



World Health
Organization

African Region

30 AUGUST 2024

Mpox in the **WHO African Region**

Regional Mpox Bulletin



Period	AFRO countries affected since	AFRO countries with active transmission	AFRO Suspected cases	AFRO Suspected deaths	AFRO confirmed cases since	AFRO confirmed deaths since
2022-2024	16	12			7733	54 (CFR:0.7%)
Since 01/01/2024	13	12	21 422	635	5 356	32 (CFR:0.6%)
Change since the last update on 25 August 2024						
Week 34	+1	+1	+1	0	+1793 (+30.2%)	+6
In collaboration between WHO HQ, AFRO, and EMRO, an online portal has been created where maps and epidemiological data can be found: https://worldhealthorg.shinyapps.io/mpx_global/ . ¹						

Table notes: The confirmed cases and deaths are already accounted for within the total number of suspected cases and deaths; they should not be added separately.²

Key strategic developments in epidemiology³

- The Republic of Congo is active once more following two additional confirmed cases in August
- Another confirmed case was identified in Liberia on 30 August
- One new case was reported in Kenya on 29 August with a travel history to Uganda; the Gabon case was also reported to have travel history to Uganda, indicating the likelihood of undetected transmission
- Nigeria became the first country in Africa to receive vaccine doses (10,000) for non-research purposes

Epidemiological summary

Since 1 January 2022, cases of mpox have been reported to WHO from **16 Member States across the African Region**. As of 30 August 2024, a total of **7 733 laboratory confirmed cases**, including **54 deaths**, have been reported to WHO.

In 2024, as of 30 August 2024, **13 countries have reported 5 356 confirmed cases**, including **32 deaths**. The three countries with the majority of the cases in 2024 are Democratic Republic of the Congo, (n = 4 883), Burundi, (n = 281), and Central African Republic, (n = 48).

A significant number of suspected cases, that are clinically compatible with mpox are not tested due to limited diagnostic capacity and get never confirmed. **Work on integrating this data is currently ongoing and will be included in future updates of this report.**

¹ Please note: The numbers produced in this report may not align exactly with global portal given the there are approximately 1,600 confirmed cases from DRC without a testing date, which prevents incorporation into global datasets.

