AfricaCDC
Centres for Disease Control and Prevention

World Health Organization
African Region

MPOX CONTINENTAL RESPONSE PLAN 2.0

Intensification, Integration and Legacy

March 2025 – August 2025

Incident Management Support Team

AfricaCDC
Centres for Disease Control and Prevention

World Health Organization
African Region

Incident Management Support Team

The Incident Management Support Team (IMST) is Africa's continental effort co-led by Africa CDC and WHO, that collaborates with ministries of Health, regional partners, and global stakeholders to expand vaccination efforts, enhance diagnostic access, and strengthen health system resilience.

Contents

Acronyms/Abbreviations

Africa CDC	Africa Centres for Disease Control and Prevention
ASLM	African Society for Laboratory Medicine
ATC	Advisory Technical Council
AU	African Union
AVAREF	Africa Vaccine Regulatory Forum
CAR	Central African Republic
CDC	Centres for Disease Control and Prevention
CEPI	Coalition for Epidemic Preparedness Innovations
CFR	Case Fatality Rate
CHWs	Community Health Workers
CBOs	Community-based organizations
COVID-19	Coronavirus Disease
DRC	Democratic Republic of Congo
ECG	Emergency Consultative Group
EPR	Emergency Preparedness and Response
EU	European Union
FAO	Food and Agriculture Organization
FTM	Financial Tracking Mechanism
GAVI	Global Alliance for Vaccines and Immunization
GB	Governing Board
HIV	Human Immunodeficiency Virus
HSC	Health Services Continuity
IDP	Internally Displaced People
IHR	International Health Regulations
IFRC	International Federation of Red Cross and Red Crescent
IMS	Incident Management System
IOM	International Organization of Migration
IPC	Infection Prevention and Control
KAP	Knowledge, Attitude and Practice
MPOX	Monkeypox
MPXV	Monkeypox virus
MSF	Médecins Sans Frontières
M&E	Monitoring and Evaluation
NIH	National Institute of Health
NPHI	National Public Health Institute
OSL	Operations Support and Logistics
PPE	Personal Protective Equipment
PPPR	Pandemic Prevention and Preparedness Response
PHECS	Public Health Emergency of Continental Security
PHEIC	Public Health Emergency of International Concern
POCT	Point-of-care Testing
RCCE	Risk Communication and Community Engagement
WHO	World Health Organization

Executive Summary

On August 13, 2024, the Africa CDC declared mpox a Public Health Emergency of Continental Security (PHECS). The following day, the WHO declared it a Public Health Emergency of International Concern (PHEIC). Following these declarations, a joint continental Mpox Preparedness and Response Plan was developed and implemented from September 2024 to February 2025, under the coordination of a continental Incident Management Support Team (IMST), co-led by Africa CDC and WHO, in close collaboration with global partners. This six-month response plan was based on the "4-One" principle of one team, one plan, one budget, and one monitoring and evaluation framework.

Despite the significant achievements such as streamlined coordination and leadership of mpox response, strengthened mpox surveillance systems, increased testing capacity, implementation of the RCCE activities, administration of mpox vaccines and enhanced case management during the first six months of the response, mpox continues to pose a public health challenge in Africa, highlighting the need to maintain a structured, coordinated, and sustainable response. Out of the 22 countries affected by end of February 2025, seven are in control phase and 15 are in active phase of which, three in the active phase are observing a declining trend (Burundi, Rwanda and Central Africa Republic). However, the increasing trend in Uganda and Sierra Leone remains concerning. In addition, the worsened security situation in DRC, further complicates the mpox response efforts. Cognizant of the mpox epidemiologic situation and recent changes in global health and security dynamics, the third International Health Regulations (2005) (IHR) Emergency Committee and the fourth Emergency Consultative Group (ECG) meetings convened on 25th and 26th February 2025 respectively , unanimously recommended the extension of the existing declarations for another six months and issued updated recommendations to boost response coordination, surveillance, laboratory testing, vaccination, community protection, case management and research efforts.

This mpox Continental Response and Legacy Plan 2.0 for Africa will cover the period from March to August 2025 and serve as a roadmap to finish the response phase and transition it to routine programs by strengthening the health system's resilience as a legacy for future public health emergencies.

The mpox Response and Legacy Plan 2.0 outlines essential priorities to stop outbreaks of human-to-human transmission of mpox, emphasizing improved (1) coordination and leadership, (2) risk communication and community engagement, (3) surveillance, (4) laboratory, (5) case management, (6), infection prevention and control, (7) vaccination, (8) research and innovation, (9) operations support and logistics, (10) continuity of essential healthcare services. Among these 10 pillars, the plan emphasizes on acceleration of vaccination, decentralization of diagnostic capacities to increasing of mpox laboratory testing, integrated community package of mpox interventions, including active case finding, contact monitoring, IPC promotion and RCCE, unified database linking surveillance, laboratory testing, case management and vaccination, as well as strengthening the resilience of national health systems.

The intensification phase will focus on accelerating immediate interventions to quickly control the mpox outbreaks, while the resilience phase will aim to strengthen national health systems to effectively address future health emergencies. Member states are categorized into three risk-based groups to better direct response efforts and resource allocation more effectively: countries with sustained human-to-human transmission, those with sporadic cases or localized outbreaks, and other countries with no recent cases or minimal transmission risk. This approach ensures targeted planning and optimal use of resources.

The total estimated budget required for the implementation of mpox Response and Legacy Plan 2.0 is USD 429,595,970, with the largest share directed towards vaccination

and logistics (26%) and surveillance (25%). Most of the funding (80%) is allocated to intensification activities, focused on halting the outbreak within an additional six-month period. Based on FTM data and shifts in the funding landscape since the plan's launch, an estimated USD 196 million remains available for the second plan, leaving a funding gap of USD 224 million.

This funding is vital for addressing immediate response needs and transforming mpox response investments into a catalyst for broader health system strengthening, leaving a legacy and outbreak resilience across the continent.

Introduction

Multi-Country Outbreak

The mpox outbreak in Africa saw a significant expansion in 2024, affecting 22 countries by end of February 2025. Initially considered a rare and localized disease in the 1970's and 1980's, mpox has since emerged as a persistent public health threat in Central and West Africa, with increasing human-to-human transmission in urban settings. Between 1970 and 2022, multiple outbreaks of mpox were reported across Africa, but the global outbreak of 2022-2023 significantly altered the epidemiological landscape, increasing the urgency for a coordinated response on the continent.

Over the decades, epidemiological surveillance and genomic analysis have identified two major clades of the mpox virus (MPXV): Clade I and Clade II, with further subdivisions within each clade (Ia, Ib, IIa, IIb) based on genetic diversity and epidemiological characteristics. These clades exhibit distinct geographic distributions, observed virulence levels, and transmission dynamics, necessitating adapted public health approaches.

Clade I (Central African Clade): Clade I, historically confined to Central Africa (DRC, CAR, Congo, Cameroon), has been previously associated with higher virulence and a case fatality rate particularly in remote areas with limited access to free and quality healthcare, where it affects mostly children.

- **Clade Ia** has primarily a zoonotic transmission with limited human-to-human spread. Outbreaks are localized in forested, rural areas, linked to bushmeat consumption and animal contact. However new data also show that emerging strains of clade Ia MPXV are characterized by increasing human-to-human transmission, notably in urban areas More recently this strain has shown sustained human-to-human transmission once it entered Kinshasa, where it is circulating primarily through sexual contact.
- **Clade Ib** detected among human cases, it shows sustained human-to-human transmission, with longer transmission chains and broad community spread in DRC and neighbouring countries, requiring enhanced surveillance and containment efforts.

Clade II (West African Clade): Clade II, historically found in West Africa (Nigeria, Ghana, Côte d'Ivoire, Liberia, Sierra Leone, as well as Cameroon),), has presented with lower CFR depending on the setting and access to healthcare, but demonstrated the potential for widespread transmission.

- **Clade IIa**: Thought to be primarily zoonotic, with limited human-to-human spread. Most outbreaks remain localized, although they have been detected also in urban areas such as Abidjan
- **Clade IIb**: Responsible for the 2022–2023 global outbreak, driven by sustained human-to-human transmission, including sexual transmission in high-contact networks. This clade requires enhanced global surveillance and integration with sexual health services.

In August 2024, in response to the escalating crisis, Africa CDC and WHO declared mpox a Public Health Emergency of Continental Security (PHECS) and a Public Health Emergency of International Concern (PHEIC). This led to the launch of a Joint Continental Incident Management Support Team in September 2024, headquartered in Kinshasa, DRC. The IMST, operating under a "One Plan, One Budget, One Monitoring Framework" approach, strengthened coordination among affected countries.

Epidemiological situation from September 2024 to February 2025

The progression of the mpox outbreak in Africa from January 2024 to February 2025 highlights a significant increase in transmission across multiple countries. From January to April 2024, six Member States were affected, with a weekly average of 376 suspected cases and 55 confirmed cases, and a case fatality ratio of 5.6% among suspected cases. From May to August 2024, the outbreak expanded to 7 other countries (Total of 13MS affected), with 909 suspected and 186 confirmed weekly cases, while the case fatality ratio among suspected cases dropped to 1.6%. The September to December 2024 period saw further escalation, reaching a total of 20 MS (+7 new MS), with an average of 2,777 suspected and 488 confirmed cases per week, alongside a case fatality ratio reduction to 1.3%. In January to February 2025, the outbreak spread to 22 MS (+2), including South Sudan and Sierra Leone, recording a weekly average of 3,264 suspected and 728 confirmed cases, with a case fatality ratio decline to 0.8% among suspected cases. Internationally, travel-linked cases of MPXV Ib were reported in at least 15 countries at the time of writing (Sweden, Thailand, Germany, Belgium, UK, Canada, India, China, Ireland, Oman, Pakistan, Qatar, United Arab Emirates, Brazil and the US).

