JUABEN Hospital, GHANA

I spent my elective placement in Ghana, West Africa, in a Government Hospital for four weeks. My aim of travelling abroad was to experience healthcare under a different health system; specifically in a developing country and experience the challenges it faces in comparison to the UK. I created four learning objectives to utilise this experience and directly improve my nursing care and education, these were:

1. To explore nursing and healthcare in another country, using a different healthcare system, grounded with differing beliefs. Explore the effects on healthcare provided and the challenges they face in comparison to the UK especially to children in remote areas.

2. To experience paediatric nursing in a new environment, with limited technology, solidifying current nursing skills and participating in new skills whilst becoming less reliant on technology to perform nursing care.

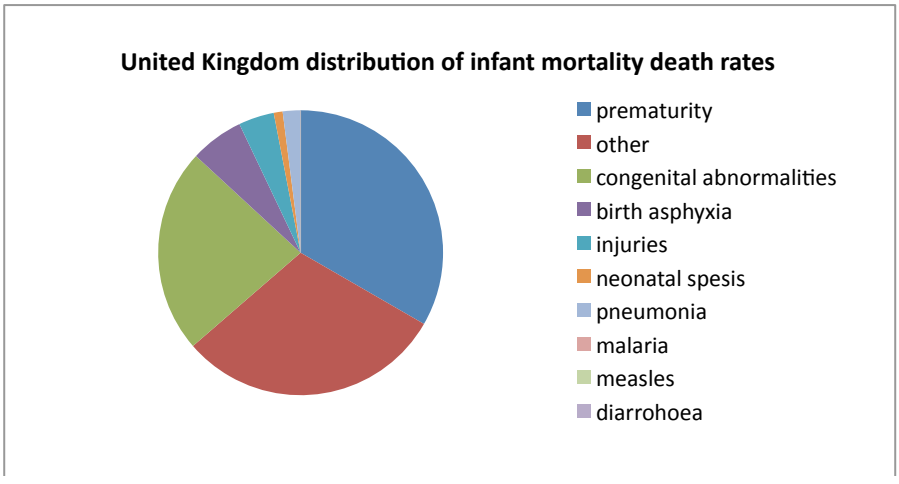
3. Practice nursing in a place with different philosophies and religious influences; comparing these to my personal nursing philosophies to develop a wider view of nursing care.

4. Be able to adapt my nursing skills to new environments and become more confident in my abilities, begin practicing with limiting supervision, thus developing my confidence further.

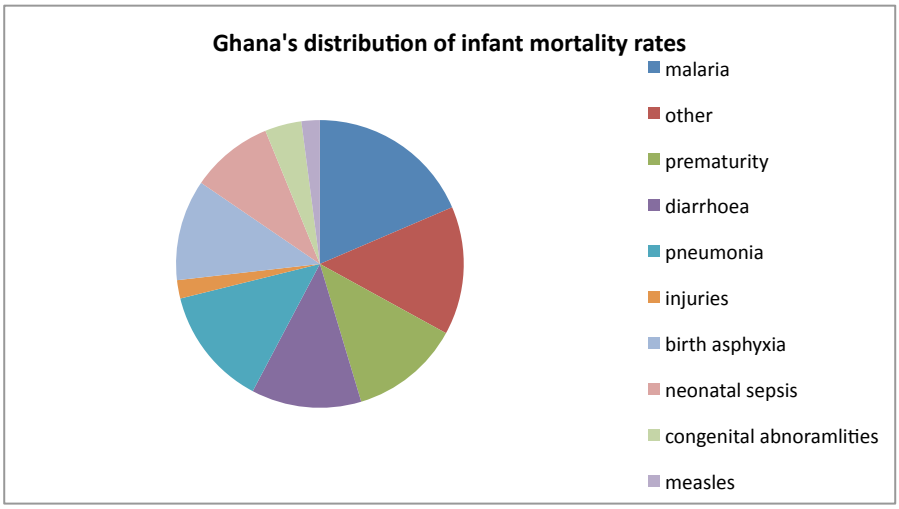
The four weeks were divided between working on the wards and alongside the public health nurses, so I could experience the range of services offered by the hospital. The hospital served a population of 180,000 people and had 47 beds. There was one ward for males and females, and also a paediatric ward, and a maternity unit (Juaben Government Hospital, 2011).

