

This article was written for Communication Therapy International by Michael Terry in April 2010. It gives an insightful description of his experience working in Nairobi as a speech and language therapist.

From February 2007 to January 2009 I worked as a VSO volunteer in Mukuru, an informal or 'slum' area sprawling around Nairobi's industrial district. VSO had attached me to an organisation called The Association for the Physically Disabled of Kenya (APDK) which had been running a Community Based Rehabilitation (CBR) programme in Mukuru and other slum areas around the city for several years. My role was to provide training to APDK staff in the CBR programme with an aim to developing their ability to diagnose and treat speech and language difficulties. The plan involved training 'technical' staff i.e. qualified occupational therapists, physiotherapists, social workers etc and eventual 'cascading' of their skills and knowledge to community based field workers carrying out work in the slum. I would also be working alongside staff in 'the field' providing direct therapy to clients as a means to demonstrate therapy in practice.

APDK has been a well known NGO in Kenya since independence and has a long history of working on programmes for people with physical disability. APDK helped eradicate polio from the country and is well known for being the largest producer on the continent of prosthetic aids and wheelchairs outside of South Africa. The sight of their shiny, blue wheelchairs and hand propelled tricycles are a common feature in downtown Nairobi. These have special adaptations allowing people with disability to transport and trade items in Nairobi's bustling street markets, thereby achieving for themselves a small measure of economic empowerment, an essential tool for survival in the absence of limited state assistance. APDK also employs many people who have disabilities themselves.

Jointly with VSO APDK provided me with accommodation and an allowance, the equivalent of a small local wage. This was in fact almost double that received by some of my colleagues many of who lived within the slum. I lived in a small flat, part of a family compound on the outskirts of Nairobi. Sometimes the family I rented from would invite me to join them for dinner. They were a family of 4 called Okila but the girl I had assumed was their daughter was in fact a niece. Both her parents had died from AIDS and Mrs Okila had taken her in as if she was her own child. This I found to be common among many Kenyan families.

My journey to work began at sunrise (about 6 a.m.) and involved catching a matatu (minibus) from the nearby stop all the way into the centre of town. Nairobi traffic seems to veer between death defying speeds and a virtual crawl, not a comfortable experience crammed with 20 other people into a matatu with a 14 seat capacity. And you better enjoy the music which is usually a mixture of hip hop and the latest grinding American R&B played extra loud! Once in the centre the next stage of my journey involved a walk

down the notorious River road to make my connection with the matatus travelling south to the industrial area and the slums. This road alone has done much to contribute to Nairobi's reputation for violence and general lawlessness. Still, VSO were very clear about the risk you took being in this area after dark.

My final destination would be any number of townships, called 'villages', in Mukuru Slum. Roughly 500,000 people live here in conditions of extreme overcrowding. Houses are made of recycled materials such as cardboard, tin and wood. There is a lack of clean water and sanitation is virtually non-existent. In the heart of this squalor APDK run a small day care centre for children with disability. I would often find myself based here demonstrating suitable communication activities for the children or supporting Miriam the special education teacher to work on communication goals for their education plans. It was one of the easiest destinations for me to arrive at as I simply followed the stream of stinking, purple sludge seeping from one of the nearby factories. I once saw a child fall into this while playing and emerge seemingly unscathed from his experience. What long term effects he may have I can't say but there is little surprise in knowing that Mukuru has high rates of child disease and mortality.

The vast majority of clients in Mukuru were children with cerebral palsy often as a result of contracting malaria or meningitis in infancy. I also saw a number of children with autism, Down's syndrome and profound learning difficulty. Nearly all the children I worked with were physically disabled in some way. I was generally introduced to children and their families by my colleague Kibet, an occupational therapist in the CBR team assigned to be my counterpart. In the long term Kibet would learn from me through our joint working and then go on to train the community field workers. Kibet and the other therapists had successfully used this model to train the field workers so they had enough functional knowledge to administer occupational and physiotherapy. Kibet was quick and eager to pick up knowledge and we soon put together a functional assessment tool which we could use to identify goals. I always felt it best to emphasise those that were functional and made sense to the family's situation so typical targets would be developing language around every day activities. We focused on activities like naming items while dressing or washing the child and encouraging parents to do things together with their children. A child that can contribute in some small way to domestic activities was an important factor for APDK's clients and I would try to include these in our goals. From Kibet's point of view it was particularly useful for him to know what level of ability to expect from children and what was realistic.

