

## **The Ghanaian Experience: Summer 2007**

### **Introduction:**

Africa has always held a special place in my mind. It all started when I was at high school in Bahrain and I made a pact with my closest friends that we'd one day travel to this great continent that has been ravaged by poverty and famine and yet, find fulfilment in using our talents and skills to improve the lives of those who were less fortunate than we were. In May 2007, I was given such an opportunity. I won the Cosyfeet Study Award 2007 of £1000 which enabled me to cover the bulk of my travel and living expenses. Suddenly, my trip to Africa was becoming a reality step by step. I received a great deal of support from my university (University of Wales Institute, Cardiff) and from Cosyfeet particularly, Vicki Palmer and David Price. Cosyfeet is a family owned company that specialises in providing extra roomy footwear for people suffering with different types of foot pathologies, particularly oedema.

### **Why Ghana?**

Cosyfeet was incredibly supportive of my plans and obviously shared my desire to understand first-hand not only the diabetic pathologies affecting patients, but the socio-economic and cultural facets associated with a developing country such as Ghana. Diabetes is a challenging adversary of podiatrists worldwide and in Africa, this statement hits very close to home. Studies have shown that a third of diabetic patients have had to undergo amputations due to progressive infection and over half of these die as a consequence of the delay in reporting their foot problems. The 'successful' have dramatic changes induced on their lifestyles; loss of independence, inability to work and life-threatening complications.

The International Diabetes Federation has consistently reported on the dearth of podiatrists in Sub-Saharan Africa. With the help of Dr Kwameena Beecham, President of the Ghana Diabetes Association, I was able to spend three weeks at the Korle-Bu Hospital and the Ridge Hospital in the capital city of Accra. Past the rainy seasons and the hot, dry harmattan winds of the previous months, August was the most opportune month to start to my trip. The reason I chose Ghana was two-fold: its reputation as a friendly, hospitable country where English was the national language and secondly, the fact that a large proportion of patients admitted into hospitals are diabetics of both known and previously undiagnosed cases. In light of UNite for Diabetes Campaign (United Nations) which culminated in World Diabetes Day (November 14<sup>th</sup>), it was imperative to understand and help highlight that diabetes is a pandemic and needs immediate attention if countries are to develop and advance economically.

**The crux of the matter:**

In 1901, Albert Cook reported, that in sub-Saharan Africa, diabetes was a 'rather uncommon and very fatal' disease. Today, the International Diabetes Federation purports that 245 million people worldwide are living with diabetes and about two-thirds of these people live in developing countries such as Ghana, in Sub-Saharan Africa. The limited statistics available are disturbing. Although communicable diseases such as malaria and tuberculosis are currently the main priority of health-care systems, non-communicable diseases such as hypertension, dyslipidaemia and diabetes will surpass these in under two decades. Therefore the looming threat of a major health catastrophe cannot be underestimated. Already diabetes is a major cause of morbidity, premature mortality and disability and as such is a costly disease bearing individual, psychosocial and economical implications.

In developed countries, such as the United Kingdom, the keys to diabetic patient management are well-organized foot care, good diabetes control and patient education.

Diabetes awareness programs, leaflets, the internet and written and verbal advice from health care providers facilitate in solidifying a patient's knowledge about the disease. Therefore, patient empowerment is fundamental to successful self-management of diabetes and as a direct consequence improves health outcomes (Cavan 2001). However, this proves to be a first in a long line of obstacles facing diabetic patients.

**My experiences:**

In Ghana, I was able to experience working in a secondary level (Korle-Bu Hospital) and tertiary level hospital (Ridge Hospital). I shadowed GP's who performed full scale neurological assessments on diabetic patients; spoke to a lot of patients about their conditions and learnt about the obstacles that Ghanaian diabetics face: poverty, lack of education, lack of health education; miscommunication and misinterpretation of information provided by health centres; and their faith and belief in spiritual origins of a disease (omens, spirits and juju's).

In Korle-Bu Hospital, there were many different perspectives to experience as it is the only tertiary hospital in Southern Ghana and is affiliated with the University of Ghana Medical School. In the Diabetic Unit, I was able to talk to both patients and practitioners and get a better understanding of the high prevalence of diabetes mellitus in Ghana and what is being done to manage the condition on a national scale. I was also involved in a study by Professor Albert Amoah at the National Diabetes Management and Research Centre about the prevalence of erectile dysfunction (ED) in Ghanaian males as although it is a common occurrence in diabetes, it tends to be under reported. This is a particularly vital study in order to quantify the prevalence of ED in the Ghanaian population and by extrapolation understand the consequences of this condition for individuals and devise strategies for awareness and treatment programs.

At Ridge Hospital, I worked in the wounds and dressings unit where the main patient group was diabetics with severe ulcerations. With a team of vascular surgeons, nurses, and fellow medical and nursing students, we were responsible for patients and wound management provision. This entailed assessing a wound, thorough saline irrigation of the area, debriding any surrounding dead tissue and providing antiseptic and palliative relief to patients. This was definitely the highlight of my trip as I was able to acquire hands-on experience of wound management in a high-risk patient demographic.

I accompanied vascular surgeons on ward rounds and talked to patients who had recently undergone amputations as a result of infections and subsequent necrosis of the lower extremities. This was particularly insightful as the rate of gangrene and infections rates are comparatively much lower in the United Kingdom. Perhaps the biggest learning curve for me was appreciating the substantial cultural and socio-economic connotations a diabetic patient was exposed to.