The Ghana Health Service was established in 1992 as an outcome of the medium term health strategy (Ghana Health Service, 2011a). Organised in a hierarchical format with the Government's Ministry of Health at the top (Tabi, 2003), appendix 1 shows the organisational structure of the Ghanaian Health Service (Ghana Health Service, 2011b). The nursing workforce in Ghana is made up of various levels of qualified staff; however they do not have the structured hierarchical banding used in the UK. This has resulted in the more educated nurses, such as those with a degree, with little additional prospects in comparison to their lower educated work colleagues and an unclear job role (Tabi, 2003). In theory, members of the nursing workforce who have minimal training, for example the auxiliary nurses should be supervised by the registered nurses in practice (Tabi, 2003). However, in experience, this is not the reality. The job roles are undefined and often the auxiliary nurses are left to undertake the majority of the nursing workload. This included signing prescription forms and drawing up IV medications without supervision from the registered nurse.

There are high infant mortality rates in Ghana, in the under 5 population (Talley, 2006); World Health Organisation (WHO) statistics show 69 per 1000 infants die a year, in



comparison to the global average of 60 per 1000 (WHO, 2011a). Although this is not a significant increase in comparison to the global average, in comparison with the UK it is much higher, as the UK annual infant mortality rate is 5 per 1000(WHO, 2011b). The pie charts below have been created from the WHO's data (2011a, 2011b).



There are significant differences in the cause for infant admission between Ghana and the UK. The pie chart shows malaria as the key cause of infant mortality in Ghana, however malaria is not a problem within the UK, prematurity is the highest cause of infant mortality. However the Ghanaian Health Service is only predicted to reach 65% of the population (Lavy, Strauss, Thomas et al, 1996) which leads us to question the accuracy of these figures.

In the UK the image of the nurse is described fondly, often with affection; throughout history this persona has remained, adapting with each new generation, and reflected back to Florence Nightingale, and the image of self-scarifying women, with the drive and ambition to care (Hart, 1994, Deloughery, 1991). Porter, Porter and Lower (1989) analysed this public perception and found the common characteristics described as, caring, empathetic and sensitive. However, in Ghana, when talking to patients, nurses did not uphold this reputation; patients appeared to be afraid of the nurses and did not turn to them for emotional support. This was a hard concept to accept as it defies not only the societal view I have grown up with, but also my personal view of nursing. Takase, Kershaw and Burt (2002) researched the impact public image can have over nursing practise, finding it to have the potential to lead to negative implications for the nurses and their practice. The only solution being nurses need to develop a positive self-esteem and strong view of themselves as nurses to maintain well-being and act in defence of the negative issues (Takase, Kershaw, Burt, 2002).

This assignment will now reflect over the experiences I have accumulated during my placement and how these have led to achieving my learning objectives.

Objective 1

In Ghana religion has a large and fundamental role in healthcare, a large number of the population are either practising Muslims or Christians (BBC News Africa, 2012). This religious influence was more monumental than I had anticipated, and its repercussions were prominent across the healthcare setting. On one occasion I witnessed a public health nurse who was told by a mother her child had been possessed by witches and she was therefore sending her to pray camp. Despite this child looking anaemic with a

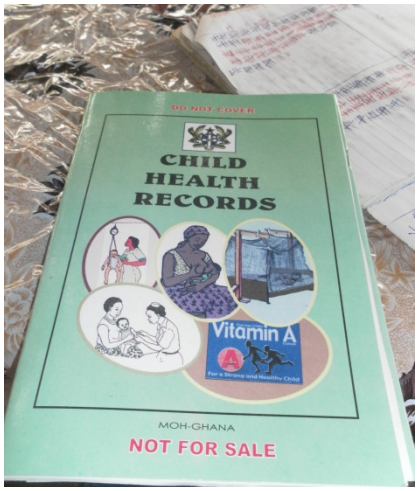
sudden weight loss the nurse advocated this and suggested we all pray for the child, rather than undergo medical investigations and treatment. I found the religion vs. medicine beliefs unbalanced at times by the nursing staff and this potentially could put the patients in danger.

