A Journey of Hope: Discovering Ties Between Health and Education in Atorkor, Ghana

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A Quest

As I inhale the salty sea breeze on a typically slow morning on my way back to our compound, I am not surprised that one of the few children I see is Zara. Everyone else is in school at this time. Zara avoids eye contact with me once again as I ask her why she is not in school today. Unlike her older sister Ruth, Zara dislikes school, and would much rather stay home and help out her grandmother. Though the family would prefer if Zara went to school, since she is never forced to attend, she often just stays home. As a result, she is about three grade levels behind her peers. At her young age of eight, she shows no zeal for wisdom, nor motivation or desire to learn.

The more time I spent in Atorkor, the more curious I became about how situations like this arose – how a disinterest in education among the younger population could somehow become so commonplace in a society. By teaching health to elementary and high school students and working at the medical center in the village, I sought to learn more about key development issues in the community, specifically relating to health and education. On a journey to explore underlying educational and health care disparities in the village, I slowly realized that the complexity of these issues stemmed from far beyond the work of one non-profit, but was rather deeply rooted in country-level lack of resources.

Finding Purpose

Before leaving for Ghana, I had a certain experience in mind. Though I was not completely mentally prepared for the journey ahead, I thought I was ready enough. I took a leap of faith by going to Ghana, by leaving my friends and family behind for the summer, to join a new community and become accustomed to an unfamiliar culture. Of course I was scared, but I guess there is no better way to get over one’s fears than to dive into the intimidating situation in an attempt to quell the built-up anxiety. My interests lie within the realms of global health, social policy, public health, and education, and I wanted to simultaneously pursue those interests while abroad in Ghana. I sought to work with Atorkor Development Foundation, a non-governmental organization based in the Volta Region of Ghana, that aims to transform the impoverished village of Atorkor into a self-sustaining community by providing the villagers with a basic school, vocational school and medical center to enhance educational and medical conditions.

As a university student studying public health and aspiring to apply to dental school in less than a year, I am extremely interested in studying health conditions through a global lens and exploring new and innovative ways to combat health care disparities and inequities. I wanted to learn about how to be resourceful and work efficiently and effectively with the resources with which I was presented. I went to Ghana to teach, but more importantly, to learn. Growing up in the United States all my life, I sometimes take for granted the health care access that I have, and through traveling to different nations, I have seen firsthand the different health conditions. Inadequate access to health care services is a major issue in
low-income countries, and even in many areas of higher-income countries such as the U.S. By going to Ghana, I hoped to gain an inside look at how health care is accessed and delivered, and why some subpar health services exist in communities like Atorkor, Ghana.

Finding a New Place
Arriving at the airport in Ghana, I was thankful that I had made it to my destination safely. As relief flooded my body, I tried not to stand out as an American as I went through customs, though this was hard to do while holding an American passport in my hand. I liked the fact that I blended in. This made things for me a lot easier. As I started leaving to wait for my ride, I soon saw Nathaniel and Dahlia, my supervisors for this internship, waiting for me right outside. I tried to seem enthusiastic and happy to see them, but nevertheless, I think they could still see the fatigue written all over my face.

Everywhere smelled like dirt, and I loved it. It was a familiar smell, of not ordinary dirt, but Earth. Soil. Rebirth. Hard work. Happiness. It was almost as if I had been there before. I looked like I could be from Ghana; I just had to play the part. Though I anticipated what some of the culture would be like, little did I know about all the lifestyle variations that I would encounter in the village, as well as how teaching health in this community would be so much more complex than I imagined due to cultural and economic differences.

Finally arriving at the village was overwhelming. There were two other volunteers who would be working with me during my time in Atorkor, Jade and Zachary. Jade carried my heavy bag up a narrow and steep spiral staircase that led to my room, a kind gesture that anticipated her sweet and caring personality. It was a small room with a tiny desk, a plastic chair, a bed and a small rack with clothes hangers. It was not that much, but it was more than enough for me. I had to sleep under a mosquito net, which covered the whole bed. When I opened my window to see my view, I was a little surprised to see a small burial ground, filled with tombstones. After a minute, the surprise went away because I felt like this cemetery was in its appropriate place. After all, it was there before I was, so I figure my opinion should not have mattered anyways.

