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TABLE OF CONTENTS

<u>INTRODUCTION:</u>	5
<u>NATIONAL HEALTH INSURANCE SCHEME</u>	9
<i>Introduction</i>	9
<i>The Basics of the Scheme</i>	
<i>I. Registration Process</i>	10
<i>II. Coverage Inclusions and Exclusions</i>	11
<i>III. Funding</i>	12
<i>Penetration of the Scheme</i>	12
<i>Local Opinions</i>	
<i>I. Insurance Scheme Manager</i>	14
<i>II. Pharmacist</i>	15
<i>III. Nurse</i>	17
<i>Assessment</i>	
<i>I. Ministry of Health Assessment</i>	18
<i>II. Our Assessment and Further Suggestions</i>	19
<u>REFRACTIVE ERROR AND VISION SCREENING</u>	22
<u>MEDICINAL PRACTICES IN GHANA</u>	29
<i>Barriers Facing the Utilization of Traditional Ghanaian Healing Methods</i>	29
<i>Medicine Trapped by Trust and Law</i>	40
<i>Undergraduate Research Proposal to study Herbal Medicine in Ghana</i>	52
<i>I. Project Goal</i>	52
<i>II. Project Description</i>	52

III. Student's Responsibilities.....	54
IV. Faculty Sponsor's Responsibilities.....	55
V. Duration of Project.....	55
VI. Award Option.....	55
VII. Budget Justification.....	55
<u>CLEAN WATER PRACTICES</u>	57
<i>Introduction</i>	57
<i>The Dependent Variable</i>	58
<i>Synthetic Literature Review</i>	62
<i>Proposed Explanation</i>	64
I. Duration of the Project.....	65
II. Select Award.....	65
III. Budget Justification.....	66
<i>Methodology</i>	66
<i>Implication</i>	66
<i>Conclusion</i>	67
<u>STUDY ABROAD PROPOSAL: WAYNE STATE UNIVERSITY SCHOOL OF NURSING</u>	69
<i>Abstract</i>	69
<i>Introduction</i>	70
I. Research Question.....	70
II. Hypothesis.....	70
III. Objectives.....	70

IV. <i>Significance of Proposal</i>	71
<i>Background</i>	71
I. <i>About Ghana</i>	72
II. <i>Nursing in Ghana</i>	72
III. <i>Literature Review</i>	73
IV. <i>Georgia Southern University</i>	73
V. <i>University of Missouri</i>	74
VI. <i>Michigan State University</i>	75
VII. <i>University of Michigan</i>	76
<i>Method</i>	77
I. <i>Ghana: Explorations in Global Healthcare</i>	78
II. <i>Program Descriptions and Administration</i>	78
III. <i>Attracting Students</i>	80
IV. <i>Benefits of Study Abroad Programs</i>	81
V. <i>Conclusion</i>	83
<u>JOURNAL REFLECTIONS</u>	84
<u>REFERENCES</u>	110
<u>MEDIA</u>	119

INTRODUCTION TO GHANA: Explorations in Medicine and Culture in Western Africa

Sixteen Wayne State University students set off on an ambitious journey to immerse themselves into the nation of Ghana located along the coast of Western Africa. Arriving there was a trip which consumed many hours divided among two flights and a four hour bus ride until we reached our final destination of the city of Cape Coast. Majors of studying ranging from Environmental Science to Spanish, Biology to Geology, Psychology to Nutrition, they all came together as medical anthropological researchers determined to uncover the harrowing circumstances of African history; the rich, ancient culture of the Ghanaian people; and the alternative forms of treatment and medicine, an untapped knowledge held by an ever decreasing amount of the population

Most of the students were unaware and inexperienced as to what they would encounter upon their stay in the country, especially concerning the medical anthropological research they would be conducting in the field as participant observers. Dr. Eric Montgomery, a cultural anthropologist and professor at Wayne State University, was significantly supportive and helpful in guiding and educating the students, as well as preparing them for the three-week research excursion. An anthropologist can complete no authentic, substantial, or enduring research in the field without immersing him or herself in the culture and becoming a part of the community for a considerable amount of time. Moreover, Dr. Montgomery provided us with informative and illuminating lectures as well as helped us in the development of questions in order to conduct interviews with the locals and amass the required information to properly produce a research paper, anthropologically constructed.

Medical anthropology is “one of the youngest” subgroups belonging to the anthropological field of study, and “concerns itself with the many factors that contribute to disease or illness and with the ways that various human populations respond to disease or illness” (Baer, Singer, Susser vii, 3). Furthermore, it may be defined as “the study of human health and disease, health care systems, and biocultural adaptation,” that is the ways in which individuals or social groups undergo biological or behavioral changes, a supporting notion of Darwin’s “Survival of the Fittest” theory (McElroy; Baer, Singer, Susser 32).

Among the challenges faced by medical anthropologists are the cultural divides and the disparities among different social groups. Diseases are “packed with cultural content” and an individual is unable to view a disease or illness without including his or her own cultural ties, life experiences, and world perceptions (Baer, Singer, Susser 34). The causes of disease and illness may be discussed or viewed through naturalistic, personalistic, and emotionalistic disease perceptions or theories. Personalistic disease theories blame supernatural forces such as “sorcerers, witches, ghosts, or ancestral spirits,” whereas emotionalistic disease theories believe illness is dependent upon the “emotional experiences” of an individual. Naturalistic disease theories attempt to explain illness in far more “impersonal terms,” such as “Western biomedicine” (Dr. Montgomery).

Contrastingly is the endeavor of defining “health” and what that means for an individual. According to the World Health Organization, health may be defined as “complete physical, mental and social wellbeing,” a holistic observation (Baer, Singer, Susser 4). In other words, in order to correctly treat someone the complete person, both physical and psychological, must be acknowledged as important entities.

Furthermore, critical medical anthropology defines health as “access to and control over the basic material and nonmaterial resources that sustain and promote life at a high level of satisfaction” (Baer, Singer, Susser 5). Therefore, the environment of the individual and group and the means by which they deal with or adapt to the environment is a crucial factor when assessing the health, both cause and effect, of an individual.

“Many societies rely upon multiple causes of illness or disease” (Baer, Singer, Susser 312). The multiplicities of cultural beliefs as well as these multiple causes within a society call for much anthropological research. The aim of medical anthropological studies is to conduct this research in order to gain knowledge of disease and illness, and other health issues. This is under the terms of their social and political relatedness within a social group, as well as how they are viewed and treated within these social groups.

“[D]isease must be understood as being as much social as it is biological” (Baer, Singer, Susser 6). The students had to understand this concept and immerse themselves within the community in order to gain any insight into the Ghanaian culture. Undoubtedly, a greater period than 3 weeks is needed to access and gather enough information to make any conclusions or deductions of their views of health and disease, and their health care system. However, the student researchers were effectively able to create connections to the country and establish relationships with its people, learning of the various health challenges that face different Ghanaian populations. Moreover, they were able to see first-hand the unfamiliar alternative methods of healing that ancient cultures possess upon visiting a medicinal farm as well as a research institute which tested different herbal medicines.

In addition to the medical anthropological fieldwork performed concerning malaria, HIV/AIDS, traditional and herbal medicines, and Gorovodu spiritual rituals, the students were also able to gain an understanding of the necessity of medical anthropologists in the world's future in order to create a cross-cultural system of health and disease. There is also a need to recognize the cultural diversity that exists and to eliminate misunderstandings or lack of knowledge of various health systems that are present in the world. This must be done in order to gain a more complete record and study of this knowledge, and an ability to effectively treat patients in all countries. Orthodox, western practitioners and traditional herbalists, shamans, etc. must have an exchange of dialogue and information considering there are similarities and differences, strengths and weaknesses to each system. We must find them as well as conduct experiments to reach better conclusions for the health of the world population. These changes must then cross social, political, and cultural barriers in order to more efficiently and effectively treat people.

NATIONAL HEALTH INSURANCE SCHEME

INTRODUCTION

The nation of Ghana had long struggled with delivering quality health care without an established insurance design. The National Health Insurance Scheme was begun around a decade ago in an effort to offer affordable medical care to 19 million Ghanaians. Implemented at a time when the national daily minimum wage was around one U.S. dollar and curable diseases were slaughtering thousands, none could deny the immediate necessity of this social intervention program (IRIN News). It was designed specifically to aid the very poor, who are not hard to find within this underprivileged country. Prior to the establishment of the National Health Insurance Scheme, hospitals, clinics, and other health care providers operated with a “cash-and-carry” system. Under this arrangement, services rendered must be paid for prior to their administration, and several Ghanaian lives were lost as a result. The main flaw with the “cash-and-carry” method was converting assets to cash—especially in cases of catastrophic illnesses. Those who did not have the funds required for a service were simply left un-serviced (“NHIS Issues”). Needless to say, this type of system kept health care out of arm’s reach for most average Ghanaians. John Kufuor, elected President of Ghana in 2000, sought to abolish the cash-and-carry system and ensure that treatment was always provided *prior* to payment requests (“Health Insurance in Ghana”).

With a clear need for a more sensible and versatile system, the National Health Insurance Act was established in 2003 under Act 650. The act established three distinct insurance schemes to be instituted and operated in Ghana. The vision of the new act was “to be a model of a sustainable and equitable social health insurance scheme in Africa and beyond” (“NHIS Issues”). With the establishment of this act, the government hoped to cater to all of its citizens, including

those of the indigenous village populations that were stationed in remote and rural areas. The mission statement of this act is “to provide financial risk protection against the cost of quality basic health for all residents in Ghana, and to delight our subscribers and stakeholders with an enthusiastic, motivated and empathetic professional staff who share the values of accountability in partnership with all stakeholders” (“NHIS Issues”). The National Health Insurance Council (NHI) was established to secure implementation of the NHI policy to all residents of Ghana. The role of this council includes registration/licensing schemes, supervision of schemes, and granting accreditation to healthcare providers (“NHIS Issues”).

Venturing to Ghana to explore medical anthropology and understand its various healthcare operations allowed much room for assessment. After learning about the National Health Insurance Scheme, we became intrigued with its function and proceeded to investigate it in further detail. After conducting interviews with locals and analyzing the statistics, we have been able to pinpoint this scheme’s fortes and flaws. The following is a brief summary of the National Health Insurance Scheme, including a breakdown of its policies, an analysis of its efficacy, and a description of local opinions. With the statistical and primary sources we have accumulated, we also offer our suggestions to improve Ghana’s healthcare initiative to better accommodate its citizens.

THE BASICS OF THE SCHEME

I. Registration Process

In Ghana, everyone qualifies for the National Health Insurance Scheme—however; those who do not register obviously will not reap the benefits that the scheme provides for its recipients. All Ghanaians must undergo a registration process in order to be considered covered

by the National Health Insurance Scheme. This registration process can be completed at a community District Mutual Health Insurance Scheme office. Ghanaians can also become members through contact with Registered Agents and Scheme officers who visit homes and workplaces. The registration process involves filling out a two-page form with basic information (“The Benefits of the National Health Insurance Scheme”).

A stipulation of the registration process is the required payment of a registration fee and a premium fee. However, this condition is revised depending on the type of applicant. Everyone is required to pay the appropriate premium fee unless they belong to the exempt group. The exempt group consists of: Social Security and National Insurance Trust (SSNIT) contributors or pensioners people aged 70 and above, people aged below 18 who are claimed as a dependent and indigent individuals. Those who are deemed a dependent or indigent are exempt from having to pay the registration fee as well. Following the registration process and the payment of fees, recipients must wait for their NHIS Membership ID card to be generated. The waiting period is allegedly reported to be around three months. It is then that the insurance coverage goes into full effect (“National Health Insurance Scheme Ghana”).

II. Coverage Inclusions and Exclusions

The National Health Insurance Scheme functions in a manner such that primary care services, constituting 95% of reported cases, are covered (“The Benefits of the National Health Insurance Scheme”). This also includes the drugs associated with these illnesses. The most common ailments include malaria and typhoid. The NHIS also adheres to a policy known as the “gate-keeper system.” Within this system, all health cases begin at the primary level and if specialization is deemed necessary, only then can a Ghanaian citizen get referred to a specialist. However, because the scheme works in a way that covers most primary care ailments, some

specialties do not lie under the scheme and are therefore not covered. Hence, if someone seeks the care of a specialist, the funds must come from him or her. More specifically, the inclusions of the NHIS are: outpatient services, inpatient services, oral health (not cosmetic), maternity care, and emergencies (See addendum for detailed list of inclusions). The services that are excluded from coverage are: appliances and prostheses (optical aids, heart aids, dentures, etc), cosmetic surgeries, anti-retroviral drugs for HIV, dialysis for chronic renal failure, organ transplants, all drugs not listed on the NHIS list, heart and brain surgery that did not result from an accident, cancer treatment other than breast and cervical, mortuary services, diagnosis and treatment abroad, and VIP wards.

III. Funding

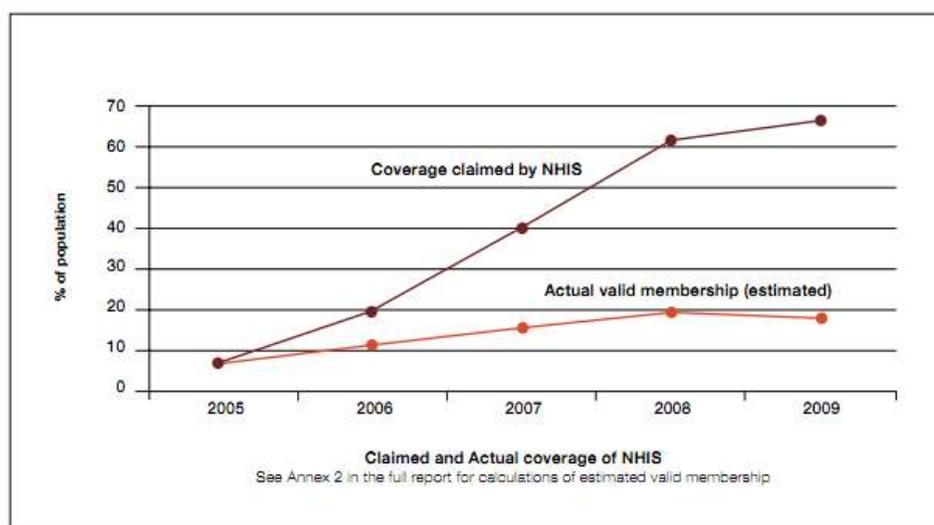
The Ghanaian National Health Insurance Scheme is funded mainly through tax revenue. Every Ghanaian citizen is required to pay the Value Added Tax (VAT), a tax on general consumption expenditure. VAT accounts for roughly 70% of the NHIS financial source. Another 20-25% of funding comes from Social Security contributions, which are collected in proportion to the income of workers primarily in the formal sector. About 5% of funding comes from the payment of flat-rate premium fees from those outside of the formal sector (Akazili).

PENETRATION OF THE SCHEME

As with any social program, a periodic analysis of its diffusion through society must be conducted. The National Health Insurance Scheme of Ghana has grown tremendously since its establishment in 2003, and continues to infiltrate society deeper. Today, approximately 145 district mutual health insurance schemes are under operation throughout Ghana. The growing availability of registration sites has allowed for a rapid increase in members and deeper

penetration of the NHIS into rural areas. As of June 2010, 66.4% of the total population was registered to receive coverage under the scheme. This amounted to 15,555,816 registered members in total, as compared to only 4,400,279 in 2005. Of these registered members, about 80.6% of them, or 53.5% of the total population, are considered to be active members. (See addendum for categorical breakdown of various types of members). In addition, there are currently over 5,000 service providers registered under the National Health Insurance Scheme (Ministry of Health).

While the above assessment is that which was tabulated and endorsed by the Ghanaian Ministry of Health, other parties claim the effectiveness of the National Health Insurance Scheme to be far less. Recently, Oxfam International, an international confederation working with local partners to combat poverty and injustice, published an executive summary of the scheme titled “Achieving a Shared Goal: Free universal health care in Ghana.” This report estimates that Ministry reports of the scheme’s coverage have been grossly exaggerated, and the



Note: The methodology for our calculation is based on annual NHIA income from insurance premiums and is detailed in Annex 2 of the full report. To date we have had no response from the NHIA to our requests for more accurate membership data.

Figure 1. Estimated valid NHIS membership from 2005-2009

scheme could actually be reaching as low as 18% of the population. Figure 1 below, taken from the executive summary, depicts the severity of this exaggeration. It appears the estimated membership is far below the coverage claimed by the NHIS. Although every Ghanaian citizen pays for the insurance through VAT, Oxfam estimates that up to 82% of the population remains excluded from its coverage benefits. In addition, although the reform was brought about to aid the nation's poorest; it seems twice as many of the nation's richest individuals are registered as the nation's poorest. 64% of the upper class is registered under the NHIS; while a mere 29% of the lower class is registered. For those unregistered with the scheme, a parallel cash-and-carry system appears to be at work. These patients must pay for all medical services upfront at the time the service is rendered, much like within the previous system ("Achieving a Shared Goal").

LOCAL OPINIONS

Careful analysis of the Ghanaian National Health Insurance Scheme reveals several internal successes, as well as failures. It is without a doubt that this scheme has prevented more deaths than the previous cash-and-carry system, but it is not without its faults. In addition to careful research, much is revealed through casual conversations with Ghanaian locals, who are directly influenced by the insurance policies, and thereby able to offer insider views.

I. Insurance Scheme Manager

Speaking to Ghanaian locals revealed much about the ins and outs of the Ghanaian National Health Insurance scheme. Many of these individuals were health care professionals, and thereby observed the effectiveness of the scheme through a professional lens. First off, we spoke to the Scheme Manager overseeing one of several districts within Ghana. He explained that reform was initially mandated in an effort to help Ghana's poor receive much-needed

medical care. He indicated the premium fee to be 20 cedis, and the registration fee to be 5 cedis. Once registered within the system, individuals must undergo a three-month waiting period before the insurance plan begins to apply. After this time, individuals may seek treatment in any hospital nationwide without having to pay any costs, unless a special service is requested. Furthermore, he discussed how those who are deemed ‘very poor,’ or indigenous, by the district mutual health insurance scheme are not required to pay even the registration premium. However, in order to have the fee waived, the individual must present himself/herself in person at the scheme office. The individual must not have a permanent residence or a steady source of income. In the Scheme Manager’s opinion, the new plan has helped countless individuals who would otherwise be left stranded, without any options for affordable medical care. He stated that the vast majority of medications are covered under the insurance plan, with the most common being for upper respiratory diseases.

