



# Mulanje Mission Hospital Newsletter

September 2017

**Mulanje Mission Hospital**

**CCAP Blantyre Synod**

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**Malawi**

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**National Bank of Malawi  
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**Hospital accounts:**

**407275 (\$)**

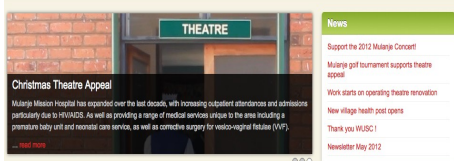
**286818 (£)**

**380873 (€)**

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the news from MMH.**

**MMH website  
is regularly updated**



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**[www.mmh.mw](http://www.mmh.mw)**

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**[info@mmh.mw](mailto:info@mmh.mw)**

## Editorial Comment

We are so glad to bring you yet another edition of MMH newsletter because we have numerous success stories to report. The outstanding success of MMH is that our research has shown that we have managed to reduce the number of malaria cases in our catchment area. MMH implemented its malaria control strategy in 2012 targeting villages with highest numbers of malaria cases from the catchment area. There has been significant drop in the number of cases comparing the 2016 to 2017 season and the 2010 to 2011 season before any interventions were done. Congratulations are in order.

**Sam Matandala**

On a sad note, Dr. Isobel King's stay at MMH has come to an end. We will miss her in countless ways, her mentorship, hard work, dedication to her patients and most of all her friendship. She would always light up a room with her smiley face every time. She shed tears with us in sad moments and danced with us in happy times. A down to earth person who completely put aside her racial and cultural differences and found a new home at MMH. We hope one day after her many years of study she will find it in her heart to come back to MMH and help us again. We wish you all the best good friend.

## *You have a new text message from MMH! Ezron Mwenibabu & Dr. Isobel*

Text messaging (SMS) is being used increasingly across Malawi to disseminate health messages to the rural population. For the last two years, the primary care team have been aiming for a culturally acceptable, technologically sound and clinically relevant approach. Since 2015, Dr. Ben, Wise and Charity have been working with pilot villages, village health committees, health surveillance assistants (HSAs) and safe motherhood committees.

First, they researched how other health facilities used this technology and explored reports from around the region to find out what had been trialled successfully or posed problems elsewhere. Next, the MMH team invited community leaders from two pilot villages to join them in discussing the way forward. Together, they ascertained levels of mobile phone ownership and explored issues of privacy and acceptability. Although sending medication and appointment reminders to patients seemed a good use of the technology, half of all those with access to a phone shared it with other community members and concerns about confidentiality were raised. Thus, general messages promoting health were suggested, which would be applicable to



everyone in the community. The group decided to focus on antenatal care, family planning and ART services to begin with. After much hard work from Dr. Ben, an account with TNM was established so that mass text messages could be sent from a computer to mobile phones. Messages were successfully sent to the pilot group and we turned to the rest of our 72 villages. The HSAs embraced the challenge to recruit interested clients and at last we had over 600 clients recruited and were able to finally send our first messages. We have already received positive feedback from clients which is excellent news. Our next challenge will be to maintain momentum and continue recruiting patients through our outreach clinics. We are grateful to our HSA and community based colleagues for their hard work and commitment.

## **“But the greatest of these is love”: the Bed Sponsorship Fund**

*Isobel King*

Mulanje Mission is a paying hospital and mission hospital, meaning two things: sometimes, patients have to pay, and always, we profess to be Jesus’ disciples, never turning away someone in need.

Some treatments – including medicines for HIV, TB, malaria and palliative care, plus the care of under 5s and maternity care – are free. But for most other services – for problems acute, chronic and urgent - we have to levy a fee. Our fees are not designed to make any profit, simply to contribute to the cost of treatment. Many medicines are very cheap – for £1/\$1.25, you could buy 200 paracetamol, a month’s supply of anti-BP medicine or see a clinician in outpatients and get a week’s course of antibiotics. The free government hospital is not so far away, and patients know they have to pay when they come to us, but make that choice based on a variety of reasons, often secure drug availability and a reputation for good quality care. Many wait until payday to come and consult on less urgent problems.

