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An Exodus of African Nurses Puts Infants and the Ill in Peril

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LILONGWE, Malawi — Six women suddenly went into the final, agonized minutes of childbirth. Hlalapi Kunkeyani was the only nurse. There were no doctors.

Panicky cries rent the fetid air of the ward, a cavernous space jammed with 20 women laboring in beds, on benches, even on the concrete floor. Mrs. Kunkeyani worked with intense concentration, her face glowing with sweat, but she was overwhelmed.

Four of the babies arrived in a rush without her to ease their passage into the world. She found one trapped between his mother's legs with the umbilical cord wrapped around his chest. The face of another was smeared with his mother's feces. Yet a third lay still on his mother's breast, desperate to breathe. The nurse swiftly suctioned his tiny mouth until at last he gulped a breath.

Mrs. Kunkeyani, 36, is the stalwart nurse in charge of this capital city's main labor ward, where 10 overworked nurse midwives deliver more than 10,000 babies a year. But soon, she will vanish from this impoverished nation, joining thousands of African nurses streaming away from their AIDS-haunted continent for rich countries, primarily Britain.

"My friends are telling me there's work there, there's money there," said Mrs. Kunkeyani, who will soon make in a day's overtime in Britain what she earns in a month in Malawi. "They're telling me I'm wasting my time here."

The nursing staffs of public health systems across the poor countries of Africa — grossly insufficient to begin with — are being battered by numerous factors that include attrition and AIDS. But none are creating greater anxiety in Africa than the growing flight of nurses discouraged by low pay and grueling conditions.

The result of the nursing crisis — the neglect of the sick — is starkly apparent here on the dilapidated wards of Lilongwe Central Hospital, where a single nurse often looks after 50 or more desperately ill people. What is equally visible is the boon to Britain, where Lilongwe Central's former nurses minister to the elderly in the carpeted lounges of nursing homes and to patients in hushed private hospital rooms.

It is the poor subsidizing the rich, since African governments paid to educate many of the health care workers who are leaving.

In May, African countries banded together at the annual assembly of the World Health Organization to urge developed nations to compensate them for their lost investment. After an intense debate, the assembled countries resolved to search for ways to lessen the damage of what they called increasing rates of emigration.

The brain drain of health professionals from Africa, and, more broadly, the severe staffing shortages, will be an issue at the 15th International AIDS Conference in Bangkok. Physicians for Human Rights, a Boston-based nonprofit group that shared the Nobel Peace Prize in 1997, will be releasing a report on the topic and proposing steps to avert a deepening of the human resources crisis.

At Lilongwe Central, an 830-bed hospital, there are supposed to be 532 nurses. Only 183 are left. That is

about half as many as there were just six years ago. And only 30 of those are registered nurses, the highly skilled cadre that is most sought abroad.

The hospital's director, Dr. Damson Kathyola, a peasant's son educated at University College London, seems to feel an almost physical pain when he describes trying to run a major medical institution that is hemorrhaging nurses.

"Unbearable," he said, leaning his head back and squeezing his eyes shut. "Unbearable."

In Malawi, afflicted with one of Africa's most severe nursing shortages, almost two-thirds of the nursing jobs in the public health system are vacant. More registered nurses have left to work abroad in the past four years than the 336 who remain in the public hospitals and clinics that serve most of the country's 11.6 million people, according to Malawi's Nurses and Midwives Council.

Many of these English-speaking nurses have flocked to Britain, which is confronting its own acute shortage of nurses to care for an aging population. Its central nursing register shows that the number of nurses being certified from Malawi, South Africa, Nigeria, Ghana, Kenya, Zambia, Zimbabwe and Botswana — all former British colonies — has soared since 1999.

African nurses are also migrating, though in smaller numbers, to the United States and New Zealand, with trickles to Australia and Canada. There are now more than 3,100 registered nurses from Africa in the United States, according to a national survey of nurses by the Department of Health and Human Services.

As projections show the shortfall of nurses in the United States ballooning to 800,000 by 2020, the pressure to recruit abroad is likely to grow.

"The U.K.'s experience could be a harbinger of what we'll see in the U.S.," said Julie Sochalski, associate professor of nursing at the University of Pennsylvania.

But Africa's nurses are not just moving overseas. They are also quitting government service for better-paying jobs in their own countries at private hospitals and foreign-financed nonprofit groups and research institutions.

Thousands more have left the profession or are simply dying, especially in southern Africa, where rates of H.I.V. infection are highest. In Malawi, a quarter of public health workers, including nurses, will be dead, mostly of AIDS and tuberculosis, by 2009, according to a study of worker death rates in 40 hospitals here. Drugs for people with AIDS have been unaffordable up to now.