When asked about the biggest challenge the scheme was currently facing, the Scheme Manager commented on the drift away from the intended target group. Although this social intervention program was instated to help society’s most needy, it is mostly those who can already afford medical bills who are taking advantage of the scheme, and not those who actually need it. He went on to elaborate that the only solution for this is awareness education. Communities need to be effectively educated before registration numbers can be expected to rise. In addition, a minor issue is transportation to the facility. He also touched upon another widespread issue—often times, months pass before service providers are reimbursed through the entire claims process. He indicated that although the situation has improved, they are working on minimizing this time for future transactions.

II. Pharmacist

Not much longer thereafter, we spoke with a pharmacist on the same topic of Ghanaian National Health Insurance. The pharmacist confirmed that the vast majority of patients who purchase medications from the pharmacy are insured, and hence pay nothing, or next to nothing for them after showing their insurance card. While most prescription drugs that patients typically come looking for are fully insured under the plan, some are only partially insured, and in these cases, the patient is responsible for paying the remaining cost difference. The prices are previously set by the government and these quotes are printed on a drug list. New drug lists are released quite frequently, with February 2011 being the most recent edition. The most common medications sold include hypertensive medications such as Amlodipine, and malaria medications, which are fully covered by the insurance.

The pharmacist indicated that unfortunately, a major problem with the current plan, and one that is conveniently ignored by the Ghanaian government, is that certain drugs are bought by the pharmacy at higher prices than they are reimbursed for through the National Health Insurance Authority (NHIA). As a result, many pharmacies will not sell certain drugs, even though they are technically covered through the national plan. Patients who need these drugs have a very difficult time finding them at a pharmacy, or persuading a pharmacy to sell them. Many patients are deeply frustrated by this, and the pharmacists are the ones who must handle the angry outbursts. The pharmacist indicated that unfair pricing is actually causing the insurance scheme to hurt business. She mentioned that in the beginning, the prices were much fairer, but the government has reduced them since. Consequently, pharmacies are making fewer and fewer profits, and some are fighting to remain open. The pharmacist mentioned that they have been attempting to initiate reform by holding meetings with the office in Accra, but lawmakers have not yet made progress on any concessions.

In addition, the pharmacist mentioned the same problem that the Scheme Manager had alluded to, but this time from the perspective of the victim. She revealed that it often took upwards of six or seven months before the pharmacy was reimbursed for a drug sold under insurance. This proves to be quite detrimental, as it becomes difficult to maintain regular operations and continue serving customers with such a prolonged lag period. For instance, this particular pharmacy building is under lease, and rent has to be paid every month—a struggle without a consistently prompt claims process. The pharmacist indicated this to be the largest problem with the scheme, at least on the pharmacy's end. However, she did emphasize that overall, she is supportive of the new health insurance system, as she has personally seen it help many individuals who would otherwise struggle to afford quality healthcare.

III. Nurse

Having gained perspectives from professionals dealing directly with the insurance process, we decided to also speak with a nurse—one dealing more closely with the patients themselves. Much to our surprise, we learned from a newly trained nurse that nurses are often forced to manage insurance issues, as hospitals lack the personnel to aid patients with the tedious insurance paperwork. If even a portion of the paperwork is not properly completed, the claim will be denied, and the patient will be forced to pay for the service out of pocket through a series of installments. Given that much of Ghana's population is not literate or even functionally literate, the task of filling out paperwork can be daunting, if not impossible. Nurses are often forced to aid with this, a duty that is not, and should not be their responsibility. It detracts from the amount of time and quality of care they are able to offer other patients, and adds abundant stress to an already demanding job. The nurse mentioned that some individuals do not use the

insurance coverage simply because of the amount of time the paperwork requires to complete, and would rather pay out of pocket for the sole reason of saving time and effort.

The nurse also touched upon the broader implications of the new National Health Insurance scheme. First off, it has made hospitals busier than ever, resulting in terribly long lines and occasionally, the need to turn patients away. It has also caused a visible shift from traditional medicine to hospital care, as the plan does not include coverage of herbal medications whatsoever. In fact, societal perceptions of health care are rapidly changing, and not in a good way. Ghanaians are beginning to go to the hospital even when such intensive care is really not needed. This abuse of insurance is causing the government to cut short its policies, as it is becoming difficult to maintain them. The nurse suggested that the only solution for this problem lies within the realm of education. Ghanaians need to be assured that they do not need to go to the hospital for such simple ailments as the common cold or headache. Education on how to effectively assess symptoms and manage treatment can go far in preventing abuse of the system. Overall, he agreed that the change in system is highly beneficial, and is much preferred over the previous cash-and-carry system. It has undoubtedly saved lives, as less privileged people have more access to care than they once did.

ASSESSMENT

Ministry of Health Assessment

In August of 2009, the Ministry of Health met to assess the growth, success, and challenges of the National Health Insurance Scheme. Their report indicates that 10 zonal offices have been established for registration today—one in each of the ten regions of Ghana. Over 140 schemes were provided with operational vehicles for emergency services. One of the biggest

struggles previously for the NHIS was cooperation with private hospitals and healthcare facilities. The report shows that over 800 private healthcare providers have been accredited, showing promising progress for the future. With the success also comes a great deal of struggle that the ministry still faces. One of the main challenges is identifying indigents for free coverage and proving they are worthy of that coverage. Many of the established schemes lack suitable office accommodations. Various software programs and types of ID cards have alienated and divided regions making management difficult.

The Ministry of Health set forth strategies and goals to implement in the coming years. Introduction of a consistent technology platform would be useful for addressing system unification problems. They also hope to assist schemes to establish suitable office accommodation, beginning with those that do not have permanent buildings. To serve the indigenous rural population, the ministry has suggested a study design to focus on how best indigents can be identified for exemption and free policy coverage. Although the Ministry has performed a thorough assessment of its own system, we are able to offer additional insight as to how reform can help the Scheme better achieves its mission.

Our Assessment and Further Suggestions

Through extensive research on the Ghanaian National Health Insurance Scheme as well as contact with local health care professionals, we have formulated a brief summary on the effectiveness of the scheme and suggestions for improvement. Although the system was set in place with the righteous intent of helping Ghana's indigent population, much can be done to reform the scheme and better serve this purpose. First and foremost, education is needed on a multitude of levels. Communities need to be educated on the benefits of the system and the

process for registration. Simple awareness is the first step to raising the current 66% registration rate and reaching out to a greater number of Ghanaians—particularly those who need it. In addition to community outreach, the system must be provided with a strongly educated foundation. Not enough personnel who are well-versed in the entire insurance process are currently present within the clinics and hospitals to assist patients with the process. Currently, nurses are often forced to attend to insurance duties in addition to their actual duties, since even one tiny error on the patient’s part can result in a denied claim. The entire process is quite intricate, and more trained personnel should be provided to assist with it.

In regards to registration, the process often requires a full day, since the queue can be very long. Many Ghanaians cannot afford to waste an entire day, so many simply do not get registered. Those who are truly indigenous and would be waived of all registration fees are also those who do not have the means for transportation to the district center. To this end, more district insurance centers are needed so that each center is serving a smaller portion of the population. Another option is initiating some sort of door-to-door registration program that would not require Ghanaians to travel long distances and waste valuable time. Such a program would reach many more citizens, and better serve those who truly need it most. Too many citizens are currently paying for the NHIS through taxes, but still paying for health services and medications out-of-pocket. Before the system can even take on a larger portion of the population, however, the administrative sector of NHIA must be reformed. Claims should never require as long as six months to facilitate. Service providers and pharmacies are suffering due to NHIA’s lack of efficiency.

While it is true that treatment options for most major illnesses are covered within the benefits of the scheme, one major category of treatment has been excluded—anti-retroviral

drugs. For a nation battling an HIV/AIDS epidemic, we feel this is simply unacceptable. Additional conditions are always being considered to be added to the coverage benefits, and this should be at the forefront. For instance, the rising prevalence of prostate cancer is qualifying this particular type of cancer for review for inclusion (Joy News).

While the actual efficacy and penetration of the Ghanaian National Health Insurance Scheme remains questionable, it is impossible to deny that Ghana has taken bold steps within the past decade to offer affordable quality healthcare to its citizens. The time has come to initiate bold reforms. Major changes on the administrative, service, and community levels are necessary to not only reach out to many more Ghanaians, but aid the service providers in offering timely, quality healthcare. As Americans, we have a great deal to learn from this national initiative.

REFRACTIVE ERROR AND VISION SCREENINGS

Refractive Error Correction and Vision Screenings for Ghanaian Primary and Secondary Schools

Imagine how simple a routine eye vision exam is for you. Now imagine not being able to see the board at school at only 9 years old, and knowing you cannot get the proper care you need because the equipment is not available. This situation, like any other situation that may interfere with your education, will lessen the enthusiasm and the drive of a person to complete a full education. The people of Ghana, being compared Americans, are at a disadvantage that is unimaginable unless seen with your own eyes. The inspiration of this proposal is solely based on the children of Ghana. The children that could not see the words spelled out on the board with white chalk, and the ones with glasses way too thick for their own good, or glasses that are missing a lens. Vision is one of the simplest of all health issues to get corrected, you simply go get glasses, or contacts, or even a simple laser procedure to correct your refractive error here in the States. The children of Ghana, as of now, have no such options readily available to them at minimum to any cost, in their own schools. When you cannot see, it becomes that much harder to focus, to take notes, to play a simple game of soccer, and as a child, you do not ever want to feel like the odd one out. All it takes is a pair of glasses, and I truly hope we can put together two regular drives that will supply glasses of different lens strengths, and also the proper equipment for vision testing, including the Snellen chart that measures vision acuity, to the Primary and Secondary Schools in Ghana. Although there are many health problems that need to be addressed

in Ghana, and as much assistance with funding, hands on assistance, and equipment as the nurses, doctors, and nongovernmental organizations (NGO's) need in conducting school health screenings, vision tests are one of the more important tests to be given to students, and therefore, I would like this to be the main focus of this research proposal.

Currently in Ghana, there are outreach programs and NGO's that focus on conducting health screenings in and around various communities and schools, such as HEPENS (Health Protection and Environmental Sanitation). They focus on providing health information, immunizations, and general health tests, but with this, it is still very limited and very simple, not nearly as much attention and care is given to each individual as they require. This is due to the lack of hands, funding, and equipment. All things that can be established if there was proper funding from grants that focused on these topics.

The importance of having eye health screenings and the availability of proper glasses is to reduce the instances of blindness. According to the Community Eye Health Journal, "The commonest causes of blindness and visual impairment in the region are cataract, glaucoma, and uncorrected refractive errors." Although cataracts and glaucoma are more prevalent around the age of 40 and older, it is important to have eye health exams and care for children, in order to reduce the chance of acquiring these eye conditions. This step of implementing regular eye examinations, prevention tips, and treatment at a young age will reduce the chances of adult onset blindness in Ghana. What I wish to accomplish with this, is to help supply the proper testing equipment and glasses to organizations that conduct eye examinations, but also help them find a sustainable solution to carry on these eye examinations and to be able to supply specs for the correction of simple refractive errors, such as being nearsighted or farsighted.

General Child health is very important to monitor, children need the proper examinations and care to catch and eliminate any health concerns that may develop later in their adult life. Medical anthropologists mention all the time how much more important it is to prevent rather than wait and have to cure; this is particularly precise when it comes to the health of the eye. In some cases there may be predetermined blindness due to genetic disposition or other reasons that one cannot help, but in cases such as glaucoma and refractive errors, with prevention education, and proper treatment if needed, blindness can be stopped. Many children today in America are seen wearing glasses, whether it is only to read, to see the boards in schools, to use the computer, to see their friends down the street; vision is a health issue that has solutions. When in Ghana, there was not one child in any of the schools that I volunteered in that I saw wearing proper glasses, yet the lighting and the board seemed very dim and worn out, what I did notice was the squinting of the eyes to read a word or see a picture. Since the education in the classrooms was conducted only using the board and chalk and a couple posters of the alphabet, it is important that the child have the ability to see what the teacher is writing or pointing to. In that way, they can copy down the notes, and even be able to write them in their notebook on the lines, in a straight manner. As mentioned before, no child wants to feel like the odd one out. Vision is something we might take for granted, but when you cannot see, it becomes so difficult to enjoy anything around you, including learning. The goal is to keep children in school, and allow them the opportunity to get a higher education.

Doing some research from the World Health Organization (WHO) it was indicated that ratios are an issue. Ratios of nurses to doctors, health care system providers to funding, and so on. In contrasting Ghana to the United States, these were my findings:

<u>Indicator</u>	<u>Ghana</u>	<u>Year</u>	<u>United States of America</u>	<u>Year</u>
• <u>Net primary school enrolment ratio female (%)</u>	71	2007	93	2006
• <u>Net primary school enrolment ratio male (%)</u>	73	2007	91	2006
• External resources for health as percentage of total expenditure on health	22.4	2006	0	2006
• <u>Number of other health service providers</u>	7132	2004	4138567	2000
• Other health service providers density (per 10 000 population)	3	2004	145	2000
• Ratio of nurses and midwives to physicians	6.1	2004	3.7	2000
• Infant mortality rate (per 1 000 live births) both sexes	76	2006	7	2006

In this case, other health service providers include optometrists and opticians. From this data, we see a huge disadvantage for the Ghanaians, and unfortunately, I do believe that this chart speaks for itself. Something has to be done, and although one proposal cannot change this, there is something that can be done to better the quality and emphasize the importance of vision screening examinations and proper treatment for those that need it, because with general health screenings as well as regularly implemented vision screenings, a reduction in infant and child mortality rate as well as adult blindness can be seen. On May 18th 2011, I had the opportunity to speak to one of the headmasters at Almadiyya Primary and Junior High School in Cape Coast, and when he was asked about health screenings at the school he mentioned that they do have them but it is not often, and that nurses were the primary providers of these screenings, but for eye vision examinations, students got sent to facilities. When I was in the classroom with the primary students and I noticed how many squinters I had, the headmaster's answer allowed me to see that this simple check up kids need was way more complex than it needs to be. Eye examinations can be done by teachers with simple training to monitor the child's distance and

sight ability, but yet this was not available at the schools. To many of us, going to a clinic, hospital, or facility seems like a simple task, but when there is no clinic in your community, and no hospital for miles, no money to cover costs, and no form of quick transportation, taking your child to get an eye exam is very difficult; vision correction being one of the simplest and most avoidable health issues, this is truly a disappointing fact for the children of Ghana. “The implemented National Health Insurance Scheme that is in Ghana covers the initial health screenings at communities and schools, yet if further care and treatment is needed, the families are left on their own, and since poverty is so prevalent in Ghana, going to get extra help at hospitals or clinics is rarely seen.”, according to an interview with Nurse Nicholas. Nurse Nicholas also stressed the importance of educating the public and parents about where they can receive proper health care, and how to prevent things like refractive error, blindness, malaria, STD’s, and other diseases. Another article that I found very helpful was one from the WHO, called the “Cost-effectiveness of screening and correcting refractive errors in school children in Africa, Asia, America and Europe”, by Baltussen, Naus, and Limburg. Once again, the article states, “diagnosis and treatment of refractive errors is one of the easiest ways to reduce impaired vision or even blindness. Clearly, access to eye care services, public awareness of the need for them, and availability of spectacles have not yet reached adequate levels. There are three population groups that require spectacles: children with refractive error, the middle age with presbyopia, and, to a lesser extent, the older group with pseudo (Aphakia).” The article also discussed the cost and effect of having eye screenings in schools since “The lack of refraction and spectacle provision in underserved communities is believed to have important negative effects in terms of lost education and future lost employment opportunities, which might influence the quality of life of the individual, the family and the community.” The article

conducted a study of cost and effect of vision screenings in primary and secondary schools in Africa, and without a doubt these screenings are not cheap; cost includes paying the doctors, nurses and assistants, cost of glasses, and cost of equipment. What I hope we can work towards is cutting down the cost by supplying ophthalmic equipment, and spectacles. Glasses usually last around 4 years, so the annual cost will notably decrease. Wayne State University students can really make a difference and give children the opportunity to receive higher education, which in turn ensures a variety of future employment options, which in turn creates a happy economy; imagine what a pair of glasses can do!

Taking things for granted is part of human nature. Everybody goes about their day, taking the simplest things for granted. Once we realize that there is an entire world filled with people who are less fortunate than us, we become thankful, and more humble. Having traveled to Ghana, I gained an entire new level of humbleness, and I greatly increased my want to give. No, one cannot change the state of a country in a month, nor alone, but one can make a difference in the smallest sense. Glasses, spectacles, specs, bifocals, and any other word for glasses out there is my difference. I propose putting together a glasses drive to collect, glasses of any strengths, glasses from grandparents, old glasses from the fourth grade, spare glasses, or even brand new ones that one wants to donate. Supplying glasses to Ghanaian school children would be one of the easiest and most rewarding ways to give back and feel humble, but also to change the life of a child, and their entire family. Along with glasses drives, supplying the nurses and optometrists, and NGO's with the proper equipments like charts, and retinoscopes to measure visual acuity and light reflection respectively, can also be done by receiving donations from hospitals and clinics.

The importance of monitoring eye health and having vision screenings regularly is not emphasized as much as needed be, especially for school aged children. Refractive errors and blindness due to lack of care are avoidable, and easily treatable with early detection. It is so important to have health screenings that monitor the growth of children, but it is as important to monitor the health of their eyes and vision abilities. Being able to supply the needed children with glasses so they can complete simple tasks such as taking down notes, or kicking around a soccer ball, is a cheap and very rewarding thing for us to do. Although Ghana has a lack of sufficient funding for programs that conduct health screenings, and the National Health Insurance only covers basic screenings, we can assist NGO's such as HALP and Nurse Nicholas's NGO, HEPENS, by supplying glasses and equipment through donations and drives that students at Wayne State University can partake in, in the Fall and Winter semesters of each year. Having gone into the local schools and interacting with and teaching these beautiful bright kids, they really touched my heart. The one thing I can do regularly in my life is to give back, and what better way to give, then to give a child the ability to SEE!

MEDICINAL PRACTICES IN GHANA

An Overview of Barriers Facing the Utilization of Traditional Ghanaian Healing Methods

Modern Ghana is a beautiful cacophony of day-to-day human activity, with people working, playing, and otherwise making a living between the contrast of a hazy blue sky and the blushing orange dust. But the visual disparity of earth and sky echoes a different contrast that modern Ghanaians live between: the divide of western versus traditional ideology. Nowhere is this more apparent than in health and medicinal practices, where many Ghanaians can choose between a western-based biomedicine system – with chemical drugs, allopathic doctors, and germ theory – and a traditional healing system based on spiritual beliefs that incorporates herbal medicine, holistic care, and a balancing of the spirit. However, while traditional healing remains popular with at least 65% of the population, the majority of government spending on health is allocated towards hospitals, clinics, and services run with a biomedical mindset (National Health Policy 25). Further, firsthand accounts from Ghanaians seem to reveal a shrinking of the knowledge base of traditional medicine as well as a turn towards biomedicine especially in the younger generations. All in all, traditional medicine in Ghana is facing barriers both culturally and structurally that prevent it from being fully utilized alongside biomedicine as a viable treatment option. This investigation seeks to summarize the issues that most concern the use (or disuse) of Ghanaian traditional medicine in hopes that an overview of each obstacle might guide more detailed study into this problem in the future.

