About Malawi

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Healthcare

For English

MALAWI About Healthcare Health System
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With the cooperation of Dr. Jan Petit
After 20 years as a general and oncological surgeon in a large Dutch hospital, Jan Petit returned to Africa in 2004, where he had once started his medical career as a tropical doctor.
In Malawi, he has since been involved in surgically training and training Clinical Officers in peripheral hospitals across the country.

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Healthcare, an introduction

Already in colonial times, the disease and mortality rate in Malawi was described as very high, both in children and adults. There was no registration about the cause of death, so there is no relationship to be discovered with today's high mortality rates. What has remained unchanged over time is eating the low-calorie corn porridge (*nsima*) daily. The annual food shortages also certainly affect the resilience of the population. Then it is about resilience to diseases and defects due to lack of nutrients, especially proteins. Poor hygiene and also drinking contaminated water can be fatal.

Until 2000, health care in Malawi was not structured. Due to *emergency and development aid*, hospitals existed here and there that were usually operated by charitable institutions. Locals in the remote villages were usually left devoid of medical care. Between 2011-2016, research was conducted by the Ministry of Health to work with stakeholders to make a plan *to improve the quality of life of all the people of Malawi by reducing the risk of ill health and the occurrence of premature deaths, thereby contributing to the social and economic development of the country*. The research built on the *United Nations Millennium Development Goals*. The ministry's report that appeared in 2017, the *Health Sector Strategic Plan I (HSSP-I)*, described a positive development and greatly reduced mortality. From 2017 to 2022, the plan and findings were implemented (HSSP-II).

Situation

Diagnosed diseases are currently mainly HIV/AIDS, malaria and other tropical diseases, but also tuberculosis and conditions due to air pollution, respiratory infections, infectious diseases and perinatal complications.

Adolescent pregnancies account for 20% of maternal mortality. Of the approximately 70,000 women who undergo abortions each year, about 33,000 women are treated for complications every year. Unsafe abortions cause 17% of maternal death in Malawi. The health burden due to teenage pregnancies is significant. Maternal mortality is the highest in percentage terms in all of Africa.

Malaria is endemic in the low-lying part of Malawi and is a major public health problem with an estimated 6 million cases per year. This is a major cause of mortality and mortality in children under five years of age and in pregnant women. Malaria is responsible for more than 30% of outpatient visits. The use of mosquito nets is obvious, but rural residents usually lack conviction and financial resources to purchase the impregnated nets.

AIDS infections with complications. (photo dr. Jan Petit)

With about 34,000 new HIV infections per year, almost one million people in the country have been infected and AIDS is the cause of 34% of recorded causes of death.

Many Malawians are hypertensive and diabetic, 32% and 6% respectively due to protein deficiencies and the one-sided diet, among other things.

By cooking on a wood fire in a cabin with little ventilation, children die, especially from breathing in smoke that damages the lungs as particulate matter.

Growth disorders have been detected in many children, possibly due to periodic malnutrition.

Household access to safe water and toilet use are critical in combating waterborne diseases and poor hygiene. In recent decades, the drinking water supply and its quality has greatly improved by pumping up from boreholes in particular.

The funding of current health care in Malawi is mainly based on contributions from donor countries that contribute an average of 60% of total health expenditure. For the care and treatment of HIV/AIDS patients even 85%. The huge health challenges contrasted with limited economic resources, food shortages and the huge unemployment among young people are putting a significant burden on the government budget on which almost 20% of GNP is now spent.

Despite these efforts, the health system does not function optimally. This is largely caused by lack of manpower, lack of basic/expert skills, overcrowding, lack of equipment/technology, corruption, lack of political engagement, lack of sufficient funds, poor prioritization in budgeting and the low motivation among staff combined with a skewed distribution of resources in favor of urban areas. There are many vacancies at all levels, especially for senior medical officer positions. It turns out that 50% of doctors and nurses are stationed in the four central hospitals and that is seen as unreasonable. Demotivated staff, non-functional drift of tasks and lack of good interdisciplinary work models therefore also hinder the progress of the implementation of the current care system.

Organization structure

Health services in Malawi are provided by a number of public service care agencies that vary greatly in size and are staffed by nurses, midwives, *Medical Assistants, Clinical Officers* and *Medical Officers* (doctors) in clinics and hospitals and a single specialist in the *Central Hospitals*. In this chain, curative services are usually provided with minimal laboratory support. Traditional healers and midwives are also part of this health care system. The provision of health care by the public sector is free of charge.

