Mission to Malawi

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An opportunity to travel to Africa with a mission team to work in a health clinic presents itself. You ask yourself, why not? Is it because you don't have enough money for the airfare or immunizations? Is it that you can't see yourself leaving family or children? When you ask yourself why travel to Africa, the answers can start you on a journey of self-discovery. Overcoming the "why nots" can be easier than you think. Funding can be obtained from different sources if you start early. You'd be surprised at how many of your colleagues will support you in picking up or switching your shifts. As for your children, your experiences will rub off on them and expand their world as well.

Decision made! After 41 hours, three planes, and a two-hour van ride, we found ourselves at the Lifeline Malawi Health Clinic in the fishing village of Ngodzi on Lake Malawi. Our Calgary mission team was made up of seven nurses, one construction expert, one cameraman and one pastor. Basically, we were to provide medical care, construction assistance and spiritual support for the Malawian people in the area. The country of Malawi is wedged between Zambia, Tanzania and Mozambique. Most of its eastern border is formed by Lake Malawi, the third largest lake in Africa. The population of Malawi is more than 12 million with an average life expectancy of 30 years. There are only about 150 doctors in the entire country.

Lifeline Malawi was started in 1998 by Dr. Chris Brooks from Calgary. He moved with his wife and young daughter to Malawi to administer medical aid to the African people. His "practice" has evolved from the back of a pickup truck to two self-standing health clinics and regular outreach clinics employing Malawian nurses, medical officers, and support staff. Each clinic will see more than 150 patients per day, five days a week.

The medical focus for our three-week mission was to help provide treatment for malaria, tuberculosis, tropical skin diseases, malnutrition, respiratory infections and GI disease, worms, and HIV/AIDS. The first few days we shadowed the Malawian nurses who assessed and treated the patients on their own, relying on the clinical officer or doctor only for the more severe cases. The Malawian nurses then interpreted as we tried our hand at their job. This was crucial training for our time at the outreach clinics. We needed to learn from them about the kinds of diseases and health issues we might see at the outreach clinics where, as nurses, we were diagnosing and treating patients on our own. We were provided with a community interpreter and, like the Malawian nurses, relied on the clinical officer or physician only for the more severe cases. With the limited laboratory resources and lack of radiological support, clinical judgment was of the greatest value. Rehydration of even severe cases of vomiting and diarrhea consisted first of oral rehydration salts, leaving IV hydration for only the most severely ill. Patients would travel to the health clinic by foot, bike, or public transport, which could take many hours. "Bicycle ambulances" recently donated through Lifeline Malawi to several of the surrounding communities will hopefully reduce progression of most diseases allowing the Malawians to access established medical clinics instead of treating patients at home.

Unfamiliar to most of our nursing team was the management of HIV/AIDS. The first case of AIDS in Malawi was in 1985. Since then it has spread by epidemic proportions. It is the leading cause of death in Malawian adults, estimated at greater than 30% prevalence. The labour force is rapidly becoming too small to support the needs of the young, old and chronically ill. In many cases, aging grandparents are caring for children as the middle generation is dying of AIDS and other related diseases. Many homes consist of blended extended households or children left to fend for themselves. An estimated one million children are orphaned or homeless. We were touched by the numbers in the local orphanage. Hopefully, the little trinkets we brought for them lightened their spirits a bit. The growing HIV/AIDS assessment and treatment area of the clinic owes its success to careful data gathering and analysis with ongoing teaching, demystifying the local misconceptions of AIDS itself.

Community health is in large part accomplished by outreach clinics, immunization clinics and community health nurse visits. At an outreach clinic in remote Kaphaizi, a four-year-old girl was brought in by her dad due to frequent vomiting. After much cajoling to get the full story, it was determined that she

vomited several times a day due to crying out of loneliness when she was left unattended all day while her dad worked. Do you blast him for neglect when he probably had no choice, or try to help him out with suggestions of better alternatives? The latter was chosen along with some nutrition guidelines.

