Since commencing my Adult Nursing degree at the University of Southampton, I was intrigued by the block of teaching time put aside for students to undertake a Professional Development Experience. The broad remit which allows for students to plan and organise learning experiences in anything that interests them and which they believe will be an asset to their future career allows for an exciting array of opportunities outwith the NMC mandated learning outcomes for students who intend to join the nursing register. Since our professional code as nurses impels us to consider cultural sensitivities in order to competently respond to patient's needs, I wanted to participate in a learning experience which would allow me to reflect on what this actually means. I knew that some students used this time to arrange electives outside the UK and thought carefully about whether this type of experience would be right for me. I had mixed feelings about participating in a short-term placement organised by a commercial company and I wanted to ensure that that I would be in a position to participate in learning from the community in a meaningful way.

Attending a talk at university by Ruth Markus, CEO of AMECA, made me think about the learning opportunities involved in a self-organised placement at a hospital in Africa and the chance to consider how I might be able to apply the core nursing skills embedded in the 6C's in a different environment as well as the opportunities for personal development in terms of organisation and professional confidence was persuasive. Through the AMECA database, I found the contact details for Thyolo District Hospital (TDH) and arranged to spend six weeks observing practice. As a local government hospital where patients are not charged for treatment, I hoped my experience would allow me real insight into the challenges faced by healthcare services seeking to provide care for communities despite a lack of funding and resources and an introduction to the positive efforts put forward by local services in this regard. I also hoped that exposure to a different way of working would enable me to view embedded institutional cultures and practices in the UK healthcare system with a more critical eye and that my experience might help me as a reflective tool for perspective when faced with difficulties or stressors at work in the future.

Although TDH provides services for a largely rural and spread out population, it's position on a decent road a short distance from the urban centre of Blantyre enabled me to reach it easily by public transport and combine my time at the hospital with R&R visits to tourist locations such as Liwonde National Park, the Mulanje Massif and Zomba Plateau at the weekends. Basic hospital accommodation is provided for some of the students, clinical officers and nurses and a room was available for my use throughout my time at Thyolo. Although I expected to experience some degree of culture shock given how greatly my nursing placements to date would differ from TDH, this allowed a great opportunity to interact with colleagues socially and ensured I was able to integrate quickly as another fellow student. This was especially important to me – I wanted it to be clear that my purpose in visiting Malawi was as a student seeking to share in learning experiences, not as a skilled volunteer. Student nurses at TDH would rotate to different specialities in two week blocks. Similarly, I decided that observing practice in different areas would allow for an interesting breadth of experience. As such, I observed care in the adult (male and female) wards which were subdivided into surgical and medical specialities, the emergency department, which would either admit patients or direct them to an appropriate outpatient department and the children's ward, with additional visits with community outreach services as opportunity allowed.

My university rules prevented me from participating directly in clinical care and this restriction, although in place for my safety and the safety of the patients, proved to be an issue which distanced me from the nurses working at TDH at the beginning of my stay. Because of staff shortages in Malawi, it seems unlikely that nursing duties could be performed at TDH without the practical assistance of student nurses on placement. That is not to say that they are not supervised as novices; I witnessed qualified nurses questioning students on their clinical decisions and monitoring practical competencies throughout my visit. But in terms of learning outcomes, many of the students focussed on practical tasks to be mastered and were surprised that UK nursing students are not permitted to insert cannulae or give IV drugs as these are considered basic skills which novice student nurses would routinely perform from their first placement. However, through getting to know the staff better, I discovered similarities in nursing education and practice such as use of the Nursing Process of assess, plan, implement and evaluate to structure care planning and a focus on holistic assessment through use of the Activities of Living and was better able to demonstrate how I could contribute to the team through sharing my knowledge and experiences from UK practice. When discussing nursing philosophies, I also found core values in common with my Malawian colleagues. We agreed on the importance of developing a therapeutic relationship with patients and I found they were impressed with my enthusiasm for learning Chichewa and keen to help me learn in order to be able to interact with patients. (Indeed, I impressed myself on this score – not being a natural linguist, I expected most of my communication with patients to be through translators but found this insufficient for building rapport and was able to learn much more phrases during the six weeks than I would have thought possible). As such, I found that patients and their families were more relaxed in my presence and staff were motivated to both share their knowledge with me and seek my ideas on how care could be provided.

