PHIM PUBLIC HEALTH INSTITUTE of MALAWI

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WEEKLY IDSR EPIDEMIOLOGICAL BULLETIN

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Epidemiological Week 4 (19 – 25 January 2026)

This epidemiological bulletin aims to inform all stakeholders at local authorities, district, national, and global levels about disease trends, public health surveillance, disease outbreaks, and emergencies in Malawi. In this issue (Volume 1, Issue 4 of 2026), we present the following updates:

- Key highlights on events of public health significance in Epidemiological (Epi) week 4
- Performance of Integrated Disease Surveillance and Response (IDSR)
- Reported Event-Based Surveillance (EBS) signals
- Reported Diseases/Conditions of Public Health Importance
- Ongoing outbreaks and emergencies in Malawi

1. Key Highlights on Events of Public Health Significance in Epi-week 4, 2026

- IDSR reporting was 97.6% for completeness and 94.6% for timeliness on the One Health Surveillance Platform (OHSP).
- Eighteen (18) EBS signals reported
- Zero (0) new confirmed Mpox cases and seven (7) Mpox alerts.
- Other alerts generated were Malaria cases (51,408 including 8 deaths), Severe Acute Respiratory Infections (SARI) (83 cases, including 1 death), Diarrhoea with blood (1,279 cases), Adverse Events Following Immunization (AEFI) (103 cases), Typhoid fever (36 cases), Acute flaccid paralysis (AFP) (6 cases), Maternal Deaths (7), Meningococcal Meningitis (3 cases), Rabies (2 cases including 1 death), and Measles (78 Cases), as shown in Figure 1.

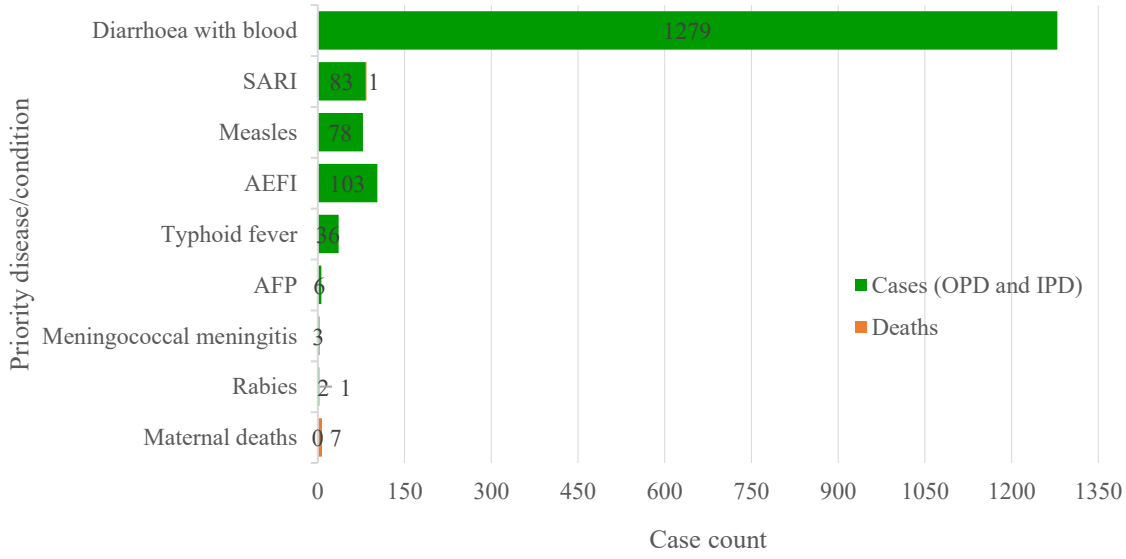

Figure 1. Notifiable diseases/conditions alerts reported in Epi-week 4 in Malawi (Data accessed on 30th January 2026).

2. Performance of the Integrated Disease Surveillance and Response

2. Timeliness and Completeness

2.1.1 Reporting rate at the National level up to Epi-week 4

During Epi-week 4, the completeness of reporting slightly increased from 96.9% in Epi-week 3 to 97.6 %, while timeliness remained at 94.6% (see Figure 2).

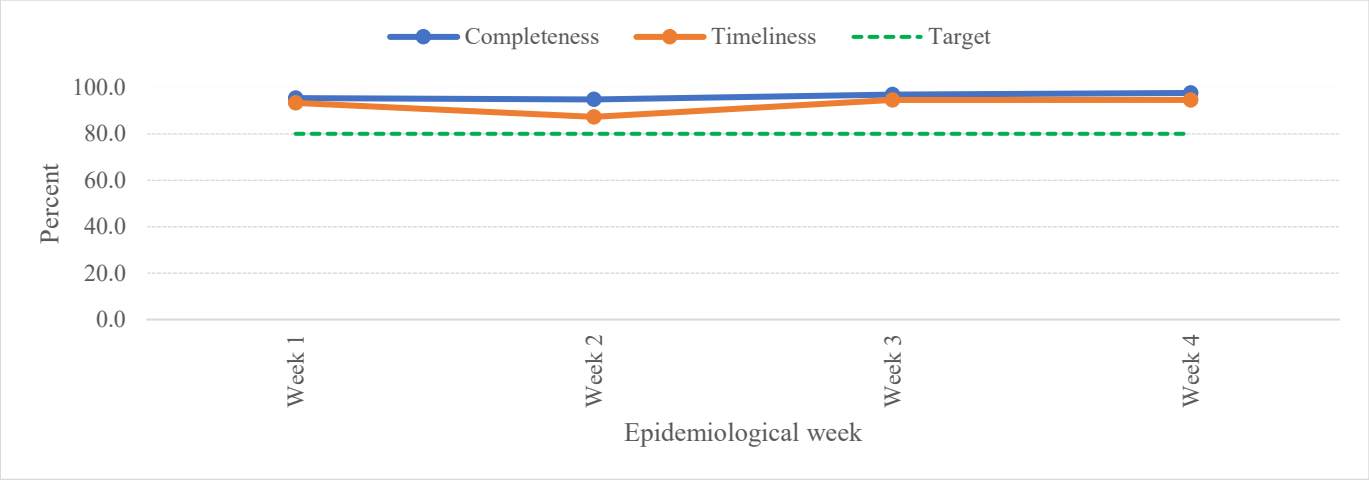

Figure 2. Trend of national IDSR weekly reporting rates in Malawi, Epi-week 4, 2026 (Data accessed on 30 January 2026).

