

Mpox in Africa (2022-2025)

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Background

In December 2022, the Democratic Republic of Congo (DRC) declared a national outbreak of mpox as cases increased and spread at rapid rates¹. While the DRC has reported the highest number of mpox cases, 20 other African countries across all five regions of the continent reported cases between 1 January 2024 and 26 January 2025, including previously non-endemic countries². Mpox is a zoonotic infectious disease caused by the monkeypox virus (MPXV)³. It is closely related to smallpox caused by the variola virus which is part of the same genus as MPXV; the *Orthopoxvirus* genus⁴. Mpox was first discovered in the DRC (formerly Zaire) in 1970 around the same time the last smallpox case was reported^{5,6}. Shortly after, several other West and Central African countries began reporting mpox cases with repeated zoonotic spillovers and limited human-to-human transmission⁶. Before 2022, mpox was endemic to 11 West and Central African countries affected by two distinct clades of the MPXV: clade I (formerly the Central African clade) and clade II (formerly the West African clade) which can be further subcategorised into clade IIa and clade IIb⁷. Clade I MPXV is suggested to be more deadly with a case-fatality ratio (CFR) of 10.6% compared to a CFR of 3.6% for clade II⁸.

Transmission, Clinical Presentation, Diagnosis, and Treatment

Mpox spreads from infected animals to humans or from infected humans to humans through direct contact with skin, bodily fluids, or contaminated objects^{3,9}. Although it is less common, infected pregnant individuals can also transmit the virus to their foetus or newborn⁹. The incubation period ranges from approximately 1 to 21 days but on average, symptoms present within a week^{3,10}. Individuals suffering from mpox typically develop fever, lymphadenopathy, malaise, muscle aches, and a rash^{3,10,11}. The rash begins as an ulcer which becomes fluid-filled, itchy, and painful, before crusting and falling off as it heals³. In most cases, mpox is a self-limiting disease however, in people with a weakened immune system the disease can be fatal and complications such as bacterial skin infections, encephalitis, myocarditis, and eye problems can develop^{3,11}.

The preferred laboratory test for confirming mpox is a polymerase chain reaction (PCR) test to detect viral DNA³. Swabs tested are taken directly from the rash³. Blood samples are not recommended, and antibody testing cannot distinguish between orthopoxviruses³. Laboratory confirmation is necessary as mpox is difficult to distinguish from similar diseases such as measles or herpes³. Antivirals such as tecovirimat have been used to treat mpox however, recent preliminary evidence demonstrates that tecovirimat is ineffective at treating clade I MPXV, and further research is needed to understand its effectiveness^{3,12–14}. Bavarian Nordics Modified Vaccinia Ankara vaccine (MVA-BN) known as JYNNEOS in the United States (US) or Imvamune and Imvanex outside the US is a licensed mpox vaccine that is safe and effective however, further research is needed to understand the vaccine's effectiveness in different at-risk groups^{12,15–17}. These vaccines have been recommended for use by the World Health Organization (WHO) Strategic Advisory Group of Experts on Immunization and from 7 August 2024, Emergency Use Listing of the vaccines enabled GAVI and UNICEF to procure them for distribution without national regulatory approval^{18–20}. The MVA-BN vaccine is the first mpox vaccine to be prequalified by the WHO²¹. Recent findings from a clinical trial based in the United States demonstrate that the MVA-BN vaccine is safe in adolescents aged 12 to 17 years old²². These results provide encouraging evidence supporting the extended use of the vaccine to younger individuals²². However, there is a need to continue evaluating the vaccine in even younger age groups²². The Japanese-manufactured LC16m8 vaccine has been recommended for use in children over the age of one, and was added to the WHO Emergency Use Listing (EUL) in November 2024²³.

