health threat particularly for those who are most vulnerable. Efforts continue to raise awareness, sustain access to diagnostics and strengthen surveillance worldwide, support community protection initiatives, improve access to vaccines and immunization and advance the mpox research agenda.

Figure 4. Number of confirmed mpox cases reported to WHO, by country, 1 - 28 February 2025

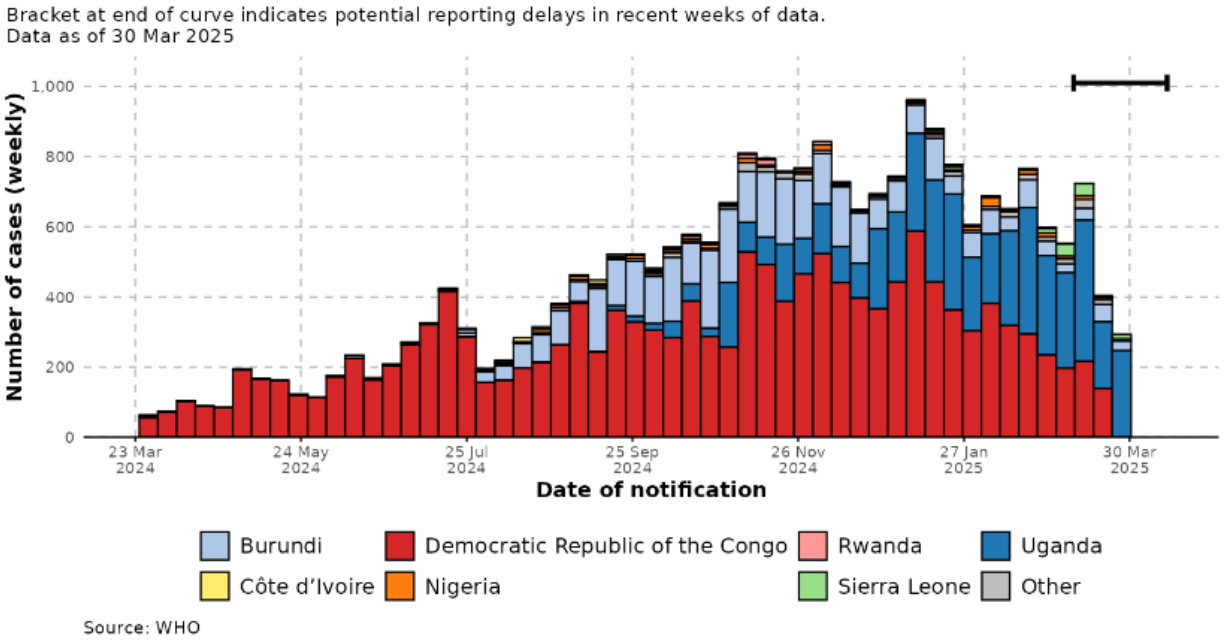


Confirmed cases reported in Africa

In Africa, from 30 December 2024 to 30 March 2025, 8647 confirmed mpox cases, including 49 deaths (CFR – 0.6%), have been reported by 17 countries. The most affected country continues to be the Democratic Republic of the Congo (3924 confirmed cases, including 18 deaths)[9] followed by Uganda (3528 confirmed cases, including 25 deaths), and Burundi (779 confirmed cases and no deaths) (Figure 5).

In more recent weeks the highest number of confirmed mpox cases in the Region has been reported by Uganda, with more than 200 new confirmed cases per week, while Burundi has shown a stable decrease over the last months, with fewer than 50 new confirmed cases per week.

Figure 5. Epidemic curve of confirmed mpox cases in Africa, by country, in the past 12 months, 23 March 2024–30 March 2025.



