

General Country Information:

The Republic of Mozambique is located in south-eastern Africa and borders Tanzania, Malawi, Zambia, Zimbabwe, Swaziland and South Africa with an east coast along the Indian Ocean. Its capital and largest city is Maputo. Beira, in Sofala province, is the second largest town. Mozambique is a former Portuguese colony and became independent in 1975.

Civil war and economic collapse characterized the first decade of Mozambican independence. It is now a multi-party republic ruled by a president and a prime minister. Mozambique is divided into 10 provinces which are subdivided into 129 districts. The majority of its 18 million people live in rural areas with an urban population of only 29%.

Its economy is based on agriculture products (such as sugar, cashews, oil-bearing seeds and tea) and industry products (such as cement, cigarettes and alcoholic beverages). Mozambique is vulnerable to climatic hazards such as floods, droughts and cyclones. Malaria is the first cause of mortality among children and the tuberculosis rate is 138 per 100' 000 (2002), ranking 11th on the high-burden Tuberculosis countries.

Cholera Background History:

Since 1973, cholera has always been present in Mozambique. During the years 1992, 1993, 1998, 1999 and 2004 notified cholera cases from Mozambique represented between one third and one fifth of all African cases. Beira, a port city in the Sofala province, has been affected by cholera outbreaks since early 90s.

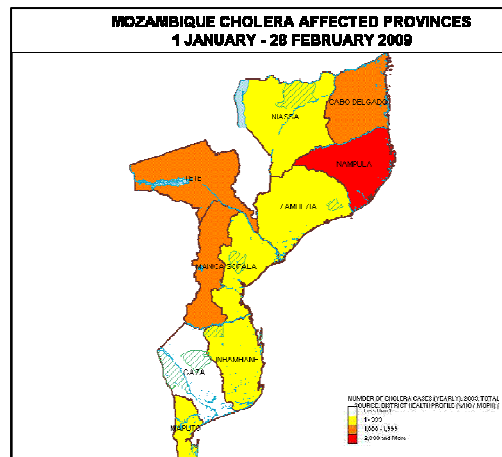
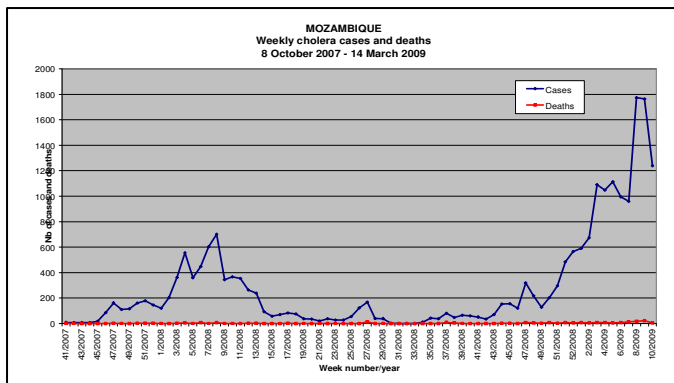
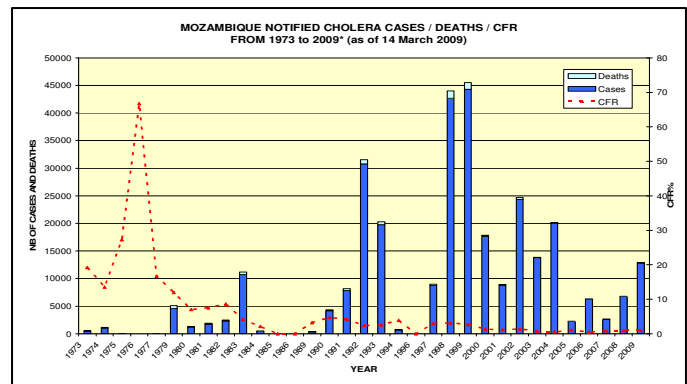
In 1998 a cholera outbreak in Mozambique, which started in Beira City, reported 42 672 cases and 1353 deaths with a Case Fatality Rate (CFR) of 3.2%. The already poor sanitary conditions in Beira had deteriorated following a storm that affected the central region of the country.

In 1999, an outbreak occurred in Tete Province, with 4725 registered cases and 148 deaths (CFR 3.1%). In late September a resurgence occurred in the Macanga district of the same province.

In 2004, the Ministry of Health reported a total of 9391 cases and 61 deaths from 20 December 2003 to 16 February 2004 in 6 provinces. Maputo City was the most affected area, reporting 65% of all cases. Typically, the number of cases started to decrease only with the diminishment of the rain falls.