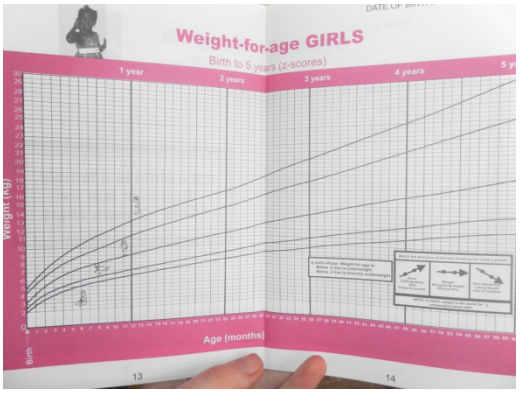
The cultural beliefs stemming from religion had a monumental impact on family planning and the use of contraception. Social stigma surrounded the idea of using contraception; the public health nurses explained women were viewed by the community as promiscuous for wanting to use contraception. As a result despite contraception being readily available in pharmacies and clinics it was rarely used (*pers.comm*), the WHO (2011a) found only 24% of the Ghanaian population were accessing contraception, in comparison to the 84% in the UK who access contraception services (2011b). The public health nurses ran a family planning clinic within the hospital, open 5 days a week between 9-4pm; however this clinic was rarely used as the town was small and women often worried about being seen by other members of the community. The clinic was held in the public health nurses' office, where multiple nurses would often be taking a break; therefore when the women did arrive they did not receive the privacy and dignity they deserved.

Unprotected sex in Ghana has led to an increase in HIV prevalence, which is 10% higher than the global average per 100 of the population (WHO, 2011a). Despite in practice the public health nurse promoting family planning in experience religious beliefs overruled this. In rural villages gender inequality is visible and the autonomy contraception would provide these women over their fertility would have a major impact on their lives (Bawari, Akweongo, Simmons et al, 2003). The local churches promoted mixed health messages on HIV and Aids, suggesting premarital sex is the cause of HIV and Aids, yet they did not discuss the possibility of contracting the disease after marriage or prevention through the use of contraception. In a country with a large emphasis on a religion healthcare working alongside them is vital to gaining the public's awareness and promoting informative public health messages.

The rural communities were more remote and isolated than imagined, often taking over an hour to travel a few miles down pot-holed tracks to reach and provide healthcare to the villages. Public transport was widely used by the majority of the population as few owned private vehicles; nevertheless public transport was often in poor condition and the heavy rain on the roads destroyed these further, and made travelling difficult and lengthy (Talley, 2006). However the outreach clinics are often the only access to healthcare some communities receive and therefore the monthly running of these clinics are a vital service.

The mothers attend these clinics with their children from birth until 5 years, and on average the clinics had a high turnout. During the clinic the child would be weighed and immunisations were given, in addition the nurses would provide any health advice if the mother required. The mothers held a Child Health Record book, similar to the red book used in the UK for each of their children. Below are photographs I took during my elective of the Child Health Record books:





The image on the left shows the cover of the book, the image of the right is a centile chart used to plot the weight of girls between birth and 5 years old.

The Child Health Records were introduced into Ghana between 2002 and 2004 (Bawari et al, 2003), however the booklets are written in English, which despite being the national language (BBC News Africa, 2012) is the more educated citizens. I found many of the mothers during the clinics were unable to speak basic English and therefore expecting them to read the advice in these record books was unrealistic, although the public health nurses believed the illustrative pictures resolved the language barrier. Quality Health Partners (2006) conducted a review of the Child Health Records across Ghana, taking a comparative sample of the population from various districts. They found caregivers with no education are 80% less likely to use the record for advice when their child is ill; the suggested cause for this was their inability to read the information, this highlighting the ineffectiveness of the pictures.

The mothers received health education during the clinics, the picture shows one of the sessions I witnessed, which provided advice on tuberculosis awareness and alternative feeding methods. These sessions were ran during the clinic and mothers would wait with their child to listen to the nurses speak. These teachings sessions were spoken in twi, the local language, and therefore more beneficial to the mothers. However this teaching was only carried out in the larger communities, although still beneficial these are closer to the healthcare amenities and can access services easier; therefore health education especially in early detection of diseases and first aid would be beneficial to the remote villages, enabling them to realise when to access services rapidly.

