

Speech and language therapy in East Africa:
The first East African speech and language therapy conference in January 2005 in Nairobi

A report by Drs. Angela Jochmann (neurolinguist and coordinator SLT course Uganda)

The first East African speech and language therapy (SLT) conference was held in a hot week in January in Nairobi. 6 of the then 7 existing speech and language therapists from Uganda and Kenya (the one from Tanzania unfortunately could not attend) met at a 5-day conference to discuss SLT challenges in East Africa and to train each other in therapy methods.

Participants of the course were Emma Shah (trained in the UK, working in Nairobi, Kenya), Reyhan Hosgor Erdugon (Turkey, Nairobi), Elisabeth Scheltema- Kruger (Netherlands, Nairobi), Nuala Alibhai (Mombasa, Kenya), Clemence Aryanyijuka (SLT assistant, Kampala, Uganda) and Angela Jochmann (Germany, Kampala).

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SLT in East Africa

Speech and language therapy in East Africa consists of little therapy islands in Nairobi and Mombasa in Kenya, Moshi in Tanzania and Kampala in Uganda¹. But the demand is immense:

Research in Uganda has shown that half of the population with disabilities (10% of the total population of 26 millions) suffer from communication or feeding disorders².

Brain lesions (caused mostly by road traffic accidents and violence), strokes, brain tumours, cancer, AIDS and psychological trauma cause SL disorders in another estimated 3% of the population. Furthermore, an estimated 2% of the total population suffers from temporary or permanent voice disorders and dysfluencies, thus raising the number of people with communication disorders (pwcd) to approximately 2.6. Million in Uganda. At the moment only 1 SLT and 1 assistant provide service in Uganda.

We think that the percentages will be similar in Tanzania and Kenya.

Because service is only provided in 4 cities in East Africa, access is limited to residents of the cities and their surroundings and to wealthier East (and even Central) Africans who can afford travel and accommodation costs³.

Furthermore, service in Kenya is private and users have to pay fees in Aga Khan Hospital, Nairobi Hospital and Mombasa Hospital. In Uganda the service is provided within the biggest governmental hospital, Mulago Hospital, and thus is free of charge.

Speech and language therapy in Mulago Hospital treats about 200 children every year and since 2004, about 100 adults every year with communication and feeding disorders. Service is provided at the out patient clinic and on the wards.

¹ Speech and language therapy in general is a very rare service in Africa. We do not know of any countries except for Uganda, Kenya, Tanzania, Namibia, South Africa, Zimbabwe and Malawi that provide SLT. If any of the readers can provide us with information about SLT in Africa we will be very grateful.

² Hartley, S. & Wirtz, S., 1999: *Service priorities for children with limited communication ability based on disability rather than impairment analysis*. Postgraduate Doctor Africa, 21 (4), pp. 89-92.

³ Robinson, H., Afako, R., Wickenden, M. & Hartley, S., 2002: *Preliminary planning training speech and language therapists in Uganda*. Folia Phoniatica et Logopaedica. Vol 55/6. pp 319-323.

The caseload

For several reasons, the work of speech and language therapists in East Africa is quite different from the workload in Europe.

Therapy *frequency* is one reason. Most of the clients only come once or twice to therapy because they can not afford the time or the transport to the hospital⁴. Speech and language therapy consists more of counselling and co-training caretakers on therapy than of giving regular therapy.

The *paediatric* caseload almost exclusively consists of children with moderate and severe communication and feeding disorders. Cerebral malaria, infection diseases as German measles and meningitis and/or malnourishment of the mother during pregnancy and malnourishment of the infants and children often cause severe multiple disorders. For example, cerebral malaria can lead to cerebral palsy often combined with deaf- and/or blindness. German measles are one of the reasons the Ugandan population has a big percentage of people with hearing impairment or Deafness.

Children with autistic spectrum disorders are often sent to SLT as there is no institution in Uganda for them so far.

Among the *adults* a great percentage of communication and feeding disorders results from open and closed brain injuries caused by road traffic accidents, assaults and the wars in Uganda, Congo, Sudan and Somalia.

Helmet and safety belt laws were recently implemented in order to reduce traffic victims. The traffic in East Africa is murderous, over- speeding normal and driving under alcohol frequent. The dusty air in the cities and the habit of teachers, preachers and Imams to use a very loud and strained voice while speaking often leads to voice disorders.

Eating habits and the diet of a lot of East Africans cause a high percentage of chronic reflux. Untreated the risk of laryngitis is increased (and not confirmed but assumed by Ugandan ENT doctors the risk of larynx cancer is increased as well).