From 1 January 2024 to 28 February 2025, over 100,886 suspected cases had been reported, including 22,728 confirmed cases and 69 related deaths among the confirmed cases. The virus persists in several countries, regions and its spread might be undetected in areas with weak surveillance systems and limited testing coverage, particularly in conflict-affected areas of the DRC. Despite a 2.6% decline in suspected cases from late 2024 to early 2025, confirmed cases continued to surge in Uganda, Nigeria and the Republic of Congo as of February. Conversely, Burundi saw a declining trend in new cases, with additional decreases observed in Central African Republic, Kenya, Liberia, and Rwanda.

The ongoing armed conflict in eastern DRC has severely disrupted Mpox control efforts, forcing over 500 patients to flee treatment centers, leading to increased cross-border transmission risks. Testing coverage in DRC has also decreased in recent months, remaining below 50%, and delayed disbursement of pledged funds has hindered response scale-up.

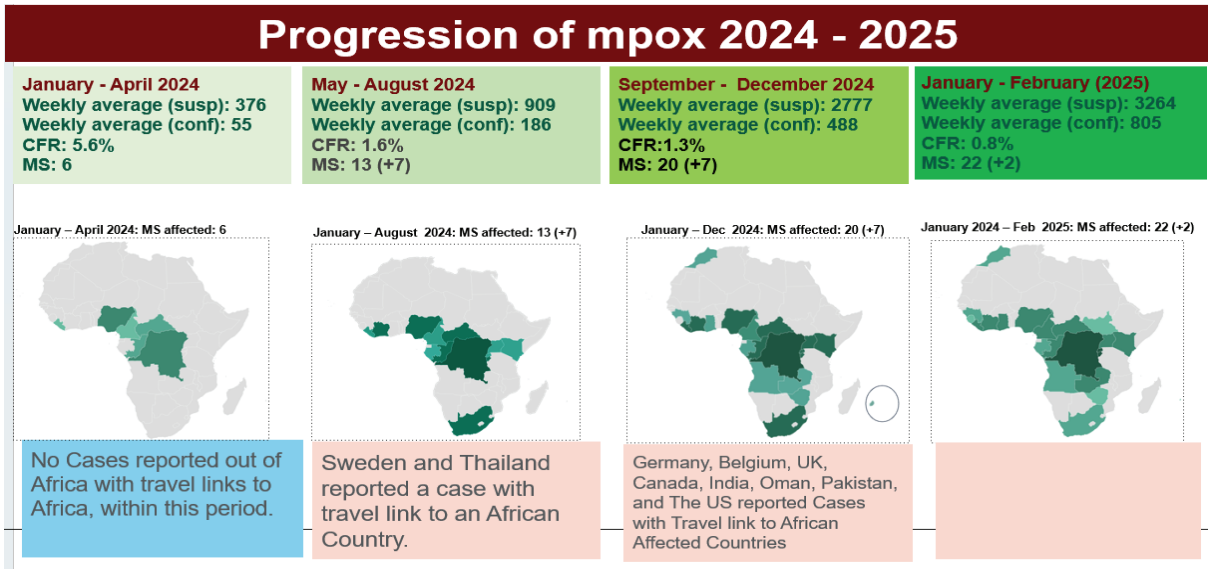

Figure 1: Geographic expansions of mpox in African countries, including number of suspected and confirmed cases, case fatality ratio (CFR) and number of member states (MS) affected, January 2024 – February 2025

Achievements from the First Six Months of Response (September 2024 – February 2025)

The mpox outbreak has demonstrated the importance of a unified and coordinated response across African nations. The disease does not recognize borders, making it imperative to implement a harmonized continental approach that ensures timely information sharing, resource mobilization, and collective action. Within the first six months, the mpox response successfully unified partners under a single coordination mechanism co-led by Africa CDC and WHO, ensuring strategic alignment and minimizing duplication of efforts. High-level political support and the establishment of IMSTs at continental and country levels were pivotal in enhancing coordination at all levels. The institutionalization of the IMST model across member states and at continental level facilitated coordination, decision-making, and operational efficiency. Some of the key achievements for RCCE include the ToT, the development and dissemination of communicators guide and communication tools, and the assessment conducted in 6 affected countries and the review and tailoring of messages at community level. The surveillance system was strengthened with the development of a harmonized database for mpox which improved data analysis.

The laboratory pillar recorded a tremendous milestone, particularly in DRC with the decentralization of laboratories from 9 in September 2024 to 19 by February 2025. This resulted in increased diagnostic capabilities and testing coverage. IPC efforts resulted in the development of comprehensive guidelines and SOPs, effective training programs, and the deployment of supplies and IPC-WASH teams in hotspot areas, ensuring safer healthcare delivery. Case management was bolstered through regional webinars, clinical care tools, and the integration of nutrition and mental health support for patients. On the logistics front, the creation of a vaccine dispatch tool, dashboards for supply and demand visualization, and streamlined procurement processes significantly optimized last-mile vaccine delivery and essential medicine availability. Furthermore, the research pillar advanced through multi-country studies and cross-disciplinary collaboration, yielding valuable insights into the mpox epidemic and treatment strategies. The IMST model played a crucial role in coordinating national and regional response efforts, enhancing information sharing, and streamlining decision-making processes.

Table 1: Main achievements of the mpox response, Sept 2024 – Feb 2025

Pillar	Main achievements	Effects
Coordination and Leadership	Established IMST structure, mobilized 1.1 billion USD, engaged high-level leadership and partners, conducted weekly press briefings on the emergency, deployed rapid respondents (CHWs, epidemiologists, data managers, lab experts). Mobilized over 6 million doses of lifesaving mpox vaccines in-kind donation	Coordinated mpox outbreak response at continental and country level with 28 partners involved, 1.1bn USD pledged, and over 3M mpox vaccine doses mobilized
RCCE	Developed RCCE guideline, developed and conducted RCCE training modules for practitioners and volunteers, developed qualitative and qualitative bank of questions, supported social and behaviour data collection and analyses, established social listening and feedback mechanisms, produced debunking videos to address misinformation, co-create/developed evidence-based messages, organised webinars with affected countries for learning exchanges, supported the engagement and empowerment of key community influencers	High level of awareness of mpox (Source: CRAs 1st round, U-Reports Chatbots in 13 countries); Increased public knowledge on the disease (eg. DRC, as per the U-Report two series of data collection), high level of willingness to take the vaccine (eg as per the Community Rapid Assessments done in 6 countries and other data sources)

Pillar	Main achievements	Effects
Surveillance	Developed enhanced mpox surveillance protocols, strengthened cross-border information exchange and coordination mechanisms and contact tracing, enhanced surveillance data management systems, trained surveillance personnel in mpox-affected countries	Increased detection of cases, more timely reporting for better monitoring of outbreak expansion and better oversight of the spread of different clades and subclades
Laboratory	Provided 7 qPCR machines and 7 sequencing equipment, supplied 41,000 sample collection and transportation swabs, specimen transport bags, and sample storage and transportation boxes, over 74,000 test kits and sequencing reagents to 21 countries, trained 169 laboratory personnel	Increased testing capacity from 9 labs to 21 labs in DRC, 1 lab to 30 labs in Burundi, improving testing rate in Africa from 38% in August 2024 to 58% by February 2025
Case management	Held a mpox case management Trainer of Trainers in Kinshasa with 50 clinicians trained across the affected country and supported subsequent cascaded training, held 7 webinars to build capacity of health workers on various aspects of mpox clinical management with over 3000 HCW joining the webinar; Distributed essential medical supplies to managed over 6,000 patients; developed and disseminated 5 clinical tools to aid clinical care; nutritional support with over 2000 beneficiaries mostly vulnerable children and pregnant women; held 4 webinars on MHPSS	Supported overall mpox clinical response by availing medical counter measures and essential tools to guide clinical care resulting in lowering CFR to below 1% in affected member states
IPC	Supported PPE to healthcare facilities, trained healthcare providers	Reduced in-facility transmission of mpox
Vaccination	Administered more than 406,056 doses of vaccine in 5 countries [1]by end of February 2025. 12 countries[2] were allocated doses and 17 countries[3] participated in a regional convening on mpox vaccination plan development	Expected reduction of human-to-human transmission and number of cases in the hotspots where vaccination has been implemented
Research	Coordinated continental mpox research, developed 41 research protocols,	Addressing the knowledge gap and contributing to innovation of vaccines and therapeutics.
Supplies and logistics	Supported mobilization of a tune of 6 million doses and donor management, Supplied 742, 500 doses of vaccines, diagnostics worth $7,446,777.1, PPE materials worth $616,310.6 and supported the attainment of the IMST office, developed essential medical lists and quantification of medical supplies tools, vaccine dispatch tool, vaccine fractionating strategy, Supported in country logistics for vaccination, established dashboards to enhance visualisation of the medical counter measures demand and supply	Supported overall mpox response by availing medical countermeasures, essential tools to guide their supply, enhanced visibility through digitalisation, and in general enabled the operationalization of the response
Continuity of essential services	Supported countries to continue essential healthcare services	Essential healthcare services continued in the affected countries

1 DRC, Uganda, Nigeria and Rwanda

2 Countries with allocated plans: DRC, Uganda, Sierra Leone, Liberia, CAR, Nigeria, Rwanda, Cote d'Ivoire, Kenya, Angola, Guinea South Africa

3 17 countries participated in the mpox vaccination plan development: DRC, Burundi, Uganda, Republic of Congo, South Africa, Kenya, Zimbabwe, Zambia, Tanzania, Guinea, Cote d'Ivoire, Nigeria, Ghana, Central Africa Republic, Gabon, Cameroon, Liberia

Challenges Affecting the mpox Response

Despite the achievements and progress made so far, the mpox response has been affected by several persistent and emerging challenges. The recently emerged conflict in the eastern part of DRC, severely affected the mpox response efforts. Funding gaps, due to delayed disbursement of committed funds, have affected the response.