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

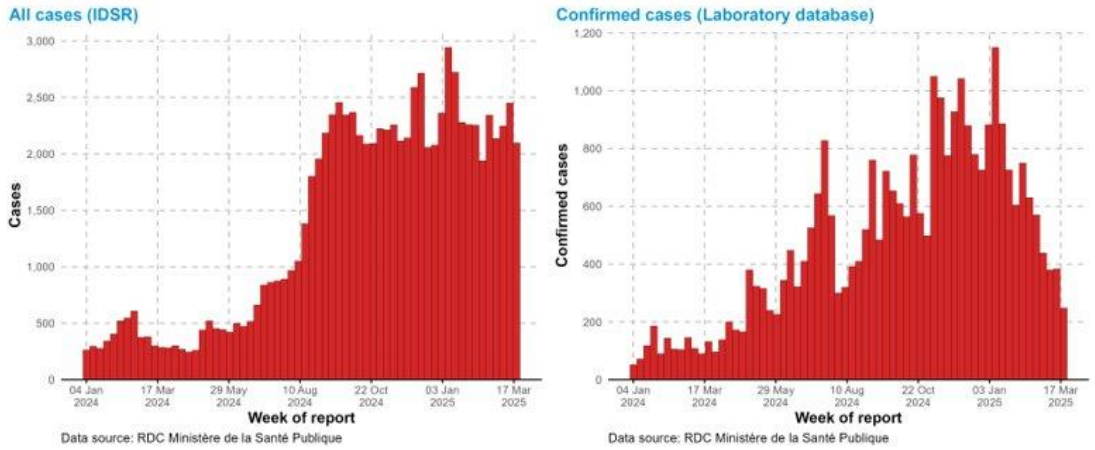
Mpox outbreaks in the Democratic Republic of the Congo continue to be driven by both clade Ia and Ib MPXV strains.

The analysis of the epidemic trend of reported suspected mpox cases (left, Figure 6) shows that there was a notable rising trend in the second half of 2024, likely owing to enhanced surveillance following the PHEIC declaration, and the number of suspected cases reported has remained at a high level, largely in the range of 2000 to 2500 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 since the start of 2025. The trends in reported confirmed cases should be interpreted with caution, since they are more an indication of access to testing in the country than of ongoing mpox transmission.

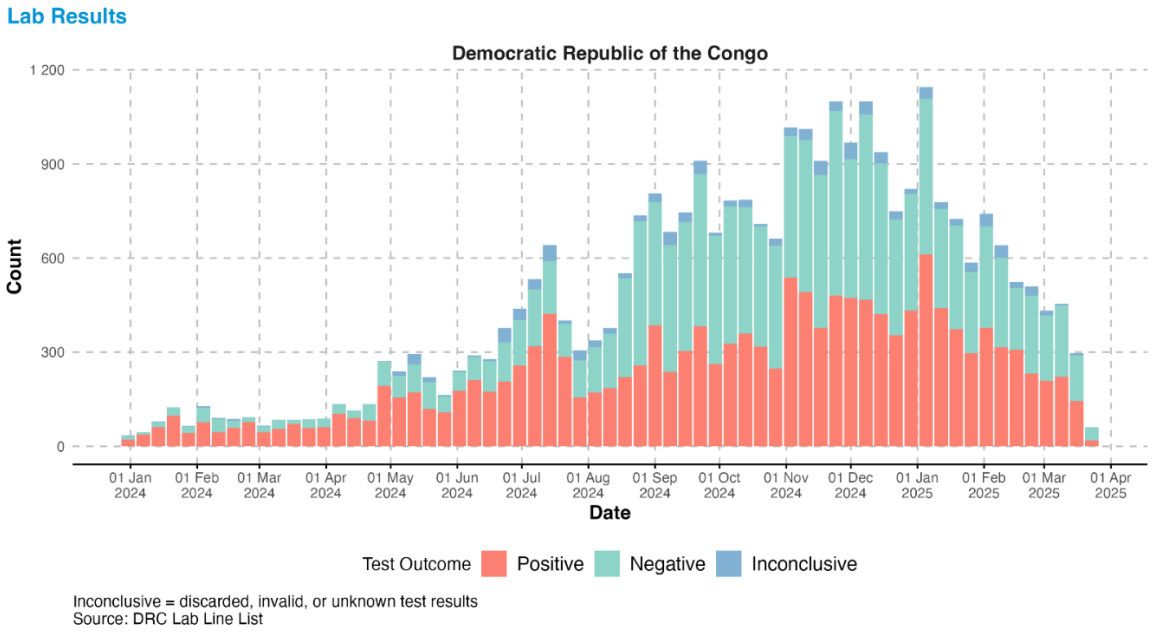
[9] The national-level case counts for the Democratic Republic of the Congo indicated here are based on the national laboratory database for mpox.

