GENERAL INFORMATION ABOUT HEALTHCARE IN MALAWI

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Healthcare in Malawi, Africa

RIPPLE Africa receives many general enquiries each month asking about the conditions of health and healthcare services in Malawi, Africa. To help those wishing to learn more, we have created this document which contains information about what healthcare is like in Malawi, and most specifically, in the Nkhata Bay District where RIPPLE Africa is based.

For RIPPLE Africa, one of its three main pillars of activity is healthcare. RIPPLE Africa's healthcare aims are mainly delivered through its support of the Kachere Health Centre and Mwaya Community Dispensary. Much of that support is delivered through the important volunteer work of our overseas doctors and nurses who provide much needed assistance to the community.

There are approximately 15.2 million people in Malawi, and 215,000 people in the Nkhata Bay District where RIPPLE Africa is based. Important general healthcare indicators for Malawi include national life expectancy from birth at 47 years (44 for men and 51 for women). In contrast, the global average life expectancy is much higher at 68 years, and as high as 80 years in the UK. In the Nkhata Bay District where RIPPLE Africa is based, average life expectancy is slightly lower than the national average in Malawi, at 45 years; almost half the average life expectancy in the UK. This low life expectancy in Malawi can largely be attributed to malaria, HIV/AIDS, chronic malnutrition, sub-standard health services, and inadequate access to safe drinking water and proper sanitation. The World Healthcare Organisation (WHO) indicates that one in 10 children in Malawi will die by the time they are 5 years old. Yet the total public expenditure on health per capita, is just $50.

Health Service Provision in Malawi

The government of Malawi has a national healthcare service which is government funded, and free to all Malawians at the point of delivery. Government healthcare is provided in three forms: Health Centres at the local level, Regional/ Rural Hospitals one level up, and District Hospitals at the highest level. According to WHO, total expenditure on health per capita is just US$50, and expenditure on health as a percentage of GDP is only 6.2%. With very little funding, investigations are limited by resources, and diagnosis is largely based on clinical presentation. Most laboratory, imaging, and testing facilities are often only available at the major District Hospitals. Malawi has very few doctors (only one for every 50,000 people in Malawi), so hospitals are staffed by Clinical Officers (trained for a minimum

Most health centres have very basic facilities

of four years, and who are very experienced practitioners), and Medical Assistants (trained for a minimum of three years.) The Clinical Officers and Medical Assistants are usually in charge of their workplace, and manage any in-patient care. They diagnose, treat, and prescribe. All clinics and hospitals will have a team of nurses (trained in midwifery and nursing), who also diagnose and prescribe. Health Surveillance Assistants (HSAs) have a diverse role, including the management of the community health needs, assisting in clinics, collating all records, and performing VCT (Voluntary Counselling and Testing for HIV/AIDS.) In the Nkhata Bay District where RIPPLE Africa is based, the ratio of population to doctors is significantly worse than the national average, with just one doctor in the district to 99,542 people, and one registered nurse to every 18,098 people. There are only three laboratory technicians, two pharmacy technicians, and one radiography technician for the entire district.

Malaria

According to WHO, about 3.3 billion people (half the world's population) are at risk of malaria, and malaria kills nearly one million people worldwide every year. In Africa, one in five childhood deaths (20%) are due to the effects of the disease. Malawi is no exception: malaria is still the leading cause of death in the country. Malaria is transmitted by the bite of an infected mosquito, and causes fever and flu-like symptoms which, if left untreated, can lead to death. Of course malaria is a completely treatable disease; however, survival depends on early diagnosis and access to medication before the disease progresses. This makes access to proper healthcare facilities and trained physicians essential. In addition to quick diagnosis and treatment, malaria can also be controlled and reduced by taking a number of preventative measures. Firstly, the mosquito which carries the malarial parasite is most active at night, so the use of mosquito nets when sleeping can prevent the opportunity for a malaria-infected mosquito to bite its host. In Malawi, many people have access to mosquito nets; however, not everyone has them, and not everyone is consistent about using them. (We have seen many people using their nets for fishing instead!) In order for mosquito nets to be effective at combating malaria for an entire community, 80% of a community population has to be using them. Secondly, control of the mosquito population at large can also help prevent the disease and Malawi has recently introduced a scheme where houses are being sprayed with insecticides which are very effective at killing mosquitoes, and last up to 12 months. As with the mosquito nets, however, this residual spraying must take place in at least 80% of homes in an area to be an effective preventative measure to the community at large. People do have access to medication to treat malaria, but often wait until the last minute to seek medical care, especially where a healthcare centre is a great distance from their home. The longer someone waits before seeking treatment, the greater the risk of complications.

