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# Short report : Voluntary work in Bukavu, DR Congo (NF13026)

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By Renate Häger, January 2014

## The Kivu region

Bukavu, formerly called Costermannsville, is the capital city of the South Kivu region in the eastern area of the Democratic Republic of Congo. It is a noisy town of about 1 million inhabitants, beautifully situated by the shores of Lake Kivu, 1500 m above sea level. Because of the altitude the climate is very nice, like a good Norwegian summer plus daily tropical rains in the rainy season. Today the town and the Kivu region are suffering from lack of maintenance, infrastructure and development. The region has been suffering from wars and conflicts for a long time; it is officially advised not to travel there – although it has been quiet for a while. International organisations are numerous, and UN and MONUSCO are very visible in and outside the town.
Most people belong to different Christian churches, only a few are Muslims. Religion is practiced in much more expressive ways than what we are used to in Norway. The official languages in the region are French and Swahili.

## Health service in Kivu

Bukavu has many small health facilities, small hospitals and two big hospitals, one of it being the Panzi hospital which is famous for it's fistula operations and it's support programmes for violated women. Most hospitals are church hospitals owned by different churches in Congo and supported by different churches in the developed countries. The health services are supposed to be supported by official authorities in Congo, but in reality access to resources is dependant on the personal contacts, activities and abilities of the hospital directors. There is little or no governmental coordination of the health services although a supervising authority exists. Patients have to pay for each service: consultations, laboratory, ultrasound, operations, drugs etc., and prices differ in the different health institutions. Panzi hospital seems to be the best hospital since it has a lot more resources available through the Panzi foundation after it's director, gynaecologist Denis Mukwege, became well known because of his work for violated women. Norwegian and Swedish Pentecost churches have supported the health service in eastern Congo for a long time.

## Voluntary work in Kivu

Through personal contacts after a previous 3 years stay in Tanzania I got the possibility to work in Bukavu for 3 months. The decision was also influenced by

my knowledge of Swahili which is – besides French – the official language in Kivu.
I was invited by a small hospital, CELPA (Communauté des Eglises Libres de Pentecôte en Afrique), to work there as a specialist in gynaecology and obstetrics. Before my arrival it was not possible to define what kind of work was expected of me, and I got to know little about what type of hospital this is. A working permit and a doctor's license proved not to be necessary, and I got the impression that this was not important.
During the practical preparations for the journey I got in touch with another Norwegian gynaecologist who was planning to spend 2 months in Bukavu and who was requested by the Panzi hospital to do some teaching in emergency obstetric care with the help of the model of MamaNatalie and BabyNatalie. It was agreed that I would participate in this project.

**CELPA Hospital, general description**
From 7th of September until 12th of December – interrupted by altogether 4 weeks of work with the MamaNatalie project (see below) - I worked in the CELPA hospital. This is a small hospital in the town centre, which has been supported by the Pentecost church in Kivu region and by it's mother organisation in Norway. During the later years there have been attempts by the hospital director to improve the service and to ease the access for the general population with a focus on newborn and maternity health. The hospital has now 60 beds, a department for internal medicine, a surgical department, a children's department, a gynaecological/obstetric department. There are 5 doctors, all of them "generalists" except for one who is a specialist in orthopaedic medicine. There is one operation theatre. As in most other hospitals in Africa there is no possibility for microbiological exams, and antibiotic treatment is therefore extensive. Cytological and histological examinations are sometimes possible. There is no x-ray, but the hospital is about to get a machine from Australia. The ultrasound machine is some years old and has an abdominal probe only. Like in the town and elsewhere in the region electricity is unreliable and absent much of the time, a generator is available, but is not used widely due to the costs of gasoline. Operations often have to be performed with the help of headlamps. Typhoid fever and malaria are the most common diseases.
There is a very small library with some out-dated medical books. Internet is not available in the hospital. Internet cafes and modems provide slow and expensive internet connections which suffers from frequent break downs.
The morning meetings are in French while the daily language between staff and patients is Swahili.