Figure 6. Epidemic curve of suspected (left) and confirmed (right) mpox cases reported in the Democratic Republic of the Congo, 1 January 2024 – 23 March 2025[10].



The decrease in mpox testing 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.

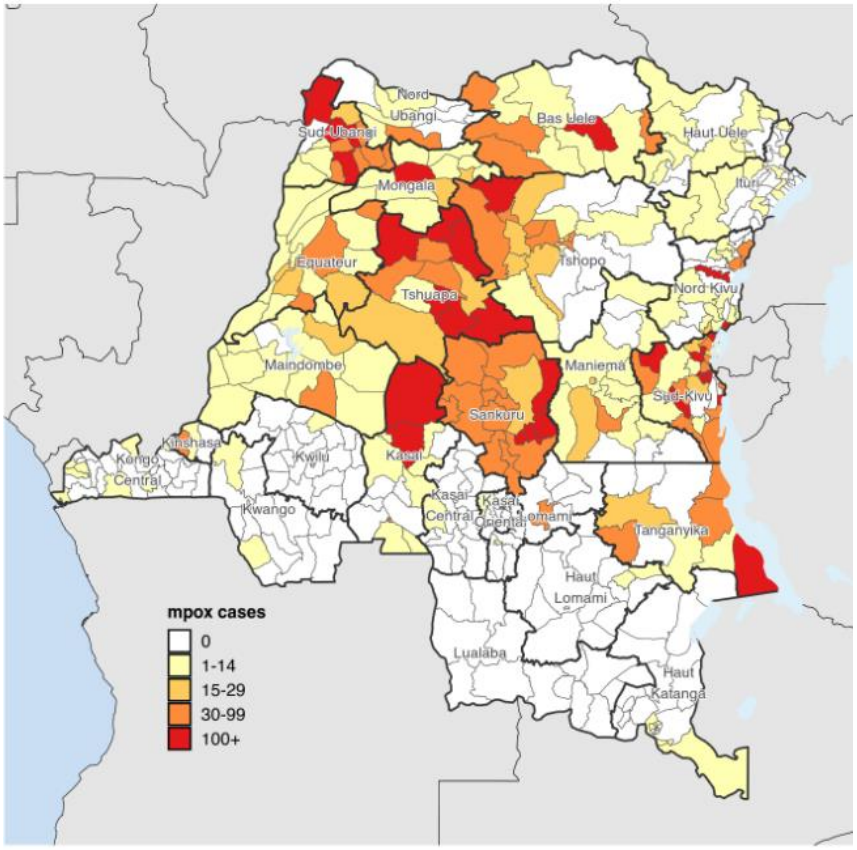
Figure 7. Epidemic curve of tested mpox cases by week and test results in the Democratic Republic of the Congo, 1 January 2024 - 23 March 2025.



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 8) shows wide geographical distribution of suspected mpox cases and variation between different health zones. Historically endemic provinces in the north-west of the country continue to report high number of cases, although the virus is also affecting big parts of the eastern, and south-eastern provinces.

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

Figure 8. Geographic distribution of suspected mpox cases in the past six weeks, by health zone, in the Democratic Republic of the Congo, 10 February - 23 March 2025[11].



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

Mpox testing and test positivity in the Democratic Republic of the Congo

This section presents indicators related to mpox testing in the Democratic Republic of the Congo, including the proportion of suspected cases that are sampled and test positivity over time. Testing is conducted through a nationwide laboratory network using both conventional PCR and GeneXpert PCR platforms. Sampling proportion is calculated by dividing the number of sampled cases (as recorded in the national laboratory line list) by the number of suspected cases reported through the syndromic surveillance system, aggregated by geographic area. This metric combines data from two distinct sources and is used solely to estimate testing activity. Due to potential date misalignments and other discrepancies between the two databases, these estimates may vary from week to week and should be interpreted with caution. Test positivity is calculated as the proportion of positive PCR results among the total number of tests conducted for each geographic area.

