

International Practicum Report: Rwanda

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INTRODUCTION

My international practicum took place in Gisenyi, Rwanda at the Ubumwe Community Center in June 2012. This practicum was a result of three years preparation and hard work. It was the most fulfilling and rewarding week of my life. This practicum was a partnership with Partners In Conservation (an organization within the Columbus Zoo and Aquarium). From this partnership, five students (including myself) from the graduate interdisciplinary global health student organization “Buckeyes Without Borders” were able to travel to the Ubumwe Community Center (UCC) in Gisenyi, Rwanda (a center for people with disabilities) to provide education and conduct a needs assessment. I traveled with students from the following disciplines: medicine, occupational therapy (2), and pharmacy. I represented the profession of physical therapy.

The UCC provides many services for people with disabilities and to the local community.

Below is a summary of their current programs:

- 1) Skills program: people with disabilities are taught how to make local arts and crafts so they can learn a marketable trade.
- 2) Computer program: people from the community with and without disabilities are taught computer skills.
- 3) Program for mentally challenged children: these children receive basic education (such as math and English) and are taught life skills.
- 4) Deaf/hearing impaired program: these children are taught American Sign Language and receive primary school level education. After three years, they take a competency test. If they pass, they are moved into an inclusion program in a local school where they have an interpreter in the classroom.
- 5) Sports and culture program: people with physical disabilities participate in soccer, sit volleyball, or traditional dance and compete with others throughout the country.
- 6) Move-Into-Action program: upon completion of the skills program, people with physical and mental disabilities are placed with a job to use the skills they have learned to become economically independent.
- 7) Wheelchair and assistive device distribution: the center distributes this equipment to people as needed and as available.

In addition to the above programs, one of the co-directors of the UCC goes on home visits in the community for those who are physically unable to come to the center. The UCC also opens its classrooms in the evenings and weekends to people and organizations in the community to host events. They are also in the process of building a preschool for early intervention. Finally, the UCC is expanding to open a new center in the Democratic Republic of the Congo.

In order to supplement the already wonderful programs that exist at the UCC, we brought healthcare knowledge and education for the first time to this center. We developed several education programs to deliver to the center, brought supplies, provided consultation, and conducted a thorough needs assessment to inform future service-learning trips.

LEARNING OBJECTIVES

Prior to departure for this trip, I outlined three primary objectives for myself.

1. To learn at least three new words in Kinyarwanda everyday and use these words in practice to help me better connect with the people.
2. To identify at least three priority physical/occupational therapy concerns in order to inform and provide adequate preparation for future rehabilitation student trips to the UCC.
3. To identify strategies that do and do not work with leading and setting up this service trip to inform future trips.

In terms of objective one, I was very successful in achieving this goal. I became very immersed in the culture and the language followed. The people were very appreciative of my effort to learn their language and saw this as a gesture that I really cared to try and connect with

them. In turn, they would try to use English with me, which was very special. Learning the language also made it functionally easier to live in Gisenyi. One of my proudest moments was being able to communicate at the market to obtain supplies we needed without having our translators with us.

While in Gisenyi, I collected a plethora of information regarding physical therapy and occupational therapy concerns. One of the first major aspects I identified was the patient population at the center. Most people had a physical disability that impaired their mobility and activities of daily living. None were receiving physiotherapy services. However, the activities that they all participated in at the center were very therapeutic in nature. Common diagnoses observed were cerebral palsy and Down syndrome, along with many other physical impairments, which could have been caused by birth defects, chromosomal disorders, and infections such as Polio. Secondly, it was apparent that the assistive devices and wheelchairs available were not appropriately fitted for the individual and furthermore, this equipment was difficult to use on the terrain in Rwanda. In the future, it would be very helpful for physical therapists to come and appropriately fit individuals for assistive devices and wheelchairs. I think it would also be a good project for the rehab engineering class to build assistive devices and wheelchairs that can last on the rough terrain in Gisenyi. Many people at the center would also benefit from adaptive equipment and devices that could be fabricated by occupational therapists. Another issue that was very apparent is current information in rehabilitation offered to physiotherapists. The model of physiotherapy appears to be compensation rather than recovery (this may be an artifact of resources rather than knowledge however). Most importantly however, nothing is known about autism in Gisenyi (full discussion below). Finally, I was able to create relationships that will

allow physical and occupational therapy students the opportunity to have clinical rotations at the local hospital and clinics.

There were many things I learned that I would like to keep doing or not keep doing for future trips. First, in terms of things that need to be fixed in the future, we need to bring more pens. We all kept running out of ink, so it will be important in the future to stock up on pens so that we can record the events of our trip! The power goes out frequently, so it is important for everyone to bring at least one flashlight (a headlamp would be ideal) or candles with matches so that we can continue to do work into the night. It might also be beneficial in the future to go to the grocery store in the Kigali mall before departing in Gisenyi so that we can stock up on non-perishable foods for lunches and snacks during the week—there is not a large selection in Gisenyi. Down the road, it might not be a bad idea to consider hiring a translator (especially as the trip expands and people are working in different places at the same time). If possible, at least a two week trip should be considered. Finally, it will be important to add home visits into the trip---having people devoted to this while others are stationed at the UCC during the week.

