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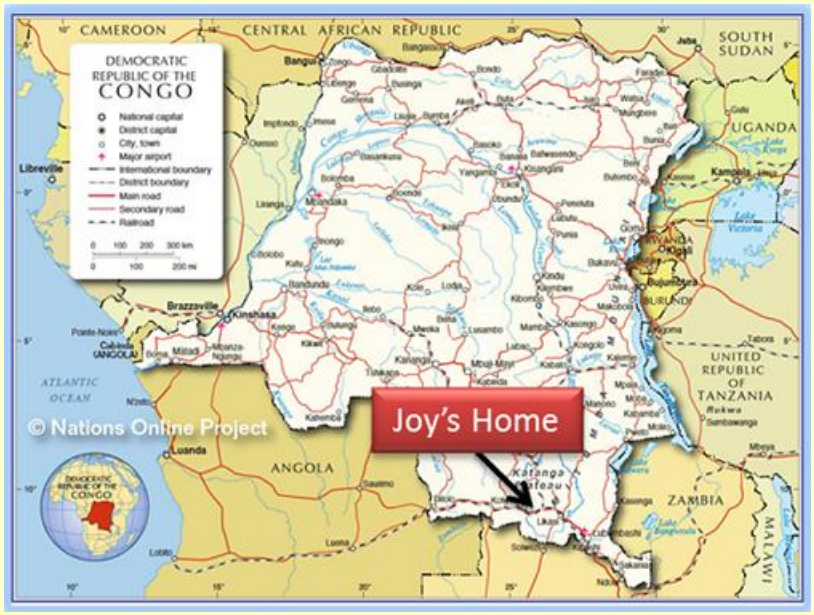
Respiratory Therapist's Experience of the Respiratory-Related Health Conditions in the Democratic Republic of Congo

By JOY K. KITANGA, BS, RRT

MULUNGWISHI, DRC — In May of 2011, as an international student on an F1 visa, I completed the respiratory care program at Salisbury University in Salisbury Maryland. The knowledge and training I acquired during my academic career and years of respiratory care practice in the United States were fundamental to my returning home to the Democratic Republic of Congo (DRC) and applying what I have learned. This was my primary goal; to become a healthcare provider with knowledge and experience that one day I could return home and bring valuable contribution to the healthcare system in the process of finding solutions to the dire health problems in the country. There are many great reasons why I chose respiratory care as my career path; however, the primary reason was considering the need of this health-related field of practice in my country. Before I came to the U.S. in 2002 I never knew such practice as respiratory care existed.



Because cardiopulmonary diseases are common health problems in the DRC I knew I wanted to be in a career that could help finding solutions to these and other related problems. In the US, my journey began when I enrolled into English as a second language (ESL) classes in 2002. This was followed by general studies in 2004 from Baltimore City Community College (BCCC) where I received my first degree in respiratory care in 2008. Before attending Salisbury University (SU) in2009, I practiced as a licensed respiratory therapist at Saint Agnes Hospital in Baltimore, Maryland. After years of hard work, I graduated with a Bachelor of Science degree in Respiratory Care from Salisbury University. Throughout my academic years both at BCCC and SU, I was involved in respiratory-related extracurricular activities. To accomplish my primary goal, in January of 2012 I returned to the DRC as a registered respiratory therapist with the goal of using my knowledge and experience to help save lives and improve the poor health conditions found in the country.

In retrospect, at the time I left the DRC in 2002, I was aware of the hopeless condition of the health care system there. One of the primary causes of death in the country was, and still is, Malaria (a parasitic infectious disease caused by mosquitoes). It is mostly treated with quinine and paracethamol (acetaminophen) for the associated high fever. However, there are incidences of tuberculosis, pneumonia, diabetes, severe trauma (third degree burns, farm injuries), and AIDS. There are cases of asthma, hypertension, and low blood pressure, which are all very common in my family. What I noticed before coming to the United States was that many people learned to live and survive around these cardio-pulmonary conditions. Our grandparents had different names for these health conditions. At the time, I did not know how they took care of these problems, but what I learned later was that many health conditions were treated using traditional medicine. Even though these methods of care were successful in some cases, others were not. Many people trusted traditional medicine more than scientific medicine. So what had happened in the span of time from 2002 to 2012?

