

Editorial comment

It gives us great pleasure to present to you yet another edition of MMH newsletter. We hope you will find it informative. We thank you for taking time from your busy schedules to read our newsletter or visit our website and better still answer our prayers by sending financial and material support. We thank you for your contributions towards the construction of our road. Rains have started and soon the road to the hospital will be impassable so we still appeal to you to please donate generously so that the road can be constructed.

In the last edition we were bidding farewell to Lonnie Ncozana who had worked at the hospital for 17 years and in this edition we are sadly announcing the departure of Dr. Sue Makin who has worked for MMH for 11 years. We thank them so much for their great dedication and positive contribution that has brought MMH this far. We wish them all the very best and God's blessings in their next undertakings.

Wishing you a happy reading.



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ART & Palliative care Updates

by Sam Matandala

It is now ten months since the ART and palliative care team moved into the new spacious building. Things have been looking up lately with a steady increase in the number of patients coming to start ARVs at our clinic. I spoke to some of the patients recently and they expressed their gratitude and happiness with the new clinic. It is more spacious and there is room for everyone to sit comfortably than in the past when they had to be crammed in a narrow poorly ventilated corridor that passed as a waiting area. Even staff is happy to be working in an aerated environment with a reduced risk of catching air borne infections like TB. Group counseling of many patients at one go is now possible thanks to the roomy counseling hall that is right inside the clinic.

The clinic has started 2799 patients on ARVs since its inception in 2004 and 540 of these have unfortunately died so far. About 145 patients have defaulted, 20 have stopped taking ARVs for various reasons and 247 have been transferred out to other centers. At first the ART clinic was confined to helping people from only our catchment area of 72 villages but then over time as demand grew we are now catering for everyone regardless of their residence. Patients even come as far as Mozambique since we are just a few kilometers from the border.

More and more people are coming in to demand ART when they test HIV positive because they see people in their communities who were previously bedridden with AIDS and are now back on their feet after starting ARVs. This is the reason why we should have our own CD4 machine to help even those without symptoms but maybe with a low CD4 count. Unfortunately we have no functional CD4 machine and we depend on our sister hospital at the district where we send blood samples twice a week which causes a bit of a drag in the system.

Illiteracy level in this part of the world is unfortunately still high and the understanding of HIV and AIDS is relatively low. We still see patients who believe that AIDS is a curse or due to witchcraft, that is why we hardly see any significant drop in infection rate. These are the people who stop the ARVs at some point or just get lost in the system. With continued education at community level might in the long run reverse this trend.

The palliative care program is also making



Patients in the ART clinic spacious waiting area ▲

strides in the right direction. Currently 163 patients are benefitting from the holistic care of the palliative program. Mercy Siliya, the program coordinator, told me that they recently trained 303 volunteers and 69 Health surveillance assistants who will act as a link between the palliative care team and the patients in the community. This is going to improve patient follow up and referral. With funding from our partners it has enabled the program to start providing nutrition supplements to the patients on palliative care in the form of fortified meal popularly known as Likuni phala. This is going to help boost the general health condition and energy levels of these patients who are most often too poor to afford nutritious food.

There are ongoing trainings that have been scheduled to take place, soon targeting nurses and clinicians. Currently there are 37 nurses and 5 clinicians who were already trained in palliative care. One of the nurses, Anne Mlandu, has just left for Uganda for a five weeks training in TOT and health professional's course.

Currently four palliative care nurses and a clinician are being trained in motor bike riding because two bikes will soon come to ease transport problems during outreach programs. There is still a need for a vehicle to transport patients to the hospital from the community and vice versa.

Being housed in the same building with ART clinic has helped to cut the time patients needed to go from one office to the other because some of the patients on ART are also on palliative care and are therefore being given one review date for both clinics. The referral system is also effective, it is now easy to refer a patient to the ART clinic next door and vice versa and the team in both clinics can easily discuss a case. Thank you for the wonderful clinic.

