ST. GABRIEL'S HOSPITAL

ANNUAL REPORT 2009

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EXECUTIVE SUMMARY

There were four major accomplishments for St Gabriel's Hospital in rural Malawi in 2009: 1) the May 9th Celebration of 50 years of quality health services by the Carmelite Sisters to the rural poor in central Malawi; 2) addition of a much-needed surgical component to reduce the need for referrals to Lilongwe; 3) implementation of bed-nets for prevention of malaria for all beds in the hospital; and 4) completion of an ART clinic with a new 4-bay Family Centered Care (FCC) facility for intermediate and terminal care of those needing intensive family education or rehabilitation exercises before discharge or team-supported end-of-life care. Each of these achievements has significantly impacted health care delivery in central Malawi.

St Gabriel's maintains a commitment to providing best quality and affordable care to anyone seeking care at the institution. Despite challenges related to staffing, hospital staff was able to provide care to 55146 people; assist in safe delivery to 2794 mothers; initiate 545 new patients on ART and maintain 1630 on treatment. Major surgical interventions were provided for 248 people, and minor procedures provided for 3734. As the threat of HIV/AIDS may appear to better controlled, other infectious illnesses remain a significant problem.

Malaria continues to account for the greatest number of admissions (7197) and deaths (123) at the Hospital. Addition of the bed-nets is a first step towards expanding a prevention component in the community in cooperation with Traditional Leaders. Children paid the highest price in terms of morbidity and mortality caused by malaria, while bacterial meningitis carried the highest fatality rate. Where curative services are not attainable, the hospital recently opened the Family Centered care Unit to care for chronically and terminally ill patients and support and their families.

Preventive Services were provided with community participation and included education, immunization, hygiene and sanitation strengthening, as well as early nutrition supplementation to underweight children.

Supportive Services included the pharmacy, which was able to secure essential drugs throughout the year. The laboratory supported diagnostic services, in addition to endoscopy of the upper and lower digestive system, and radio-imaging (i.e. x-ray and ultrasound. Emphasis on professional and staff development remained a primary focus of hospital management. Four eligible candidates were able to further their studies and training in healthcare resulting in a better trained staff on-site.

The hospital was able to facilitate and host more than 45 students, volunteers and professionals interested in furthering the hospital mission and expanding their exposure to tropical medicine, public health, and palliative care issues in a rural setting. Ties with those who receive such training have a lasting value for sustainability of service delivery at St Gabriel's Hospital.

ABBREVIATIONS

APGAR	Appearance, Pulse, Grimace, Activity, Respiration (Score for Babies at time of birth)
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BS	Blood Smear (malaria)
CHAM	Christian Health Association of Malawi
DHO	District Health Office
EGD	Esophago-gastro-duodenoscopy
FBC	Full Blood Count
GoM	Government of Malawi
HBPC	Home-Based and Palliative Care
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
HTC	HIV Testing and Counseling

Table of Contents

16. APPENDICIES SUMMARY

Outpatient Department (Appendix 1)
Female Ward (Appendix 2)
Male Ward (Appendix 3)
Pediatric Ward (Appendix 4)
Total Death (Appendix 5)

ACKNOWLEDGEMENTS

We are most appreciative of **FIFTY YEARS** of committed and unwavering support from the **Congregation of Carmelite Sisters of Luxembourg, and Open Hand Fir Malawi.**

We are ever grateful for having a dedicated and competent **Board of Directors** that continues to inspire the institution throughout the years with guidance and technical support

The hospital is indebted to the **Government of Malawi (GoM)** for paying staff salaries, in-service training, assistance with healthcare guidelines, provision of free HIV Tests, Antiretroviral (ARV), tuberculosis (TB) anti-malaria treatments and mosquito nets for pregnant mothers and under five children

As a hospital in the Diocese of Lilongwe, we are grateful for support and guidance offered particularly through the **Diocesan Catholic Health Commission and the Christian Health Association of Malawi (CHAM)** especially for its role in coordinating with the Government of Malawi.

Our partnership with **Lilongwe DHO** and **Mchinji DHO** has allowed extension of the *Service Level Agreements (SLAs)*. These agreements allow continued offering of free maternal and child health care within the immediate twenty-one (21)villages surrounding the hospital.
Over the years, St. Gabriel's Hospital HIV/AIDS Program has been positively influenced by the teaching, mentoring, and financial support from **Professor Robert Redfield MD** and his team at the University of Maryland School of Medicine-Institute of Human Virology (UMSOM-IHV).

We finished the third year of a grant from **The Diana Princess of Wales Memorial Fund**, which has allowed development of Home-Based and Palliative Care Services. **The Fund** has given a second grant for another three years to improve home-based care services and staff a Family Care Center that can provide step-down/intermediary and hospice services for patients in need of less intensive services, family teaching, and a peaceful dying.
An initiative of **Joshua Nesbit** - the Frontline SMS Communications Network was the first step toward integrating services provided by hospital staff and community volunteers.

The **Children's AIDS Fund (CAF)**, USA, through guidance of **Anita and Shepherd Smith,** has contributed immensely by advocating for the hospital and promoting the mission and objectives. Their support has resulted in a number of funded projects that benefit the institution and community.

The continued support of **Mr. and Mrs. Raymond Ruddy** of USA who previously co-funded expansion of the pediatric ward, has been graciously extended again with their support in building a four-bay Family Centered Care Facility with an ART clinic

The **United Nations Children's Fund (UNICEF)** and **World Food Program (WFP)** have sustained nutritional rehabilitation efforts at the hospital and in the community through *Therapeutic and Supplemental Feeding Programs* since 2002. In the past **WFP** responded to our request to support HIV infected pregnant women and provided family food baskets for all affected families for not less than eighteen months. Recently, WFP provided support for *Community Empowerment Programs* that benefit People Living with HIV/AIDS (PLWHA) in the community. The **UNFPA** complemented the District Health Offices (DHOs) efforts in improving maternal and child health by eliciting community participation in reproductive health programs.

Through inspired work of **Gabriel Fund Stiehting** facilitated by **Dr Van Wijk Jacob** of Rotterdam who has volunteered medical services for many years, and **God's Economy, Inc**. through Mrs. Cricket of Baltimore, Maryland, the hospital has been able to address a number of specific needs that contribute to providing quality curative medical care and community assistance.

Since 1999, **Sonnevanck Stitching Suppletiefonds** has been supporting tuberculosis (TB) diagnosis, treatment and nutrition activities resulting in improved treatment outcomes for patients.

Joyelle Dominique (USA) and her parents have immensely contributed to the development of the laboratory and recently donated a new Facs Count Instrument to evaluate and monitor the immune status of HIV/AIDS patients.

We have to thank the following donors who especially supported building up a surgical departement :

Prof. W. Strecker, Bamberg, Germany

Kreisklinik Bad Neustadt / Saale, Mrs. Boerste, Germany (Implants, instruments, intramedullary nails)

Prof. Meffert, Dr. Ziegler, University of Wuerzburg, Germany (set classic nail)

Dr. Roth, Fulda, Germany (x-ray-protecting aprons, single theater towels, dressings)

Dr. Carl Oehlund, Varberg, Sweden (theater table, arthroscopy unit, instruments)

Dr. Kathrin Baumgartner, Austria (theater table + accessories)

Dr. Paul Kaiser, Luxembourg (theater table + accessories)

Hospital Staff of Zitha Clinic, Luxembourg, esp. Gunar Jamros (equipment, tools, instruments)

Klinikum Fulda gAG, Fulda, Germany (instruments, implants, sterile containers)

Stefanie Schwab, Kathleen Jonas, Erlangen, Germany (suture material)

German Embassy, Lilongwe, Malawi / German Ministry of Foreign Affairs, Berlin, Germany (external fixator)

and of course Zitha Foundation Luxembourg (x-ray-C-arm, bone instruments, POP instruments and tools, spareparts and tools for the technical departement, external fixators). More equipment for theater and radiology is already on its way to Malawi and will be mentioned in the next year report.