However, cultural influence and structural differences in care responsibilities meant that values such as autonomy, informed consent and the right to confidentiality were sometimes difficult to realise. All patients at TDH – adults as well as children – had 'guardians' present with them in hospital at all times. These were usually members of the patient's family who would take on the bulk of caring for their personal needs while they were in hospital; feeding, toileting, bathing, providing clean sheets and clothes and being a source of emotional and practical support. Given the responsibility the guardian takes on, they often felt entitled to all patient information and it was difficult to gain real consent from the patient for this information-sharing given the guardian's constant presence. It was often difficult to tell whether patients, even fully competent adults, were making treatment decisions for themselves or if they were being influenced by their families. It was a conflict the nurses were acutely aware of. It seemed like the Malawian nurses sometimes struggled to balance the Western moral norms and ethical values commensurate with their education and middle-class identities with the more communitarian ethos present in some of the communities they serve.

The nurses were also troubled by their position of power in relation to patients who, because of economic or educational barriers, might not be aware of their rights or in a position to advocate for their own needs. Although they did not wish to act in a paternalistic manner, it was often apparent that middle-class patients or those with relations working at the hospital received a higher standard of care, simply because they had the wherewithal to demand it. This is of course

in opposition to principles of justice. It is a difficult problem to reconcile and I do not envy the Malawian healthcare workers the task of challenging existing power structures, of which they are a part, to address issues such as these. Though I have come across similar problems of power in the relationships between patients and healthcare workers in the UK, the issues, in my opinion, are not quite as stark and I feel aided and supported by existing traditions of empowerment in UK nursing to address these problems in my future practice.

I also sensed a degree of fatalism in the attitudes of nurses concerning their power to address other inequalities in their country which had a bearing on health. For example, in the UK, we might educate people about healthy diet options but would consider it a matter of choice and strive to be non-judgemental towards people who continue to eat badly despite knowledge of the effect on their health. However, in Malawi, a lack of variety in diet is often not a choice at all; some nurses I encountered spoke of the futility of counselling people to eat a more varied diet when they subsisted on less than $1 a day and were struggling to pay for basics such as nsima (ground maize flour – the staple food of the region). However, both in the hospital and on community visits, I witnessed examples of how social and community networks could act as protective factors in terms of health – for example, I spoke to a woman who told me about how other HIV+ women had supported her after she had received her own positive diagnosis and how they helped each other in sticking to their medication regimens and during periods of illness when they would be unable to earn.

The responsibility that Malawian nurses have in caring for all patient groups, often without access to specialist support or training, made a deep impression on me. For example, I discussed with some student nurses their anxiety about caring for people with mental health needs. Malawian nurses, like UK nurses, receive some mental health education prior to qualification but may expect to be the primary clinician caring for a person in the community with both physical and mental health needs – a position I would not consider myself to have the knowledge and skills necessary to perform. Similarly, I witnessed community nurses taking on various responsibilities from day to day – from instructing a group of older adults on health behaviours to prevent cardiovascular disease, to informing young women on contraceptive options or monitoring the growth of young children to check for signs of malnutrition and symptoms of HIV infection in infants. Although I knew that the UK was privileged in terms of access to material resources, I had not previously thought about how lucky we are in terms of our human resources, access to continuing professional development opportunities and a variety of career paths.

In terms of cultural competence, my experience at TDH was invaluable as I met and interacted with people whose life experiences were completely unfamiliar to me. For example, I witnessed the position of patients and families who believed witchcraft to be concerned in illness or were distrustful of Western medicine. One case in particular highlighted this to me; a family wished to remove a seriously ill patient from the care of the hospital and take him to a traditional healer because his condition was not improving. Of course, I cannot presume to speak authoritatively on a subject as profound and personal as this family's belief structure but the desire to do everything possible to save the life of their relative is completely relatable. On encountering other situations in which a lack of resources meant diagnoses could not be confirmed or explained, I can understand why people might not be satisfied with the impalpable answers

offered by Western-style healthcare. Similarly, many people were resistant to oxygen therapy because of a belief that it kills people and again, I can understand how this belief originates. Scarcity of resources at TDH meant that only the most poorly patients would be put on oxygen and as such, these patients often would die, confirming their worst fears. In the future, I want to ensure I question people about their perceptions of health, illness and treatment rather than attributing divergent or erroneous beliefs to lack of knowledge.