From the Medical Director's office

As we approach the end of the year, I feel privileged to update you once again on the developments at Mulanje Mission Hospital.

I want to take this opportunity to reflect on my contribution in the previous newsletter. As much as we thought to step into a bright future, knowing that Malawi has the highest economic growth rate of the continent, an unexpected turn of tide occurred when government announced in September that they are unable to fund tuition fees of nursing students at all colleges around Malawi. It was not less than a shock. After successfully negotiating to increase the fees by over 50% , but with a plea from government to wait with the new intake till October, we were surprised to hear that the new intake would be excluded from the support. After six years of an emergency plan to increase the number of nurses in the country, this HIPC fund has dried up, but should it take the country back to square one in terms of up-scaling the number of health workers in the country. We planned to have an intake of 65 students, the highest number ever, made possible by the Norwegian partners who built the facilities to host them. Were all these efforts in vain?

Capacity building remains an essential component of development. Education is one of the main Millennium Development Goals. Already only few people manage to finish secondary school and they need to get the opportunity to attend a professional training. Failing to get into higher education will not only slow down the chances of individuals to escape poverty, but will leave the health sector with human resource gaps that eventually hamper quality of services as well. Initial trainings and upgrading courses have built the reputation of the hospital. I therefore would like to appeal to our partners to continue to support investments in capacity building.

Speaking of capacity gaps: Dr. Sue Makin has left after 11 years of services. She was an inspiration for us all and truly built the reputation of the maternal health services at our hospital. Her dedication to patients has been an example for many. We will miss her tremendously (*more on page 4*).

On a more positive note, I am pleased to inform you that the rehabilitation of the pharmacy is making good progress. A new set up of the back store and additional space will



The pharmacy undergoing rehabilitation and extension. ▲

increase the capacity to meet the higher demands.

I also like to refer you to our website, www.mmh.mw to read about the fantastic piano concert that was organized in Amsterdam to fundraise for the renovation of our labour room. Hopefully soon we will be turning the large room into more private labour suites, yet another investment to improve the quality of our services. Any contribution towards this project is still welcome. Together we can make a difference.

Blessings to you all.

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You can also visit our website: www.mmh.mw

Mens sana in corpore sano

As we continue to promote good health and cure the sick in our community, Mulanje Mission Hospital also strives to provide a healthy and conducive environment to its members of staff as well. 'Mens sana in corpore sano' as the famous phrase by the well known Latin poet Decimus Iunius Iuvenalis goes - a healthy mind in a healthy body or at least we do pray for that. Apart from taking care of the sick, Mulanje Mission Hospital supports a number of social clubs for both the youth and the senior members of staff. The hospital's senior social club is one such organization that organized a hiking trip to the all-time famous Mulanje Mountain.

The day was a Saturday the 8th of August 2009, and proved to be cool, quiet and not so sunny. A total of over thirteen members of staff registered for the famous mountain hike. Members were extremely excited and



A rest by the waterfall ▲

looking forward to the climb. Believe me – this is no ordinary mountain for the faint hearted to go hiking. There are stories of people disappearing or even dying whilst hiking this mountain.

At around 8.45am the real long climb up started. Accompanied by a porter, the team stayed together for as much as possible and allowed even the slowest of the climbers like me to cope with the ascent. The route we took is known as the skyline path and takes about three hours for the fit to reach Chambe hut. We stopped four times to rest but in general we steadily hiked for about four hours before reaching our final destination 'Chambe Hut' where we sat and rested. Chambe hut is located within the famous Chambe basin at an altitude of 1904 meters and this is where hikers are advised to spend the night before proceeding to the mountain's summit. There are a total of ten such types of huts on the mountain located at different locations to provide shelter to hikers on the mountain. At Chambe we played games and shared stories and experiences for the day. Naturally plans for the next climb meant to reach the summit of the famous Sapitwa were laid down.