Global 2022 mpox outbreak

In May 2022, the United Kingdom (UK) reported a mpox case in an individual who had recently travelled to mpox-endemic Nigeria²⁴. Shortly after, several community-acquired cases with no links to endemic countries were reported²⁴. By July 2022, the WHO declared a Public Health Emergency of International Concern (PHEIC) as mpox spread globally²⁵. The US became the most affected country, with 32,820 cases reported between January 2022 and April 2024²⁶. The global mpox outbreak was driven by clade IIb MPXV and differed in transmission and clinical presentation from what was traditionally known^{3,27}. It spread predominantly via sexual contact and heavily affected men who have sex with men²⁷. Some cases would present with only a few genital lesions before prodromal symptoms such as fever or malaise²⁷. Mpox cases globally began to decline and the PHEIC was no longer in place by May 2023²⁵. In August 2024, a PHEIC for mpox was declared again due to the rapid rise of cases in Africa^{28,29}.

Mpox in the DRC

Epidemiology

Between 1 January 2022 to 26 January 2025, there were 15,775 confirmed mpox cases and 45 deaths in the DRC². Between 16 December 2024 and 26 January 2025 alone, the DRC confirmed 984 mpox cases². Many suspected mpox cases remain unconfirmed due to limited diagnostic capacity, and it is estimated that only 40% of suspected cases are tested, with almost half testing positive^{2,30}. Before 2022, 11 out of 26 provinces in the DRC had been affected by mpox, but by 25 August 2024, this increased to all 26 provinces³¹. South Kivu province has reported the highest number of mpox cases in the DRC and confirmed 4,872 cases between 9 December 2024 and 19 January 2025². This is followed by Kinshasa, which reported 1,467 cases over the same period².

The recent escalation of conflict in Eastern DRC risks fuelling the spread of mpox and hindering the accessibility to life-saving interventions³².

Populations impacted

Individuals less than 15 years old remain heavily impacted, possibly due to their reduced immunity exacerbated by high malnutrition rates and a lack of protection that previously administered smallpox vaccines would have provided to older populations^{33,34}. In addition, an increasing number of children in the DRC are presenting with mpox-measles co-infection, particularly in South Kivu, heightening the risk of co-infection in treatment centres where measles vaccination rates are low³⁵.

Concerningly, mpox has spread to highly mobile populations, including displaced people, in Eastern DRC which suffers from ongoing conflict and insecurity^{1,36,37}. This region, particularly North and South Kivu, is most affected by the outbreak³⁸. In North Kivu, approximately a third of the people affected are internally displaced people (IDP)³⁰. Half of the cases within this province are children and this increases to 75% within IDP camps³⁰.

Transmission of Clade I MPXV

The DRC is affected by the clade I MPXV strain, which has suggested increased lethality¹. Traditionally, transmission mainly occurred via zoonotic spillover events and household contacts in provinces close to tropical rainforests⁶. However, this outbreak has seen sustained human-to-human transmission of clade I MPXV and geographical spread to urban provinces, including the densely populated capital city, Kinshasa³⁹.

In April 2023, sexual transmission of clade I MPXV was reported for the first time from the Kwango province in DRC³⁹. The case (case 1) was a Belgian male resident who frequently travels to the DRC³⁹. After arriving in the DRC in March 2023, the individual had several sexual encounters (six men and three women)^{39,40}. Five sexual and non-sexual contacts of case 1 tested positive for mpox. Epidemiological investigations reveal that the exposure to MPXV likely occurred in Belgium, and genomic sequencing confirms that the cluster of sexually transmitted cases from Kwango is being driven by clade I MPXV³⁹. Belgium has not identified the circulation of clade I MPXV yet⁴¹. Between September 2023 and February 2024, South Kivu province in DRC reported clade I MPXV cases driven by sexual transmission, and female professional sex workers were especially affected, comprising 29% of cases⁴². Concerningly, mpox has spread to displaced people in Goma, one of the most affected regions in the North Kivu province, where rates of sexual violence are high, increasing the likelihood of spread to victims of sexual violence^{30,43}. Transmission in North Kivu is exclusively human-to-human, with a significant portion reporting sexual transmission, particularly among professional female sex workers³⁰.