From January 2024 to mid-March 2025, all suspected mpox cases are reported to have been sampled in Kinshasa and North Kivu provinces (Table 2). In contrast, the proportion sampled remains below 50% in South Kivu and around 20% in endemic provinces, where access to sampling and testing materials is more limited.

Positivity among tested cases also varies across these geographic areas. In Kinshasa and North Kivu, where testing is more widely accessible, positivity ranges between 30 and 40%. In contrast, South Kivu and the endemic provinces report much higher test positivity overall—above 60% in endemic areas and over 70% in South Kivu. In line with the decreasing trend of cases, test positivity has been going down in 2025, around 50% (data not shown),

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

while it has increased in Kinshasa in 2025, around 75% (data not shown), as the outbreak continues to spread mostly among adults mainly through sexual contact.

Table 2. Estimated proportions of suspected mpox cases that are sampled and positive samples among those tested, by main geographic area, in the Democratic Republic of the Congo, 01 January 2024 – 16 March 2025[12].

From 1 Jan 2024 through 16 Mar 2025		
	% cases sampled	% cases positive
Kinshasa	-	39.1%
Sud-Kivu	47.2%	71.0%
Nord Kivu	-	32.1%
Endemic provinces	19.7%	63.7%

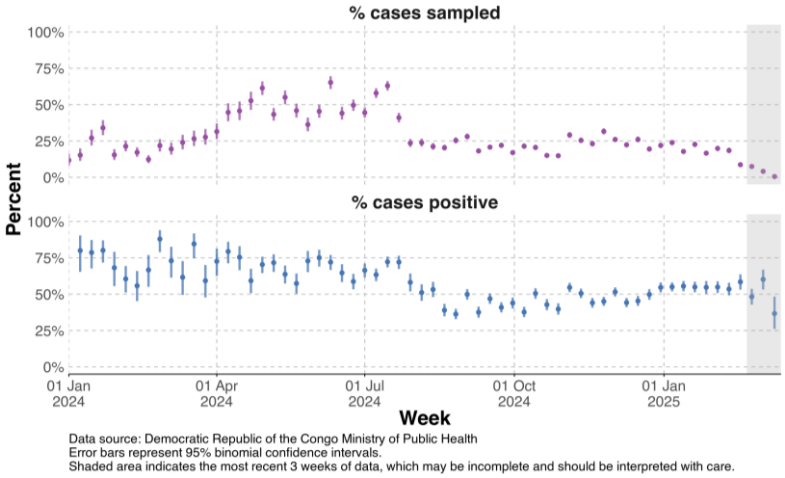
When examining the percentage of suspected cases for whom a sample was collected for testing, a decline from around 50% to around 25% is observed by late July 2024 (Figure 9). This drop likely reflects the impact of the PHEIC declaration, which led to increased case detection and reporting (Figure 6), but without an immediate corresponding increase in sampling capacity. As more suspected cases were identified, the system was unable to keep pace with sampling demand. The narrower confidence intervals around these estimates also reflect the larger number of cases reporting since then. In more recent weeks, sampling coverage has declined further, particularly due to insecurity in the eastern part of the country and the limited response capacity previously described.

Test positivity, around 75% prior to the PHEIC declaration, has since decreased and has more recently stabilized just above 50%. Here too, the narrower confidence intervals suggest a higher volume of tests performed, contributing to more stable estimates.

Currently, approximately 2 out of every 10 suspected mpox cases are sampled, and among those two sampled, one is confirmed mpox through laboratory testing.

Constraints in case confirmation hinder the full implementation of key response measures, such as case isolation and contact tracing, allowing the virus to circulate undetected and contributing to the persistence of ongoing outbreaks.

Figure 9. Weekly percentages of suspected cases for whom a sample was collected (above) and weekly percentage of confirmed cases among those that undergo laboratory testing (below), in the Democratic Republic of the Congo, 01 January 2024 – 16 March 2025[13].



[12] Proportion of cases sampled is not shown for Kinshasa and Nord Kivu because all suspected mpox cases are sampled.

[13] Positivity rates are based solely on national laboratory line list data. Wider confidence intervals indicate smaller sample sizes or more variable positivity.