Our sincerest gratitude goes to **St Gabriel's Hospital Staff**, without whom nothing could have been achieved. This list is not exhaustive and our sincere thanks are extended to many other institutions and individuals that have contributed in some way or another toward improvement of care of St. Gabriel's patients.

BACKGROUND

St Gabriel's hospital is a Catholic mission; member of the Christian Health Association of Malawi (CHAM). It was established in 1959 by the Congregation of the Carmelite Sisters from Luxembourg. It is owned by Diocese of Lilongwe, advised by the Board of Governors and operated by the management team.

The mission statement of St. Gabriel's Hospital states:
"To provide excellent services to the poor rural community and all those in need, in a transparent and accountable manner."

As a not-for-profit facility, and in accordance with ethical principles of the Catholic Church, St Gabriel's Hospital provides curative, preventive, supportive and palliative health care services in both hospital and the community for a population estimated to be approximately 205,000.

The Hospital has 265-bed capacity composed of general male and female wards, a surgical ward since August 2009, a labor ward, maternity ward, children's pediatric ward, Nutritional Rehabilitation Unit (NRU), a private wing and a Family Centered Care (FCC). The Outpatient Department (OPD) offers services from Monday through Saturday. Maternal and Child Health Services are provided through both static and outreach clinics. The hospital functions as a referral institution for six health centers operating in the catchment area.

Support from donors and partnership with local, national and international organizations has allowed St Gabriel's to expand its scope of work within the hospital and in the community; resulting in overall improved care for the central regions of Malawi.

5. HOSPITAL ACTIVITIES
1.1 CLINICAL MEDICINE (appendix 1)

1.1.1 OUTPATIENT DEPARTMENT

Cases managed in Outpatient Department (OPD) in 2009 numbered thirty eight thousand nine hundred and six (38906), a figure comparable to last year. Activities and practices instituted by the hospital to lessen the burden on OPD capacity, as well as naturally occurring changes in incidence and attendance fluctuations were sustained. These activities include increasing the mobile outreach capacity in surrounding villages with treatment of some pediatric conditions during mobile clinics, and efforts to dispense antiretroviral drugs (ARVs) up to three months to patients who displayed one hundred percent (100%) ART Adherence for six (6) to twelve (12) months.

Malaria remained by far the primary cause of OPD consultations. The total number of malaria cases treated numbered ten thousand and two hundred and ten cases (10,210). Continued efforts to reduce the burden of malaria are focused on ensuring availability of anti-malaria drugs throughout the year and on-going health education, both at community and hospital level. **In anticipation of scaling up prevention efforts at the community level the hospital was able to secure treated mosquito nets for all inpatients bed**s.

HIV/AIDS was once again the second cause of OPD consultations with ten thousand and fifteen (10015) visits. Most of the patients attended to at OPD were follow ups. A gradual decline of new HIV/AIDS patients is being observed over the last two years. Improved community awareness about HIV/AIDS, combined with demonstrated successful treatment for those on ART and prevention may have contributed to this trend.

Respiratory tract infections were reported as the third cause of OPD consultations and consumption of antibiotics, followed by musculoskeletal and Non-communicable diseases.

Outpatient Department (O.P.D)

Month	2007	2008	2009	% Difference from 2008
January	3518	4121	3144	-23
February	3673	4072	3977	-2
March	4929	3823	3802	-0.5
April	3764	3273	3678	12
May	3943	2782	3057	10
June	3590	2807	3463	23
July	3698	2544	3446	35
August	3258	3272	2792	-15
September	3126	3598	3069	-15
October	3476	3430	2895	-16
November	3942	2938	2754	-6
December	3880	2475	2829	-14
Total	**44,887**	**39,135**	**38,906**	**-0.6**

The average number of patients seen per month was about three thousand (3,000) ranging from (2754 – 3977) with a peak in the rainy season when there is an increase in malaria.

1.1.3 HIV Testing and Counseling (HTC)

The hospital has been working with the community to increase awareness and encourage people to know their HIV status. Selected members of the *Community Volunteers Network* and People Living with HIV/AIDS (PLWHA) were trained in *Antiretroviral Therapy (ART) Adherence* and assisted the hospital in sustaining high *ART Adherence* (97%). Community volunteers' involvement in adherence monitoring also helped the hospital to provide Antiretroviral (ARV) drugs for two or three months in selected patients who have demonstrated consistent one hundred percent (100%) adherence for six months to one year, respectively. This effort helped to reduce unnecessary travel burdens on PLWHA who are receiving ART and decreased congestion in the OPD, resulting in more time for other activities.

To improve access to HIV testing a pilot program supported by a World Bank grant award provided mobile HIV Testing and Counseling (HTC), including CD4 Count Testing and clinical evaluations. The aim of the outreach program was to reach families

near their homes and provide early diagnosis and education for prevention. The project was highly appreciated by the communities but abruptly stopped the operation due internal problems of the partner organization that was managing the grant.

HIV Testing and Counseling (HTC) for Inpatients and Outpatients

Year	**2007**	**2008**	**2009**
Clients Counseled	9376	7735	6750
Clients Tested	9366	7735	6750
HIV Positive	1241	787	617
HIV Negative	8125	6948	6133
Discordant	23	15	20
Prevalence	13%	10%	9%

HIV Testing and Counseling (HTC) is well integrated in clinical practice and the hospital continues to realize strong community support in terms of sensitization for HIV testing.

A Family Centered Care Unit with sufficient space for education in HIV prevention, testing, stabilization of opportunistic infections, and ARV therapy has been generously granted thanks to Mr. & Mrs. Raymond Ruddy through the Gerald Health Foundation.

Over the last four years, it has been observed that the prevalence of HIV infection in the tested population has been steadily decreasing from twenty-eight percent (28%) to nine percent (9%). While this figure is encouraging, there is no room for complaisance because the number remains alarmingly high and continues to threaten the population and future generations. The hospital remains committed to pursuing its efforts, in coordination with the community to strengthen education strategies that are in place.

1.1.4 Antiretroviral Therapy (ART)

In 2009, there was a sixty percent (60%) increase in new patients started on ART; while mortality was similar to the year before at seven percent (7%). Overall, the cumulative mortality for the four years the program has been in place was less than eight percent (7.7%) and below that national average which stands at ten percent (10%).

Antiretroviral Therapy Table

Status		**2007**	**2008**	**2009**	
Ever started on ART		656	340	545	
Alive		572	307	462	
Dead		44 (7%)	23(7%)	39 (7%)	
Defaulted		1	0	-	
Stopped		12	2	4	
Transferred out		27	8	32	

ART in Pediatrics

In collaboration with Baylor Clinic, the hospital provides early HIV infant diagnosis from six weeks of age to all exposed children (born to HIV infected mothers) using HIV DNA PCR.

In 2009, there has been a dramatic increase in children started on ART reaching 13% of adults on ART .At the same time the mortality in children started on ART dropped from 16% to 3% .The results are a reflection of an increase sensitization and implementation of early diagnosis and treatment of exposed children to HIV

ART in Pediatrics Table

Year	**2007**	**2008**	**2009**
Ever Started on ART	63	37	71
Alive	53	27	60
Died	7 (11%)	6 (16%)	2(3%)
Stopped	0	1	0
Defaulted	1	2	2
Transferred out	2	1	7

ART Community Education Outreach

Current activities to optimize St Gabriel's HIV/AIDS Family Centered Approach consist of:

i. Strengthening and expanding prevention activities with particular emphasis on

youth.

ii. Continued support for involvement of the community in HIV/AIDS information and sensitization for HIV testing.

iii. Pursuing and increasing involvement of PLWHA in the community who are trained in *ART Adherence*.

iv. Exploring opportunities to work with local churches in order to involve them in all activities related to HIV education, prevention, testing, treatment and support.