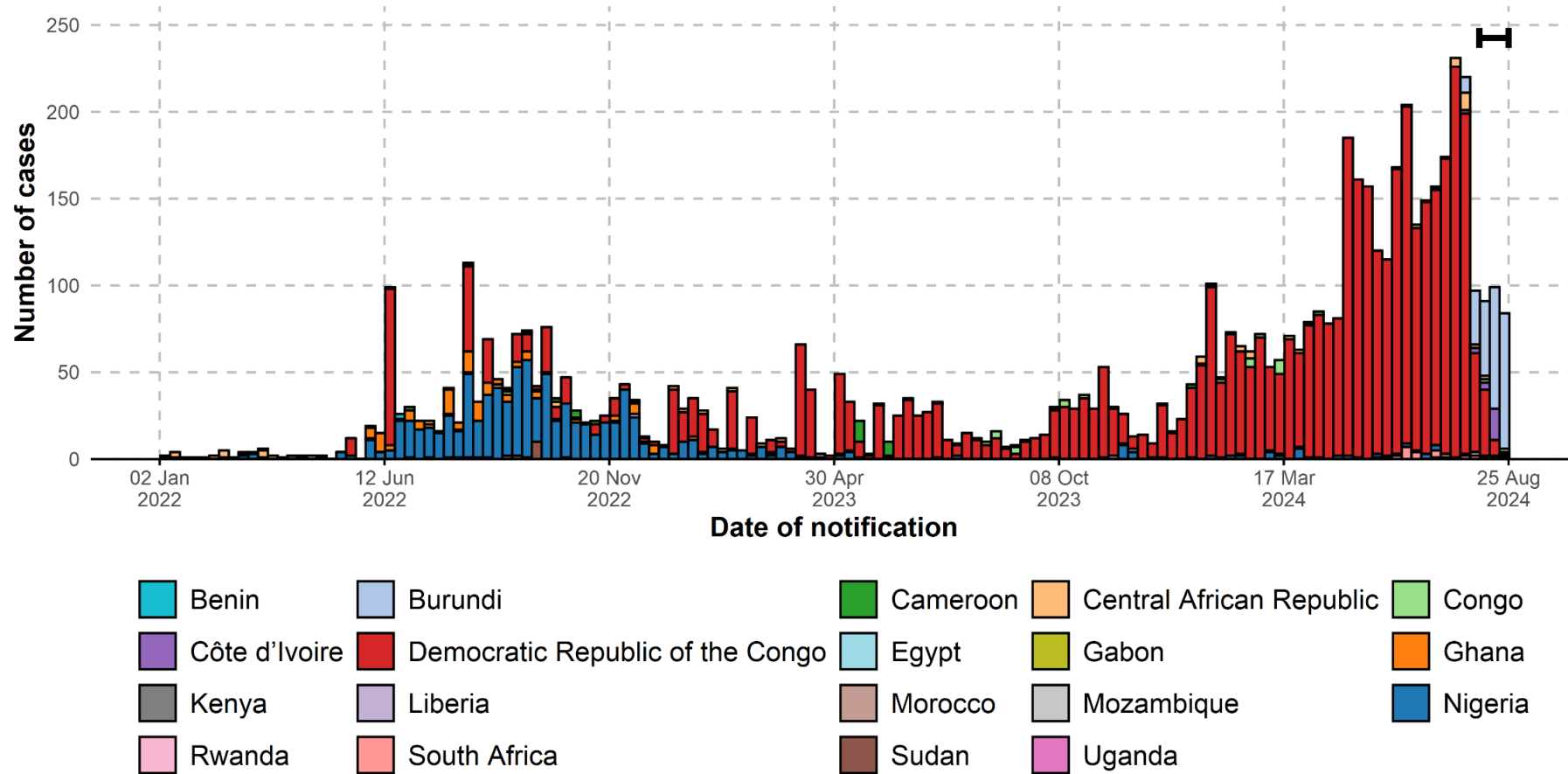
² Suspected cases refer to those that are clinically compatible with mpox but may not have been tested. Not all suspected cases will be confirmed, as other conditions like chickenpox may present similar symptoms. Suspected cases data for the period 2022-2024 is not available or reported for all countries, contributing to the limitations in interpreting these figures. The suspected cases figures have limitations, including incomplete data from some countries, making the numbers less comprehensive.

³ These updates may include recently acquired information not yet included in the weekly report submission cycle and therefore, not yet included in the WHO Dashboard. Therefore, there may be small discrepancies between the information noted here and the information noted on following graphics.

An epidemic curve shown by week for laboratory confirmed cases reported up to 30 August 2024 is shown in Figure 1. Note that for the purposes of these epidemic curves, countries with more than one clade present are presented in multiple epidemic curves. **The most recent weeks presented in the epidemic curves should be interpreted with caution, as there are delays associated with reporting.**

Mpox in the WHO African region
Regional Situation Report #2| 30 August 2024

Bracket at end of curve indicates potential reporting delays in recent weeks of data.
Data as of 25 Aug 2024



