Healthcare in Ghana – The Harsh Reality of a Developing Country.

Trixton May

Background

‘Yaw’, that was the local name given to me as a male, born on a Thursday; one of many traditions the locals live by here in Takoradi, Ghana. My independent venture to West Africa during my second year of student paramedic studies was a challenging decision. Still, one I will always hold as my most significant life experience to date. With aspirations to serve in areas less fortunate in my future career, this step was the first of many more to come within humanitarian medicine. Ghana was a country I had no motives behind travelling to, I wanted to walk into a new culture and health care system blinded to learn to survive.

Ghana is a standout country compared to other West African cultures, with 40% of the population signed up to a National Health Insurance Scheme (NHIS). On paper, these schemes seemed beneficial to the Ghanaian Government. However, in practice, they have been shown to fail. Many factors play a role in funding health care in Ghana, the primary source being the country’s oil production capabilities. The Government of Ghana is pushing to have a healthcare service beyond aid, meaning they are moving not to become donor dependant.

Due to the adversity of Covid-19, I had multiple barriers travelling and working in Ghana, which resulted in having my trip condensed. I have no concerns that the few images displayed in this article will talk enough for themselves about the working conditions. Additionally, I must warn you that some topics and visuals may be disturbing. However, I strive to summarise my experience of the healthcare system in Takoradi, with the attempt to highlight the privilege for which we withhold having a free and established, yet unfortunately abused, healthcare system in the United Kingdom (UK). My end goal is to encourage others to see the beauty that we refer to as the National Health Service (NHS) and change the approach we all view and use the NHS.

All images and cases discussed were consented to for educational purposes

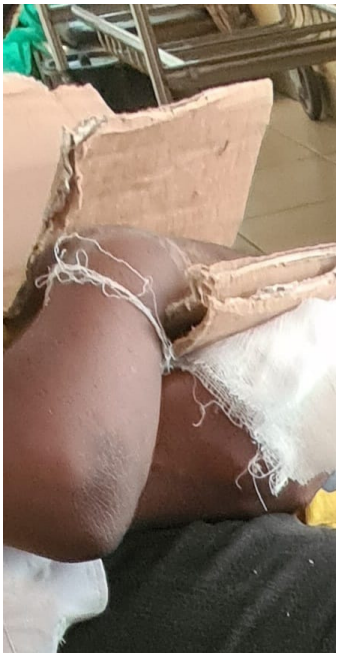
Day 1 - Thrown In The Deep End

Day one in the Emergency Department (ED) sparked an abundance of emotions: shock, excitement, and a wealth of feeling helpless. Within just a few hours of working alongside my exceptional team, we used initiative to tackle the problem of limited resources. From ripping elasticated medical gloves to use as tourniquets, a frosty cereal box converted into a radius splint, and a pizza box placed on the floor to catch the dripping blood from a compound Tibia Fracture. I instantly knew this experience was going to be a challenge. I took a tour around the area, where I found their wasteland for clinical waste disposal and their facilities for cleaning equipment for re-use, such as oxygen masks.

Understanding the True Meaning of Limited Resources.

My central role in the ED was to triage every patient coming through the door. I used their own new triage scoring system and other assessments methods depending on the various presenting complaints. Being faced with language barriers, a lack of equipment and a stressful environment meant each day was a more significant clinical challenge than I have ever met before. ED working hours in Takoradi were not twelve hours; the intensity was not possible for such long periods. Shifts were separated into a morning crew from 08:00 to 15:00 and an afternoon crew from 16:00 to 19:00. The hour between 15:00 and 16:00 meant a few nurses ran the ward without doctors until the second staff changeover arrived.

Amongst the chaos and deteriorating patients, I quickly became frustrated with the lack of resources and new cases arriving periodically. To manage the whole of the ED, we were all fighting over one broken pulse oximeter, one armpit thermometer, and one manual blood pressure cuff. We had a single glucometer replaced with large needles as the only available lancets, requiring force to pierce the thick skin. It felt unethical.