Emergence of Clade Ib MPXV

Genomic sequencing from South Kivu samples obtained between October 2023 and January 2024 revealed a novel variant of clade I MPXV had emerged with APOBEC3-type mutations^{1,44}. This is now referred to as clade Ib. Mutations represent the deletion of a gene in the same position as the clade Ib MPXV and have led to the failure of the clade I specific RT-PCR diagnostic tests recommended by the CDC⁴⁵. However, a new RT-PCR test specific to clade Ib MPXV detection has recently been developed to mitigate this⁴⁶. The novel variant is indicative of virus adaptation from sustained human-to-human transmission, and recent evidence suggests that this variant is mutating at a higher rate compared to clade Ib MPXV^{42,47}. Further research is needed to determine if this novel variant is more transmissible or deadly¹. As of 19 January 2025, clade Ib MPXV has been reported mainly from Eastern DRC (South Kivu, North Kivu, Tanganyika, and Haut Katanga), which has detected only clade Ib². Provinces impacted by clade Ia and Ib include Kinshasa, Kasai, Tshopo, and Maindombe². The remaining provinces are affected by clade Ia only². Provinces affected by clade Ia MPXV have a CFR of more than 4%, whereas provinces where clade Ib MPXV is circulating have a CFR of <0.5%⁴⁸. Further research is needed to determine if this difference is due to the viral, population differences, or differences in case detection and reporting⁴⁸.

Mpox in Africa

Beyond the DRC, the spread of mpox in Africa is alarming. Overall, mpox cases in Africa increased by more than 500% in 2024 compared to 2023 and by 79% in 2023 compared to 2022^{49,50}. South Africa, Guinea, and Côte d'Ivoire reported clade II MPXV cases in 2024 after not reporting any cases in 2023⁵¹. This is in addition to Nigeria, Ghana, Liberia, Morocco, and Cameroon, which continued to report clade II MPXV cases in 2024 (**Figure 1**)^{2,20,52–54}. This highlights the ongoing transmission of clade II MPXV and the continued threat it poses. Gabon has also reported mpox cases in 2024 after not reporting any in 2023, alongside Mauritius and Angola which have confirmed mpox cases in individuals with recent travel history to endemic regions. The MPXV clade responsible in these countries is yet to be determined². As of 12 January 2025, Sierra Leone reported two mpox cases (the clade responsible remains unknown) from the Western region of the country in individuals with no travel history^{55,56}. Along with DRC, the Central African Republic (CAR) and the Republic of Congo have continued to report cases of clade Ia in 2024²⁰.

