PHIM PUBLIC HEALTH INSTITUTE of MALAWI

Mpox Situation Report

Published on 08th July, 2025

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

- **Five new cases** recorded since 01st July 2025 - when the last situation report was released.
- Forty-seven (47) cumulative Mpox confirmed cases: 31 males and 16 Females in the age range of 2 to 57 years
- Thirty-three (33) discharged from care, twelve (12) in isolation and two (2) lost-to-follow up.
- Five hundred forty-five (545) contacts identified
- No death reported

2. BACKGROUND

Malawi has recorded a total of forty-seven (47) confirmed cases (Lilongwe - 38, Mangochi -2, Salima -2, Ntcheu -1, Likoma -1, Nkhatabay -1 and Blantyre -2) of Mpox, formerly known as Monkeypox. Thirty-one of the cases are males while sixteen are females. The cases are in the age range of 2 to 57 years.

Thirty-three (33) cases (26 - Lilongwe, 2 each from Salima and Mangochi, 1 each from Ntcheu, Likoma and Blantyre districts) have recovered and been discharged from clinical care. Two (2) cases under Lilongwe district have been classified as lost-to-follow up after proving difficult to trace. Meanwhile, the remaining twelve (12) cases are under clinical care—one under hospital isolation in Lilongwe, while eleven are under home isolation: Lilongwe -9, Nkhatabay -1, and Blantyre -1.

Since August 2024, a total of 264 samples from suspected cases have been tested, and no Mpox-related death has 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 forty-seven Mpox cases have been recorded since the outbreak was declared on 17 April 2025 in Malawi. The graph below displays the number of Mpox cases recorded, along with an inset detailing the distribution of confirmed cases by occupation.

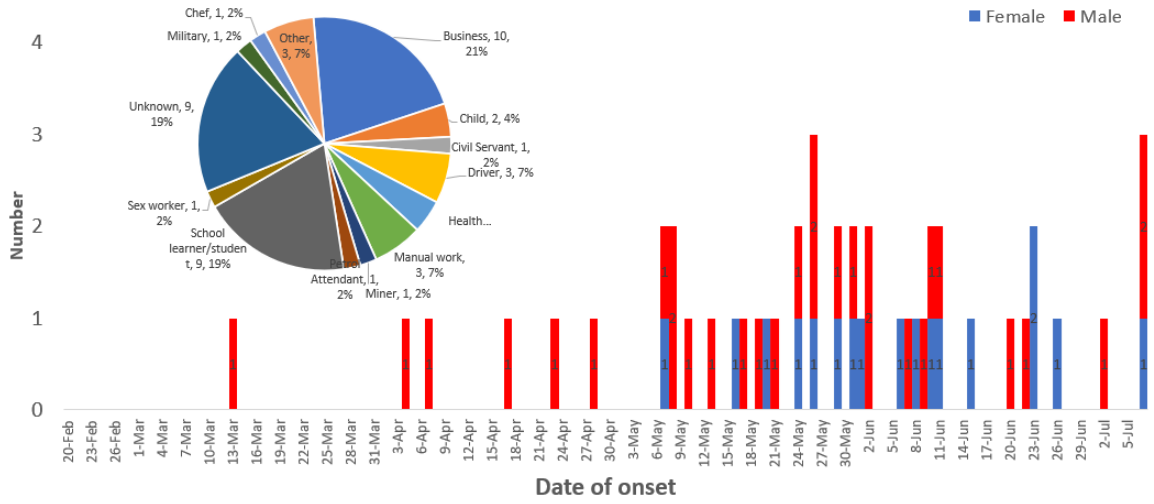

Figure 1: Confirmed cases of Mpox in Malawi by date of onset as of 7th July 2025

Distribution of Mpox cases (suspects including confirmed)

Twenty-eight (28) out of the twenty-nine (29) districts have reported at least one Mpox suspect. Cumulatively, 265 suspects and 47 confirmed cases have been registered across districts. The Maps below shows districts that have reported Mpox cases so far.