Other countries reporting cases of mpox due to clade Ib MPXV

This section of the report includes countries that report community transmission of clade Ib MPXV or travel related cases of clade Ib MPXV in the last six weeks and are therefore considered active for clade Ib transmission (Table 3). The remaining 11 countries (of total 28) that have reported clade Ib MPXV cases more than six weeks ago are not included and are currently considered in control phase for clade Ib.

Table 3. List of countries reporting transmission of clade Ib MPXV, as reported to WHO, as of 9 April 2025.

Country	Cases since Jan 2024	Cases in past 6 weeks	Transmission status	Additional notes
Democratic Republic of the Congo	18 713[14]	806[14]	Community transmission	-
Uganda	4881	1394	Community transmission	-
Burundi	3725	178	Community transmission	-
Rwanda	111	6	Community transmission	-
Kenya	61	13	Community transmission	-
Congo	51	6	Community transmission	Not all recent reported cases are sequenced, and the total is a mix of clade Ia and Ib MPXV
Zambia	31	10	Community transmission	-
United Republic of Tanzania	31	31	Community transmission	-
The United Kingdom	11	2	Community transmission	One case with no reported travel or links to travelers
South Sudan	8	5	Community transmission	One case with no reported travel or links to travelers
South Africa	6	6	Community transmission	
Belgium	5	1	Cases linked to travel	-
Thailand	5	1	Cases linked to travel	-
Qatar	3	1	Cases linked to travel	-
France	2	1	Cases linked to travel	-
Brazil	1	1	Cases linked to travel	-
Switzerland	1	1	Cases linked to travel	-

Note: Imported cases are updated as of 9 April 2025 whereas case counts for countries classified as community transmission are updated as of 9 April 2025.

For countries classified as having cases linked to travel, only cases of mpox due to clade Ib MPXV are included. Cases in these countries for which clade and subclade classification is not determined or pending are not included. Note that multiple exported cases have been detected in travelers returning from United Arab Emirates, indicating likely community transmission in-country.

Countries with cases linked to travel also include instances where one to two generations of onward transmission have been reported and linked to index cases.

[14] Cases reported in Congo and the Democratic Republic of the Congo are known to be a mix of clade Ia and clade Ib MPXV.

First case of mpox due to clade Ia MPXV reported in China

On 4 April 2025, China notified WHO of the first confirmed case of mpox due to clade Ia MPXV detected in the country. The case is an adult male Chinese national with a recent travel to the Democratic Republic of the Congo. He developed symptoms on 15 March, while still in that country and sought treatment locally. On 27 March, he departed for China, reaching on 28 March and seeking treatment the next day. On 1 April, China Centers for Disease Control (China CDC) confirmed infection with clade Ia MPXV. The patient is currently hospitalized in isolation and in stable condition. Considering the surveillance and response measures rapidly initiated, and findings of the case investigations, further onward local and international spread in relation to this case are considered unlikely.

First case of mpox due to clade Ib MPXV without any international travel link reported in the United Kingdom of Great Britain and Northern Ireland

On 24 March 2025, the United Kingdom of Great Britain and Northern Ireland notified WHO of the eleventh case of mpox due to clade Ib MPXV identified in the country. The case is an adult male who developed symptoms and sought medical care mid-March, when clinical specimens were collected. Laboratory testing and whole genome sequencing confirmed clade Ib MPXV.

The case did not report travel outside the United Kingdom in the 21 days prior to symptom onset and reported no contact with any known mpox case or with anyone who had travelled to any affected country. After thorough investigations, it was not possible to establish the source of infection for this case.

Case investigation, contact tracing, and other response activities are underway. Considering the surveillance and response measures rapidly initiated and the findings of the case investigations, further onward local and international spread in relation to this case are considered unlikely.

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

On 9 April 2025, Switzerland notified WHO of the first confirmed case of mpox due to clade Ib MPXV detected in the country. The case is an adult male with recent history of travel to Uganda. The case is clinically stable and currently in isolation. Case investigation and contact tracing were initiated immediately following detection, and no contacts were reported.

Mpox vaccination in the African Region

As of 8 April 2025, six African countries have started mpox vaccination, all using MVA-BN vaccine. More than 610 208 doses have been administered as part of the current outbreak response. Notably, 95% of these doses have been administered in the Democratic Republic of the Congo, the country reporting the highest number of cases.