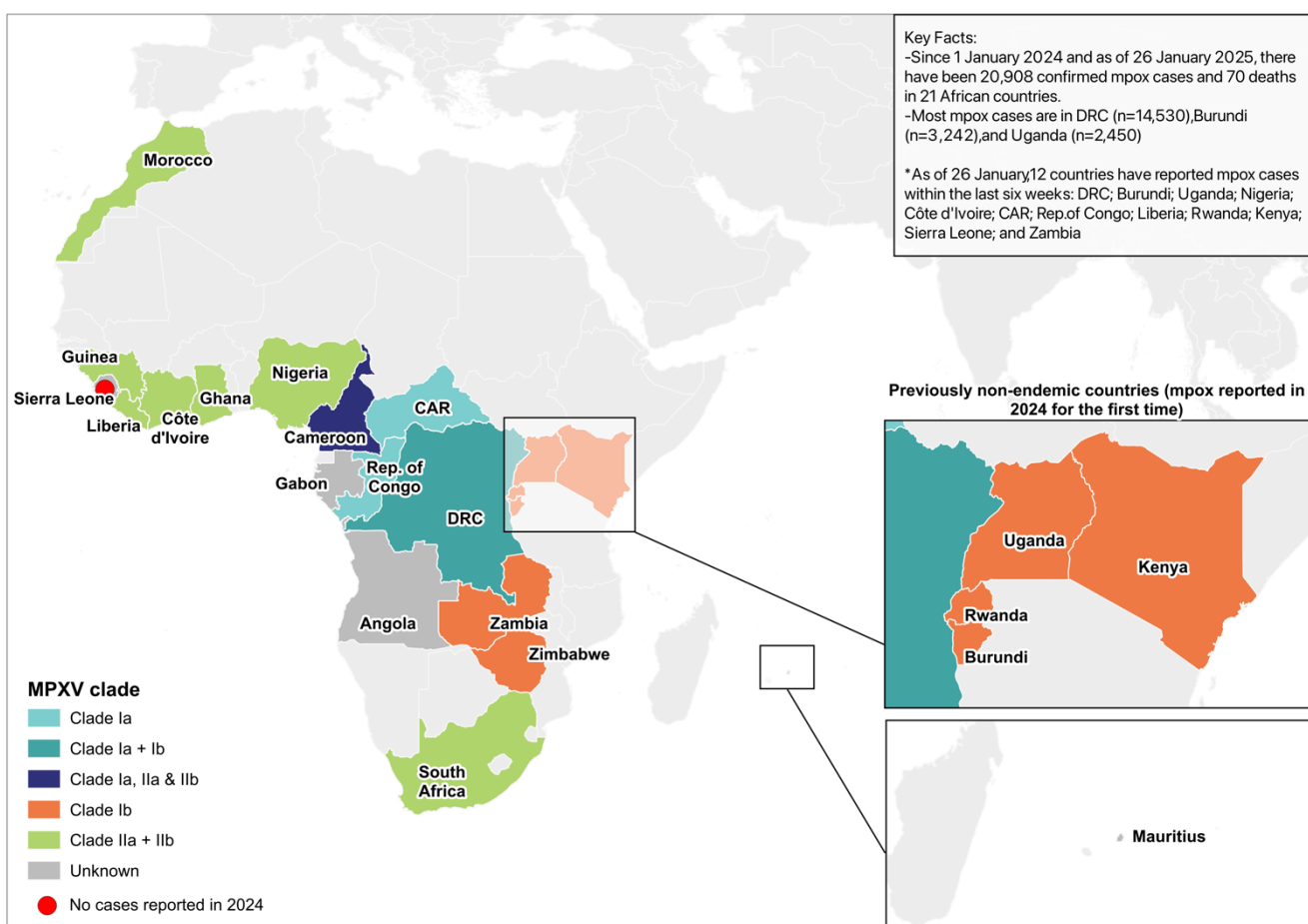


Figure 1: Mpox cases in Africa (2024)

Abbreviations: CAR (Central African Republic); Rep. of Congo (Republic of Congo); DRC (Democratic Republic of Congo)

Map made in QGIS using Natural Earth Data. Data on mpox cases was obtained from the WHO [2022-24 Mpox Outbreak: Global Trends](#) (5 Nov 2024)².

In 2024, clade Ib MPXV spread to four previously non-endemic countries: Rwanda, Burundi, Uganda, and Kenya^{52,54}. As of 26 January 2025, Burundi has reported the second largest number of mpox cases in Africa since 1 January 2022, after the DRC^{2,57}. The mpox outbreak in Uganda, which is now the third largest, has been expanding and predominantly affects sex workers however, household contacts, including children, are increasingly affected^{2,48}. This shift in transmission dynamics has been reported from Eastern DRC and Burundi⁴⁸. The initial case identified in Kenya was a long-distance driver who had driven from Kampala in

Uganda to the Taita-Taveta County in Kenya at the Tanzanian border⁵². He intended to travel through Tanzania to Rwanda, demonstrating the impact that highly mobile populations have on the spread of disease beyond country borders⁵². Most cases reported in Kenya as of 20 October 2024, have been persons with a history of travel including long-haul truck drivers⁴⁸. By 23 October 2024, Kenya and Uganda reported their first deaths due to mpox in persons living with HIV, emphasising this population's high risk for poor mpox outcomes⁴⁸. Genomic sequencing revealed that cases detected in East Africa had been infected by the novel variant (clade Ib MPXV) mainly circulating in Eastern DRC^{52,54}. In addition, Zimbabwe and Zambia have also reported cases of clade Ib MPXV for the first time in 2024 after not reporting any mpox cases in 2023^{2,58}.

Central Africa remains the most impacted region and accounts for >85% of cases and >99% of deaths on the continent^{50,56}.