HIV Testing in Ante-natal Clinics

Year	**2007**	**2008**	**2009**
First Ante-natal Visit	4137	3553	3062
HIV Tests (primary, subsequent, and labor ward visits)	4053	3743	2943
Positive Results	121	105	66
Negative Results	3932	3638	2877
% Positive	3.1%	2.8%	2,2%

The HIV prevalence in expecting mothers tested at St. Gabriel's Hospital has been recording gradual decline for three consecutive years. If these results are confirmed the, we should expect significant reduction of new HIV infections

2.1.1 INPATIENT DEPARTMENT
Inpatient Department Table

WARD	**BED CAPACITY**	**ADMISSIONS OCCUPANCY RATE (%)**					
		2005	**2008**	**2009**	**2005**	**2008**	**2009**
Male	35	1259	1445	1719	66	91.0	92
Female	35	2159	2289	2678	93	96.0	105
Pediatric	100	4677	6949	8524	123	190.0	68
Maternity	42	3282	2772	2850	49	62.0	56
Private	13	-	148	165		5.0	13
Surgical FCCU **TOTAL**	24 **16** **265**	- - **11377**	- - **13603**	304 **16240**	- - **102**	- **69**	59 **N/A**

Over the last five years the hospital bed capacity increased by around 60%. During the same period the number of patients admitted increased by 42% (11,377-16,240). The inpatients hospital expansion has resulted in very significant improvement in hygiene and sanitation, reducing the risk of intra-hospital infections and providing more safety both for the patients and the staff.

General Wards

The overall numbers of admissions were nineteen percent (19%) higher in 2009, compared to 2008 mainly resulting from a twenty three percent(23%) increase in pediatric admissions and at a lesser extend the opening of a twenty four (24) surgical beds from August 2009.

Female Ward (appendix 2)

An approximately seventeen percent (17%) increase in female ward admission was recorded in 2009. There were forty- four percent (44%) more female patients admitted than males.

The primary causes of female admissions were malaria followed by complications from abortions. Non communicable diseases were third causes of female admissions, followed by respiratory tract diseases and anemia

Male Ward (appendix3)

A nineteen percent (19%) increase in the number of male ward admissions was seen in 2009, compared to 2008. Respiratory tract infections (13%) and tuberculosis (9%) combined were the leading cause of admissions. Malaria accounted for twenty percent (20%) of the admissions while traumatic conditions declined to 6% from 10% in 2008.

Pediatric Ward (appendix 4)

Pediatric admissions accounted for 57% of the total hospitalization with 23% of children aged less than five years.

The number one cause for admission and death in the pediatric ward is malaria. Over fifty percent (> 50%) of pediatric deaths resulted from malaria and anemia (the second leading cause of admissions); both of which are treatable and preventable diseases. Improvements in community sensitization, education and mobilization remain imperative if these numbers are to decrease.

Respiratory tract infections, diarrhea and malnutrition were respectively the remaining top five of leading causes of pediatric admission.

Neonatal outcome

There were fifty-seven (66) neonatal deaths in 2009 compared to fifty seven (57) in 2008 (16% increase). Most of the neonatal deaths had an unspecified cause; however, many of the most common reported conditions were associated with low Apgar score and neonatal sepsis.
Most of the deaths (64%) occurred in four months (June, July, August and November)
With the support of the pediatric residents from University of Stanford (USA) all the midwives were re - trained in neonatal resuscitation. Impact evaluation of the training shall be carried out this year

Private Wing

Private wing admissions and outpatient attendance suffered from competition with some new well-staffed and easily accessible private clinics in Lilongwe District. Seventy percent (70%) of both inpatients and outpatients come from outside our catchment area. However, due to the distance from the city center, many urban patients are not inclined to travel the dusty and pot-holed dirt road, four 4Km from the tarmac road, in the rainy season in particular. The prospect of having a tar road from Namitete to the hospital in a near future may facilitate the travelling to our hospital from patients who were concerned about the poor condition of the road.

Maternity

The hospital continued providing free maternal and neonatal care to those residing in the twenty–one (21) immediate catchment area villages. This was possible with the renewal of the *Service Level Agreement* with Lilongwe District Health Office (DHO). The services provided at no cost to the patients also covered all referred cases from the six (6) health centers surrounding St. Gabriel's Hospital.

The Ministry of Health has made a recommendation for women to deliver at the nearest health centers unless there is a complication. During the same period, maternity services were made available at Chileka Health Center, located less than 10 km from the hospital. The numbers of deliveries were similar in 2009 and 2008.

Maternity Table

Mode of Delivery	**2007**	**2008**	**2009**
Spontaneous Vertex Delivery	2190	2088	2058
Breech	67	66	56
Vacuum Extraction	80	81	104
Caesarean section	496	474	576
Total	**2,883**	**2712**	**2794**

1.1 Family Centered Care Unit

The construction of the Family Centered Care Unit was finally completed in November 2009 with one year delay. The unit was needed in order to better organize and consolidate HIV prevention, testing, care and treatment activities around the family unit in a suitable environment.

Previously, the *HIV testing and treatment services* were provided in the General OPD in small and congested rooms that did not provide neither sufficient space nor privacy.

The unit has currently six HIV testing rooms, a large conference / education hall, nutrition evaluation and treatment room, pharmacy and therapeutic feeding food storage spaces. Part of the building with sixteen beds is devoted to palliative care, to provide services to chronically/incurable/end of life patients and support their families. The introduction of palliative care services in the hospital is a major step to providing a continuing of care that no longer focuses only on the curative aspect but emphasis on providing comfort both for patients and their families.
The unit opened for admission in December 2009.

1.1.1 Surgery

During the whole year 2009 surgical service was offered at St. Gabriel's except in September when the surgeon was on leave. That is to say that the goal permanent surgical service has been nearly achieved.
The service included emergency operations as well as planned / booked ones and in general surgery, trauma and orthopedics, urology, e-n-t-surgery and a few special gynecological / obstetric procedures. Most of the work was done in the general OPD, the majority of which was wound management including opening and cleaning of abscesses, debridement of septic and necrotic tissue and other cleaning and dressing procedures.

Burn cases were seen less than in former years, but those who were treated were mostly patients with extended burn wounds requiring a lot of time and material. Debridement and skin grafting was frequently done in those cases.
Scheduled, booked operations like in patients with hernia, hydrocele, goiter and prostate enlargement and other diseases were done all around the year. The experience with booking was that about 30 % of patients did not come to the booked date, some came one or a few days later. We hope that with a second operative theater and a booking deposit the compliance can be improved.
Between august and December 2009 a total number of 302 patients were admitted to the surgical ward.
The operative procedures and the OPD activities are shown in details further below.

Establishing a surgical department was not achieved during the year except opening a surgical ward in the old measles ward in august 2009. The only operative theater had to be shared because also gynecological and obstetric operations had to take place, where especially the emergency cesarean sections made planned surgical operations frequently to be shifted to another day.
The activities to build a second theater out of the x-ray-room were started in June after finishing the 50-years-jubilee-celebrations. By checking the quotations decision was made to give order for building to Terrastone. Unfortunately the contractor changed the date of the start several times until finally the country was hit by the lack of fuel. We were promised a start in mid-January 2010.