2.1.2. Reporting rates at the Zonal level up to Epi-week 4

Figure 3 illustrates the reporting rates across various health zones in Week 4. All health zones and central hospitals managed to meet the minimum target of 80% for both completeness and timeliness (see Figure 3).

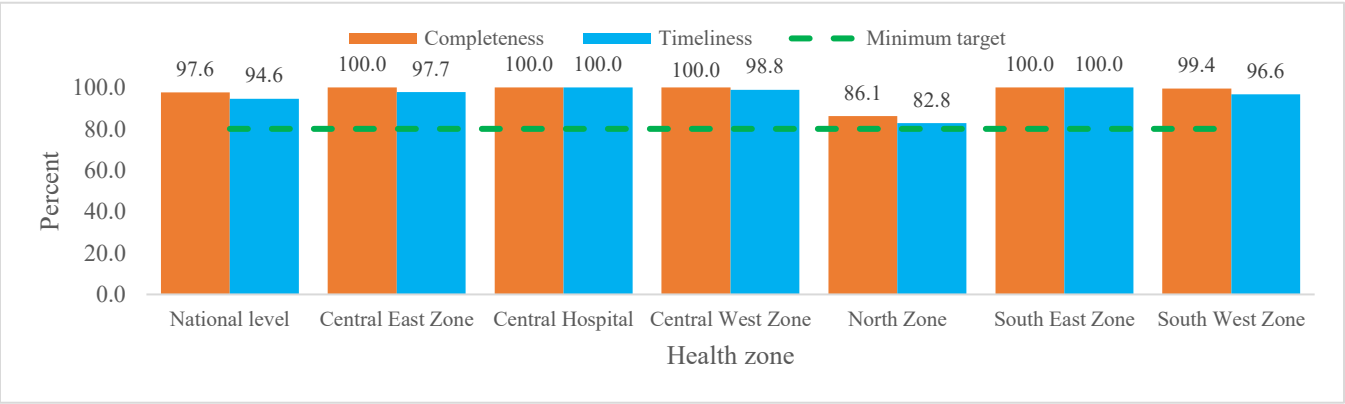

Figure 3. Reporting rates of IDSR weekly reports by zones, Epi-week 4 (Data accessed on 30 January, 2026).

2.1.3. Reporting rates at the District level for Epi-week 4

Among the 33 reporting sites (District and Central Hospitals), 30 (90.9%) met the national target of ≥80% for both completeness and timeliness, two (Karonga and Machinga) failed in timeliness (74.0% and 77.0%, respectively), while Mzimba North failed in both completeness (38.0%) and timeliness (38.0%) (see Figure 4).

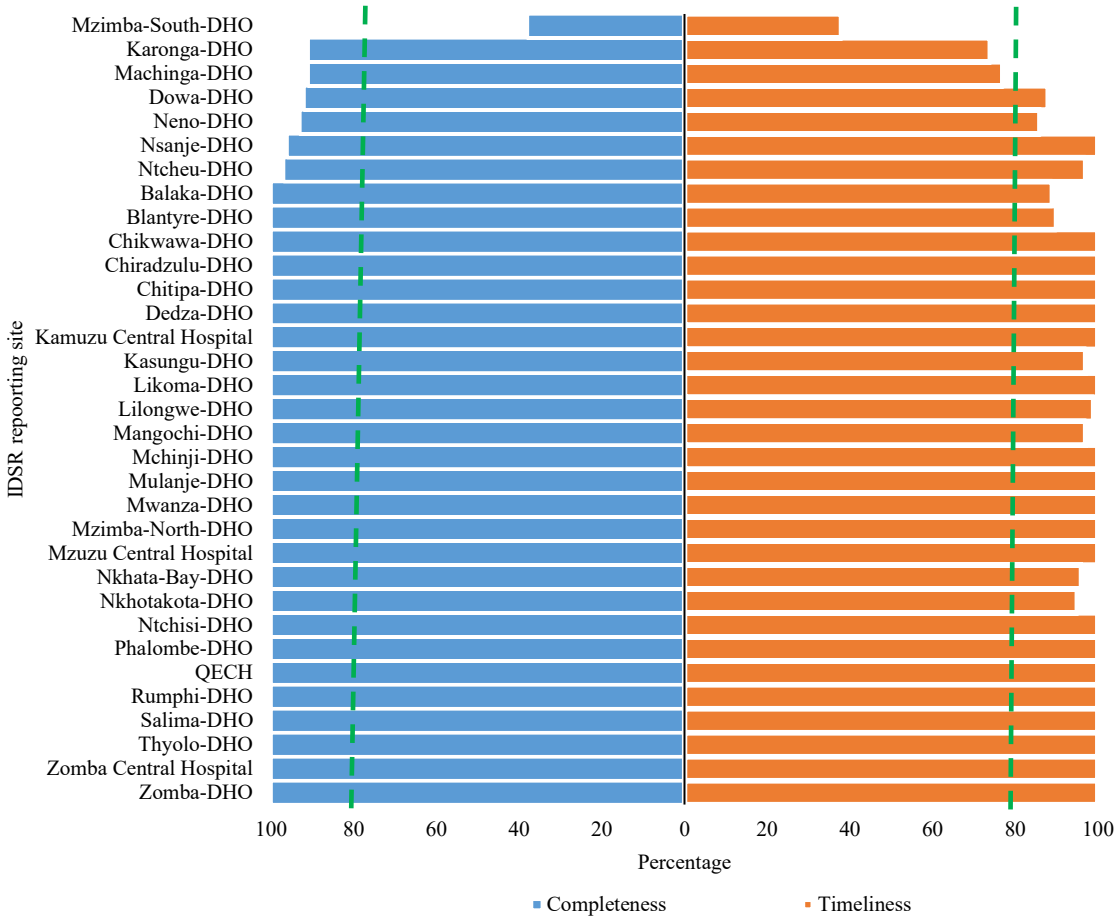

Figure 4. Reporting rates (completeness and timeliness) by reporting sites for Epi-week 4 (Data accessed on 30 January 2026).

3. Event-Based Surveillance (EBS)

3.1 Community EBS signals reported in Epi-week 4.

Figure 5 presents the list of signals that were reported in Epi-week 4. In total, 18 signals were reported in Epi-week 4 from 8 districts. Thirteen (72.0%) of the signals were verified as events, while the remaining were neither verified nor discarded.

