VSO JANUARY 2007-APRIL2007 AT KUMI HOSPITAL, N.E. UGANDA

Kumi Hospital is a private not for profit hospital that was established as a Leprosy Centre in 1929; over the years with the introduction of drug therapy leprosy has become a treatable disease. Kumi hospital was subsequently developed and became a general hospital in 1986.

Kumi hospital is now a 300 bedded hospital providing both in and out patient treatment for adults and children. The hospital relies on charitable support both in monitory donations and voluntary work from visiting medical staff.
Kumi receives significant support from CBM- Christian Blind Mission- who provide life changing surgeries, physiotherapy, occupational therapy, provision of appliances, accommodation in hospital, outreach clinics and home visits.

My contact with Kumi hospital was enabled by the local charity, FOAG- Farmers Overseas Action Group. FOAG is committed to helping communities in Uganda to improve their quality of life by supporting a growing range of small educational, health and agricultural community projects in Uganda, East Africa.
Established in 1981 by a group of Midland farmers, FOAG has grown to become a small but dynamic action group with supporters from all walks of life. The charity raises on average £80,000 each year which is used to financially assist 11 small health, educational and agricultural projects in Uganda.

It was felt that as an experienced paediatric physiotherapist Kumi hospital would be the most suitable base for me to share and exchange skills. I consequently took a career break for 3 months and embarked on an unforgettable and life changing experience.
I have never visited a developing country before and went out with a very open mind as to the environment, culture and healthcare provision that I was to experience. I can honestly say that nothing could have prepared me for the shocking level of poverty.
Kumi hospital is situated in the N.E of Uganda, which is very rural, flat, dry and windy with much poverty. Water and power are unreliable but the hospital now has an emergency generator and water pumped from a local lake, treated and stored in large water tanks and giving running water. All healthcare has to be paid for, or at least a contribution made, sometimes as little, in our eyes, as a chicken or a bag of ground nuts!!
I became very aware that the patients valued greatly any treatment or appliance as they had had to make a personal donation and appeared to have greater ownership of it; nothing was taken for granted, as is often the case in the NHS! Admission into hospital is only possible if an attendant is able to stay with the patient as the nursing staff provide only basic nursing care; the attendant has to provide and cook the food, wash and care for the patient and provide some sheeting for the mattress. The attendants cook on small charcoal stoves in the grounds and sleep on the floor under the beds at night.
In Uganda there is only one school of physiotherapy with approximately ten graduates per year.When I was at Kumi I was the only physio, there were two physio assistants who had worked there for many years and were very skilled. They were responsible for reading X rays, reducing fractures without any painkillers, applying and removing plaster

casts and sutures, setting up traction on broken limbs and running a variety of clinics. I was amazed at the diversity of their skills but there are so few staff that those that are there have to be able to multi task. There is no dispute as to whether a task is on their job description or whether it has or has not been risk assessed!!
Initially I was unsure how I was going to be able to be useful, I was learning much from my Ugandan colleagues but I was not sure how much I could share with them. The care of children with disability is, in the main, provided by the Community Based Rehabilitation Workers-CBR workers, these people have had four months training on all childhood disability. They visit families with children with disability in the community and run Outreach clinics. It was within this area of work that I felt that I could share some skills. I was timetabled to work alongside the CBR workers in both clinics and the community, this was very rewarding as their desire to learn was great and I was asked to do a few days training to all rehab staff.

Childhood disability in Uganda presents very differently compared to the picture we have in Europe. Malaria is the main cause of disability, leading to post malarial Cerebral Palsy-CP. The most common causes of CP in England are prematurity and perinatal trauma, in Uganda these two causes result in death as there are no intensive care facilities. I had to significantly adjust my therapy objectives when working with a family with a child with CP where that child is one of 10 children, the parents have to work the land to grow the food, walk kilometres to collect water, have no electicity,minimal clothing, no mattresses or mosquito nets. The extended family is of great importance as often the children only have one parent as the other has either died of Aids or been killed in the insurgency. My ability to think laterally improved quickly. Often by using the charity money inventively enabled families to access hospital treatment and medicines. For example, buying two goats so that the resulting kids could be sold or purchasing a second hand sewing machine to enable income generation.. Income generation projects are vital to enable families to become self sufficient and not dependant on external help.

Equipment for children with disability is very basic but can be effective when designed and used correctly. There was a workshop at Kumi hospital and the technicians were fantastic; over my time there they became used to this strange white woman arriving with odd drawings of what items of equipment she wanted! They were very excited to make different items, within a week of giving them a drawing of some tripods they were made, trays were designed and made for the standing frames and shoes made from my drawings of the children's feet. Their efficiency was far superior to the NHS!

I could continue for pages with my experiences but if you wish to hear more I invite you to come and listen to my talk and slide show

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I will try to summarise my thoughts on how this experience has affected me both personally and professionally. From a personal perspective I feel privileged to have been able to live and work in a very different culture; I found it hugely challenging, both physically and emotionally. It gave me a first hand experience of being obviously different and therefore potentially vulnerable as being constantly noticed. I was humbled

by the Ugandan people, who as a race, are happy, open and giving people who appear to need much but manage with little and are grateful for what they have.
This experience helped me put into perspective the most important aspects of living and working as part of a community- resources such as water, power, food are to be valued and not squandered or abused, people should be enabled to be self sufficient not reliant on others and the extended family is the most important support network. Access to education and healthcare is viewed as a privilege not a right and is therefore valued.

Professionally I have learned much about healthcare, disease and disability in a developing country. Firstly the infrastructure within Uganda makes movement within the country time consuming and all activities are labour intensive, e.g., transportation of goods, medicines and patients takes hours due to the poor road conditions, very few people have access to cars therefore walking and cycling are the main forms of transport. Lack of resources i.e. manpower, medicines, power, buildings, water, the list is endless, has a profound effect on access and delivery of healthcare. Often people are unaware that medical intervention can be beneficial, so Outreach clinics actively seek children whose lives could be improved by medical intervention.
Core skills of communication, listening and sharing of knowledge and skills are transferable within any healthcare setup; the most significant and important acquisition is to be culturally competent and aware. An understanding of the culture that you are to work in is paramount to a successful and fulfilling experience.
I believe that I was able to integrate with my Ugandan colleagues and have an exchange of knowledge and skills, humour and friendship that was both fulfilling and life changing for the children, my colleagues and myself

On my return to England and work I undoubtedly suffered from reverse culture shock. The abundance and yet waste of all resources and the culture of dependence that has been bred in our society I found as equally shocking as I had found the poverty in Uganda. I think the NHS is and should be a very valued service, sadly I think generally it is taken for granted and seen as a right as people have paid their taxes, as I have told by some children's parents! Complaints and litigation have been bred from our blame culture, in Uganda, families waited for four hours to see me in clinic after they had travelled two days to reach the clinic; no complaints were heard only gratitude and thanks were given. I think lessons can be learned from a people who have so little but give so much.

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