Equipment for the second theater already has arrived or is on the way to St. Gabriel's, such as a theater table including orthopedic devices, lamps, anaesthesia and resuscitation machines and so on.
We faced a shortage of clinical staff throughout the year 2009. The assistants to the surgeon who rotated during their internship had to do also their general night duties with off from daily routine work. Nevertheless three clinicians were trained, one of them, except when on duty, is full-time attached to surgery which is a great relief and a guarantee for a mid-level-continuity when the surgeon is away.

Operations done in major theater

1. Head and neck

Tumor debulking Kaposi sarcoma of the eye	2
Lipoma res. cheek	1
Lip reconstruction after trauma	2
Rem of skin tumors	2
Rem of sebaceous glands	1
Scalp reconstruction, skin flap	1
Lymph node biopsy	6
Thyroidectomy, partial	2

2. Chest

Breast amputation due to cancer	2
Breast biopsy	4
Breast abscess, huge	3
Breast amputation due to huge fibromas	2
Resection of aberrant breast	2

3.Abdomen

Gastrotomy, polypectomy	1
Revision, septic, adhesiolysis	3
Ileus, resection of small instestine	5

Spenectomy due to trauma	2
Revision of abd., reanastom iliostoma and closure of stool fistula	1
Revision of abdomen, release of old retroperit. haematoma	1
Burst abdomen, revision and closure	2
Revision of abdomen, psoas abscess	3
Revision of abdomen, decompression of small instestine	3
Revision of abdomen, stomach ulcus excisision and Gastrojejunostomy due to advanced antrum carcinoma	2
Gastrojejunostomy due to adv. antrum –ca	3
Subtotal gastrectomy	1
Excisision und suturing of perf. Gastric ulcer	1
Sigmaresection, Volvulus	6
Iliocoecal res. and anstaomosis due to tumor	1
Iliocoecal res. and anastomosis due to infection / perforation	4
Resection of liver cyst (4 liters)	1
Revision of abdommen, palliative tumor debulking	5
Revision of abdomen due to peritonitis	17
Reanastomosis after Hartmann`s procedure	1

4. Abdominal wall

Umbilical hernia, Mayo	5
Epigastric hernia, Mayo	4
Inguinal hernia repair	24

5. Extremities

ORIF distal femur	2
ORIF distal tibia	2
ORIF humerus	3
ORIF humerus supracondylar	2
ORIF radius or ulna, intramedullary wire	3
Rep. distal radius , K-wires	4
Ext. fixation distal tibia	2
Ext. fixation shaft of tibia	2
Ext. fixation prox. Femur	1
Hip arthrodesis	2
Osteomyelitis, bone debridenet	7
Osteomyelitis, path. Fractur, bone debr. and ext. fix.	
tibia	2
femur	1
Bone biopsies	4
Amput. Femur	2
Upper arm	1
Lower arm	2
Lower leg	3
Fingers, Toes	7

Reconstruction 1st toe and tendon repair	2
Soft-tissue debridement due to infection/ foreign body	10
Rem. of K-wires	4
Tumor resection (neuroma ulnar nerve)	1
Tumor debulking (Myxoma) hip area	1
Tumor Resection metacarpals	1

6. Skin

Tumor removal	14
Secondary suturing	5
Extended debridement	7

7. Gyn.Obs

Hysterectomy and bladder repair due to vesicouterine fistula	1
VVF repair	2
Repair 3rd degree tear, temp. colostomy	1

8. Plastic and reconstructive

Spit skin graft	16
Full thickness skin graft	2
Rotation flap	3
Release contracture, z-plasty, skin graft, fingers and knee(burns)	7
Scar / ulcer excisision chest wall and reconstruction	1

9. Urology

Prostatectomy	2
Bladdertumor, partially resected	1
Circumcision	5
Orchidectomy	8
Orchidopexia	1
Hydrocelectomy	7

Procedures in the Treatment rooms

Cleaning and dressing	1929
Incisision and drainage of abscesses	502
Septic and burns debridement and dressing	232
Suturing of wound , suture removal	352
Rem of for. bodies (eye,ear,nose,oesophagus)	26
Biopsies	4
Rem. of skin tumors	13
Procto-, rectoscopy	15
Haemorrhoidectomy / release of anal throbosis	11
Chest drainage	14
Skeleton traction in adults	8
Skin traction in children	22
Reposition of joints : shoulder	2
hip	2
jaw	2
finger	4
Removal of external fixator	5
of K-wires	6
Amputation : fingers and toes	7
lower leg	2
POPs applied	334
removed	136
Figure of eight - bandages	28
Cuff and collar	24

NURSING DEPARTMENT

The Nursing Department remains a critical component of all institutional activities providing healthcare. The core function of the nurses was to render nursing care for in patients, out patients and home care for those patients on Home Based and Palliative Care. The nursing department operates on average with twenty (20) nurses which were far below sixty four (64) nursing staff as per staff the establishment. The extreme shortfall in the nursing personnel exerted a lot of pressure on the nursing department. Despite these shortfalls, the nursing department took a leading role in maternal and child health services, nutrition rehabilitation services, pharmacy and community programs (HBPC, HIV/AIDS, and IGA).

Maternal and Child Health Services (MCH)

These services were largely provided by nurses. Maternal and Child Health Activities comprised of:

Under Five and Antenatal Clinics

These were conducted at both hospital and community level. Health Surveillance Assistants and Community Growth Monitoring Volunteers were largely involved in health education, growth monitoring, immunizations, and distribution of food supplements to the eligible under five children, nursing and pregnant mothers. HIV testing for antenatal women and their partners is one of the routine activities done in antenatal clinic. During 2009 there were three thousand and sixty two (3,062) antenatal mothers attending antenatal clinic for the first time and two thousand nine hundred forty three (2,943) were tested. A total of six hundred seventy two (672) men accompanying their wives to antenatal clinic were also tested. For details see *(table on HIV/AIDS)*

Maternity Ward

Out of the two thousand seven hundred ninety four (2,794) deliveries conducted in 2009, the majority with low risk (79%) was assisted by the nurses and the remaining twenty one percent (21%) were caesarian sections.

There was 16% neonatal death increase in 2009. The nursing team has been working in improving skills in neonatal resuscitation in order to reduced deaths related to asphyxia.

Kangaroo Mother Care

Kangaroo Mother Care has been introduced to the hospital four years ago but its implementation has been unsuccessful. Part of the failure is due to shortage of nurses. One of the organization ; Mai Khanda that helps the hospital to reduce the neonatal death is exploring ways to train hospital attendants so that they support mothers in need of kangaroo mother care services.

Antiretroviral Services

Organization of day to day management of ART (Antiretroviral Therapy) Clinic, ART education sessions and orienting of patients to appropriate care and treatment was smoothly managed by nurses and HIV/AIDS Coordinator

Outpatient Department

Throughout the year the nursing department failed to allocate nurses to deal with day today outpatient care requiring nursing management. However those client requiring nurses attention were channeled to the ward for care and treatment.

5.2 SUPPORTIVE SERVICES

5.2.1Pharmacy

The head of the nursing department and her deputy managed the pharmacy. The pharmacy work comprises (but is not limited to) drugs and supplies forecasting, procurement, stock updating, and dispensing to both inpatients and outpatient.

Exchange of short shelf life drugs, those not in frequent uses with those frequently used was done with other CHAM hospitals.

The expansion of the hospital with the new Family Centered Care Unit that encompasses a pharmacy and a dispensing outlet increased the workload of the pharmacy managers who were already strained. This is not likely to improve unless the hospital finds either a pharmacist or a pharmacy technician since the cumulative number of patients attended at the ART clinic increases over time.

Most of the drugs and supplies were provided by the NGO (Open Hand Fir Malawi) that has been supporting the hospital over the last twenty (20) years.