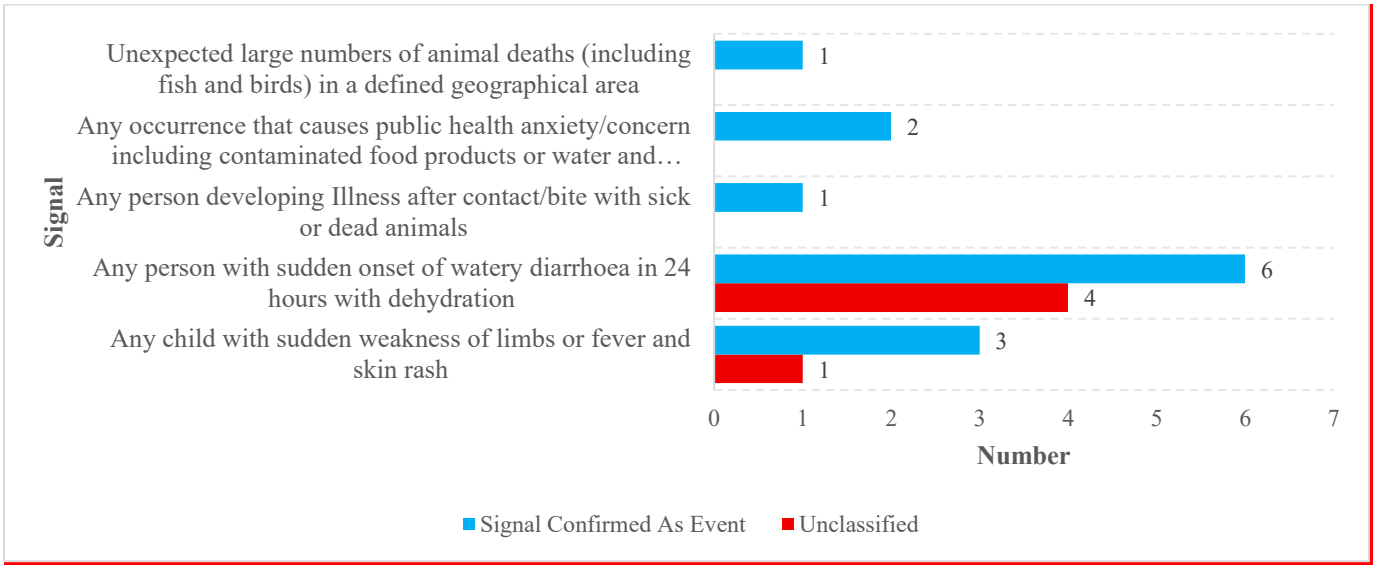

Figure 5: Event-based signals reported in Epi-week 4 (Data accessed on 30 January 2026).

3.2 Risk Assessment Level of the Community Signals

Risk assessments were conducted for all thirteen (13) events, while the other five (5) signals were not assessed as they were neither discarded nor verified as events. One (1) event was classified as high risk, while three (3) as very low risk, as shown in Figure 6

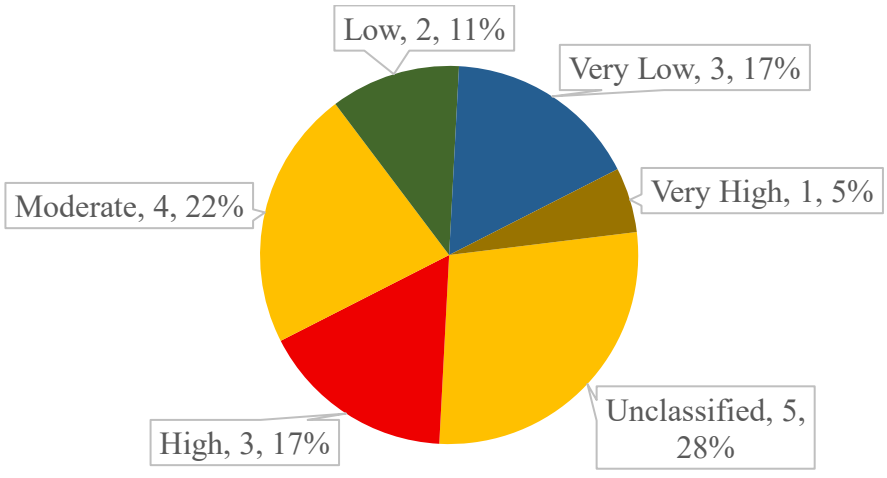

Figure 6: Distribution of EBS signals reported in Epi-week 4 (Data accessed on 30 January 2026).

4. Diseases/Conditions of Public Health Importance in Epi-week 4

Table 1 highlights the alerts related to diseases and public health conditions during Epi-week 4. Apart from malaria, diarrhea with blood accounted for the second highest number of alerts (1,279 cases) and Lilongwe DHO contributed the highest (162 cases), (see Annex 3 for further details).

Table 1. Reported alerts of diseases/conditions of public health importance in Malawi, Epi-week 4.

	Suspected cases	**Deaths**
EPIDEMIC PRONE DISEASES		
Diarrhea with blood	1,279	0
Meningococcal Meningitis	9	0
Typhoid Fever	36	0
SARI	83	1
Cholera	56	0
Mpox	7	0
DISEASES TARGETED FOR ERADICATION/ELIMINATION		
Measles	78	0
Acute Flaccid Paralysis	6	0
Neonatal tetanus	0	0
CONDITIONS OF PUBLIC HEALTH IMPORTANCE		
Food-borne illnesses	0	0
Maternal death	0	7
Yellow fever	0	0
Rabies	2	1

5. Ongoing outbreaks and emergencies in Malawi as of 25 January 2026.

5.1. Mpox

Malawi is responding to an Mpox outbreak confirmed on 17 April 2025. The country has recorded a total of 147 confirmed cases: Lilongwe (117), Blantyre (3), Mangochi (3), Salima (3), Ntcheu (9), Nkhatabay (1), Mzimba South (4), Ntchisi (1), Karonga (4), Zomba (1), and Likoma (1). In addition, four (4) cross-border cases were reported—one each in Likoma, Chitipa, Ntcheu, and Karonga districts. Of the total cases, 81 (55.1%) are male and 66 are female, with ages ranging from 2 to 75 years.