I lived with Zachary and Jade at the village chief’s house. The chief, Samuel Adiorlolo, founded Atorkor Development Foundation (ADF), and currently is a practicing dentist in London. This was ironic since Atorkor does not have a practicing dentist, yet their chief works as a dentist elsewhere. Nevertheless, his home is used for housing volunteers from overseas – it is one of the nicest houses in the village. Attached to where I stayed was another small building that housed the chief’s extended family members and their children. We had a cook named Rafaela who prepared our lunches and dinners. I had the opportunity to get to know Rafaela better over the course of my time there, and she greatly contributed to my happiness at ADF.

That first night, I ate a small dinner of vegetable rice, fish and papaya and chatted a little with my new family. I then had a brief group meeting with some of the Atorkor Development Foundation administrators, and found out that I started work the next day at 8 a.m. sharp. I would be working at the clinic in the morning, and then the school in the afternoon. I did not know specifically what I would be doing, just that I needed to be present.

Finding Health Care
Sister Ama and Sister Belda are two nurses with whom I worked daily at the clinic⁴. Sister Ama has been involved in the health care system in Ghana for 32 years, while Sister Belda, who is younger, has only been a nurse for three years. Along with caring for patients, their daily duties included issuing health insurance cards, recording insurance information, and cleaning the clinic. Sister Belda also did home visits to see babies who were sick or underweight, held family planning workshops to provide sexual health education for adolescents and young adults, and provided pre-natal and postnatal care for pregnant women. I spoke with the nurses about their opinions of their jobs and both had suggestions for
Improving the Atorkor health care system and the clinic. Some suggestions included more assistance for the nurses and more staffing, such as the addition of a midwife. They also suggested an extension of the clinic so that it could include a lab.

In Ghana, most people had government health insurance and used this insurance to pay for their health care, while others paid in cash. The amount of insurance coverage depended on the health condition. Sister Belda explained to me that the biggest health problems in the village were malaria, diarrhea, respiratory tract infections and hypertension. Sister Belda wished she had more opportunities to talk to villagers about their lifestyle choices and how these choices impacted their health, and also more chances to give family planning and sex education talks to schools and adolescent groups at churches.

Sister Janice, another nurse at the clinic, had been working there for two years. She explained to me how the government hired the clinic workers and paid for the clinic supplies. She told me the clinic needed new chairs, as many of the chairs were broken, and how the clinic would also benefit from more up-to-date supplies such as stethoscopes, blood pressure apparatuses, and weighing scales. In the Volta region, nurses were trained in Ho, but doctors usually had to leave the Volta Region and get trained in Accra. Because doctors were leaving Volta to be trained elsewhere, there were fewer doctors in the Volta Region. Sister Janice told me that nurses could diagnose diseases such as malaria, acute respiratory tract infections, pneumonia and diarrhea, but could not diagnose major diseases or infections. In more serious cases, the patient would get referred to the Keta Hospital, as there was not a hospital in the village of Atorkor, and there were no doctors at the Atorkor clinic. Because of the lack of doctors, the clinic was not allowed to see emergency cases and the nurses were only allowed to refer patients. Since the hospital was about 30 minutes away by taxi, and not all villagers had enough money to pay for taxi transport, this created a significant health care disparity in terms of adequate access to care.

Because the clinic did not deal with emergency patients and the village community was relatively small, the clinic only saw about 25 to 30 patients a day, and the days were usually slow. Nevertheless, Sister Janice explained to me that more villagers were using the clinic now than in previous years. Most villagers who were sick came to the clinic rather than using traditional medicine because the majority of the villagers were now Christian, hence, there were fewer people with indigenous beliefs than there were many years prior. When the patients came in, I would help weigh them on the scale and take their blood pressures and temperatures before sending them to Sister Janice, who gave them their prescriptions and medications.

For every patient, an insurance claim form had to be filled out so that the insurance could pay for the treatment. Most patients had insurance, so only a couple of patients a day were expected to pay with cash. The insurance office was in Keta and villagers were expected to renew their insurance card annually. Sister Janice told me children up to five years old received a five-year insurance card, or the equivalent of 1.25 in U.S. dollars. The cost of the card differed depending on whether the citizen was a government worker, non-government worker or elderly. Elderly citizens had the cheapest rate of two Ghana Cedi, or roughly .60 in U.S. dollars. Though the government provided universal health care, depending on the cost rate health care was still unavailable to some villagers.

