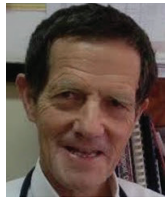


A medical career in Malawi – personal reflections



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As a medical student of St Bartholomew's Hospital in London, I spent my 1967 paediatric elective period in Zululand (now Kwazulu-Natal), and then travelled northwards with my fellow student John Barrett (now a professor of haematology in Washington, DC). On 5th July we arrived in Blantyre, Malawi, and the next day were allowed to attend the country's celebrations of the first anniversary of its becoming a Republic (third anniversary of Independence), held at the Kamuzu Stadium in Blantyre. The occasion was joyful but tough, as a wet and chilly *chiperoni* blew all day and we had come equipped for tropical heat. The absence of toilets added a challenge that I survived then but wouldn't now.

John and I travelled northwards to visit Fort Johnson (just acquiring its new name, Mangochi) and the little town of Lilongwe. Tarmac ended a few miles north of the capital city, Zomba. From Mangochi onwards, the dust we inhaled was mingled with a powerful odour of fish: the lorry giving us a lift was also delivering a consignment of large *chambo* to the markets of Lilongwe.

Today the roads are tarred and the *chambo* are smaller.

After spending 30 of the last 40 years working in Malawi's health service, I am prompted to reflect on other changes that have occurred in the country during the final decades of the old millennium and the first decades of the new.

1974-1984

With a national population of around 6 million in 1974, each of Malawi's 22 districts contained a district hospital and several health centres and health posts. Many districts also had a mission hospital, either sharing the general workload or dividing specialties with government services. "Under-fives" clinics and mobile vaccination programmes had recently been rolled out through each district. Health facilities of all sizes were largely staffed, with legendary competence, by Malawian clinical officers, medical assistants, and nurse-midwives. The few Malawian doctors tended to be in central facilities or in government, or abroad. Many district medical officers and most specialists—with notable exceptions—were expatriate.

During this decade several things began to change, gradually paving the way for dramatic developments to come that were, back then, unpredicted—and in some cases unimaginable.

Health research and family planning, both long regarded as forms of exploitation, started to become recognised as acceptable, and even necessary. National programmes to monitor and manage tuberculosis, malaria, acute respiratory infections and diarrhoeal disease became established. A million refugees from neighbouring Mozambicans built crowded linear villages on the Malawi side of the border, increasing the population by about 12% and for several years providing an extra challenge to Malawi's health services, until they vanished as suddenly as they had appeared.

In the *Medical Quarterly* (forerunner of the *Malawi Medical Journal*) of January 1983, a case report described a 15-year-old boy with skin nodules and a mass compressing the left main bronchus: biopsy showed Kaposi's sarcoma. The discussion mentioned that Caucasian homosexual adults had recently shown an increased incidence of this tumour, but at that time HIV had yet to be discovered, and we did not know that a devastating epidemic was about to explode in Malawi.

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1984-1995

During this period, my wife and I were in the UK, but we visited Malawi at least every year. The good news was that in 1986 the Life President approved the recommendations of the Tripartite Committee (on which I was privileged to serve) for the founding of a medical school in Malawi.

The bad news was that the HIV epidemic mushroomed like a nuclear or volcanic cloud, with the prevalence of the infection in women attending the antenatal clinic, for example, rising from 0% to 31% between 1984 and 1995. In retrospect, these early years constituted the worst phase of the epidemic, both for its victims and for the health profession, because therapy was not available to any but a tiny minority of the wealthiest among the population. For the huge majority, treatment was temporising, and the fear of stigma kept many from seeking it. The global provision of antiretroviral therapy (ART) and Malawi's acquisition and distribution of this measure throughout the country have been spectacular achievements in response to a devastating situation.