Today, cardiologists and pulmonologists are trusted by the community and are needed more than ever, however, there are so few they can't be found. I have learned since my arrival back to the DRC that in the entire country of 71 million people, many who have cardiopulmonary problems, there might be only two or three cardiologists and just possibly one pulmonologist. Many clinics and hospitals are private and/or operate in collaboration with non-profit organizations, who take upon themselves to train individuals on how to use the equipment they bring along. There are hospitals now that can do chest x-rays, echocardiography, and many other diagnostics tests, which were not available in the past. Many heart cases or health conditions require surgical procedures or advance diagnostic tests, and further care had to be sought in South Africa or Europe if the family had means to pay for the expenses. However, as mentioned earlier, now there are advance diagnostic tests, an ENT doctor, and non-profit

organizations providing funds for patients requiring further care inside or outside of the country. With the few cardiologists or pulmonologists, there have not been cases of heart surgeries that I have heard of; they are still referred outside of the country. Any follow up care could be monitored in the DRC by trained nurses or medical doctors affiliated with the non-profit organization. So things seem to have improved and I observed a drastic improvement from the time I left the country in 2002 compared to now. So I often ask myself, what is the role of a respiratory therapist in all of this change?

One morning, during the period the weather changes from rainy to dry season, I experienced my first respiratory case in my village, Mulungwishi, DRC. A ten-month-old child had a history of malaria, typhoid fever, severe anemia, and had a persistent cough. After weeks of medical treatment for all of the above conditions, the child recuperated, although he still had the cough. The family lives near a farm and mother takes the child to the farm with her daily. That morning as I walked passed by their house, I heard a whistling sound generated by the child's effort to breathe. I knew the child had been receiving medical care for various things, so I asked if there were any changes or improvements, and if the child had been given medication for his respiratory condition. The answer was simply no. As the days went by the child's condition was worsening and the whistling sound that I heard few hours earlier progressed to a loud course wheeze. He was getting pale and weak. I told them to go to the clinic, which is forty-five minutes away traveling by bike with the mom holding the baby on the back and dad riding on.

The local clinic where residents seek out medical care.

At that moment I thought of the days and nights in the United States, where parents will rush to the hospital with such cases before it turns into a nightmare. I recalled all the interventions that will be happening in the emergency room: a physician diagnosing the problems, continuous nebulizer treatments, pulse oximetry, vital signs, patient assessment, ABGs, diagnostic tests, and therapies that may have included being given a steroid among other drugs to relieve the child's symptoms. But here I am in the DRC with ideas on how to intervene by few options. Hours later the couple returned from the clinic

with only cough medication and drugs for the anemia. The fear of the child dying quickly overcame me. Slowly I felt guilty for I knew many ways to intervene but all were out of reach. I asked the parents if this condition had occurred before and their answer was no. So I asked simple questions I learned during my respiratory care education; why do we breathe? How do we breathe? I thought as a respiratory therapist, oxygen therapy is always number one while you figure out the solution, but in this village where do I get

supplemental oxygen? I can have all the oxygen in the world but if there is no airway it is useless. In an instant I recalled the Vicks VapoRub that my mother used on me during my childhood when I had congested cough and she would rub it on my chest to "open my airways". I thought of providing cool mist to breathe, but the wheezing from this little boy was so loud I began to wonder whether it was an upper or lower respiratory problem. Is this something that has been progressing over the course of time or was it sudden? I could see the infant was retracting with labored breathing. I held the neck, began palpating while I listened curiously. I was once so used to stethoscopes and machines to give me answers, but now all I had were simple maneuvers to apply. We knew the hospital couldn't help. So we used what we had, Vicks VapoRub® to rub on the chest and a solution of palm oil mixed with traditional salt the villagers told me of to rub on the child's throat (which the mother did with her finger). Eventually he was getting better. This child's situation was one of many with upper respiratory problems I see in the DRC. The challenge is to determine whether these cases are croup or epiglottitis or any other obstruction problem.

