



**General Country Information:**

The Republic of Malawi is located in south-eastern Africa, and borders Mozambique, Tanzania and Zambia. Malawi is divided into three regions (Northern, Central and Southern) which are further subdivided into 28 districts. Lilongwe is the capital since 1971, however the major commercial centre and largest city is Blantyre.

In 1891, under the control of the British Government, Malawi was called Nyasaland Protectorate. The first half of the 20<sup>th</sup> century was marked by several attempts to obtain independence, but it was only in July 1964 that Malawi became a fully independent member of the British Commonwealth. It became a Republic two years later.

Malawi's economy mainly relies on its agriculture and represents 80% of all exports. Its three most important crops are tobacco, tea and sugar. Economic development and trade suffer from factors such as inadequate and deteriorating roads, poor electricity, water and telecommunications infrastructure. Malawi must import all its fuel products and transport costs are high. Malawi's Human Development Index is 160 over 182.

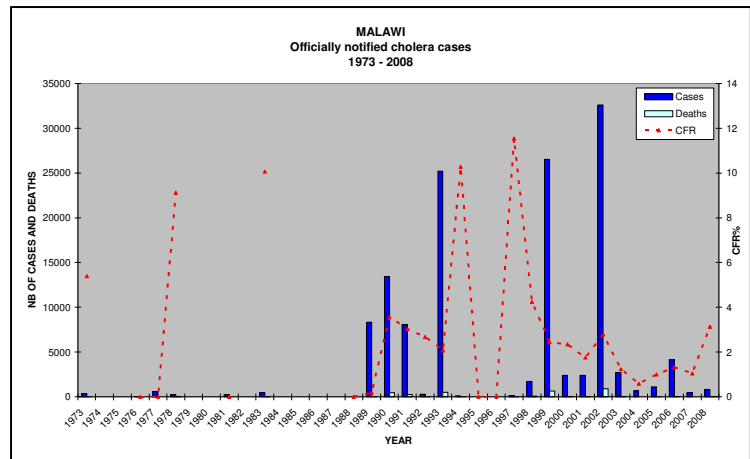
The child mortality is 120/1000. The prevalence for HIV is 12.5% and an estimated 700'000 children became orphans when their parents died of AIDS. Malawi has repeatedly been affected by famines since 2002 like other Southern Africa countries. It also faces poor access to medical treatment and insufficient school education.

**Cholera Background History:**

The first reported cholera cases occurred in 1973 during the pandemic wave that hit most Eastern African countries.

In 1989/1990, Malawi faced its first major outbreak with 21 808 cases and 497 deaths. (Case Fatality Rate 2.3%). This was followed by another large outbreak in 1993, recording 25 193 cases and 524 deaths (CFR 2%). The outbreak started at the end of December 1992 in the Central region (Lilongwe, Ntcheu and Dedza) and further spread to the Southern region.

In 1999, the outbreak recorded 26 508 cases with 648 deaths (CFR 2.4%), however precise time and geographical spread are not available.



Malawi encounters cholera outbreaks from September/October to April/May each year, which corresponds to the rainy season.

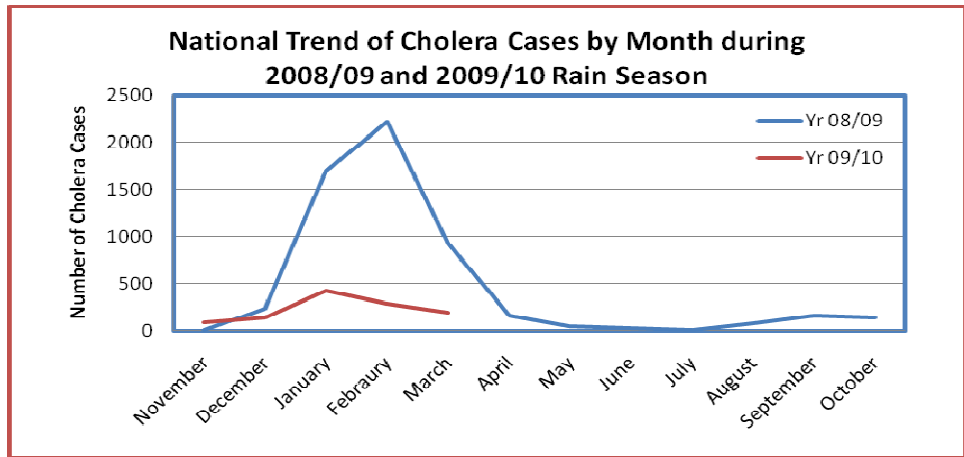
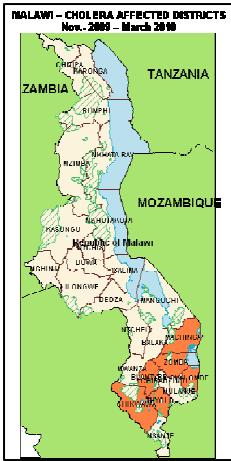
From October 2001 until April 2002 (rainy season), Malawi recorded its worst outbreak with 33 150 cases and 981 deaths (CFR 2.96%). The epidemic reached its highest peak between week 5 and 11, affecting 26 districts out of 28. The southern region was the worst affected with 69% of reported cases. Although the overall CFR was 2.96%, in some districts, the CFR was as high as 6.7%, indicating the possibility of inadequate case management and/or shortage of supplies. A review of the epidemic response showed that refresher training for health staff was not conducted this time unlike in previous years.