The bottom line: sub-Saharan Africa's low-income countries need to more than double their nursing work forces, adding at least 620,000 nurses to grapple with severe health emergencies, according to estimates developed for the Joint Learning Initiative, a network of more than 100 scholars and analysts studying human resources for health and coordinated from Harvard University.

The nursing crisis is intensifying just as billions of dollars in foreign aid is beginning to pour into Africa to provide life-saving drugs to millions of people afflicted with AIDS and tuberculosis.

The money includes the first installment on a total of $15 billion promised by President Bush and $2 billion from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The shortage of nurses compromises the ability of countries to use this money effectively, and the money itself is likely to aggravate the nursing shortage in public hospitals. A substantial portion will be channeled to nonprofit groups that are likely to hire away yet more nurses at higher pay.

As the world focuses its resources on AIDS, the risk is that more women giving birth and more children needing hospital care for easily treatable conditions like respiratory infections and diarrhea will die, experts say.

"I think it will destroy the whole system," Dr. Kathyola said.

One Nurse and 26 Babies To spend a few weeks roaming the wards of Lilongwe Central is to see the human cost of the nursing shortage.

Late one night on the nursery for sick and premature newborns, the sole nurse on duty stepped away — and 26 babies, packed two and three to a bassinet, were on their own.

In one crib, a tiny baby girl, blue and dead, lay next to her sister, eyes open, tiny fists clenched, mouth yawning.

Earlier, on the day shift, Tereza Kachingwe, a rotund, kindly nurse, had steadfastly stood by the premature babies, trying to keep them alive. But the hospital had run out of the thinnest tubes needed to suction such miniature throats.

"If this tube was smaller, I could go deeper into the trachea," she said ruefully, as she easily held one of the featherweight newborns in her palm, sweeping the tube back and forth in the infant's mouth.

Mrs. Kachingwe looked around at the many other babies who needed her attention, then turned back to the tiniest ones barely clinging to life. "Today, I'm stranded," she sighed.

On another day in the gynecological ward, Tandu Mbvundula was the only nurse tending 51 patients, dispensing pills and a bare minimum of words. Unsmiling, she pushed a medicine cart into a room so packed with patients that some lay on the concrete floor in the darkened spaces beneath the beds.

She rolled up to Mary Kaliyati, a mother of five whose uterus had ruptured giving birth in a mission hospital. Mrs. Kaliyati was transferred to Lilongwe Central. After surgery to remove her uterus, she had developed an infection.

The nurse explained that the hospital was out of its most potent antibiotic, so she had given Mrs. Kaliyati a weaker combination. The first round had failed. The woman was still feverish. So the nurse was giving her a second round of the same weaker antibiotics.

Will the treatment work?

Mrs. Mbvundula shrugged numbly. "Maybe," she said, and then moved on.

Hospital officials say the rate at which women die of causes related to pregnancy at Lilongwe Central has held steady in recent years, but cases of ruptured uteruses have sharply spiked. Dr. Bernard Reich, one of only two obstetricians working at Lilongwe Central, said such complications should simply not happen to women giving birth in a hospital.

In Malawi as a whole, the rate at which women die of causes related to pregnancy almost doubled from 1992 to 2000. One in 89 births results in the death of the mother, among the worst such rates in the world.

A 2001 review of hundreds of confidential maternal death audits from 18 hospitals in southern Malawi found that more than half the deaths were associated with substandard hospital care.

"It's the worst change in a health indicator — outside of wars and natural disasters — that I've seen in the 36 years I've been knocking around developing countries," said William Aldis, who represents the World Health Organization in Malawi. "It tells me that there's a catastrophic failure of the health system in this country to meet the minimum needs of the population. The sheer lack of skilled people is the major contributing factor."

The Ministry of Health in Malawi is proposing an increase in the number of nurses and health professionals

being trained, while more than doubling their pay. Major donors, including Britain and the Global Fund, said they recognized that Malawi faced a staffing emergency and would provide financial support to help it hang on to its health workers.

Here at Lilongwe Central, registered nurses, who make about $1,900 a year, said if their pay were doubled or tripled, they would be more likely to stay, but added that they had heard such promises before.

In recent interviews with the hospital's 30 remaining registered nurses, 20 said they planned to leave for better paying jobs in Malawi or abroad. Six more said they were thinking about it.

Beatrice Mkandawire, 40, a senior nurse on the children's ward and a mother of four, dedicated her entire salary from the month of May — $145 — toward paying the initial $215 fee to register as a nurse in Britain. She and her husband will beg for help from relatives and skimp on food to make ends meet. She hopes to be there by the end of the year.

Tall and stately in a pristine white dress, she wondered sorrowfully, "If I leave, who will look after the patients when I'm gone?"