Given the supply-constrained context of the current outbreaks, WHO recommends the off-label use of a single dose or intradermal fractional dosing of MVA-BN vaccine. At its March 2025 meeting, the WHO Strategic Advisory Group of Experts on Immunization (SAGE) re-emphasized the importance of dose sparing strategies during times of vaccine shortages in outbreak response situations.

Below is a summary of the countries that have started mpox vaccination, the number of doses administered to date, and the target populations:

- **Democratic Republic of the Congo**: Vaccination began on 5 October 2024, with a total of 582 196 doses administered to date. During phase 1 (October 2024 – 21 February 2025) a two-dose regimen was administered to individuals aged 18 years and older targeting healthcare and frontline workers, contacts of mpox cases, and key populations including sex workers, men who have sex with men, hunters, and eco-guards/wildlife-rangers. In phase 2 (from 22 February 2025), the country shifted to a single-dose strategy for individuals aged 1 year and above in hotspot health areas across five of 35 health zones in Kinshasa, as well as contacts of cases.

Currently mpox vaccination is temporarily on hold as the strategy is being revised in light of limited supply.

- **Uganda**: Since 2 February 2025, a total of 10 210 doses have been administered in two of the most affected districts in the capital, Kampala. Vaccination with single-dose MVA-BN has focused on individuals aged 12 years or more from the following groups: key populations (sex workers, men who have sex with men, people who inject drugs, lesbian, gay, bisexual, transgender, queer individuals), long-distance drivers, fishermen, healthcare workers, and contacts of cases.
- **Rwanda**: Since 17 September 2024, 9513 doses have been administered (7721 first doses and 1792 second doses). Target population includes individuals aged 18 years and older among healthcare workers, contacts of cases, and other high-risk groups.
- **Nigeria**: Since 25 November 2024, 7959 doses have been administered (4329 first doses and 3630 second doses) across six states. Vaccination targets individuals 18 years and older, including healthcare workers, contacts of cases, and other at-risk groups such as immunocompromised individuals. Currently, vaccination is on hold, pending operational funding.
- **Sierra Leone:** Since 27 March 2025, 227 doses have been administered using a single-dose strategy. Target groups include individuals 12 years and older among healthcare and frontline workers, sex workers, contacts of cases, and other high-risk populations.
- **Central African Republic**: Since 18 January 2025, 100 doses have been administered, primarily targeting contacts of confirmed cases. Plans are underway to expand vaccination to additional provinces.

Other countries in the African Region are expected to start mpox vaccination in the coming weeks. Liberia and South Africa are preparing for vaccination activities due to start later in April.

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 4 April 2025.**

1. Emergency coordination

- WHO is finalizing the update of the global mpox strategic preparedness and response plan and working with partners to finalize the continental preparedness and response plan for Africa.

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 has published interim guidance on social and behavioural research for the mpox public health response. This interim guidance is the first of its kind, developed to strengthen the quality, ethics and impact of producing such evidence in an emergency response. The guidance builds on the outcomes of a multi-stakeholder meeting in Kinshasa, Democratic Republic of the Congo, in 2024, which brought together Ministries of Health, researchers and academics, operational partners, Civil Society Organizations and funders. For more details on this meeting, please refer to the report, available in both English and French.

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.
- To date, 1 001 480 vaccine doses have been delivered to nine 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 six countries (the Central African Republic, Democratic Republic of the Congo, Nigeria, Rwanda, Sierra Leone and Uganda) while The United Republic of Tanzania, and Zambia are preparing national mpox vaccine deployment plans and are likely to submit vaccine dose requests to the AAM soon.
- 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 resumed discussions last week on the shipment of the remaining doses of LC16m8 vaccine to the country which had been put on hold following a period of 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, 69 manufacturers have contacted WHO and 41 pre-submission calls had been scheduled as of 7 April 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.

Mpox resources

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Regional information products

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- OpenWHO. Mpox and the 2022-2023 global outbreak (2023)

  - English: https://openwho.org/infectiousdiseases/503162/Mpox
- AVigiMobile AEFI reporting 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

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[15] *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.**

[15] 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.