Indeed, I must exclaim just how beautiful the mountain with all its natural landscapes is. It was amazing. Indeed we need to protect this mountain from the many pyromaniacs who deliberately set fire on this mountain. Every one of us felt like they truly had accom-

plished something great during and after the climb and the short stay at Chambe Hut was indeed a rare experience. At Chambe basin, the atmosphere was cool; the air 'unpolluted' and we all felt that kind of feeling that comes only once in a life time. Reaching Chambe station alone was like we had reached the summit by itself. Well, we did set some record, and next time the club will seriously consider reaching the summit, 'Sapitwa'.

Mountain climbing is not a common sport amongst many Malawians hence our hospital's social club will continue to encourage all staff members and visitors to attempt hiking or participate in whatever activity the club undertakes. We hope next time we will have more staff members on the trip to the summit To all our staff and entire community lets continue to pray for a healthy mind in a health body.



A group photo at Chambe hut ▲

Dr. Roland van de Ven

by Dr. Peterkins Kalungwe

Globalisation & the cost of Health care

by John Munthali -Principal Hospital Administrator

Globalization has been most equated with economic liberalisation and the 'freeing' of trade. This has led to companies trading without many restrictions from governments of the world. Bigger pharmaceutical companies have seized this opportunity to dominate and control the trade in the drugs. The US-based Centre for Concern has recently accused the IMF and World Bank of being ringleaders of globalisation (Collin and Lee, 2003). They argue that 'with the rise of "casino capitalism", governments are weakened and marginalised (ibid, 2003). Through deregulation, governments transfer power to the market. Some governments become more accountable to external investors and creditors than to their own citizens (ibid, 2003).

All over the world governments are losing control of macro-economic policy, with knock-on social and health impacts (Woodward et al., 2001). By 1996 foreign exchange trading by big investors was worth \$35bn, 10 times more than the world's gross economic product of \$30bn. Of the world's largest economies, over half are now not countries but companies (ibid 2001). Increasingly it is transnational business which is the provider of a whole range of public essentials - transport, utilities, and welfare and health services. Transnational corporations, shareholders and investors, control the world. So where does this leave health?

The globalisation movement has resulted in the cost of health services to sour so high so that the poor masses of the developing countries are finding it hard to access the services. Many of the people in the developing countries are leaving just on less than one dollar a day. Although the WHO aims to assist governments to strengthen the health services, government involvement in health care policies has been decreasing. Consequently offering health services is becoming unbearable expensive and it is the poor masses who are shouldering the costs. Hospitals can no longer offer health services at a cheaper rate as the cost of drugs and supplies are becoming expensive. Health is increasingly perceived as a private good leaving the law of the market to determine whose health is profitable for investment and whose health is not. Populations of transitional economies are no



Mr. Munthali ▲

longer protected by a centralized health sector that provide universal access to everyone and some groups are even denied the most basic medical services (Huynen et al., 2005). Literature has shown that the United States of America and several Latin American countries have witnessed a decline in the accessibility of health care following privatisation of health services.

Much as there may not be literature about the cost of health services in Africa and Malawi in particular following globalisation, the cost of health services seem to be following the trend going on in the U.S. and Latin American Countries. The government of Malawi though has a policy on universal access to everyone, however the government hospitals are run without drugs since the government can not afford to buy the essential drugs. The law of the market has had a profound effect on the availability and accessibility of the drugs. Consequently, hospitals have been forced to start offering some services on a private basis just to realise the costs of the services. This become discriminatory as the majority can not afford to pay any fee attached to the health services because of rampant poverty.

The booming of the private health sector has had profound effect on the public health services. There has been much migration of the health workers from the government run health institutions and Mission Health Institutions to the private sector. This is already compounding the existing problem of inaccessibility of health services by the local poor masses. Such an environment makes it difficult to provide services to the expectation of the clients. The increasing trade in

health services can have profound implications of proper health care. Although it is perceived as to improve the consumer's choice, some developments are believed to have long-term dangers such as establishing a two-tier health system, movement of health professionals from the public sector to the private sector, inequitable access to health care and the undermining of national health system (Owen and Roberts, 2003).

