Internship Reflection at the West Africa AIDS Foundation

I have been interning at the West Africa AIDS Foundation during my time in Ghana, which has proven to be an incredibly practical learning experience. I have absorbed a variety of things in all aspects of life here, but some of the re-occurring themes that have been prominent in my work experience have been adjusting expectations, being flexible and always being ready to learn. Although it is not always easy, as us humans tend to become stuck in our ways and very attached to our expectations, remembering these social tools is very beneficial.

In coming to Ghana, I was expecting to work one-on-one with human patients in the medical setting in hopes to gain insight on whether I wanted to pursue a career working with humans or animals. Unfortunately due to the Ebola Outbreak in Guinea, Sierra Leon and Liberia the Interns in our program were restricted from working in the clinic with patients in case Ebola made its way to Ghana. Of course I was angry and devastated when I found this out but I do understand and respect the liability and precautionary aspects that are encouraged at a time like this. I am blessed that I have the ability to play it safe and not work in a clinic that could be exposed to Ebola rather than be for forced to work in a clinic that is running rampant with Ebola patients which is unfortunately a reality for so many people.

My work focus shifted from working with patients to the educational outreach aspect, which is extremely important, as education is the most powerful tool. The three most personally influential projects have been the Cholera Outreach Project, the LGBT Clinic and Nothing for Us Without Us Tuberculosis project.

Cholera

My Cholera Project journey began during my first few weeks in Ghana when I first heard about the severity of the Cholera Outbreak. It had been labeled the worst Cholera outbreak in the history of Ghana. In epidemic prone regions like Ghana, Cholera outbreaks have been linked to multiple environmental and socio-economic causes. Unfortunately some aspects of Ghanaian culture, the reality of poverty, lack of resources and the country's economic status make containing the outbreak a slow process. Improving infrastructure has long been known as a critical component for successful prevention and eradication of preventable communicable diseases like Cholera. Cholera can spread rapidly in areas with no safe disposal of human waste like in some areas of Accra. Another factor that further complicates the eradication is the heavy rains. Sure the heavy rains themselves aren't responsible, but they sure do a thorough job of polluting the gutters and water sources with waste-contaminated runoff. In addition, although Ghana does have a relatively successful water system in the Accra region it is still not always safe. A problematic cultural aspect is that Ghanaians tend to be very friendly, warm and touchy. The issue lies within the touchiness, as it is a gateway for the bacteria to be transferred to another host. Since taping, touching, hugging and hand shaking is a part of everyday communication and interaction, one can encourage minimal touching, but old habits die-hard.

Another huge aspect is addressing the attitudes of the Ghanaian citizens. Changes will be needed to redirect the thinking and perspective of the general population regarding their perception of waste. In order for this to be successful, the participation and partnership of

the private sector, civil society and public agencies in the management of waste in Accra will be needed. The type of good governance that needs to be encouraged revolves around leadership that uses power in a way that ensures resources are used to bring about positive change in the attitudes of people. Because of the systemic flaws, unfavorable environmental dynamics and cultural factors, Ghanaians have to be motivated on an individual level to make personal changes to decrease the likelihood of contracting Cholera. With this idea in mind, I created a relevant PowerPoint presentation and interactive activities to present to students and food vendors.

My main goals while making my presentation were to be brief, deliver accurate and helpful information and create interesting slides. Being a student myself, I am familiar with boring lectures and not being able to absorb all of the words off of a screen. My PowerPoint (see appendix A) and subsequent engaging activities were presented in about a half an hour. Delivering a succinct presentation increases the likelihood of maintaining active listeners. Since my goal was to ensure that as much of this information resonated with as many people as possible, this was a very important aspect. I brought three other presenters with me and we all took turns presenting. The idea was that with a new topic, comes a new face and new surge of curiosity. With respect to accuracy, my presentation offered information based off of the “Stop Cholera” poster created by WAAF, which is well developed by health care professionals and widely distributed. In addition, my presentation featured helpful visuals to strengthen and further commit these educational points to memory. These visuals also served as an especially important educational tool to the illiterate population.