Before moving on, it will be useful to define traditional medicine and describe how it is present in various forms in the lives of Ghanaian citizens. Broadly, the World Health Organization defines traditional medicine as a comprehensive term referring to traditional and

indigenous therapies that, inferably, exist or were developed independently of allopathic medicine, some examples being Chinese medicine and Indian Ayurveda (WHO Traditional Medicine Strategy, 1). By this definition, all forms of medicine and healing therapies developed in Ghana outside of allopathic medicine (also called biomedicine) would be considered traditional medicine. The Ghanaian national government defines traditional medicine a bit more narrowly in the Traditional Medicine Practice Act of 2000 as “practices based on beliefs and ideas recognized by the community to provide health care by using herbs and any other naturally occurring substances” (14). However, in this discussion, the phrase traditional medicine will not be limited to only those practices that utilize herbs and other substances for healing. As we shall see, Ghanaian traditional medicine includes various types of spiritual therapies and cultural health behaviors, as well as herbal remedies.

In fact, it may be slightly misleading to refer to Ghanaian traditional medicine as if it were one monolithic entity, because it actually encompasses many different healing practices used by different cultural groups. Indigenous medicine, as its name implies, is based on the knowledge and traditions of different indigenous groups. Ghana has more than 70 different tribes (Lentz, 11); thus there is a range of different ethnical populations that have established healing systems. One large ethnic group, the Ashanti, have spiritual healers who often diagnose illnesses by going into trance and offering themselves as mediums through which the gods can speak the reason for disease. Treatment depends on the nature of the illness, but may include herbal medicine, prayer and fasting, or in some cases, not allowing the sick person to rest or be quiet in the hopes that a malignant spirit will no longer want to dwell inside the patient (Twumasi, 45-46). Gorovodu, a belief system of the Ewe people, also serves as a healing system and is considered an “atike” or medicinal vodu order (Rosenthal, 41). While there are many herbal

remedies included in healing practices of Gorovodu, many healing methods aim to employ the agency of the gods against illness.

Though these much-too-brief glimpses of some traditional medicine systems are not enough to really appreciate their complexity, they illustrate that although the medicinal practices of indigenous groups in Ghana are different, they display many of the same features. First of all, there is usually a strong holistic component as traditional beliefs do not categorize and compartmentalize what makes up an individual both physically and mentally, as biomedicine is apt to do. As Rosenthal puts it, “Gorovodu treats the whole life-text of an individual, with no teasing apart of the body from the mind or from numerous souls that make up an individual...” (42). This is in strong contrast to biomedicine which “radically separates the body from the nonbody” as necessitated by its mindset of physical reductionism (Baer, Singer, and Susser 11). Secondly, traditional medicine systems often include spiritual or supernatural agents within their theory of disease as opposed to biomedicine, where all diseases are attributed to specific physical entities such as bacteria, viruses, or physical traumas. For many Ghanaians, the causes of an illness could include such things as: punishment by the gods for breaking religious code (Montgomery, 2), destructive jealousy called *n’bia* that other people harbor against the patient (Rosenthal 229), or simply the influence of deceased relatives who are not remembered enough. Both the holistic approach to healing and the belief in supernatural disease agents are important qualities that set traditional medicine apart from biomedicine and will factor into the discussion of the barriers that traditional medicine faces.

At first glance, traditional medicine may not seem threatened at all in Ghana; its use is both widespread and well-known. Indeed, a report on African herbal medicine points out traditional medicine’s vitality by reporting that in the Kwahu District of Ghana, there are 224

people to every traditional medicine practitioner while there are a staggering 21,000 people to every university-trained doctor (Rukangira, 1). Part of the popularity of traditional medicine is a matter of cost. Many traditional healers charge on accord with what their patient can pay, with richer people paying more and poorer people paying less, and never turn patients away for lack of money. Also, most accept payments other than cash which not only gives patients more options, but points to the bond between traditional healers and their patients. A traditional healer is part of the community they treat and patients are comfortable discussing payment for medicines with them, whereas hospitals can be bureaucratic, foreign, and rigid. All in all, traditional medicine can offer availability, affordability, and familiarity to patients and currently serves an integral part of the Ghanaian answer to health and wellness.

However, although traditional medicine still treats the majority of the population of Ghana, its full effectiveness is hindered by governmental forces, and its continuity is threatened by cultural changes. Specifically, traditional medicine does not get the support it deserves from the government: no part of the national health insurance plan covers traditional medicine (“NHIS Benefits Package”), and while a Department of Traditional Medicine exists, CEO Hlortsii-Akakpo admits in a 2010 report that they face severe restraints from understaffing, underfunding, and inadequate office space (12-13). Further, there are many problems with the process of researching and developing traditional herbal remedies that limit both scientific advancement and the ability of traditional practitioners to use the legalization system of herbal drugs. Finally, a persistent mindset supporting biomedical hegemony is growing, and not only enforces these policy issues, but also delegitimizes traditional medicine which threatens its ability to contend as a valid source of medicinal knowledge. An overview of all of these obstacle types will serve to

give us a picture of the complex nature of traditional Ghanaian medicine, and how it faces challenges in the modern world.

The barriers facing traditional medicine have their roots with the colonialism of Ghana – well before most of biomedicine was ever discovered under the microscope. From the first French ships landing in the fourteenth century, European influences forced their way into Ghanaian life and introduced not only new crops, technologies, and theologies, but also a sense of European superiority, furthered by colonist explicitly “denying the existence of highly developed African cultures and political structures” (Naylor 16). This sense of superiority continued into the 1800’s when biomedicine began to enter the picture as British physicians and Christian missionaries arrived on the coast of Ghana, now an English territory. Although there were many benefits of the introduction of biomedicine (one being the smallpox vaccination: needed to treat a disease that was introduced by colonialist centuries earlier), it also served to enforce the instilled inferiority of native African traditions by scientifically validating the claims of colonialism (Baer, Singer, and Susser 331). Traditional medicine had begun its fight to maintain value in the face of a “more advanced” form of health care, a fight that continues to this day.

A huge contributor to the modern denigrating of traditional medicine is the Ghanaian school system, which in effect has continued the sense of inferiority experienced by African medicine. Two teachers from different public schools told me that “scientific medicine” is the only type of medicine taught in schools (Personal Interviews. Abura, May 13 and 18.), and this exclusivity seems to create a new divide: not so much African versus non-African, as before, but rather educated versus non-educated. The first teacher seemed almost insulted that I would think that traditional medicine would be taught in schools, and hastened to clarify that only health

practices that were based on “logic and scientific theory” were presented to students (Personal Interview. Abura. May 13). Although many other Ghanaians that I met supported the use of traditional medicine, most that had reached higher levels of education, especially in science and technology fields, seemed to scoff at the legitimacy of non-scientific healing systems. Some may view their knowledge as a mark of the elite, and thus feel as if they are above traditional knowledge. This is supported by a study where Ghanaian citizens were asked to describe why they choose the type of health care that they do, and some participants responded that, “accepting information from a traditional healer with lesser education was demeaning” (Tabi n.pag.).

The same study recounts a Ghanaian man who, “was born in a village and knew only traditional ways until he went to school, where he learned ‘herbal concoctions are unhygienic,’” and thus put less faith in traditional medicine. Many students hear statements like these and are led to believe that traditional medicine is inferior to western medicine because it does not follow the laws of scientific theory. This has controversial effects: a generation raised on the scientific method and a western disease theory are more likely to practice sanitation techniques and lead a life that is less susceptible to infectious disease; however they also are more likely to disregard traditional medicine. As the Ghanaian school system reaches more and more children, and as these children grow up and make their own health choices, traditional medicine could receive a serious blow from the changing mindset of the nation.

Furthermore, while education is turning many young people away from using traditional medicine, many are also turning away from a career as a traditional medicine practitioner for similar reasons. Devaluing of non-western medicine in schools is the primary factor, but another is the length of time it takes to become a successful traditional healer. For Ashantes, the process begins with a spiritual call and requires at least three years of non-paid apprenticeship with an

experienced medicine man (Twumasi 50-52). In other communities, the training is informal, with trainees either learning about plants and herbal remedies from family members or other available elders (Tsey 1067). Either way, the continuation of herbal and traditional medicine depends on a vast amount of verbal information being passed on from one generation to another. Just one uninterested person and conventional knowledge can be lost. For example, a man I met in a taxi told me his grandmother was famous for knowing a cure for elephantitis, but that none of her sons bothered to learn the secret, so now the knowledge is lost because he knows of no one else who knew her methods (Personal Interview, Cape Coast). Luckily though, the strength of spiritual systems in Ghana seems to be holding strong into modernity if Gorovodu can be taken as an example (Montgomery 24-25). With healing being tied so tightly within the circular contexts of spirituality, this should provide a safe vessel for many types of traditional medicine to be passed on for future use.

Other cultural influences are threatening the popularity of traditional medicine. One of these is the infusion into the Ghanaian belief system of Christianity and Islam which often interpret spiritual traditional healing as “witch craft” and ban its use. Tabi’s study of the reasons that people chose either traditional or western medicine mentions that some strict Christian and Muslim adherents viewed the power behind vodu healing as “demonic and synonymous with evil.” However, this is not a strong factor because many people who list themselves as religious also practice traditional beliefs, as reported by Rosenthal who notes that despite efforts of missionaries to convert the Ewe people to Christianity, many “continue to carry out Vodu or ancestral cult practices” (20).

This cultural willingness to accept foreign ideas and use them alongside traditional ideas, evident in the Ghanaian acceptance of both outside religion and outside medicine, is a strong

factor working in the favor of traditional medicine, as it allows people to flexibly utilize the system that best fits their needs. And for most Ghanaians, it is easy to accept the fact that some diseases require the hospital and some require the priest-healer; after all, some ailments are regarded as spiritual and some are physical, and often people recognize that one medicinal system's treatment is simply more effective than the other (Tsey 1069). But the nature of biomedicine is to lend validity only to knowledge that makes sense within the confines of scientific ideology, thus a strict adherence to biomedicine can exclude traditional medicine, whereas an adherence to traditional medicine leaves open the possibility for accepting other types of healing.

This difference in exclusivity links the psychological and structural barriers that traditional medicine faces, because it is the underlying reason why governmental actions favor biomedicine, whether intentionally or not. As we have seen, the well educated are more likely to back biomedicine, thus creating an elite class whose ideologies support science and exclude ideologies that do not stand up to scientific reasoning (Baer, Singer, and Susser 337). As it is the well-educated and elite that typically makes decisions on behalf of the nation, governmental policies are structured accordingly. This leads to two main problems that traditional medicine faces in the governmental system: competitions with biomedicine for the allocation of funds, and difficulty in getting legal approval for the sale of herbal remedies.

First of all, the topic of allocation of funds for health reasons must be recognized as a highly controversial subject. In Ghana, there are still people dying from malaria, diarrhea, and typhoid fever ("National Health Policy" 21), all of which have known treatments in biomedicine. If there are not enough funds circulating to provide basic immunizations and antibiotics, then the decision to spend money on traditional medicine without solid evidence in its effectiveness is not

only morally difficult, but also politically risky. It becomes more and more difficult to fund traditional medicine when a greater need is perceived in funding biomedicine, exemplified by a recent account from Nigeria where “a traditional birth attendant (TBA) training program attracted resentment from underfunded rural midwives as resources were given to birth attendants when maternity centers lacked equipment” (Bodeker 10). The lack of funding is a very real problem limiting the use of traditional medicine and its integration into the government sponsored health system. Although traditional healers typically make ends meet purely from the payment of their patients, it would require government funding to include traditional medicine use in the national health care plan and to utilize traditional healers in government clinics, both of which could increase the positive impact that traditional medicine could have in the future.

Besides funding, traditional medicine is also limited by the Ghanaian process of drug registration, which is required for any herbal remedies that are sold outside of their location of production (Tsey 1070). Fortunately, once separated from spiritual overtones, herbal medicine “fits nicely into the western paradigm of scientific study” (Ashar 65) and thus has served as an enriching route through which biomedicine and traditional medicine can collaborate. In Ghana, a main site for advancement of herbal medicine is the Center for Scientific Research into Plant Medicine which is a governmentally funded research institute that both researches and develops herbal cures as well as testing the safety of herbal medicines sent in for approval. While the successes of CSRPM and its continuing progress into promoting traditional herbal medicine should not be downplayed, it enters our discussion because it is the primary agency that tests and regulates herbal medicine, in combination with the Food and Drug Board. Thus, although the center represents a progression in herbal medicine practice overall, it will be examined by the

ways in which its regulating functions fall short in their goal to allow traditional healers to get their herbal remedies approved for sale.

First of all, the registration process is costly – a major prohibitory factor against many small scale traditional practitioners. To get herbal remedies tested at the CSRPM costs about \$100 as quoted to me by a staff member (Personal Interview, Mampong). According to Tsey, at the time of his research the average income for a Ghanaian was roughly \$70 monthly and the salaries of traditional practitioners he interviewed were all reported lower than this (1070). Many traditional healers simply do not have the money to register, or do not think it is worth it to pay fees in excess of a month's income. Additionally, this is only the first step of the process, as there are additional fees once the herbal drug is approved and sent to the Food and Drug Board for final licensing and patenting. According to an African study of herbal medicine, "Traditional healers' associations have identified the high costs of filing patent applications as the biggest obstacle to the acquisition of patents by practitioners of traditional medicines" (Rukangira 15).

Another barrier in the process is literacy amongst traditional healers. Without being able to read and write in English, herbal practitioners would not be able to fill out the many forms required for licensing their medicines. Although the literacy rate varies enormously throughout Ghana, the average rate is 62 percent for males and 42 percent for females (Naylor 47). Illiteracy, as well as language barriers, not only mean that traditional healers are unable to complete registration forms, but also that they may not understand the process of registration or even the purpose of the CSRPM, as much of its information is presented textually. This can breed misunderstanding between traditional herbalists and government agency and cause collaboration on herbal medicine to fall apart. On one side, herbal healers withhold information

out of fear of piracy while scientific researchers see refusals as the “impossible attitude of traditional healers, staving off invasion of their magic and mysticism” (Archampong 11).

However, perhaps this mistrust of governmental agency is warranted. The head of a medicinal farm in Tepa said that many indigenous healers are wary of exposing the knowledge behind their medicines because these secrets are so often stolen and exploited by large pharmaceutical companies without any acknowledgement or payment to the source of their information (Personal Interview, Tepa). He went on to say that the government also steals remedies and that they overstep “human intelligence rights.” While a staff member of the CSRPM enthusiastically disagreed with this accusation (Personal Interview, Mampong), it is interesting to wonder if all of the herbal medicinal products that the CSRPM develops for profit are really created independently of the analytical research that simultaneously goes into herbal remedies sent in for registration. Now, paradoxically, traditional medicine practitioners must fear idea stealing in the very process that would lead to the obtaining of copyrights and patents. Whether this mistrust is a misunderstanding caused by lack of communication, or an actual flaw caused by greed and corruption, it is a detriment to the registration of herbal medicine, and thus a detriment to expanding the use of traditional medicine.

All in all, whether barriers present themselves in the form of registration difficulties, lack of funding, or challenges in the mindsets of Ghanaian elites, it is imperative to understand these obstacles because, from a medical standpoint, traditional medicine is currently the most applicable answer to serving the medical needs of the majority of rural Ghana, and hindrances to its use could literally be costing lives. Although biomedicine offers many benefits, it cannot match the affordability and accessibility of traditional healing nor can it fulfill the spiritual aspect of disease that many Ghanaians rely upon. Therefore, traditional medicine should not suffer from

the hegemony of biomedicine in Ghana's pluralistic medicinal system. Additionally, obstacles to traditional medicine should be taken seriously because conserving traditional medicine should be viewed as a preservation of the diversity of medicinal knowledge. Biomedicine certainly is neither perfect nor all-knowing, and Ghana abounds with stories that suggest that biomedicine still has a lot to learn from other healing methods. For example, Rosenthal recounts her daughter's struggle with sickle-cell anemia and thanks a Gorovodu priest for his herbal treatment that had "greater efficacy than modern medicine is capable of achieving" in stopping her sickling crisis (248). Traditional medicine needs conservation or else a huge source of medical knowledge could be lost. As a Ghanaian once told me, "The death of one of those old men [traditional healers] is like the loss of a library" (Personal Interview, Cape Coast).

In the end, this overview of factors contrary to the use of traditional medicine in Ghana should only be a starting point, directing further study into the elaborate interactions of biomedicine and indigenous healing methods. As shown, Ghana still has many health problems to face as it moves into modernity. With a better understanding of traditional medicine and the barriers that hold it back, Ghana can work to fully utilize this valuable healing asset alongside their use of biomedicine. In doing so, the disparity between western and traditional medicine may lessen, and both forms can find validity as practical solutions to problems still facing Ghanaian health care.

Medicine Trapped by Trust and Law

Medicine has been discovered, created, and used for hundreds of years to cure the diseases and ailments of humans. However, not all medicines and methods of treatment are the

same, some work better than others, and some don't work at all. There are different types of medicines and different types of medical systems. For instance, traditional medicine, which professionalized medical systems have their roots in, combines empirical and magicoreligious beliefs and practices to diagnose and cure diseases (Baer 308). Modern medicine relies more on scientific methods, and views diseases and cures on a biological and chemical level. However, these forms of medicine can become blurred when looking at, for instance, herbal or plant-based treatments; especially since "about 25% of the prescription drugs dispensed in the United States contain at least one active ingredient derived from plant material" (Herb Place). When it comes to medicine on a global system with the purpose of curing all, regardless of demographics, it can become difficult to decide what form of medicine to use, and whether any exclusion should be carried through. The current cosmopolitan medical system takes the form of what we know today as western medicine or biomedicine. Though biomedicine is not a monolithic entity, as different countries have their own thoughts and emphases on different parts of the system, doctors and staff are trained in the germ theory of disease (Baer 9-14). For instance, all biomedical doctors' practice based on theories of natural causation which include: infection, stress, organic deterioration, accident, and overt human aggression opposed to other traditional forms of medicine which practice based on theories of supernatural causation (Baer 311-312). Both biomedical and traditional medical systems have differences in their theories of disease causation, and also methods and drugs used to cure human beings, but they both have believers and followers in their respective systems.