Every Tuesday at the clinic the nurses held maternal-child health day, during which new mothers in Atorkor and neighboring villages would bring their children up to five years old to have them weighed and to receive their immunizations. The clinic would be held in different surrounding villages each week, and the schedule would rotate between the villages of Atorkor, Srogboe, Whuti and Akplorlortorkor before starting the rotation again each month. On the morning of the maternal-child health day, women and babies started to congregate at 9 a.m. and usually spent the whole morning and sometimes even part of the afternoon waiting to be seen by one of the nurses. Since there was often no specific order or systematic organization of patients, some patients who arrived early would still be among the last ones to leave. Mothers of newborns received a Children’s Health Record Book that they then had to bring with them every time they visited the clinic or a hospital. In the book, the nurses wrote down the baby’s weight and which medications the baby received on that day. When looking at the book, I would notice that some mothers would bring their children every month, while other mothers...
brought their children only sporadically. Since mothers often walked to the clinic or had to pay a taxi to reach the clinics, I assumed factors such as weather, cost, or other obligations such as cooking or caring for other children probably interfered with attending maternal-child health day.

At the clinic, it was usually my job to weigh the babies to make sure that they were at healthy weights. Almost all the babies were underweight, and because of this, in the health records, the nurses considered all babies who were moderately underweight to be “healthy weight,” and only babies who were severely underweight were considered “unhealthy.” Though I knew that the nurses did this so that they would only have to give special care to the babies who had the highest risk of health problems, the system of essentially ignoring the underweight state of virtually all the other babies was still unsettling.

The babies would be hung from cloth diaper bags on devices resembling meat scales in order to be weighed. The mothers would have to bring their cotton diaper bags, and they would undress their children and then hand them to me, so that I could hang the bag on the hook and take the baby’s weight. Many of the younger newborns would just hang quietly, unaware of what was actually going on; however, many of the older babies would start to scream and cry as soon as they were hung, bouncing up and down on the meat scale, making it impossible for me to get an actual weight. These were the times when I would simply just make up a weight based on the baby’s size, to protect the child’s safety. Once when I was weighing a baby, he was crying and bouncing out of terror so badly that he flipped over and would have fallen on his head if I had not caught him. If I had not been paying close enough attention, this situation could have resulted in a serious or even fatal injury.

It is conditions like this that upset me. Though this was an extreme case and situations like this did not happen often, it is still a safety hazard that needs to change. It is imperative for newborns to be able to be weighed in the safest manner possible, without the mother or health care provider having to worry about whether the baby will fall off the hanging scale. These scales get the job done; however, it would be beneficial to have a soft safety mat or cushion under the scales, to protect the babies from severe injury in case of an accident. These mats could be handmade or sewn using cloth and filled with cotton or foam and placed under hanging scales to provide a safety cushion for babies during the weighing process. Small changes such as these could greatly improve the safety of children during medical examinations, without having to completely modify the existing system.

One day during the maternal-child health day, I was able to see another clinic being run for those who have walking disabilities. I saw an elderly woman crawling on her hands and knees to go to the clinic to receive medication. This woman, despite her health condition, was still resourceful with what she had and determined to seek health care. This image sometimes comes to my mind when I think about health care conditions in Atorkor. I think about this elderly woman and how much better her quality of life would be if she had a wheelchair, an item that I never considered a luxury until I saw someone crawling on a rocky, dirt road. More people all over the world need to be made aware of injustices like these so that these inhumane conditions can eventually change.

There are people all over the world in small village communities like Atorkor who have to suffer on a daily basis. The least I can do is let these stories be heard, to promote awareness about the conditions in these communities, in hopes that these issues can be brought to light and addressed by the Ghanaian government.

Finding Answers

In September 2000, 189 heads of state gathered at the United Nations in New York at the Millennium Summit and adopted the Millennium Development Goals (MDGs): eight goals set out to encourage all countries, rich and poor, to focus on development problems. These goals were about human rights — the right of all people to health, education, shelter and security.