So far, 147 patients have recovered and been discharged from clinical care: 117 from Lilongwe, 8 from Ntcheu, 4 from Mzimba South, 3 each from Blantyre, Mangochi, Salima, and Karonga, and 1 each from Nkhatabay, Ntchisi, and Zomba. Among these, five cases from Lilongwe were classified as lost to follow-up after proving difficult to trace. Currently, zero (0) case remain under clinical care. One Mpox-related death has been reported, corresponding to a case fatality rate (CFR) of 0.68%.

Below is the distribution of mpox cases by sex and age-group (Figure 7), and an epi-curve of the confirmed cases by week of onset (Figure 8). Further details are in Annex 4.

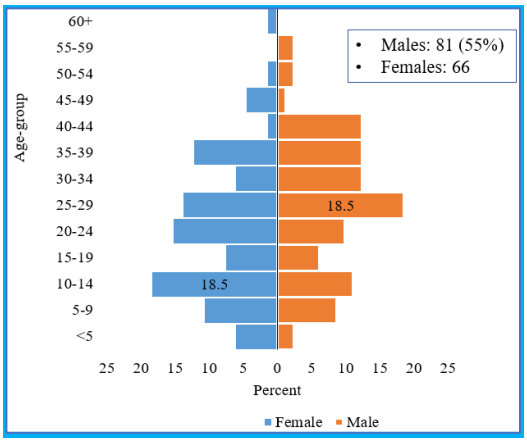

Figure 7. Mpox cases by sex and age-group as of 11 January 2026

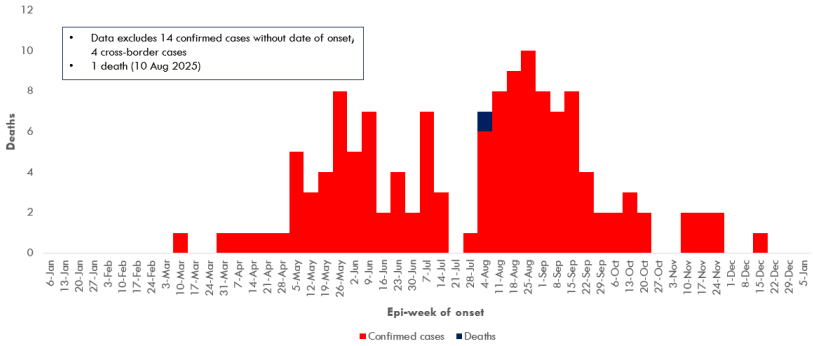

Figure 8. Mpox cases by week of onset as of 11 January 2026

6. On-going interventions

Coordination

- Activated the Incident Management System (IMS).
- Developed the Mpox Incident Action Plan (IAP), including costed activities.
- Training of Surveillance and Laboratory staff on Mpox
- Completed Training of Trainers across all 29 districts and 4 Central Hospitals (297 HCWs trained).
- Conducted cascaded training for healthcare workers and other cadres on Mpox down to the health facility level in ten (10) districts and four (4) central hospitals
- Cascade training of health workers in some border districts – Chitipa, Karonga, Nsanje, Chikwawa, Mwanza, Mangochi, Mzimba North – including Blantyre, Li-longwe, Dowa, and Central hospitals.
- Trained district PHEMCs on Mpox and cluster coordination
- Oriented 20 non-human health technical staff (Animal Health, Civic Education, In-formation, Tour- ism, Parks and Wildlife, and Disaster Management)
- Provided orientation on Mpox to *Chipatala Cha Pa Foni* staff.

Surveillance

- Deployed the Rapid Response Team (RRT) to conduct detailed investigations and trace additional contacts.
- Enhanced the surveillance system at community levels, healthcare facilities, and Points of Entry (PoE) to monitor Mpox cases.
- Conducting daily follow-ups with contacts.
- Maintaining a line list of suspected cases.
- Disseminated case definitions and reporting tools to districts.
- Supportive supervision on EBS, including mpox active case search in some districts (Lilongwe, Blantyre, Chikwawa, Nsanje, Kasungu, Mangochi, Rumphi, Mzimba South, Ntchisi, Ntcheu, Nkhatabay, Chiradzulu, and Salima).
- Trained surveillance officers in surveillance data management

Laboratory

- Collecting and testing samples from suspected Mpox cases using PCR, with results shared with case management and surveillance teams.
- Conducting genomic sequencing of MPXV to determine clade and phylogenetic analysis.
- Competency assessment training
- Trained laboratory officers in sample collection, packaging and management
- Establishment of Molecular lab in Mzuzu Central Hospital
- Distribution of viral transport media (VTM) to all districts
- Provided capacity to all health facilities (district and central hospitals) across the country to be testing Mpox using the GeneXpert platform

Case management

- Developed and distributed case management and community-based guidelines to all districts.
- Identified isolation facilities for managing cases.
- Case management
- Trained health workers on Mpox 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 and Mpox Infection Prevention and Control (IPC) guidelines
- Adapted the WHO rapid IPC/WASH assessment checklist
- Reviewed and updated national IPC/WASH guidelines
- Developed home-based Mpox IPC guidelines integrated with case management
- Oriented IPC focal persons from high-risk districts virtually
- Constructed temporary latrines and bathing shelters at holding areas for suspected Mpox cases at KCH
- Trained 40 technical health workers from LL DHO, KCH, and MoH on IPC/WASH measures, integrated with the case management pillar
- Developed posters on the 3-bucket mopping system and surface disinfection in Mpox settings
- Supported the setup and zoning of isolation units in affected districts
- Adapted the Mpox IPC checklist for schools

Risk Communication and Community Engagement

- Developed, translated, and disseminated Mpox communication materials in local languages
- Distributed tailored information materials at major Points of Entry (PoEs)
- Produced and aired Mpox programs on national and community media platforms
- Delivered audio messages through the Interactive Voice Response (IVR) platform of *Chipatala Cha Pa Foni* and oriented its staff members
- Sent over 2.7 million SMS messages via Airtel and TNM to expand public awareness
- Conducted U-Report polls and Rapid Qualitative Assessments (RQAs) to capture community perceptions and insights (UNICEF)
- Engaged communities in affected districts, particularly Lilongwe, through meetings,

sensitization on vaccination, and mobile van loud-hailing in busy trading centres (WHO and UNICEF)
- Held regional media engagement meetings across Central, Southern, and Northern regions
- Built RCCE capacity among community health workers, social service workforce, school-based stakeholders, traditional and faith leaders, and key populations (e.g., female sex workers, transport groups, PLHIV leaders) with UNICEF support
- Delivered expert health talks in schools within Lilongwe district

Logistics

- Distributed essential medicines and Personal Protective Equipment (PPE) (from non-commercial stock) to districts.
- Set up a treatment unit at Kamuzu Central Hospital.

