Nurse Training in Malawi: Time to Shift from Numbers to Competence, Context and Career Pathways

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Introduction

IN Malawi, nursing is not just a profession; it is the health system. Nurses and midwives provide over 80% of direct clinical care, lead district health facilities, and are often the only health worker a community will ever see. How we train them, therefore determines the health of the nation. Over the last two decades, Malawi has made bold strides. We have moved from hospital-based training to a regulated system of 16 accredited colleges, led by the Nurses and Midwives Council of Malawi, and anchored by university programmes. The intent was right: increase numbers to address critical shortages. The unintended consequence is now clear: we have focused more on quantity than on quality, relevance and retention. For this inaugural issue, I argue that nurse training in Malawi stands at a crossroads and needs three decisive shifts.

The Triumph and Strain of Expansion: The decision to double and triple intakes *of nurse training* was necessary. Malawi's density of nurses is still 0.4 per 1000 population against the WHO recommended 4.45 per 1000 for Universal Health Coverage. Yet expansion has outpaced investment. Most training institutions operate with less than 60% of required faculty, and many tutors lack specialized training in nursing education. Libraries lack current texts, skills labs lack functional manikins, and student accommodation is overcrowded. More critically, clinical learning is in crisis. With 50-100 students competing for placement in one central hospital ward, competing for limited patients, equipment and qualified preceptors: hands-on learning is diluted. Students observe rather than practice, and qualified nurses, already overworked, have little time or incentive for preceptorship. We are at risk of producing graduates who can pass examinations but struggle with clinical reasoning, decision-making, and compassionate care in resource-limited settings.

A Training System Divided: We have created a two-tier system. At the base are Nurse Midwife Technicians (NMTs) - diploma holders who form 70% of the workforce and sustain rural services. At the top are university-trained Registered Nurses with degrees. The bridge between them is fragile. Upgrading from NMT to *Bachelor degree* is costly, requires leaving employment for years, and offers little guaranteed career progression within the Ministry of Health structure. The result is demotivation. Many young nurses see only two options: stagnate as an NMT or migrate abroad. Neither serves Malawi. Furthermore, our curricula, though recently revised to be competency-based, still lean heavily on Western textbooks and hospital-centric models. They under-prepare nurses for the realities they will face: managing conditions without a clinician, running a non-communicable disease clinic, providing adolescent mental health support, or leading quality improvement in a district with erratic power supply.

Training for Export: The Ethical Dilemma: We cannot discuss nurse training without discussing migration. Since 2021, active recruitment from the *United Kingdom (UK), United States of America (USA)* and Gulf states has intensified. The UK alone added Malawi to its list of countries with significant out-migration of health workers. We lose experienced nurses and, increasingly, new graduates within 12 months of registration. While individual rights to mobility must be respected, and we cannot ethically blame

individuals seeking better livelihoods, we must be honest: Malawi, is subsidizing the health systems of some of the developed countries while rural facilities at home remain unstaffed. Our training model does not account for this loss. We need a training and retention model that assumes some migration will happen and plans for it.

The Way Forward: Three Imperatives*:* The next decade of nurse training must shift from counting graduates to building competence, context relevance and career pathways.

Invest in the clinical learning environment as much as the classroom: The Nurses and Midwives Council of Malawi should enforce a minimum preceptor-to-student ratio and the Ministry of Health, should create a formal, incentivized Clinical Preceptor cadre. Every accredited nursing training institution must have standard, a low-cost but high-fidelity, functional simulation laboratory to bridge the gap before students touch a patient. This calls for both public and private training institutions to receive an investment for this.

Make curricula context-relevant and interprofessional: Let us teach what Malawi suffers from and in the realities of a resource-limited setting. Prioritize midwifery, critical care, NCDs, and mental health. Embed leadership, digital health, and research utilization from year one *of nurse training.* Interprofessional education, where nursing, midwifery, medical and allied health students learn together, should be mainstreamed to foster teamwork from the classroom.

Build retention into the education pathway: Retention starts during training. If a student never experiences a well-supported rural placement, they are unlikely to return there to work. We must strengthen rural immersion programmes, provide district-based scholarships with return-to-service agreements, and create clear academic ladders from certificate to PhD within Malawi. Digital learning and blended programmes, can allow nurses to upskill without leaving their duty stations or families. If a nurse can see a future here, he/she is more likely to build his/her future here.

Conclusion

Malawi does not lack young people eager to serve as nurses. Our duty is to ensure that when they answer that call, we give them training that is rigorous, relevant, and respectful of their potential. We have succeeded in producing more nurses. The next 20 years must be about producing the right nurses, rightly supported, for Malawi.

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