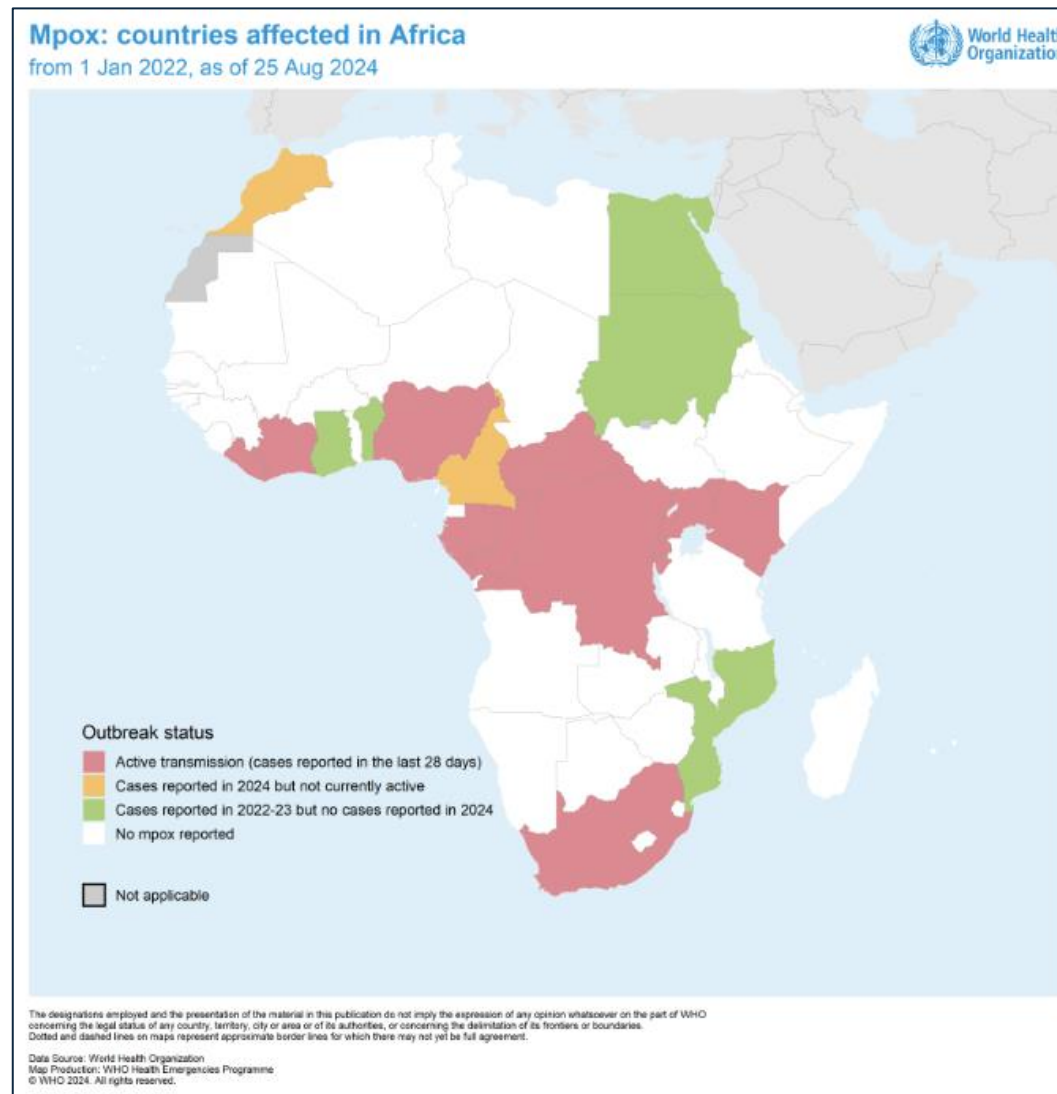
Source: WHO

Figure 1: Epidemic curve of laboratory confirmed cases, by country

*Data as of 25 August 2024. Bracket at end of curve indicates potential reporting delays in recent weeks of data. WHO AFRO region does not include Egypt, Morocco, and Sudan. Cases from these countries are not reflected in the data presented on page 1.

Mpox in the WHO African region

Regional Situation Report #2| 30 August 2024



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Country details

The DRC remains the most severely impacted, accounting for 90% of the reported confirmed cases this year. As of 25 August 2024, the country reported 18 815 suspected cases and 620 potential deaths (CFR:3.3%) among them this year only. Due to limited access to laboratory testing in remote areas, less than 50% of all suspected cases are tested and 4 869 confirmed cases were recorded this year. The DRC's mpox outbreak is concentrated in a few key provinces out of the 26, with Equateur bearing the brunt of the cases and deaths, followed by South Kivu, Sankuru, and Sud Ubangui provinces.