A good deal of damage to the hospital's staff is already done. Workloads worsen every time another nurse leaves. Even the most basic supplies and medicines are in short supply or simply absent.

The labor ward at Bottom Hospital, an aging appendage to Lilongwe Central, is especially afflicted. The hospital got its name because it is at the bottom of a hill and also because it served poor Africans during British rule. The British went to Top Hospital at the top of the hill.

The sewage system at Bottom has never worked properly. The maternity ward often smells like a toilet. Blood, sweat and amniotic fluid have seeped through torn vinyl covers into the thin mattresses, adding to the stale odor.

There are no bed linens, or enough scissors to cut umbilical cords. Pregnant women are required to bring a thin plastic sheet to lie on and a razor blade to slice the cord. If they forget the razor, nurses scold them and take one from the supply cabinet, breaking it in half to double its use.

Bathrooms used by nurses often lack soap, raising the risk of passing infection. For two days in May, nurses refused to do vaginal exams because the ward was almost out of latex gloves — this in a country where nurses have to assume that any woman they examine may be H.I.V. positive.

With only 10 nurses to cover the ward around the clock, they often have to work extra shifts. The hospital has almost no money for such expenses. For overtime, they earn less than 20 cents an hour.

Lured by Money and Comfort

Mrs. Kunkeyani, the glue who holds the labor ward together, has decided she must leave Malawi for the sake of her family.

Like many employed people in a country where life expectancy has fallen to 38 years, she and her husband, Isaac, a civil engineer, are helping support eight orphaned nieces and nephews, as well as their 9-year-old daughter.

The Kunkeyanis have been trying to complete construction of their red brick home over the past two and a half years, but money has been scarce.

For almost a year, they lived without electricity. They cooked over a wood fire behind the house. They ate dinner by the light of a hurricane lantern. Mrs. Kunkeyani rose at 5 each morning to heat pails of water for bathing.

Their money woes are constant and nagging. Her daughter was recently sent home from the private school she attends because the Kunkeyanis had not kept up with the fees. They can only afford meat once a week, on Saturday. They drink their tea black, to save on the cost of milk.

When the letter of acceptance from Britain's Nursing and Midwifery Council arrived in April, Mr. Kunkeyani ripped it open. He phoned his wife, at work on the ward. She said she literally jumped for joy.

Mrs. Kunkeyani has only to look to her elder cousin, Jane Banda, to see what her family can gain by moving to Britain. Like Mrs. Kunkeyani, Mrs. Banda was herself the nurse in charge on the labor ward at Bottom in the mid-1990's and led Malawi's national breast-feeding program until she moved to England in 2001.

Mrs. Banda, 44, reared the teenage Mrs. Kunkeyani and inspired her to be a nurse. Once again, she has scouted the way ahead.

She now lives in a modest two-story house on a quiet, winding lane in a tidy English city that she asked not be named to protect her privacy. She works full time as a nurse on a surgical recovery ward in a National Health Service hospital where she cares for five patients or so.

"Here, you go into wards, they're spic and span, like hotels," she said admiringly.

She puts in another 10 hours a week in an elegantly appointed nursing home looking after elderly men and women who sit in comfortable club chairs watching television.

Her husband, B. F. Banda, a slender, bespectacled former bureaucrat, used to be in charge of human resources planning for Malawi in the office of the president — a good perch for assessing the shortcomings in pay for government nurses and their value elsewhere.

He explained that Malawian nurses like his wife who go to Britain generally started in private nursing homes. Once established, they apply to the National Health Service, which offers a steady salary and good benefits.

Despite taxes and the higher cost of living, Mrs. Banda said she lived comfortably. Starting pay for a nurse in the National Health Service is about $31,000, but she has progressed beyond that. She also earns $21 for each hour of overtime.

Mrs. Banda is able to send more money home to her parents each month than her cousin, Mrs. Kunkeyani, earns in a month.

"If I'm broke, I simply phone her and the following day she sends me 200 pounds," said Mrs. Banda's husband, who remains in Malawi and now works as a management consultant.

With their expanded income, the Bandas are building a new house in Lilongwe, where she will settle after their three children finish school in Britain. It is ornamented with intricate, wood-inlaid ceilings and glittery terrazzo pillars. It will boast servants quarters, an orchard of mango, guava and banana trees and security cameras at a gated entrance.

Another nurse who left Lilongwe Central, after 15 years there, is Chimewmwe Nhlane, who has worked in a private hospital in Bristol for three years. She is thrilled with her new job. Her salary tops $35,000 a year, and she receives annual merit raises and bonuses. For outstanding work, the hospital gives her a box of chocolates or a bottle of wine.