The American biomedical system was in part grown through capitalism as supporting foundations poured money into medical institutions that emphasized the germ theory of disease. Biomedicine grew and with it came medicalization, which Baer describes as biomedicine

creating jurisdiction for it to reach into new conditions and behaviors. One example is the medicalization of the birthing process which begins at withholding information on the disadvantages of obstetrical medication, then expiation of hospital birth, then chemical induced birth, and so on (14-15). Medicalization seems to contribute to a process of medical glaucoma; meaning, because of the social expectations, government funding, and availability of western hospital systems due to the capitalist influence on our medical system, we may be ignorant, untrusting, or unwilling to accept other forms of medicine which exist in our world, and thus we are becoming ever more blind to these other medical systems. I am not saying that the modern medical system is wrong; nor am I saying that the other systems are correct, but it does seem as though we invest so much into our own “scientific” standards that plausible medical treatment could be kept from the American people and many others simply through political and social barriers that we created. The real question is what barriers are keeping truly beneficial medicine, like possibly herbal medicine, from widespread use in America and within the established medical systems of the respective countries? Does the problem lie somewhere within the drug registration processes between and within countries, or is there a deeper problem tied to a negative connotation towards alternative medicine, specifically herbal remedies, coming from the western mindset?

To understand the differences in the drug registration process and western feelings on herbal medicine, it is important to first understand what the major differences between the medical systems and treatments are, and what our western mindset really is. Baer (309) lists three forms of pragmatic medicines as described by Grossinger (76):

1. **Pharmaceutical medicine** – consists primarily of a wide variety of herbal remedies

2. **Mechanical medicine** – consists of surgical techniques as well as techniques that simulate physiological processes such as bathing, sweat-bathing, shampooing, massage, cupping, emetics, burning, incision, and bloodletting
3. **Psycho physiological healing** – relies on a wide variety of magical and psychotherapeutic techniques such as what Grossinger refers to as the “sucking cure”, in which a shaman orally extracts intrusive objects from a patient’s body (76-95).
4. **Spiritual medicine** – emphasizes the spiritual origin of disease and views it as the “primary weapon of the spiritual world” according to Grossinger (99).

The Western world is familiar with arguably all four of these forms of medicine. However, America may not be familiar with the full scope of practices which define each category of medicine. For example, Gorovodu is a religious order in West Africa which literally means tree root as described by Rosenthal in her book *Possession, Ecstasy, and Law in Ewe Voodoo*. “One of the reasons that Gorovodu is so important to the village of Dogbeda and to all Gorovodu communities is that it is an *atike* or “medicine” Vodou order.” She goes on to describe that the villagers practice Gorovodu because sickness exists and it harms people close to them like their children. They believe the vodues can heal them and keep them from dying. This belief system is so ingrained to the society that even the families that have the means to go to the best clinics employ Gorovodu, because they believe that “clinic medicine treats only the physical disease, not the deep reasons that a person falls ill” (41). From the texts available concerning medical anthropology and biomedicine, these indigenous people could be right in the respect that Western medicine does not do much to resolve the reason for receiving disease (whether it be rooted in social interactions, work, or elsewhere), but instead almost exclusively offering

treatment for the disease. This situation aside, it is obvious that the Gorovodu order and its view on disease and health are very different from the cosmopolitan medical system.

Not only do those who believe in traditional African healing believe in a different origin of disease than those who believe in biomedicine, but as could be guessed the method of healing can be considered different as well. Because the African traditionalists believe spirits and dark magic are the roots of disease they see the cure coming from the realm of the supernatural as well. However, in addition to prayer and ritual, physical herbs and other natural sources may also be used in healing. According to the book *West African Traditional Religion*, “The practice of medicine is closely tied up with the practice of religion in Africa” (Opoku 15). The Winti religion believes that in medicinal plants, it is the “energy that gives plants the medicinal power that cures diseases in man’s body” (Wooding 36). However, “Although the practice of medicine is of a religious nature, there is also a scientific aspect to it.” Opoku goes on to describe how the herbal medicine is discovered and obtained by applying “close observation of nature and practical experience” to medicine. For example, he illustrates the discovery of potent snake anti-venom used in Ghana which came from the observation of one snake tending to another’s bite wound using a leaf it obtained from the forest (15-18). Coincidentally, a similar story of observing animals to discover medicine was told to me by an herbalist and employ of Africa First LLC. Upon my visit to Ghana, Africa, during the spring of 2011, I had the opportunity to visit this medicinal herbal farm and meet much of the staff as they walked us through their acreage of land donated specifically for the propagation of herbal medicine. From what I gathered during my time at this farm, there are a lot of trusted herbal remedies to a plethora of disease, and ailments, and all of which I saw did not require any special ritual or religious ceremony to receive full effectiveness of treatment from the herbs.

Speaking with the Ghanaian people and representatives of various primary and secondary schools, it seemed to me that both herbal and modern medicine was taught in schools with emphasis on modern biomedicine, and those we talked to, who seemed to be in middle class, would go to a modern hospital first, but would go seek herbal or traditional treatment as well or secondly. My observations are backed by Baer who writes, “Although the upper and middle classes resort to traditional medicine as a backup for the shortcomings of biomedicine and for divination, advice, and luck it constitutes the principle form of health care available to the masses” (333). Obviously, Western medicine has left its mark to some degree on the West African people. Baer writes, “As a result of financial backing of initially corporate-sponsored foundations and later the federal government of its research activities and educational institutions, biomedicine asserted scientific superiority and clearly established hegemony over alternative medical systems” (335). With the influence of Western medicine there comes not only a wide variety of effective treatments for life threatening diseases, but also possibly the same mind set Westerns hold on herbal healing. However, there are still many people who practice and/or prefer traditional healing systems instead of, or in combination with biomedical institutions. Baer comments on a Haitian village, “In addition to access to biomedicine or “metropolitan medicine,” the villagers turn to various other practitioners and healing systems in their search for better health” (334-335).

It can be assumed that traditional medicine will not completely disappear under biomedicine in West Africa anytime soon. Ghana, a relatively “developed” West African country, understands this and has passed the Traditional Medicine Practice Act 595 in 2000 (see attachment A). “The Act establishes a council to regulate the practice of traditional medicine registers practitioners and licenses them to practice and to regulate the preparation and sale of

herbal medicines” (Ghana, *the Traditional Medicine Practice Act 595*). However, neither Ghana nor any part of Africa offers International Coverage for Homeopathy, Naturopathy, and Phytotherapy (healing from plants); this means that the people will not receive any funding from the government to seek help from these, under the Traditional Medicine Practice Act, licensed herbalists (Montgomery). At least Ghana, other West African countries, and a large part of the developed world have National Policies for traditional medicine, where the US only has legislation. According to the book *Knowing What Your Body Needs* by David Gebhart, America is a country where, “More money per person is spent on health care in the United States than in any other nation in the world, and a greater percentage of total income in the nation is spent on health care in the U.S. than in any United Nations member state except for East Timor. Despite the fact that not all citizens are covered, the United States has the third highest public health care expenditure per capita” (25). However, the Americas (North and South America) only offer 21 percent International cover for homeopathy, naturopathy and phytotherapy (Montgomery). It seems as though the Western influence on government and medical institutions has hindered or slowed the spread of traditional medicine and specifically herbal remedies. Now the question must be asked again, why does the Western influence hinder the spread of herbal medicine? Why is it that when one goes to the doctor’s office one would never expect to be prescribed an herbal remedy?

To begin to answer these questions one can look at a critical turning point in the history of Western medicine. At one point in time, even in America, herbal drugs were used as the main source of medicine to cure disease. “Once scientific methods were developed to extract and synthesize the active ingredients in plants, pharmaceutical laboratories took over from providers of medicinal herbs as the producers of drugs. The use of herbs, which for most of history had

been mainstream medical practice, began to be considered unscientific or at least unconventional and to fall into relative obscurity”. This may seem like not a big deal as the main medicinal “ingredient” of the plants could be removed and mass produced. However, “In addition to active ingredients, plants contain minerals, vitamins, volatile oils, glycosides, alkaloids, bioflavanoids, and other substances that are important in supporting a particular herb's medicinal properties” (Herbal Place).

It is the function of the Center for scientific research into plant medicine, and similar institutions in West Africa, specifically Ghana, to test herbal medicines for safety and functionality. While there, I was told that all of the herbal medicines underwent clinical testing as regulated by the FDB; clinical trials according to the FDB include a four-phase process beginning with studying on animals and finishing with detecting long term effects of the drug on the market (see attachment B and C). Herbal remedies must also be registered under the FDB (see attachment D and E). The herbal registration process requires, among other things, a Safety Report (Acute and Chronic Toxicity) and Certificate of Analysis (Finished Product). The question is, is this enough for the FDA in America to approve herbal medicine from Ghana as prescribable medicine in the States?

First of all, Herbs are regulated between countries in a number of different ways. “A single herbal product could be defined as a food, a dietary supplement or an herbal medicine, depending on the country.” Understandably, “This disparity in regulations at the national level has implications for international access and distribution of products” (WHO | Traditional Medicine). Unfortunately, according to the Hackensack University Medical Center department of anesthesiology website,

“The United States Food and Drug Administration (FDA) classifies herbal medicines separate from nonprescription and prescription medications. An herbal remedy is considered a dietary supplement, a product that is taken in addition to a normal balanced diet, but is not a food or drug. Dietary supplements do not have to meet rules for safety, effectiveness, and quality. And herbal remedies do not undergo the same research requirements as prescription drugs or over-the-counter drugs.”

This means that, as policies and legislature are now, one could not recognize if the severity in differences between the herbal drug registration processes and America’s drug regulation process for drugs overseas is truly the cause of non-widespread use of herbal medicine. However, if herbal medicines are ever going to be classified as drugs, then surely there will need to be synchronization between West African drug registration policies and Americas.

The FDA states off of their web site that their “decision whether to approve a new drug for marketing comes down to answering two questions: (1) Do the results of well-controlled studies provide substantial evidence of its effectiveness? [And] (2), do the results show that the product is safe under the explicit conditions of use in the proposed labeling? Here "safe" is a relative term; it means that the benefits of the drug appear to outweigh its risks.” A West African policy on herbal drug registration needs to adhere to both of the above requirements if the FDA would ever consider herbal remedies as drugs. It is relatively safe to say that the latter requirement is soundly met as herbal medicines, coming from plants that have been used for generations, are known for their mild, if any side effects. Also, as previously explained, the finished product of the herbal remedies undergoes toxicity testing in a laboratory setting which I observed personally. The former stipulation from the FDA is most likely where problems may lie. First of all, one needs to define a “well controlled study.” In the past, and probably still to

this day, a traditional African remedy's discovery and qualification is what some Westerners may call "unscientific." For example, previously I described how anti-snake-venom was discovered by watching and copying the actions of wild snakes. It is likely, from my conversations with natives of Ghana, that the anti-venom came to be a reputable drug through trial and error on other victims' snake bites; obviously in America there are months if not years of testing before drugs hit the market. Second, do West African drug registration policies include credible "substantial evidence of [the drugs] effectiveness?" There has been much development in the scientific method for testing of West African herbal medicine compared to the past, but are the "improvements" enough for the FDA to consider the Ghanaian policies on herbal drug registration as showing substantial evidence of effectiveness? To answer this question one must compare what the FDA asks for to show drug effectiveness compared with what the FDB asks for (see attachment F)¹.

Whether the differences between what the FDA and FDB are asking for are similar or completely different, in the current day herbal medicines are not considered drugs in America. However, a physician could recommend obtaining herbal medicine just as he could recommend rest, drinking water, or starting a diet. The Cory Holly Institute ran by Dr. Cory Holly states, "[P]hysicians have little or no support from the policy makers and enforcers from above, in fact they are often discouraged from practicing any form of medicine perceived by medical boards as being non-scientific, unconventional or a form of quackery. For fear of losing their medical license and being sued for malpractice after many years of specialized medical training, many physicians who would like to stretch themselves, simply choose not to and conform to the rules of engagement." David Gebhart, who has experience in marketing and sales of pharmaceuticals

¹ List of questions which needed to be answered to be able to compare drug registration processes between West Africa and the America.

and clinical laboratory services, has a different opinion as to why physicians are not likely to recommend herbal remedies to their patients. He believes greed is a big reason as to why herbal medicines are not recommended by physicians. In a phone interview, he said, “99% of doctors could care less about alternative medicine.” He explained that if there were a procedure a doctor could perform on a patient and a there was an herbal remedy that could potentially cure the patient that the physician would choose to do the procedure, thus, making money in the process. Although there may be a tone of exaggeration In Gebhart’s opinion, greed is without a doubt tied to the Western medical system. An article by the *New York Times* describes a case in which anemia drug companies are paying millions to physicians. “Doctors receive the rebates after they buy the drugs from the companies. But they also receive reimbursement from Medicare or private insurers for the drugs, often at a markup over the doctors’ purchase price... The rebates are related to the amount of drugs that doctors buy, and physicians that agree to use one company’s drugs exclusively typically receive higher rebates” (Berenson et al.). Drug companies are probably not working with doctors to extinguish herbal medicine, and neither are policy makers, but it is clear that the capitalist drive for success and fear of being sued has not helped widen the medical perspective of doctors to recommend complementary and alternative medicine including herbs.

Traditional herbal healing exists in and all over our world today. People have been using herbal remedies to cure disease and illness far before biomedicine has ever reached the world seen. Yet, as many see herbs as their primary source medical treatment, Americas Western ideology sees them as unscientific food additives. There is no doubt that mediclization of the American society and in some areas where Western influence has had some impact to make people feel untrusting of herbal medicine. As believers in biomedicine, knowing the history of

herbal medicine is wrapped in religion, animal mimicking, and coming from “primitive” societies, it is understandable that the general public and many doctors would see herbal medicine as quackery. American people’s negative views on herbal remedies are probably reinforced by herbal products available to them as the FDA does not require herbal drugs to go through the same stipulations as other pharmaceuticals, and thus misleading labels and non medicinal products could be sold to produce nothing more than a placebo effect. This could be the reason why doctors do not receive support from the policy makers and enforcers from above and why physicians are so easily persuaded by greed, all to ignore the possible benefits of herbal medicine. One could observe that the solution would be to hold herbal medicine to the same stipulations as western medicine, but as much of herbal medicine comes from across the seas, such as Ghana, Africa, would there be issues with synchronization of the drug registration policies, and if there weren’t would the FDA trust the other countries drugs anyways? According to the Herbal Place, founded by Dr. Lian Jin Chong, “[F]or the most part, the United States Food and Drug Administration (FDA)... does not recognize or accept findings from across the sea.” Therefore, the solution should be to educate the medicalized Western American and other countries’ people and those in charge of creating and accepting others drug registration policies to know the full picture of herbal healing. Also, synchronize drug registration policies between countries and across seas to build trust in each other’s system. It is no easy task to change the minds of a nation, nor is it to change ones policies and accept others, but it must be done before America and other medicalized Western countries can reap the full benefit of natural herbal healing.

A research proposal to better understand the usage of herbal medicines in Western Africa

I. Project Goal

To explore the possible applications of natural, herbal medicines in modern-day American society, while creating a catalog depicting the uses of the different plants observed and their properties in order to take advantage of their benefits in a rational and effective manner.

II. Project Description

According to the World Health Organization, herbal medicines “include herbs, herbal materials, herbal preparations, and finished herbal products that contain parts of plants or other plant materials as active ingredients.” Furthermore, the WHO estimates that 80 percent of some African countries still heavily rely on medicinal plants to meet the primary health care needs of their populations (“World Health Organization”). Specifically in Ghana, 70 percent of the populace solely depends on the health care provisions of approximately 45,000 healers. The majority of these healers “are recognized and licensed through various associations that fall under the overall umbrella of the Ghana Federation of Traditional Medicine Practitioners’ Association (Romero-Daza 173-176). Despite the extensive use of traditional medicine in Asian and African countries, its lack of regulation and credibility or acceptance has prevented its spread in not only the Western world but on a national-scale in several African countries as well. According to Ivan Addae-Mensah, a professor of Chemistry at the University of Ghana, Legon, there is mainly five arguments against the use of herbal medicines:

- (1) that the herbalist is not competent to diagnose;
- (2) no data on long-term toxicity of herbs have been documented;
- (3) absence of standard dosages can lead to over dosage or under dosage

(4) herbal preparations are generally unhygienic and poorly packaged;

(5) dosage forms are usually voluminous and difficult to cope with

In addition to these arguments, obstacles arise when there is an inclusion of rituals, which may not seem rational or necessary, “though they may serve their own psychological purposes of putting the patient in the right frame of mind for a cure to be effected” (Addae-Mensah 3-20).

Dr. Nancy Romero-Daza, a medical anthropologist, further implies the substance and logic of these systems of traditional medicine by stating they “are usually rooted in long-standing cultural traditions, take a holistic approach to health, and are community based. The WHO has long recognized the central role traditional systems of care can play in efforts to provide health care, especially in rural areas” (Romero-Daza 173-176). There is a need for systematic research into medicinal plants.

Professor Ivan Addae-Mensah recognizes the need to provide “some authentic scientific bases to the practice of [Ghanaian] herbalists” (Addae-Mensah 3-20). He compiled a list of questions and conducted research in various African countries to acknowledge the great use of herbal medicines in Ghana and other African countries and the need for a “new strategy” in gathering data and information on the plant-life that, as a result, could benefit many people.

For our research we will be observing and studying under Africa First Medicinal Farm in Tepa Ahafo-Ano in the Ashanti Region of Ghana. While working with them we will be creating a catalog depicting the different types of plant life observed. This catalog will include the following about each specimen: scientific name, detailed pictures and physical descriptions of the specimen, part of the plant used in the medicine, its healing properties, method in which it is used for treatment, length of period the medicine is recommended to accurately influence treatment, and the climates and areas around the world where it’s found. Ideally we will use this

catalog to help educate those in Western Africa about the importance of these natural medicines as a primary treatment over synthetic medicine and Western medicine properties, as well as encourage and bring forth the idea of natural medicine usage in the United States.

Africa First LLC is a limited liability company that was established in 1999. Its goal is to spread knowledge and education about new approaches in natural medicine. They set up experimental farms working with traditional healers as well as westernized medical practitioners to bridge a gap of indigenous knowledge and scientific technology applied to medical care. Africa First provides different study tours for students and other interested professionals about alternative healing methods (Africa First).

While studying and working in Tapa with Africa First Medicinal Farm we will be helping them complete their project goals by embarking on the following tasks:

- (1) Develop a sustainable production system that is environmentally friendly, profitable and benefits society;
- (2) Improve the quality of life for the families that reside and work within the community where this project is located;
- (3) Create a model farm to train farmers about organic production of medicinal plants, food security and sustainable forest management; and
- (4) Use the activities developed in the eco-farm and its natural resources for biodiversity and environmental education (Africa First).