Clade I MPXV outside of Africa

On 15 August 2024, mpox associated with the novel clade Ib MPXV was reported from Sweden in an individual with a recent travel history to an African country where clade Ib MPXV is circulating^{54,59,60}. This was the first reported case of clade Ib MPXV outside of Africa^{59,62}. By 16 January 2025, imported clade Ib MPXV cases with no or limited onward transmission have been reported from 12 other non-African countries⁶¹. Belgium, Canada, China, France, Germany, Thailand, the UK, and the USA report affected cases had recent travel history to a clade I-affected African country⁶¹. India, Oman, and Pakistan report affected cases had a recent travel history to the UAE⁶¹. The UAE has not reported cases of clade Ib mpox yet⁶².

Public Health Response

In 2024, mpox was one of the top five high-burden health emergencies in Africa⁵⁶. The mpox situation is concerning for the following reasons:

- Rapid human-to-human transmission is driving mpox as opposed to zoonotic spillover.
- The reports of sexual transmission associated with clade I MPXV for the first time have introduced a new mode of transmission that puts female sex workers and victims of sexual violence at increased risk.
- Children less than 15 years old are most impacted by mpox and represent the largest portion of deaths.
- A novel variant (clade Ib MPXV) has emerged and there is a lack of understanding about its transmissibility and ability to cause severe disease.
- Mpox has spread to highly mobile populations in Eastern DRC, which suffers from ongoing conflict and insecurity. This increases the risk of spread other countries. Four previously non-endemic East African countries and four non-African countries have already reported clade Ib MPXV cases (mostly imported).
- There is a lack of capacity and medical countermeasures in DRC to control the mpox outbreak and the situation is likely worse than what is being reported.
- Countries including South Africa, Côte d'Ivoire, Guinea, Zimbabwe, Zambia, and Gabon that reported no mpox cases in 2023 are reporting cases in 2024 indicating the threat of continued global mpox spread.

Declaration of PHEIC

On 13 August 2024, Africa CDC declared a public health emergency of continental security (**Figure 2**)⁶³. This is the first time the declaration has been used⁶³. The declaration is designed to empower Africa CDC to coordinate a response and mobilise resources⁶³. The organisation has set up an Incident Management Team to support affected countries and while the situation is concerning, Africa CDC states that there is no need for travel restrictions at this time⁶³. In alignment with the Africa CDC, the WHO declared the mpox outbreak a PHEIC on 14 August 2024^{28,29}.