Though Ghana has incorporated the MDGs into the national development framework in order to reduce poverty in the nation, there are a few shortcomings,
partially due to wide disparities in regional and district poverty levels and a socio-economic divide between the north and south of the country. Ghana’s status as a middle-income country with fast gross domestic product (GDP) growth has not significantly improved human development indicators. Specifically, though Ghana has made large improvements in reducing extreme poverty and hunger and increasing access to primary education, child and infant mortality remains high, and maternal health needs significant improvements as well. Though overall in Ghana, many aspects of health, education, and employment conditions are slowly improving, in smaller communities such as Atorkor it is harder to obtain accurate and up-to-date development information. For this reason, while at Atorkor Development Foundation I set out to learn more about the social conditions that the villagers live in daily, to see what changes, specifically with regard to health and education, were most crucial to improving living conditions.

Over a 10-day period, Jade and I conducted a community-wide health assessment to screen the villagers of Atorkor for different health conditions. Two young Ghanaians, Afi and Kwame, assisted us with translation to allow for easy communication and to limit the misunderstandings that would arise from Jade’s and my three-word Ewe vocabulary. For the first week, we set up a table and a few chairs under a large tree, to shade us from the typical sweltering Ghanaian heat, as we waited for villagers to arrive and get screened. The purpose of the screening was to collect both demographic data and health data from the villagers to assess current health behaviors, problems and risk factors. This information was collected with the objective of creating a health needs assessment profile so that the Atorkor Development Foundation and the Atorkor Medical Center could better meet the health needs of the community and focus more attention on future outreach programs to address the most pressing health challenges faced by the village.

For the second week of the health screenings, we traveled throughout the village, going door to door, to collect the health assessment information for those families that did not participate in the screening during the first week. The assessment form consisted of 13 questions asking for both demographic data and medical data from the participants. The screening covered a wide range of health topics, including immunizations, malaria, nausea/vomiting/diarrhea, respiratory illnesses and asthma, malnutrition and anorexia, hypertension, headaches, chest pain, diabetes, pregnancy and HIV. We also used an automatic blood pressure cuff to take blood pressures of family members 18 years and above. For the majority of these topics the information was self-reported and thus some of the reported data was probably inaccurate. Nevertheless, the screenings gave us more insight into the health conditions of the villagers.

In total, 1,351 individuals resided in the 190 houses surveyed and out of these 1,351 individuals, 814 (60.25%) were adults and 535 (39.75%) were children. The average age of individuals surveyed was 26.49 years. Additionally, on average there were 7.5 individuals residing in a household ranging from one to 26. The homes were mostly one floor with a few small rooms, and were constructed with either cement or straw. The villagers were asked about whether their children were in school and reasons their children may not be enrolled in school. The school enrollment rate was relatively high, with about 90% of children over five attending school. Out of the households that did not have their eligible children in school, 27.27% were not in school for financial reasons, 9.09% were not in school due to the family choosing not to send them and for 63.64%, the
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family wouldn’t provide a reason for why their children were not in school. Though financial constraints were the primary reason for lack of enrollment in school, the 40% response rate to the question may suggest that villagers were either embarrassed or hesitant to admit why the children were not in school.

Out of the households that had their children’s vaccinations up to date, 92.86% of them stated that they had their child’s vaccine records, while 8.57% of them did not have any sort of vaccination records for their children. Despite these numbers, villagers did not bring their children’s immunization books with them, so there was no proof of whether records were actually up to date, or even existed at all.

Furthermore, out of the 190 households surveyed, 79 (41.58%) were not affected by malaria, while 111 (58.42%) were. Out of the individuals residing in those households, 225 of them had malaria within the last year. This accounts for 16.65% of the surveyed population. Finally, out of the households that were affected by malaria, 89.19% received treatment, while 10.81% did not receive treatment. These numbers illustrate the pressing issue of malaria in the region, and the importance of malaria prevention measures, such as mosquito nets and insecticides, that the clinic should be aware of in order to make sure that the population is adequately protected.