III. Students' responsibilities

Immersing ourselves into the different cultures and learning from these herbal practitioners to get a feel of the communities' ideologies of the herbal medicines; along with the

opinions of medical professionals in these cultures. We will be observing and recording the different uses of certain plants in medicinal form. Along with observation, physical descriptions and pictures will be recorded into our catalog from which we will compile a database of the different plants researched and observed. Education to the communities promoting the usage of herbal medicine will also be a key project that we participate in.

IV. Faculty sponsor's responsibilities

The primary role of Dr. Eric Montgomery will be to guide and provide researchers with connections and different resources to facilitate and reach the desired goal. Dr. Montgomery is knowledgeable in matters concerning West Africa and connected to the regions' people, specifically in the countries of Ghana and Togo. Therefore, Dr. Montgomery will be helping researchers to establish accommodations and studying opportunities with herbalists in Ghana. As an anthropologist he will be essential in adaptation to the communities in which the research will be conducted, a key factor of its success. It is believed that the most beneficial information will be obtained through earning the acceptance and respect of the community.

V. Duration of Project

During the Spring/Summer 2012 term researchers will be traveling to study in Ghana. Specific dates cannot be assessed at this time until an agreement has been reached with both John William Danquah and Dr. Montgomery.

VI. Award Option

Option 1: Student \$2,300; Faculty \$750; Total \$3,050

VII. Budget Justification

Three-month single entry visa to Ghana - \$50.00

Flight (average) from United States to London- \$1,200.00

Flight (average) from London to Accra- \$600.00

Lodgings- estimated around \$500.00

Food- estimated around \$500.00

Total cost per student- \$2,850.00

*The remainder of the cost will be left to researchers.

CLEAN WATER PRACTICES

I. Introduction

To commence our research procedure, it is vital to define the extent of the problem. Ghana faces high rates of poverty with nearly 30% of the rural population falling below the poverty line (CIA). As immigrants from India, we have seen the sheer amounts of innocent people condemned to a life without the basic necessities for survival. We have also witnessed this first-hand in Detroit where nearly half the population is at or below the poverty line. Poverty affects nearly all other aspects of Ghana's success as a nation. Proper education is withheld from many children in rural as well as urban African settings. Furthermore, access to basic health care and proper hygiene education in the country is also inadequate. Initiatives to improve living conditions must be taken to ameliorate the people of Ghana's well being. Access to clean; disease-free water is a growing necessity in Ghana. With increasing numbers of water-borne diseases amongst the Ghanaian people, it is crucial for the Black Star's government to act swiftly upon making improvements to the infrastructure.

The lack of clean drinking water and sanitation systems is a severe public health concern in Ghana, contributing to 70% of diseases in the country including such endemics as schistosomiasis in 74 developing countries with 80% of infected people living in sub-Saharan Africa (CIA World Factbook). Thus, a plethora of water-borne illnesses affects a large portion of Ghanaian individuals. The villages have extremely poor sanitation awareness. Bleak is the epitome of many rural settings in Ghana lacking proper basic necessities. Education for these villages is a must. To sustainably develop a country, it has been proven that education is one of the best ways to do so. In the case of South Korea, the Asian country has invested heavily in

education as a central part of its economic future, and has seen vast improvement in its academic rankings in comparison to the world. In the 1960s, South Korea had a lowly national wealth on a level with Afghanistan, but is now amongst the world's best financed countries (BBC. Education). Undeniably, Ghana needs to follow South Korea's precedent. The logistics of how to holistically accomplish this mission is another paper, for another day. Basic human rights such as water are of greater importance in 2011.

Luckily, a water purification pot from MIT known as the Kosim Filter that Josh and Alex are working with is a revolutionary idea that may already have been implemented in Northern Ghana, but requires further research. Funding can increase the chances of coming across a feasible method of eradicating traces of diseases caused by the lack of sanitation or clean water. Oil found in the Takoradi region of Ghana provides large amounts of revenue that can be used to tackle these pressing issues. The proposition rests on us to research the specific amount of money that has been found in the Takoradi region, and use it to create a sustainable method of purifying water in villages. Furthermore, educating the natives on the importance of sanitation by looking into such filtration and purification devices as the Kosim Filter, and Aquatabs is of utmost importance.

II. The dependent variable

The dependent variable regarding the country's receptivity in helping to fund and distribute water purification devices rests in the awareness and attitude of rural villages. Understanding the full background of the issue requires researching preexisting water quality and sanitation methods, addressing how water is affected in tandem with effects of privatization of water, assessing the awareness of the villages to holistic cleanliness in prevention and cure, and

finally analyzing what has been done so far and why it has not worked to its full potential thus far.

Ghana, as a developing country in the sub-Saharan Africa is vulnerable to many detriments to the quality of drinking water. With industrializing cities too preoccupied by increasing company efficiency to avoid dumping wastes into water, tropical diseases have found their niche in the region. As of 2008, 1.3 to 2.0 billion people were without access to safe drinking water (water that is below government water quality limits) across the globe (Smith, 2008). In Ghana's specific case, proximity to large urban centers and the water-rich Volta region plays a major role in the accessibility to water, as well as the quality of it. In communities with fewer than 50,000 inhabitants, water supply systems are owned and managed by the community on a demand-driven basis. These systems do not receive any cross-subsidies and 5% of the cost of providing the facility is paid by the operating community (Nyarko). It is largely up to the prosperity of the village or community to take on the additional effort to establish a water supply system; otherwise they may rely on natural bodies of water which can be scarce, depending on the region, but dangerous considering the water-borne illnesses.

Furthermore, while availability of water may correspond to geographic or urban characteristics, the water-borne diseases and contaminants within the water vary depending on origination. Unequivocally, poor water filtration is an issue as, "in Ghana, there have been over 27,000 reported cases since 1999" (Osei 2008). In one of the significantly affected regions in Ghana, the Ashanti region has dealt with massive outbreaks and high incidences of cholera. This killer disease has predominately occurred in urban and overcrowded communities. The main causes of cholera in this area are due to excessive urbanization, high levels of overcrowding, and close proximity to the Kumasi Metropolis. In considering an effective and sustainable treatment

of water in any region of Ghana, we need to analyze not only at biological threats, but threats faced by inorganic compounds as well. In a study done by the British Geological Society, “Arsenic in drinking water from streams, shallow wells and boreholes in the Obuasi gold-mining area of Ghana range between < 2 and $175 \mu\text{g l}^{-1}$. The main sources are mine pollution and natural oxidation of sulphide minerals, predominantly arsenopyrite (FeAsS)” (Smedley *et al* 2004). Interestingly enough, they continue to indicate that not only are there issues with arsenic poisoning, but the methane levels from the mining encourage bacterial growth, which consequently boosts the levels of pathogenic bacterial microbes in the streams. Thus, solutions that have been attempted thus far, as well as proposed potential solutions, cannot rely on a single method of filtration or purification, but must interweave a multi-layered defense against a full range of water contaminants. “Both capped and uncapped springs had bacterial counts in excess of the WHO standard, suggesting that water treatment from all sources is necessary to ensure clean and safe drinking water. Negatively impacted subterranean microbial ecosystems, poor sanitation practices, shallow karsts aquifers with open flow paths, and high spring water temperatures, averaging 26.5degC , may be contributing to the observed bacterial abundance“(Wampler *et al*, Haiti). All sources of water, as innocent as natural springs, should be taken into account by potential filtration and purification systems.

As a result of the dire need for clean water, the next potential step is to privatize the water distribution industry. Two benefits that will result from this change is the lessening of the load on the institutions already set in place, and to experiment with long term solutions. It is important to note that “corporate obligations under the human right to water can potentially be based on the right to water as set in national law and in the international human rights treaties and in corporate codes of conduct” (Cernic). Though not a matter of privatizing drinking water and aquifers, there

still remains the possibility that corporate-distribution of water can, down the line, deny regions of water. In 2004, WBO (World Bank Organization) approved a credit, which eventually turned into a grant, of US\$103 million for an ‘Urban Water Project’. The goals of the program, which was extended an additional two years to 2012, are to significantly increase access to water supply systems in the urban areas of Ghana with an emphasis on the urban poor; and restoring financial stability and sustainability of the Ghana Water Company Ltd. (World Bank). Additionally, “In March 2008, severe water shortages in Accra were reported, leading the Minister for Water Resources, Works and Housing to review whether AVRL is working in compliance with the management contract” (Benson 2008). With the AVRL being a partnership between a Dutch and South African corporation set to support the initial Ghana Water Company Ltd., the overall scheme has added more water-distribution infrastructure, but again as stated, the target for this venture is the poor urban population, who are also at risk, but this neglects to give attention to the rural villages.

Finally, the last piece of background information to understand before attempting to craft solutions is to understand how savvy the people of the communities are themselves. Undeniably, “understanding the relationships among perceptions, behaviors and awareness of environmental initiatives is important for both policy makers and social scientists... [In South Africa] Africans and those with lower socio-economic are more likely to perceive water pollution as a community problem; educational attainment is unrelated to this perception...education is positively related to taking action to treat water for drinking and food preparation” (Anderson *et al*). Though in South Africa with a considerably larger population of foreigners and “non-whites”, education still has a positive correlation in Ghana with the demand of treating water. This sets the framework for why sanitation awareness is only effective with those of higher socio-economic status and education,

because they are already more likely to have similar efforts, and furthermore, this is why simple sanitation awareness cannot be as effective in rural villages, considering that socio-economic and education rates are generally lower in these regions.

In Ghana specifically, Mr. Francis Tapena, acting Brong Ahafo Regional Manager of Ghana Tourist Board, expressed his concerns on how caterers within the Ghana Traditional Caterers Association are not as environmentally and medically sanitary as should be for the food industry, and went on to mention how they created training programs to better the members, however the screening methods by the National Health Insurance Scheme are seen as inadequate (GNA 2009). The very NHIS that we heard about when visiting the Ghana National Hospital did not pass the bar when it came to screening potential caterers based on sanitary awareness. This information is crucial in anticipating the government involvement with both the preventative awareness and the physical distribution of potential solutions to rural villages as it would be run through the National Health Insurance Scheme structure.

III. Synthetic Literature Review

So far, there have been a multitude of low-cost mechanisms and schemes that have been applied to raising the standard of water quality for consumption and use or to enable people to do so. One such method, a sanitation awareness similar to what we participated in with HALP's school outreach missions, provides a form of water-sanitation education, however, it focuses on curing rather than prevention and, in the case of rural villages, fails to take into account human variables that would prevent sanitation and cleanliness from being feasible approaches to safe water. Mainly the issue with HALP's outreach, albeit they took place at regions of higher relative socio-economic status, is that the day to day priorities of people would outweigh the cost

of anti-bacterial soap. In a true rural setting, it really doesn't matter how much antibacterial soap you use, if the water which is used for consumption is murky with sediments and toxic levels of arsenic, lead, or mercury.

Multiple academic institutions have partnered up with other institutions or NGOs to work on practical and sustainable forms of water filtration. One such was collaboration between the University of Edinburgh and the Kwame Nkrumah University of Science and Technology. "A water purification system is under development at the University of Edinburgh and KNUST, Ghana, using ultra-filtration (UF) coupled with adsorbents. UF removes bacteria, parasites and viruses, while toxic heavy metals can be removed by adsorption" (Mondialogo 2007). Theoretically, this filtration device is amazing, considering that it has the bi-layered protection of neutralizing both biological and virus threats, as well as adsorbing toxic heavy metals like arsenic. Adsorption is a process like absorption but things stick to the surface rather than get sucked in. The practicality of ultra filtration membranes makes it more useful in large scale municipalities, and is too expensive for a rural setting as we would like to achieve. It is not something portable and easy to assemble on the spot, it must be inserted into large scale treatment machines. Nonetheless, it poses a good option for funding on part of the government through the National Health Insurance Scheme in combination with other layers of rural and urban filtration and purification schemes.

Similar to the European partnership, a few American Universities have also taken interest in researching in Ghana. The University of Michigan is currently working on a traditional medicine analysis, but more importantly, Massachusetts Institute of Technology has paralleled the Ultra-Filtration Membrane with the Kosim Pot, a ceramic sediment filtration device of which we will explore applications in tandem with some water purification methods. This model, in

comparison to the Ultra-Filter Membrane processed by the aforementioned institutions is more portable, easier to transport or build on site, and is relatively low-maintenance and low-cost. At approximately a mere \$11 for the initial cost of the ceramic filter alone, the filter itself can be extrapolated to a 11-year service time, eventually requiring only the initial capital at the end of its service life. “Reached over 100,000 people with the Kosim ceramic pot filter, through direct sales and emergency distributions (flood, guinea worm outbreak) since 2005” (Pure Home Water). The only maintenance required is for timely cleanings of the inner ceramic with a brush provided by the technician who sells the pot as well as informs the customer or community on proper care of the device.

IV. Your proposed explanations.

Waterborne diseases (diarrhea, typhoid, etc.) are just one of the many effects of this glaring issue. Currently, there are four billion cases of diarrhea per year worldwide, resulting in 1.8 million deaths (90% of which are amongst children under five years old) (WHO/UNICEF, 2006). Furthermore, statistics show that 10 million people die each year from cholera, typhoid, dysentery and other diarrheal diseases caused by poor sanitation (MIT). Due to the prolonged disregard to the underdevelopment of water purification systems throughout many third world countries, it is extremely difficult to reverse the cycle of water-borne diseases and poor sanitation practices. Whether this ignorance to suffering individuals in the past was a purposeful act, remains a mystery. All that matters is the action taken in the future to correct the mistake of allowing regions to deal with problems that should be non-existent.

Trying to eliminate poor water and sanitation in Ghana is a herculean task for college students from Wayne State University. Distributing Kosim Filters and Aquatabs to select rural

villages afflicted by large amounts of water-borne diseases is a far more feasible mission. In addition, it is also vital that further research commence on the subject of how to collect rainwater and purify it in a low-cost way. The primary function of Aquatabs is to kill pathogenic microorganisms in drinking water, which can cause waterborne diseases like cholera, typhoid, dysentery, diarrhea, etc. They are effective at treating natural waters with various pHs and fecal contamination values (Medentech, 2007). In combination with a filtration device such as the Kosim pot, this innovation could greatly eradicate the unnecessary deaths caused by a bad water supply. Clean water is a right for all humans. Whether they live in a 2 bedroom apartment in Detroit, MI, or in a wooden hut in Tema, Ghana.

In the case of proper funding, the government can establish a sustainable method of recycling the waste from water treatment facilities in Ghana. It has been shown through research that, “sludge created from water purification plants, which is otherwise difficult to dispose, can be used to create non-structural concrete” (Sales 2010). Normally the waste sludge would be dumped into fills which would contaminate the local watersheds of the region. Instead of perpetuating the problem, the sludge can be recycled and would benefit both the environment and the community.

Duration of Project:

The first segment of this research timeline occurs between the 9th and 27th of May. During this period, we will be in Africa conducting my experiment. The other segment of research proceeds when we return from my trip. From June 1st to August 1st, we will be analyzing our observations and completing the final report at Wayne State University.

Select Award:

We are applying for Option 1.

Budget Justification:

Airfare to Accra, Ghana costs a mere \$1,800. When we reach our destination, we shall require \$100 for surveys, paper, and pencils to conduct the experiment within several villages. Another \$200 is allotted for taxi money to and from various places, such as villages, hotels, and restaurants throughout Ghana. Finally, we will need \$200 for food and water during our stay.

VI. Methodology.

There are several ways that data will be obtained during the experimental procedure. One such method of data collection is interviews with local villagers on their opinions of the impact of Kosim Filters and Aquatabs on their health and everyday lives. This is vital in making improvements in our effort to delineate the most effective way of distributing these products. Also, by recording the occurrence of water-borne illnesses and parasitic diseases amongst a representative sample of Ghanaians, such information can provide useful statistics that may substantiate the positive effect of life-saving innovations.

VII. Implications.

The implications of our research extends far greater than the narrow scope of saving certain individuals from water-borne diseases. In a broader sense, we aim to set the precedent for other NGO's and philanthropists to turn their heads and listen to Ghana's cry for aid. Hopefully, a few of them can answer with their own forms of help to improve the water quality throughout the country. In the end, the bleak situation in Ghana can only be affected when action to directly influence people is taken. Kosim Filters and Aquatabs have proven effectiveness, therefore

validating our efforts to implement a system that utilizes such revolutionary inventions to aid as many individuals as possible. Unfortunately, the circle of life cannot be broken. Poverty and poor water will continue to envelop the myriad of villages in the Black Star nation, but as Mohandas Gandhi once said, we can be the change we wish to see in the world. Ultimately, enough like-minded volunteers devoting their time and energy for a good cause such as H₂O for Everyone Yo! can be heroes to many families in Ghana's country full of loving citizens.

Conclusion

H₂O for Everyone Yo! is just a start to the battle of improving the underdeveloped regions of Western Sub-Saharan Africa. There is a greater initiative on our part to conduct further research in the field of water purification and sanitation. It is vital to the development of Africa, in particular the Central Region of Ghana. West Africa, specifically rural areas, have major problems with sustainable water treatment. However, sanitation cannot be efficiently discussed without a relatively clean source of water. Therefore, to catalyze the movement to reduce preventable diseases either through infected water or poor sanitation, we will need sufficient funding to make a difference. The initial plan is to work with Wayne State University to host fundraisers that will provide our goal revenue of \$2000 for the purchase of Kosim Filters and Aquatabs. Upon distribution the following year, we plan to conduct a more holistic experiment on the effectiveness and feasibility of Aquatab distribution in the Central Region of Ghana. Also, interacting with native Ghanaian's to formulate a system of symbiotic understanding of the problems that hinder further improvements in the water infrastructure is crucial to the success of implementing the best system for the people in rural settings. Contacting local NGO's can combine our efforts in tackling this problem and also reduce the burden of fighting this problem. Finally, delineating the amount of money generated from the oil found in

the Takoradi region can guide us to writing to the Ghanaian government. This information is important in directing possible funding to improve water purification throughout the Black Star nation.

STUDY ABROAD PROPOSAL: WAYNE STATE UNIVERSITY SCHOOL OF NURSING

Abstract

As of late there has been an increased focus in incorporating study abroad programs in nursing school curriculums. A relatively new idea to health sciences, nursing students across the nation are experiencing the benefits of study abroad. With an ever diversifying nation, there has been a focus on creating real-life experiences outside of the classroom to promote culturally competent nurses. This proposal provides a literary survey of four successful, established study abroad programs in universities across the United States as well as the benefits of study abroad programs. It seeks to answer the question of feasibility in incorporating a study abroad opportunity in Ghana for Wayne State University School of Nursing. It also provides a tailor-made study abroad program attractive to Wayne State University nursing students.