Burundi declared the mpox epidemic on 25 July 2024. As of 29 August 2024, a total of 1 029 suspected and 281 laboratory confirmed cases have been reported in 29 out of the 49 districts. Burundi accounts for with 4.8% of cases reported in the African region. Among the confirmed cases, 56% are male, with children under 10 years of age making up 37.5% of the total cases. The most affected age groups are those aged 20-30 years (24.6%), children under 5 years (24.0%), and children aged 5-9 years (16.0%). A total of 455 tests have been conducted, resulting in a positivity rate of 37.6%. The Bujumbura Nord district is particularly impacted, accounting for 41% of all confirmed cases.

In **Côte d'Ivoire**, as of 18 August 21, a total of 28 cases of mpox including one death (CFR:3.6%) have been reported across 15 out of 17 health districts that have reported suspected cases. The first confirmed case was a 46-year-old patient in Tabou district, located in the San Pedro region near the Liberia border, with mpox confirmation by the Institut Pasteur de Côte d'Ivoire on 3 July, later validated by the Institut Pasteur in Dakar on 14 July. The second confirmed case involved a 20-year-old patient in the Koumassi health district of Abidjan on 14 July. A total of 277 contacts have been identified, with 208 currently under follow-up. Although Côte d'Ivoire has a history of mpox, no cases had been reported since the beginning of the multi-country outbreak in 2022. However, the exact transmission chain for these cases has not yet been definitively determined.

Gabon reported its first confirmed case of mpox on 22 August in Libreville. The case involves a 30-year-old male who had recently travelled to Uganda, where he likely contracted the virus. Upon returning to Gabon, he developed symptoms, including fever, fatigue, and a generalized skin rash, and sought medical attention on 21 August. As of 29 August 2024, out of six suspected cases identified and tested, only one tested positive for Mpox. The patient is currently in good condition, and contact tracing efforts are ongoing to identify and monitor those who may have been exposed.

The **Central African Republic** reported 45 laboratory-confirmed cases of mpox and 1 death from January to 25 August 2024, across 11 health districts. Since 2022, the CAR has recorded a total of 247 suspected cases, 92 confirmed cases and 2 deaths (CFR = 2.2%). The most recent outbreak of mpox clade Ib was declared on 18 July 2024, following an alert on 17 July from the Pasteur Institute of Bangui regarding confirmed Mpox cases detected in the Bangui 2 health district. In week 34 (ending 25 August) 11 new suspected cases and no confirmed cases were reported in the country.

Nigeria, between epidemiological weeks 1 to 34 in 2024 (ending 25 August), reported a total of 868 suspected cases of mpox across 33 states and the Federal Capital Territory (FCT). During this period, with clade IIb circulating, 48 confirmed cases were identified in 19 states and the capital. In week 34 (ending 25 August), Nigeria recorded 57 new suspected cases and 8 confirmed cases (from 15 states and FCT) compared with 25 suspected cases with one confirmed positive reported in week 33 (12-18 Aug 2024) (from 5 states). Bayelsa state reported the highest number of confirmed cases (5), followed by Cross River, Akwa Ibom, and Enugu, each with 4 confirmed cases. Overall, since the re-emergence of Mpox in September 2017, a total of 4685 suspected cases have been reported from 36 States and FCT in the country. Of these cases, 1134 (24%) were confirmed (with males predominantly affected) from 35 States and FCT. seventeen (17) deaths have been recorded since the re-emergence in 2017.

Kenya declared a mpox clade Ib outbreak on 31 July 2024, following the first confirmed case in a 42-year-old male truck driver from Taveta Sub-county, Taita Taveta County. As of 29 August, Kenya has reported 3 confirmed cases and at least 42 suspected cases across 11 counties.