Therefore, running health services in the face of globalisation is becoming expensive and accessibility by the local masses is low. Pharmaceutical companies have dominated and prices of drugs are souring. Alliances existing between pharmaceutical companies are only aimed at making profits and this does not help either the health system in Malawi where there is the universal accessibility of health services. With reference to the Porter's five forces theory, what is happening is that the power of suppliers is becoming more in the health care industry. The suppliers are wielding more power and therefore the costs of the health services seem to be at the mercy of the suppliers. It can be clearly seen that globalisation can be cruel to the poor masses and have severe ramifications to their health and life expectancy.

Operating in such an inequitable global world, Health institutions like Mulanje Mission Hospital find it tough and expensive to work effectively and efficiently. Therefore globalisation can indirectly affect the operations of Health Institutions in such a way that it has to deal with people who have reduced life expectancy, living in dire poverty and in countries whose economies can no longer sustain health services on universal accessibility policy.

The fees of our services can not be on a cost recovery basis despite the cost of drugs is so high because none of our clients in the rural areas where we are can afford. Our survival as a mission hospital is largely attributed to the committed individual donors and church partners abroad who have supported the hospital ever since its inception in 1928. We are so grateful to these donors. You can be part of these donors and make a difference to the thousands of people we serve. Visit our website www.mmh.mw

Nursing students in financial uncertainty

by Keith Lipato - Principal tutor

The future of Nursing and Midwifery students at Mulanje Mission College of Nursing from this year's intake hangs in a balance following government's announcement that it will not be able to offer scholarships to students as it has been doing for the past five years. According to a letter from the Ministry of Health, government will not be able to sponsor the students, because the six-year human resource emergency plan under which the students were being sponsored expires next year. The government of Malawi has not yet identified an alternative source of funding for the students. This development has not only affected us, but eight other colleges that belong to the Christian Health

Association of Malawi (CHAM) and those from the Malawi College of Health Sciences (MCHS). CHAM colleges and MCHS were expecting to enroll over 600 students this year but with the current development the number might even be less than 100 because most students can not afford to pay fees by themselves.

For a student to complete his/her 3 years of training they need to raise not less than MK 1,100,000 (close to USD 8,000). Most Malawian parents and guardians can not afford to pay this amount of money. On average most Malawians who work in the public service earn between MK 15,000 – MK

30,000 per month.

Government will continue funding continuing students that are in year two and three. However, the main challenge for the college at the moment is food for the first year students. If government will not change its position and students fail to pay the fees, the college will have to send the students home. Therefore the college is appealing to well wishers to assist in cash or kind as a short term measure to ease the food problem. In the long run and with adequate notice, Malawian student Nurses and Midwives should brace themselves to making a significant contribution towards their education.

New PHC coordinator's first few months in office

by Jane Mweziwina

My name is Jane Mweziwina; I am the new Primary Health Care (PHC) Coordinator. I am married to Henry, and have two children, Michelle 10 and Mtendere 4. I had previously worked as a nurse midwife at Mulanje District Hospital and later joined Mulanje Mission Hospital as a tutor at the College of Nursing.

I am delighted to have picked up this new challenge because community health nursing is my area of specialty. During my short stay in this department I have been impressed with the various programmes that are taking place both at the hospital and in the community. I am particularly interested in the water and sanitation projects, care of the orphans and the chronically ill that the department with assistance from various partners is undertaking. Through these programmes the communities have access to safe water and orphans have access to quality education; they also have an opportunity to get food supplementation. It is a fact that a learner cannot concentrate in class if s/he is going to school on an empty stomach. If it were not for the fortified meal (Likuni phala) that is provided to the orphans most of them could not have achieved the nutritional status they



Jane at the entrance to her new office ▲

have now and could have dropped out of school way back. There are several chronically ill patients who could not have made it to this day on ART alone but they have managed because of the improved nutritional status due to the Likuni phala supplementation.