However, patients face difficulty when the problem moves from simple to complicated, anticipated to urgent. For those patients, costs start to add up: medicines, fluids, x-rays, blood tests, transfusions, operations. As clinical teams, we work to make cost-effective decisions, only ordering tests that are necessary for altering patient’s care and reviewing treatment every day to see if we might make it cheaper, for example switching from injectable to comparably cheaper oral drugs. However, it is not unusual for an inpatient’s bill to come to over £30/\$37, which is over a month’s wages for many. Sometimes, patients have bills which exceed £100/\$125. A young woman with a complication of pregnancy needing lifesaving operations and

drugs; a young man involved in an accident which damaged his bowels, requiring repairs and washouts; a cancer patient requiring multiple transfusions so they might be fit enough to start the treatment they need; a man with failing kidneys who has been accepted for one of the precious dialysis slots in the city but who can’t afford the transport. As a hospital, we do not deny these patients treatment and we never withhold treatment waiting to see if the family can pay. As well as these emergencies, we have patients who incur regular high costs for life-saving treatment, most notably our insulin-dependent diabetics. Without insulin, they would die, but it costs about £16/\$20 each month – an insurmountable cost for many. Families also incur significant costs when someone is sick: transport, preparing food away from home, the loss of earnings for the patient and guardians. Families work with our compassionate Accounts department to agree payment plans to spread the cost, but sometimes families are in desperate measures. It is then that we use the Bed Sponsorship Fund. Families still contribute but we are able to absorb the burden and cover part of the bill. We are only able to do that because of individuals and small organisations who contribute to that Bed Sponsorship Fund.

To all who have contributed generously, and on behalf of my clinical, nursing and administrative colleagues, let me say thank you. Thank you for the moments when we can take hold of a desperate husband’s hand and say, “do not worry, we will help you”. I can’t imagine working somewhere where this option didn’t exist, where I had to shrug and look helpless and say there was nothing we could do, they would have to find the money. The fund only exists because of your willingness to share with the most vulnerable in society and we know it costs you, but on behalf of those whom you will never meet but whom it is our pleasure to serve – thank you.

It’s very easy to support the Bed Sponsorship Fund. £800 or \$1000 sponsors a bed for a year, enabling us to offer these services. As with all donations to MMH, the money stays in the Fund to which it was donated and doesn’t disappear into other budgets. In Malawi, money goes a long way, and so any contribution – as a one-off or regular amount, has the potential to really impact a family in some of their darkest moments. You can make payments to our £, \$ or € accounts using the details on the front page of this newsletter, or contact the Medical Director for further information about the most cost-effective methods of transfer.



*Work has started to improve the water supply to staff houses at MMH. Pdraig Kelly from Mott Mac who are supporting this design work for the new system, seen here with Pearson, Ruth and Wilson ▲*

## FARE THEE WELL DR. ISOBEL KING

Sarah Kadango

2016 was a year of blessings, MMH received a new Doctor, Dr. Isobel King in January. After working with us for 1 year and 7 months, it's sad to say good bye to her for she will be going back home. Words alone cannot best describe how wonderful she has been. Many of us would agree that she was one special kind. From all levels, many were impressed with her performance. If you have worked with her, you would agree that she loves her profession. She's so loving, caring, God fearing and believes all were created equal and respects and values human life regardless of race, religion, nationality, age or social status. We have seen how she per-

formed in the work place, and the fact is, she has made that difference! She has worked so hard in the wards, the diabetic clinic, the introduction of asthma clinic and has been working with different teams at the facility, all in helping to improve the care that we give to our customers. Tell her it's an emergency; while others would wait to finish a cup of tea, surely she would leave her cup of tea and rush to save a life. We need that spirit, we have learnt a lot from her, she's hard working, she has a humble spirit, respecting colleagues even those under her knowing there are some things that she needs to learn from them and her belief in team work.

Dr. Isobel, thank you for taking your time to work in Malawi and for choosing to work at Mulanje Mission. It was quite a challenge to take especially when it's your first time in the country. You have been a great mentor, a good friend and a lovely neighbor to many. We loved working with you and we hope you enjoyed working with us. Life has many paths for us, wishing you the best in your profession. If it was for people to cast votes for you to stay, you would get a million votes for you to stay with us for more years. Remember Mulanje Mission when you go and we hope in the future you will choose to come back.