### **Illiteracy and Patient Education:**

As of 2003, UNESCO estimates that 25% of Ghanaian adults are illiterate. This automatically hinders the possibility of patient empowerment with regards to written documentation about the disease. At Korle-Bu Teaching Hospital, the diabetic clinic holds over 80,000 patient records and each day, around 160 patients attend the clinic from in and around the catchments areas. They assemble before their appointment times for a health education talk which details the minutiae of basic foot care, blood pressure regulation, diet and exercise as well as additional information to family members of diabetic patients. Their blood glucose levels and blood pressures are also assessed. However, a large majority of these patients have returned for more medications simply because they could not afford the initial 3-month oral anti-diabetic medication. This further contributes to the burden of health resources.

Alternative methods of communication are therefore essential to the diabetes awareness campaign. The medium of television has proved a useful tool in highlighting not only the signs and symptoms of the condition but explaining to the public that the nature of the disease is not shameful or spiritual but rather a manageable condition where severe complications such as amputations can be avoided. In a country as deeply devout as Ghana, using a pulpit to 'spread the news' of diabetes and raise the profile of the condition is common practice.

### **Healer Shopping:**

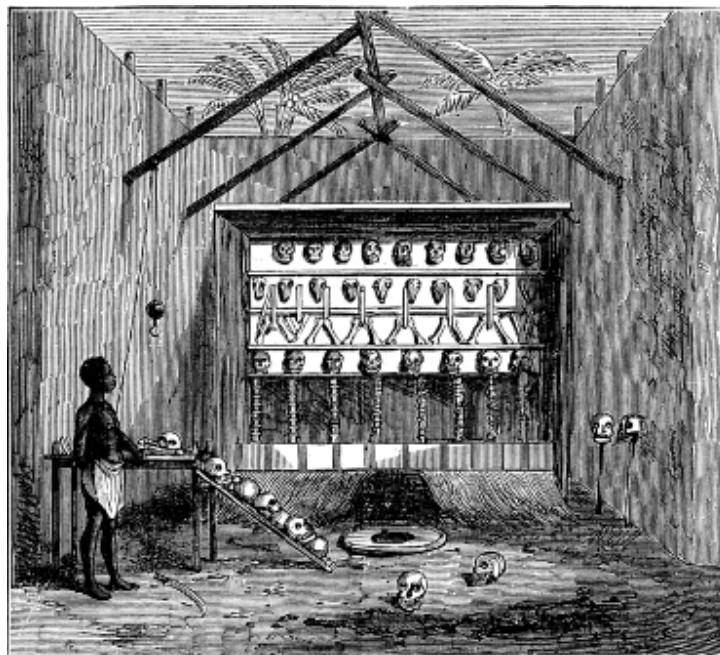
The spiraling diabetes figures have been blamed on a variety of factors. One of them is the inappropriate use of traditional medicine particularly the practice of 'healer shopping'. The belief in a spiritual origin of a chronic illness is prevalent in Ghana and is further compacted by belief in the powers of traditional religious leaders and their apparent ability to cure the effects of witchcraft. In Korle-Bu, traditional medicine proves a bane to medical practitioners as it leads to non-compliance with allopathically prescribed medication and a lack of lifestyle alteration in terms of diet and physical activity. It must be noted that healer shopping is '*a secondary practice in Ghana, co-existing with biomedical management, spiritual action and medical inaction*' (Aikins 2005).

Patients on low incomes are incapable of bearing the cost of prescribed drugs and varied, modified diets and are therefore driven to traditional 'ethno medical' practitioners out of necessity for medicines, psychosocial and spiritual support. There is a focus on providing cheaper drugs, including stringently-tested scientifically approved traditional drugs, and establishing self-help groups for people with diabetes. Incidentally, at the Korle-Bu Diabetes Clinic, patients are encouraged to discuss their illnesses with their peers in the large waiting area, thereby sharing experiences and breaking the stigma attached to being diabetic. This was evidently a source of much needed psychosocial support and encouragement.

### **Dispelling Pre-conceived Notions:**

Another salient feature of the diabetes awareness campaign in Ghana is breaking the various taboos associated with the disease. This includes dispelling the notion of the disease being contagious and/or shameful. The main focus therefore is basic health education: conveying the message that diabetes is a condition that is neither contagious nor shameful and as such can be appropriately and successfully managed. In this author's experience, patients seem reluctant to report any anomalies with their health for fear of the unknown/the worst. The following documents some of the myths and misconceptions regarding diabetes in Ghana according to Diabetes Education Training Manuel for Sub-Saharan Africa:

- Eating too much sugar.
- Having sexual intercourse with a diabetic patient.
- Stepped on a Juju trap. ( Juju refers to spirits or ghosts in African lore)



A Victorian Illustration of a Juju House in the Gold Coast. Juju is a word referring to supernatural powers ascribed to objects.

- Being bewitched
- Being cursed
- Punishment by the gods
- Diabetes is a disease of white men
- Allopathic treatment cannot cure it but herbalists can.

It was clear that understanding the culture of a country allows health care providers to influence views on the disease and therefore determine healing and prevention criteria. Another example is the fact that obesity is sometimes considered as a sign of good health and prosperity. This can severely derail healthy eating patterns and increase the risk of diabetes as well as create unnecessary obstacles for diabetes educational campaigns.

**Summary:**

The trip has been invaluable on both a personal and professional level. In the United Kingdom, diabetic patients are well cared for with excellent follow-up programs and a variety of resources available to them. However, I have learnt of problems that the health sector in Ghana faces, not just from diabetes but from more pressing communicable diseases such as Tuberculosis or HIV. Cultural dimensions obviously have a significant role to play, too. The truth is that diabetes is a global disease and therefore should be a global concern. Countries such as the United Kingdom have excellent diabetes management systems and if these can be emulated in light of the above highlighted factors, diabetes

can be controlled and successfully managed. As for myself, I am looking forward to my next trip to Africa where I can hopefully continue to learn about different cultures and different approaches to managing conditions such as diabetes.



**Gwen and Dr Beecham**

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