At the same time as training Kibet in the field I had one day a week in the APDK clinic training my other CBR colleagues. This was more formal and class based but I would try and make it participatory along the lines I had been trained in by VSO's Trainer of Trainers course. In general I was impressed by the knowledge people already possessed but could see that they required a more technical and detailed understanding of speech and communication. For instance a child with expressive difficulties might be described as communicating 'in their own way' rather than explaining the

specific methods they actually use to communicate. So I designed my training to thoroughly include all the components of communication, how to describe and assess them and from this information to devise and put into practice a home based programme. With Kibet's support therapists began using the assessment tool and then we could use our weekly clinic day to discuss goals, therapy activities and ways of measuring progress.

Besides visiting clients house to house, the day care in Mukuru provided a brilliant setting for staff to carry out activities and hone their skills. It was originally set up by parents within the slum who wanted their children to have access to some kind of basic support. I found the motivation of parents and many inhabitants all over the slum astounding. They were determined to seize opportunities and had begun little businesses with the help of micro enterprise schemes like those run by APDK for people with disability. Against all my expectations there was a thriving sense of commerce and vitality in Mukuru.

The day care also made an excellent base for storing materials that could be used for therapy. We built up a stock of every day speech and language resources: bubbles, musical instruments, spatulas, pots of honey (for licking), cotton wool, small mirrors, straws for blowing etc. The emphasis was on keeping therapy functional and low tech using materials readily available locally. My most rewarding days would often be demonstrating to colleagues and parents how such resources could be used in games and for them to realise there was no great mystery in working on 'communication,' that there were in fact simple activities they could do themselves. Later on I also conducted training here with the field workers who showed such an interest in managing communication difficulties that I found it just as effective to work jointly with them on their home visits. Along with Kibet these fieldworkers gradually learned to carry out a range of suitable communication therapies to add to the physical and occupational therapy they already did.

By no means was any of this plain sailing. Working in Mukuru constantly presented enormous challenges and frustrations. I certainly came across attitudes towards disability which were not helpful. Some people still believe that disabled children are cursed in some way and consequently there is a stigma attached to them and their families. It was not uncommon to find adolescent children who had hardly been taken outside, incredible to think of in sunny Kenya. Some local communities had their own treatments and cures. I once worked with a 3 year old severely disabled boy with heavy burn marks over his body which it transpired was the work of a local 'doctor.' In this case APDK had to withdraw their service to avoid conflict with the community. Colleagues told me often when they first worked in the slum people had been afraid and attacked them thinking they had come to cast spells on their children. Thanks largely to APDK's work at raising awareness with parents and communities such views are disappearing rapidly.

Disastrously for me Kibet found a job with another NGO a year into the programme. We'd built a close working relationship and I know he took with him a lot of knowledge which he will make use of. Celestine, the CBR manager, and I worked on solutions deciding that I should work instead with a

number of therapists. Unfortunately other team members had their hands completely full and there were few days when I was able to work alongside a member of the technical team. I'm afraid CBR was also not prioritised within the organisation. It was rumoured donations specifically for maintaining and developing CBR within the slums did not necessarily end up where they were supposed to and immediate colleagues were underpaid and undervalued for their extremely challenging work. More than anything else this was the greatest handicap to building some sustainability from my placement. Other volunteers in other placements would often console themselves with the explanation that 'this is Africa' and turn a blind eye to corruption. We all knew though, deep down, that this wasn't good enough.

The post election crisis at the very end of 2007 was another huge blow. We were unable to work in some parts of Mukuru again due to the increased risk to our security. Clients were displaced and some that we'd been seeing for quite regular sessions just disappeared. And on top of this I was evacuated for 6 weeks! I was of course lucky not to have been confronted with any violence myself.

As a volunteer I felt I had taken away more from the experience than I was able to impart. My colleagues and the people of Mukuru made me feel like an honoured guest. I remember sitting with my colleague Steve in one family's makeshift shack. We'd arrived to do some therapy with their daughter. Some tattered curtains were drawn across the entrance and the small charcoal stove was the only light. I could hear rustling among a pile of pots and pans in the shadows and made out what I thought was a pet cat. It was in fact a large rat! This family literally had nothing. Yet the girl's father was so honoured by our presence he insisted on going out to buy some soda for us, on credit, so that he could express his gratitude. At the end of the day the acceptance and welcome people afforded me along with their cheerful optimism and fun made me feel like the one who had learned and the one who had gained.

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