*Dr. Isobel and some of the staff members* ▲

## Mulanje Mission Golf tournament

By Evelyn Dzidekha

Mulanje Mission hospital has been conducting an annual golf tournament for six years now as part of our fund raising efforts. The proceeds from this year's tournament which was held on 6<sup>th</sup> August, at Mulanje Golf Club will go towards the procurement of oxygen concentrators.

It was colourful and well patronized. We would like to extend our gratitude and thanks to all companies

and individuals for their sponsorship. A list of those who sponsored teams will be made available on our website.

Special thanks go to the convener, Tony Chiwaya, Principal Hospital Administrator Pearson Soka and Mulanje Golf Club Captain Ajay Singh for pulling everything together to stage the fundraising tournament.



*Some of the players posing with Mr. Soka, the principal administrator of MMH ▲*



*Teeing off ▲*



*Prize presentation time with the Medical Director, Dr. Ruth Shakespeare ▲*

## **BRAVO LAUNDRY DEPARTMENT!!**

At exactly 3:35pm, Wednesday afternoon of 19<sup>th</sup> July 2017, the Laundry department, represented by Mr. Martin Kim, lifted up the trophy for emerging the winner of 2016/ 2017 Infection Prevention (IP) assessment.

Mulanje Mission Hospital, through the vibrant Infection Prevention team conduct these assessments in all hospital departments every year to assess if departments are committed to the IP standard set by the Ministry of Health. The findings proved that staff members are indeed committed.

In her remarks, Hospital matron, congratulated the winning team, and also continued thanking all other staff members for the commitment they show as far as IP is concerned and further encouraged

the staff to continue showing it. "Following IP standards plays a vital role in preventing the spread of the infection both to us as workers and also to our patients", she explained.

Mr Kim did not hide how joyous they are as the department to be

*by Ezron Mwenibabu*

the winning team and committed to "defend" the trophy in other assessments to come.

IP assessments are done quarterly and MNCH project is supporting the exercise.

*Zikamatele Zokoma.....!!!*



*Mr. Kim showing off the trophy while Hospital Matron (L) and Dr Arie looks on. ▲*

## **Antenatal Ward Update**

Tabu Gonani

The antenatal ward was officially opened on 12<sup>th</sup> March, 2017 and it has been in operation for 4 months now. 5 nurses and 1 clinician are fully allocated to this ward to provide the services to the in-patient pregnant women. The ward has a capacity of 16 beds but sometimes it becomes full to the extent of putting floor beds to add to the capacity. Patients are either admitted through doctor's consultation or transferred in from labour ward. All pregnant women from 28 weeks gestation and above with any condition in pregnancy requiring

admission are admitted in antenatal ward. In these 4 months, it has been a busy ward with common conditions like preterm labour, Malaria in pregnancy, pregnancy induced hypertension, anaemia in pregnancy, and mostly, patients in latent phase of labour. Antenatal ward provides services approximately 180 patients a month.

Antenatal ward has been of much help to pregnant women as they are taken care of their needs in time. These women are provided with daily routine assessments which help in identifying individual needs

and intervene accordingly. It was during these assessments where 2 women who were not in labour were once identified to have fetal tachycardia and fetal bradycardia respectively and were prepared for caesarean section with good outcome. If not for antenatal ward, these are the types of women who could have been identified with intrauterine deaths once labour starts because of lack of fetal monitoring. Antenatal ward has also reduced the workload for female and labour ward in caring for these pregnant women.