Vaccination

- Developed a vaccination roadmap.
- Drafted the budget and implementation plan.
- Reviewed training materials, and the EPI manual to incorporate Mpox
- Integrated Mpox vaccination guidance into measles vaccination protocols.
- Secured approval from the Malawi Immunisation Technical Working Group (MAITAG) for the Mpox vaccine (MVA-BN) to be used in Malawi.
- Trained health workers to administer mpox vaccine
- Received 33,600 doses of the MVA-BN vaccine, and in the process of administering to the target groups in 12 districts
- Conducted training of trainers and district-level trainings on vaccine distribution.
- Vaccinated the at-risk group with 33,605 doses: 17,467 (52%) females and 16,138 (48%) males

Points of entry (PoE)

- Intensified surveillance and screening of travellers at all Points of Entry (PoEs)
- Coordinated with mobile network providers to disseminate Mpox messages (TNM has pushed messages to its customers; Airtel is yet to provide the service)
- Continued Mpox awareness campaigns targeting travellers
- Conducted Mpox/PHEICs screening orientations for PoE staff
- Distributed IEC materials at Points of Entry
- Strengthened cross-border Mpox surveillance and coordination with neighbouring countries
- Delivered and displayed Mpox banners at Bakili Muluzi International Airport (BMIA)

Challenges & gaps

- Shortages in laboratory supplies (reagents and viral transport media) and IPC materials.
- Power blackouts affecting running of laboratory samples
- Lack of integration between LMIS and OHSP weakens data flow and coordination

4.2 Measles Outbreak

Since January 2025, districts have been reporting measles alerts. Laboratory results have confirmed localized outbreaks in the following districts: Balaka, Blantyre, Dedza, Dowa, Lilongwe, Machinga, Mangochi, Neno, Nkhotakota, Nsanje, Ntcheu, and Salima. Sporadic measles cases continue to be reported in other districts outside these outbreak areas. In addition to routine activities, targeted measles-rubella vaccination campaigns have been conducted in some districts experiencing outbreaks. Figure 9 illustrates the trend of suspected measles alerts reported from districts since January 2025.

4.2.1 On-going interventions

- Case management
- Active case search
- Sample collection and laboratory analysis
- Intensification of routine immunisation
- Supportive supervision
- Community engagement and mobilisation

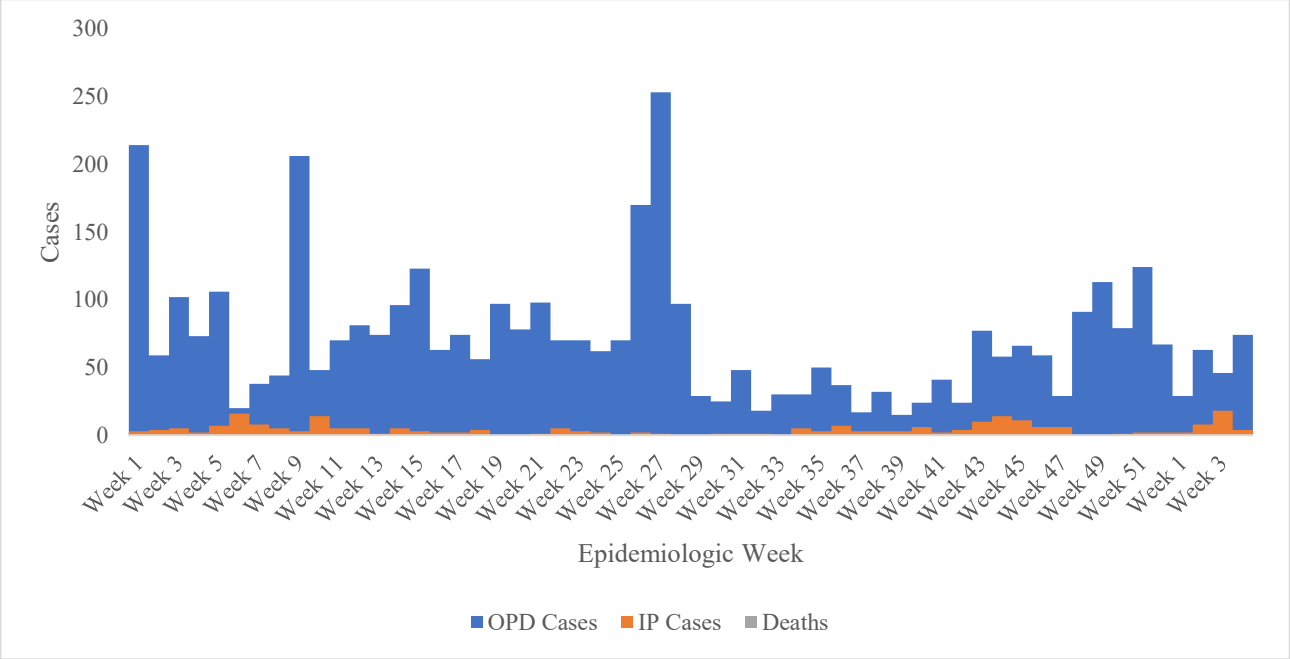

Figure 9. Measles disease alerts by epi-week of report in Malawi, January 2025 – January 2026.Source OHSP

5.3. Cholera Outbreak

Malawi is currently responding to a cholera outbreak that was declared 28 December 2025. Cumulatively, 42 cholera cases, including 2 deaths (CFR: 4.8%), have been reported. Malawi has also reported 41 imported cases through Mwanza (37), Ntcheu (2), and Chikwawa (2). As of Epi-week 4, Lilongwe had reported 2 cases, Balaka (1), Chitipa (1), Mzimba North (1), Neno (3), Kasungu (5), Blantyre (24),

Karonga (1), Dowa (1), Chikwawa (1), Chiradzulu (1), and Mulanje (1). Currently, three districts (Lilongwe, Chikwawa, Chiradzulu and Blantyre) are still reporting cases. Fifty-two (52%) of the cases are male. The epidemiological situation is as described below.