Since October 2007, cholera cases have been reported in the country each week except during 3 weeks in August 2008. (see graph 3)

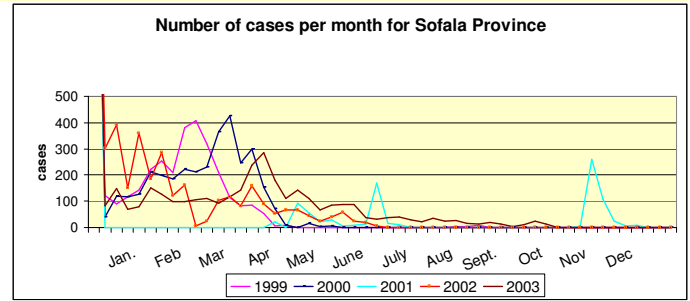
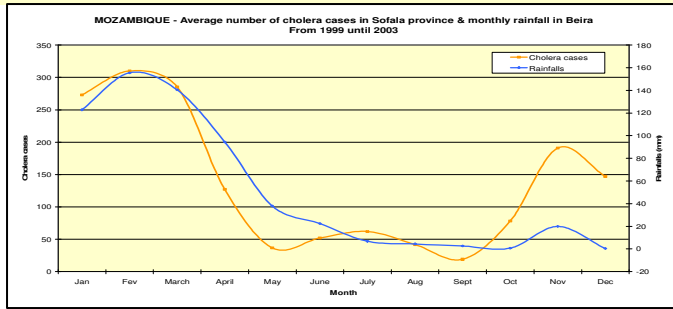
Since January 2009, 12'819 cases including 119 deaths are being reported out of 9 provinces and Maputo City. The two most affected provinces are Cabo Delgado (2'345 cases including 35 deaths) and Nampula (2'137 cases including 7 deaths).





Seasonality of cholera:

Cholera epidemics mainly occur during the period from December to May/June, therefore coinciding with the rainy season. (see graphs 2 & 3 for Sofala province)



Cholera Vaccine Use:

In 2003, the Ministry of Health decided to engage in the first demonstration project using oral cholera vaccines in Beira City which involved with the different partners, such as WHO, IVI and MSF/Epicentre.

References:

- [1] Effectiveness of Mass Oral Cholera Vaccination in Beira, Mozambique, N England J Med 2005 Feb 24; 352(8):757-67
- [2] Feasibility of a mass vaccination campaign using a two-dose oral cholera vaccine in an urban cholera-endemic setting in Mozambique

WHO Support Actions:

- **2009:** MoH is leading the response with WHO and UNICEF support in the areas of health and water and sanitation. MoH and WHO continue to carry-out refresher training of Provincial Rapid Response Teams (RRT) and have conducted trainings on cholera outbreak investigation and management for a total of 189 technicians trained in Manica, Zambezia, Tete, Nampula, Cabo Delgado, Sofala and Niassa Provinces. WHO in collaboration with MoH and partners continue to map resources of cholera affected districts. Portuguese version of the manual “cholera outbreak: assessing the outbreak response and improving preparedness”, leaflets on “first steps in the management of an outbreak of acute watery diarrhea disease” continue to be made available to MoH, provinces and NGOs.
- **1993-1997:** Southern African Initiative, WHO project on preparedness and response to cholera and other epidemic diarrhoeal diseases in Southern Africa
- **2002:** Consultancy for the support of food safety (exportation of seafood)
- **February 2002:** WHO/Mozambique Assessment mission of the outbreak response
- **June 2003:** WHO/HQ Assessment mission of the outbreak response
- **November-December 2003:** WHO/HQ Water and sanitation mission
- **February 2004:** AFRO/Cholera Epidemic Response
- **2003-2004:** First demonstration project using oral cholera vaccines in Beira City

Demographic and Socio-Economic Data: Sources: WHO, UN (MDG), UNHCR, UNICEF, UNDP

Geography	Total surface	801 590 km ² (coastline of 2 470km)	
	Capital	Maputo (population in Maputo: 966 837)	
	Provinces	10	
	Official language	Portuguese	
Environment	Climate	Tropical-subtropical, rainy season from January to March From April to September, the coast has warm, mainly dry weather, 10 degrees cooler in the western mountains	
	Floods and droughts	Devastating floods in 2000-2001	
Demographics	Population	19 792 000 (annual population growth rate: 1.38%)	
	Religions	23.8% Christian, 17.8% Muslims, 17.5% Zionist Christian, 17.8% other, 23.1% no religion	
	Ethnic groups Migrants	Not representative	
Economy	Industry	Most of the postwar industry is located near Maputo, which produces cement, cigarettes, alcoholic beverages and seafood	
	Farming	Sugar, cashews, and a wide range of oil-bearing seeds. Tea, in the highlands near the Malawi border.	
Health Indicators	Per capita total expenditure on health PPP(\$)(2006)	56\$	
	Life expectancy at birth (yrs)	Males: 49	Females: 51 (2006)
	Child mortality rate (per 1000) (Under five)	Males: 140	Females: 137 (2006)
		514 physicians (2004)	
Communicable Diseases	Malaria (15-30% of all under-five death), tuberculosis, HIV prevalence (15-49 yrs): 14.4% (2005)		
Risk Factors for Cholera	Population with access to improved water source (2006)	71% (urban)	26% (rural)
	Population with access to proper sanitation facilities (2006)	53% (urban)	19% (rural)
	Population undernourished (2002-2004)	44%	