Disruption in global health financing have affected the mpox response, for example, sample transportation, vaccine logistics, medical countermeasures etc. Moreover, the mpox response efforts were affected by weak decentralization of coordination at sub-national levels, poor data quality, and limited country-specific support, compounded by workforce demotivation and staff turnover. The RCCE has also struggled with overly reliant mass media interventions and insufficient targeted engagement for high-risk groups. The mpox surveillance efforts were undermined by human resource shortages, fragmented data collection, and delays in laboratory turnaround times. The laboratory pillar faced challenges in data collection and reporting, sample transportation and airport clearance for lab equipment. Case management faced challenges such as limited clinical supervision and overwhelmed healthcare facilities. In the Eastern Region of DRC, due to the humanitarian crisis, patients were forced to flee from the health facility, increasing the risk of transmission at the community level. For IPC, there has been inadequate IPC implementation, poor infrastructure, and insufficient isolation facilities further increased transmission risks. The delays in vaccine shipment, limited visibility into country-specific micro-plans, and low vaccine utilization exacerbated logistical challenges. Additionally, gaps in vaccine regulatory approvals and a lack of monitoring and evaluation plans impeded vaccination efforts. Coordination issues in research, including delayed fund transfers, financial constraints, and slow ethical approvals, further delayed the initiation of critical studies.

These compounded challenges underscore the need for improved coordination, better resource allocation, and more targeted interventions to enhance mpox response efforts across Africa.

Purpose and Scope of the Plan

This plan is designed to provide a structured and coordinated approach to managing the ongoing mpox outbreaks while building long-term resilience within Africa's public health systems. It outlines key strategies to accelerate current efforts to control the outbreaks and transition from emergency response towards greater systems resilience for sustainable preparedness. The focus will be strengthening surveillance, laboratory capacity, case management, infection prevention and control (IPC), vaccination and accelerating country support through the One health approach. This will involve equipping national health systems with the tools, resources, and governance structures to prevent, detect, and respond to future outbreaks and integrating mpox preparedness and response into broader health security frameworks. The operational scope will include the following core pillars: Coordination and leadership, RCCE, Surveillance, Laboratory capacity, Case management, IPC, Vaccination, Research and Innovation, Logistics and Continuity of essential health services. This plan will be implemented in the mpox affected and at-risk AU Member States through the continental IMST and country-level response teams.

Risk Assessment and Country Categorization

Mpox Risk and Readiness Assessment

The risk of mpox transmission in Africa remains high, driven by ongoing community transmission in several countries, weak surveillance systems, and cross-border movement. As of February 2025, 22 Member States have reported cases, with sustained human-to-human transmission observed in 11 countries (DRC, Congo Republic, Central African Republic, Burundi, Kenya, Rwanda, Uganda, Zambia, Nigeria, Liberia, and Cote d'Ivoire) and sporadic transmission in 3 others (Sierra Leone, South Africa and South Sudan).

A gradual decrease in case fatality ratios (CFR) from 5.6% in early 2024 to 0.8% (among suspected cases) in early 2025 was observed, however the overall testing coverage remained suboptimal during the same period particularly in high-burden and conflict-affected regions such as Eastern DRC, where laboratory capacity and case detection remain constrained.

The risk of international spread outside of Africa remains moderate particularly through travel-linked transmission. Cases linked to African clade Ib outbreaks have been detected in several countries[4]. Countries with direct air travel and land border connections to high-burden nations remain at elevated risk, emphasizing the need for strengthened cross-border information sharing and coordination mechanisms and rapid response mechanisms.

The conflict in Eastern DRC presents a significant challenge to outbreak containment, exacerbating the risk of undetected transmission and delays in response activities. The displacement of over 850,000 people due to conflict in early 2025 has led to the disruption of health services and the forced closure of Mpox treatment centers, with over 500 patients fleeing isolation units. The risk of spillover into neighboring countries remains high, necessitating urgent humanitarian and health interventions to ensure access to testing, case management, and vaccination.

While mpox vaccination efforts have been scaled up, with over 1.1 million doses allocated to 12 countries, vaccine coverage remains low in the most affected regions due to delays in implementation and resource constraints. Moving forward, intensified surveillance, digitalized community-based monitoring, strengthen and enhanced harmonized data collection and analysis system, decentralized laboratory, and targeted vaccination strategies will be essential to reduce transmission risks and strengthen regional outbreak preparedness

WHO and Africa CDC have categorized African Union Member States based on their risk level and vulnerability to guide targeted preparedness and response measures. This assessment considers epidemiological trends, surveillance capacity, healthcare infrastructure, and cross-border transmission risks. The classification is structured into three risk categories, aligning with recent transmission dynamics and the evolving epidemiological landscape.

Categorization of Member States Based on Risk and Vulnerability

Priority Category I: Sustained human to human transmission/ Local community transmission
Countries in this category are experiencing continuous and widespread transmission, with a high case burden and potential for regional and international spread. These include DRC, Uganda, and Burundi, where Clades Ib are co-circulating , as well as Tanzania. Additional high-risk countries include Republic of Congo, Central African Republic (Clade Ia), and Kenya, Rwanda, Zambia (Clade Ib only). Nigeria, Liberia, and Côte d'Ivoire are also included due to Clade II transmission. Urgent vaccination scale-up, enhanced laboratory testing, and reinforced outbreak control efforts are needed, particularly in conflict-affected regions where case ascertainment and access to care remain limited.

4 https://worldhealthorg.shinyapps.io/mpx_global/#sec-clade-export

Priority category II: Sporadic transmission or localized outbreak/ Imported or travel related cases

Countries in this category experience sporadic transmission, localized outbreaks, or travel-associated cases but do not yet show sustained transmission. As of February 2025, South Sudan, South Africa, and Sierra Leone, where community-based transmission has been detected in limited clusters. Strengthening active case search, case isolation and contact tracing as well as increasing genomic surveillance, and improving community engagement are essential to contain localized outbreaks and prevent further escalation.

Priority Category III: No recent cases or minimal transmission risk/ Unaffected countries or no cases in the last six weeks This category includes countries that have reported no confirmed cases in the past six weeks or have limited exposure to high-burden regions. These include Angola, Zimbabwe, and Ghana, as well as Mozambique, Ethiopia, Lesotho, Eswatini, Sudan, Benin, Egypt, Niger, Burkina Faso, Mali, and Chad, which border endemic regions but have not seen active outbreaks. While the immediate threat is lower, proactive readiness efforts such as mpox surveillance, diagnostic capacity, rapid response training, treatment protocols and engagement with the communities remain critical to detect cases early and control transmission.

Cross-Border Transmission Risks and Regional Priorities

The cross-border movement of people, goods, and animals continues to be a major driver of mpox transmission across the African continent, with porous borders, inadequate health screenings, and weak surveillance at points of entry (PoE) contributing to the spread of Clades Ia, Ib, and IIb MPXV. As of early 2025, at least 14 African countries are experiencing active transmission, with confirmed travel-linked cases of clade Ib reported in Sweden, Thailand, Germany, Belgium, Spain, Finland, the UK, Canada, India, Oman, Pakistan, and the US. High-risk cross-border zones, particularly in Central and East Africa, remain critical areas for enhanced surveillance and intervention, with the DRC, Uganda, Burundi, Kenya, and Rwanda serving as epicenters of ongoing transmission.

Given the evolving epidemiological landscape, regional priorities have been established to strengthen mpox preparedness and response at border areas. Despite progress in cross-border collaboration, significant gaps remain in data sharing, contact tracing across jurisdictions, and harmonized risk communication strategies. Weak regulatory frameworks and inadequate financial resources continue to undermine effective border health security, necessitating greater investment in regional preparedness and response infrastructure. Moving forward, integrating mpox response efforts within broader One Health frameworks—linking human, animal, and environmental surveillance—will be critical in mitigating future cross-border outbreaks and ensuring long-term regional health security.

Update on Declaration of mpox as a PHECS and PHEIC- 2024- 2025

On 13 August 2024, Africa CDC declared mpox a PHECS in response to the escalating outbreak across the continent, marking the first-ever use of this designation to enhance regional coordination and resource mobilization. The following day, on 14 August 2024, WHO declared mpox a PHEIC due to the rapid increase in cases, particularly in the DRC, Burundi, Kenya, Rwanda, and Uganda, highlighting the growing public health threat. Following this declaration, a continental IMST was established and a joint mpox preparedness and response plan was developed and implemented from September 2024 – February 2025.

Following the end of the 1st declaration period, the Africa CDC ECG and the WHO Emergency Committee (EC) convened separate meetings on 25th February 2025 and 26th February 2025 and reaffirmed the PHECS and PHEIC status, extending temporary recommendations until August 2025 due to the persistent increase in cases, expanding geographic spread, and the continued detection of Clade Ib MPXV. Since the PHECS and PHEIC declarations, Africa has witnessed a tripling of weekly reported cases, with mpox spreading to nine additional African countries.

Goal and strategy

Goal: To stop human-to-human transmission of mpox outbreaks[5], reduce by half the burden of mpox in endemic areas[6] and strengthen health system resilience for sustainable epidemic preparedness and response in affected and at-risk countries.

Response strategy

A comprehensive strategy is required to enable African countries to control mpox transmission and strengthen their health systems to effectively address future health emergencies. The Mpox Continental Response and Legacy Plan for Africa emphasizes a community-centered, well-coordinated, multisectoral, and differentiated approach adapted to the epidemiology and risk category of member states. The intensification phase will bolster (i) digitalized facility and community-based surveillance with a unified data base including laboratory and case management, (ii) decentralized laboratory testing, (iii) Vaccination of high risk individuals in hotspots based on local epidemiology and it engages communities and ensures availability of critical countermeasures. The legacy phase will consolidate the interventions of the intensification phase and strengthen health systems' resilience and equity.

