PHIM PUBLIC HEALTH INSTITUTE of MALAWI

Mpox Situation Report

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Mpox Situational Report (SITREP)			
Incident Name	Mpox	**District affected**	Lilongwe, Mangochi and Ntcheu
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

- **Two new cases** recorded since 20th May 2025 - when the last situation report was released.
- Twelve (12) cumulative Mpox cases, 11 males and 1 Female and in the age range of to 2 to 41 years
- Six (6) discharged from care, six (6) in isolation.
- One hundred sixty-eight (168) contacts identified
- No death reported

2. BACKGROUND

Lilongwe, Mangochi and Ntcheu districts collectively recorded a total of twelve (12) confirmed cases (Lilongwe - 10, Mangochi -1 and Ntcheu -1) of Mpox, formerly known as Monkeypox. Eleven of the cases are males and one female in the age range of 2 to 41 years.

Five cases from Lilongwe and one from Mangochi district have recovered and been discharged from clinical care. Meanwhile, the remaining six cases are under clinical care—five on home isolation and one being managed at Kamuzu Central Hospital. Since August 2024, a total of 183 samples from suspected cases have been tested. Since the onset of the outbreak, no Mpox-related deaths have been reported.

Mpox is a disease caused by a virus, and it can spread from animals to humans and between humans. It presents with symptoms such as fever, rash, and swollen lymph nodes. The virus spreads through respiratory droplets, direct contact with skin lesions or bodily fluids, and contaminated surfaces and materials. People at higher risk of infection include children, pregnant women, immunocompromised individuals, and people with multiple sexual partners. While there is no specific treatment, supportive care can alleviate symptoms and prevent complications.

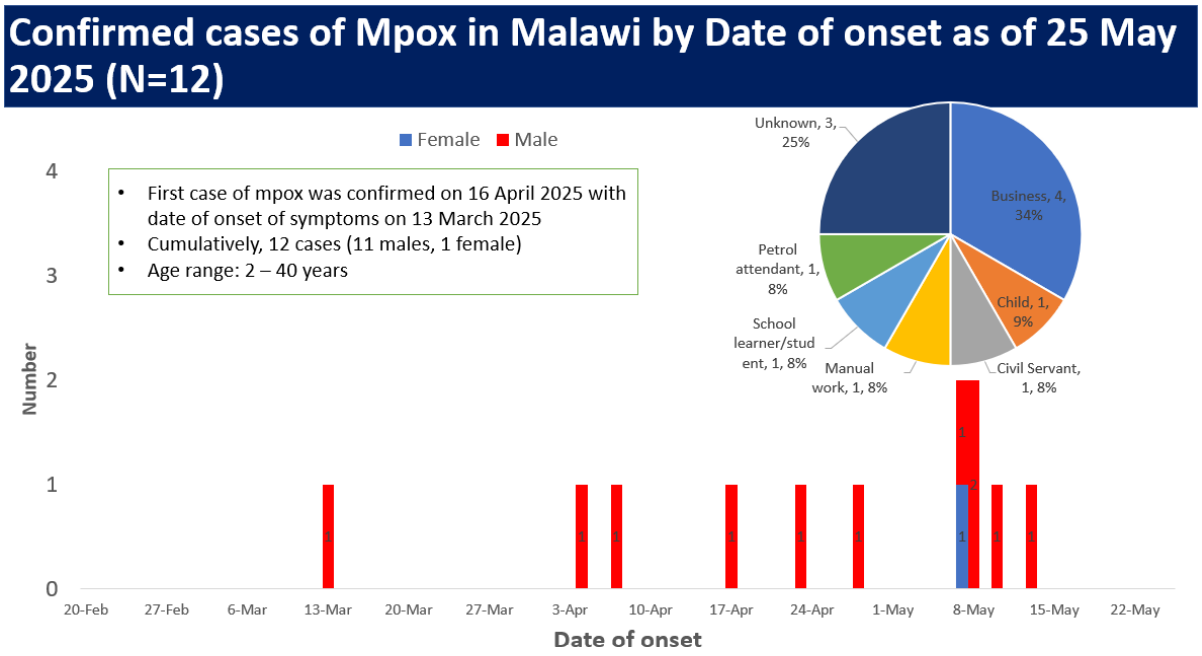
3. EPIDEMIOLOGY & SURVEILLANCE

Case definition

Please refer to annex A for case definitions.