The local women and children around Ngodzi were much healthier looking than those we saw at the outreach clinics. The immunizations, medical care, and teaching about diet, drinking water and birth control were obviously improving the health of the local residents. The introduction of mosquito nets and community teaching will hopefully reduce the mortality rates of malaria. Due to illiteracy, knowledge was passed on through the pre-clinic testimonials, community gatherings, and story telling through song and dance.

Our construction focus was to help the locals finish the cement slab foundation of two of the six houses being built for some of the Lifeline Malawi staff. Shoveling dirt and cement in a skirt (a cultural expectation) was very difficult. One cultural aspect that we noticed was that the Malawian laborers worked very hard when the men in our group were with us, but were content to watch us women work if the men were out of sight.

The third focus of our team was a religious focus. Christianity is the major religion in Malawi, with Islam being the second most common. We spent one Sunday participating in the local Christian churches, which were usually small brick buildings with dirt floors, some with cement pews, and some with no pews. Some had a thatch roof, some had no roof. Some had no building at all. The joyous singing and dancing in the midst of our dusty, sparse surroundings were truly inspirational. At the Ngodzi Church we were blessed to hear the acapella youth choir, which was to perform at the National Choir Festival.

Our accommodations consisted of dormitory bedrooms with mosquito nets and bedding, indoor plumbing with running water and electricity. We were treated to our own cook and housekeeper. The medical clinic and some of the staff housing was within the walled compound. Local pumps provided clean water to the villagers. Nsima, the local staple of ground corn meal, was part of our lunch most days. Salt, chutney, goat stew or quail eggs added the much needed flavouring to the Nsima. There are more than 600 species of fish in the lake, and we were treated to several meals of local fish. Mangoes for sweets were provided by the local children hanging around the compound.

The lake was absolutely gorgeous and very inviting if it weren't for the fact that any swimmer would invariably be infected with Schistosomiasis (a parasitic infection). The locals use the lake for drinking, bathing, washing clothes, swimming and just about anything else, including the latrine. A huge part of our community health teaching included the benefits of using the community water pumps and digging more pit toilets.

Poverty is the norm, with 76% of the people living on less than $1.00/day, and 65% of the people unable to meet basic needs. Family life has become desperate. With more than 25% of the men working away from the home in Zimbabwe or South Africa, many households are headed by women who work to support and care for their families. The people of Malawi do not have much in the way of material wealth, but they do have great pride. The children took joy in the simplest of things such as a toy truck made out of wire and wooden wheels, an old tire rim to roll, and soccer fields of dirt with wooden goal posts.

The welcoming of our team into their dirt-floored, brick homes with thatched roofs was an eye-opening experience. The simplicity and hardship of their lives stung in the face of the complexity and conveniences of our own. At one outreach clinic in Kaphaizi, lunch was quite late coming and William, the interpreter, invited us to dine with him. Three of us followed him to his home in the village. His front room was smaller than many of our bathrooms, but he had starched white doilies on the couch and offered us a place to sit. He then opened up the pots of lunch, which was Nsima and quail eggs with tomato sauce, the best of our entire stay. It was truly a humbling experience.

One of the most memorable days was a walk in town with a few of the children not in school. They started singing a chant that was quite catchy, so it was videotaped and interpreted at the clinic. They were singing, "White person is good". Later, they started singing Frere Jacques in Chechewan, the local language. When they finished, we sang the French version and after a few rounds alternating between Chechewan and French, the children ended up singing "Ding Dang Dong" and we ended up singing "Di Do Da".

We were overwhelmed at the needs we witnessed, yet delighted with the medical care, construction assistance and spiritual support that we were able to provide. The basics were not taken for granted; generosity and kindnesses were not diminished. The willingness of the Malawians to direct and improve their own future was evident. One nurse explained that what gave them hope and encouragement was simply that we were willing to travel so far to help them. The few supplies that we brought and our medical care at the outreach clinics were precious to them. We hope that any future missions experience the satisfaction and joy that we did. Travelling on a mission trip offers a way to help others with the many gifts we have been provided. One person can make a difference!