The intensification and legacy phases of the response plan will overlap to ensure a seamless transition from emergency response to sustainable national ownership. While the intensification phase focuses on scaling up interventions, strengthening coordination, and addressing immediate challenges, the legacy phase will gradually shift toward institutionalizing response strategies within national health systems. This overlap will provide countries with the necessary technical and operational support to enhance their capacities, ensuring they are well-prepared to take full ownership of the response once the plan concludes. By embedding best practices and strengthening key systems, the legacy phase will set the pace for long-term sustainability and resilience against future outbreaks.

Pillar 1: Coordination and Leadership

Intensification Phase

Strategic Objective: By May 2025, enhance coordination mechanisms at the continental, national, and local levels, ensuring that at least 80% of key stakeholders actively contribute to a unified "one team, one plan, one budget, and one M&E framework."

Actions:

- Advocate for political commitment of member states: Conduct high-level leadership advocacy meetings with the most affected and at-risk countries to gain high-level political commitment and support in preparing for and responding to mpox, integrating response efforts, and ensuring the sustainability of the mpox response investments.
- Mobilize Resources and Funding: Support countries on the mobilization of additional funding, including domestic resources to support intensified mpox response efforts, particularly in affected hotspots, and update financial tracking and donor engagement. In addition, support political advocacy for greater commitment of domestic resources to the mpox response. Moreover, follow up the disbursement of already pledged (committed) funds from various partners.
- Strengthen Country Support and Coordination: Support countries to adapt and align their mpox response and legacy plan 2.0 with the continental plan by end of March 2025. Conduct deep dives and joint field support missions in at least 5 most affected countries to accelerate

5 42 days with no confirmed cases

6 This will be measured by number of notified cases from 1st March 2025 to the end of the plan

response implementation, address gaps, and enhance national coordination mechanisms.

- Ensure coordination of mpox response with other necessary and essential government agencies and partners at all levels, including but not limited to national HIV/AIDS control programmes, immunization programmes, national public health laboratories, and humanitarian response actors.
- Enhance Data Management: Support the deployment of the unified DHIS2 database led by coordination in collaboration with surveillance, laboratory, case management, and vaccination pillars, build capacity of MS and establish analytics unit within IMST to improve data quality, completeness and promptness and analysis to better guide response actions.
- **Engagement of humanitarian partners:** With the growing insecurity in the Eastern DRC, ensure the involvement of humanitarian actors in mpox outbreak response activities in conflict-affected and displacement settings.
- **Improve Health workforce**: Strengthening of human resources availability in high-burden areas by supporting priority countries with critical human resources (data managers, epidemiologist, IPC, risk communication, Community health workers, Community Volunteers)
- **Community-centered package:** Support countries on implementation of an integrated community package of mpox interventions, including RCCE, CBS, IPC, and home-based care with tangible allocated resources and an emphasis in the most affected settings.
- **Strengthen cross-border surveillance mechanisms:** through joint outbreak response plans, data-sharing agreements, and cross-border coordination meetings in at least 5 priority border regions.

Legacy/Transition Phase

Strategic Objective: By August 2025, ensure integration of lessons learned and innovations of the mpox preparedness and response into national health systems.

Actions:

- **Unified database legacy:** Scale up the unified DHIS2 database, integrating surveillance with laboratory, case management and vaccination with the unique identifier for the management of future outbreaks.
- Integrate mpox interventions into national health systems: Support the countries to integrate the mpox interventions into national health programs, including Integrated Disease Surveillance and Response (IDSR), HIV, tuberculosis, and routine immunization programs.
- Expand decentralized coordination: Support the countries on decentralization of the coordination mechanisms of the response, including EOCs at sub national level (provincial/ district level).
- **Sustainability mechanisms for community health workers**: Support countries in developing national policy/strategy for community engagement for the health sector with emphasis on sustaining health care workers implementing integrated community package. Support countries to facilitate knowledge and skills transfer initiatives to sustain the gains during the mpox response.
- **ONE Health integration:** Support countries to engage all ministries and partners of One Health initiative to joint their resources for better preparedness and response to mpox and other zoonotic epidemics.

Pillar 2: Risk Communication and Community Engagement

Intensification Phase

Strategic Objective: Support countries to increase to 80% knowledge, attitudes, practices and behavior of at-risk communities/ vulnerable groups to enhance community engagement, service access and protection.

Actions

- Intensify outreach to communities through community leaders, community health workers, and CSOs to strengthen

community engagement engagement in local communities and in most affected groups including key populations, coupled with community-based surveillance for active search, reporting of alerts and events and contact listing and monitoring.

- Engage and build capacities of the media and influential leaders in community engagement and interpersonal communication towards promoting interactive dialogue in and messages on mpox preventive measures including vaccination (extended to 1-17 years old age groups) and for at risk health care and laboratory workers through trusted channels and efficient (evidence-based, socio-culturally adapted) RCCE techniques
- Intensify proactive outreach through local community health workers to boost vaccination acceptance, including in countries where immunization for children 1-17 years is conducted, engaging key actors and promoting key messages for vaccine hesitancy cases
- Strengthen the capacities of the local community health workers and local media to collect, analyse, and address mpox infodemics, social stigma related issues.
- Utilize evidence generated from community feedback mechanisms and other social and behavior data sources to adjust the mpox interventions, including immunization, and guide the overall response

Legacy/Transition Phase

Strategic Objective: Support countries to consolidate gains from engagement of 80% of the community structures and local community health workers and integrate national strategies or strategic plans in a sustainability perspective.

Actions

- Implement integrated RCCE interventions in training materials/manuals for local community health workers
- Develop guidance and operational tools to orient systematic infodemic management, community feedback mechanisms and other rapid socio-behavioral data collection approaches.
- Develop operation/practical guide to enhance learning from lessons and best practices to strengthen integrated RCCE with other sectors and overall community protection approach
- Develop operational guidance to institutionalize practice of recommended measures including, community-based surveillance, vaccination and management of emergencies

Pillar 3: Surveillance

Intensification Phase

Strategic Objectives: By May 2025, enhance mpox surveillance by scaling-up case detection, community-based and cross-border surveillance in the top 5 high burden countries

Actions

- Enhance a functional event- and, community-based, mpox surveillance system at continental, national, and subnational levels to ensure early detection, rapid response, and data-driven decision-making across 100% of the top high-burdened countries.
- Strengthen human resource capacity by deploying additional trained epidemiologists, data managers, Community Health Workers, and community volunteers in all identified hotspot districts to improve case detection and reporting.
- Build capacities for surveillance in mpox endemic areas using the One health approach, and collaborate with animal health services, government and health services as well as private sector to support comprehensive investigation and response.
- Enhance cross-border surveillance by improving coordination between border regions/countries for better tracking and data sharing of mpox related information

- Improve the quality, timeliness, and interoperability of mpox surveillance data by standardizing SOPs, enhancing digital reporting tools (DHIS-2), and implementing anonymized unique IDs for data security.
- Enhance the use of real-time surveillance data for decision-making by maintaining and expanding Mpox surveillance dashboards and training Member States on surveillance data analysis.
- Strengthen surveillance data analysis capacity in Member States to enhance data use for informed decisions and response

Legacy/Transition Phase

Strategic Objective: To ensure the sustainable integration of mpox surveillance, preparedness, and response into national and regional health systems with 100% reporting through IDSR/DHIS-2, sustainable CBS funding in 70% of high-burden countries, and formalized cross-border surveillance in priority-1 countries, by August 2025.

Actions

- Institutionalize Mpox surveillance within national health systems by ensuring 100% of affected Member States transition mpox reporting into IDSR and DHIS-2 platforms by August 2025.
- Integrate mpox surveillance into syndromic surveillance systems by linking it with measles, chickenpox, and other skin-related disease surveillance in at least 50% of high-burden countries.
- Strengthen regional coordination and cross-border collaboration through institutionalized data-sharing agreements and cross-border surveillance meetings in the 5 African Union regions.
- Ensure sustainable funding mechanisms for mpox surveillance by securing long-term financing models for community-based surveillance and national surveillance systems.
- Define exit indicators and criteria for downgrading national and continental mpox response.

Pillar 4: Laboratory Capacity

Intensification Phase

Strategic Objective: Sustain and expand mpox laboratory testing and sequencing capacity across all affected member states to achieve 80% mpox testing coverage, 100% testing rate, of suspected cases, 8% sequencing rate of confirmed cases, and a 48-hour turnaround time.

Actions

- Accelerate the decentralization of diagnostic capacity in areas with high numbers of cases and/or high incidence: Leverage existing Point of Care (POC) platforms and integrate qPCR capabilities to enhance mpox testing in high-burden regions.
- Strengthen Workforce Competencies: Provide necessary training on Mpox diagnostics, sequencing, and biosafety to ensure a skilled and sustainable laboratory workforce.
- Improve Sample management and Referral: Ensure the availability of sample collection materials and continue supporting countries in enhancing and optimizing sample collection and transportation systems, establishing efficient transport networks to maintain sample integrity and achieve a maximum turnaround time of 48 hours.
- Reinforce Biosecurity and Biosafety: Implement strict biosafety protocols and provide sufficient materials to ensure safe handling of Mpox samples.
- Enhance Digitalization for Timely and Secure Results: Enhance laboratory data management by deploying electronic systems that accelerate result reporting and integrate seamlessly into national surveillance systems.
- Equip all hotspot regions in priority countries with multiplex PCR testing capabilities by deploying additional Point of care and qPCR machines and training laboratory personnel taking into account the One health approach.

Legacy/Transition Phase

Strategic Objective: Support Member States in fully integrating decentralization of laboratory capacities into national health systems, ensuring 50% of districts have Multiplex Point-of-Care (POC) testing and 100% of provinces have qPCR for sustained, timely, and reliable diagnostics.