Unfortunately, still a large percentage of East Africans suffer from AIDS. AIDS can inflict meningitis, tuberculosis and/or dementia and the consequences can be respiration-, speech-, language- and feeding disorders.

Disability

Disability is still linked with a stigma in East Africa, especially in rural areas. Children and adults with disabilities are often hidden by their care takers because neighbours will not tolerate them. “The devil is in that child”, “this is the result of adultery”, “God punishes you for your sins” are some of the phrases a desperate mother or caretaker might encounter. Families with disabled members, especially with communication impaired members, are often at the rim of the village communities. The burden is on the mother who often gets abandoned by the husband after one of the children becomes/is borne disabled. Pwcd often end up as “village idiots”. Fortunately, due to big awareness raising campaigns and the presence of CBR (community-based rehabilitation)- workers, this attitude slowly vanishes. People become more aware of the causes of disability and learn about the existence of specialists who are able to help.

Last year, speech and language therapy performed a country wide sensitisation campaign in Uganda to train medical, paramedical and education staff on the identification of communication and feeding disorders and on basic intervention methods. More than 300 people in 29 institutions were trained.

⁴ Robinson, H. & Tumweheire, G., 2001: *The provision of a centralized speech and language therapy service in Uganda: a 3 year case note study (1999-2001)*. Unpublished report ENT department, Mulago Hospital, Kampala, Uganda (available from first author and from SLT Mulago, sltuganda@yahoo.co.uk)

Disability not only has social but also often financial consequences. Health care is expensive and specialists normally live in the bigger towns and cities. Travel to these specialists is expensive and means that the caretaker can not work during this time. A stay in the hospital does not seldom mean the financial ruin on the family as a care taker has to accompany the person. Hospital stays are expensive as the hospitals do not provide food and beddings. Drugs have to be paid for and the care taker can often not leave the hospital because s/he has to wash and to feed the sick person and will thus not be able to earn money during the stay.

Cultural challenges and ethical dilemmas

Expatriate speech and language therapists face several challenges and ethical dilemmas in the treatment of people with communication and feeding disorders in East Africa.

One of the challenges concerns the treatment of Muslims with dysphonias and dysarthrophonias. As therapy for these disorders includes physical contact, female SLT's are faced with the problem of how to check muscle tone and to train breathing and/ or relaxation without touching male Muslims. In the case of one Muslim imam with laryngectomy, therapy had to stop because the imam could not take advice from a white non-Muslim woman.

East Africa's cultural systems, especially in rural areas, are still dominated by men. Some of the East African SLT's encountered situation where the husband/brother/father of a female client refused therapy given by white women because "she will put rebellious ideas into my wife's/sister's/daughter's head". In one case it was the advice given to a dysphonic woman not to carry too heavy and to talk at the same time in order not to strain the neck muscles. Another incident was about a woman who was advised to do her breathing exercises in a lying position in order to train costo- abdominal breathing what led to the remark of a man that "these white woman try to make my daughter idle".

Speech and language therapists have to be very sensitive on these issues, and finding the balance between obeying cultural taboos and providing effective therapy is often a tricky affair.

Aphasia therapy poses one challenge in terms of word finding strategies. Circumscription of words demands knowledge about the culture and the way concepts are formed in this culture. *Stereotypical concepts* vary from the Western ones (and even vary within the Western cultures; I once tried to use American photo cards with Germans patients and was not very successful as a lot of the pictured objects look different in Germany).

A stereotypical fruit in the west is the apple (denoted by a short and monomorphemic word), in Uganda it is maybe the pineapple "enanansi", denoted by a longer, non- monomorphemic word. (btw, you might have thought it is the banana, but Ugandans have at least 6 different words for "our" simple concept of the banana to denote the different types of bananas). And stereotypical animals for Africans are not elephants and lions (these are more the stereotypical animals the Westerners associate with the concept of Africa) but rather goats, cows or cats.

Highly frequent words are often only bi- or trisyllabic, but the therapist has more work to do to find out what words are highly frequent for the individual/ tribe/ culture.

Synonyms and antonyms are sometimes very different from the Western ones as they are highly culturally dependent. The word pair "fat- overweight" is not synonymous in most Ugandan cultures, the word pair "fat- beautiful" is.

Most of our *therapy material* is not useful in the East African context and speech and language therapists have to be very flexible to adapt material and to invent appropriate one.