5.1.2Laboratory

The three most requested lab procedures for clinical investigations were Full Blood Count (FBC), blood smear (BS) for malaria parasites, and biochemistry tests. Full Blood Count (FBC) and blood smear for malaria (BS) requests resulted from the most frequent causes of OPD consultation and admissions; which are malaria and anemia. Biochemistry tests were needed to investigate liver, kidney and pancreas diseases, among other metabolic and physiological conditions.

Laboratory Procedure Table

Type of Test	2007	2008	2009
Hematology ·FBC ·CD4 Count	8883	15683	12740 12165 583
Biochemistry ·Liver ·Renal ·Pancreas	4007	5962	2433 1518 530 385
Parasitology · Malaria parasites · Schistosoma Ovas	6123	9320	10047 10034 13
Microbiology ·AAFB ·Gram stains ·Stool ·India Ink	1627	1093	2590 1399 567 199 425
Serology ·HIV ·Syphilis ·HBsAg ·Cryptococcal Ag	359	1250	1223 220 468 327 208
Pregnancy Tests	452	571	656
Urinalysis	1579	1501	1099

The workload in the laboratory procedures was significantly increased in 2009 in the Microbiology where there has been a dramatic increase at 136%.

Status of Laboratory Instruments & Reagents Supply

Type of Instrument	Non-Operational / Breakdown	Reagents Out of Stock
Full Blood Count (FBC) - Coulter ***Humacount***	10 months ***N/A***	No reagents from March – December 2009 ***Regular supply***
Biochemistry - Vitro DT 60 ***Humalyser 3000***	Out of order ***N/A***	N/A ***Regular supply***
CD4 Counter – Point Care Now	10 months	No reagents from August – December
Cryptococcal Antigen Test	N/A	Regular supply
Viral Load Test (VLT) – Tecan	Instrument not in use	N/A

The laboratory experienced problems with two (2) instruments at the beginning of 2009. With Hematology Coulter Count the technician who was providing maintenance service defaulted and the reagents vendor was unreliable. The DTE Chemistry instrument broke down and had to be sent to South Africa for repairs from where it has never return.

Thanks to the Congregation of Carmelite Sisters the hospital acquired a new Humalyser 3000 Chemistry instrument and a Humacount that has been running with no problem. The viral load instrument donated by University of Maryland has not been operating due to prohibitive cost of reagents but also lack of local expertise.

1.1.2 Radiology

Radiology Unit performed less X- ray with two thousand seven hundred fifty four (2754) compared to three thousand two hundred twenty seven (3,227). Chest x – ray was the most common x – ray performed.

The department utilizes a second hand machine. An automated x – ray processor was donated to the unit to reduce the time of processing manually the x – ray films. Ultrasound – scanning explorations for general outpatients, private patients and maternity unfortunately inconsistently recorded.

1.1.3 Endoscopy

Endoscopy explorations were reduced to one session a week due to limited staffing. In 2009, four hundred fifty seven (457) procedures including esopha-gastroduodenoscopies (EGD) and colonoscopies were performed. There were a 20% les procedures performed. Daeyang Luke Hospital is now offering endoscopies with start of the art video endoscopes. It is likely that many of the patients that were coming from Lilongwe might be going to that hospital that is closer.

Esopha-gastro-duodenoscopy (EGD)

Procedure Outcome	**2007**	**2008**	**2009**
Normal	308	272	246
Peptic Ulcer Disease	95	97	88
Esophageal Cancer	74	49	44
Other Cancer	27	42	11
Others	54	107	68
Non-Conclusive	0	8	
TOTAL	**558**	**575**	**457**

Colonoscopy

Year	**2007**	**2008**	**2009**
Number of Procedures	31	27	24

The others diagnosis included Esophageal caustic burns, varices, candidiasis webs, perforated duodenal ulcer, and gastric polyps
The proportion of peptic ulcers and cancers remained similar to the previous year. Treatment for peptic ulcer disease was available throughout the year. Patient with advanced cancers were referred to Home-Based and Palliative Care for pain management

1.1.4 Primary Health Care (PHC)

Primary Health Care (PHC) Services consisted of, immunization, nutrition, environment health and prevention of communicable diseases.

Immunization

Vaccines	Coverage 2007	Coverage 2008	Coverage 2009
BCG	285%	216%	1091 (153%)
Pentavalent	195%	161%	595 (83%)
Polio	206%	149%	663 (93%)
Measles	183%	142%	751 (105%)
Vitamin A	81%	788%	3983 (557%)

For the last two years the expanded programme on immunization has been above 80% and the hospital was commended by the MCH Coordinator of Lilongwe District Office for achievement made and was excluded from measles catch up campaigns conducted in April and October 2009.

Growth Monitoring

Growth Monitoring	2007	2008	2009
Number of weighed under 5	13923	10569	8388
Under 5 with normal weight	11963	6858	3120
Severe malnutrition admitted	428	261	262
Cured	339 (80%)	185 (71%)	194 (74%)
Death	52 (12%)	35 (13%)	34 (11%)
Absconders	33 (8%)	14 (5%)	10 (4%)
Still under treatment	2 (0.46%)	27 (10%)	24 (9%)

There has been a decrease in the number of children weighed since 2007 due to new demarcation of St Gabriel's immediate catchment area. As a result, St Gabriel's is operating only two under five outreach clinics as opposed to ten (10) in 2006 but continues with Antenatal care services in all but one where services were temporary suspended due to low attendance.

Nutrition and Rehabilitation Unit (NRU)

Nutrition and rehabilitation has three components namely; Nutrition and rehabilitation unit for severe malnourished children, Outpatient Therapeutic Program (OTP) for malnourished children with good appetite and Supplementary Feeding Program (SFP) provided for children discharged from OTP/NRU, moderately malnourished children, pregnant and lactating women up to six months after delivery who have a middle upper arm circumference below 22cm.

With the introduction of ready for use therapeutic food (RUTF) locally known as chiponde the number of severely malnourished children who died or absconded has declined. Those who died mostly came from outside our catchment area. It was observed that absconders mostly happen during the rainy season when people are busy in the gardens.

Prevention of Communicable Diseases

Prevention of communicable diseases is done through community information, education and communication at OPD, outreach clinics, static clinics and in the villages. In 2009 St Gabriel's catchment area did not experience any epidemic outbreak

Leading Causes of Fatality Table (Detailed)

Disease	Total number of cases			No. Died			Fatality rate (%)		
	2007	2008	2009	2007	2008	2009	2007	2008	2009
HIV/AIDS	236	196		33	59	22	14	30	15%
Sepsis	241	50		31	11		13	22	
Meningitis	124	140		34	29	25	27	21	26%
Malnutrition	433	229		52	38	37	12	17	14%
TB	291	362		23	24	15	8	9	4%
Heart Disease		220			15	28		7	9%
Pneumonia	1091	905		79	52	73	7	6	5%
Anemia	1236	2021		65	63	78	5	3	3%
Diarrhea	387	321		26	-		7	-	
Non Communicable	6	1665		34	54	48		3	5%
Malaria	3154	6128		106	111	123	3	2	1.7%
Surgical	-	442		-	-	22		-	3%

Bacterial meningitis reemerged as the number one cause with highest fatality (26%) while HIV/AIDS related conditions comes second (15%) followed by malnutrition (14%), heart diseases (9%) and TB and pneumonia (9%)

Maternal Death Review

The maternal death at this institution has been around seven – eight (7-8) per year in spite of all efforts put in place to minimize the risk of maternal death once mothers arrive at the hospital. In 2009 Out of eight (8) deaths, six (6) were due to direct causes, two (2) were due to indirect causes (Acute Bacterial Meningitis and Lung Infection (Pneumonia /PTB).