Keywords: nursing school, study abroad programs, Ghana.

GIVING BACK TO GHANA: ENCOURAGING ACTIVISM IN HEALTH EDUCATION ABROAD

Introduction

A vital responsibility of nursing schools in the United States today is creating an environment that encourages cultural awareness, sensitivity, and competence in its students. In a country that is continuously diverse, it is paramount to equip students of nursing with the tools to address such diversity and to incorporate cultural competence in their nursing practice. An excellent way for instructors to expose students to cultures is an international experience. Study abroad programs have proven successful in submersing students in diverse cultures to produce an awareness that would not have been warranted instate. Regretfully, in tight requisite programs

there are too few opportunities available to undergraduate nursing students to experience cultures and health care abroad. This research proposal focuses on opening up an opportunity for Wayne State University nursing students to study abroad in Ghana. Additionally this proposal will give Wayne State University nursing students an opportunity to challenge their beliefs and values, increase their awareness of self and others, and assist them in recognizing their own beliefs and opinions of other cultures alongside their own. In combination with Ghana's National Governmental Organization (NGO): Health Protection and Environmental Sanitation Organization, Wayne State nursing students will learn about the various health challenges that face different Ghanaian populations, also utilize community health nursing skills while teaching health education in primary and secondary schools.

Research Question

This body of work will seek to answer the following question: Is it feasible for Wayne State University's College of Nursing to offer students the opportunity to study global health issues and challenges in Ghana, as part of a study abroad program?

Hypothesis

If Wayne State University College of Nursing implemented a study abroad experience in Ghana, then nursing students will benefit in the following ways: (1) observe and experience things that they are taught in the classroom regarding cultural differences in health care, (2) increased cultural competence, (3) increased intellectual development, (4) expanded international perspectives, (5) personal development as reflected by personal decisions and philosophy, values, beliefs.

Objectives

Objectives of this research proposal are as follows: (1) provide research of successful Ghana study abroad programs in various United States nursing schools, (2) literary review of the importance of study abroad programs in nursing schools (3) provide program description and administration (4) describe aims of working with the Ghana's National Governmental Organization (which will from now on be referred to as NGO) Health Protection and Environmental Sanitation Organization (which will from now on be referred to as HEPENS) (5) argue institutional change in the incorporation of a study abroad program in Ghana to Wayne State University's College of Nursing.

Significance of Proposal

This proposal is significant in the sense that study abroad is a vital aspect of one's college career. In a university that encourages its students to "aim higher", Wayne State University College of Nursing should provide various opportunities for their students to obtain a global education. There are numerous nursing curriculums across the United States that have already been reaping the benefits of a study abroad program in Ghana. Since nursing is an ever-changing, expansive profession, rudimentary curriculums are becoming outdated and a nationalized form of nursing curriculum is now including study abroad options. Being knowledgeable and sensitive to diverse cultures is a key component of an excellent nurse. One way Wayne State can ensure that their nursing students are global minded, is to incorporate this study abroad program within their curriculum. The next section of this proposal focuses on providing information as to how this can become a reality. It also provides information on the current state of Ghana and its healthcare needs.

Background

About Ghana

The Republic of Ghana is a country of West Africa situated between Cote D'Ivoire and Togo. According to the World Health Organization "2009 Ghana: health profile" the total population of Ghana is 23,837,000. Under-5 mortality rate for both sexes is 69 per 1000 live births. Maternal mortality ratio is 350 per 1000 live births. The most prevalent health issues that Ghana faces are malaria, parasitic and diarrheal diseases, malnutrition, and maternal mortality (Tabi and Mukherjee 2003). Not to mention the epidemic of HIV/AIDS. In 2009 UNAIDS Joint United Nations Programme on HIV/AIDS estimated that there are 260,000 people, 1.8% prevalence of the population aged 15-49 are living with HIV. There have been 18,000 deaths due to AIDS and 160,000 orphans due to AIDS aged 0 to 17. Despite their fight against diseases, Ghana is praised for their hospitality and congeniality. The Ghanaian government is a stable growing democratic body. Ghana is also known as "Africa for beginners". All of the above make Ghana a great learning environment for study abroad programs.

Nursing in Ghana

Like most everywhere in the world, Ghana is experiencing a shortage of nurses. Ghana battles not only a shortage of nurses due to lack of facilities but a shortage due to educated nurses leaving the country for better monetary opportunities. Nurses and midwives account for the majority of the health workforce in Ghana. There are 10.5 nurses and midwives for every 10,000 people (2009). In order to prevent recent nursing graduates from leaving the country after their schooling Ghana instituted a national service requirement. After completing nursing school, students must pass a registered general nursing licensing exam. Once the students pass the exam they are licensed and are required to fulfill a year of governmental service to Ghana. During these five years nurses are placed, mainly through the government, in regional hospitals. The

conditions are overbearing and overwhelming, with ratios of 1 nurse to 200 patients. There is a great need for resources at the nursing schools and health facilities.

Literature Review

There are numerous successful programs being implemented across the nation for study abroad programs in nursing schools. The following is a result of research spent on global study in nursing schools across the United States.

Georgia Southern University

In 2003, Marian M. Tabi, PhD, RN of Georgia Southern University incorporated a study abroad program in their college of nursing called: “Nursing in a global community”. The purpose of this program is to provide students with the opportunity to experience health care in developing and developed countries using Ghana and the United States as examples (Tabi and Mukherjee, 2003). The program has a community health focus and it was developed to give students the opportunity to learn, observe, and experience transcultural nursing and health care at the international level (2003). It is a six week study program that is broken into two sections. The first is two weeks in length, online cultural orientation before departure to familiarize students with Ghanaian culture and course expectations. The second section is four weeks in length at the University of Cape Coast in Ghana. Students are housed with host families. Teaching methods used include: lecture, discussion forums, supervised clinical observational experiences, reading assignments, course-related and research activities, and field trips including historical and cultural excursions (2003). The course is open to junior and senior undergraduate and graduate nursing and health-related majors. The students are evaluated and given course grades based on the following three criteria: students are required to keep succinct weekly journals to document learning activities, required to attend and participate in all activities, and submit a written

scholarly paper on their selected area of study for a project. The class counts for six undergraduate hours. The program fee is \$3,900 and includes tuition, fees, round trip airfare from Atlanta, in-country transportation, housing, meals, two-day stay in Great Britain, course-related excursions, cultural and historical activities and program fees. The program duration is from May 26th – June 23rd. Georgia Southern University has had success with this well-constructed program.

University of Missouri

University of Missouri's Sinclair School of Nursing incorporates a study abroad program titled: "Public and Community Health" for its eighth semester undergraduate nursing students enrolled in NU 4970. This fulfills a 90 hour clinical requirement for Nursing in Communities nursing students must complete (Public & Community Health 2011). The MU International Center, Sinclair School of Nursing and the Bachelor of Health Sciences programs sponsors this January intersession, faculty-led study abroad program in conjunction with ProGhana. ProGhana, a division of ProWorld is a for-profit institution whose mission is: "To empower communities, promote social and economic development, conserve the environment, and cultivate educated compassionate global citizens" (About Us 2011).

ProWorld arranges all student accommodations and land travel for the duration of the program (Public & Community Health 2010). According to the program information all students participating in the program will have an increased understanding of how public health interventions are implemented in a developing country. The program encourages students to reflect on how their own social and behavioral context impacts their susceptibility to a variety of health outcomes. Course requirements include a short series of on-line classes before departure, journaling, active participation in discussion in-country, and a final paper. The total program cost

paid to MU is \$2,922. The program has been a success and has had a considerable impact on the students. In *Mizzou Nursing Magazine's* feature "Students Impact Health in Africa: Creating Health Communities" states,

"We thought a study abroad opportunity like this really helps build cultural competence, which in the nursing profession is becoming more of a critical skill because our patient populations are so diverse," said Phillips. "We devised a way to measure the impact of the trip on the students ... it really shook up their worldview" (Pedroley 2011).

Dean Judith Fitzgerald Miller PhD, RN, FAAN of Sinclair School of Nursing summarizes the implementation and impact of the study abroad program in Ghana in *Mizzou Nursing Magazine*:

"While in Cape Coast and Accra, Ghana, students completed health screenings for diabetes, hypertension and HIV. They provided health self-management information about these conditions ... The impact on our students was profound from developing their cultural competence to being engaged in health promotion tailored to developmental and cultural specification" (Miller 2011).

University of Missouri continues to experience success with its study abroad program in Ghana: "Public and Community Health".

Michigan State University

"Healthcare in Ghana: A Public Health Perspective" is a four-week program arranged through the Office of Study Abroad and sponsored by the College of Human Medicine at Michigan State University. It combines classroom lectures with field trips and a service learning experience to introduce students to public health in Ghana (Healthcare in Ghana: A public health perspective, 2011). Students register in HM 848 Preparation for Health Care in Ghana for one credit and HM 847 Health Care in Ghana: A Public Health Perspective for four credits. While

this program is tailored to public health students, it is open to students from all majors (2011). The program offers lectures about Ghana's historical, political, social, cultural, and economic environment to provide a context for understanding health care beliefs and practices in Ghana, and covers topics on health care needs, Traditional and Western health care delivery systems, and public health problems and practice (2011). This program is available to at least junior status students in good academic standing, with a grade point average of at least 3.00 (2011). Students will live at the Ghana Registered Nurses Association Guest House while in the capitol, Accra. While in the village of Danfa, students will stay in a University of Ghana facility for medical students (2011). The program fee in 2011 is \$3,000. MSU students who apply to this study abroad are eligible for Office of Student Affairs Scholarships. A student who participated in Health Care in Ghana stated:

“In addition to all the factual information I obtained ... this reminder of the importance of cross-cultural awareness/sensitivity when dealing with any issue of public health in the US or abroad will have a lasting positive effect on my performance as a public health practitioner” (2011).

Although this program is not specifically identified for nursing students, those who are enrolled in Michigan State University's College of Nursing are encouraged to participate in this study abroad in Ghana. This is another example of a successful study abroad program in Ghana.

University of Michigan

The University of Michigan incorporates a concept of Global Course Connections (which will now be referred to as GCC) into its curriculum as one option for students to study abroad. GCC are short-term programs offer an excellent and affordable opportunity for students interested in field-based extensions to on-campus course (Center for Global and Intercultural

Study 2011). Students enroll for selected courses on campus in the fall or winter terms and then travel for, two to four weeks, with classmates to field site where they can put into practice or experience what they have learned (2011). Students receive additional one to two credit hours for the projects they complete on site. The GCC available to only nursing students is located in Ghana. The topic covered is “Introduction to Global Health: Issues and Challenges”. There are three classes nursing students can combine this GCC with: Nursing 420: Introduction to Global Health: Issues and Challenges Nursing 421: Perspectives in Global Health, Nursing 422: Community Care Nursing. In these courses students learn about providing nursing care in developing countries and then apply these new skills through international travel (Undergraduate Global Opportunities, 2011). These classes are available to students with sophomore standing. The concept of GCC is a very practical way of making study abroad options available to nursing students.

Overall each program characteristics were listed to compare and contrast differences between the researched universities. Each program was different in various aspects but all had two common themes: Ghana and healthcare. Three out of the four universities researched incorporated study abroad options specifically for their nursing students. The fourth university (Michigan State University) made its program in Ghana also available to nursing students. Even with stiff curriculums these universities made study abroad programs in Ghana a reality, if they can do it Wayne State University College of Nursing can as well.

Method

Wayne State University College of Nursing utilizes a lock-step program method to its traditional and second career/second degree nursing programs. Each student is given a set

curriculum to follow upon admission to the program; traditional students are not in school during the summer. Students cannot receive lower than a 74% in any class or drop classes to be retaken. Both traditional and second career/second degree programs incorporate 61 credits of nursing, the traditional program spans across 3 years to fit in general education requirements as well as nursing classes, the second career degree program is completed within 16 months. The following is a proposal to incorporate a study abroad program in Ghana to be available to all junior and senior level nursing students as well as graduate students enrolled at Wayne State University's College of Nursing.

Ghana: Explorations in Global Healthcare

This proposal is focused around one aspect: creating a study abroad option in Ghana at Wayne State University's College of Nursing. The information above has supplied four viable study abroad programs across the United States, two of which are in the state of Michigan. The following proposal is a harmony of those four proposals tailor made for Wayne State University's College of Nursing.

Program Description and Administration

Through this program nursing students will participate in an eight week long program during the spring semester. The course is open to undergraduate nursing students, graduate nursing students and College of Nursing faculty. This course will fulfill a foreign culture competency requirement and a writing intensive requirement for graduation. Students will gain clinical experience hours in community nursing and will conduct research on health issues under the supervision of faculty. At the end of eight weeks, students will be required to submit a research paper or proposal on their selected health issue to fulfill the College of Nursing's

writing intensive requirement. Students will be evaluated on three methods: active participation, weekly journal entries, and research paper or proposal.

The first week of the program will be a series of five online lectures prior to departure for Ghana, given by the faculty. The purposes of these lectures are to prepare students as much as possible for what they will be experiencing so that they can utilize their time most efficiently while in the country. The first two lectures will be an introduction to Ghana, covering issues such as population, healthcare, economy, religion, language, etc, but most importantly it will be an introduction to culture. The third and fourth lectures will be regarding aspects of community health nursing, cultural competence, and course expectations. The fifth lecture will be a crash course in traveling and information regarding water sources and accommodations during the trip. This lecture will address any traveling issues. Also, these lectures will be a great way for students to include their family. Foreign travel can be a stressful experience on those staying home, therefore the lectures will be available any time during the trip for information and a detailed program description will be provided for parents before departure.

Then students will embark on a three week faculty-led study program in Ghana. They will be spending the majority of their time in Cape Coast and the capital Accra. In Cape Coast they will be working in conjunction with ProGhana. Students and faculty will be housed in a ProGhana facility and work with various NGOs to engage in service-learning projects and educational travel in the country. It is with these NGO's that students will be able to apply and incorporate aspects of community health. The specific NGO that the students will be working with is the Health Protection and Environmental Sanitation Organization (HEPENS). HEPENS is a NGO of good will founded in 2008 by registered midwife Nicholas Baidoo, with the aim of bringing health and environmental awareness to Ghanaian communities (HEPENS Organization,

n.d.). Their mission statement is: to promote relevant and current health and environmental information in the community bringing out awareness to vulnerable communities, addressing and making health delivery and information accessible and affordable to all without prejudice to tribe, sex religion etc (n.d.). These vulnerable communities include children, women, aged, and youth. They have visited 17 schools within the Cape Coast area, Central Region addressing both health and environmental issues. For the duration of a week, students will work in primary and secondary schools, developing and implementing health promotion programs appropriately designed for the participant's age. They will teach aspects of healthcare such as: sanitation, diseases: cholera, malaria, HIV/AIDS, sexually transmitted infections, and focusing on aspects of prevention with the assistance of HEPENS. For the second week they will be participating in several community outreach programs where they will hold discussions on various health issues. Students will also complete health screenings for diabetes, hypertension and HIV during the community outreach programs. The third week will be spent touring the country and observing University of Cape Coast nursing school. Students will be able to sit in on various lectures in the nursing school and observe clinical facilities. Weekends will be utilized for field trips to Elmina Castle, Cape Coast Castle, beach resorts for relaxation, and shopping. The final days will be spent in Accra for shopping and tourism.

When the students come back from Ghana they will have four weeks to complete their reflections and research papers. There will be meetings each week to review progress and discuss themes of the trip. All assignments will be due June 28th at the end of the semester.

Attracting Students

The financial burden on nursing students is extensive. With increasing tuition costs, students are finding it difficult to entertain the option of study abroad without an incentive other

than experience. With the options of students to fulfill a foreign competency and writing intensive requirement, the burden of taking another class to fulfill these requirements is reduced. Students must also be made aware of funding opportunities available to them. Students can be direct toward Wayne State University's Office of Study Abroad and Global Programs for more information on financial support.

Benefits of Study Abroad Programs

In addition to the supplied information above highlighting successful study abroad programs in Ghana, it is important to point out the educational benefits to these programs. In 1996 CeCelia R. Zorn PhD, RNC described the long-term impact of study abroad experiences on baccalaureate nursing school graduates in her study. Zorn states in the introduction of her study, "The rapid changes in our world, such as increased ethnic diversity and the recognition of nursing internationally as a vital health care resource, are demanding larger numbers and types of international education opportunities" (Zorn, 1996). Zorn utilized a non-experimental descriptive survey design to evaluate 27 research participants, all of which graduated between 1979 and 1993 with a baccalaureate degree (1996). The four dimensions participants were assessed on include: professional nurse role, international perspective, personal development, and intellectual development.

The results of the study showed a long-term impact was found in all four of the dimensions, but the strongest impact was on (1) on the enhancement of one's international perspective or global understanding and (2) on the facilitation of one's personal growth, personal decision making, and personal values and beliefs (1996). The discussion also states that findings from this research also support the impact of international education programs on the enhancement of student's personal growth, a commonly identified goal for liberal higher

education (1996). Results of the study did not show that the year the respondents participated in international education was not associated with the degree of long-term impact. Zorn summarized that programs open and available to students at all levels would be appropriate (1996). Overall active faculty and administrative efforts to make international education a reality for undergraduate nursing students are essential.

In addition to Zorn, Linda V. Walsh, PhD, CNM and Jeanne DeJoseph, PhD, CNM, FAAN explored experiences of nursing students and faculty mentors who participated in a short-term immersion learning project in Central America in their study: "I Saw it in a Different Light": International Learning Experiences in Baccalaureate Nursing Education (Walsh and DeJoseph, 2003). The purpose of the immersion project was to students to identify conceptual themes that may contribute to development of cultural competence (2003). Student's experiences were evaluated through pre immersion and post immersion semi-structured audio taped interviews. Primary data sources for the study were the interview transcriptions and student journals. The study produced the following results: (1) the students recognized they were ready to practice as professional nurses and expressed confidence in their abilities to move from the role of student to graduate (2) in the post immersion interview, students reported that recognizing this aspect of the care provider role resurrected their own sense of "calling" into nursing (3) participant's journal entries and post immersion interviews demonstrated that they did begin to view the world in a different way (2003). Overall findings from this study suggest the short-term effects of increased confidence and belief in one's abilities as a nurse are important outcomes for individuals transitioning from students to graduates (2003). It also suggested an international immersion project is associated with participants' personal growth and professional identification as nurses.