Facial expressions and body language are often highly dependent on cultures. Often the same facial expression conveys different meanings in different cultures. In Western cultures, raising the forehead often indicates to doubt something the communication partner has said. In East

Africa it simply means “yes”. Training the frontalis muscles is thus one of the priorities in the therapy of facial paresis or dysarthrophonia.

The training of *gestures* is an important feature in aphasia therapy. But the therapist needs to know the gestures. Beating the top of the left fist with the right open hand has a rather obscene meaning in German. In Luganda, it simply means “full” or “filled”. In order to use PACE, a profound cultural knowledge is required.

Establishing and maintaining *eye contact* is considered very important in Western speech and language therapy, e.g. of dysfluencies. But the possibility to establish eye contact depends on the hierarchical position of the person: if the patient is in a low tribal/ social position s/he is not allowed to establish eye contact with somebody who is superior, in this case the therapist. This feature of social hierarchy is often encountered among children and women from rural areas and the therapist faces the challenge of finding new therapy strategies in order to account for this cultural taboo.

Linguistic challenges

Most languages spoken in East Africa are Bantu languages. Swahili (a mixture of Bantu, Arabic and other languages) acts as the official language in both Kenya and Tanzania. Uganda has over 40 languages besides English and Swahili, the majority of them belong to the Bantu family.

Bantu languages compose the whole grammar around 8-12 different semantic noun word classes. *Syntax* is mostly agglomerative, there are no determiners, and affixes are attached to the noun to denote grammatical relations as modus, tempus and number.

Personal pronouns are attached as prefixes to the noun. Tense markers change the whole verb stem morphemes (as irregular or “strong” verbs in Indoeuropean languages do as well).

Example in Luganda (one of Uganda’s languages):

to work = omukola

I work = nkola,

you work = okola,

I worked = nnakoze (near past) and nnakola (far past)

Adjectives and verbs almost always carry the same prefix the noun has.

Examples:

the human = omuntu,

the humans = abantu;

the white human = omuntu omweru,

the white humans = abantu abeeru;

the white human works = omuntu omweru akola,

the white humans work = abantu abeera bakola.

Morphology of words is different from most Indoeuropean languages as there are almost no monosyllabic words and monomorphemic words consist of two or more syllables.

Thus we can not apply some of our therapy strategies of cuing words. Cuing a word via the initial sound does not lead to the desired effect. Cuing the word via the first letter is another challenge as many people do not know how to read or write their tribal language or English.

Further, a lot of East African languages do not have a single *orthography*: “Pineapple” can be “enanansi”, “ennanansi”, “enannansy” etc.

Often, Ugandans write as they hear the word (a phonetic strategy some Europeans tried to implement in their schools with sometimes rather curious results; see the Dutch and the Germans).

English is far away from a phonetical orthography and Ugandans writings often reflects phonetical translations. “facial” can become “fashial”, “books” “buku”, and one of my physiotherapy students who assessed a dysphagic patient wrote “the woman joked on her food” when the poor patient aspirated her porridge (“choked”).

With aphasic patients the assessment and treatment of writing can be a problem, as it may never be clear whether the spelling is idiosyncratic, phonetical, a functional dyslexia, an acquired dyslexia or just lack of school education.

The sounds /l/ and /r/ are interchangeable in some Bantu languages. “Makerere” and “Makelele” denote the same object. A therapist needs to know if this a language feature or a phonetical or apractical problem in order to decide whether to treat it or not. The interchange is also sometimes a social class feature. Some Ugandans consider using /l/ for /r/ as a sign of lower education.

Treating *bi- and multilingual* patients can be difficult if the therapists does not know the languages of the patient. For example, the patient may name a picture in a language the therapist does not know. The accompanying caretaker might tell the therapist that the word is right because s/he does not want to embarrass the patient or the therapist by admitting an error.

Expatriates providing language therapy are heavily dependent on *interpreters* (normally a family member of the client). Often the therapist has to check and re-check if the interpreter translates advice and tasks correctly and the therapist also has to make sure that tasks are understood correctly in the beginning by the interpreter before being translated.

Other challenges

Therapy on the wards of Mulago Hospital requires creativity and flexibility as most of the wards lack equipment, food for the patients and “basic” things as painkillers, catheters and tubes. Many adult patients with brain injuries suffer from aspiration pneumonia because the nasal tube does not fit, care takers do not know how to manage a nasal tube (they often feed too fast, too much and with the patient lying in a horizontal position; beds with movable back rests are rare), nasal tubes stay for weeks without being replaced or/ and 2 or more patient have to use the same suction machine. Speech and language therapy intervention consists very often on training the care takers more than once on nasal tube management. PEG’s are rarely used, on the one hand because they are expensive, and on the other hand because they carry a stigma in Uganda because they are associated with AIDS and death.