The presentation that I gave at a school in Nima went very well but I was faced with several challenges that forced me to be resourceful, think on my toes and also brought some aspects of preparedness to my attention. First off, the available wall for projecting was very dark so although the power was on and all of our equipment worked beautifully, it was very difficult to see the presentation. Not only was this frustrating because I put so much time, energy and thought into this presentation, but because I really wanted everyone to benefit from this information as much as possible. Next time, I will bring a white sheet or perhaps invest in a drop-down screen to increase the effectiveness and clarity of the presentation. Because of this, I incorporated hand and body gestures while presenting to enhance the educational points. For example, on the symptoms slide, because the audience could not see the photos of a boy suffering from profuse diarrhea and vomiting, I motioned spurting liquids from both my mouth and bum. The language barrier was an obstacle that forced me to think beforehand. I asked Auntie Sharon, one of the program coordinators for the UCEAP program, if she would come along to translate for me. Although the teenage students understood English very well, many of the vendors and cooks did not. Having Auntie Sharon translate and present ensured not only that they understood the entirety of the presentation, but also that they could ask specific questions and receive personalized answers. During my presentation, I educated the audience about two useful liquid solutions. The first, a sugar-salt-water solution to increase hydration, and the other was a beach-water safe drinking solution. Although I provided the specific measurements in teaspoon/tablespoon format, it occurred to me that these might not be commonly known measurements. Because of this, I brought along and displayed the appropriate ratio of solutes and solvents to provide a useful visual.

Towards the end of the presentation, one student raised his hand and asked me how he should wash his hands if he doesn't have water and what he could use as an alternative to soap. After questioning, it became clear that ash and hand sanitizer were not available and I was stopped dead in my tracks. I wanted to provide him with an answer but due to my privileged lifestyle, this is not an obstacle I have ever had to overcome. I spoke in circles, suggesting that the combination of soap and water was the best and pretty much only efficient way to clean his hands. Then, another little boy raised his hand and said "What about lemon?" In my mind, I thought "Brilliant! So simple yet so effective!" I thanked the boy for his suggestion and confirmed that that method was indeed effective as lemons are packed with hydrochloric acid and the acidity will act as an anti-bacterial. This reminded me that learning is indeed a two-way street and that I always need to consider and promote easy, cheap and accessible options. Exploiting natural, handy lemons for their antibacterial properties is brilliant and this learning experience encouraged me to meet with locals to understand their existing traditional methods for dealing with these health issues.

Another issue that I ran into was criticism about suggesting that people use a bleach-water solution to drink if they don't have access to clean water. Although the women were respectful, they were obviously scolding me, insisting that I will hurt people and make them sick if I encouraged them to "drink bleach." I tried my best to explain that this was a last resort (after exhausting the options of bottled water, sashays, boiled, and chlorine-treated water) and that in a very small quantity; the bleach-treated water would do more good than harm. I explained that they had to be careful with this option as bleach solutions often come in various concentrations but that if possible, they should make a

0.05% solution. Knowing that doing the math may not be an option, I provided them with a visual. They understood and thanked us for the suggestion, but they felt more comfortable with other options, which is very understandable.

Tuberculosis

Tuberculosis (TB) is an understandably very hated disease worldwide, but especially in Ghana where it is endemic to the area. When attending the Nothing for Us Without Us (NUWU) meeting, I learned that TB was once (and maybe still is) referred to as the 'Death Cough.' If someone in a community showed symptoms of the death cough, they were often ostracized and disowned by the community and sometimes even their families. From an evolutionary standpoint, this makes perfect sense. Survival of the fittest always underlies our motivations especially when dealing with a contagious, potentially deadly and not well-understood illness. In the past, Ghanaians have had no insight into the mechanisms of TB or access to health care. Therefore TB has been viewed as a monstrous incurable cloud.

Thankfully, times are changing, health care is becoming more available and education is being more widely distributed. The NUWU project has spearheaded an educational project that aims to increase community knowledge of the disease as well as nominate TB infected and affected individuals to represent the platform at the international level to advocate on their behalf.