Rwanda, as of 18 August 2024, has reported a cumulative total of 4 confirmed mpox cases, with zero deaths. The cases include individuals identified in Kigali and Rusizi, with contact tracing underway for 11 individuals. Rwanda declared an outbreak on 27 July 2024, and these are the first confirmed mpox cases ever reported in the country. No new cases have been reported in the last four weeks, as of 29 August 2024.

Uganda has reported five confirmed cases since the beginning of the outbreak that followed heightened surveillance for mpox along the border with the DRC in June and early July 2024 and led to the identification of 6 suspected cases in Kasese District, with 2 confirmed positive for MPXV Clade Ib. As of 29 August, four districts including Kasese, Jinja, Amuru, and Kampala have reported confirmed cases. In total 41 contacts were listed and of these, 18 have completed the 21-days of follow-up.

South Africa reported a cumulative number of 29 confirmed cases since 2022, and 24 cases of mpox, with 3 deaths (CFR = 13.6%) between April 2024 and 28 August 2024, distributed across three provinces: Gauteng with 12 cases and 1 death, KwaZulu-Natal with 11 cases and 2 deaths, and the Western Cape with 1 case. All confirmed cases (Clade II) are males, with 18 identifying as men who have sex with men (MSM). Of these cases, 16 are classified as severe due to factors like lesions, hospitalization, and co-morbidities such as unmanaged or recently diagnosed HIV. Sequence analysis has identified 6 cases as Clade IIb, linked to the multi-country outbreak. Ongoing contact tracing efforts are monitoring 215 contacts across the affected provinces. No new confirmed case has been reported in the last three weeks.

Cameroon reported a total of 5 laboratory-confirmed mpox cases and 2 deaths, with a high CFR of 40.0% from January to April 2024. Since the beginning of the mpox outbreak in 2022, Cameroon has reported 50 cases and 5 deaths with a CFR of 10.0%. No new case has been reported since May 2024.

The **Republic of Congo** has 19 mpox cases that were reported with no associated death from January to 23 April 2024. However, as of 29 August 2024, the country has reported 121 suspected cases, 13 probable cases, 45 laboratory-confirmed cases and 2 deaths since the beginning of the outbreak in 2022 (CFR = 4.4%). There is currently no active transmission of mpox reported in the country since May 2024.

Interpretation

The mpox outbreak in the African region presents a varied epidemiological landscape, with the Democratic Republic of Congo remaining the most significantly impacted, accounting for the majority of cases and deaths. The situation in the DRC is characterized by limited laboratory testing capacity as less than half the suspected cases are tested, particularly in remote areas, which hampers accurate case confirmation. Burundi, after declaring its epidemic in July 2024, has seen a significant number of cases, particularly among young children. Nigeria and the DRC are both endemic to mpox, contributing to the persistent transmission observed in these countries. In the region, clade Ib is predominantly circulating in countries like DRC, Burundi, Uganda, and Kenya, while clade IIb has been identified in South Africa and Nigeria, reflecting the diverse clade landscape contributing to the ongoing mpox outbreaks across the African region. Other countries in the region beside the DRC, Burundi, and Nigeria are experiencing relatively smaller outbreaks, but overall, the region is grappling with diverse epidemiological challenges, underscoring the need for sustained public health interventions and coordinated international support to manage the outbreak effectively.

Public health actions

WHO AFRO has established an Incident Management Support Team (IMST) and developed a Strategic Preparedness and Response Plan (SPRP) to coordinate efforts across the region. WHO AFRO continues to work with Africa CDC to elaborate the Mpox Preparedness and Response Plan for the African Continent.