## Celebrating success

Ruth Shakespeare and Tikondwe Katumbi

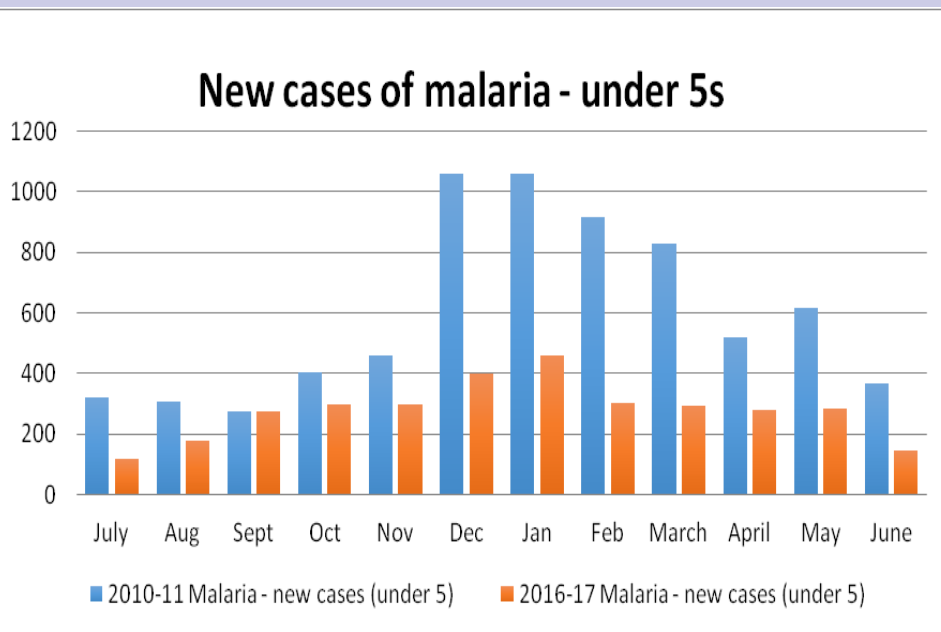
Malaria is a major disease burden in Mulanje, particularly from December to May each year, and is the leading cause of death in the Under 5s. Over the period July 2010 to June 2011, MMH treated 12,437 cases of malaria, 58% in children under 5.

In response to this challenge, Mulanje Mission Hospital launched a malaria control strategy in 2012, covering five main areas: Programme Leadership, Strategy Implementation & Governance; Monitoring & Surveillance; Long Lasting Insecticide Treated Net Provision and Usage; Prevention in Pregnancy and Indoor Residual Spraying (IRS)

IRS was introduced in 2012. The four villages with highest malaria incidence were piloted with a spraying programme during this first year. As well as spraying, MMH also developed the infrastructure for the programme, bought capital items such as sprayers and constructed a secure storeroom and a washroom. An experienced trainer was employed to provide a 2 week training course for spray operators.

MMH works with the University of Malawi, Chancellor College on insecticide sensitivity testing to check the resistance of the mosquitoes, and measuring parasitaemia.

In 2015 mosquito resistance to pyrethroids was first noticed, so MMH changed in 2015 to spray with an organophosphate (Actellic). In 2016 we could spray only 35 villages because Actellic 300CS is much more expensive than the pyrethroid used previously.



*Bar graph clearly showing the reduction of Malaria cases in the 2016 to 2017 season compared to the 2010 to 2011 season before any interventions were done ▲*

Routine surveillance data from MMH Health Management Information System shows that this programme has been highly successful, reducing new cases and deaths from malaria over the period since the malaria control strategy, including IRS, was introduced. Inpatient deaths from malaria in the Under 5s have reduced from 55 in 2010-11 to 11 in 2016-17. And Inpatient deaths from malaria in those aged 5 and over have reduced from 40 in 2010-11 to 21 in 2016-17. Challenges remain, in particular the high cost of chemicals which limits the number of villages that can be covered, and the effects of climate change - the start of the rainy season is increasingly unpredictable in Mulanje and it is difficult to know when to start spraying for maximum coverage of the wet season.

In 2017 MMH plans to spray 50 villages with Actellic CS, a population of 54,778. This increased coverage from last year has been

made possible by access to Actellic at \$19.30 through a low cost programme, NGenIRS. Next year we hope to extend coverage even further.

So let's congratulate all those who have brought about this remarkable change – our thanks to Mike Wade, Tikondwe Katumbi and Sheilla Mangwiyo – the instigators and implementers of MMH malaria control programme, Dylo Pemba from Chancellor College who assists us every year, MMH management, drivers, stores clerks and the spray operators who make the programme happen, and our supporters who have funded the work – Good Little Company, with special thanks to John Heaslip who now knows more about IRS than most, Fane Valley, the Ardbarron Trust, Global Affairs Canada through Presbyterian World Service and Development, and the EC, through Edinburgh Medical Missionary Society Isabel project.

IRS—WOYEE!!