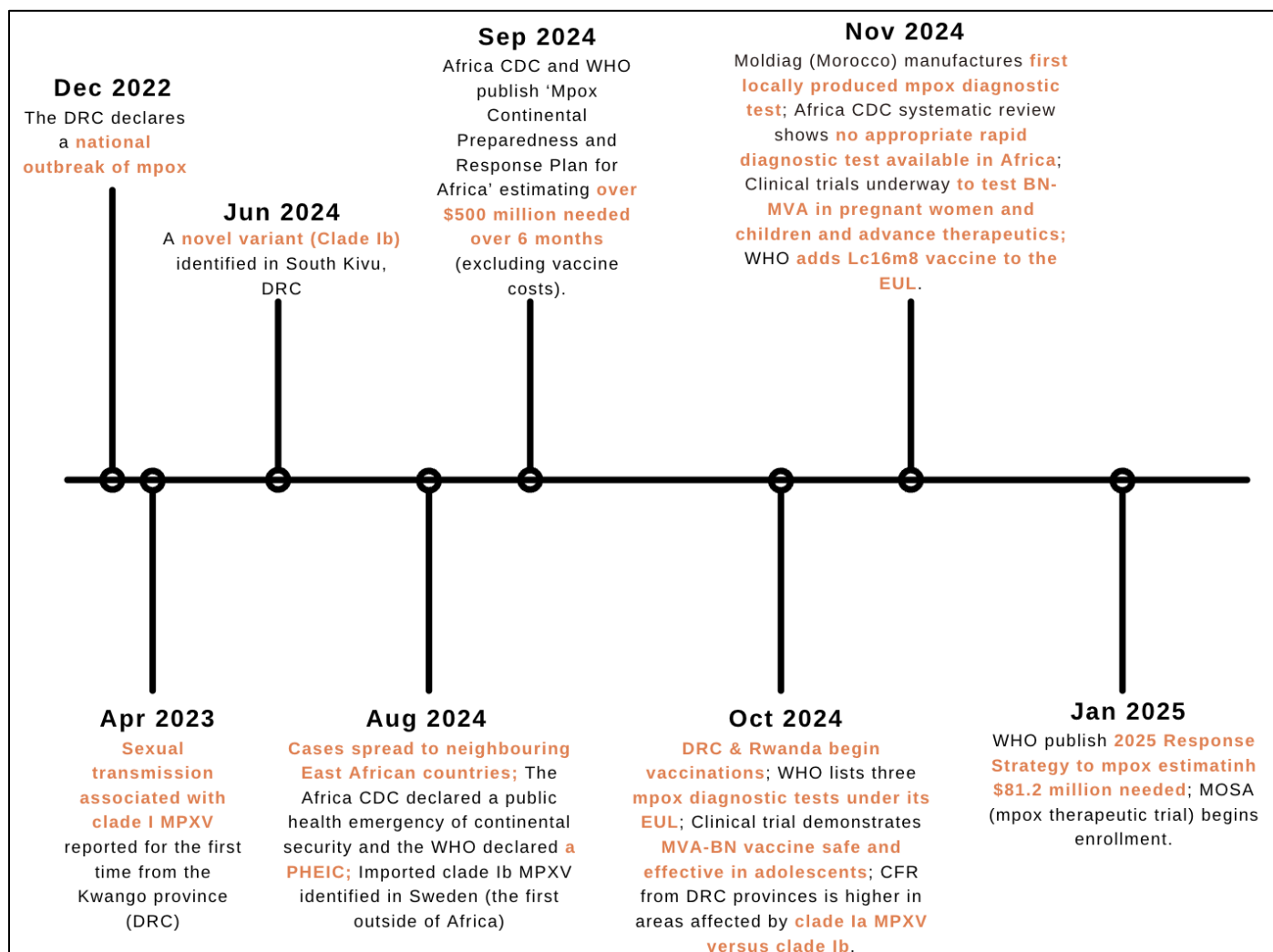


Figure 2: Summary timeline of significant events related to the DRC mpox outbreak

WHO Risk Assessment

The latest WHO risk assessment for mpox was conducted in November 2024². Within DRC, the risk of Clade Ia MPXV is high². Within DRC and neighbouring countries, the risk of clade Ib MPXV is high². Within Nigeria, Central Africa, and Western Africa, the risk of Clade II MPXV is moderate². Globally, the risk of Clade IIb MPXV is moderate².

Response plans and estimated funding required

The WHO Director-General emphasised the importance of an internationally coordinated response and UN agencies are working with the governments of affected countries^{28,29}. The WHO developed a regional response plan and anticipates that \$15 million is needed to support surveillance, preparedness, and

response^{28,29}. The WHO Contingency Fund for Emergencies has released \$1.45 million and appeals are being made for donor support^{28,29}.

Africa CDC and the WHO published a Mpox Continental Preparedness and Response Plan for Africa and estimated a budget of over \$599 million needed between September 2024 and February 2025 (excluding vaccine costs)⁴⁹. The preparedness and response plan outlines ten essential priorities considering cross-border transmission and highly impacted countries⁴⁹. An updated Response Strategy for 2025, developed by the WHO, estimates \$81.2 million will be needed⁶⁴.

After the US announced a temporary suspension of all foreign assistance, Africa CDC advocated for a waiver for life-saving humanitarian assistance, which was granted^{32,65}. This has enabled the continuation of critical interventions³².