Conclusion

Regardless of its numerous plights, Ghana is an incredibly hospitable and welcoming country. Numerous universities have found success in their study abroad programs centered in Ghana. Georgia Southern University, University of Missouri, University of Michigan, and Michigan State University have all incorporated study abroad programs in Ghana centered on public health. These programs have made incredible life-long imprints in their nursing and non-nursing students. It is time that Wayne State University College of Nursing experiences what Ghana can do for its students and what its nursing students can do for Ghana. As stated by Subarna Mukherjee a former nursing student of University of Georgia at Athens who studied abroad in Ghana, “We cannot become complacent in our comfort or callused from hard work.” With an ever diversifying nation, it is nursing instructor’s duty to prepare culturally competent nurses. Incorporating a study abroad option in Ghana in the curriculum provides an excellent opportunity for nursing students to become globally aware and culturally competent.

JOURNAL REFLECTIONS**Culture Shock**

Breah Elder

Before embarking on the journey that I knew would change my life I was very apprehensive. What would it be like? Would it be something out of a Hollywood movie? Would I be so homesick that I would want to come straight back to the U.S.? All of these questions have one thing in common—I would not know until I actually got there. However, this brings up the first feat my peers and I had to persevere through, actually getting there. It seemed as though it would take forever until we actually *got* there! It was this part of the trip alone that made me so irritable that I got to a point that being home in my own bed seemed like a perfect alternative to the madness. Please do not misconstrue this sentence for an American's inability to deal with environments not suited to their liking, for there were a multitude of reasons that I felt this way.

Let's begin with the plane ride. I got sick on the first leg of the trip and was unable to sleep throughout the whole ride. Then with a 5-hour layover in Frankfurt with rude, seemingly pretentious airport staff taking my backpack a part for twenty minutes, this of course did not help. With my sore throat and congested nose I began the second leg of the trip to Accra. I sat on that Lufthansa plane and watched the "Air show" for at least three hours! I could not wait to arrive. Then we finally did, with a seemingly smooth customs experience, we were finally here! Then the bomb dropped. We would all have to get on a very stuffy bus for an additional four hours of traveling *just* to get to Cape Coast. My heart dropped and my mind was fuming! Reflecting on this trip now I would say my biggest irritation was the excessive amounts of time we spent on the road in that sweaty bus. It was hot, compressed, and downright smelly (although that may have been due to us given that we had all traveled more than 20 hours at this point).

However it was during this miserable bus ride that I actually began to relax. I sat at a window, and my eyes never left that window for the duration of the bus ride to our hotel in Abura. During the bus ride I saw hundreds of people; I saw women, children, men, elderly people, and probably the most daunting of them all—terribly ill people. Women and men walked around with baskets on their heads filled with a plethora of things ranging from fried plantain chips to sunglasses to cell phones. Their posture as they walked, with everything you could imagine on their heads, was regal-like. I was in complete awe and despite my utter exhaustion I could not shut my eyes! It was a whole new world and I was taking so many mental photos so that when I returned from what I knew to be too short of a trip, I would remember all that I saw. There was one particular image that will never leave me. Quite often during our bumpy, heavily trafficked ride, Ghanaians would approach our windows attempting to sell us various products. However in this sea of merchants one man caught my eye; and reflecting on that now I am not even sure how he did given that he was crouched on the ground and moving like a crab. I was in awe by him! Dr. Montgomery also noticed this gentleman and solemnly explained that he suffers from polio. My brain registered this information and quickly remembered that this is a disease that can lead to nerve damage that ultimately paralysis, which seemed to be the case for this man. The lack of control this poor man had over his body burnt me up. In the U.S. the polio vaccine is very easy to obtain and it is mandated by law that all children be vaccinated as infants for it. It was this image as well as many others that I will certainly carry with me for the rest of my life. Ultimately your life is determined by one thing—where in this world you are born. I am so fortunate to have been born in the United States and to a wonderful family. I would soon learn that despite the struggles Ghanaians face every day they are some of the happiest, most gracious people I would ever have the pleasure of knowing.

Before setting out on this trip, Dr. Montgomery urged us to understand that things here would be very different from what we were used to! He pleaded with us to have an open mind for if we did not there was no sense in even coming. That was one promise I made to myself before embarking on this. To stay away from judgment and instead do my best to embrace the culture as best as I possibly could. What I did not foresee were the many instances in which I would have to take a step back and remember: “This is Africa”.

Hospitality and Civility

Hind Fakourhy

When we first arrived in Ghana, I had no idea what to expect, and that made the whole thing so much more exciting. Every culture has a spectrum of personalities and such, but the Ghanaians overall were the most kind and the most hospitable people I had ever met in my life. The hotel staff was just that, and everyone from HALP was respectful and kind. We did run into a few uncomfortable situations here and there as girls that stood out, but overall I think it was ok. I am the kind of person that won't put myself out there and risk anything on purpose, but I find it important to soak in every experience whether positive or negative, because I feel it makes me more humble, and I learn from these situations. The “Choosing Civility” book by Forni was a light and interesting read. I felt that one can learn a lot about the way we go about treating others, and not take things like waiting for everyone to eat, and being on time for granted because those are all signs of respect, and if you notice people do that for you, you should do the same in return. The culture of the Ghanaian is so rich and so beautiful. We saw everything from poverty to richness, and I think the poverty was more intriguing than the richness in all honesty. It's the way the Ghanaians work together to survive, and stick together to help each other out no matter what the need, and no matter what they have or don't have. After returning from Africa, I really

changed myself and my perception of what really matters in life. Their personalities were also very unique, just with HALP we saw two extremes, Ben was shy and introverted, and Immanuel was loud and out there. I think each one of the Ghanaians that we interacted with, children, adults, and the elderly all were so unique, but they were all the kindest people I had ever met. The compliments we all got, the taking care of us, everything was so great. Also, I loved how they shook hands, how they held your hand when they were talking to you, asking you of your name and where you are from and how everything is going. I also really loved the GMT, Ghana maybe time was so cool to have to adjust to, even though in the Forni text, we read how important it was to be on time and punctual, the fact that Ghana had GMT just made their culture even more unique. I really cannot describe in words alone how I felt about their culture and each personality we encountered because that is something I think I will forever hold on to with me, and I think all of us share that same feeling together. I can say however, that this one trip alone that I went to Ghana really changed who I am and really opened my eyes and let me enjoy a culture and learn about a culture that I never had encountered to raw and so real like that before, and you have no idea the joy I got out of it, so to you Dr. Montgomery, and George and Nancy, I am seriously forever grateful!

Experiencing a Vodun Ceremony

Samantha Kaufman

Boom, Boom, Boom! Boom, Boom, Boom! The pounding of the drums began, suddenly and strongly starting up above the babble of the crowd and exploding through the warm night air. Was this the drummers practicing again, or were they really starting the ceremony? Yes, it's not stopping. This must be it! The rhythmic cacophony of drums blasted out from the group of

drummers next to me as the young men played tempos of deeply layered rhythms of vibrations that echoed in the center of my chest. The beginning of the drumming seemed to make the dark and magical scene before me become even more dark as people holding flashlights and lanterns cleared from the center of the area in front of me, leaving the scene to be lit by only a few yellowish electric sources of light, the stars peaking through the palm roof above us, and the spastic camera flashes whose random appearances were in sharp contrast to the regular beat of the drums.

Finally, I had a scene before me set for a Gorovodu ritual, not only serving as the physical location for what was about to take place but also serving as the new backdrop in my mind for my understanding of vodu rituals. Up until this point, the visual images built up in my head were entirely imagined – based off of firsthand accounts from Dr. Montgomery and descriptions from Judy Rosenthal. My understanding of Gorovodu was entirely academic and ideas about what it was, what it looked like, and how it actually felt were merely wisps of speculation. As I watched more and more of the ceremony, things began to click into recognition, and objects and actions that I had known as fragments were brought into the real world as pieces of one unified whole.

Brekete had at once taken a new identity in my mind as the strong beats showed me how repetitive, overlapping rhythm brought continuous energy to the scene like I couldn't imagine. The dancing, too, was different from what I expected, with the motions being softer and more graceful than what my mind would have matched with the powerful drums. But perhaps the most enlightening of all was when, after hours of drumming, chanting, and clapping into the night, a man began to go into trance. I had been watching him, sitting on the edge of the circle quietly with his eyes closed, as sweat dripped down his head and women around him kept getting up to

dance their way across the dust and back. Then, he burst forth shouting in a high-pitched, raspy voice, and seemed to sway on the spot as if dazed. In a moment, he continued on, moving in unpredictable ways and crouching down with frantic motions to a woman, who must have been a *senterua*, to pour water on his head.

Despite all of this, I still was unsure exactly what I was seeing. I had expected to see strange behavior if I was fortunate enough to see trance, but I suppose I had a lot of different expectations for what a *trosi* would do. First of all, I had expected trance to include costuming, as Rosenthal had noted what colors different *gorovodus* preferred while controlling their hosts. I also expected, perhaps foolishly, that *gorovodus* would speak much more through their hosts than what I saw, as if those in trance would turn to people around the circle and tell them some piece of advice or warning from the gods. I also had anticipated not being personally able to identify the visiting deity; after all of the different descriptions presented by Rosenthal I was ready to throw in the towel when it came to remembering which *Gorovodus* tended to act one way and which ones acted another way in a system where every identity seemed to overlap with another. But the use of water and crouching on the ground gave it away for me, and I was delighted later when Dr. Montgomery confirmed my prediction that the visiting *tro* had been Nana Wango, the crocodile spirit. By witnessing the vodu ceremony, I now understand much more of what it means when someone is in trance, and appreciate what a powerful experience it must be for those who go through it and for those who regularly witness the presence of visiting spirits.

All in all, this glimpse of a *Gorovodu* ceremony was the crowning gem of participant observation of my experiences in Ghana. I was able to experience an insider's view of a *Gorovodu* ceremony that very few people are fortunate enough to see without spending years in

the field. From an anthropologic point of view, I was given the opportunity to witness how the Ewe people practice religion and a chance to begin developing my own emic point of view. Although my experiences are still too limited for me to claim a complete understanding, I can now see how Ewe people use trance as a way to “become the other” and in doing so turn themselves over to the unpredictable nature of the northern spirits that they both love and revere. I also have a new appreciation for the sheer psychological changes that occur in an individual during trance, and I would like to better understand this phenomenon that transcends boundaries of the self and is able to flip usual dichotomies such as male/female, old/young, and slave/master.

However, my experiences from witnessing this ceremony and from the entire trip go deeper than just provoking a sense of academic curiosity that can be contained within a label like anthropology. I learned lessons about myself and other human beings that shaped my mind far beyond the simple learning of facts or rephrasing of ideas. For me, getting to know the Fante and Ewe people was an adventure that allowed my mind to wander down ways of thinking that are valued by other cultures, and in doing so I gained a deep appreciation for the diversity of cultural mindsets that exist in the world. I also developed an ability to think beyond my own cultural framework so that I could consider the validity of foreign ideas without needing to force them into my own thought constraints. Gorovodu is a prime example of this as I can now accept that Gorovodu need not prescribe to the scientific scrutinizes or religious ideologies of western thought for it to be just as real as any western institution.

Finally, I now realize the huge necessity for people around the world to get to know one another as our group has begun to get to know the Ghanaian people. Global peace depends on humanity seeing the world as a global community and developing an understanding and respect

of other cultures rather than a fear of their differences. Overall, the opportunity to expand my understanding into the realm of Gorovodu and other aspects of Ghanaian culture allowed me to expand my own self into a more open, thoughtful, and informed human being, and I would encourage all other American students to embrace the world and see how exploring other cultures can widen the limits of perception and identity.

Medical Anthropology

Saira Khan

Human Health Care. Three simple words with so many implications. **Care** implies considering an individual's vulnerable state, and providing aid-whether it be in the form of compassion, empathy, advice or medicine. To effectively describe what **health** is, one must put on a cultural relativity lens, and more importantly, they must be ready to face the hard facts: to one, health can be defined as being free from sickness or disease, to another it may describe physical, mental and emotional wellbeing, whereas to another, it may simply include the blessed day when a mother managed to scrape up a bowl of food to feed their starving baby. A general truth: humans are liable to facing illness. But that will come later. **Human**. The term seems to be rather self-explanatory. But explain to me this: how is it possible that millions of these "humans" are grouped together as mere numbers. Why do we not know their names? How it is these numbers are herded together as if they are animals. Why is it that these "nobodies" rarely considered human when it comes to human healthcare? Human health care: supposedly a human right.

A universal truth: human race tends to get sick and fall ill. Despite the countless treatments discovered and medications produced, diseases and sickness continue to evolve and become an issue of concern. This is something that is not going to change. There is a high need for

individuals to understand the factors that contribute to disease and sickness. Our world needs to establish a thorough understanding of medical anthropology and rid itself of the ignorance, naive mindset or lack of awareness that we have grown accustomed to. Medical health is affected by countless variables. Human development is dependent on the freedom from sickness and freedom from sickness is dependent on access to health care, which depends on human development. To put it simply, “disease must be understood as being as much social as it is biological” (Baer, Singer, Susser 6). Disease must be seen as more than parasites or viruses. One must be able to understand the exploitation, social warfare, and the powerlessness and helplessness that cause the disease. This type of sickness has and continues to plague communities, as “the body also serves as a cognitive map of natural, supernatural, sociocultural, and spatial relations” (Baer, Singer, Susser 6).

A basic knowledge in medical anthropology is necessary to understand the extreme suffering that is prevalent in the world. Suffering in itself is an extremely difficult and intangible thing to define. It is difficult to compare suffering taking place in the ER to the premature and painful illnesses or suffering originating from torture or even rape. Human suffering can be caused by social factors including gender, ethnicity or due to socioeconomic factors. It is difficult, even impossible to isolate social issues due to geographic, political and economic issues. However, what can be concluded is that extreme human suffering is more endured by those living in poverty. Along with human suffering these individuals experience increased amounts of immeasurable pain. It is crucial for us to try to begin to understand this unexplainable realm of suffering.

Human suffering can be explained with syndemics, “which is a set of intertwined and mutually enhancing epidemics developed and sustained in a community because of harmful social

conditions and injurious social relationships” (Baer, Singer, Susser 17). For example, if HIV and Mycobacterium tuberculosis are present in the same population, there is a higher risk for individuals to be co-infected. There is a deadly consequence of co-infected individuals where they have a reduced survival time. Additionally, this creates a catalyst where individuals who are HIV positive will develop active and rapidly revolutionizing tuberculosis compared to those who are HIV negative due to a decreased immune response. (16) This disease interaction has led to an enhanced, undefeatable sickness. Adding onto the epidemic is the mere epidemic named poverty. Poverty and discrimination leave the poor inaccessible to diagnosis and available treatments for TB. Economic and social crises prevent the individual to have a cure for their sickness. Worse, the transmission of these diseases spread and impacts countless individuals within the community.

Another danger to health is malnutrition. “The Bread for the World Institute estimates that over 800 million people in developing countries are chronically malnourished and that at least half of the 31,000 children under five years of age who die every day in the world are victims of hunger-related causes” (17). Nutrient deficiencies will lead to compromised immune systems, which provide easy access to viruses and other pathogens. Lack of nutrition can lead to heart disease, which can cause severe problems in an individual’s lifestyle. One does not need to look far to see the affects of malnutrition. In our own backyards in Detroit there are thousands of individuals who are paralyzed in their socio-economic situation due to their health. Without properly acquiring the proper nutrients, one is incapable of generating enough energy to fight for another day. The vicious cycle continues. In fact, the World Health Organization recognizes that poverty is the world’s greatest killer: “Poverty wields its destructive influence at every stage of human

life, from the moment of conception to the grave. It conspires with the most dead and painful diseases to bring a wretched existence to those who suffer from it” (Farmer 50).

While medical anthropology is a huge area of knowledge, I have realized how crucial it is to develop an understanding of medical anthropology to better establish relationships between any patients that I may have. In order to deliver better medical care, I need to understand my patient’s perceptions of illness and disease. I need to understand their personal reaction to the sickness I am about to diagnose them with. In order to guide my patients to change their behaviors to maintain a healthy life style, it is necessary for me to have an awareness of the importance of their culture and their social background. One must be sensitive to a patient’s individual pain and human suffering. Public health is a social practice, and in order to effectively do justice to the profession, one must understand the social implications on the health of his patients.

International Volunteering

Ashley Joseph

Our service and medical anthropology trip to Ghana has been a life-changing and transformative experience. Our group of almost twenty Wayne State University students and faculty travelled to this region of Africa for an international volunteering and learning opportunity in hopes that we would not only contribute to the wellbeing of Ghanaians, but also gain a deeper understanding of health practices outside of America. For this journal, I will be reflecting on the theme of international volunteering, our impact on the Ghanaian population, and the effect the trip had on me.

I felt very privileged to be giving my time for the benefit of others in Ghana. It makes me realize that different people help in different ways. Many students take part in local volunteering, others write a check, and other people donate their time through overseas volunteering. Margaret Mead once said "Never underestimate the ability of a small group of committed individuals to change the world...Indeed; they are the only ones who ever have". Everyone has the capacity to impact the world in their own way. We are a small group of Wayne State University faculty and students and we will definitely impact the lives we encounter in Ghana.

In Choosing Civility, P.M. Forni emphasizes the importance of kindness and consideration in our daily interactions with each other. In essence, this is what international volunteering entails. Many people travel abroad with the desire to make a difference in an underserved area of the world. One's heart must be full of kindness and compassion in order to leave their comfort zones and enter a new place where adjustments and compromises might have to be made. Whether volunteers are teaching in schools, establishing health clinics, or doing construction, the goal of the project is to contribute to the wellbeing of the native people. That is demonstrating kindness and compassion.

On several days throughout the trip, we had the opportunity to travel to various schools in the Cape Coast region of Ghana and teach about relevant health care topics. Providing health education to this community was a vital aspect of our trip. We taught classes ranging from 20 students to over 300. It was a very beneficial experience, not only for the students, but also for us as future health care leaders. I hoped that the lessons we taught about topics such as sanitation, hygiene, sexual education, and substance abuse resonated with the students. It is ideal that the students take what they learned, apply it to their own lives, and spread the word to their friends

and family. We also had the opportunity to volunteer our time in constructing a library, which was a very rewarding experience.

Forni also notes that civility has to do with courtesy, politeness and ethics. As I mentioned above, international volunteering entails new environments and circumstances that the volunteer may not be used to. In Ghana, I felt like we were in a whole new world. The environment, climate, living conditions and culture were very different than in North America. There were so many different cultural nuances to learn about. For example, doing anything with the left hand is considered rude in Ghanaian culture. It is important to remember to shake hands, wave, or pass money only with the right hand. Also, it is important to greet others and be open to speaking to complete strangers. Although this may seem strange to foreigners, it is a part of Ghanaian culture that we, as guests in this country, should respect. This is a vital aspect of considerate conduct. We need to act upon the realization that the quality of our lives depends on our ability to relate and connect to people. This establishes relationships based on respect, consideration and kindness. The people we encountered in Ghana – volunteers from other areas of the world, the people we served, individuals that took care of us – have in some way, small or large, impacted our lives. We, in turn, have also impacted theirs.