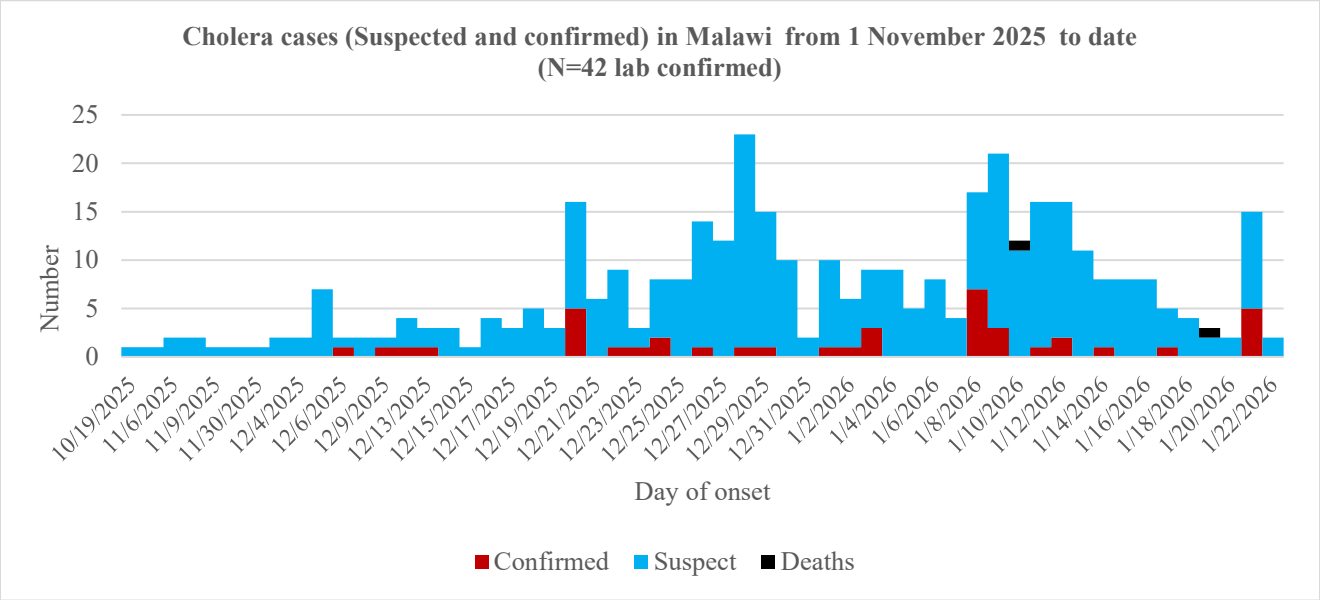

Figure 10. Weekly Trend of Confirmed Cholera Cases and Deaths, Malawi 2025-26

The most affected age group among males in the confirmed cholera cases is 25–29 years (27.3%), while among females it is 5-9, 20-24, and 35-39 years (47.4%).

5.3.1. On-going interventions

Coordination

- National Public Health Emergency Operations Centre activated for response and Incident Management Team (IMT) in place.
- IMT and Public Health Emergency Management (PHEMC) meetings over the last 2 weeks including updates from districts
- Conducted supportive supervision to Blantyre and Neno
- The cholera preparedness and response plan in place
- Engaging partners to mobilize resources for cholera response

Surveillance and Laboratory

- Production of the daily and weekly cholera situation reports
- Line-listing of cholera cases
- Support contact tracing and monitoring of confirmed cholera cases
- Mentorship of district surveillance teams on cholera case definitions and reporting
- Conduct cholera data verification with reporting sites through phone calls
- Support affected districts with fuel for supportive supervision and mentorship
- Conduct media scanning for cholera case detection

- Sample collection, transportation, and testing

Case management

- Quantified case management needs - Shared with IM
- Conducted a death audit on a Cholera Death that occurred on the 08th January 2026 in Blantyre.
- Tents erected and designated as Cholera Treatment Units (CTUs) in affected districts
- Patient triage, isolation, and referral systems established and functional
- Essential supplies for treating patients ensured, including:
    - Oral Rehydration Salts (ORS)
    - Intravenous (IV) fluids
    - Antibiotics

Infection Prevention and Control (IPC)

- IPC pillar coordination meetings with IPC focal persons
- Consolidation of IPC needs for the priority districts is underway
- Conducted Cholera IPC supervision in Blantyre.
- Conducting final validation of Cholera SoPs

Water, Sanitation and Hygiene (WASH)

- Distributed WASH supplies (Chlorine, water guard, buckets, handwashing facilities, soap, water testing kits) in Lilongwe, Blantyre, Nsanje, Chikwawa, Mwanza, Kasungu
- Supported sanitation and hygiene promotion activities in Mwanza, Neno, Kasungu, Chikwawa
- Mapping of WASH partners to support coordination at council level, including supportive supervision
- Mobilising of essential WASH supplies such as Chlorine, water guard, Soap, handwashing buckets. So far identified about 3 million sachets to be distributed based on requests from Kasungu, Dowa, Blantyre, Salima, Nkhotakota and Lilongwe.
- Provision of water supply and sanitation facilities were available in CTCs

Risk Communication and Community Engagement (RCCE)

- Disseminated key cholera messages to the media
- Trained 40 health workers in RCCE in Lilongwe and Dzaleka refugee camp
- Development Communications Trusts engaged by UNICEF conducted health promotion activities in affected districts
- Continued sharing of the National Cholera cases daily updates dashboard
- Printed 4,000 cholera leaflets and posters recently (UNICEF) and distributed
- 9,500 posters and 21,000 Tithetse Cholera leaflets/stickers being distributed in affected districts.
- Community engagement meetings continuing in the affected districts
- Community radios phone in programs e.g. Kasungu

Operations Support and Logistics (OSL)

- Conducted distribution of Cholera supplies mainly PPEs (donations sourced through Health Sector Joint Fund)-
    - all South districts and QECH Hospital. Zomba Central and Zomba Mental supplies to deployed Monday
    - Nkhotakota- left at Benga, Salima, Kasungu