In terms of things that worked, 5-6 people is an ideal number for this trip and should remain this way unless services expand a great deal. This allowed for everyone to have a job to do, we were not overbearing to the center, and we were all able to live in a house together so that we could work on projects at night. Having this many people also kept the costs of the trip down. \$400 is an adequate program fee that will cover all hotel, travel, supply, and food costs in Rwanda. A separate budget of at least \$250 is sufficient for supplies and materials for projects onsite. It is good to have one person in charge of the budget for lodging and travel, one person in charge of the budget for food for the group for the week, and one person in charge of the budget for supplies on ground (since there is so much money to keep track of for one person to carry

with the exchange rate). Finally, it was particularly beneficial for all of us to have several preparatory meetings prior to the trip. Because of this we were well prepared and able to accomplish a great deal within a short period of time.

INDIVIDUAL RESPONSIBILITIES

I had a large amount of individual responsibilities in organizing and leading this trip. I made sure that we were all able to get from point A to point B each day. I communicated with the directors of the UCC to determine what they wanted from us, what we had to offer, and determined a plan of events for each day. I participated in a thorough needs assessment of the UCC and gathered information on Gisenyi and the local hospital. I formed new relationships and partnerships to make this a sustainable trip for OSU students and faculty. Additionally, I provided a great deal of education to people related to health concerns to help enhance their quality of life, participated in a hearing education program and oral rehydration therapy program for the teachers at the UCC, made wheelchair cushions, and assisted in the fabrication of an adaptive spoon. Most importantly, we were able to collect data on hearing in the deaf children to send to an organization that BWB is now partnering with in England who is in a position to send audiologists to Rwanda to do hearing testing and treatment.

AUTISM IN RWANDA

From my encounters with health care professionals and people in the community, it became clear that autism is a relatively unknown term and diagnosis in Rwanda. However, during my short time in Rwanda, I encountered several children with autism spectrum disorders. According to Wallace et al.,¹ there is increasing awareness of autism spectrum disorders in developing nations from efforts lead by Autism Speaks who launched a Global Autism Public

Health Initiative in 2008. Unfortunately, I did not see evidence of this campaign to train global health workers in Rwanda. Apparently this program has been established in over 20 countries.¹ I feel that Rwanda would benefit greatly from this program. If it does exist in Rwanda, it has not spread to the town of Gisenyi where autism is prevalent.

To date, there are no published studies on the prevalence of autism in Rwanda. However, there have been studies that have looked at prevalence and knowledge of autism in other sub-Saharan Africa; namely, Nigeria. Bakare et al.² sampled 134 healthcare workers in Nigeria to assess their knowledge about childhood autism and opinions about autism. They found that there is the greatest gap in knowledge regarding symptoms of obsessive and repetitive patterns of behavior.² There are also gaps in knowledge regarding symptoms of impairments in social interaction, type of autism disorder and associated co-morbidities, and symptoms of communication impairments.² Interestingly, the group with the greatest gap in knowledge are those healthcare workers who are younger than 40 years old.² In this study, those who were in their fourth decade or older were more likely to have greater knowledge regarding children with autism.² One would expect that the younger generation would have more knowledge from school (where one usually has access to the latest science and evidence on topics). Bakare et al.² attribute this finding to more years of clinical experience with children with autism. This finding has many implications. First, this tells me that current education in countries in sub-Saharan Africa is not up to par on current knowledge and treatment regarding autism spectrum disorders. Second, if health care workers who have more knowledge learned about autism in school, their information is severely dated (older than 20 years old). Twenty years ago, developed countries had poor understanding of autism and treatment strategies. Since there is no continuing education in countries such as Rwanda, there is little hope that these health care workers are practicing or

understand the most successful treatment techniques or understand the full range of co-morbidities associated with autism. A similar article from Nigeria also confirms that knowledge of autism is low among undergraduate students in their final years of medical, nursing, and psychology programs.³ Looking in retrospect, perhaps the reason no one had heard of autism in my encounters was that it was an artifact of their young age and they have not yet had the experience to encounter autism in their clinical practice yet.

Some may argue that in countries such as these, Nigeria and Rwanda, perhaps the reason for the poor understanding of autism is simply due to the fact that there is a low prevalence of autism in these countries. However, I do not think this is the case. From my experience, autism is prevalent, it is just not understood. One particular case that I saw involved a boy who was 16 years old with autism. For years, his family took him to doctors for evaluation. However, they concluded that there was nothing medically wrong with him and they do not know why he behaved the way that he does. According to Bakare and Munir,⁴ it was commonly believed that autism was only a disease in the West. However, evidence is showing that this is not the case anymore.⁴ Furthermore, studies have shown that in countries in Europe, children who were born to parents from sub-Saharan Africa were at greatest risk for autism.⁵ While evidence is emerging, not enough data has been collected to understand the prevalence of this disease in Africa.⁴ I feel that this is a direct artifact of poor understanding of the diagnosis, symptoms, and treatment of autism. I think Rwanda in particular would benefit from the training of healthcare workers to recognize and treat autism disorders. Perhaps this could be an aspect of future trips to Rwanda with Buckeyes Without Borders.

CONCLUSIONS

This trip was the best week of my life. I have never accomplished so much in one week. Everything went very smoothly. I felt very safe the entire trip. We did not have any travel problems on ground and did not have any communication problems. Our living accommodations were very nice, though you need to be prepared for power outages and to have ice showers the entire stay. The food was very good and no one got ill. The hotels all provided mosquito nets, though no one got any bug bites. The weather was beautiful and very mild. I would highly recommend this experience to other students.

References

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PICTURE STORY































































UCC ACTIVITIES CYCLE



