A Year in Malawi

One nurse’s experience working to improve the country’s limited health care capacity.

If you want to go quickly, go alone. If you want to go far, go together.
—African proverb

Returning to Malawi—the self-proclaimed “warm heart of Africa”—was something I had anticipated doing since I first traveled there in 2008, when I was a student at Rhodes University in South Africa. Malawi is a landlocked country in southern Africa, the majority of its eastern border flanking Lake Malawi, a 365-mile-long body of water lined with small fishing villages and impressive baobab trees. Locals dub it the “lake of stars” for the bobbing fishing-boat lanterns that line the horizon on most nights. Poor populations in rural parts of Malawi are juxtaposed with urbane, fashion-forward young professionals in Lilongwe and Blantyre, where an emerging elite has become noticeable among the day laborers and hawkers on the city streets.

During my brief visit in 2008 I was already taken with the country’s beauty and the people’s friendliness. But I was also startled by a noticeable lack of health care resources. I felt an urgent calling to return to share the valuable skills I was learning in my nursing education, and also to know more about the country’s health care challenges. (See Health Care in Malawi: A Snapshot.1–6)

In July 2013, after three years as a pediatric NP in the Boston area, I joined the first cohort of 15 nurses and 16 physicians in the Global Health Service Partnership (GHSP)—a program developed by Seed Global Health, the Peace Corps, and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR)—whose aim is to educate nurses and physicians in Malawi, Tanzania, and Uganda. (Seed Global Health was named in recognition of its commitment to “sowing the seeds of change and cultivating the next generation of health providers where they are most needed.”7) As volunteers, we helped strengthen health care systems by teaching practical skills in both university and hospital settings, alongside host country faculty.

Vanessa Kerry, a physician and the founder of Seed Global Health, has often referred to the “multiplier effect” of teaching: if one person teaches five instructors, and each instructor goes out and teaches 20 students, and each of those students teaches 20 more students, more lives will be affected than if one teacher instructs a limited number of students.

WORKING IN MALAWI

My role was to fill gaps in Malawi’s health care education system, which currently does not have enough qualified faculty. I taught philosophy of nursing to first-year students and pediatric nursing to third-year students, sharing knowledge and skills that the students could then impart to their colleagues. I also taught in the clinical setting and assisted faculty with such projects as the Nurse Education Partnership Initiative’s nurse mentorship program—part of PEPFAR—designed to support local faculty in sub-Saharan Africa by mentoring students in the clinical setting.6

Teaching was an exhilarating challenge in Malawi. Not only did I need to understand what information would be most relevant to my students, I also had to learn the value of humanizing statistics. Child mortality is hard to grasp when presented as 68 deaths per 1,000 live births,2 but when one encounters these deaths daily, numbers become human beings. I remember, for example, walking into the ICU one morning and finding the bed suddenly empty where a three-year-old child with cerebral malaria had been lying for a week. This put a heartbreaking face to the numbers.

Three infants wrapped in traditional Malawian chitenges share an incubator in the Mzuzu Central Hospital special care nursery. Photos by Brittney J. Sullivan.
and name to one of the many children who would not celebrate a fifth birthday that year.

I lived with another GHSP volunteer in Mzuzu—a city in northern Malawi—in a simple, comfortable house on the university campus. We had modern amenities—electricity, hot water, running water—most of the time, although power outages were routine every other Sunday and occurred at other unpredictable times. We were within walking distance to the hospital and the main road, where we could share a taxi to town to do the shopping at the open market. 

My activities varied a great deal from one day to the next. While I taught in Mzuzu, my clinical rotations took place in Zomba in the south. The journey between Mzuzu and Zomba—about 360 miles—could take anywhere from seven hours by private transport to a grueling two-day trek combining rides in taxicabs, buses, and pickup trucks, interspersed by somewhat treacherous walks through crowded and often muddy bus depots, a 30-pound backpack with stethoscope and nursing supplies in tow. I traveled between Mzuzu and Zomba two or three times during each six-week rotation.

At the start of the rotation in Zomba I introduced students to the pediatric unit, gave a few pertinent lectures on health assessment, and taught classes on respiratory and cardiovascular health. I also discussed topics that were not specific to nursing, such as bullying in the workplace, working within interdisciplinary teams, and caring for a dying child. Back in Mzuzu I lectured on conducting community health assessments and developing laboratory skills, helped local faculty design mentoring projects, and attended interdepartmental meetings.

The frenzied pace of Zomba—where I scurried through the crowded hospital with 10 or 12 students, showing them how to change a colostomy bag, examine the abdomen of a baby, or hear a heart murmur amid the cacophony of the pediatric unit—was interrupted by periods of endless tedium. It was not unusual to wait an entire day for a student to show up at the hospital for an assessment only to learn she was in another city on a different rotation. Or to linger for hours in a crowded depot waiting for the bus to fill to maximum capacity before it could depart. Most surprisingly, in the spring, about eight months into the GHSP program, my students were granted an unexpected month-long vacation. This meant that I, too, had a month of no teaching, no grading, and few projects to keep me busy at the university.
Many Malawians I met faulted Americans for being perpetually busy, working too much, and living as though “time is money.” In Malawi, by contrast, time is just time. I began to develop an appreciation for patience and gradually learned to slow down too. I spent many electricity-free weekends enjoying Lake Malawi with friends and strangers, trading stories and gaining a deeper understanding of different cultures—including my own. Not only had the red African dirt permeated my skin, but the people, the work, and even the pace had become a part of me.