The average blood pressure of the surveyed population was 141/80, which is a little higher than the universal average blood pressure of 120/80. Out of the surveyed population it was found that 44.05% had high blood pressure, 54.62% of the population had normal blood pressure, and 1.3% of the surveyed population were at risk due to obesity. Though high blood pressure is a relatively common condition worldwide, this 44% high blood pressure level in the population still contrasts with the U.S., which has a lower rate of 31% of high blood pressure in the overall population. In more urban areas of Ghana, the prevalence of hypertension reaches 54.6% of the population. Many people living with high blood pressure in Atorkor do not even know they have the condition, but if the government could work with more health institutions in the country to instill a yearly screening program for diseases such as this, more advice and counseling could be given to patients to prevent this condition from worsening and causing further health problems in the future.

We found many inconsistencies in the self-reported data that contrasted with the actual statistical, pre-existing demographics of Ghana. Out of the 190 households surveyed, only two of them reported having a resident who was either malnourished or anorexic. While teaching at the Atorkor Basic School, working in the Medical Center and even just walking around the village, I would encounter malnourished children who were much thinner than a child of the same age in the U.S. would be. From this, I realized that the villagers probably had a different definition of malnutrition than I did. Maybe to them, being “nourished” meant simply having enough food to feed everyone in the family something, rather than having enough to feed everyone what they needed. Or maybe it meant just having access to food, regardless of whether it was “healthy” or not, as others might be even worse off.

We also found that 185 out of 190 of the surveyed households had never had HIV testing (97.36%). Due to the stigma of HIV, I feel as if this question was heard as “Do you have HIV?” and not the true question of “Have you been screened for HIV?” I appeared that as soon as anyone heard “HIV” they started saying no and shaking their heads, without giving our translators the chance to ask the entire question. It seemed unlikely that so few villagers had an HIV screening, as in 2013, it was reported that 220,000 people in Ghana were currently living with HIV and that there were 2,400 new HIV infections in children in 2013. Despite some limitations of the study due to response bias, I learned more about the villagers’ perceptions of health care through these community health assessments, which allowed me to get a better idea of how these health demographics influence development in the community.

Finding the Sea
The beach was a major part of Atorkor’s economy. Fishing was the biggest occupation in the village – even though the ocean had recently been overfished. One day while walking through the soft sand, I
passed a long line of fishermen, all working on repairing a large fishing net. The nets were so long and beautiful, intricately woven. The nets, colored various shades of blue and all bundled up, reminded me of billowing clouds. The beach was also lined with many small fishing boats scattered throughout the sand. During my first visit to the beach, these boats were one of the first things that caught my eye. They were hand-painted with beautiful colors, usually containing the iconic red, yellow, green, and black representing Ghana. Oftentimes, the boats also had Bible verses painted on them, which was not surprising given the predominantly Christian demographic of the village. The fishing nets were usually draped around or inside the boats. Palm trees also line the outside of the beach, a feature so prominent in Ghana, but nonexistent in the Greater Boston area, where I live.

I found the beach to be breathtaking, but I often wondered if the locals felt the same way. I felt as though in their eyes, the ocean was just a source of income: a means of survival. I could sit and enjoy the ocean and appreciate its beauty because as a foreigner, I had no other relationship or feeling about the sea other than one of admiration. The ocean ebbed and flowed as it should, and when I was tired of watching it, I could go home and go about my business completely unaffected. I did not have to depend on the ocean, just as it did not depend on me. We just coexisted. Many locals on the other hand, had a completely different relationship with the ocean. If the waters were too rough, it became difficult to navigate. If the fishermen did not catch any fish, they would not have sufficient income or their families might even go hungry that night. Their view of the ocean was not as simple as mine; they did not usually go home unaffected by it, as I did. The beach was not just sand and water, a source of relaxation, but rather their source of income.

Finding Rafaela

Rafaela, a young Ghanaian woman in her late 20s, is the niece of the chief of Atorkor. She grew up in Atorkor, and has lived there all her life. I met her when I first arrived at the village. She always had a warm, welcoming smile; I found it very easy to talk to her. During my first week there, Rafaela took me to one of the local shops so that I could get beads for my family and friends back home. I have a love for African hand-painted beads. I think their bright colors and intricate designs are absolutely stunning. However, everyone in the village spoke Ewe, a language of which I barely knew five words, so I asked Rafaela to accompany me. She agreed without any hesitation. Rafaela was fluent in both English and Ewe, and as I continued to go to the woman who sold the beads, Rafaela always went with me to haggle for the best prices. I appreciated Rafaela’s kindness and openness – especially towards someone she barely knew.