Thanks to the marvellous commitment of the doctors, nurses and care takers, a lot of patients recover from the pneumonias, pressure sores and other secondary infections.

Tongue tie is one issue surrounded by myth. Often, a mother is told by well-meaning neighbours to let the child’s tongue cut if the child fails to speak. Not seldom, this surgery is performed by “witch doctors” or traditional healers and the consequences are often infections and badly scarred tissue. During a talk to the association of dentists and oral surgeons it came out that they perform up to 10 tongue tie surgeries per week. Referrals to SLT are rare and if children get referred to SLT at all, it is after the surgery. Clinical experience has shown that a lot of these “tongue-tied” children are hearing impaired or deaf or suffer from cerebral palsy.

Selective mutism is a disorder very often found in victims of the civil war in Northern Uganda. Former child soldiers and abducted people are too traumatised to be able to express themselves in language. Although this is a disorder treated normally by psychologists and social workers, both of these professions are rare in Uganda and Speech and language therapists will have to face this disability. Official numbers consider 12% of the Ugandan population will have a mental disorder but aid worker consider this number too small.

For most of the speech and language therapists, *workshops and further trainings* in therapy are difficult to access because those take place in Europe and costs are too much for us to join in.

Speech and language therapists have to rely on SLT journals (that are often too expensive as well), internet resources and books.

Therefore the conference was a perfect occasion to train each other on certain therapy approaches. Stimulation of respiration according to Bobath, aural rehabilitation and laryngectomy aids were some of the workshops we held for each other.

We also exchanged lists of each others' therapy materials as books on assessment and therapy have to be imported to Africa.

Despite or even because of all these challenges, speech and language therapy is a highly rewarding task in East Africa. Seeing how little changes have a big effect is very gratifying. Many East Africans also possess a wonderful sense of humour and therapy is often a time with a lot of laughter involved.

The first speech and language therapy course in East Africa

Since 1986, VSO has sent speech and language therapists to the ENT department in Mulago Hospital in Kampala/Uganda. As this has not proved sustainable due to language problems (Uganda has over 40 local languages) and cultural diversity, VSO Uganda and ENT decided 3 years ago to set up the first East African speech and language therapy course together with Makerere University in Kampala. The training of Ugandans and other East Africans as speech and language therapists will be a much more sustainable and efficient way as the trainees know the languages and the culture(s) of the clients and can counsel and treat accordingly. Since 2002 VSO SLT volunteers work with full power to realise this project. Writing the curriculum and the modules, dealing with bureaucracy and fundraising as well as running the paediatric and adult clinics are just some of the challenges we have to face. With the help of Viataal (a Dutch organisation) and Standard Chartered Bank Uganda we hope to start the course in February 2006.

20 students each year will be trained in a Higher Diploma course. The duration of the course is 2 years, equipping the students with basic knowledge of anatomy, psychology, sociology, counselling, community-based rehabilitation, linguistics, general assessment and treatment methods and surely on the several communication and feeding disorders. The SLT modules include hearing impairment, language delay and –disorders, neurological disorders, physical disabilities, learning disabilities, cleft-lip palate, tongue tie, dysfluencies and mutism.

The aim of sustainability might be reached within 5 years, in this time we might have trained enough speech and language therapists that they run the school without expatriate lecturers. Within 10 years we hope to be able to provide speech and language therapists to the governmental hospitals (at least 170 are needed).

Encouraged by our Ugandan efforts, the Kenyan SLT's now try again to set up their own course.

In summary, the conference was a total success as we not only learned about our expertises, could profit from each others' knowledge because we could also discuss and share our experiences and the challenges we face. But time was much too short. We are planning to hold another conference next year.

The year 2006 has provided us with 4 new speech and language therapists in Uganda and Kenya. Kampala has now a new paediatric specialist (a VSO volunteer) whereas Nairobi has received three SLT's: 1 VSO volunteer and two free lancers.

Drs. Angela Jochmann is a neurolinguist (Rijksuniversiteit Groningen) and specialised in the treatment of patients with severe neurological disorders (patients in coma, waking coma or with Locked-In syndrome). She has been working in Uganda since February 2004, providing adult therapy and training as well as coordinating the set up of the SLT course.

Therapists and other people interested in our project, general issues or a job as a VSO SLT are very welcome to contact us:

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