Actions

- Integrate Laboratory Capacities Decentralization into National Health Systems: Align the decentralization of testing capacity at subnational levels with regional and national policies, protocols, and surveillance systems, ensuring institutionalization and sustainability. Moreover, support countries to strengthen the laboratory health workforce through in-service training differential diagnostic and syndromic approach.
- Increase Multiplex Point-of-Care (POC) testing platforms: Equip 50% of districts with Multiplex POC testing devices and ensure their validation and deployment, providing rapid and accurate diagnostics at subnational levels.
- Scale Up qPCR Capacity: Strengthen laboratory infrastructure by upgrading existing facilities and establishing new ones, particularly in underserved areas, while ensuring 100% of provinces are equipped with qPCR platforms.
- Ensure Sustainable Supply Chains: Establish robust procurement and distribution systems for reagents, consumables, and maintenance services to keep POC and qPCR testing operational.
- Enhance Digital Connectivity and Data Management: Implement Laboratory Information Management Systems (LIMS) and integrate them into Health Information Management Systems (e.g., DHIS2) to ensure real-time data collection, secure result reporting, and improved data sharing for better disease surveillance and response.

Pillar 5: Case Management

Intensification Phase

Strategic Objective: To expedite implementation of a comprehensive, coordinated clinical response systems to maintain the CFR below 0.5% for all confirmed mpox cases.

Actions

- Using webinars, cascaded trainings, mentorship and supportive supervision, train healthcare workers in the comprehensive management of mpox including clinical care, mental health and psychosocial support in Centres for Treatment of mpox (CTMpox).
- Support resource mobilization for the procurement of supplies of medical products including drugs and equipment, and nutritional support to vulnerable population.
- Deployment of trained frontline clinicians to hotspots to support clinical care services
- Ensure sustainable supplies of medical products including drugs and equipment
- Develop mpox syndromic management protocols that integrates syndromic management of mpox co-infection with measles, VZV and other STIs with visible genital and skin lesions.
- Develop and disseminate job aids on differential diagnosis, triage and management strategies including identification and management of skin lesions, pain management and other associated complications.
- Support utilization of mpox global clinical platform to facilitate regular mortality and clinical records data review to inform clinical decisions
- Implement patient follow-up system to ensure an integrated approach to care after discharge, especially for those with chronic co-infections or long-term mpox complications.
- Support countries to roll out home based care for mpox patients, ensuring

home based care (HBC) tools and kits are developed and disseminated and CHW and HCW capacitated to support implementation of HBC.

Legacy/Transition Phase

Strategic Objective: To sustain provision of high quality integrated comprehensive treatment and holistic care for mpox patients in 100% of mpox treatment centers through capacity building, establishment of treatment centers, integrated where feasible and equipped, standardized and leveraged for use for other VPDs.

Actions

- Advocate for MS to establish infectious disease treatment centers for epidemic prone diseases.
- Inclusion of mpox clinical care into clinical guidelines for STIs and communicable skin diseases.
- Advocate for the integration of mpox care into standard health systems. Ensure the provision and access to appropriate treatments for mpox and co-infections (e.g., antiretrovirals for HIV, acyclovir for chickenpox), Nutrition and MHPSS.

Pillar 6: Infection Prevention and Control

Intensification Phase

Strategic Objectives: Enhance infection prevention and control (IPC) measures at 100% of CTMpox and in 80% of households with mpox patients.

Actions

- Train and build capacity of HCWs, including CHWs on mpox-related IPC measures, encouraging them to IPC compliance
- Provide IPC supplies and resources such as personal protective equipment (PPE), alcohol-based handrub, chlorine, water purifying tablets, equipment for the sterile services department (decontamination and sterilization of medical and/or surgical instruments).
- Monitor and Evaluate IPC Implementation using the rapid assessment tool for mpox during supervisory visits.
- Ensuring effective adherence to IPC/WASH best practices following IPC guidelines at the community level including households (home-based care) and schools.

Legacy/Transition Phase

Strategic Objective: Establish a continental IPC program targeting 500 healthcare facilities in category 1 mpox affected countries to improve the knowledge, resources and practices of IPC.

Actions

- Scale Up IPC Training and Capacity Building Across 500 Healthcare Facilities
- Ensure Availability of IPC Resources and Infrastructure in Target Facilities
- Implement a Continuous Monitoring and Evaluation Framework for IPC Practices

Pillar 7: Vaccination

Intensification Phase

Strategic Objectives: Scale up mpox vaccination to reach at least 80% of high-risk populations based on national targets in countries with active outbreaks guided by local epidemiology, by implementing an outbreak response targeted vaccination approach aiming to stop the human to human transmission.

Actions

- Strengthen coordination and collaboration with partners and key stakeholders to ensure equitable, timely allocation and delivery of vaccines to affected member states through regular information sharing, joint planning and problem solving to ensure delivery of vaccines to countries within 6 weeks of submitting requests.
- Guide countries with active outbreaks to develop quality and targeted mpox

vaccination plans focused on stopping human-to-human transmission and including consideration of different mpox vaccines and how to access them, and have the plans submitted to the TRC within 2 weeks of expressing interest.

- Provide technical assistance and operational support to scale up mpox vaccination rollout through a targeted vaccination approach and implementation in hotspots and in those areas, focusing on vaccination of high-risk populations guided by local epidemiology, and vaccination of at least 80% of the high-risk group populations and based on national targets by July 2025.
- Support the establishment and strengthening of national/regional Vaccine Adverse Events Expert Committees to strengthen capacity for vaccine safety surveillance, monitor and assess reported AEFIs.
- Proactively support countries' immunization policy guidance capacity - National Immunization Technical Advisory Groups (NITAGs)
- Proactively support National Regulatory Authorities (NRAs) to make or update Emergency Use Authorizations (EUAs) or import authorization of vaccines by implementing reliance mechanisms and utilizing data or product assessment report prepared by WHO PQ/Emergency Use Listing, EMA or US FDA market authorization.
- Support stock taking peer-to-peer learning amongst priority countries and disseminate guidance on monitoring and reporting of mpox vaccination, including adopting a standard DHIS2 module and ODK template by affected countries
- Actively support countries in assessing vaccine performance in the current outbreak, mobilize resources at continental level and support domestic resource mobilization to ensure availability of adequate funds to operationalize the continental and country vaccination plans

Legacy/Transition Phase -

Strategic Objective: Sustain mpox vaccination efforts through integration into existing primary healthcare services

Actions

- Advocate to vaccine manufacturers for the transfer of technology and talent development to facilitate local manufacturing in Africa, while continuing strengthening NRAs to reach adequate maturity level to oversee vaccine productions.
- Advocate for establishment of a strategic global/continental emergency reserve for mpox vaccines.
- Develop guidance for countries to implement reactive vaccination during mpox outbreaks including for areas where mpox is endemic.
- Generate evidence on mpox vaccine effectiveness, safety, acceptance and strategies in targeted areas and groups.
- Enhance multi-stakeholder collaboration and coordination on relevant essential service delivery with other response pillars

Pillar 8: Research and Innovation

Intensification Phase

Strategic Objectives: Coordinate mpox research across the continent and use the findings to improve response to mpox.

Actions

- Regularly upload mpox research status, commencing or ongoing, on the designated online platform
- Use interim data analysis from the ongoing Socio-ecological Study in the 9 Member States to inform response and the vaccine rollout in the 22 countries with mpox.
- Strengthen Data Sharing and Collaboration on ongoing research and implement a robust data-sharing

framework to ensure timely dissemination of research findings across the continent, informing public health strategies and policy decisions.

- Integrate Research into Policy and Practice: Ensure that research outcomes are translated into actionable policies and practices that can be rapidly implemented during mpox outbreaks. Engage policymakers, public health authorities, and communities in the research process to align efforts with public health needs and priorities.
- Support research data analysis and write up in high impact journals and translate into policy to govern research response in future outbreaks
- Continue to support vaccine research, assessment and development initiatives including on methods of administration to ensure a robust basket of options in future.
- The successful conduct of the Brin cidofovir (only Therapeutic trial) and AI-powered diagnostics of mpox will be a legacy project.

Legacy/Transition Phase

Strategic Objective: Establish and operationalize a Continental Research Coordination Mechanism to enhance emergency preparedness and response in Africa

Actions

- Establish a continental research mechanism to effectively coordinate research during emergencies in Africa, including streamlining ethics approval processes through the establishment of the Continental Health Research Ethics Committee (CH-REC).
- Strengthen collaborations with regional and international organizations to share resources and expertise.
- Regular publication of research findings in peer reviewed journals, reports and through regional health conferences
- Continued advocacy efforts towards dissemination and use of the research findings throughout the decision-making processes, including policy design.
- Strengthening research on One Health to better understand animal-to-human transmission and human-to-human transmission in the different contexts

Pillar 9: Logistics

Intensification Phase

Strategic Objective: To support Member States and partners to set up and managed in setting up the required health logistics and end to end supply chain capacity to allow implementation of the continental Mpox emergency response plan:

Actions

- Enhance last mile distribution of medical countermeasures through engagement and coordination of In-country Logistics Partners implementation
- Increase by 100% visibility of the lead time in delivery of medical countermeasures
- Accelerate supply of medical countermeasures through robust procurement and management of donations, monitoring of demand, utilization of dashboards to ensure end to end visibility and engagement of partners and donors.
- Strengthen partners logistics and supply coordination aiming to steer Mpox global supply chain toward response priorities, reduce risk of duplication and gaps
- Enhance the visibility of the guiding frameworks for medical countermeasures supply and distribution
- Support the set up of adequate and safe Mpox treatment facilities in accordance with patient care standards, patient flow and IPC recommendations
- Support the waste management of medical counter measures through adapting existing tools, collaborative

monitoring of stock levels and consumption and the

- Support and procure cold chain equipment for at least 25% of the category one affected countries
- Enhance knowledge and best practices sharing