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LACK OF ACCOUNTABILITY AND LIMITED RESOURCES
The Malawian health care system is task oriented. At the hospital in Zomba, one student was in charge of admissions, another handed out medications, a third inserted IV lines and administered fluids, a fourth discharged patients, and a fifth rounded with the clinical officers. While nurses were tasked with managing the flow of the unit, patients’ families were expected to provide basic feeding, bathing, and toileting. Little accountability—individual or collective—existed for patient care.

In addition, the scarcity of both human and material resources was apparent in the university and hospital settings. While the university had a shortage of faculty and basic resources such as printers, paper, and textbooks, the hospital suffered hardships more acutely: in one of the tertiary hospitals with a 10-bed burn bay, dressing supplies were always in high demand. Nurses had sterile water to cleanse wounds and gauze to cover wounds, but very little else: no astringents, silver sulfadiazine, or burn bandages—not even tape to keep the gauze in place. Despite these challenges, the nurses—an average of about six for every 122 patients—did what they could, even if that meant simply keeping wounds covered to prevent flies from infecting vulnerable tissue.

On other units, it was not uncommon to run out of salbutamol for asthma patients or to encounter broken oxygenators or sinks without soap—and, at times, without water—even in the operating theaters. Units were often overcrowded, exceeding twice the occupancy limit. At the height of malaria season in Zomba, we had 271 children in a unit fit for 91. Sometimes three or four children would lie listless on the same bed while their mothers sat on the damp concrete floors, never fully dry from the incessant rain.

THE EMOTIONAL TOLL
Health care workers in resource-limited settings rarely have the luxury to mourn. In a 2012 episode of 60 Minutes, Susan Shepherd, a pediatrician serving Médecins Sans Frontières (known in English as Doctors Without Borders) in Niger, discussed the harsh realities of working in a developing country where malnutrition and other ailments strike children disproportionately. “It breaks your heart,” she said. “It can break your spirit. . . . I carry memories of many, many children with me and [I will] my entire life. But you certainly cannot indulge yourself in that kind of sadness.”

On many occasions in Malawi I could relate to Dr. Shepherd’s comments. So much pain and sorrow burdened both patients and caregivers. But I kept pushing forward because I felt that if I took time to mourn, I might be overcome by the reality of the
situation and lose the ability to continue working. Besides, pausing to mourn felt almost self-indulgent. When I wanted to sit down and weep—as when I watched a dead six-year-old wheeled out of the unit, followed by her wailing mother and mourning aunts—I did not. I took a deep breath, bowed my head, and proceeded with my responsibilities, just as my Malawian colleagues were doing.

This approach could have been seen as a lack of caring. But it was a way for me and my colleagues to cope with the sadness of witnessing children dying day after day from preventable illnesses. Still, because I had built a trusting relationship with my students—one that allowed for discussing topics not directly related to nursing theory or physical assessment—I had many talks with them to debrief difficult situations, such as the death of the six-year-old child. Their feedback about these discussions was incredibly positive.

ADAPTING TO LOCAL CULTURE

In America—where almost everything works and connects instantaneously—moments of beauty often go unnoticed. In Malawi I learned to listen to the belly laughs of children running down a dirt lane shouting after the mzungu (white foreigner), appreciate the blooming purple jacarandas, savor a juicy ripe mango, and pause for the rains to end and the harvest to begin. Although the language barrier was a major challenge for me, it offered me a chance to be a better observer. In the hospital, I could not bombard parents with questions as I normally would in the United States. Instead, I quietly observed a child’s breathing, took note of the orange soda his mother fed him, and tried to determine if the mass of cloth and bloody vomit on the floor was from my patient or the one lying next to him. Moments of pause and stillness—of simply being an observer—were invaluable. And ironically, my communication skills, language barriers aside, were enhanced. I learned to better connect with patients—and that, to me, is the essence of health care and nursing.

FUTURE PROSPECTS

At the end of my year in Malawi, I was both ready to reunite with family and friends at home and content with the work I had completed, although I wished I had been able to do more. Being part of the inaugural year of GHSP volunteers gave me invaluable insights into the process of international development. I understood the importance of a program’s sustainability and the value of partnering with organizations already integrated into the community, since establishing infrastructure can be a lengthy and arduous process.

Learning to differentiate between what I could and could not change in one year was an ongoing struggle. Measurable results take time. But with better education, enhanced equipment, and more nurses and physicians to fill the shortages, patient outcomes in Malawi should continue to improve. And while one individual can’t change a system or educate an entire country in one year, each volunteer contributes to the process.

Brittney J. Sullivan is a PhD student at Duke University School of Nursing, Durham, NC. Contact author: brittney.sullivan@duke.edu. The author has disclosed no potential conflicts of interest, financial or otherwise.

REFERENCES