A 10-year-old child entered the ED the next day, victim to a motorbike trauma incident with his father. Visually there is a broken wrist. In Takoradi, analgesia is a strange topic. If you could afford analgesia, you got it, but the doses and choice of analgesia were not as effective as I am used to seeing in the UK. The young patient was sat on his father's lap for over four hours in a splint made from cardboard. When the time came for the wrist realignment, the pain screams were so loud that the child was restrained and given a cloth to bite down on. A noise of terror that could give anyone a sleepless night.

Accepting The New Cultural Norms

As I was absorbing and processing how to adapt to this new environment, I looked in the distance where I saw a lady walking towards the ED. As I approached, I made out that she was holding a baby. As the mother handed me their limp six-month-old into my arms, I watched the relief lift from her shoulders, and I began to triage. Shortly after, the charge Doctor stopped me and said that before taking or starting any treatment, I was to ask the mother for five Cedis to pay for a glucose strip and question whether she had the additional financial means to help treat her child. I never felt like I was more of a monster than that moment, asking for money in cash from a crying mother before starting the treatment on her dying child. Unfortunately, the mother did not have the financial means and quickly fled the situation.

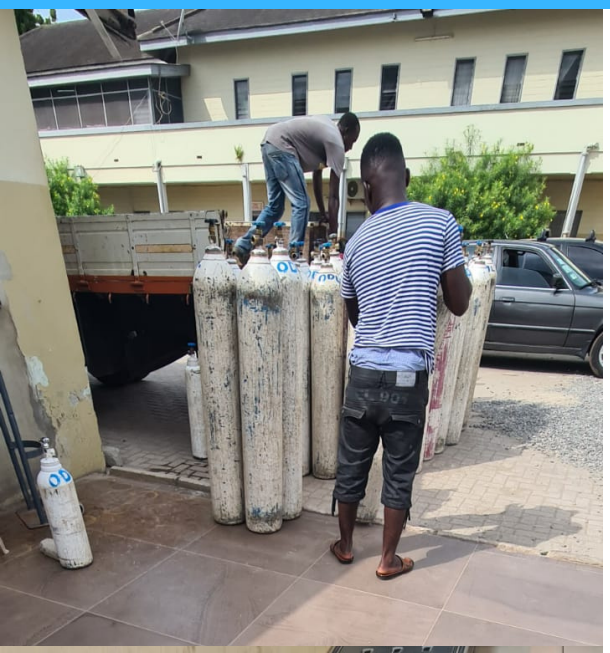
Now, see if you can guess what is being carried in the yellow shopping bag by the porters pictured here. If you thought of a deceased baby, you would be correct.

Family and Culture

I walked into the shade for a few seconds in an attempt to cool from the 31-degree heat. In doing so, I saw many Ghanaians rough sleeping on cardboard outside ED. I quickly found out how vital families are in a patients treatment process. The family will sleep rough outside the ED and follow their family member around the hospital experience. Their role is to take blood to the lab in used gloves turned inside out and buy antibiotics and any other medicine we take for granted so that their relatives and children have a fighting chance. Those who couldn't afford it, unfortunately, relied on hope. In the United Kingdom, It seems to be a fading moral, family taking responsibility to care for their loved ones, no matter the cost. The family here in Ghana also do all the manual handling and personal care, something only trained personally can do in the UK.

The dehydration, malnutrition and skin thickness due to the climate created a world of difficulty when taking blood and putting in lines. The picture of a cardboard box under the only cannulation trolley in ED was their version of a sharps box. With the common problem being overfilling, it didn’t take much for a needle to pierce through. Additionally, you can see nasal oxygen tubing as tourniquets.

Location Adversity



Four hours was the journey to get oxygen cylinders refilled; the truck pictured collects them multiple times a day. The oxygen supply process meant, on some occasions, the ED survived with no oxygen. At this particular time, a family came in with a patient only responsive to pain stimuli. Five minutes later, the patient went into a tonic-clonic seizure on the bed, with no oxygen. When I say bed, the emergency department was always out of them. Other options were either a metal stretcher low to the floor or the ground itself. Attached are images of the stretchers and one single wheelchair we would run to grab if a new patient arrived. During this time, I got approached by a taxi with an unconscious woman in the back. The husband of the new patient grabbed me tightly by the wrists and begged me to do everything I could for her. At first glance, she was presenting with signs classicly associated with having a cerebrovascular event. I knew the patient would not receive a computed tomography (CT) scan any time soon and would thus be reliant on faith. Although I knew the patient was unlikely to recover fully, I had to instil hope where I could; often, I questioned if I was giving hope or just lying.