Half of the mothers who died came from our immediate catchment area (TA Kalolo and Mavwere) and the rest came from Mozambique.

Maternal Death Table

Patient stay in hospital	Diagnosis	Management	Comments
2 days	Severe sepsis post – induced (traditional) abortion at home	Ceftriaxone, Metronidazole, O2 therapy and in fluids	Appropriate but unsuccessful treatment.
12 hours	Severe sepsis post abortion	Ceftriaxone, evacuation	Severe condition associated with poor outcome.
3 days	Labour pneumonia / PTB in pregnancy (1^{st} trimester)	Ceftriaxone	The final diagnosis was not clearly stated.
15 minutes	Post abortal haemorrhage / anaemia	IV fluids	Arrived too late at the hospital.
30 minutes	Acute Bacterial meningitis / puerperal sepsis, delivered at home	X-pen chloramphenicol from H/C	Late reporting to the hospital.
1.5 hours	Streptococcal meningitis in 3^{rd} trimester, came in coma	Ceftriaxone	Delay in reporting
5 days	Anaemia in pregnancy, HB 3.1g/dl	Got 1 pint of blood	Lack of blood No donors No blood at MBTS
0	Brought dead	Confirmed death	Arrived dead .

1 DEVELOPMENT PROJECTS (Currently In-Progress)

1.1 Strategic Plan Implementation

The hospital's development has been guided by a *Five Year Strategic Plan* to initiated in 2006 to end this year (2010). The Management has been working hard to source funds to implement various strategic activities. Implementation has been dependent on resource availability.

St Gabriel's Hospital can be proud of several activities though few interventions are yet to be completed

1. **Land demarcation:**
   The hospital was recently granted land by Lilongwe Diocese to respond to the hospital future development. The process of demarcation of the hospital land with a new master plan under way.

2. **Security Fence:**
   The security fence has not yet been built due to lack of funding; the Congregation of Carmelite Sisters has recently pledged to cover the cost of the security fence.

3. **Tarmac Road from Namitete Trading Centre to St Gabriel's Hospital:**
   The hospital has made several unsuccessful attempts to many potentials donors to built a tarmac road from Namitete trading center.
   After preliminary contact, the Chairman of the Board encouraged to submit a reapplication to his Excellency the President of the republic of Malawi. It is with the personnel input of our Bishop Remy Ste. Marie that the hospital application was presented to the President
   It is with deep gratitude to His Excellency, the President of the Republic of Malawi that St Gabriel's Hospital Community learned that the tar road so much waited was going to be built this year.

4. **Emergency Department / OPD Expansion:**
   The construction of an upgraded OPD with an emergency department will start this year (2010). Thanks to the support of the Congregation of Carmelite Sisters and the NGO (Open Hand Fir Malawi).

With the completion of those above items the 2006 -2010 Strategic Implementation would have been achieved by 98%

1.2 Home-Based and Palliative Care Services

1.3

The hospital has been providing services to patients with chronic and incurable diseases under the Home Based and Palliative Care program with the grant of Diana Princess of Wales Memorial Fund since September 2006 and Capital Hospice since June 2009.The services are now fully intergraded into the hospital core activities with referrals from all Health Centers as well as the communities within and outside St Gabriel's Hospital catchments area.

During 2009 the program aimed at: pursuing service delivery, replenishing Home Based and Palliative Care kits, strengthening capacity building, monitoring and evaluation of the whole program. All the above objectives were fulfilled except on service delivery where the number of patients enrolled in the program was less than the number expected at the time of the proposal design. This was due to a successful Community Mobilization that resulted in early HIV testing and ART initiation preventing some patients to reach the HIV stage that require Home Based and Palliative Care.

Three hundred ninety two (392) new patients were enrolled in the program. Thirty eight (38%) suffered from cancer, thirty two percent (32%) were living with HIV/AIDS (PLWHA), twenty three percent (23%) from cardiovascular and heart disease and ten percent (10%) from other various conditions. Figure 1 summarizes number of new patients registered, number of home visits, discharges and deaths.

Figure 1: Bar graph below summarizing the service delivery and patients' outcome

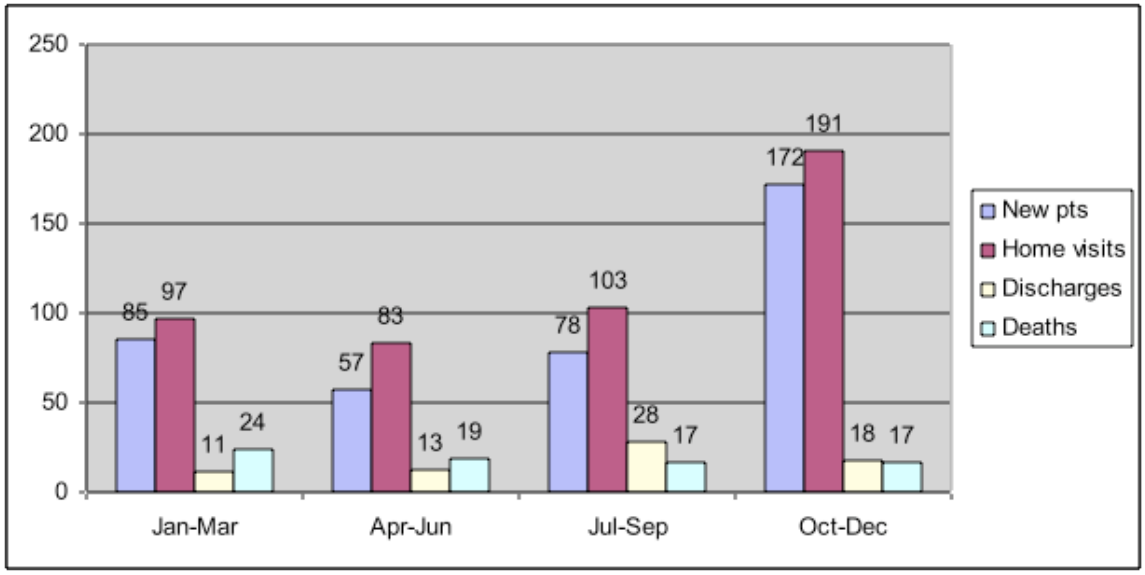

Figure 2: Shows cumulative number of patients enrolled in Home Based and Palliative Care from 2007 - 2009

CONDITION	**2007**	**2008**	**2009**
HIV/AIDS	106 (53%)	140 (32%)	124 (32%)
Cancer	31 (15%)	123 (28%)	149 (38%)
CVS	43 (22%)	128 (29%)	92 (23%)
Others	18 (9%)	45 (10%)	27 (7%)
TOTAL	**198**	**436**	**397**
Registered on morphine	26 (13%)	67 (15%)	89 (23%)
Died	76 (38%)	132 (30%)	77 (20%)

The hospital was successful in its second application for funding to continue the Home Based and Palliative Care activities and the opening of the hospice.

One of the biggest challenges has been the hiring and staff retention what impacted on timely identification and enrollment of some of the patients who were not at an advanced stage of their illness.

However, the program enjoyed a community support and communication with the volunteers was greatly improved with the utilization and of the SMS Frontline Network.

1.4 Community Empowerment

St Gabriel's Hospital has a strong commitment for working with communities within its catchment area. During 2009 the focus has been on increasing food security and source of income. With the assistance from God's Economy the hospital was able to distribute farm inputs such seeds, fertilizer and tools to five (5) Support Groups each comprising of twenty (20) to thirty (30) members.