But above all these activities, I am particularly interested in the food security and dairy goats' projects. These are some of the projects that would fulfill the vision that I have for PHC. These projects are community owned and self sustaining in the sense that the community is provided with starter packs

but are supposed to generate their income for the future running of the projects. In this era of climate change, these are some of the projects that need to be encouraged in order to address issues of environmental degradation. The output from the goats or the crops is used for uplifting the livelihood of both the community and the individual house holds. The goats produce milk that is both for consumption and for sale to generate income. The money could be used to send children to school, access quality medical care hence improving the health of the household and in turn the community. The dung is collected to make manure; in fact there is nothing that is wasted. Similarly for the community gardens, the produce could be used for household consumption and the excess for sale, enabling the households to have food throughout the year and have some for sale to use the money for other aspects of development both at household and community level.

In a special way I would like to extend my gratitude to all partners that provide moral, spiritual and financial support to the running of these programmes.

Sponsor a hospital bed



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Farewell Dr. Mary Sue Makin

by Sam Matandala

Earlier this month we sadly bade farewell to Dr. Makin, obstetrician and gynaecologist, who had to go back home to USA after working for Mulanje Mission Hospital for eleven years. She joined the hospital in October 1998 after working in Zaire, now DRC, for almost nine years. She was sent to Africa for missionary work by the Presbyterian church of USA. She had a choice of either going to Cameroon or Malawi and we thank God that she chose to come here. She had a heart for Africa and her desire was to help disadvantaged women in the unknown far reaches of Africa.

In her early years in Africa while in Zaire she recalls that she used to live in a remote town that had no bank, post office, telephone or electricity but this did not deter her and she endured for nine years in the equatorial jungle bringing hope to women there.

When she came here the hospital had only female, labour and children's wards but later the same year male ward was opened. There was no gynaecology examination table or speculums and she had to do her exams in theatre. At that time there was no anaesthetist and so it was difficult for her to perform any major surgeries like hysterectomies. Slowly things began to improve in the hospital and basic equipment began to come in. She helped to acquire ultrasound scan machines which are paramount in her line of work. We will ever be indebted to her for the USS machines



Sue showing off one of the gifts she received at her farewell party ▲

whose importance can never be over emphasized.

Many women traveled from far and wide to seek medical help from her. The hospital is well known across the country and even across the border in Mozambique because of her care. She used to perform about 80 to 100 hysterectomies a year and these were largely due to uterine fibroids. She was also much involved in teaching clinical officers and students. She has mentored countless clinicians in doing ultrasound scanning, taking care of women in labour, cervical cancer screening and performing ob/gyn surgeries.

Dr. Makin helped to establish the VIA (Visual Inspection of the cervix with Acetic Acid) program for cervical cancer screening. It is free of charge so every woman regardless of financial stand can be screened for cervical cancer and be offered free cryother-

apy or electrosurgical excision if there is any suspicious lesion noted in the exam. Sue conducted a series of trainings for clinicians and nurses here at Mulanje mission Hospital and several other hospitals. The VIA program is now well established in most centers and also cryotherapy is done. She hopes the Government can improve on service delivery on cervical cancer screening. Public awareness has already been achieved through various media like newspapers, radio jingles, TV, pamphlets and posters. There is need of political will and financial support from the government on the VIA program. The Government also needs to offer technical support and training.

She is not aware of any American Doctor coming to replace her. We pray that PC-USA sends another Sue Makin. She promised to keep on supporting the hospital by lobbying for financial and material support from churches in the USA. She will spend the next six months traveling across the USA making speeches about her stay in Malawi in different churches and afterwards she is hoping to get a job in North Carolina.

She said she will miss Mulanje Mission Hospital so much, especially the friendly people. She loved living in the small Christian community where everyone knew each other.

We greatly appreciate the wonderful work Dr. Makin did in this place we will indeed miss her. God bless you Sue.