Lack of hospital transportation had a huge impact on the outcome of many children

living in the outreach communities. The only ambulance system in the area was to transport patients between hospitals or transport the public health nurses to the remote

communities. Therefore ill patients had to rely on public transport to arrive at hospital in time, which according to the hospital records often would not happen. However the Ghanaian Government established the National Ambulance Service in September 2011 (Government of Ghana, 2011). They launched 161 ambulances with the aim of expanding this further to several district hospitals in the near future, and hopefully this will eventually lead onto Government hospitals. Prior to this trip I never fully appreciated the importance the emergency services had in the rapid provision of medical intervention. Looking through the medical records book in the hospital, dehydration was a recurring factor in paediatric deaths, often secondary to another disease. On admission to hospital often the dehydration was so severe intravenous (IV) access could not be obtained, due to the clinical officers only having access to limited and basic IV access resources.

Objective 2

On observation and discussion with medical and nursing staff resources were limited within the hospital setting. As a result of this equipment and resources were used sparingly, usually only if the patient was high risk (Talley, 2006). This shortage was reflected in the high costing of resources patients without health insurance would be charged.

In Ghana, limited resources resulted in unsafe nursing practice. A key example was IV administration, due to the cost of IV fluids and IV giving sets the same fluid bag would be reused until it was empty and the same IV giving set was used throughout a patient's admission. Within the UK, policy states the administration sets must be changed every 72 hours and immediately after contamination (Royal College Nursing, 2010). Poor IV infection control provides microorganisms with direct access to the blood stream, which causes infection (Scales, 2008). Unfortunately due to cost and access to resources, patients were often exposed to a high risk of infection; the clinical officers' response was to prescribe all patients with antibiotics as a prophylaxis as these were cheap for the patient and readily available. This image was taken on one of the wards and was a common sight; the giving set would be removed from the patient and left to hang, then later reconnected to the patient's cannula.

The UK is an affluent country with resources available to allow best practice, however in Ghana, the risk and potential harm to the patient by not having the IV fluid is greater.

An example is the treatment of malaria through Quinine; the risk of harm to the patient becoming hypoglycaemic from Quinine, especially when administered via injection (British National Formulary, 2011) was greater than the risk of infection due to the preventative antibiotics. Blood glucose monitoring sets were also limited and therefore the 5% dextrose prevention fluids were imperative in maintaining the patient's glucose

levels, little medical intervention could have occurred if a hypoglycaemic attack happened.

Through the abundance of resources and technology reliance on technology in the Western World is becoming more prevalent. Despite being taught as a student how to undertake nursing skills manually these are rarely transferred into practice; a patient's condition is determined predominately by the machinery readings. Whilst in Ghana I utilised these manual observation skills due to a lack of technology, especially whilst taking vital signs, the only pulse oximeter in the hospital was used for anaesthetic in theatre. Therefore my confidence in manual nursing skills and spotting the sick child grew, and acting on my gut instinct developed.

In the Ghanaian hospital the paediatric ward had 10 beds, constantly full. 90% of these children were admitted with malaria, and they often also had secondary problems to this, usually anaemia and sepsis. The busy bed state of the paediatric ward often resulted in children being admitted onto the adult ward for treatment. In the UK this would not be acceptable as services on the adult ward would not be to a sufficient standard; instead they would be transferred to a different local hospital. The staff would not have undertaken paediatric training and provisions such as parental accommodation and play facilities would not be available; without these the hospital would be breaching the Department of Health (2011) policy for treating children in hospital. Play facilities and allowing children in hospital to play is an integral aspect of some children's coping mechanisms allowing them to relax and express fears and emotions (Great Ormond Street, 2008). Play can also be used during procedures to distract the child (Great Ormond Street, 2008). In Ghana toys and stimulation were not present on the paediatric ward, in addition play was also absent from the paediatric hospital experience, children were treated as small adults and no additional support was provided. Therefore the approach to paediatric nursing in Ghana was very different to those in the UK, witnessing this has solidified my paediatric family-centred care beliefs, practised in the UK.