In addition, the project was able to built five (5) kraals one (1) for goats and four (4) for pigs respectively. Three (3) Support Groups were successful in piggery farming that they were able to share the siblings among themselves. Following this success one group has been awarded a second phase of project of pig rearing which will be completed in 2010.

Family and Reproductive Health Services

These services were mainly implemented at community level by Reproductive Health Committee members with the assistance of the PHC Coordinator under the direction of

the nursing department. The main focus was to work with the Traditional Birth Attendants as well as helping the Birth Attendants to understand their role in Reproductive Health Services.

Though the program targeted seven (7) Group Village Headmen from T.A. Mavwere and eight (8) from T.A. Kalolo, most of the Group Village Headmen were involved. There were several meetings and exchange visits which helped built capacity of the Reproductive Committees to improve their work in the area of neonatal health. In most Group Village Headmen a ruling has been imposed that any Traditional Birth Attendant deliberately delivering a woman will be fined. Monitoring of results outcome will be presented in the future

1.5 Family Centered Care Unit

The construction of a Family Centered Care Unit was justified by the need to organize and consolidate the number of HIV prevention, testing, care and treatment activities around the family unit in a suitable environment.
After one year delay, the building was finally completed in November 2009 and is in use.

The facility has two units; the front part with six HIV testing rooms, a large conference / education hall, nutrition evaluation and treatment room, pharmacy and therapeutic feeding food storage spaces. The rear unit is suited with sixteen (16) beds currently in use to provide Palliative Care Services to eligible patients as well as for information, education and support for the families.

The Palliative Care Unit has been funded to employ four (4) trained nurses in Palliative Care with a Clinician, a team of eight (8) Nurse Aides and two (2) drivers who will be equipped with ambulance motorcycles to transport patients who may wish to rest in peace at their homes. So far the unit has been able to hire only two (3) nurses. While waiting for the Clinician the clinical work is provided by the hospital clinical staff and the supply of the Ambulance Motorcycles has been delayed but is expected to be finalized this month. Out of the four nurses to work in the Palliative Care unit two are funded by Diana Memorial Fund and the remaining by Capital Hospice USA.

1.6 Construction of Staff Houses

The Congregation of Carmelite Sisters of Luxembourg has been assisting with improvements of staff housing. In 2009 two semi detached houses funded in 2008 were completed and soon occupied. The Congregation of Carmelite Sisters also funded the renovation of the Surgeon's house.

2 PREVIOUSLY FUNDED PROJECTS

1.1 Incinerator

The state-of-the-art incinerator donated by Foundation Ste. Zithe was commissioned in November 2007 and the system has been operating well since installation. The installation was in response to the hospital need for safely processing hospital biohazardous wastes while protecting the environment. Its acquisition and operation have since been paired with significant improvement in hospital infection control.

The hospital has contacted potential users that are sensitive to the issue of environmental protection and biohazard waste management to share in the use of the systems great capacity. To date, two institutions including ABC Clinic and the US Embassy are utilizing the facility. Cooperative users are requested to pay a fee to cover part of the operational overhead of the incinerator (e.g. diesel costs, etc.). Increased usage of the incinerator may be limited by the fact that institutions have not made budget allocations for enhanced waste processing services. It is hoped that this resource will be more widely utilized in the future and eventually become an income generating activity.

1.2 Water Tank Storage, Sewer, and Water Reticulation

With the gradual expansion of the hospital, the water reservoir built several years ago was no longer able to meet the needs of the new buildings and infrastructure. Upgrades were instituted and also extended to the sewage and the water reticulation systems that were no longer suitable for the growing institutional needs. Open Hand Fir Malawi, based in Luxembourg, donated the funds required to increase the water tank capacity to sixty thousand liters (60,000 L) and upgrade the water reticulation and sewage systems. The new structures securely provide enough water for general usage and no problems of sewage blockage have been reported since the upgrades were carried out.

1.3 Storm Drainage

The Storm Drain Upgrade Project was a response to the problem of recurrent flooding of the pediatric ward during the rainy seasons. The upgrades corrected the deficiencies and no flooding has occurred since the upgrades were instituted.

1.4 Construction of New Pediatric (Children's) Ward

The previous pediatric ward built in 1975 had a capacity of twenty-seven (27) beds. During the rainy season, at the peak of malaria outbreak in the region, pediatric ward was forced to house around 200 children under stressful conditions.

Thanks to the combined generosity of the Raymond Ruddy Family through the Gerald Health Foundation, the European Union (EU) Delegation in Malawi, and the Foundation Ste. Zithe based in Luxembourg a new facility was constructed. The new facility offers improved lighting and ventilation, significantly improved space for one hundred children's beds at any given time, isolation bays to separate infectious cases from others cases, partitioned rooms for procedures, treatment, pharmacy and a welcoming admissions counter and waiting area that has stemmed crowded conditions apparent in the former ward. The new unit is a well-planned and welcoming structure that is celebrated by patients and staff alike.

1.5 Construction of Kitchen for Malnourished and TB patients

The construction of a decent cooking facility to prepare food for malnourished and TB patients was very much needed. The previous cooking area was inadequate and very poorly ventilated. The new kitchen was constructed with a grant provided by the Foundation Ste. Zithe of Luxembourg. The facility is equipped with all the required utility of a modern community kitchen. Utilization of the facility was delayed in 2008 due to electrical wiring problems.

1.6 Mobile HIV and CD4 Count Testing

The major problem encountered in the implementation of HIV/AIDS activities has been the inability to reach all of the extended family members of the infected individuals to provide them with comprehensive HIV/AIDS services. The primary factor reported to contribute to the inadequate access to services aimed at stemming the HIV pandemic is the problem of distance and / or lack of money for transportation to treatment and service locations.

To respond to this challenge the hospital embarked on a pilot project on mobile CD4 Count Testing in partnership with Pointcare after winning a World Bank Award. The hospital was to provide the technical part of the project and Pointcare was responsible for the Finance Administration of the World Bank grant.

Due to internal problem of Point Care, the project s so much appreciated by the communities was abruptly interrupted. The hospital has not yet secured another donor to support the continuation of the project that was consider to be one of its kind in Africa

1.7 Prevention of Mother to Child Transmission (PMTCT) of HIV Program

The Prevention of Mother To Child Transmission (PMTCT) Program was instituted in 2002 with a grant from Glaxo Smith Kline (GSK) through the *Children AIDS Fund USA*. The program also greatly benefited from the technical, as well as financial support from The Institute of Human Virology

(IHV) in Baltimore, Maryland, USA. The program helped to establish and build Village AIDS Committees (VACS), as well as educate and mobilize volunteers to assist in the community support efforts.

The PMTCT Program is now integrated into routine hospital activities with one hundred percent (100%) of pregnant mothers accepting HIV testing in Ante-natal Clinics (ANC) or in labor wards.

GSK also generously provided a grant to build a guest house for GSK staff and other visitors who visit the hospital on a regular basis to follow up the progress of the HIV /AIDS programs.

ADMINISTRATION AND HUMAN RESOURCES

1. Staffing in 2009

Cadre	Establishment	Employees Jan – Dec 2008	Employees Jan – Dec 2009	Staff Appointed in 2008	Staff Appointed in 2009	Left in 2008	Left in 2009
Clinical/Medical division							
-Medicals	4	3	3	0	1	0	0
-Para-medics	20	7	12	9	10	6	4
Nursing							
Nurses	56	30	24	11	12	11	6
Hospital / Patient Attendants	48	46	48	4	7	2	5
Preventive health services	19	4	3	2	0	0	1
Health technical support							
- Laboratory	6	4	5	5	1	3	3
- Radiology	6	0	1	0	0	0	0
- Pharmacy	5	3	0	2	0	1	0
- Dental	5	1	1	1	0	0	0
- Ophthalmology	5	0	0	0	0	0	0
- Dermatology	3	0	0	0	0	0	0
Finances and Administration							
Principal Hospital Administrator	1	1	1	1	1	1	1
Finances Management	8	10	7	4	0	0	1
Human Resources	8	4	5	1	0	0	0
Office services	55	39	45	6	2	1	4
Total	**249**	**153**	**155**	**46**	**34**	**25**	**25**

Note: In general more staff were recruited/appointed in 2008 than 2009 i.e. 46 and 34 respectively. The overall turnover rate was almost the same for both years, although that of 2008 was slightly higher i.e. 16.34% and 16.12% respectively.