Access to diagnostics and MCMs

Africa CDC has published a reporting protocol for mpox surveillance for African Union Member States⁶⁶. This intends to standardise effective mpox surveillance⁶⁶. However, a lack of diagnostics hinders a country's ability to rapidly detect mpox cases. To boost mpox diagnostics in Africa, Moldiag in Morocco developed an RT-PCR mpox diagnostic test, which is recommended for use by the Africa CDC as of November 2024⁶⁷. This is the first locally developed mpox diagnostic test and hopes to increase diagnostic capacity by providing rapid access to these tests at an affordable cost⁶⁸. Rapid Diagnostic Tests (RDTs) to boost testing at a community level are also urgently needed⁶⁹. A systematic review by Africa CDC's Diagnostic Advisory Committee (DAC) found that there are no independently validated RDTs with a sensitivity of at least 80% suitable for use in Africa⁶⁹. The WHO Emergency Use Listing (EUL) of three diagnostic tests aims to improve global access to mpox testing (**Table 1**)^{48,70}.

WHO EUL listing date	Manufacturer	Product name
3 October	Abbott Molecular Inc.	Alinity m MPXV assay (Alinity m AMPXV Amplification (AMP) Kit & Alinity m MPXV Control (CTRL) Kit)
14 October	Roche Molecular Systems Inc.	Cobas MPXV Qualitative assay for use on the cobas 6800/8800 Systems
28 October	Cepheid	Xpert Mpox

Table 1: Diagnostics listed under WHO Emergency Use Listing⁷⁰

The lack of medical countermeasures (MCMs) available is concerning. Africa CDC has called for international solidarity as it states that the continent needs 10 million vaccines⁷¹. Several steps have been taken to support DRC and the wider African continent in obtaining MCMs. These include:

- The WHO-initiated process for Emergency Use Listing (EUL) for mpox vaccines enabling Gavi and UNICEF to procure vaccines and increase access to countries yet to obtain national regulatory approval^{28,29}.
- The establishment of an access and allocation mechanism for mpox medical countermeasures (including vaccines) by the WHO and partners⁷².
- The prequalification of the MVA-BN mpox vaccine by the WHO that will help accelerate the procurement of mpox vaccines²¹. In addition, the inclusion of the LC16m8 mpox vaccine in the WHO EUL will facilitate access to vaccines, particularly for children²³.
- A UNICEF issued emergency tender that aims to secure mpox vaccines for the most impacted countries in collaboration with various partners, including Africa CDC, GAVI, WHO, and PAHO⁷³. One

outcome of this tender has been an agreement to secure MVA-BN vaccines at the lowest market price ensuring vaccine access to 77 low- and middle-income countries⁷⁴.

- A partnership between Africa CDC and Bavarian Nordic to enhance vaccine manufacturing capacity in Africa⁷⁵.
- The MOSA clinical trial sponsored by PANTHER, which aims to advance mpox therapeutics across Africa⁷⁶.
- A clinical trial jointly funded by CEPI and Global Health EDCTP3, which will test the BN-MVA vaccine in pregnant women and children less than 2 years old⁷⁷.

As of 5 October 2024, the DRC has started vaccinating high-risk groups in Eastern DRC, the most affected region⁷⁸. They have also extended use to adolescents⁵⁰. They obtained vaccines against mpox from Bavarian Nordic, the United States, Gavi, and Europe including the European Commission's Health Emergency Preparedness and Response Authority (HERA)^{78,79}. While over 280,000 vaccine doses have already arrived in Africa, 5.4 million doses have been pledged so far, as of 12 November 2024⁷⁹. Rwanda has also started vaccinations against mpox alongside Nigeria^{50,80}.

Useful Resources

- Pandemic PACT has our dedicated [Mpox page](#) in the Outbreak section of the website which provides information and analyses of active mpox research and funding globally since 2020.
- The WHO Research & Development (R&D) Blueprint for Epidemics team has developed vaccine and therapeutic trackers for mpox which can be found in the 'Technical Areas' section of their [webpage](#) on Mpox^{81,82}.
- The WHO R&D Blueprint team has also developed '[A Coordinated Research Roadmap](#)' which suggests necessary research and a '[Mpox outbreak and study sites](#)' interactive online tracker with information on studies being conducted in the African region.
- ANRS publishes a [Weekly Scientific Review](#) on the mpox outbreak. This contains up-to-date information on relevant mpox publications and guidelines.

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