

Everybody Has a Story

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Everybody has a story. Every woman in Malawi has her version of the common theme of struggling to survive, raise her children, and keep them alive. This spring, I had the privilege to care for many Malawian women as they sought help at their local hospital. I was able to bear witness to the myriad challenges they face and capture pieces of their stories along the way.

Malawi is a small country in Africa where I served as a Peace Corps Volunteer from 1992 to 1994. It is consistently ranked as one of the poorest countries in the world, ranking 165th of 177 countries on the United Nations Development Programme Human Development Index,¹ and its health indicators are among the poorest in the world.² The maternal mortality ratio is 1,800 per 100,000,² and a Malawian woman's risk of dying from a pregnancy-related cause is 1 in 16.³ Most Malawians live in a

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All names have been changed for patient privacy.

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cycle of devastating poverty, and as a result, they live a hand-to-mouth existence at barely a subsistence level. I was discouraged to see upon my return that life for the average Malawian is no better today than it was 12 years ago. Life's focus remains surviving the day. There is no future tense in the Chichewa language. Conversation is not about tomorrow or next week; it is about today.

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I last worked in Malawi in 1995, and this year I was given the opportunity to return as a volunteer physician. I had many questions for myself before I left home this time—most importantly, why am I going back? Is it to reclaim romanticized memories or create new ones? Is it to redefine my professional path? Is this a purely selfish mission, or is there a piece of it from which a few Malawian women may benefit? When I step off the plane onto the steaming tarmac under the African sun, will I be taken back with bittersweet nostalgia?

Embangweni Hospital is 30 km off the tarmac on a dusty dirt road riddled with potholes and crowded with people. You can get there via

a hitchhike, a bicycle, an oxcart, or on foot. The hitch costs 50 cents, the bike ride 30 cents, the oxcart 20 cents, and the walk is free. The hospital has 130 beds and services a catchment area of approximately 100,000 people. Most of the patients are subsistence farmers from the surrounding rural areas.

There is one physician for every 100,000 people in Malawi,¹ so rather than relying on doctors for health care delivery, the backbone of the health care system is made up of the clinical officers. The heavy burden of patient care lies upon them. Their training consists of a 3-year course at a postsecondary school, followed by a lifetime of learning through direct patient care. Embangweni Hospital employs three clinical officers and three medical assistants, and they are together responsible for all of the clinical work in both the inpatient and outpatient setting at the hospital. The scope of their work encompasses all areas of medicine and includes a large volume of orthopedic, obstetric, and general surgical procedures. What they lack in formal training is compensated for in patient care volume and experience over time.

The clinical officers did excellent caliber work within the confines of limited resources and extreme disease states. I was often in awe of their skills, their ability to accurately diagnose complicated patients with nothing but their hands. But despite their efforts and skill, people died daily on the



wards. In part, this is due to a constant interruption of the supply chains that provide appropriate medical supplies, to a lack of blood product or intensive care treatment, and frequently to a patient's late arrival and late diagnosis of disease. However, tantamount to this is the human resource crisis created by the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) pandemic. The high staff mortality in every sector has exacerbated the dearth of resources. This has created a lack of capacity through which to deliver health services, especially in the rural areas, and overall health care has become extremely compromised.²

I gained a tremendous respect for those hospital staff members who have persisted, year after year, in such a difficult system. The clinical officers' practice is based on a series of treatment protocols developed specifically toward best practices for common diseases in the low-resource setting. These protocols are not designed to save every patient, but rather they focus on using the limited resources where they can potentially have the biggest impact. The data used to support the national protocols stem from a body of work compiled by the Ministry of Health in conjunction with the World Health Organization, as well as from evidence collected from clinical officers' experiences over time. The resident with me wanted to know why none of the treatment plans used were "evidence based." In fact, they are evidence based, just not based on evidence she knows. That evidence does not necessarily apply.

Everyone who comes to see me here has seen a traditional healer first, often several times by the time she gets to the hospital. The fresh tattoos from the razor blade nicks, and the black mankwala (tradi-

tional medicine/herbs) still seeping from the fresh wounds tell the pieces of the story. They tell of the path taken before reaching the last choice for most, that is, going to the hospital for care. Traditional healers play a large role in the health care of rural Malawians. Most traditional healers are located within the village and are an integral part of the village culture. A recent Malawi/World Bank survey found that only 31% of communities have access to a health center,² and in these areas, the dependence on the care of a traditional healer is greater out of necessity. They are close, they are familiar, and they are generally cheaper than the hospital fees. The health centers and hospital remain an unknown for many people still, and there remains a belief among many that the hospital is a place one goes to die. The hospital is usually filled to capacity, but it is rarely the first stop for the patients who are there.

Mpatso had been to the traditional healer in her village every week for the past several for "recurrent malaria." She had not been to the mobile clinic that provided antenatal services to her village for 3 months, but when she realized late in her third trimester that she had not felt her baby move in several days, she decided to go for a visit. She was still feverish despite the traditional medicine she was taking. She was taken in an oxcart to the nearest health center. The nurse heard no heart tones with her fetoscope, and the patient was sent by bicycle ambulance on a hot, dusty, bumpy ride to the hospital 20 km away.

When she got to us, she was in early labor, with a footling breech and a narrow pelvis. She was febrile, hypotensive, and tachypnic. She was remote from delivery. Her body was thin and her skin taut and her pregnant belly tender to the

mildest touch, covered in neat rows of fresh black razor nicks.