During my first week at ADF, I had the pleasure of interviewing Rafaela about life in Atorkor and about the Foundation. She told me most of the jobs in Atorkor come from fishing, farming and trading goods. I learned that about 80% of villagers go to church on Sundays, and that when funerals occur they often take up most of the weekend with drumming, singing and music. She told me that everyone in the village speaks Ewe, but mostly only the younger children can speak English, since they learn it in school. Few adults speak English, and most of the ones I met who speak it are either administrators of ADF, or schoolteachers. Overall, about 50% of the population speaks both English and Ewe. Few villagers travel to other parts of Ghana, so they do not speak other languages such as Fante, Ga or Twi.

Rafaela recounted to me what the village was like before ADF was established. She spoke about how most of the children were poor and could not afford school, and people had to go to a neighboring town, Anloga, for healthcare. ADF was able to sponsor children to go to school and buy books and supplies. ADF also established a medical center so that villagers would not have to travel out of their way to obtain health care. Despite what ADF has accomplished to make Atorkor a more sustainable community, Rafaela believes...
that there are critical needs of the village that still need to be met – specifically with regard to finding employment for more women and increasing microfinance and entrepreneurship. There is still more that needs to be done to help the village, such as more job opportunities promoting creativity and innovation, and low interest rate loans for graduating students to help fund start-up businesses and companies. Ghana’s government has a large role to play in creating these opportunities for its youth, to give them hope for the future. The students need to know that their education is not all for nothing, and that employment is actually an attainable goal after graduation, not just a lost dream.

Non-profit organizations in small village communities like Atorkor often face the challenge of dealing with issues that are more complex than the scope of their projects, problems that require the partnerships of government, health and business organizations in order to yield tangible solutions.

Finding Common Ground
Teaching at the basic school allowed me to challenge myself in new ways and build relationships with my students. Class sizes were overwhelming, with often more than 70 children crammed into a single classroom. When I entered the classroom, all the students would stand up and greet me with “You are welcome, Madame!” – a gesture I never quite got used to. In the classroom of boys 12 and up, a young student named Micah was always the first to raise his hand, the first to answer questions, and the first to offer to help. Many of the other students were shy. They sat quietly and some seemed to not even acknowledge my presence at all. Teaching offered me an inside look into the classroom dynamics of the local school in the village. Similar to a U.S. classroom, often it seemed as if the same students were consistently raising their hands. I soon realized that many students chose to remain silent not because they did not understand the material being taught or were indifferent and uninterested, but because they were intimidated by my presence. They were afraid to speak to me, even more so in English, because they were embarrassed at the idea that they may not speak English that well. It was barriers like these that I was trying to break every day while teaching.

One day, after teaching my group of boys age 12 and up, the boys went racing out the door to go to their next class. Jade, another intern who was also teaching at the basic school, had stopped by my class since her group of girls had gotten out of class a little earlier. I remember the group of boys running up to us after class, which often happened after teaching with all the age groups, so this did not surprise me at all. One boy shouted, “Can I touch your skin?” I let out a shy laugh and soon got mobbed by a bunch of kids lightly pinching my skin. But we look the same. I'm just like you. Skin color is not important. Various thoughts raced through my mind, but I struggled to find the best explanation.

During my time in the village, I had a lot of time to think and reflect on my experiences. With my dark skin and African heritage, I had hoped that I would not attract too much attention while I was there, and that I would be able to fit in and relate to others around me. However, looking back on my experiences, I realize just how much I stood out.

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I remember the first day I taught my group of teenage boys. I remember standing in front of the class and shaking with nervousness, unsure if the children could even understand a word I was saying. I remember doubt, uncertainty and confusion. For the younger age groups I was given a translator to assist in teaching; however, for the older groups, I was expected to teach without a translator so that the students could practice their English. The lesson was about basic hygiene and puberty. I had underestimated how much the students actually knew about health, and they ended up teaching...
me more that I taught them. I left the classroom feeling embarrassed and disappointed in myself, unsure of whether I was really capable and qualified to teach a class of more than 70 teenage boys.