Another example occurred when I volunteered as an interpreter at a clinic in a Methodist camp in Disanga, Mulungwishi, where I saw mothers bringing their children with respiratory problems. A pediatrician (a missionary from El Paso, Texas) I worked with shared assessment information about the respiratory conditions we were seeing. I was no longer the interpreter, it was clear they needed me because of my invaluable contributions to the many respiratory-related cases. The pediatrician told most of the mothers that either their children were asthmatic or suffering from seasonal allergies. Some of these patients we saw were given albuterol and ipratropium via nebulizers or MDI therapies. These drugs were brought by the pediatrician's group from Texas. It was recommended to them by the group that came the year before, summer 2011. Before they returned to Texas we were out of the drugs because of the need. It was during this period that I got to talk with people in my village that I saw the dire need for a respiratory therapist. A few people complain of chest pain, and take only pain medicine like paracethamol. Some expressed to me how the clinics or hospitals do not do much. I could understand and I share my sympathy. As a well-trained health care provider, it is very important to know the history. I asked further questions such as when did the pain start, or does it gets worse with specific movements, how sharp is it? For a few, I concluded it was from hard labor (farming). But for those not related to hard work, I could understand the inability for the hospital to not offer much help. The clinic is located in the middle of many villages: it has no means to do further tests and when the

clinic refers patients to the hospital in the city, many of these patients are unable to pay even the transportation fees (roughly $15 round trip). It is easy to say the neither the hospital nor the clinic are unable to care for their health conditions because their hope is in it. But how do you go beyond hope when all seems to be out of reach?

That was my experience in my village, but in the city, I had another experience. It was when I visited a small clinic in Lubumbashi (one of major cities in the DRC, Katanga Province) that a nurse in charge indicated to me that most of the patients with respiratory problems experience this condition during seasonal changes and humidity, especial from when the weather changes from dry to rainy season. I look forward to October 2012 as it is the month the nurse invited me to go observe their practice and share my experiences as a respiratory therapist.

My experience in the Democratic Republic of Congo as a healthcare provider has added value to my life and improved my skills as a respiratory therapist. There was a time I had everything in hand (the necessary equipment) to enable me to care for a patient and give hope to a family in hard times. No matter the amount of effort and knowledge put together by the medical team to save a life or give hope, there was a moment as well when the medical team and life circumstances could not change the destined outcome. I had the opportunity to make a difference in someone's life through healthcare or any another ways in the United States. Patients as well as many individuals did the same for me for the past ten years in the United States. As it was in the U.S., so it is in the DRC. Today is no different; and through this experience I have learned that no matter what circumstances or situation one finds themselves, as a trained healthcare provider he or she has everything it takes with or without equipment to make a difference - if they just take moment to recall the simplest things taught in school.

Although things have changed from 2002 to 2012, the health care conditions in the DRC still need improvement to better the lives of Congolese. I have not ceased to search for ways to improve the health conditions. My primary goal has allowed me to carefully assess the need for healthcare providers, through my eight months (and counting) experience in the DRC. I have a new mission: I desire to go to graduate school at Rush University, Chicago, Illinois, and enroll in their advance respiratory program. As a student at Rush University, I will continue to be involved in different activities—as I did at BCCC and SU—to bolster my knowledge, excel academically and share my experience. I will be empowered to lead a respiratory program in my country that will teach the basic and fundamentals of respiratory care while changing poor health conditions there. I will also be able to conduct research that will help find treatment and/or preventions for a better tomorrow for the Disanga community and the world.

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