The odor was pungent and foul as we opened the uterus and extracted the severely macerated full-term fetus. We irrigated and closed and covered her with every available antibiotic, as well as intravenous quinine. She got better. She survived. Maybe if she had come sooner, she would not have been so sick. Maybe if she had come sooner, she would not have lost her baby. Maybe there is a role for the traditional healer in some cases, but maybe not in this one.

Chimwemwe was 15 years old and 20 weeks pregnant. Her story was pieced together through bits of history from her mother and the health center nurse because the patient and I hardly got to speak at all; she was dying when she arrived. She had taken herbs given to her by her grandmother to abort the pregnancy. She had told no one and bled heavily through the night at home in her village. She was found comatose in her own blood. She was taken to the health center in Mabiri where the frightened nurse had nothing to offer a patient this ill. Chimwemwe reached us septic, hemorrhaging, and anemic. Her bleeding was controlled with a dilation and evacuation, but it was in vain. Despite antibiotics and an infusion of her mother's blood, she died. The only thing I ever heard her say was "Ndinafuna kukhaka ku skulu," or "I just wanted to stay in school."

The most difficult task was telling Chimwemwe's mother that her child had died. The grief was silent at first, then followed by a wailing that was loud and deep and guttural, hitting the hollow of her womb, the marrow of her bones. Listening to her heart crack, I desperately wanted to turn my back and walk away; I knew I could not.



I knew that I needed to stay. I was a part of this story now.

Her body was wrapped in a chitenje (cloth wraps worn by women to protect clothing, carry bundles, or babies), and she was taken by her mother and her relatives to the oxcart waiting at the hospital gate. It was a processional of wailing grief; the hospital's patients and staff were out on the grounds sitting silently, watching, their expressions as though each one had known this pain before. It is the rare woman here who has not lost a child; it remains Malawi's reality.

Nearly 60% of all unsafe abortions in Africa are in young women aged 15–24, and 30,000 women in Africa die each year from unsafe abortions.⁴ Abortion is currently illegal in Malawi, but Malawian leaders have joined with representatives of several other African countries to call for the legalization of abortion.⁵ In the face of the profound loss of women's lives due to unsafe abortion complications, these leaders have been mobilized to attempt to make policy changes to provide safe abortions to women. They have been moved to make maternal mortality and reproductive health a priority to change Malawi's reality to one of living mothers.

The death in all of the wards was overwhelming. Each morning I came into the wards and reviewed the charts. The charts of patients who died overnight sat on the top of the pile and have "R.I.P." written on the front. Each ward contributed to the list, with its daily tally of morbidity and mortality due to HIV/AIDS, malaria, tuberculosis, postpartum hemorrhage, eclampsia, overwhelming sepsis, trauma, malnutrition, anemia, and

dehydration, as well as the many cases that were never fully diagnosed before the patient's death. The litany of deaths at each morning report left everyone feeling deflated and drained.

The dream became recurrent. I would fall asleep and dream of going into the ward and sitting down to review the charts. On the front of every chart I reviewed were the letters "R.I.P." written in red marker. I would frantically search through the stack, trying to get to the bottom, but it was endless, and everyone was dead.

Malawians are the strongest people physically and mentally that I have ever known, yet despite that strength, the body gets pushed here to the limits of its endurance, and eventually the power of fatigue and disease prevail and people die. It is amazing to watch the disease process, the pathophysiology in its rawest natural form take place. It is heart wrenching and awful and astounding to watch the miracle that is the human body process a disease to its fullest and finally give in. And likewise, it is glorious to watch the spirit to persevere prevail. In the face of all odds and cruel reality, people do survive.

I ran most mornings at dawn on the path through the village, when the sun was still below the horizon, with only the pink streaks in the sky to tell me it was the break of day. The sounds were the whisper of feet as women carried their pails to the well, the breaking of twigs as they started their day's cooking fire. Often I would see an oxcart carrying a body, followed by a processional of villagers walking down the path away from the hospital, taking their loved one home. There was a sway in the hips of this heavy walk; it was somber and slow and

gentle and beautiful. There was visible pain on all of the still faces. As the dawn lifted, the early rays of the spectacular day rested on the bold colors of the women's chitenjes. I would step off the path and into the grass as they passed and offer quiet greetings and respect. They were always startled and grateful. They would pause for a moment and then proceed on their way.

This return journey to Malawi turned out to be a time of tremendous personal and professional growth for me, during which all of my questions were answered and more were asked. It was rich with new joys and old memories, triumphs of survival and testaments of will. It was rife with tragedy and sadness, the visceral ache of helplessness and grief. It was rich in reality, strength, and truth.

REFERENCES

1. United Nations Development Programme Human Development Report 2006. Beyond scarcity: power, poverty and the global water crisis. Available at: <http://hdr.undp.org/hdr2006/statistics>. Retrieved August 22, 2007.
2. World Health Organization. Malawi country profile report 2006. Available at: <http://www.who.int/hac/crises/mwi/en/>. Retrieved August 22, 2007.
3. Department of Reproductive Health and Research, World Health Organization. Maternal mortality in 2000: estimates developed by WHO, UNICEF, and UNFPA. Available at: http://www.who.int/reproductive-health/publication/maternal_mortality_2000/mme.pdf. Retrieved August 22, 2007.
4. Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, et al. Unsafe abortion: the preventable pandemic. *Lancet* 2006;368:1908–19.
5. Medical News Today. Leaders of 10 African countries call for legalization of safe abortion to help reduce the maternal mortality rate. Available at: <http://www.medicalnewstoday.com/articles/75567.php>. Retrieved August 22, 2007.