She tells the British nurses she works with, "What I'm doing here is child's play compared to what I was doing at home."

The recruitment of nurses like Mrs. Banda and Mrs. Nhlane has long been a sore subject with Britain's former African colonies.

Nelson Mandela, when he was South Africa's president, criticized Britain for recruiting its health workers. The country has spent $1 billion educating health workers who migrated abroad — the equivalent of a third of all development aid it received from 1994 to 2000, according to a report of the Organization for Economic Cooperation and Development.

But even as the British prime minister, Tony Blair, has championed increased foreign aid to Africa, his government has faced political pressure to improve health care at home. The government has since hired tens of thousands of nurses, many from overseas.

In 2001, Britain adopted codes to limit the government's active recruitment of health professionals from developing countries. But the code does not apply to private recruitment agencies or private employers.

Nor does it prohibit the National Health Service from hiring foreign nurses who apply on their own. Since 1998, 12,115 African nurses have registered to work in Britain.

A debate has begun within the British government about the migration of health workers. Sarah Mullally, chief nursing officer for the Department of Health, said, "We can't stop mobility — that would be against human rights to say people can't move."

But Suma Chakrabarti, who heads Britain's Department for International Development, voiced discomfort with some consequences of government policies.

"Frankly, it's too easy to get into the U.K., which may be good for the U.K., but may have a deleterious effect on Malawi," said Mr. Chakrabarti, who visited Lilongwe Central earlier this year and saw firsthand its depleted staff.

A similar debate is going on in Malawi. Joseph Mutso-Bengo, a professor of bioethics at Malawi's College of Medicine, noted that nurses could barely make ends meet and asked, "Do we have the right to force them to stay?"

But Anthony D. Harries, a British doctor who has lived and worked here for 15 years and advises the Health Ministry, called it immoral for Britain to allow the easy migration of Malawian nurses.

"Come on," he said, "train your own unemployed people."

Hard Time at the Labor Ward

Night had fallen. The labor ward at Bottom seethed with the moans, shrieks and whimpers of women suffering through childbirth. "The Look of Love" played scratchily on a transistor radio propped on the counter. Babies were being born at a steady, intense pace. The two nurses on duty sometimes did not have time even to mop up puddles of amniotic fluid and blood the new mothers lay in before moving to another bedside.

As the clock neared midnight, the two nurses had already delivered a dozen babies and still had eight or nine hours of work ahead of them.

"Nurse, nurse, please help me, I'm in pain," pleaded one woman.

Lesnat Chatambalala, a small-boned, soft-spoken nurse, approached her and said tersely, "It isn't time yet."

"Please, help me, I'm begging you," the woman insisted in a quavering voice.

Mrs. Chatambalala walked away.

She began talking about her desire to quit for work in a private organization in Malawi that pays better. "I'm willing to go to the U.K., but I can't leave my kids," she said miserably.

For Mrs. Chatambalala, 36, there is no respite. Her husband, a high school biology teacher, was hospitalized last year. Doctors found he had a candida infection common to people with AIDS. But before he could be tested, he jumped off a fourth-floor balcony in Lilongwe Central. Mrs. Chatambalala is now the sole support for their four children.

After 15 hours of hard labor on the ward, she trudged the final steps home in her dusty black pumps and white dress. Her children were in the courtyard waiting for her. Two-year-old Sterns climbed in her lap and wrapped his arms around her neck. More work lay ahead of her. There were children to be bathed, a house to be cleaned.

Back on the labor ward, an exhausted Mrs. Kunkeyani was starting her seventh straight day shift. She was alone when the babies started coming out in such rapid succession that she could not be there for four of the births. She and the women there described later what had happened.

Faida Yusuf, 20, had her first baby alone on the floor. The force of the final push ripped her vaginal wall because Mrs. Kunkeyani was not present to guide the baby boy's head at its narrowest diameter or to make a neat incision.

Finally, four hours later, Mrs. Kunkeyani found time to suture the tear, but Mrs. Yusuf pulled away. A big-hearted woman with reserves of steely religious faith, Mrs. Kunkeyani coaxed and cajoled the frightened young mother. "Don't be scared," she said soothingly. "You've already been brave. Please trust me. You know when somebody is cut by a razor blade. It hurts, right?"

"Yes," Mrs. Faida said uncertainly.

"So it's like that," the nurse told her, explaining she needed to give her an injection to blunt the pain. "Be brave. The tear is inside."

Again, the mother drew away, pulling her legs close into her body.

"You must lie back," Mrs. Kunkeyani insisted. "We can't leave the wound. It has to be stitched. There's no other way. You're saying you're hungry. You can't eat until I finish. What do you want me to do? Leave?"