Slavery

Douglas Mack

Slavery is one of the horrors of the human world. Taking another human being and stripping them from their rights in the way that so many countries did to Africa is wrong and disturbing, to say the least. It is without a doubt that slavery, which occurred so long ago in Africa's past, is still affecting them today. Through development, culture, and religion slavery has shaped Africa, and it uniquely affected western costal countries like Ghana which

participated in the slave trade, though not to the same degree, with the outside enslaving nations. Rosenthal goes into great depth to describe the Gorovodu religious order in Ghana. A religious order which devotes its worship to the slave spirits of the North which they themselves “enslaved.” Yes, Africa’s inclusive people have indeed had encountered much strife in surfacing to the new world, but there are those who are trying to help, and there are those who are trying to exploit a people that to this day have been looked down upon as a lesser group.

Within my short time in Ghana, Africa, I had the opportunity to see a slave castle, and to walk the final path many slaves would take before being confined to a slave trading post and shipped to other parts of the world. Both places offered much to internalize, as we could only picture in our minds what terrible things must have happened in the very spots in which we stood, years ago. Now, years later, what does Ghana have to show for all of the suffering that went on behind the walls of the castle, and in the forest being lead by chain and whip? Poverty and anguish is everywhere as street merchants were constantly asking for attention and help while I was there. However, there is one other thing that has come out of all the ciaos, and that is religion. Gorovodu ceremonies involve fetishes, priests, music, dancing, anyone who would like to join, and trance. Trance is when someone willingly becomes taken over by a northern slave spirit. When this possession occurs, that person has the influence of a god, as the Gorovodu people see the northerners, who died as slaves under the rule of the south, as unhappy god like spirits, who need to be appeased and asked for forgiveness from because of their terrible past. The trance that the natives may fall into can lead to many different things from advice and prophecies, to dancing and asking for particular rhythms. Sometimes when in trance, the person(s) will perform a kind of mimicry of the past, reenacting times of slavery to pass the memory and knowledge of what happened so that a culture with no written language could still

pass the stories to succeeding generations. It is these people's way of paying tribute to the people they wronged in the past, and trying to make it right in the present.

Obviously, other countries that partook in slavery over the years do not center their lives on what they did in the past, but are they even attempting to help fix a problem they created. When slavery occurred, everyone with healthy working ability was taken, meaning the old and the very young were left behind to advance Africa over the years following slavery; undoubtedly, doing so must have had large impact on economic, political, and physical development in Africa. Not only this, but due to the psychological mindset countries installed in Africans – White people are superior, they are your masters – many problems in Africa are happening even to this day. Large outside industries own large plots of land in Africa, like over cocoa fields which take the fruits of Africa, export them out of the country to be manufactured, and then imported back to be sold to the African people from which it came. Why is Africa allowing this to occur? The answer could be because the African people feel that they couldn't say "no" to "higher people." I am not saying that countries that participated in the slave trade are doing nothing in the present to help Africa – in fact, Nicolas van de Walle writes that America has increased political support for Africa from 2.5 billion to 7.5 billion dollars between 2000 and 2007 (8) – I am saying that I am not so sure the good America and other countries are doing in Africa, out-way the bad.

Going to Ghana and seeing what slavery has done to their country has made me reflect on how I view African Americans and other dark skinned people as well. Growing up in a white suburbia, I did not know too many African Americans growing up. However, in my opinion I did not view black people in any stereotypical or negative light until I began to get to know more people and more African Americans. Unfortunately, while in high school I never saw any of our

few black students really succeed academically, I witnessed a lot of immature behavior come from them, and on a wrestling team, it never seemed like they would try very hard in practice. All of these reinforced stereotypes of course are caused cumulative causation: lower economic class → more distractions at home → not as motivated to perform → People like myself see an under motivated people and begin to stereotype → African Americans grow up feeling inferior and thus more likely to contribute less to society → and back to the beginning. I often thought about this in high school and in college, but it is hard to shake a stereotype. However, going to Ghana definitely helped me blur the line between black and white. When one is submerged in a culture where ones race is not dominant it surely opens almost everyone's eyes to untrue stereotypes. I did not see many lazy people without a drive while in Africa, and I think it did a lot to break my own personal prejudices. I just need to be careful to not start to think, "Oh, it's only black people in America that..." and restart the process.

Slavery is a terrible mark on mankind's record, but we can remember the past, and work in the present to make a brighter future for ourselves. There is a lot Americans can learn from the dark days of slavery, and as long as we remember the history we can become one united world.

The Beginning of My Mimesis

Michael Michayluk

One of the most memorable passages from Rosenthal's *Possession, Ecstasy, and Law in Ewe Voodoo* comes in Chapter 5, "Parasites and Hosts". Here Rosenthal lets her "moral imagination" run wild as she contemplates what could happen if Americans could become

“mimetically capacious” and slaves were worshipped and divinized as the romantic foreign other. She states,

“What if descendants of both slave owners and slaves could become for a moment, those slaves, empowered and divinized, with African languages glossing their tongues, and the steps of ancestral dances enlivening their bodies the way Ewe, through trance, become their ancestor’s slaves from the north?

What if European Americans as well as African Americans (and all the other Americans) could become “mimetically capacious” (Tausig 1993) in this context? The slaves would come back to heal their descendants and the descendants of the slave owners and to cyclically receive payments for ancient debt, for lives and labor spent in the service of the white people. The African slave spirits would be the beloved stranger gods (although their own descendants are no longer foreign but also hosts); the descendants on both sides would be host-worshippers. The hospitality would be sacred and reciprocal, a seasonal remarking of history that cannot be undone but that must also be commemorated with full honors, gratitude, and eloquence. It would also be a request on the part of the white people generation after generation, to be forgiven for having inflicted the unhealable wound of slavery- not a request for this unspeakable injustice to be forgotten....Yet this commemoration would also be a reemphasis of the profound differences between cultures and peoples that can never be, and should never be effaced” (Rosenthal 154-155)

Surely this vision of Rosenthal’s will not be seen on America’s horizon any time soon but she made me think, what if it did? Would racial tension still be so prevalent? Would it change the way the way whites look at Africans as spear-chucking savages and African-Americans as

gun-toting savages? Such questions are impossible to answer, but in my own beginnings of mimesis in Ghana (walking the path at Assin Manso, witnessing Elmina castle and hearing about the unimaginable horrors perpetrated, witnessing the power and intelligence of nature at Taipa, and seeing Gorovodu festival) my view of Africans and African Americans has certainly been altered.

Let me begin by reinforcing that not only is America far from becoming mimetically capacious, but is currently the polar opposite. In my experience growing up in rural Michigan, living in Detroit, and traveling around this large nation, many truly would have slavery be forgotten (Many I fear might even want it reinstated). They scoff at any idea of reparations, as those silly blacks must only want more welfare and are too lazy to work for it (quite ironic as it was the slaves sweat and blood the provided the foundation for this country's wealth and European wealth around the globe). Instead of commemorating slavery with profound festival and asking for forgiveness as Rosenthal dreams above, many instead commemorate the "unspeakable injustice" with a good ol' confederate flag flying out their window or displayed for everyone to see on the back of their gas-guzzling trucks. "I didn't enslave anyone," they say. Why can't they just forget about it already? Do they know that those flags which might symbolize rebellion and family history also symbolize one of the greatest injustices humanity has ever seen. How can there be any pride in that?

A couple weeks ago, I was home for a graduation party of a close friend. It was a beautiful summer day and I was having a conversation with a teenager from Atlanta, Georgia (my friend's cousin) when he said, "Wow! I wish I lived up here in Michigan, I live next to a bunch of black people." My jaw dropped as he said this phrase so nonchalantly. "So do I," I said. "I live in Detroit, what the hell is wrong with living next to black people?"

“Oh, nothing,” he said, sensing my rising anger, “It’s just how I was raised.” The rest of the conversation consisted of me yelling at this poor kid while my friend shrugged his shoulders at me.

When I made the decision to come to Wayne State University and live on campus, I can’t tell you how many people in Holly, Michigan seemed legitimately concerned for my safety. After all, Detroit is a Black city. “It’s safe down there?” they would ask. “Try not to get shot,” they would jest.

My personal view of blacks before the expedition to Ghana was the same as my view of all races and ethnicities, generalizations will get you nowhere. You can say blacks are this and whites are that but in the end there will always be individual people that break whatever mold you have constructed for whatever particular ethnicity. This is not to say I don’t carry my own prejudices and generalizations no matter how objectively I try to look, because certainly I do. (The previous two paragraphs are full of generalizations talking about whites). I don’t, however, let these generalizations create a false hierarchy of human species.

Beginning my mimesis in Africa did not change this part of my view about Africans and African-Americans and I’m not sure that anything can. But what I did start to realize is just how much Americans, as a former European colony, owe to these people who have been continually exploited by us for centuries and continue to be this day. The funny thing is I have known this fact my entire life. I have known about the Atlantic Slave trade, but it did not really sink in until I walked barefoot through the bush at Assin Manso and smelled the raw brutality and inhumanity of Dutch slave traders at Elmina Castle. I have known of the exploitation of Africa’s vast natural resources and but it did not sink in until we visited the farm at Taipa. I have known about the iron fist of colonialism, and its relentless unwavering attempts to stomp out every last bit of

indigenous culture, but it did not sink in until we began to witness the power of *Gorovodu* in Tema. Because of this, I can now sympathize a lot more with Rosenthal's dream of mimetic capacity for Americans.

This is not to say I necessarily think Americans should start making fetishes and worshipping the slave spirits to which we are eternally in debt, and this in fact is impossible. Rosenthal said it best when she states there indeed are differences in cultures and peoples, "that can never be, and should never be effaced". What I do think is that we are indeed eternally in debt and we damn well better remember it.

Moral Dilemmas and Vicious Cycles

Rashmi Patil

As I've witnessed on numerous occasions throughout my lifetime, people do what they can to survive, but desperation can lead to abandonment of even dear values. Desperate times do, indeed, lead to desperate measures. This is not unique to third world countries, or the United States; it is a nearly universal ideal. As I saw in Ghana, parents are often forced to lend their own children to the evils of child labor. Time and time again, I found myself wondering—in a life such as this, where does one draw the line? While teaching on the topic of teenage pregnancy at Ntranoah Junior High School in Cape Coast, one young woman posed a 'hypothetical' situation that I suspect may have consisted of more truth than she was letting on: What is a girl to do if her mother is terribly ill and the family does not have enough money to take her to the hospital, but the girl is approached by an older man and offered money in exchange for sex? Posed with this 'hypothetical' question, I don't think I have ever felt more inadequate in my entire life. I knew I was unqualified to be standing up there; after all, what I had I ever experienced, that would even come *close* to the appalling situation she had just

described? How do I even relate? What do I tell this girl? Do I tell her that her body is too precious, and that she should make money another way? The next question is inevitably—How? This was not the first, and definitely not the only time I felt completely helpless while in Ghana. There is an entire world out there full of evils that I know next to nothing about. Hearing their stories and seeing it all around me surely allowed me to gain perspective, but it also seared a burning question into my mind: *What can I do?* This question I am still frantically attempting to find the answer to.

Simply traversing the streets of Ghana quickly showed me that child labor is still a common practice in this nation. We were often faced with a dilemma—if we buy whatever it is the children are offering, we are merely perpetuating the cycle, since success will only prompt their superiors to send them out onto the streets again. However, turning away these children is easier said than done, as they look up at you with their big wondrous eyes, just waiting. If I don't buy the plantain chips from him, will he eat tonight? Perhaps not, but if we keep him in business, he will never be sent to school where a child his age belongs. Many take one look at these kids and shell over some cash. And so—the vicious cycle is perpetuated. The kids continue to prove themselves, and all the while, rid themselves of any chance for a bright future. It is as if every immediate success is pecking away at any chance for long-term success.

As an American, I have always taken for granted the chance for upward mobility. For many Ghanaians, rising in the ranks is simply impossible. It is not a matter of how hard they work, or how long they work; some dreams are forever out of reach. In the U.S., *we* are the primary determinants of how far we get in life. Sure, some dreams are simply unattainable, and some are just plain ridiculous. Not everyone can become the president, or go into outer space. But for the most part, we are the sealers of our own fates. Here I was, in a place where people

can seldom control how their lives turn out, and hard work does not always pay off. Needless to say, it was a much-needed reality check. With all that I am given, especially seemingly boundless chances for upward mobility, my drive to become somebody is intensified. The Ghanaians reminded me that opportunity should never be taken for granted, for it is a precious commodity that not everyone can come by. Ignorance may be bliss, but it sure isn't helping anyone. With the opportunities to engender change and the wisdom to know I have them, I vow to not allow these chances to go to waste.

As for Isaac and Isaac, and the thousands of other child laborers in Ghana and in the world, I know that happy endings are unlikely. We come from a society that thrives on fairy-tale endings. All the stories of struggles we are told end in ultimate reward. I have come to realize that this is a very American notion. Effort and reward are *not* linearly related, and will not be in Ghana until a major reform is engendered. I have seen Ghanaians working ten times harder than me, who will probably never experience one-tenth of the comfort or stability or simple peace of mind that I experience. Knowing this, I look to find small ways I can help out in, however inconsequential they may be.

Perception of Blacks

Carolyn Reimann

Black, a term used to classify a group of people based on their skin color. Yet skin color does not give an insight into a culture of people. In Detroit Blacks, African Americans to be politically correct are commonly associated with poverty. Ghanaian Blacks, true Africans, are also associated with poverty, yet this poverty is on an entirely different level.

Poverty in Africa is everywhere, much like it is in Detroit. Yet the difference between Africa and Detroit is the diversity in economic standing. Needless to say there are spreads between financial classes in Ghana, but it is not to the extreme of that which is present in Detroit. Another thing to consider is in Ghana there may be difference in wealth based on cultures, but in Detroit it is based on skin color as in black vs. white when it comes to poverty. The population of Detroit is around 85 percent black and 9 percent white. Of those whites only 5.9 percent are considered under the poverty line, while 24 percent of the black population falls into that category (Galster). Due to this poverty separation based on skin color in Detroit, many come to associate poverty with a specific race. In Ghana we weren't able to look at a person's skin color and determine if they were likely to be considered poor in their community.

Unfortunately with Detroit continuously being at the top of much publication's Most Dangerous Cities list, it adds to a negative connotation for the Black population in the city. According to Megan Wolfram in Forbe's 2009 publication of America's Most Dangerous Cities list, "Detroit has, historically, been one of the more violent cities in the U.S." (Greenburg). Not only has Detroit been declared one of the most dangerous cities in the United States, it has also been placed on the list of most dangerous cities in the World. This past month The Urban Titan site ranked Detroit as the 3rd most dangerous city in the world (Titan). This list places Detroit before Baghdad in Iraq as being more dangerous. The association with being a dangerous city and having the majority of the population Black leads to the stereotype of Black's in Detroit as dangerous.

A comment that was used multiple times on the trip went along the lines of "no matter how poor you are here, you will never go hungry." This was meant to show the great variety of fruits and food that was accessible to everyone. An example was coconuts from coconut trees

that were found in the villages as well as the beach shore. All it took was a climb to the top of one of those trees and food was provided. Even though it is not nutritious for an individual to live off of coconut for their diet when you compare that to what is available to the poor and hungry in Detroit, it is very different. In Detroit the hungry are holding signs and begging on the side of the road for food or money for food. In Ghana this was not seen. We would have some children ask us for money, but it wasn't because they were necessarily starving, as foreigners we are associated with wealth and the children just wanted to see if we would give them anything in return to their askings.

I believe that my somewhat negative view of Blacks from Detroit was centralized around the poverty that they were associated with. Growing up I had associated the black population with the dangers of Detroit; poverty, crimes, drug and alcohol abuse. The poverty is different between the Blacks of Detroit and Ghana, which directly impacts our perceptions of them.

Health- A Human Right for All, Not a Privilege of the Few

Nichole Siegner

Our Declaration of Independence famously proclaims, “that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the Pursuit of Happiness.” Throughout our history, human rights have been denied, granted, taken away, and established. What distinguishes something as a human right that belongs to all, not a privilege of the few? What makes it something all people hold from birth rather than an advantage earned in time?

Currently, especially with talk of and debates over “Obamacare” (Affordable Care Act), people are wondering if health care should be an established human right that should be assured

to all. With all the traveling I have done, I have witnessed severe poverty and suffering and the consequences they bring. There are living conditions that are appalling and should not have to be tolerated by anyone. People should not be going hungry when there is plenty of food in the world. We need to set our standards of living way higher and ensure that every single human being gets the care he or she needs.

With hopes of becoming a doctor, I understand that everyone deserves to treatment and medicine when ill. You should not have to choose between feeding your family and paying for your medical expenses. With unemployment so high in the U.S. families are fighting to provide for their families. People are drowning in debt with no guarantee of a good life. The “Pursuit of happiness” has not proved successful. I do not know of any solution and I know there is no quick or easy solution, but it sometimes feels as though people are not doing the obvious by trying to help others. We must never settle into a comfortable life without devoting our lives to service to others.

The socioeconomic gap of the world is far too wide. The richest of the rich should not hold more wealth than the rest of the world’s population. This country tends to give the rich far too much power without regulation or consequence. The poor are entitled to just as much health care as the rich, and no amount of money should be able to buy a better form of health care. The fact that 100% of American, no, world citizens do not have health care is an outrage and people should be outraged. Why do we not protest and demand it of our governments. We should not rest until every single human has the right of health care coverage.

Herbal medicines in Ghana were so cheap and seemingly readily available. We need to tap into these potentially beneficial, affordable forms of treatment. We also need to focus more

on prevention rather than treatment. This would obviously decrease health care costs and allow us to focus more on preventative care and cures.

"Socialist" has such a negative connotation that it is usually thrown around as an insult. Why is it such a bad thing if everyone is taken care of and treated as true equals? America needs to wake up, get some energy, and finally start taking care of its people: better working conditions, universal health care, guaranteed rights to everyone. Is this too much to ask of our country? With the "Bill of Rights" America, in its youth, felt it imperative to have in writing certain rights guaranteed to all American citizens. Also, universal human rights have been determined. Sadly enough some world citizens are not granted them or even know they deserve them. I honestly do not know why the condition of "poor" even exists. Call me a Marxist or a Socialist, but how can we live another second whilst other people are living in agony and misery? It is unacceptable. Did we not learn to share in kindergarten? "From each according to his ability, to each according to his need."

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