Legacy/Transition Phase

Strategic Objective: To ensure sustainable supply and distribution of medical countermeasures to the African Member States

Actions

- Provide a snapshot analysis of the African supply chain infrastructure to improve programing and enhance Supply chain decision making
- Build a continental logistics supply platform and engage relevant stakeholders in its utilization
- Build an African novel vaccine and therapeutics logistics experts pool on crucial modules including donation management, legal processes, Temperature sensitive Logistics, pipeline logistics
- To engage relevant stakeholders on the sustainable, long-term approaches towards the delivery of medical counter measures through stockpiling strategy, tech transfer and local manufacturing approaches
- Transition the logistics pillar partners into existing Supply chain coordination structures and an emergency supply chain working group
- To create a repository of the best practices in the delivery of medical counter measures during emergencies

Pillar 10: Continuity of Essential Health Services

Intensification Phase

Strategic Objectives: By the end of the intensification phase on August, 2025, we will support countries prioritize CEHS in their mpox preparedness and response plans, taking into account objectives, budgeted activities, and indicators in the revised plans

Actions

- Support affected Member States in prioritizing the Continuity of Essential Health Services (CEHS) in their Mpox preparedness and response. The CEHS should be maintained in all hotspot districts and Mpox health centers across the most affected countries, including the DRC, Burundi, Uganda, and CAR.
- Assist Member States in creating and disseminating generic training modules on maintaining the continuity of essential health services for stakeholders in all hotspot districts and Mpox health centers in affected countries.

Legacy/Transition Phase

Strategic Objective: By the end of the transition phase on August, 2025, we will help the countries finalized and disseminated the monitoring guide for monitoring indicators for the delivery of essential health services to assess the impact of mpox on essential services.

Actions

- Provide orientation to Member States on developing and monitoring a standardized system for the continuity of essential health services in 100% of hotspot districts and Mpox health centers during the outbreak.
- Help Member States establish continuity contingency plans and incorporate supervision/exercises into the National Emergency Preparedness and Response Plan.


SAFE GLOVES

Implementation Framework for Response and Legacy

Overall Coordination and Leadership Structure

WHO and Africa CDC will work with all relevant stakeholders including UN and non-governmental Organizations and Civil Society Organizations, who will be represented in relevant 10 pillars. In line with the Lusaka Agenda calling for harmonized efforts, the continental mpox response will be implemented through one team, one plan, one budget and one M&E principle. In that regard, one continental Incident Management Team has been established including members from key partners.

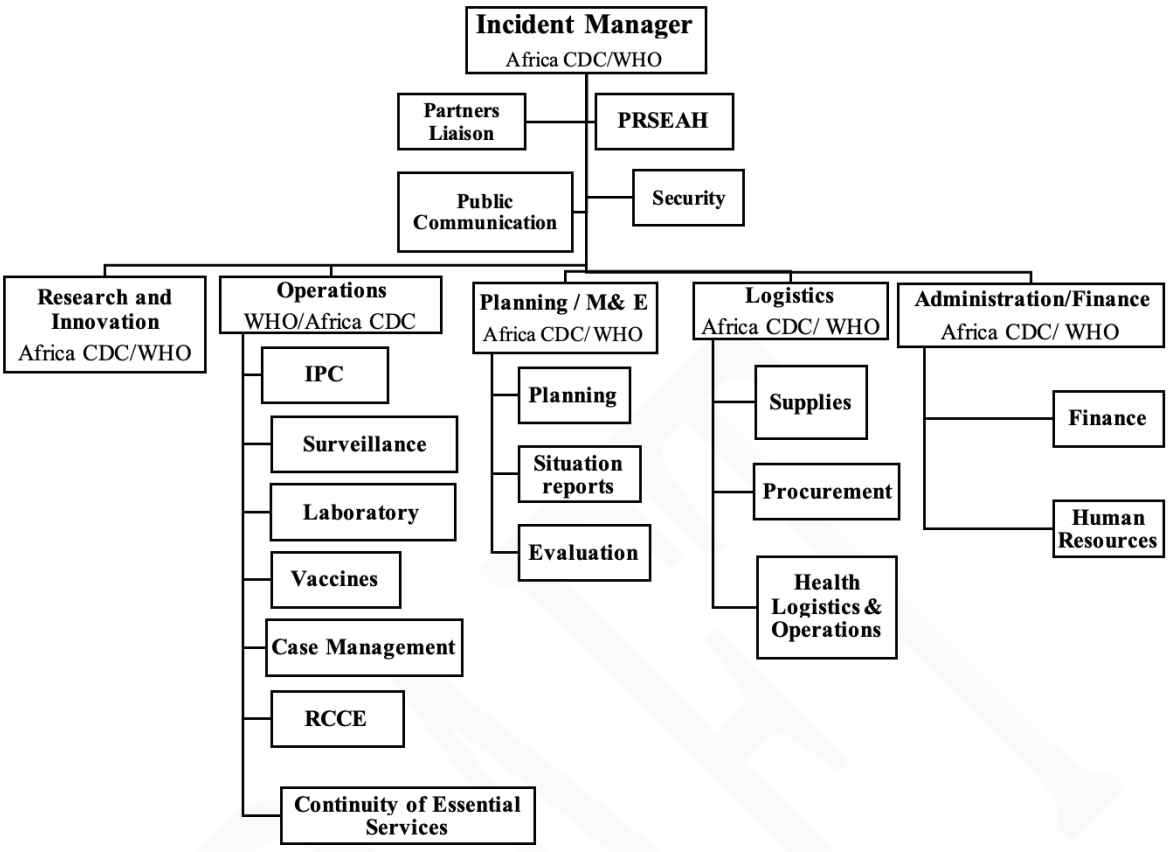

Figure 2: Continental mpox response structure

Table 2: Main functions of partners by pillars of response

Pillar	Lead	Sub-pillar	Support Partners*
Pillar 1: Coordination and leadership	Africa CDC/ WHO	Partner Liaison	Africa CDC
		Public Information	Africa CDC
		PRSEAH	WHO
		Security	WHO
		Finance/Admin	Africa CDC, GAVI, WHO
		Human Resource	Africa CDC/ WHO
		Resource mobilization and partnership	Africa CDC, GAVI, WHO
		Planning/M&E	Africa CDC/ WHO
Pillar 2: Risk Communication and Community Engagement (RCCE)	Africa CDC/ WHO	Infodemics/Community feedback mechanisms	IFRC, UNICEF, WHO
		Community engagement	GAVI, IFRC, UNAIDS, UNICEF, WHO
		Risk Communication	Africa CDC, UNICEF, WHO
		Behavioral insights and knowledge management	UNICEF, WHO
		Media	Africa CDC, IFRC, UNICEF
Pillar 3: Surveillance	Africa CDC/ WHO	Alert and Investigation	Africa CDC, WHO
		Contact tracing	Africa CDC, WHO
		Active case finding	Africa CDC, IFRC, RCRC, WHO
		PoE	Africa CDC, IOM
		Health Information management	Africa CDC, PATH
		Animal Surveillance	FAO, WOAH
Pillar 4: Laboratory Capacity	Africa CDC/ WHO	Diagnostics	Africa CDC, FIND, WHO
		Quality control and assurance	ASLM, WHO
		Genomics sequencing and bioinformatics	Africa CDC, WHO
		Biosafety and biosecurity	Africa CDC, WHO
Pillar 5: Case Management	Africa CDC/ WHO	Clinical	Africa CDC, MSF, UNAIDS, WHO
		Psychosocial	UNICEF, WHO
		Nutrition	ACF, UNICEF, WFP
Pillar 6: Infection Prevention and Control	Africa CDC/ WHO	Health facilities	WHO
		Community	OXFAM, UNICEF
		WASH	OXFAM, UNICEF

Pillar	Lead	Sub-pillar	Support Partners*
Pillar 7: Vaccination	Africa CDC/ WHO	Delivery	GAVI, UNICEF, WFP, WHO
		Pharmacovigilance	Africa CDC, GAVI, WHO
		Regulatory	Africa CDC, AMA, AUDA-NEPAD, AVAREF, WHO
		Cold Chain management	GAVI, UNICEF
Pillar 8: Research and Innovation	Africa CDC/ WHO	Clinical trials/R&D	Africa CDC, AMA, AUDA-NEPAD, AVAREF, CEPI, EDCTP, WHO
		Implementation/ Operational research	Africa CDC, EDCTP, GAVI, Wellcome Trust
		Ethics and regulatory	Africa CDC, GAVI, UNICEF, UNHCR, WFP, WHO
Pillar 9: Logistics and Financing	Africa CDC/ WHO	Procurement	Africa CDC, GAVI, UNICEF, UNHCR, WFP, WHO
		Supply	Africa CDC, IFRC, UNHCR, UNICEF, WFP, WHO
		Health Logistics and operations	Africa CDC, MSF, UNICEF, WFP, WHO
		Financing	AfDB, Afrexim Bank, BMGF, EU, GAVI, Mastercard Foundation, The Pandemic FUND, World Bank and all funding partners
Pillar 10: Continuity of essential services	Africa CDC/ WHO	Health care services	Africa CDC, UNHCR, UNICEF, WHO
		Food and nutrition support	WFP, UNICEF
		Education	UNICEF

**Support partners are arranged in alphabetical order*

Role of the IMST as a Coordinated Response Mechanism

Africa CDC and WHO will continuously work closely together to co-lead the Mpox Continental Response and Legacy Plan for Africa, leveraging their respective mandates, expertise, and strengths to ensure a coordinated, efficient, and effective response across the continent. Over the past six months, this collaboration has combined Africa CDC's regional coordination role within the African Union with WHO's global health leadership, technical expertise, and international network. Together, they have driven a robust, equitable, and sustainable mpox response, strengthening health security across African nations and contributing to global health resilience. This partnership is built on mutual support, recognizing and maximizing the unique strengths of both organizations.