The Emergency Medicine Dilemma

I am confident the image of the Emergency Drug cupboard, filled with small Tupperware containing one vial of each drug, speaks for itself. The drug shortage caused the ED to find itself out of medicine for many patients regularly.

It was the end of my first week in ED and I was getting changed in the staff room. On leaving, I noticed a 47-year-old having a tonic-clonic seizure with nobody around. The patient was on their back, with blood and vomit blocking the airway. I ran over and tilted the patient onto their side; with no suction available, I manually cleared the airway.

With the only saturation probe occupied elsewhere in the ED, I had no way of checking for hypoxia. I instantly grabbed a non-rebreather mask to administer high flow oxygen. If you look at the images of the oxygen cylinders, you will see they are all humidified and broken, therefore requiring a spanner to control the intensity. Despite my fingers best efforts, I couldn't turn the little dial without a spanner. I grabbed the Dr and explained the situation, which ended up taking four hours to get changed. The on-duty staff grabbed the required Diazepam, with it being the only vial in ED, it took some time. Once the patient recovered, they began to have another seizure, followed by another. Still, with no diazepam available, it was a matter of me repeatedly tilting the patient, clearing the airway, and managing with a faulty oxygen cylinder. It was not until the fourth seizure that the staff in charge demanded Diazepam from the hospital's pharmacy. The patient was unconscious throughout and making a loud wheezing sound. I auscultated and heard strong crackles. With the noise getting progressively worst, it was clear this patient was aspirating, and saturations were quickly declining. After eleven seizures, the plastic box (pictured from another occasion) eventually got ran over to the bedside. Stuck to the front of the box was a piece of paper, reading 'Emergency drug box', filled with vials of different drugs. Unfortunately, before we could administer any medicine, it was clear that this patient was beyond survival. As we had no resuscitation drugs or a defibrillator and a delay in treatment, the staff called the time of death. Hearing someone aspirate to death, from a treatable condition, is a haunting sound I will never forget.

Oxygen cylinders follow patients. As shown in the picture, you can see the difficulty involved. Chains are required before towing these cylinders alongside the patient's stretcher.

Death, Respect and Grievance

Death was something you quickly had to get used to, but unlike in the UK, you had to get used to it for more minor reasons and a younger demographic. One patient had five family members around their bedside. Unfortunately, the patient of this family passed away. The vehicle pictured quickly arrived outside ED. I watched as the patient got abruptly placed onto the stretcher and taken into the hearse. It broke me hearing the daughters crying and watching as the staff dismissed the family from the ED without support. With the language barrier, comforting them felt almost impossible for me. In the UK, our practice is that the family members of a deceased patient become our new patients. Seeing these procedures that I am used to at home not apply here and witnessing first-hand the devastation it caused, allowed me to understand how vital that role of my practice is.