There are often shortages of medicines in the rural health centres

Cerebral malaria can kill very quickly if the patient is not treated

RIPPLE Africa helps fight malaria by ensuring communities have immediate access to healthcare services for quick diagnosis of the disease. Patients presenting with malaria make up the majority of the cases at both the Kachere Health Centre and the Mwaya Dispensary which RIPPLE Africa supports, and RIPPLE Africa volunteers drastically increase both facilities' abilities to cater for more patients.

HIV/AIDS

Like many countries in Africa, the rate of people living with HIV/AIDS in Malawi is extremely high. WHO officially recognises that 12% of the population in Malawi is HIV positive; however, our experience at the clinics in our area has revealed that number to be much higher – as high as 30%! Despite the huge proportion of people living with HIV/AIDS, there is still a social stigma attached to the disease in Malawi. Culturally, most people in Malawi are still hesitant to talk about HIV/AIDS, and many are too afraid to be tested. Many people feel they will be ostracised from their communities if they are discovered to be HIV positive, and thus continue to live with the disease without treatment, and continue to risk the infection of others.

Fortunately, many people in Malawi have access to free ARVs (antiretroviral drugs), a combination of drugs which considerably prolong the life of a patient living with HIV/AIDS by many years, if not decades. ARVs also significantly reduce the chance of mother-to-child transmission, so mothers who are HIV-positive can give birth to healthy babies without passing the disease on to them. Despite these miracle results, the reality of ARV use in Africa is complicated. Following an ARV regime is complex and side effects have to be carefully monitored. For many people in Malawi, it is not enough that the ARVs themselves are free. Basic factors such as the cost of the bus fare to get to a clinic for treatment on a weekly basis, and regular access to enough food and water to be taken with the medication can prevent people from taking ARVs consistently or at all. Healthcare resources are also extremely limited, so physicians have much less at their disposal to monitor treatment than would be used or recommended elsewhere in the world. However, the greatest obstacle to ARV use in Malawi is still the low percentage of people who get tested early, with the majority only confirming that they have the disease once they have progressed to the final stages of AIDS. When people leave their diagnoses and treatment until the very end, their options are very limited and many people turn to traditional medicine, where treatment is often harmful, costly, and of course ineffective. WHO recognises that 80,000 people die of HIV/AIDS in Malawi each year; however, with so many people having never been tested for fear of community reaction, we believe that this number could in truth be much higher.

An HIV/AIDS awareness campaign

The great tragedy of HIV/AIDS is that it strikes down people in the prime of their lives, most often after they have become sexually active and have had children. One in eight children in Malawi are orphans, many orphaned by HIV/AIDS. Contraction of HIV/AIDS is of course preventable, ARVs make a diagnosis manageable, but as long as a stigma persists and people refuse to be tested and to change their behaviour, HIV/AIDS will continue to be a significant problem in Malawi which destroys families, communities, and lives.

RIPPLE Africa volunteers work with many patients who are living with HIV/AIDS and promote HIV/AIDS awareness at schools, clinics, and community level. RIPPLE Africa has also been involved in public health campaigns to tackle the stigma associated with the disease, and encourage people in the community to get tested.

Malnutrition

Malnutrition is one of the major health problems facing the developing world, and is one of the leading causes of death in Malawi. Malnutrition is a condition which is caused not just by a lack of food, but by taking a diet which is so unbalanced that the body lacks certain nutrients altogether, while other nutrients may be in excess, causing nutritional disorders which are not only harmful, but are potentially fatal. WHO cites malnutrition as the single greatest threat to the world's public health.