As a specialized public health institution of the African Union, Africa CDC is mandated to enhance the capacity of Africa's public health systems to detect and respond swiftly and effectively to disease threats. It serves as the central coordinating body for health-related responses across the continent, ensuring a unified approach to public health emergencies. By aligning efforts with WHO, Africa CDC reinforces a harmonized, continent-wide strategy that strengthens outbreak preparedness, response, and long-term resilience to health threats, including mpox.

Some of its key comparative Advantages for this mpox Response and Legacy Plan are:

- Africa CDC has unique deep contextual understanding, experience, expertise and knowledge in addressing public health challenges in Africa.
- Africa CDC is uniquely positioned to coordinate the efforts of the 55 AU member states. It can mobilize political support, facilitate resource-sharing, and harmonize public health measures across countries to ensure a unified continental response to mpox.
- Africa CDC has a strong track record in continental capacity building, particularly in developing and supporting national public health institutes, training health workers, and improving surveillance systems and laboratory networks. This capability will be crucial for strengthening the mpox response at the national and community levels.

WHO, as the leading international public health agency, is mandated to promote global health security, coordinate international health responses, and provide technical expertise and guidance to its member states. WHO's role involves developing and disseminating evidence-based health policies, strategies, and best practices, as well as supporting countries in strengthening their health systems.

Some of its key comparative Advantages for this mpox Response and Legacy Plan are:

- WHO has the authority and experience to set international standards and guidelines for disease control, including those for surveillance, vaccination, treatment, and public health preparedness. WHO's endorsement provides credibility and legitimacy to the mpox preparedness and response efforts.
- WHO's global reach and established partnerships with other international organizations, partners, and research institutions provide access to vital resources, including knowledge, vaccines, treatments, and diagnostics.
- WHO possesses vast technical expertise in various health domains, including epidemiology, virology, immunology, and health systems strengthening. This expertise will be critical in developing evidence-based strategies and interventions to manage the mpox outbreak effectively.

Therefore, to co-lead the mpox Continental

Response Plan effectively, Africa CDC and WHO will continue to collaborate in the following critical key areas, supported by other partners who are involved in this plan:

Joint Strategy Development and Implementation:

Both organizations will work together to develop a unified continental strategy for mpox response that will be informed by evidence and best practices, ensuring alignment with global health standards while being tailored to the African context. Africa CDC and WHO will coordinate the implementation of the plan across AU member states, leveraging their respective networks and resources to ensure comprehensive coverage.

Integrated Surveillance and Data Sharing:

Africa CDC and WHO will collaborate on enhancing and integrating mpox surveillance systems across Africa to improve early detection, reporting, and monitoring of cases. This will involve standardizing data collection protocols, facilitating real-time data sharing between countries, and utilizing digital health technologies for rapid information exchange. WHO's global surveillance network will complement Africa CDC's regional surveillance efforts, ensuring that accurate data informs public health interventions.

Coordinated Vaccine Deployment and Medical Countermeasures:

Africa CDC and WHO will jointly coordinate with UNICEF, GAVI, and other partners in the procurement, distribution, and deployment of vaccines and other medical countermeasures, such as antivirals and diagnostics. IMST partners will leverage its relationships and existing structures with global manufacturers and donors to secure vaccine supplies, while Africa CDC will facilitate equitable distribution across AU member states based on epidemiological data and risk assessments. Both organizations will work to ensure that countries with the highest need receive priority access and support capacity-building efforts to manage vaccine storage and administration effectively.

Risk Communication and Community Engagement:

Africa CDC and WHO will work together with UNICEF to lead the risk communication efforts to ensure clear, consistent, and culturally appropriate messaging about mpox prevention, symptoms, and response measures. This collaboration will involve developing and disseminating public health information tailored to different communities, addressing misinformation, and engaging local leaders, civil society organizations, and healthcare workers in public education campaigns.

Research and Development:

Africa CDC and WHO will work together to identify current gaps in knowledge and medical countermeasures to launch appropriate research and development and operational research to

address these gaps.

Capacity Building and Health Systems Strengthening:

Africa CDC and WHO will work together to strengthen national health systems to better prepare for and respond to mpox outbreaks. Africa CDC will lead efforts in building regional and national capacities, such as training healthcare workers, enhancing laboratory and diagnostic capabilities, and developing public health emergency management systems. WHO will provide technical support, guidance, and training materials, drawing on its global experience and expertise.

Resource Mobilization and Advocacy:

Africa CDC and WHO will collaborate to mobilize resources, both financial and technical, needed to implement the mpox preparedness and response plan effectively. This will involve joint fundraising efforts with international donors, governments, and private sector partners, as well as advocating for global solidarity and equitable access to medical countermeasures for Africa.

Monitoring, Evaluation, and Adaptive Response:

Both organizations will jointly establish monitoring and evaluation mechanisms to assess the effectiveness of the mpox response and preparedness measures. This will include setting up feedback loops to continuously improve strategies based on real-time data and lessons learned, ensuring that the response remains adaptive to the evolving situation.

Roles and Responsibilities of Member States

All Member States, including but not limited to those falling into Category 1-4, should also adhere to the standing recommendations, comply with IHR 2005, and follow relevant guidance found within the temporary recommendations published by WHO after the PHEIC.

- The Member States have the primary responsibility of responding to the mpox outbreak in their geographical jurisdiction.
- The activities of the member states will be supported by technical assistance from partners. Thus, member states need to create favorable working relationships and environments with all the partners and monitor the technical assistance provided by the partners.
- Member states are also required to share the epidemiological data required for the response with the Africa CDC and WHO.
- Follow Temporary Recommendations after PHEIC: Member States should also follow the relevant guidance found within the Temporary Recommendations issued by WHO after the PHEIC declaration. These recommendations are designed to enhance specific national and regional responses based on the evolving situation.
- Compliance with IHR: Every Member State must adhere to the International Health Regulations (IHR), which provide the necessary framework to prevent and respond to public health risks with the potential to cross borders. This adherence is essential for coordinated international efforts to manage the risk of mpox spread.
- Adherence to IHR 2005 standing recommendations: All Member States, regardless of category, should follow the Standing Recommendations, which have been extended through August 2025. These recommendations are vital for maintaining a robust level of readiness and ensuring a consistent response across all countries.
- Adapts existing national preparedness and response plan to include transition and legacy aspects

Engagement with WHO, Africa CDC, and Partner Organizations

Under Phase 2 of the Mpox Continental Response and Legacy Plan, engagement with WHO, Africa CDC, and partner organizations will follow a deliberately unified and frequent collaboration model. At the helm is a joint Incident Management Support Team (IMST), co-led by WHO and Africa CDC, which operates from a shared coordination office to facilitate seamless communication and day-to-day cooperation. Through joint IMST, partners—including UNICEF, GAVI, WFP, MSF, IFRC, IOM, and international donors—will attend regular partnership and coordination meetings, where they will harmonize plans, share surveillance updates, and align resource mobilization efforts. This arrangement will ensure that strategies and technical guidance are both evidence-based and co-owned by all stakeholders, promoting synergy in key areas such as vaccine deployment, risk communication, and cross-border prevention measures. Frequent consultation will foster transparency around roles, responsibilities, and budget allocations, while also allowing quick adjustments in response to emerging gaps or evolving outbreak dynamics. By centralizing these engagements under the joint IMST's co-leadership, the partnership framework will guarantee that each organization's comparative strengths—technical expertise, logistical capabilities, funding streams—are optimally deployed, thereby enhancing the overall effectiveness and sustainability of mpox control efforts across the continent.

Regional and National Accountability Mechanisms

Accountability mechanisms at both regional and national levels are critical to ensure that resources are appropriately allocated and effectively utilized during Phase 2 of the Mpox Continental Response and Legacy Plan. First, a unified budgeting approach under a single mpox plan will foster transparency, as all funding streams will be directed towards clearly defined priorities and tracked through consistent reporting systems. To maintain trust among donors and stakeholders, partner organizations and Member States shall prepare quarterly financial reports, clearly documenting how allocated resources shall have been spent and their resultant impact on outbreak mitigation and health system strengthening.

Member States will be required to adhere to regulatory frameworks—particularly the International Health Regulations (IHR 2005)—and any cross-border agreements that facilitate the timely sharing of surveillance data and best practices. Through these legal instruments, countries can better coordinate efforts and respond rapidly to regional threats that transcend national borders.

Another layer of accountability involves direct community engagement, whereby public feedback and scorecards will serve as essential tools for transparency. Community-based organizations and local leaders will play a pivotal role in evaluating service delivery, alerting authorities to potential operational inefficiencies, and fostering trust among constituents. Whistleblower mechanisms will further support these efforts by allowing individuals to raise concerns regarding the mismanagement of resources, ensuring continuous improvement of outbreak response at all levels. By incorporating these interconnected accountability measures—financial transparency, outcome tracking,

regulatory compliance, and participatory feedback—the Mpox response will be better equipped to achieve its objectives and strengthen the long-term resilience of health systems throughout the continent.

Budget and Resource Mobilization (March – August 2025)

Planning and Costing Assumptions
The estimated budget is structured around a dual strategy: intensification, which prioritizes targeted, high-impact actions, and resilience/ legacy phase, which focus on integration of mpox interventions into routine and health system strengthening. This approach aims to control the mpox outbreak and leave a lasting legacy that strengthens the broader health infrastructure and enhances preparedness for future public health emergencies.

The estimates are based on a current case load of 3,200 suspected cases per week. A 50% increase in cases is expected during the first four weeks due to intensified response efforts, including enhanced community surveillance, active case finding, improved testing capacity, and the spillover effects of the ongoing conflict in eastern DRC.