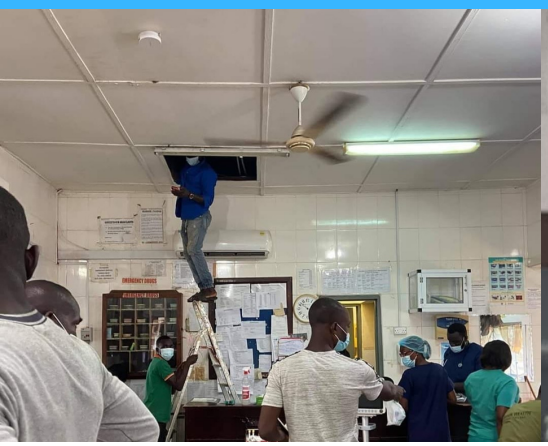
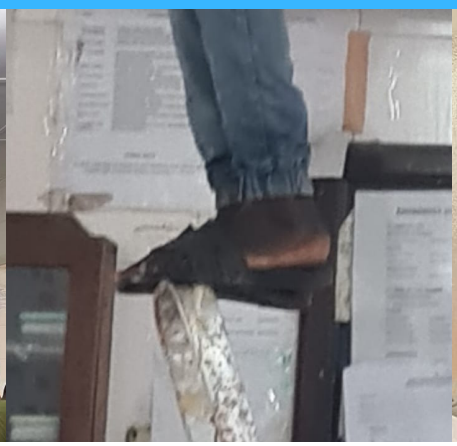
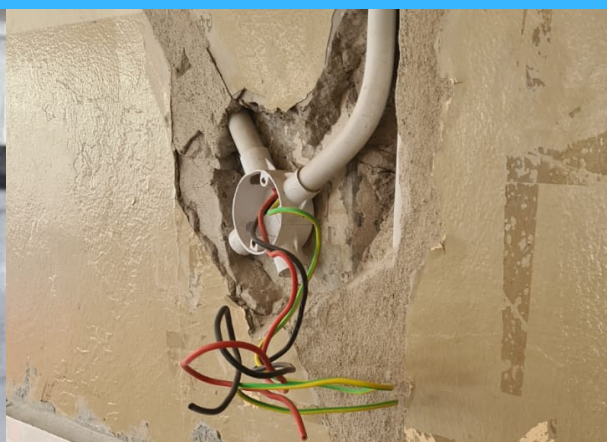
Doctors in Ghana are viewed almost as gods. Although the transition to patient-centred care is slowly creeping its way in, it does not yet exist. Patients in ED rarely get an explanation of their diagnosis before treatment. In the Ghanaian culture, it is seen as disrespectful to question a doctor, and one is to assume they are always doing right by you. At no point would a patient object or question the care they are receiving. Although I approve of consent, patient-centred care, and inclusivity within health care, we see a rise in staff disrespect and services abused in the UK. This reality breaks your heart to think about when you have worked in a culture like Ghana, where everyone has patience, understanding and respect for the system, despite its flaws.

Trauma, Pain, Restraints and Finance

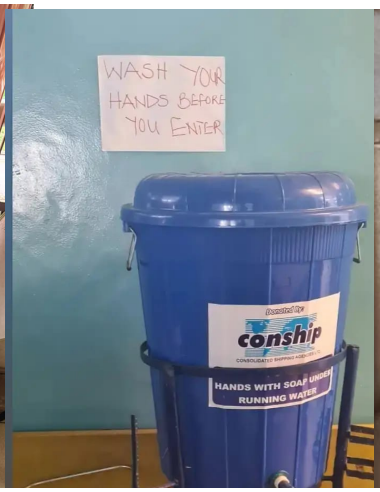
The ED found itself heavily populated by patients subject to road traffic collisions. With no personal protective equipment, these patients enter ED requiring critical emergency care, although they don't receive that care quickly. One patient was experiencing so much pain he was violently shouting and fighting. The patients head trauma meant he didn't recognise his wife. The patient was so distressed, the bottom of the bed was kicked and broken. In the image, you can see straps tied to the patient's feet. Tying ankles and wrists were a standard method to restrain patients coming to the ED with traumatic injuries instead of strong pain relief. Cardboard can be seen again in the image, placed to the soul of the foot, acting as a splint. I spoke to the patient's wife, who approached me in tears, stating she couldn't afford the treatment price for her husband and that they have a newborn together. On this one occasion, despite being informed not to, I helped pay for the treatment.

Paying for patients treatment as staff members isn't a regular occurrence. It is a complex topic because you can't help everyone. On occasions, staff members may feel particularly touched by a particular case. One 14-year-old patient, for example, was being treated by these two doctors for meningitis. With the child's treatment being out of their families financial means, I watched the doctors decide to cover the costs. Despite the efforts, when we all came back in after the weekend and checked on the progress, the patient died. However, there was little room to process the trauma, more patients were waiting, and there was a job to do. In the UK traumatic jobs like these are followed by debriefs and support, in Ghana, you took the approach of ignoring what happened, we all had our own ways of sleeping at night.