In 2005/2006, Malawi reported 4 805 cases. In 2006/2007, 262 cases were reported with the outbreak starting in October 2006 and ending in May 2007.

On 7 November 2007, a cholera outbreak started in the southern region (Nsanje and Mulanje districts). As of 13 April 2008, 1022 cases and 20 deaths were reported (CFR 2.0%) in 6 districts of the southern region (Mulanje, Balaka, Blantyre, Chikwawa, Thyolo, Nsanje) and in 2 districts of the central region (Ntcheu, Nkhotakota). The majority of cases (45%) were reported in Nsanje district.

From November 2008 to April 2009, 5'198 cases (incl. 113 deaths, CFR 2.2%) were registered throughout the country in 23 districts (out of 28) with the majority of cases being reported in Lilongwe (central region) and Chikwawa (southern region).

Between November 2009 and March 2010, 1'160 cases occurred mostly in the southern region (Zomba, Machinga, Chikwawa, Phalombe, Blantyre and Thyolo districts). (see map)



**WHO Support Actions:**

- 1994-1997: Malawi was part of the Southern African Initiative for cholera control and strengthening of Epidemic Diarrhoeal Diseases preparedness and response. This included training of trainers for surveillance and case management as well as laboratory support.
- 2001/2002: Response coordination with MoH and UNICEF, set-up of CTCs, chlorination of water supplies and hygiene education

**Demographic and Socio-Economic Data:**

<b>Geography</b>	Total surface Capital Provinces Official Language	118'480km2 (20% is water, Lake Malawi ) Lilongwe (pop. Lilongwe: 400'000, pop. Blantyre: 646'235 in 2003 ) 3 regions (Northern, Central and Southern) , 28 districts English, Chichewa
<b>Environment</b>	Climate Rainy season Floods and droughts Desertification Natural resources	Sub-tropical rainy season (November to May); dry season (May to November) Floods in Dec. 2002 and March 2005, drought in Sept. 2004 Deforestation, land degradation, water pollution from agricultural runoff, sewage, industrial wastes Limestone, arable land, hydropower, unexploited deposits of uranium, coal, and bauxite
<b>Demographics</b>	Population Religions Ethnic groups Migrants	13,571,000 (annual population growth rate: 2.38%, 2007) Christian 79.9%, Muslim 12.8%, other 3%, none 4.3% (1998) Chewa, Nyanja, Tumbuka, Yao, Lomwe, Sena, Tonga, Ngoni, Ngonde, Asian, European 4'175 refugees and 6'451 asylum seekers (Jan. 2009)
<b>Economy</b>	Industry Farming	Tobacco, tea, sugar, sawmill products, cement, consumer goods Tobacco, sugarcane, cotton, tea, corn, potatoes, cassava (tapioca), sorghum, pulses, groundnuts, Macadamia nuts; cattle, goats
<b>Health Indicators</b>	Per capita total expenditure of health (int. \$) Life expectancy birth (yrs) Child mortality (per 1000)	70\$ (2006) Males: 49                      Females: 51 (2006) 120 (2006) 266 physicians
<b>Communicable Diseases</b>	<i>Food or waterborne diseases:</i> bacterial and protozoal diarrhea, hepatitis A, and typhoid fever <i>Vectorborne diseases:</i> malaria and plague are high risks in some locations <i>Water contact disease:</i> schistosomiasis (2007) HIV prevalence (2005): 12.5%	
<b>Risk Factors for Cholera</b>	Population with access to improved water source Population with access to proper sanitation facilities	76% (2006) 60% (2006)

Sources for Document: WHO, UNHCR, UNDP