I was asked to put together a PowerPoint to preset at the November NUWU meeting, which I was excited about because it gave me the opportunity to perform an off-site activity. Although overall, the presentation went fine, I learned a lesson that will help me

create location-specific presentations in the future. In my PowerPoint, I discussed the TB testing methods and provided the examples of: Tuberculin and TB Blood Test. Although these are not wrong, the most common test used in Ghana is the Sputum test. This, I was unaware of. Not only is the Sputum test easy and cheap, but in Ghana, medical professionals are most concerned with the active form of TB which the Sputum test specifically tests for. The fact that I completely left this out of the PowerPoint was not only embarrassing but also misleading. Luckily I was speaking to an educated audience that knew about Tuberculosis because of their experience and current involvement in the fight against it. I also discussed the difference between Latent and Active TB. Later, I went into detail discussing the importance of treating latent TB and how it can negatively one's body and/or become active at a later time. Again, while all of this is true, a different message should have been preached. When I sat down, Angelina whispered to me that they don't treat Latent TB-Strike 2! I was so embarrassed. After I let out a sigh of frustration, I went on to ask why. I was informed that because TB is endemic to the area and about 60% of people have TB in the Latent form, at this point in time there is way to treat everyone with Latent TB.

Reflecting back, I relied too heavily on my prior TB knowledge when making the PowerPoint and subconsciously assumed all of the information was the same. In California, hospitals and clinics do test for Latent TB meaning that the most common tests are the Blood and Tuberculin Test. When using the Sputum test, one would only test positive if the bacteria were active in their lungs and they were releasing the bacterial particles, hence they had Active TB or TB Disease. When testing the blood or injecting

Tuberculin, you will get a positive response even for the Latent TB because you are testing for the presence of antibodies. My second mistake, regarding the treatment of Latent TB, was also due to speaking from past experiences. If one tests positive, even for Latent TB in California, they are closely monitored as they complete a full round of antibiotics. In addition, the stigma attached to TB often causes people to "freak out" and distance themselves from the TB carrier. Because of this, the severity of Latent TB has been engrained in my mind and the idea of not treating TB was not something that I ever considered. In the future, I know that in addition to general information, I need to check with local health care professionals to see what the typical protocol is for the specific disease, infection, virus etc. being discussed.

Something beautiful and inspiring that I learned at the meeting was that if you want to form a determined group to fight against something, it is best if they are all passionate about the cause. Although this world is indeed filled with educated, capable and empathetic people whose resumes may be top notch, there is an undeniable additional level of commitment and drive from a person who has survived, suffered from or been effected by a disease. The group gathered around the table listened intently, constantly asked questions, and was determined to come up with practical solutions to how to address TB-related issues. At one point, there was a pretty intense conversation between one man and one woman in the group. Another man attempted to settle the conversation, but the man said "No, I REALLY want to understand this. We need everyone to be on the same page." You could tell that the excess energy emitted during the conversation by both parties was rooted in genuine frustration. They were tired of being fed ideal yet unrealistic answers to big purposeful systemic questions-HOW are we going to address

TB? This passion was powerful and inspiring. Affected people are the ones who are going to rally enough to initiate change.

LGBT

Through working behind-the-scenes on the LGBT project, I have gained insight on how to target and accommodate an underground target population. The LGBT (Lesbian, Gay, Bisexual and Transgender) community in Ghana is often not well received, is discriminated against and sometimes individuals die from treatable illnesses because of the discrimination that they face at the hospital. Instead of receiving non-judgmental, personal medical feedback and recommendations for an STI, the patient often hears a "Well, that's what you deserve" or are handed a bible. Because of this discriminatory culture, members of the LGBT community are misinformed and sometimes tragically die from very treatable illnesses.