In Malawi, the majority of the population is heavily reliant upon nsima as the staple of their everyday diet. Nsima is a porridge-like substance made of ground maize or cassava flour which is mixed with water to form a doughy carbohydrate which is then served with different relishes to flavour it, such as potatoes, fish, boiled vegetables, tomato soup, etc. Nsima is eaten all throughout Africa, and is also known as nshima in Zambia, sadza in Zimbabwe, ugali or posho in East Africa, banku or fufu in West Africa, and pap or mieli-meal in South Africa. As a staple carbohydrate, nsima is popular because it helps Malawians to feel full, and because maize, and particularly cassava, is a dependable crop which grows well in hot climates. While nsima might be a reliable choice for a staple food, it

has no nutritional content. Eaten with fish or meat for protein, eggs or oil-based soups for fats, and vegetables for important vitamins and minerals, nsima is part of a balanced diet. However for many Malawians, poverty, food prices, crop failure, poor agricultural skills, a failure to practice crop rotation, a lack of irrigation, fertilisers, pesticides, over-fishing and more all contribute to a lack of access to a variety of foods, and many of the poorest people eat nothing but nsima, or at least not enough relish to make up the nutritional content the body is lacking. As a result, many Malawians are malnourished, and children and pregnant women are particularly vulnerable, where malnourishment not only exacerbates existing health conditions, but can be fatal in its own right.

According to WHO, 53.2% of children under five in Malawi are identified as stunted (low height for their age), 4.2% are identified as wasting (low weight for their height) and 15.5% are listed as critically underweight. Shockingly, only 15.8% of all children under five in Malawi are at the correct healthy ratios! Stunting reflects the cumulative effects of undernutrition and infections, even since before birth, and for children who are critically underweight, the risk of infection and death is severely increased. While weight loss can be corrected, the long term effects of malnutrition in the first two years are irreversible. 13% of all babies in Malawi are born underweight before they've even had a chance, often a result of malnourishment present in the mother herself. 47.3% of pregnant women and 73.2% of children under five have anaemia, caused traditionally by a lack of iron in the diet from a shortage of foods such as eggs, red meat, oily fish, beans and pulses, green vegetables, and some fruits, as well as a lack of vitamin B12 , vitamin A, folate, and chronic infections and other diseases such as malaria. Anaemia can increase the risk of maternal and child mortality, has a negative impact on the cognitive and physical development of children, and reduces physical performance and the work capacity of individuals and entire populations. Vitamin C, which is found in fruits such as papaya (pawpaw), oranges and lemons, mangoes, and pineapples, can help the body to absorb iron, making it another essential element of a healthy diet. 59.2% of pre-school age children have a vitamin A deficiency, a vitamin found in foods such as liver, carrots, broccoli, spinach, and guava fruits. Vitamin A deficiencies can cause night blindness, permanent blindness altogether, maternal mortality, poor outcome of pregnancy and lactation, and a diminished ability to fight infection.

RIPPLE Africa is helping communities to grow fruit trees to improve nutrition

RIPPLE Africa helps communities to establish vegetable gardens for HIV sufferers

RIPPLE Africa volunteers help fight malnutrition in Malawi by monitoring the weight of babies and children at the Under Fives Clinics run by staff at Kachere Health Centre on a weekly basis. These clinics help identify children in the community who are at risk, and those identified as critically malnourished join the Malnourished Children's Project to correct the imbalance. Women and children at the clinics also receive critical supplements, including vitamin A. RIPPLE Africa is also introducing 10 fruit trees to every home in the Nkhata Bay District as part of its Fruit Tree Project and Integrated Tree Planting and Cookstove Project, so that every family in the district has access to nutritious food sources at household level. In addition to being an important source of nutrition, fruit can also be sold to allow families to buy different varieties of food, particularly meat and other products to which they might not otherwise have access. Patients who are malnourished are also treated daily at both the Kachere Health Centre and the Mwaya Dispensary.