Number of Mpox Cases registered

A total of twelve Mpox cases with 168 contacts have been recorded since the outbreak was declared on April 17, 2025 in Malawi. The graph below displays the number of Mpox cases recorded.



Contact tracing and follow up

The Rapid Response Team (RRT) in the affected districts have traced a total of 168 contacts (11 in Mangochi, 131 in Lilongwe and 26 in Ntcheu). All these contacts are being followed up on daily basis by health care workers up to 21 days after the last day of contact with a confirmed case. As of 25 May 2025, 126 contacts have completed their 21-days monitoring period without displaying any signs or symptoms related to Mpox and have been released from follow-up while 42 are still being monitored. It should be noted that one of the contacts tested positive for mpox.

4. PUBLIC HEALTH ACTIONS/RESPONSE INTERVENTIONS

Pillar	Action/Interventions
COORDINATION	• Activation of Incident Management System (IMS) • Developed Mpox Incident Action Plan (IAP) including costed activities • 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 Conducted cascaded training for healthcare workers and other cadres on mpox down to the health facility level in Chitipa and Karonga districts.
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 • Daily follow-up of contacts

	• Line listing of suspected cases • Case definitions and reporting tools disseminated to districts.
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
CASE MANAGEMENT	• Case management guidelines development and distributed to high-risk districts • Identified isolation facilities for the management of cases
WASH & IPC	• Developed training materials • Developed Mpox Infection Prevention and Control (IPC) guidelines • IPC orientation in high-risk districts • Adapted WHO rapid IPC/WASH assessment checklist • Virtually oriented high risk districts IPC focal persons • Constructed temporary latrines and bathing shelters at the holding areas for suspected Mpox cases at KCH • Hold weekly pillar meetings with IPC focal persons from high risk districts
RISK COMMUNICATION, COMMUNITY ENGAGEMENT & SOCIAL MOBILISATION	• Messages are available in local languages like Chichewa, Tumbuka. Translated into Swahili and English (posters, social media posters, leaflets, factsheets, audios, audio visuals. • Dissemination of print, audio and audio visual materials • Oriented staff members from Chipatala Cha Pa Foni • Developed messages for PoEs • Audio messages for the Interactive Voice Response (IVR) platform of Chipatala Cha Pa Foni recorded and are live on the platform. • Recorded programs on ZBS, MBC , Mibawa TV, Mudzi wathu and Farm Radio • U-Report poll conducted to gain community perceptions and insights
LOGISTICS	• Distributed essential medicine and PPEs (from non-commercial stock) to districts • Set up treatment unit at Kamuzu Central Hospital
VACCINATION	• PMRA has approved the use of MVA-BN vaccine in the M-pox outbreak, this follows the MAITAG recommendation to use MVA-BN in Malawi (considering the M-pox epidemiology). • Country vaccine request-under draft. • Roadmap developed. • Budget and implementation plan drafted. • Review of training materials in progress. • Reviewed EPI manual to incorporate M-pox.
POE	• Intensified surveillance (screening) of travelers at all Points of Entry • Continued Mpox awareness among travelers

- Mpox/PHEICs screening orientation conducted to Points of Entry staff

5. CHALLENGES/GAPS

- District coordination structures (PHEMC) not yet oriented on Mpox in most districts except for Chitipa and Karonga
- Contact tracing is proving a challenge as clients are not disclosing more information
- Inadequate laboratory supplies (reagents and viral transport media) and IPC supplies
- Low global stockpiles of M-pox vaccines

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 teams
- Continue screening of Mpox on new entrants at Dzaleka refugee camp
- Fast-track ordering of laboratory reagents

7. CONCLUSIONS

Mpox is a communicable disease that can spread very fast if preventive measures are not followed. However, the disease can be prevented by following preventive measures such as refraining from close contact with individuals who have Mpox, not sharing bedding, clothing, or towels with sick people and washing hands frequently with soap and water or an alcohol-based hand sanitizer among others. PHIM will keep on updating 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.