Many other infections did their own mushrooming in the context of HIV's induced immunosuppression—most dramatically tuberculosis, bacterial infections (pneumococcus, non-typhi salmonella), viral infections (Herpes [H zoster, H simplex, HHV8]) and *Pneumocystis*. The result was a 5- to 10-fold increase in adult admissions to hospital, and a huge increase in the need for staff.

In 1992 (500 years after Columbus sailed across the Atlantic) Malawi's first medical graduates emerged from the new College of Medicine. They had been partly trained abroad, but within five years the entire medical training was conducted in Malawi. It is difficult to think of any consolation about the HIV pandemic, but for Malawi the simultaneous, although unrelated, proliferation of home-grown doctors is surely one.

In 1993 cheering crowds thronged the streets of Blantyre, a city more often typified by modest traffic and—allegedly—the world's slowest walkers. This was the year of the referendum, when, unusually among emerging nations, the Life President proposed a people's vote and, even more unusually, accepted its result, despite 65% of the 67% turnout voting in favour of multiparty democracy. Mercifully for Malawi, he also accepted his own defeat at elections the following year, so that Malawi remained one of the few African nations not to be devastated by war.

1995-2016

This has been—and continues to be—a period of growth. While doctors qualify every year, a greater proportion of these have stayed in Malawi, or have returned after postgraduate training, than ever before. Clinical officers and nurses continue to be trained in government and mission facilities. A national programme for provision of ART has

proliferated, other infectious disease programmes have strengthened, and noncommunicable diseases have received increasing attention.

The rest of the world has shown great willingness to be involved with Malawi in its development of capacities in healthcare provision and research. Large multiphase support went into the construction of the College of Medicine and then into the further training of its graduates. Several international collaborative research programmes have linked with the College and its teaching hospital; research and ethics committees function at both the College and national levels; and there are increasing efforts to foster every-way communication between policy makers, practitioners, and researchers.

My strongest impression when looking back on three privileged decades in Malawi is of a joint effort, of many people working together with others towards a common goal: hospitals with health centres and dispensaries; doctors with medical students, clinical officers, nurses and medical assistants; urban facilities with rural; the College of Medicine with the Queen Elizabeth Central Hospital and other clinical services; researchers with clinicians; affiliated research units with both the College and the hospitals; international staff and institutions with those on the ground; and all of these with the government of Malawi, endeavouring to advance knowledge and services for the people of the country.

I well remember the morning breaks when doctors of all specialties would sip coffee in the hospital library (now long since converted into part of the new Adult Emergency and Trauma Centre). Morning breaks are rarely an option now

with the increased patient load and limited staff numbers. Back then, as a young physician for adults, I enjoyed the opportunity to chat with, for example, the (almost) equally young obstetrician Dr John Chipangwi, later to become the chief instigator and principal of the new medical school. We had all watched in awe and some trepidation as he insisted, against the instructions of cabinet ministers, that during his Christmas Visit, the Life President should see the real overcrowding in the obstetrics department and should have to step over floor patients like everybody else. As a result, the president ordered and endowed the construction of the Gogo Chatinkha Banda Maternity Wing.

One vehicle that attempts to give a voice and an ear to all who serve the interests of health in Malawi is the *Malawi Medical Journal (MMJ)*. I edited its fledgling predecessor the *Medical Quarterly* from January 1980 to April 1984; since then the journal has acquired not only a new name, but also a sequence of excellent Malawian editors; recognition and registration by Index Medicus so that its contents are now widely available; and extensive international collaborations, including a special link with the *Journal of the American Medical Association (JAMA)*, through the African Journal Partnership Program (AJPP).

This general impression of a joint effort makes me look forward with optimism. There is no country, with the possible exception of North Korea, that attempts to move forward on its own. Malawi's congenial relations with the rest of the world are an asset that may be at least as valuable as minerals or nuclear technology.



Dr. Kamuzu Banda's Christmas visit to the medical wards of Queen Elizabeth Central Hospital in 1977. From here the President moved on to the maternity ward, where reality had been preserved.