Water and Sanitation

For many people in Malawi, access to safe drinking water and basic sanitation is limited, which is a major factor contributing to health issues in the country. Running water at household level is very rare, and most Malawians have to make a daily trip to a communal borehole, well, river, or the lake to collect water. In the Nkhata Bay District of Malawi, people are very fortunate to be near the lake which not only provides water from the lake itself, but provides a good source of groundwater from which boreholes can extract safe drinking water. In the immediate area in which RIPPLE Africa works, villages are very well set up with community boreholes. However, venturing just a few kilometres from the lake and this becomes more difficult, and where a borehole does not exist, many people collect water from exposed sources which can contribute to a number of waterborne diseases. WHO indicates that 80% of the population in Malawi have access to improved drinking water sources. However, it is important to note that most Malawians still have to make a daily trip to their water sources once or twice a day, and how water is stored and used will also have an impact on how safe it remains to drink.

A typical borehole pump where most households collect their water every day

Some women walk for several kilometres with buckets of water every day

Sarah, a RIPPLE Africa volunteer, paid for and organised the installation of an electric pump at Kachere Health Centre

For those who do access water from open sources, proximity to household latrines inevitably affect to the safety of that source. In rural areas, the majority of people use unimproved pit latrines (outdoor pit toilets which are simply dug into the soil and have not been reinforced with construction materials.) Only the minority of rural families use improved latrines, or drop toilets, which have been reinforced with materials such as cement. Flushing toilets do exist where there is formal plumbing, such as in the cities; however, the national average of people with access to improved latrines shows little difference between rural and urban areas. WHO indicates that just 56% of the population in Malawi use an improved sanitation facility; however in the Nkhata Bay District where RIPPLE Africa is based, just 35% of households have access to improved latrines, making basic sanitation a major health concern for the majority of families. In the rainy season, household waste from an unimproved latrine can easily wash into water sources, leading to waterborne diseases such as cholera, dysentery, typhoid fever, gastroenteritis, botulism, severe diarrhoea, and more. Open wells are also a breeding ground for mosquitoes which lead to malaria. Waste and garbage disposal is also a problem in Malawi, with no national refuse system. At household level, waste disposal is by rubbish pit and burning of waste. Despite a lack of sanitation, only 66% of families in the district have soap for washing their hands after they use the toilet or handle rubbish.

A template is used to construct the cement cover for our RIPPLE Crapper composting toilet

Another new RIPPLE Crapper has been completed

The cement cover is placed over a circular hole to provide a composting toilet which can be used for nine months, and then the toilet is relocated

RIPPLE Africa is helping to improve access to safe water and proper sanitation at community level by installing boreholes and building improved latrines in our schools and healthcare facilities. RIPPLE Africa is always looking for donors who can help raise money for additional toilet and boreholes in these facilities, please contact us if you can help!

Maternity and Family Planning

Culturally, Malawians value large families and women in Malawi on average give birth five times in their lifetime. This makes obstetrics a very important part of the Malawian healthcare system, and access to quality delivery facilities and skilled birth attendants a critical element in addressing women's health at a national level.

Traditionally in Malawi, women give birth at home with the assistance of their mother, mother-in-law, or a traditional birth attendant (TBA). Most of these traditional midwives have no medical training but rather learned their skills 'on the job,' and it is extremely common for women to experience complications during birth which would lead to the death of the mother, the baby, or both. Accordingly to WHO, post-partum haemorrhage is the leading cause of maternal mortality worldwide. Malawi has an extremely high rate of maternal mortality, at 807 women per 100,000 live births, with 25 percent of these due to post-partum haemorrhage. Where women in Malawi are giving birth at home, TBAs have no resources to stop excessive bleeding in the case of complications, and women are often brought to a medical facility when it is too late to be given medical help. The risk to the child is also great. According to WHO, of all the reasons for death in children under 5 in Malawi, 7% is due of birth asphyxia, and 5% is due to neonatal sepsis.

Only 3% of births were delivered by C-section in Malawi: 4.4% in urban areas, and just 2.9% in rural areas.