Although I did not get to work in the field with Guro, the nurse in charge of the HIV Testing Clinics, I learned many things while constructing the charts, surveys, fliers etc. First off, I learned how important anonymity is for this community. Working in the medical field for a while now, I have internalized how important paperwork and bookkeeping is. Files need to be in their correct places, updated, accurate and correspond appropriately with sign-in sheets, not only for a professional purposes but because health information such as statuses, dosing, allergies, medical history etc. can be the difference between life and death. When making the Clinic Sign-In Sheet, I was baffled after being instructed not to include a 'Name' section. I even double-checked on this, and it was further explained that not only will people not write their names, but also it could prevent

people signing up. I understand that the chart itself, which does include the name, is the most important, but an additional system needs to be understood and functional to accommodate the need for anonymity. Unfortunately because I did not get to work with Guro, I did not see how they directly dealt with this, but I am curious as to how they do this and determined to find an answer.

Another important aspect that I observed is that although medical settings universally do or should overlap in many ways such as cleanliness, the nature or culture of a clinic does change depending on the target audience. For example, with respect to the LGBT community, one of the most important elements is creating a non-judgmental environment. If a patient is not 100% comfortable with their doctor or medical attendant, they could leave out potentially controversial yet significant details about their life and activities. This could cause the returned medical advice to be different from or not as thorough as what the patient truly needs. For example, if a man comes in and is only expresses curiosity about the safe-sex tips of having sex with women, but not men because he is embarrassed, he could unnecessarily contract HIV, syphilis and/or other sexually transmitted infections and diseases. Another example is if a man is embarrassed to notify the doctor of a rash on his bum because he anticipates the doctor making assumptions about his sex life and in turn, judgments, the patient could die from something like syphilis, which is very treatable.

The “Peer Educator Best Practices” sheet I created also reminded me of how underground this target group is. When reading the document, it becomes clear that the Peer Educators are not only responsible for educating people, but a huge part of their job is recruiting people. Several times, it mentions that the Peer Educators need to make sure

that the potential patients know when and where the clinic will be. This involves relaying the basic info several times, offering them with a handout as well as providing them with nearby landmarks-indirectly making “not knowing where it is” an invalid excuse. In addition, the Peer Educators are instructed to call the potential patients the night before to make they are coming. All of this leads me to believe that there is not a huge turnout at the clinics. This is not because it is offering an unneeded service, but that even when one preaches about a non-judgmental medical environment, people still are not comfortable which is heartbreaking. I hope that with time the culture evolves to accept the LGBT population so they can surface from underground and live their lives how they want to and not suffer or die unnecessarily.

Conclusion

WAAF is incredible. I simply cannot conclude this reflection without mentioning WAAF and Dr. Naa herself. There have been numerous times where I have performed searches through Google about various health issues in Ghana and WAAF’s name was attached to the top article in one form or another. This alone says a lot about their influence not to mention the non-stop presentations, projects, support and outreach that are offered. Working behind the scenes gives one insight into how an NGO runs and the masterminds responsible.

Dr. Naa Ashiely Vanderpuye-Donton is one of the most down-to-earth, driven, realistic, concerned people I have ever met. And yes, I can absolutely conclude this with confidence despite my typical interaction with her being a “Hi” –“Hello” as we are both running off. I have received a number of emails expressing the desire for analysis of data

from past projects to see if things are working and how they can be improved. This, I truly believe is one of the main differences between a great NGO and a decent one- ongoing reflection and improvement. Not simply spewing the numbers and generating the graphs to please donors, but to truly absorb the statistics, attach faces to the numbers and always feel the uphill battle. Even with her ultra-busy schedule, Dr. Naa sincerely worries about patients hundreds of miles away getting lost in the system, how to calm the world's worries about Ebola and how to get the dying little girl who visited the clinic more than just dry noodles. Not everyone has the capacity for this line of work and not everyone has the empathy but Dr. Naa has absolutely situated herself in the right profession and WAAF is a reflection of that. I am so impressed by the West Africa AIDS Foundation and Dr. Naa and am grateful for my experience and thank you from the bottom of my heart and soul for endlessly doing what you do.

Written by: Jenna Guffy