However, I found myself experiencing a dilemma related to how I would normally express my own spirituality. Although UK nurses ask patients about religion as a matter of course; it is considered a component of how a person expresses their personhood and thus included in a number of nursing models; I have rarely had the spotlight placed on my own beliefs. When the matter has come up in discussion with patients in the past, I have been open, but have never felt this has affected my relationship with them. In Malawi however, I was frequently questioned by patients, relatives and staff members about whether I believed in God and where I attend church. Whilst not wishing to deceive patients about a matter which was of clear import to them, it was very clear to me that answering in the negative would adversely influence their trust in me as a nurse. I found situations such as this, where a conflict of cultural values was starkly apparent, more difficult to adapt to than instances where beliefs were alien to me. I found I had to give greater consideration to the difference between my professional persona and how I normally present myself in an informal setting than I have done previously and this awareness of presentation is something I will continue to develop through reflective practice.

Another major difference I noticed was in the strength of the 'nursing voice' in the multi-disciplinary setting. Upon entering the morning handover meeting, which students from all disciplines were expected to attend, clinical officers would immediately occupy the front rows of chairs whereas nursing students, who made up the larger part of the cohort, would go to the back of the room and remain largely silent during the discussion. Subsequently, the medical needs of patients often predominated. When I discussed it with the students, they seemed to view their place as inferior within the existing power structure; they feared negative consequences if they were to question senior staff or if they were to answer a question incorrectly and seemed to lack confidence in the nursing knowledge they could contribute to the discussion. This deference to medical knowledge was not overt; in fact, the doctors who facilitated these handover meetings would frequently emphasise the function of the discussions as a learning experience for all students and privately expressed to me frustration with the lack of participation.

This demonstrates how difficult it can be to affect change in an established institutional culture and has prompted me to reflect on times during my training when I too have altered my behaviour to match 'how things are done'. It has made me realise that leadership can be expressed through embracing change, resisting these influences and questioning such practices and has impacted the way I will practice in future. However, although the experience of having to justify your clinical decisions to a group of over fifty people is somewhat intimidating, I felt impressed and motivated by the emphasis placed on opportunities for communal learning by the senior members of staff. This is quite unlike the learning environment I have experienced in the UK where although the importance of multi-disciplinary working is emphasised and we are expected to work in teams in practice, there is little formal inter-disciplinary learning inherent to my nursing course.

Overall, the opportunity to undertake this learning experience has been hugely influential in terms of my personal and professional development as a nurse and I cannot begin to express my gratitude to AMECA for the support I received. I certainly arrived in Malawi with preconceived notions and prejudices about the healthcare system and the needs of the people I was to encounter and was proved wrong at almost every turn. Although differences in style and lack of resources at the hospital yielded some challenges, where I encountered serious difficulties these were strikingly similar to the issues we face in the UK which can negatively impact on patient care; compassion burnout in nurses, ethical dilemmas in providing patient-centred care and lack of communication between different healthcare professionals.

It is difficult to describe all the ways in which my professional practice developed as a result of my experiences in Malawi but I think the biggest change for me has been my understanding of what it will mean to practice proficiently in a UK which is increasingly multi-cultural. An individual is not just a manifestation of their culture and to view culture through the lens of difference doesn't really give you any insight into who a person is. It is more clear to me than ever that when I am caring for a person, I am caring for them as an individual who is the authority on their own self; not as a representative of a different culture from which assumptions can be made. Cultural understanding can only really be achieved through relationship building and a willingness to learn and listen. I would hope to one-day return to Malawi or another country in sub-Saharan Africa to nurse for a much longer period of time but need much more professional experience in order to be able to identify particular skills and expertise I might be able to contribute. However, the insight I gained on this trip has enabled me to consider the best way to develop my career in order to be able to aid local nurses in their efforts to care for impoverished communities.