POE/Cross border Surveillance

- Supported the Mwanza-Zobue cross-border engagement and monitoring the outbreak situation in Lisinje-Zobue, Mozambique through updates from Mozambique.
- National level joint cross-border virtual meeting for key actions to address the outbreak
- Mapping of uncharted routes along the border line: Mwanza, Dedza

Gaps

- Depletion of drug budgets in some districts
- Funding gaps to support the cholera response
- Poor WASH status in some hotspot areas in cholera affected districts
- Flooding complicating WASH status
- Reluctance of communities to use chlorinated water from chlorine dispensers due to myths and misconceptions

Recommendations

- Mobilise resources from partners and treasury
- Lobby with treasury for resources to support provision of safe water through kiosks in high-risk peri-urban areas in the cities
- Continued supply of WASH supplies
- Continued Risk Communication and Community Engagement
- Training and mentorship of healthcare workers on cholera prevention and control

Annex 1: Timeliness and completeness of IDSR reports by districts, from Epi-week 4, 2026

District/Central Hospital	Completeness				Timeliness			
	W1	W2	W3	W4	W1	W2	W3	W4
National	**95**	**95**	**97**	**98**	**93**	**87**	**95**	**95**
Balaka	99	94	78	100	91	94	72	89
Blantyre	81	100	100	100	76	88	98	90
Chikwawa	81	97	94	100	78	91	84	100
Chiradzulu	100	100	100	100	100	100	100	100
Chitipa	100	100	100	100	100	100	100	100
Dedza	100	100	100	100	100	100	100	100
Dowa	96	92	96	92	92	88	96	88
Kamuzu CH	100	100	100	100	100	0	100	100
Karonga	91	100	100	91	87	87	100	74
Kasungu	97	100	100	100	97	97	100	97
Likoma	100	100	100	100	100	100	100	100
Lilongwe	98	99	100	100	96	87	100	99
Machinga	91	100	95	91	68	86	95	77
Mangochi	52	98	100	100	50	66	100	98
Mchinji	100	100	100	100	100	100	100	100
Mulanje	100	100	100	100	96	100	100	100
Mwanza	100	100	80	100	100	100	80	100
Mzimba-North	100	100	100	100	93	93	100	100
Mzimba-South	88	32	100	38	97	24	50	38
Mzuzu CH	100	100	100	100	100	100	100	100
Neno	100	100	80	93	100	100	80	87
Nkhata-Bay	100	100	93	100	96	96	93	96
Nkhotakota	83	91	91	100	83	74	91	96
Nsanje	100	100	96	100	100	96	96	100
Ntcheu	100	100	100	97	100	82	97	97
Ntchisi	100	100	100	100	100	94	100	100
Phalombe	100	100	100	100	100	94	100	100
QECH	100	100	100	100	100	0	100	100
Rumphi	100	72	100	100	100	72	100	100
Salima	100	100	100	100	96	100	100	100
Thyolo	100	100	100	100	100	100	100	100
Zomba CH	100	100	100	100	100	100	100	100
Zomba	100	91	95	100	100	84	93	100

Annex 2: Distribution of EBS signals per reporting unit in Epi-week 4

District of Residence	Any child with sudden weakness of limbs or fever and skin rash	Any occurrence that causes public health anxiety/concern including contaminated food products or water and environmental hazard	Any person developing Illness after contact/bite with sick or dead animals	Any person with sudden onset of watery diarrhoea in 24 hours with dehydration	Unexpected large numbers of animal deaths (including fish and birds) in a defined geographical area	Grand Total
Mchinji	1	2	0	1	1	**5**
Lilongwe	0	0	0	1	0	**1**
Dowa	0	0	0	2	0	**2**
Thyolo	1	0	1	0	0	**2**
Mzimba	0	0	0	1	0	**1**
Kasungu	0	0	0	1	0	**1**
Nsanje	1	0	0	0	0	**1**
Nkhata Bay	1	0	0	4	0	**5**
Grand Total	**4**	**2**	**1**	**10**	**1**	**18**

Annex 3. Priority diseases/conditions/events, including alerts under surveillance, Epi-week 4