Over the past week, the WHO deployed senior emergency Managers and technical experts to key locations including Goma (2), Kinshasa for the continental IMS (4) in the DRC, Bujumbura (1) in Burundi, and Kampala (1) in Uganda, and developed a scale-up concept of operations for the DRC. WHO successfully mobilized additional **two million dollars** from the Contingency funds for emergencies (CFE) and distributed **to ten countries** (Burundi, CAR, DRC, Congo, Cote d'Ivoire, Gabon, Kenya, Liberia, Nigeria and Uganda) to support early action. This brings to **three million dollars** the total amount released from the CFE for mpox response in the Region in 2024.

Additionally, the IMST facilitated Global and Regional Partnerships Meetings to strengthen collaboration and response efforts across the region. Operational partnerships have been strengthened through regional communication platforms and bilateral engagements with key partners, with 6 Technical Working Groups established to streamline the mpox response, and ongoing mapping of partner deployments.

In the area of **laboratory and diagnostic support**, WHO AFRO facilitated the procurement and distribution of essential supplies to multiple countries, including the Central African Republic, Côte d'Ivoire, and DRC. This included the initiation of a push strategy for 2,500 starter kits per country and the prepositioning of 4,000 Mpox kits in Nairobi and Dakar. Coordination meetings with WHO HQ and other partners ensured streamlined procurement processes and the timely delivery of supplies.

Risk communication and community engagement: Last week, RCCE efforts in the DRC included extensive outreach with 252 radio broadcasts, 85 TV awareness videos, 183 community dialogues, and 2,048 home visits by CHWs, alongside training 78 CHWs in Sud-Kivu. RCCE was integrated into emergency response plans across 11 AFRO countries, with South Sudan and Mauritania proactively enhancing preparedness. Ongoing infodemic management produced 14 regional social listening reports distributed to over 900 stakeholders. Additionally, RCCE conducted 10 bilateral deep dives in multiple countries to tailor support, and engaged with IFRC, UNICEF, Africa CDC, and other partners to mobilize funds and develop joint action plans.

Surveillance and information management: WHO AFRO has implemented a system for the weekly consolidation and analysis of mpox data from affected Member States, including the recent launch of a harmonized data portal with WHO HQ. Regular data analysis and mapping have been conducted to identify hotspots and areas of transmission, accompanied by the production of weekly situational reports and bulletins to inform stakeholders. Technical briefs have been prepared for strategic insights, and 3-Level Technical Coordination meetings were held with WHO HQ, AFRO, and country offices in Burundi and DRC to address mpox data management challenges. Additionally, updates on the epidemiological situation were presented at the Global Mpox Partnership Meeting and WHO ESA Health Partners Group Meeting. WHO AFRO also developed and revised country mpox reporting templates to ensure consistency and enhance data quality across the region.

In clinical care, WHO AFRO coordinated global and regional activities, including preparations for a global meeting with experts and clinicians. Support was provided to member states for the application of the Tecovirimat MEURI protocol, and essential mpox supplies were distributed. Additionally, the Case Management TWG in the East and Southern Africa Region was reactivated to enhance clinical care coordination.

Vaccination efforts were bolstered with the adaptation of a vaccine introduction roadmap and the drafting of resource mobilization proposals. WHO AFRO worked with UNICEF and GAVI to ensure equitable vaccine access and supported high-risk countries in the joint review of vaccine dossiers.

Finally, tools and guidelines for maintaining the **continuity of essential health services** during the mpox outbreak were shared with member states. Readiness meetings with high-risk countries like Botswana and Lesotho focused on strategies to sustain essential services amidst the ongoing public health emergency.

Conclusion

The mpox outbreak in the African region continues to pose significant public health challenges, the overall response requires coordinated international support to manage the outbreak effectively. WHO AFRO's ongoing efforts, including resource mobilization, data consolidation, and vaccination readiness, are crucial in addressing the evolving epidemiological landscape. WHO is recommending to the Member States to prioritize the expansion of laboratory testing capabilities, particularly in remote areas, to ensure accurate case confirmation and improve surveillance of mpox. Member States should also continue to implement and scale up robust public health measures, including vaccination readiness, community engagement, and sustained international collaboration, to effectively control the outbreak and prevent further spread.

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