Renovations & Hygeine

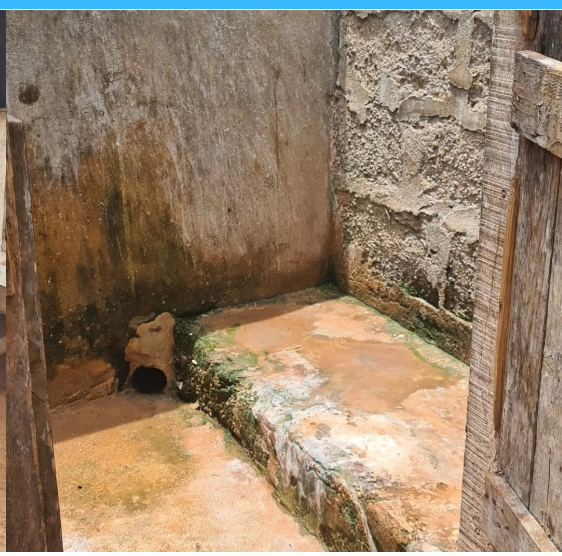
Lighting and electrical issues are a constant battle in the Emergency Department of Takoradi, so much so that it is not uncommon to gain complete power cuts often. Renovations to keep the place running are constantly in progress as we work. The Loud drilling noises around ill patients creates a challenge for communicating. Pictured is a worker in flip flops standing on the peak of a ladder, with live wires over the heads of all our staff. Still, there is no better place to risk your life than in a hospital!


Sanitisation and hygiene aren't as practised in Ghana as it is in the United Kingdom. Although the importance of hygiene is a growing topic within schools, and there is a clear understanding of the risks of infection, the issue lies in that they don't have the available resources to manage effective sanitisation. Pictured are barrels and buckets that you wash your hands in before walking into wards. In the bucket pictured, you can see a collection of dirty water from people having washed their hands. Injuries in ED cause sputum, blood, and vomit to be often seen on the floor. Occasionally, a cleaner with a mop would come around to deal with the spillage, but bodily fluids remained on the floor for long periods. In one instance, I saw a man signal he would vomit, and the staff sent him out of ED to be sick.

Tackling Hygiene and Healthier Living





Tackling hygiene and healthier living is a growing priority in Takoradi. Once a month, the community health care staff visited the local schools to educate on hygiene, amongst other topics, and I joined the teaching. The children were polite and enthusiastic about learning, showing interest in the subjects. These types of education cause intergenerational understanding of the importance of personal hygiene, applying skills they can teach to their family and friends. After the education day, we trekked with backpacks to the local communities to provide health check-ups and educate the population on healthier living. Our demographic was children aged five and younger to ensure they met target weight and milestones for their development. Our other targets were the elderly, where we checked for hypertension and provided lifestyle advice. Some of the women I spoke to said they wake up at 5 am each day to fish and feed their families. This sleep deprivation is one example of how lifestyle affects health in Ghana. However, It was beautiful to see a wealth of gratitude, happiness and pride in a population challenged to survive.


Conclusion

Before I conclude this article, I must stress the stories told here are not the most extreme situations I experienced and have been heavily diluted for various reasons. Despite the stories told may seem exaggerated, it is quite the opposite. With many more extreme cases to discuss, such as witnessing an 11-year-old boy come into hospital alone for human immunodeficiency virus (HIV) treatment, showing independence from a minor you wouldn't ever see in the UK. Or how I took a four-month-old septic patient to another ward for treatment, but as I got there, I was turned away for lack of capacity, later leading to that infant's death. I saw oxygen masks on children that didn't fit. Often, I would see babies in respiratory distress, with a sternal recession, left with an oversized face mask in the corner of a room, later dying from hypoxia, with no aftercare for the family. It almost became the new normal; I expected to come into work and see traumatic death on a much regular basis than I am used to at home. You couldn't accept what was happening around you because nobody was born to deal with seeing such extreme trauma daily and living with asking yourself, did I do enough?

The president in Ghana had announced an intention to build 88 district hospitals. Unfortunately, it remains unknown whether this dream will become a reality. I thank the incredible people of Ghana for accepting me into their country and wish them the best of luck with their journey to an improved health care system. The Ghanaian population is one of the most heart-warming I have ever come across. If you feel like visiting a country populated with kind, honest, and happy individuals, filled with gratitude for the simple things in life, visit Ghana.