PHIM PUBLIC HEALTH INSTITUTE of MALAWI

Mpox Situation Report

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Mpox Situational Report (SITREP)			
Incident Name	Mpox	**District affected**	Lilongwe
Prepared by	Public Health Institute of Malawi, Ministry of Health		
Status (activation level)	Response	**Activation date**	**16/04/2025**
Frequency of report	Weekly		

1. HIGHLIGHTS

- Three Mpox cases, all males and in the age category of 30 to 40 yrs
- No death reported so far.

2. BACKGROUND

Lilongwe District has recorded three confirmed cases of Mpox, formerly known as Monkeypox. The cases are three adult males: a 30-year-old man from Area 36, a 33-year-old man from Kawale 2 and 38 year-old man from Chilinde. The first two cases were recorded on 16th April 2025. An investigation was conducted on 17th April, 2025. The third case was reported on 18th April 2025. All the cases are stable and being managed.

3. EPIDEMIOLOGY & SURVEILLANCE

Case definition

Please refer to annex A for case definitions.

Contact tracing

The Rapid Response Team (RRT) has been deployed to conduct contact tracing for all three cases. 34 contacts have been identified so far and are under follow-up.

4. PUBLIC HEALTH ACTIONS/RESPONSE INTERVENTIONS

1. COORDINATION

- Activation of Incident Management System(IMS)
- Readiness activities as outlined below
- Developed Mpox preparedness plan
- Training of Trainers in all 29 districts and 4 Central Hospitals have been completed (297 HCWs trained)
- Orientation to 20 non-human health technical staff (Animal Health, Civic Education, Information, Tourism, Parks and Wildlife, and Disaster Management)
- Orientation of Chipatala Cha pa Foni staff on Mpox

2. SURVEILLANCE

- Deployed RRT to conduct detailed investigation and trace additional contacts

- Surveillance system enhanced at community, facilities, and PoE to monitor for any signs of Mpox
- Case definitions and reporting tools disseminated to districts.

3. **LABORATORY**

- Testing samples collected from suspected Mpox cases using PCR and sharing results with case management and surveillance teams for management
- Genomic sequencing of MPXV to identify clade and phylogenetic analysis

4. CASE MANAGEMENT

- Case management guidelines development and distributed to high risk districts
- Identified isolation facilities for the management of cases

5. WASH & IPC

- Developed training materials
- Developed Mpox Infection Prevention and Control(IPC) Standard Operating Procedures
- IPC orientation in high-risk districts

6. RISK COMMUNICATION, COMMUNITY ENGAGEMENT & SOCIAL MOBILISATION

- Translated messages into Tumbuka, Swahili and English(posters, leaflets, factsheets, scripts for jingles: designer working on draft materials)
- Oriented staff members from Chipatala Cha pa Foni
- Developed messages for PoEs and are also being translated
- Recording in progress for audio messages for the IVR platform of Chipatala Cha pa Foni

7. LOGISTICS

- Distributed essential medicine and PPEs (from non-commercial stock) to districts
- Set up treatment unit at Kamuzu Central Hospital

5. CHALLENGES/GAPS

- District coordination structures (PHEMC) not yet oriented on Mpox
- Limited funds to roll out district-based training
- Contact tracing is proving a challenge as clients are not disclosing more information
- Inadequate laboratory supplies (reagents and viral transport media) and IPC supplies

6. RECOMMENDATIONS & PRIORITY FOLLOW UP ACTIONS

- Continue mobilization of resources
- Conduct districts cascade training of HCWs
- Orient coordination structures
- Engage other key stakeholders e.g. for KPs to be part of contact tracing team
- Continue screening of Mpox on new entrants at Dzaleka refugee camp
- Fast-track ordering of laboaratoryreagents

7. CONCLUSIONS

Mpox is a communicable disease that can spread very fast if preventive measures are not followed. However, by following preventive measures the disease can be controlled. PHIM will keepupdating the public of Mpox situation in the country..

Acknowledgment

The Ministry of Health acknowledges efforts made by all districts and health facilities in surveillance activities.

For more information, support, and feedback, please contact the following

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Annex A

Case definition

Suspected case

a) A person who is a contact of a probable or confirmed mpox case in the 21 days before the onset of signs or symptoms, and who presents with any of the following: acute onset of fever (>38.5°C), headache, myalgia (muscle pain/body aches), back pain, profound weakness, or fatigue.

OR

b) A person presenting with an unexplained acute skin rash, mucosal lesions or lymphadenopathy (swollen lymph nodes). The skin rash may include single or multiple lesions in the ano-genital region or elsewhere on the body. Mucosal lesions may include single or multiple oral, conjunctival, urethral, penile, vaginal, or anorectal lesions. Ano-rectal lesions can also manifest as ano-rectal inflammation (proctitis), pain and/or bleeding.

AND

for which the following common causes of acute rash or skin lesions do not fully explain the clinical picture: varicella zoster, herpes zoster, measles, herpes simplex, bacterial skin infections, disseminated gonococcus infection, primary or secondary syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale,

molluscum contagiosum, allergic reaction (e.g., to plants); and any other locally relevant common causes of papular or vesicular rash.

N.B. It is not necessary to obtain negative laboratory results for listed common causes of rash illness in order to classify a case as suspected. Further, if suspicion of mpox or MPXV infection is high due to either history and/or clinical presentation or possible exposure to a case, the identification of an alternate pathogen which causes rash illness should not preclude testing for MPXV, as co-infections have been identified.

Probable case

A person presenting with an unexplained acute skin rash, mucosal lesions or lymphadenopathy (swollen lymph nodes). The skin rash may include single or multiple lesions in the ano-genital region or elsewhere on the body. Mucosal lesions may include single or multiple oral, conjunctival, urethral, penile, vaginal, or anorectal lesions. Ano-rectal lesions can also manifest as ano-rectal inflammation (proctitis), pain and/or bleeding.

AND

One or more of the following:

• has an epidemiological link to a probable or confirmed case of mpox in the 21 days before symptom onset

• has had multiple and/or casual sexual partners in the 21 days before symptom onset

• has a positive test result for orthopoxviral infection (e.g., OPXV-specific PCR without MPXV-specific PCR or sequencing)

Confirmed case

A person with laboratory confirmed Mpox virus (MPXV) infection by detection of unique sequences of viral DNA by real-time polymerase chain reaction (PCR)[c] and/or sequencing.

A contact

A person who has been exposed to an infected person during the infection period i.e., the period beginning with the onset of the index case's first symptoms and ending when all scabs have fallen off, and who has one or more of the following exposures with a probable or confirmed case of mpox:

- direct skin-to-skin and skin-to-mucosal physical contact (such as touching, hugging, kissing, intimate or sexual contact)
- contact with contaminated materials such as clothing or bedding, including material dislodged from bedding or surfaces during handling of laundry or cleaning of contaminated rooms
- prolonged face-to-face respiratory exposure in close proximity
- respiratory exposure (i.e., possible inhalation of) or eye mucosal exposure to lesion material (e.g., scabs/crusts) from an infected person

- the above also apply for health workers potentially exposed in the absence of proper use of appropriate personal protective equipment (PPE)

Mpox death for surveillance purposes

A death in a probable or confirmed mpox case unless the alternative cause of death is trauma.

In the endemic setting where access to laboratory confirmation of mpox is limited, this definition includes deaths among persons with suspected (clinically compatible) mpox, which are to be considered suspected mpox deaths.

The diagnosis for mpox can also be confirmed after the death has occurred if there is sufficient lesion material to perform PCR testing. There should be no period of complete recovery between the illness and death for the death to be recorded as a mpox death.