Except by government agencies, care is provided by private institutions and charitable organizations. Health care by charitable institutions is usually provided by religious institutions, non-governmental organizations and companies. The main religious service providers are organized under the *Christian Health Association of Malawi* which provides about 37% of all health services. These healthcare institutions charge user fees. The government concludes agreements through the Ministry of Health to provide essential services such as health care for mothers and children, especially in rural and remote areas.

Echelonnering

Actual care is divided and organized into three levels, namely primary, secondary and tertiary care. Patients enter the system in the first (primary) echelon and, if necessary, flow to facilities via the secondary, possibly to the tertiary level. However, medical supplies and human resources are flowing in the opposite direction. The already limited resources are first allocated to the facilities of the highest level, so that the facilities at the primary level have little to no resources.

Primary care

Primary care provides the majority of healthcare. The planned system per region should consist of health centers with village clinics, pharmacies and offers outpatient and maternity care. Within the current realized system, health professionals, traditional healers and health supervision assistants work in consultation with the village leadership as one team in contact with the health center.

The health workers are community volunteers who function as a representative of the village community out of motion without formal health training.

The health supervision assistants are executives within the region who have undergone a six-week initial health training and ideally live in the community they provide. He/she is responsible for about 1,500 people and mainly provides information and preventive health care through door-to-door visits. In the community, the health surveillance assistants are seen as 'doctors'. Their duties range from care, health promotion, diagnoses in the preliminary phase and treatment for minor disease complaints. Also control of the sanitary facilities. They are of particular importance in hard-to-reach areas as part of an integrated programme in the control of childhood diseases. Also when giving advice, because patients are difficult to refer. Not because of the system, but because they don't want to leave the village or can't pay the costs.

Originally, it was intended to station one or two doctors in the health centers, but under no circumstances are they present. Often there is one *Medical Assistant* (MA) and very occasionally a *Clinical Officer* (CO).

The CO sees, diagnoses and treats the patients in the peripheral hospitals. They usually do the operations and all cesarean sections. A number of COs, the so-called ACOs (*anaesthetic Clinical Officers*) can narcotize in their hospital after additional anesthesia training.

The MA has qualified in medicine during a four-year professional training. After three years of college and a practice-oriented internship in a hospital, he/she is expected to run a health center with nurses and medical assistants who have received clinical training for three and two years respectively. The rule of the team is largely curative with minimal attention to care. They are mainly concerned with health care for mothers and children. Other frameworks and paramedical practitioners, such as laboratory workers and physiotherapists, are usually not present. The health centers are intended to provide care to a region of about 10,000 people. In urban areas more.

In addition, it is intended to coordinate health centres with the primary care facilities and with the community-oriented services.

Currently, Malawi theoretically has a reasonable first-line structure. However, in practice, the health system is characterized by a lack of resources, poor distribution of staff and finances. The coordination between facility curative and community-oriented preventive activities from the health center is not always adequate. Coordination with care agencies at the secondary or tertiary level also often leaves much to be desired. There are organizational deficits in the search for care, lack of suitable medicines and equipment. It turns out that 80% of the positions are not filled.

The GP

GP is a discipline that aims to train doctors with a versatile mix of skills to provide coordinated care to the patient throughout his/her life phase in direct relationship with their families. The intention was that as part of a health center they would be given a task in reducing child mortality through on-site care and an immunization program. In reality, they settle in the big cities for private care.

The pharmacy

In 2017, there were about 200 pharmacists in the country, less than 10 of them in the country's hospitals. The hospitals receive medication without the intervention of a pharmacist from the Central Medical Store and usually make up their annual drug allocation in six months. Common medicines are not always available in hospitals, but can often be found in private pharmacies. There is an uncontrolled circulation of internationally banned drugs or outdated drugs in markets.

The bicycle ambulance

Secondary care

Secondary care is provided in the district hospitals. These hospitals are equipped to provide the same basic services as primary care, sometimes also X-ray examination, ambulance transport, operations and laboratory services. The 26 district hospitals are located rurally and act as referral centers for primary care. The district hospital's bed capacity can be up to 300. Each district hospital has a series of 11 to 40 health centers located in the district and serve a population ranging from 100,000 to 140,000 residents

The district health management team operates from the district hospital and includes clinical, nursing, environmental and administrative departments. The team plans, monitors and evaluates the activities of the health centres for which they need to provide care. Organizationally, the district health management team is unable to coordinate the aforementioned planning due to lack of human, material and financial resources. In addition, the target is often unacceptably unbalanced when it comes to HIV-related activities, for example.