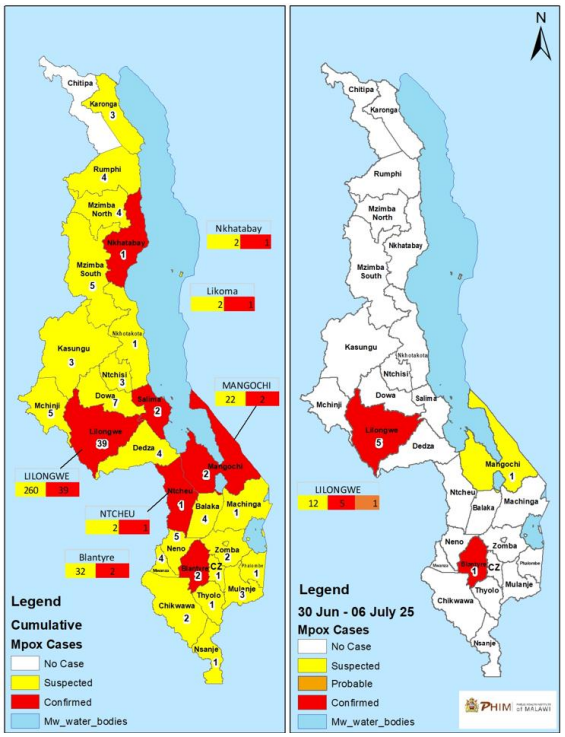

Figure 2: Distribution of Mpox cases in Malawi

Contact tracing and follow up

The Rapid Response Team (RRT) in the affected districts have traced a total of 545 contacts. 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 7th July 2025, 482 contacts have completed their 21-days monitoring period without displaying any signs or symptoms related to Mpox and have been discharged from follow-up, while 63 (Lilongwe - 10, Mangochi - 3 and Blantyre - 50) are still being monitored. It should be noted that five of the total 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 ten districts. • Trained district PHEMCs on Mpox and cluster coordination
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. • Supportive supervision on EBS, including Mpox active case search done in some districts (Lilongwe, Blantyre, Chikwawa, Nsanje, Kasungu, Ntchisi, Mangochi, Ntcheu, Mzimba south and Rumphi)
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 • Training of lab personnel on sample collection and testing • Establishment of Molecular lab in Mzuzu Central Hospital • Distribution of viral transport media (VTM) to all districts
CASE MANAGEMENT	• Case management guidelines development and distributed to high-risk districts • Identified isolation facilities for the management of cases • Some health workers have been trained on case management • Developed protocols for home-based care for mild cases • Developed standardized tools for case reporting

	• Established good coordination with other pillars like surveillance, Laboratory and RCCE
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 • Oriented some IPC/WAS focal persons on IPC/WAS checklist for rapid assessment on home based care • Trained 40 health Workers (technical) from LL DHO, KCH and MoH on IPC/WASH measures for M-pox – integrated with Case management - supported by Africa CDC
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 • Community engagements conducted in affected areas especially Lilongwe with support from UNICEF • Storming of busy trading centres • Van publicity loud hailing
LOGISTICS	• Distributed essential medicine and PPEs (from non-commercial stock) to districts • Set up treatment unit at Kamuzu Central Hospital and Bwaila 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- justification on need to have the vaccine in Malawi and budget are under development. • 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
- Distributed IEC materials in POEs

5. CHALLENGES/GAPS

- Contact tracing is proving a challenge as clients are not disclosing more information
- Movement of suspected cases before release of laboratory results
- Suboptimal active case search in health facilities
- Incomplete data capturing in registers proves difficult to trace the possible missed cases identified through active case search
- 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
- Conduct surveillance data reviews
- 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
- Conduct rapid IPC/WASH assessment in the remaining health facilities including private clinics
- Support for strengthening implementation of home based IPC/WASH measures

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.