In another one my classes, a large group of girls ranging from 9 to 12 years of age, I had to give a lecture on safe water. At the end of a lecture, I usually asked the class if they had any questions. That day, one girl raised her hand and asked if it was ok to cook with rainwater. I laughed nervously, embarrassed that I had never considered the fact that some villagers had to cook with rainwater due to lack of running water, and that at the time I did not have a definite answer to the question.

During another week, when I was teaching oral health, I realized even more cultural differences while teaching my group of children age six and under. The students knew how to brush their teeth, but when asked what a dentist was, they were unsure of what I was talking about. After teaching an older group that week, we gave out toothbrushes to students, and I remember being shocked while looking at a long line of young boys, pushing and shoving each other while they eagerly waited to obtain their new brushes, as excited as little kids waiting in line for a ride at Disney World for the first time.

The question still remains in my head. As I think about this moment, I wonder if the children just wanted to touch me because I was clearly a foreigner, or if they actually believed that my skin should feel different because I was from the U.S. I guess I will never truly know what they were thinking. I remember laughing as the group of boys started poking and pinching me, and though several thoughts raced through my mind, I never uttered a word.

It is not our skin that makes us different; we come from different cultures and have different educational and social backgrounds, but otherwise, we are the same.

If I could go back to that moment, that is what I would have said to them.

Finding Barriers to Sustainability

While in Ghana, I was able to enhance my health knowledge and teaching skills while simultaneously learning about the educational and health needs of the village. I was initially curious to see the state of oral health in the village of Atorkor and whether villagers had access to dentists. From talking to locals, especially children, I realized that there was virtually no access to a dentist in the area. While teaching oral health to students, I realized that most of the younger students did not even know what a dentist was, making it almost impossible to explain to them why oral care was important. Some students did not have toothbrushes, and many students used their toothbrushes for longer than the recommended 3-month period due to lack of money to purchase a new one. Fortunately, for those who did have money to purchase oral hygiene products, the toothbrushes and toothpaste were widely available to villagers for reasonable prices. Looking at the teeth of many older children and adults, while some had straight teeth, many more had several misaligned, missing, and decayed teeth. I realized that though the older children and adults recognized the importance of proper oral hygiene, there was inadequate access to professional dental care in the village and the cost of purchasing toothbrushes and toothpaste was not necessarily a priority for families struggling to purchase food items.

I was interested in finding out how ADF affected access to care and treatment in the village. Through my internship, I found out that ADF partially funded the clinic, but the clinic received the majority of its funds from the government. The clinic was the only place to receive health
care in the village; for serious health injuries or diseases, one had to visit Keta, a bigger city 30 minutes away by taxi. Despite not being able to provide emergency care, the Atorkor clinic still played a vital role in preventative health care measures and immediate treatment for easily curable illnesses such as fever or malaria. Students in the village were knowledgeable about preventative health and different health conditions and diseases, as I was able to see from teaching at the basic school. The curriculum and teachers did an excellent job at making sure the students knew about different public health topics and preventative health measures such as safe water, proper nutrition, exercise and oral health.

In addition to the language barrier with the younger students, teaching in overcrowded classrooms did not create the best learning environment; however, these experiences challenged me to work harder to build the students’ trust and develop meaningful relationships with them, despite the cultural barrier. I often wondered about the best way to promote preventative health behaviors to people who knew what was required in order to live healthy lifestyles, but lacked the money to purchase preventative health items such as toothbrushes and toothpaste, or healthy foods like fruit. This is a concept that I am still struggling with. It was hard to give health advice while knowing that economic and financial hurdles in access to health care, medication and dietary options limited the practicality of the advice that I was giving. Towards the end of my time in Atorkor, I realized that a larger structural change needed to happen in this country in order for the village to continue moving forward. Though ADF is trying to promote sustainability, the government must also do its part in promoting health, educational and economic opportunities in its small villages that often go neglected.

A Treasure: The Promise of the Phoenix

My journey to Ghana was accompanied by my own intellectual and emotional journey of experiencing a new culture and pushing myself to teach and interact with different community members in the fields of health care and education. Through my struggles and moments of doubt, I found myself. I discovered my weaknesses as well as my strengths, and had successes as well as failures. Being in Ghana taught me new ways to see the world and helped me further realize that there are many ways and strategies to accomplish the same goal. I became more patient and more optimistic, and I hope that I can only continue to grow from this experience.