Public district hospitals

Chitipa District Hospital
Karonga District Hospital
Mzimba District Hospital
Nkhata Bay District Hospital
Rumphi District Hospital
Dedza District Hospital
Dowa District Hospital
Kasungu District Hospital
Mchinji District Hospital
Nkhotakota District Hospital
Ntcheu District Hospital
Ntchisi District Hospital
Salima District Hospital
Balaka District Hospital
Chikwawa District Hospital
Chiradzulu District Hospital
Machinga District Hospital
Mangochi District Hospital
Mulanje District Hospital
Mwanza District Hospital
Nsanje District Hospital
Phalombe District Hospital
Thyolo District Hospital
Zomba District Hospital

Private district hospitals

Bwaila Hospital Lilongwe
Discovery Imaging Centre, Lilongwe
Dolla Hospital, Blantyre
Blantyre Adventist Hospital, Blantyre
Care Polyclinic Limited, Lilongwe
Mlambe Mission Hospital, Luntu, Blantyre
CCK Health Clinic & Diagnostic Centre, Lilongwe
Chiwaya Private Hospital, Blantyre
Daeyang Luke Hospital, Lilongwe
David Gordon Memorial Hosp, Livingstonia
Dr YB Mumba Pvt Clinic, Lilongwe
Embangweni Mission Hosp. Embangweni
Ekwendeni Mission Hosp. Ekwendeni
Francisco Palau Hospital, Lilongwe
Gulf Medical College Hospital, Blantyre
Holy Family Hospital, Phalombe
Malamulo Hospital, Thyolo
Kalemba Hospital, Rangula
Likuni Hospital, Lilongwe
Madisi Mission Hospital, Madisi
Medicare Hospital, Blantyre
Mlambe Hospital, Luntu
Mzuzu Women's Health Clinic, Lilongwe
Montfort Hospital, Ntcheu
Mulanje Mission Hospital, Mulanje
Mtengo Limodzi Private Hospital, Blantyre
Mwaiwathu Private Hospital, Blantyre
Nkhoma Mission Hospital, Nkhoma
Nyambadwe Private Hospital, Blantyre
Pirimiti Hospital, Zomba
St. Annes Mission Hospital, Nkhotakota
St. Anne's Health Center, Karonga
St John's Hospital Mzuzu
St. Joseph Hospital, Mchinji
St. Joseph's Hospital, Nguludi
St. Luke's Hospital, Malosa
St. Martin's Mission Hospital, Malindi
Trinity Hospital, Muona
Wenaafe Private Hospital, Blantyre

Nsanje District Hospital in southern Malawi. (photo dr. Jan Petit)

Tertiary care

There are four public tertiary hospitals where advanced specialist care is present. In reality, 70% of services offered at the tertiary level are for conditions that need to be treated in the first-line or district hospitals.

Central Hospitals:
Blantyre Central Hospital (Queen Elizabeth Central Hospital), Blantyre
Kamuzu Central Hospital, Lilongwe
Mzuzu Central Hospital, Mzuzu
Zomba Central Hospital, Zomba

Private Hospitals
Mercy James Institute for Pediatric Surgery and Intensive Care, Blantyre
Beit Cure International Hospital, Blantyre

Developments

The introduction of the healthcare system from 2017 has certainly led to better results. Infant mortality has fallen noticeably. Also maternal mortality after skilled post-delivery care were included in the care system. The fight against HIV and AIDS, malaria and other diseases has demonstrably improved. The current quality of health care and also the introduction of a vaccination program therefore has beneficial effects on society so that families are maintained, school dropout becomes less and work becomes more productive.

Patient care has also become more efficient due to better logistics, such as the turnaround times from the first symptoms of the disease to treatment in a hospital and that affects the condition of the patient and his environment.

In the new healthcare system, society is informed by the health surveillance assistants about nutrition to build higher resistance, about the use of clean water and better hygiene. Also about preventing a hunger period and that has a direct impact on the health status of the population.

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