Facility	OPD AEFI cases	OPD AFP cases	IP AFP cases	OPD cholera cases	IP cholera cases	OPD-Diarrhoea with Blood (Bacterial)	IPD- Diarrhoea with Blood (Bacterial)	OPD Malaria Cases	IP Malaria Cases	IP Death Malaria Cases	IP Maternal death cases	OPD measles cases	IP measles cases	IP meningococcal meningitis cases	IP rabies cases	IP rabies deaths	IP SARI cases	IP SARI deaths	OPD typhoid fever cases	IP typhoid fever cases
Kasungu-DHO	6	0	0	0	0	71	0	2676	19	0	0	1	0	1	0	0	0	0	0	0
Nkhotakota-DHO	0	0	0	0	0	13	0	1555	20	1	1	0	0	0	0	0	11	0	0	0
Ntchisi-DHO	0	0	0	0	0	8	0	395	0	0	0	0	0	0	0	0	3	0	0	0
Salima-DHO	0	0	0	0	0	90	0	1611	44	1	0	0	0	0	0	0	0	0	0	0
Dowa-DHO	0	0	0	0	0	26	0	589	15	0	0	0	0	0	0	0	17	0	0	0
Kamuzu CH	0	0	1	0	0	0	1	15	18	2	1	0	3	0	0	0	33	1	0	1
Mzuzu CH	0	0	0	0	0	6	0	16	1	0	0	0	0	0	0	0	0	0	0	0
QECH	1	1	0	4	0	0	0	3	8	0	3	0	0	0	0	0	0	0	0	0
Zomba CH	0	0	0	0	0	0	0	8	17	0	0	0	0	0	0	0	0	0	1	0
Dedza-DHO	0	0	0	0	0	79	0	2270	26	0	0	0	0	0	0	0	0	0	0	0
Lilongwe-DHO	1	0	0	2	1	162	0	4238	49	3	0	2	0	0	0	0	0	0	5	1
Ntcheu-DHO	1	0	0	0	0	32	0	1456	9	0	0	0	0	0	0	0	0	0	0	0
Mchinji-DHO	0	0	0	0	0	22	0	1611	44	1	0	0	0	0	0	0	0	0	0	1
Chitipa-DHO	0	0	0	0	0	24	1	951	14	0	0	0	0	0	0	0	0	0	0	0
Karonga-DHO	1	0	0	0	0	71	1	1411	14	0	1	0	0	0	0	0	0	0	0	0
Likoma-DHO	0	0	0	0	0	9	0	243	3	0	0	0	0	0	0	0	0	0	0	0
Mzimba-North-DHO	51	0	0	0	0	45	0	810	10	0	0	0	0	0	0	0	0	0	0	0
Mzimba-South-DHO	0	0	0	0	0	37	1	787	19	0	0	0	0	6	0	0	0	0	0	0
Nkhata-Bay-DHO	1	0	0	0	0	24	0	1485	1	0	0	0	0	0	1	0	0	0	0	0
Rumphi-DHO	24	0	1	0	0	21	0	927	7	0	0	1	0	0	0	0	1	0	0	0
Balaka-DHO	1	0	0	0	0	30	0	785	33	0	0	31	1	0	0	0	0	0	0	0
Machinga-DHO	1	0	0	0	0	25	0	1699	0	0	0	35	0	0	0	0	0	0	0	0
Mangochi-DHO	1	0	0	0	1	128	0	2673	17	0	0	0	0	0	0	0	0	0	2	0
Mulanje-DHO	0	0	0	10	0	33	0	5065	27	0	1	1	0	0	0	0	1	0	13	1
Phalombe-DHO	0	0	1	0	0	23	0	1091	17	0	0	0	0	0	0	0	0	0	0	0
Zomba-DHO	2	0	0	0	0	77	0	1207	9	0	0	0	0	0	0	0	0	0	1	0
Blantyre-DHO	2	0	0	2	12	93	2	2799	1	0	0	0	0	0	0	0	0	0	5	0
Chikwawa-DHO	1	1	0	0	8	43	0	3574	12	0	0	1	0	0	0	0	0	0	0	0
Chiradzulu-DHO	2	1	0	0	3	8	0	464	0	0	0	1	0	0	0	0	0	0	0	0
Mwanza-DHO	0	0	0	0	12	3	0	3990	25	0	0	0	0	0	0	0	0	0	0	0
Neno-DHO	2	0	0	1	0	29	0	1018	2	0	0	0	0	0	0	0	1	0	0	0
Nsanje-DHO	5	0	0	0	0	26	0	1880	33	0	0	1	0	2	0	0	0	0	0	0
Thyolo-DHO	0	0	0	0	0	15	0	1579	13	0	0	0	0	0	1	1	16	0	3	2
Total	**103**	**3**	**3**	**19**	**37**	**1273**	**6**	**50881**	**527**	**8**	**7**	**74**	**4**	**9**	**2**	**1**	**83**	**1**	**30**	**6**

Annex 4: Mpox outbreak in Malawi, 2025

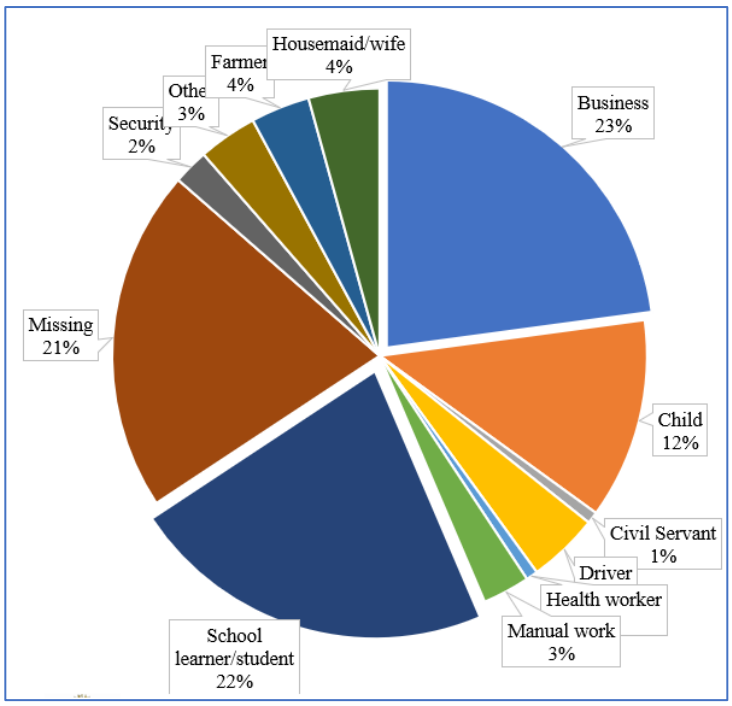

Figure 11. Distribution of confirmed mpox cases by occupation (N=147, including 3 Probable case), 2025-2026. (Source: Mpox outbreak Line list).

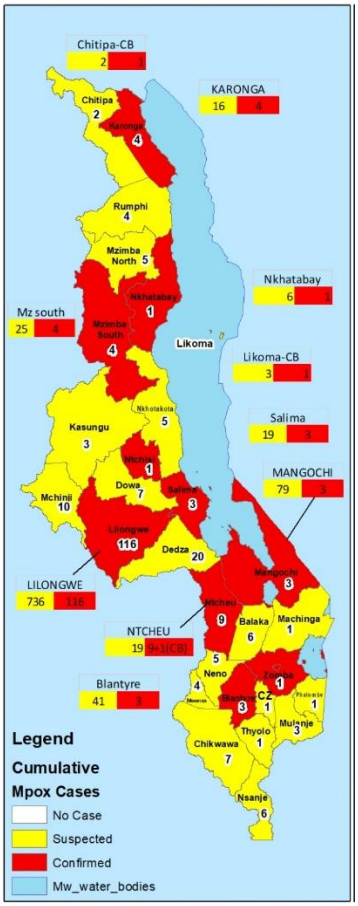

Figure 12. Cumulatively, 1,107 suspects and 147 Confirmed cases, 3 probable cases.

Immediate recommendations

- **IDSR Coordinators and Zonal Epidemiology Officers** should ensure timely verification and validation of data as soon as health facility focal persons or data clerks enter information into OHSP.
- **Balaka DHO, Karonga DHO, Mzimba South DHO, and Machinga DHO** should improve on the timeliness of reporting.
- **All districts** should improve on EBS signal detection and reporting
- **District Rapid Response Teams (DRRTs)** should conduct risk assessments for all verified signals (events) without delay.
- **Reproductive Health Department** should investigate maternal deaths

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