To address these issues, the Malawi government passed a law in 2007 requiring all women to give birth at a local healthcare facility with a Skilled Birth Assistant (SBA). In Malawi, midwifery is not considered a separate discipline from nursing, and nursing students undertake a year's midwifery training as part of their overall skill set, although this is not compulsory. According to the Impact Evaluation of the Sector-Wide Approach in Malawi published in 2010, 79% of nurse/midwives had midwifery skills, and could be counted as a SBA. While the value of giving birth with a professionally trained nurse/midwife was self-evident, passing a law without increasing access to medical facilities meant that women often had to walk for hours, if not days, to get to the nearest health centre. According to WHO, 87% of all births in Malawi take place in rural areas, compared to 13% in urban areas where most health centres and hospitals are concentrated. This meant that Malawi's poorest people in rural areas had approximately two times less access to skilled care compared to their richest counterparts – the poorest people had just 45% access to a SBA compared to 84% in the richest category. Malawian women in rural areas had to make the difficult journey to their nearest health centre, many while in labour, and others would journey to a health centre weeks in advance and camp outside the facility until they went into labour. Most health centres have just one room for delivery, and are staffed by a single nurse/midwife with no one to relieve them. Understaffed, lacking critical resources, and oversubscribed, these health centres often struggle to cope, and in the event of complications many still lack the medical facilities to handle emergency situations, including C-sections. In 2010, the law banning TBAs was reversed, and the government has preferred to offer training to TBAs rather than banning them altogether. Regardless of where and how women in Malawi give birth in the wake of all these policy changes, WHO confirms there is still just one SBA to 4977 women in Malawi, that only 57% of women receive antenatal care of up to four visits, that only 57% of births take place in a health facility, and only 54% of births are attended by a SBA; a figure which shows little improvement in almost 20 years from WHO's 1992 study. Sadly for women in Malawi, the Malawi Ministry of Health confirms that giving birth in Malawi still carries a lifetime risk of maternal death, at 1:7.

Young mothers with babies and small children at an Under Fives Clinic

Motherhood in Malawi is obviously a dangerous undertaking; however, having a traditionally large family is still an important part of Malawian culture. For many women, however, the use of birth control is becoming more prevalent, and women are beginning to have more control over their own family planning. Common methods of contraception in Malawi include condoms, birth control pills, Depo-Provera, IUCD, Norplant, and sterilisation. Still, the numbers are very low. According to WHO, the latest survey published in 2004 showed contraceptive use among currently married women to be just 28%; however, this is greatly increased from the first study conducted in 1992, which showed just 7.4%. Contraceptive prevalence at large is at 41%. Malawian culture is still very male-dominated, and many women feel they have little right to make family decisions (including about contraception and family planning) without the permission of their husband. For men, large families are seen as a status of wealth, power, and fertility. Men in Malawi can legally have multiple wives, many also have mistresses, and many women in Malawi feel helpless to ask their husbands to do otherwise. Gender inequality still presents the greatest difficulty in women accessing contraception in Malawi. As things change, however, and women have greater access to education, conscious family planning is slowly becoming more common, but it is still not the norm. RIPPLE Africa sees many of the brightest female students drop out of school at an early age due to teenage pregnancy, which could have been prevented by the use of birth control. Indeed, at a national level, WHO reveals that 34% of women aged 15-19 are mothers or pregnant with their first child. The huge growth in population is also one of the major contributing factors to poverty in Malawi, where a finite number of resources are being divided between a population which is growing in Malawi by 2.7% annually (that's a 29.8% growth in population in a decade!) There is obviously a desperate need in Malawi for better family planning, but access to contraception, proper health education and information, and issues of gender inequality all must be addressed before this is likely to happen.

RIPPLE Africa's support of maternal health is largely through the Kachere Health Centre, which has basic delivery facilities. However, RIPPLE Africa will be conducting research in 2012 to building a brand new Maternity and Family Planning Clinic at the Mwaya Dispensary to address the critical needs of maternal health and family planning in the local community. If you are interested in getting involved with this new project, please get in touch!

Further Information

To learn more about what RIPPLE Africa is doing to help with healthcare in Malawi, please go to the Healthcare section of our website — **www.rippleafrica.org**.