Following this initial surge, case numbers are projected to plateau over the following four weeks before entering a phase of gradual decline considering the increased efforts of vaccination and IPC. The total estimated number of suspected cases for planning purposes is 65,964 over the next six months.

The projected testing coverage for suspected cases is set to reach 80%, primarily driven by the Democratic Republic of the Congo (DRC), which will double its current rate from 35% to 70% from the first four weeks reach 85% by the end of the response period. All other countries are expected to maintain full 100% testing coverage. The positive rate is anticipated to at 50% during the first 8 weeks and decline steadily to 25% as the outbreak is controlled at the end of the six-month period. The figure below illustrates the case load projection.

The following costing assumptions have been made for each 1,000 suspected cases per week:

- Testing coverage: 80% of suspected cases assuming 100% testing rate
- Testing positivity rate: 50% for 2 months and decline to 25% starting in the third month of the response
- Genomic sequencing testing rate: 8% of confirmed cases per week assuming test positivity rate mentioned above
- Percentage of cases isolated and treated in health facilities: 80% of confirmed cases (60% in treatment facilities and 20% in home-based care)
- Contact tracing: approximately 20 primary contacts per confirmed case and 200 secondary contacts per confirmed case
- Vaccination coverage: 80% vaccination coverage of all target populations in the priority countries (i.e., contacts, contacts of contacts, IDPs, frontline healthcare workers, key populations, immunocompromised individuals, prison populations, etc.) and hot spot regions. Total number of persons to be vaccinated: **6.4M.**

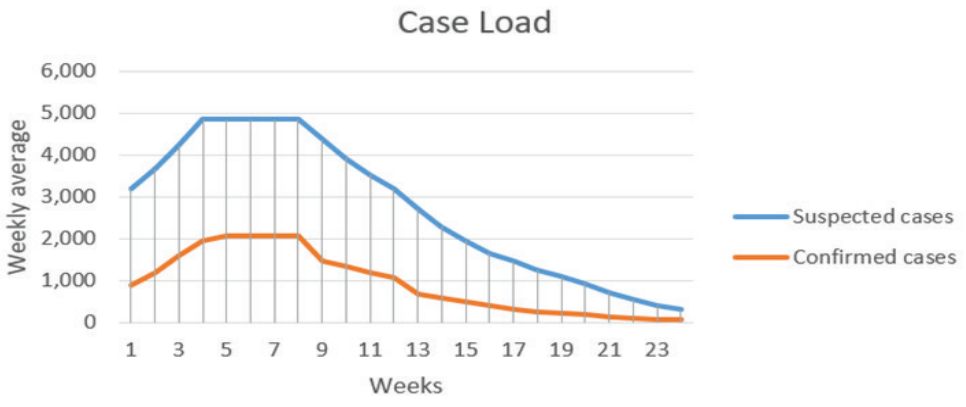

Figure 3: Case load projection

Table 3: Budget distribution per strategy and per phase

Phases	Intensification	Resilience and Legacy	Total
First 3 months	$ 274,941,421	$ 25,775,758	$ 300,717,179
Last 3 months	$ 68,735,355	$ 60,143,436	$ 128,878,791
Total	$ 343,676,776	$ 85,919,194	$ 429,595,970

Estimated Financial Needs and Funding Strategy per phase

The total estimated resource needs for the second part of the mpox response amount to USD 429,595,970. The majority of the funding (80%) is allocated to intensification activities, focused on halting the outbreak within an additional six-month period. The remaining 20% supports the resilience/legacy phase, which aims to transform mpox response investments into a catalyst for broader health system strengthening, leaving a legacy and outbreak resilience across the continent..

Allocation of Resources per Pillar

The budget allocation for the second plan totals USD 429,595,970 with the largest share directed towards vaccination and logistics (26%). This excludes vaccines, which will be provided in kind. This reflects the critical role of immunization in controlling disease spread and the logistical efforts required for vaccines and other countermeasures. Following closely, surveillance and data receives the second biggest allocation (25%), emphasizing the importance of robust active surveillance relying on community healthcare workers and data collection to track the outbreak, assess risks, and guide response strategies.

Both Risk Communication and Community Engagement (RCCE) and Infection Prevention and Control (IPC) are allocated 12% each. This highlights the need for effective public health messaging and preventive measures to limit disease transmission in healthcare and community settings. Case management (with 10%), ensures adequate medical and nutritional care for affected individuals, supporting those who require treatment and hospitalization.

Laboratory testing and sequencing receive a moderate allocation of 5%, indicating its importance while possibly reflecting reliance on existing infrastructure or prioritization of preventive strategies. Meanwhile, coordination and leadership and research each receive 4%, ensuring essential leadership and scientific advancements in response efforts. The lowest allocation is for continuity of essential services (2%), which, while crucial, is given less priority compared to direct outbreak response.

Funding Gaps and Strategies for Sustainability

From the first round of fundraising for the initial continental plan, over USD 1.1 billion was pledged, with the IMST team tracking USD 977 million through the Financial Tracking Mechanism (FTM). Based on FTM data and shifts in the funding landscape since the plan's launch, an estimated USD 196 million remains available for the second plan, leaving a funding gap of USD 224 million. Closing this gap is urgent to ensure IMST meets its objectives within the set timeframe.

Table 4: Budget breakdown per response pillar

Pillars	Amount	Allocation key
Coordination and Collaboration	$ 17,183,839	4%
RCCE	$ 51,551,516	12%
Surveillance and data	$ 107,398,993	25%
Laboratory testing and sequencing	$ 21,479,799	5%
Case Management (Medical, Nutrition & Mental Health)	$ 42,959,597	10%
Infection Prevention and Control and WASH	$ 51,551,516	12%
Vaccination and Logistics	$ 111,694,952	26%
Research	$ 17,183,839	4%
Continuity of essential services	$ 8,591,919	2%
Total	**$ 429,595,970**	**100%**

Table 5: Funding Gap analysis

Categories	Amount USD	Percentage
Overall Budget	**$ 429,595,970**	**100%**
Remaining funds from the first round	$ 196,126,678	46%
Member State Contribution	$ 9,600,000	2%
Funding Gap	$ 223,869,292	52%

Monitoring, Evaluation, and Impact Assessment

The Monitoring, Evaluation, and Impact Assessment (M&E) component of the Phase 2 Mpox Continental Response and Legacy Plan will focus on consolidating gains from Phase 1 (September 2024–February 2025) and strengthening resilience to ensure sustainability. Overall, this section aims to measure progress in preparedness, response, and legacy-building efforts across all response pillars. The approach will ensure that each country's context and risk category is considered while also maintaining a unified, continental perspective. By combining qualitative and quantitative methods, M&E activities will track the effectiveness of interventions of the pillars.

Key Performance Indicators (KPIs) for Response and Legacy Phases
To ensure a coherent measurement system across the ten pillars of the Mpox plan, an initial set of key performance indicators (KPIs) will be tracked to evaluate the functionality and impact of the response as it transitions into the legacy phase.

Data-Driven Decision-Making and Digital Surveillance
Data-driven decision-making will be central to Phase 2 of the Mpox response, with the goal of informing every stage of planning and implementation. The approach will promote real-time data sharing and coordination by building on existing digital systems such as the District Health Information Software (DHIS2), mobile applications, and electronic line-listing tools. By integrating surveillance, laboratory, vaccination, and RCCE data into unified platforms, decision-makers at both national and continental levels can more

rapidly identify hotspots or coverage gaps in testing, vaccine uptake, and community outreach. Joint data reviews, conducted periodically, will involve all relevant pillars, enabling them to cross-reference trends—such as correlating lab test positivity rates with rates of vaccine coverage or analyzing community feedback for emerging concerns.

To make digital surveillance more robust, continuous training of health workers, laboratory staff, and field epidemiologists will be conducted to build skills in data collection, management, and analysis. At the same time, user-friendly dashboards and mobile-based reporting will empower district and provincial teams to act swiftly in detecting and containing outbreaks. Predictive modeling may be introduced to forecast where outbreaks or clusters could re-emerge, thereby guiding targeted deployment of resources such as test kits, vaccine doses, or risk communication interventions. Sharing of anonymized data between Member States and regional bodies will facilitate a truly pan-African perspective, ensuring that the response remains coordinated and that lessons learned in one country are rapidly applied elsewhere.

Reporting Mechanisms and Transparency Measures

Transparent and consistent reporting will underpin the credibility and effectiveness of Phase 2 activities. Member States experiencing active mpox transmission will be expected to produce regular situation reports (SITREPs) that include data on new cases, deaths, laboratory capacity utilization, vaccine distribution, and public perception gathered through community feedback. These SITREPs will be harmonized at the continental level, enabling Africa CDC and WHO, along with key stakeholders, to maintain a real-time overview of the evolving situation. The continental IMST will provide monthly activity reports, Sitreps and progress reports. Periodic M&E bulletins will provide deeper analysis of KPI trends, highlight challenges, and document success stories or best practices suitable for replication.

In addition, robust financial tracking will enhance accountability, with partners and donors obligated to disclose disbursements and expenditures against the consolidated "One Budget." Quarterly partner roundtable meetings will allow for collaborative oversight and strategic alignment regarding resource allocation. Mid-phase review, to be conducted around May 2025, will highlight any requirement for course corrections—such as adjusting vaccination strategies or scaling up laboratory testing in certain hotspots. An end-of-phase evaluation, planned for August 2025, will then assess the overall impact of the legacy plan, examining how well Phase 2 interventions strengthened health systems, improved cross-border coordination, and laid the groundwork for durable preparedness against mpox and other epidemic threats.

AfricaCDC
Centres for Disease Control and Prevention

www.africacdc.org
africacdc

World Health Organization
African Region

www.afro.who.int
WHOAfro