**Gynaecology and obstetrics at CELPA**
My presence was announced in churches and on the local radio, so patients lined up to see me, some of them with big expectations. There were mainly two groups of patients: one consisting of women with (often general) pain over a long period of time, the other consisting of women with infertility problems. There was often not so much I could do. All patients expected to be examined with ultrasound and to get medication. Due to language problems and differences in culture the communication was sometimes challenging. There were also patients with

gynaecological problems which are hardly seen in the developed world, for example women with infertility problems and big myoma uteri.
Like in most of the African countries and because of the lack of microbiological exams, syndromic approach according to WHO guidelines is used to treat genital infections.
I attended a few operations. Most doctors are able to do them, and at CELPA one of the doctors can do most of what is possible under the local circumstances. A typical team consists of one doctor performing the operation, one assistant and one nurse to administer the anaesthesia. Ketamin is the drug of choice. Just before the operations starts there is a "time-out": everybody prays, including the patient, until she falls asleep. Pfannenstiel incision is hardly used, and with the lack of proper instruments and proper light midline incision seems to be the better method because it provides better access.
The hospital has about 30 to 40 deliveries per month. Deliveries are either spontaneously or by caesarean section. Forceps and ventouse delivery are not known. In most African countries, after the HIV epidemic, the use of ventouse for delivery has more and more diminished, and all problems are solved with caesarean section. I brought some Kiwi cups from Norway and did some teaching for midwives and doctors. Control of fetal heartbeats is by stethoscope or Sonicaid Fetal Doppler. For labour pain Buscopan is the drug of choice.
There were interesting exchanges of experience between the doctors, midwives, nurses and me. The medical staff suffers from lack of access to updated literature. Downloading big documents from the Internet usually exceeds the technical capacities. Before my arrival I had downloaded a few documents from WHO(different guidelines in French) which were very welcome.

**MamaNatalie and BabyNatalie**
From 7th to 25th of October and from 4th to 7th of November I joined Bjørg Evjen Olsen, Ingeborg Madla and Ragnhild Rosland with the teaching project called "MamaNatalie"which was initiated by Bjørg Evjen Olsen. MamaNatalie and NoeNatalie are models, which are used to simulate birth and newborn problems. The local health authorities were interested in this project and wanted it to cover the whole of South Kivu region. The opening ceremony was covered by local radio and TV. During the first week, phase 1, 25 trainers of trainers from this region were trained. During phase 2, these trainers of trainers taught under our supervision - altogether more than 300 health staff (midwives, doctors, assistants) from the whole region. They were taught in groups of about 30 participants and for 2 days. The whole project was for 6 weeks, 3 of them took place outside of Bukavu, I joined this project for 3 weeks in Bukavu and for one week in Kaziba, 50 km southeast of Bukavu.
In this project the two main topics were: how to handle post partum haemorrhage and how to handle neonatal asphyxia, both with practical exercises and role-plays. Booklets and posters on these two topics were provided for the participants and for the trainers of trainers. There was also a strong focus on communication with the mother (MamaNatalie) and within the team. The overall goal of this project is to contribute to a reduction of maternal and neonatal morbidity and mortality. Results are not easy to provide since documentation is not quite reliable. But attempts are planned and will be made if/when financial support is available. The participants were stimulated to continue/repeat the

practical trainings within their health facilities. For this purpose the 8 models were left in selected health facilities in the South Kivu region.
A separate report on the project of MamaNatalie and BabyNatalie is expected by Bjørg Evjen Olsen.

**Conclusion and personal remarks**

Although I often had the feeling that I could not do as much as I wanted, I do hope that I was able to contribute a little. Certainly I myself have learned much: about the country and it's people and about the problems they face both in private and professional life. I am greatly impressed by what they can manage in spite of all the obstacles.
It is also a good personal experience to get into "default modus", not to be able to have everything at any time: water, electricity, food, TV, radio etc. Life is – in spite of the daily small difficulties – much slower than at home.
The eastern Congo region is in many ways less developed than it's neighbouring countries in East Africa. The population has little trust in receiving support from governmental authorities. I experienced that people generally were very thankful that somebody from outside was interested in Congo. I did not always find it easy to face the many wishes for financial support.
I lived in the Swedish mission compound where I felt welcome and safe. I had some nice short trips in this beautiful area and also in the neighbouring countries.
I left the region feeling rich in experiences and impressions.

Internet Sources:

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| CELPA : | www.celpahospitalbukavo.org |
| MamaNathalie : | http://www.laerdal.com/us/mamaNatalie |
| PanziHospital | http://www.panzihospital.org |
| Kivu conflict | http://en.wikipedia.org/wiki/Kivu_conflict |

**Facts, DR Congo, 2011** (www.thestateoftheworldsmidwifery.com)

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| Total population: | 68 mill |
| Number of women of reproductive age (19-49): | 15 mill |
| Births per year: | 3 mill |
| Literacy rate (age 15 and over, male, female %): | 78/56 |
| Total fertility rate (children per woman): | 6 |
| Prop.ofbirthsattended by skilled personnel (%): | 74 |
| Maternalmortality rate (per 100 000 live births): | 670 |
| Stillbirth rate (per 1000 births): | 32 |
| Noenatalmortality rate (per 1000 live births): | 51 |
| Under-5-mortality rate (per 1000 live births): | 199 |