I know Ghana based mostly on the experiences that I had during my short time there – through the people I met, the landmarks I saw, and the interactions I had in the community. The red, yellow, green and black of the national flag remain engrained in my memory, a symbol of national pride. I remember the feeling of the loose, grainy sand between my feet as I would walk to the clinic and basic school. And I remember not only the smell of dirt, but also that of the sea. I often think about my students and I try to imagine their futures, which I assume will probably be so different from mine. Given the economic circumstances of the villagers, it is a lot harder for them to travel to other countries and experience different cultures, a privilege that I have and hope to take advantage of. Most of the people I met in Ghana were so kind and friendly; I want to know where their happiness comes from. I want to learn more about their culture and explore their foreign world.

“You are different from the other volunteers who come here, it is so easy to open up to you,” said one of my students. Two months prior, I would have never imagined myself there, sitting in the compound of my house, drinking Sprite and Fanta with some of my favorite students on the day before I was supposed to leave and start my journey back to the U.S. It was amazing how much changed over the course of just a couple of months. Through the companionships that I made, I know that my presence made a small difference in their lives.

After working at a development foundation for two months, I am still unsure of what the word “development” actually means. In a world that is constantly changing and advancing, is anything ever fully developed? How do you measure something like development, something that is not tangible? Isn’t there always room for improvement?
When Mr. John Mahama, President of the Republic of Ghana, came to Brandeis in October 2014, I had the privilege of asking him about what is being done in Ghana to combat the high youth unemployment rate in the country and to promote entrepreneurship and creativity so that more jobs could be available for young graduates. He told me about different initiatives being started in Ghana to promote education, jump-start entrepreneurship, and increase the number of private sector jobs in the country. Despite this, these new initiatives will surely be very competitive, and the success of them is obviously unknown at this point. Furthermore, these new jobs may just be available to people living in larger cities; communities like Atorkor with frequent power outages and limited internet access may never hear about such opportunities.

Nevertheless, President Mahama believes that development is something that the continent of Africa is actively working towards. He ended his speech at Brandeis by stating, “Africa rising” is meant to capture the idea of hope and promise on the continent, like the mythological phoenix that rises out of its own ashes and soars. What better way to tell the world that the continent will never be counted out; it will find a way to rise again.” To keep Africa rising, small villages and communities must not be forgotten. Instead, governments should try to ensure that opportunities are reaching even remote areas, not just the most populous or booming areas of different countries. I believe that development is not necessarily a permanent state of being, but rather an ongoing process – it is having the motivation and willpower to keep moving forward, no matter what the odds may be.

After two months of joy, tears, happiness, loneliness, success, failure and lots and lots of sand, I left Atorkor with even more questions and concerns than I had when I arrived. As I wonder about what my purpose there was and reflect back on my experiences, I see tremendous growth. I have become more knowledgeable about the cultural differences in education and medical care in Atorkor compared to higher income nations, and I have gained some insight into what development truly is.

I used to believe that development was something that came at a definite point, a concept defined by a specific set of criteria that one could check off once completed, almost like my mother’s Saturday morning grocery list. Now I realize that development is an idea so complex, as broad and far-reaching as improvements in government, health, education, entrepreneurship, and so much more. It is a concept that does not necessarily come at a defined point, but rather is a global ideal that we are constantly striving to achieve. Development cannot be achieved in two months, two years, or even 20 years. It is an ongoing process that is never complete until there is virtually no room for improvement.

I am both hopeful and optimistic for what Atorkor has in store – this village that helped me to develop into a better teacher, a keen listener and a more culturally competent future health care provider.

Notes

1. All names have been changed to protect the privacy of the individuals mentioned.
3. One of Ghana’s 10 administrative regions, located east of Lake Volta in Ghana.
4. “Clinic” refers to the Atorkor Community Medical Center, a health center that serves Atorkor and the surrounding villages.
8. Language spoken in the Volta Region due to the native and largest ethnic group in the region, the Ewe people.
12. “Basic school” refers to the public elementary and high school in Atorkor that the majority of children attend. This school is partially funded by both ADF and the Ghanaian government.