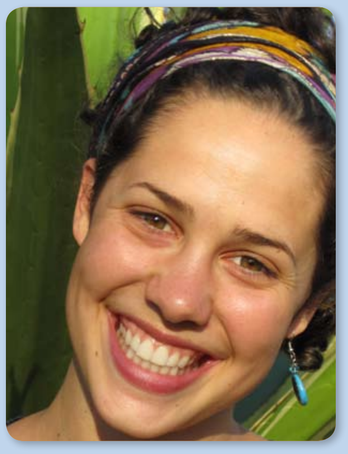
BURCH FELLOW 2010



GRACE MACNAIR
Class of 2011
Fairview, NC

Grace MacNair

MIDWIFERY IN MALAWI

When I arrived in Malawi, Africa on May 27th of 2010 I had a very rough idea of what it would be like to work as a doula/midwife's assistant in the labor ward of a public hospital in Lilongwe, the capital city of Malawi. Even though I'd been a doula for four years and worked in midwifery in India, I had never been to Africa and, at that point, knew very little about the prevention of mother-to-child transmission of HIV. The words I use now to describe my experience are intense, joyful, infuriating, sad and humbling.

CONTINUED ▶

I spent four days a week from 7:30 am – 5:00pm assisting Malawian women and the doctors and midwives who served them at a public hospital in Lilongwe called Bwaila Hospital. Lilongwe is home to 900 thousand of the 16 million people in Malawi yet, at that time, Bwaila hospital was the main referral hospital for the entire central region

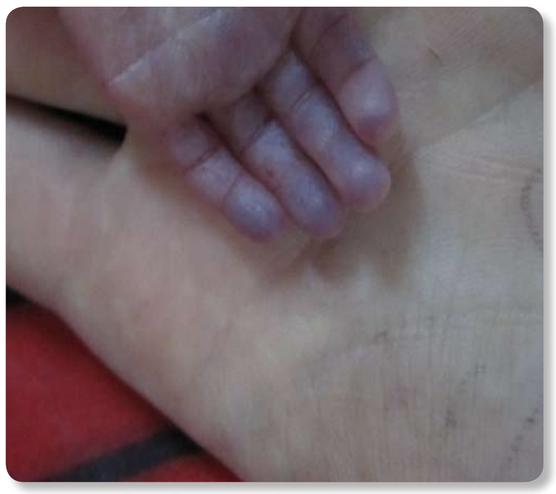
of Malawi. A large portion of our women were very high risk because of poor health and delayed transport time, due to reluctant relatives or distance. It was not uncommon for pregnant or laboring women to have to travel many hours by oxcart and bicycle. I saw many rare conditions like anencephaly, and severe spina bifida that most midwives in the US have only seen in books. Even though I wholeheartedly believe in natural birth, these cases gave me a more well-rounded appreciation for instances in which emergency technology is necessary.

The ward I was working in was actually less than a year old. It was an incredible improvement from what it had before. The old ward was a shabby L-shaped painted brick building (built by the British in 1963) where 20-30 women labored and birthed in one room. The new maternity ward had ten somewhat clean suites that two, and at the most three women, would share. It also had an OR reserved for gynecological complications and a neonatal intensive care unit. Unfortunately, while new Bwaila provided women with a much higher standard of care, the equipment in the OR often malfunctioned or went missing and the only support available in NICU was oxygen and warmth. In the absence of incubators and equipment, the hospital encouraged mothers to use Kangroo Care – a method of binding an infant to the mother to maintain proper temperature and heart rate.

At Bwaila, we delivered an average of fifty babies a day, often lacking essential drugs, equipment, staff and even bed space.
A complicated confluence of poverty, gender inequality, poor nutrition, a corrupt government, and struggling economy has lead Malawi to have one of highest maternal mortality ratios in the world, excluding war torn countries. Today this rate continues to climb – in 1992 the maternal mortality was 620 per 100,000 live births, it is currently at 1120 per 100,000 live births.
A woman's lifetime risk of dying in childbirth in Malawi is about 1:7, once again, one of the highest globally. The neonatal mortality rate follows suit at 42/1000 live births. Due to the fact that Bwaila could only give high risk and premature babies basic care – warmth and oxygen – many of my patients lost their babies. Malawi also has an incredibly high HIV/AIDS rates – HIV affects nearly a million people, including 83,000 children. Nearly a third of infected mothers pass the virus to their babies. It was not uncommon for HIV positive women to be counseled incorrectly due to staff's lack of knowledge or time. Sometimes, gloves shortages would force us to reuse gloves and the lack of clean delivery kits meant we had to cut cords with razor blades instead of scissors.

While the skill level of the staff in the labor ward varied greatly, Bwaila had a core group of excellent and very brave Malawian and European doctors and midwives. Again and again I watched them reject cynicism, opting instead for positivity and hope for improvement. After working together all day, we would often go to someone's house and cook dinner and spend hours talking. I am in awe of how they managed to deal with so many intense complications without proper equipment and facilities. Having that kind of support was an essential part of being able to handle the stress and tragedy that filled the labor ward almost every day.

Because the hospital did not have any pain relief options, Malawian



women had completely natural births. Their strength and courage was unbelievable. Because the new maternity ward allowed each mother be to be accompanied by one or two guardians (friends or family), I also spent a lot of time talking with the guardians about how they could best support the mother during her labor. Since many of the benefits of a doula are centered on a continuous presence, a few simple techniques and basic human kindness, the guardians could usually take over.

I worked with the matrons (head nurses) to ensure that the guardians had access to birth tips, positions, and comfort techniques through instructions from the re-trained staff and illustrated posters. By the end of the summer, lots of women were more than willing to try different birthing techniques because their friend or relative had given them good reviews. Although many of the 150 births I attended were hard and complicated, lots of those women had beautiful births despite the difficulty. There is nothing more joyful to me than handing a baby back to a proud and smiling mother. Many women came back to the hospital to show off their babies and thank us for helping them have a safe delivery. In total, I was able to attend 150 births. Overall, my time in Malawi was bittersweet and taught me more than I ever could have imagined about humility and how much I have yet to learn. I offer my deepest gratitude to Mr. Burch for making such a life changing opportunity possible for me and so many others.