Although the overall turnover rate was just above 16% in both years, turnover in Health professions was very high. For nurses the rate was 36% in 2008 and 25% in 2009. There was a decrease in 2009 and it would be healthy if the trend continued.

For Para-medics, the turnover rate was 85% in 2008 and 40% in 2009. Again this shows a significant decrease in 2009.

Although the actual figures of staff leaving in the health professions is small, the percentages indicate a serious problem of turn over which need to be addressed.

2. Academic Staff Development

2.1 Masters in Surgery

The Chief Medical Officer was expected to complete his training in surgery at the University of Malawi (College of Medicine) in September 2009. The training has extended up to March 2010. The Training is sponsored by Open Hand Fir Malawi of Luxembourg.

2.2 Diploma in Nursing - Upgrading

One Nurse Technician completed a two-years Diploma in Nursing in August 2009– Upgrading Programme. Foundation Ste. Zithe funded the training

2.3 Diploma in Nursing (State Registered Nurse)

One sister completed her training and obtained a Diploma in Nursing (State Registered Nurse) and resumed work on 1st August 2009.

2.4 Certificate in Midwifery

2.4.1 One Nurse Technician completed a Certificate in Midwifery course in September 2009.

2.4.2 One other Nurse Technician was supposed to start a Certificate in Midwifery course in September 2009, but the date has been postponed until further notice due complications caused by Government's withdrawal of funding such training programmes. The course is for one year.

2.5 Diploma in Nursing and Midwifery

One Hospital Attendant was supposed start a three years Diploma Course in Nursing and Midwifery at the Holy Family College of Nursing on 28th September 2009. The start date was postponed until further notice, but it started on 11 January 2010. Foundation Ste. Zithe is funding the training.

2.6 Diploma in Anesthesia

A senior Medical Assistant finished eighteen month training in Anesthesia in July 2009 and started work in August 2009. The training was funded by Foundation Ste. Zithe.

				2008	2009	2009
				ACTUAL	VARIANCE	VARIANCE
					MK	%
				42,195,521.00	844,263.66	2
				37,090,271.00	1,704,851.73	5
				45,294,110.00	(13,963,318.78)	(31)
				8,074,611.00	14,210,601.20	176
				338,721.00	(148,441.88)	(44)
				2,466,910.00	2,073,384.31	84
				4,216,465.00	(609,499.00)	(14)
				22,298,193.00	(21,391,138.00)	(96)
				11,555,946.00	(3,397,836.77)	(29)
				-	2,109,480.00	
				–	4,998,731.30	
				4,517,728.00	(4,517,728.00)	(100)
				506,780.00	2,098,492.82	414
				14,704,086.00	(4,477,374.46)	(30)
				771,166.00	4,027,868.58	522

				194,030,508.00	**(4,907,476.15)**	
					–	
				53,260,741.00	10,174,758.88	19
				8,575,441.00	(6,351,291.77)	(74)
				27,583,880.00	(17,026,623.47)	(62)
				19,643,222.00	(18,736,167.00)	(95)
				1,241,041.00	3,557,993.58	287
				4,517,728.00	1,237,791.01	27
				20,062,803.00	(9,836,091.46)	(49)
				5,366,546.00	2,791,563.23	52
				-	2,109,480.00	
				–	4,998,731.30	
				3,395,238.00	(789,965.18)	(23)
				3,156,419.00	450,547.00	14
				199,790.00	1,224,802.69	613
				1,030,554.00	1,312,773.62	127
				128,362.00	2,697,415.55	2,101
				685,062.00	4,363,946.52	637

				5,374,240.00	(1,156,446.90)	(22)
				1,712,257.00	758,812.65	44
				27,750.00	368,054.64	1,326
				1,204,364.00	787,520.81	65
					133,651.00	
				693,735.00	(366,902.00)	(53)
				–	90,000.00	
				–	312,421.97	
				–	367,690.00	
				364,715.00	605,395.00	166
					103,710.00	
				6,377,948.00	(5,977,948.00)	(94)
				23,416,193.00	574,352.78	2

NOTES TO THE ACCOUNTS

ACCOUNTING POLICIES

The principals of accounting policies adopted in the preparation of these accounts are set out below and have been followed consistently in all material respects

BASIC OF PREPARATIONS

The accounts have been prepared using historic cost conversion. In all material respects the accounts have been prepared in line with International Accounting Standards (IAS)

DEPRECIATION OF FIXED ASSETS

Fixed assets are depreciated using straight line methods to spread their costs over the useful lives. The rates are as follows:

INCOME

Income consists of Hospital fees collected from patients, Grants from Government through Christian Health Association of Malawi(CHAM), Interest earned through investment of cash, and donations. Some of donations are made for specific activities /programmes while others are for general operations of the hospital.

PROVISIONS

Provisions are recognized when the hospital has a present obligation as a result of past event, when it is probable that the obligation will result in an out flow of economic benefits and can be reasonably estimated.

DONATIONS

Cash donations are brought into accounts when they have been received. Donations of Drugs and fixed asses are credited to capital funds.
Transfers equivalents to consumption of the drugs during the year and depreciation charge for the year on the fixed assets are released to the income statements.

OTHER INCOME

As a way of generating income, the hospital has some income generating activities which includes:

Battery Charge, Bicycle parking and cafeteria rent

PREPAYMENTS

These are payments made in advance e.g. Life assurance.

DEFFERED INCOME

This is income received during the accounting period for future use.

OVERALL RESULT

INCOME
Income from hospital fees has increased by 8.1% as compared to last year due to increased number of patients in the private OPD for endoscopy . service agreement for pediatric patients and the opening of surgical wards and new Surgical doctor.

Other Income from various income i.e. rentals , internet for guest house has increased by 88% as compared to last year 2008 due to number of guest used internet and bicycle parking .

DONATION IN KIND
Donations have increased by 176% as compared to last year due to donations for the following items :. Humacount and Humalyzer machine for Laboratory and x ray Machine from Luxemburg and Mortuary Equipment from Press Trust

The total effect is that income has increased by 13.1%

PROGRAMME
Programme funding has increase by 612% due to new programme such as Gabriel Fund

STAFF EXPENSES

While on the expenditure side staff expenses have increased by 19% this is because of an increased in salaries and leave grants

MOTOR VEHICLES EXPENSES
Motor vehicle expenses have increased by 636 % since our vehicles were being taken to Motor vehicle dealers which are expensive for services i.e. Toyota Malawi .

GENERATOR AND INCINERATOR

Fuel for Generator and Incinerator have increase by 100% due to
frequent use of the Gen set which called for fuel expenditure since we were experiencing lots of black out

MEDICAL EXPENSES
There was a decrease in the medical expenses cost since we had a lot of drugs being donated by IDA and also due to decrease in the number of patients treated which affected Hospital fees also resulted in the reduction of Medical expenses by 62%

SURPLUS

There is an increase in surplus due to donations received which inflated the income.

3 APPENDIX

Outpatient Department (Appendix 1)
Female Ward (Appendix (2)
Male Ward (Appendix (3)
Pediatric Ward (Appendix (4)