Objective 3

An individual's nursing philosophy is a concept often discussed within healthcare, and something I believe develops with knowledge and experience. Smith, Coleman and Bradshaw define philosophy as; 'an explicit statement of ones beliefs and values' (2010:p. 73). Prior to my elective placement I was unaware of my personal nursing philosophy. However during my elective I witnessed nursing care in Ghana I believed to be morally wrong and unfair on the child. I began to realise the aspects of nursing I focus on in practice such as family-centred care, empowerment of the individual, treating children as children and the right to remain as pain free as possible. These appeared to be absent from the care provided by the nursing and medical staff in Ghana. However, Agyepong (1999) reported an imbalance in the nursing hierarchical roles and tasks, demoralising the nurses and potentially reducing the nurses best practice, and alongside this their nurses' philosophy. On discussion with a clinical officer at the hospital they informed me of the differences between nursing care and attitude in small government hospitals in comparison to the large district, teaching hospitals where the standard of care is much higher.

Reed and Ground (1997) explained the distinction between a good and focused philosophy to a poor philosophy; when questions can be clearly explained and difficult concepts are given clarity leading to conclusive decisions then an individual has developed a strong positive philosophy. By exposing myself to negative practice I have been able to begin to realise my nursing philosophy and now feel confident in utilising this to work at best practice benefiting the patient.

In Ghana, inpatients on the wards were forced to be independent, the nurses attended to no personal cares; patients had to rely on family to provide food, and water was

collected from the well outside. For the paediatric patients the mother stayed with the child and attended to cares, yet the mothers would often take the child home during the day to cook for the rest of the family and bring their child back for medications. The majority of children were admitted with malaria this would often result in the nurses allowing a child with a spiking and uncontrolled temperature to leave the ward for hours at a time with no monitoring. However the mothers had to cook and care for the rest of the family, and the nurses would not monitor their ill-child whilst they did this, leaving the mothers with little choice. For adult patients, those without family were expected to self-care and attend the canteen for food. During my placement I never saw a nurse undertaking any personal cares or assisting patients or their family, after a patient who had suffered a stroke had been admitted for 72hours the nurses told the family the need to mobilise to avoid bed sores, but this was prescriptive and no help or further advice was provided after this conversation.

Nursing in a hospital with no resuscitation equipment made me anxious; we asked one of the nurses what they would do if a patient arrested; their response was 'nothing, they would be dead' (*pers.comm*). This was difficult to accept and against my nursing philosophy, I was conscious about being proactive rather than reactive to a sick child. During one shift a child was spiking extreme temperatures and losing consciousness. However the nurses were not concerned and the medical team did not intervene, they did not expect the child to live, as their condition had not been diagnosed. As student nurses we understood without resuscitation equipment time was even more limited and interventions had to happen rapidly. The nursing staff ignored our concerns, however despite the limited resources it was against our nursing philosophies to leave this child and therefore we continued to intervene by approaching the medical team. The younger clinical officers were hesitant, wasting resources on a patient who would not survive, yet eventually one of the clinical officers began to respond and prescribe the necessary drugs, gain IV access and take blood samples. After 7 hours of constant IV infusions, observation and sponging the child began to respond to treatment, and regained consciousness, managing to breastfeed, the doctor was in tears, astounded the child had survived. This experience grounded my own nursing ability and philosophy, the importance of giving every patient a chance. The child is now thriving and their condition diagnosed.

Communication between the nurses and the patients were limited, this experience has reinforced the importance of communication and the benefits for the patients, even across a language barrier. I became more aware of my non-verbal communication, using soft options of non-verbal communication, for example positive body language and eye contact (Davies, 1994), helping to develop a relationship with the patient. The caring approach to providing comfort, especially towards parents was not displayed in Ghana, yet Davies (1994) describes the improvement this can have on their quality of care.

<u>Objective 4</u>

Ghana was a new environment, both as a country and within its hospital setting, the support provided by the nursing staff in Ghana was of a different nature to that at home, this pushed me further, working to the limit of my abilities whilst abiding with the Nursing and Midwifery code of conduct (2008) and this resulted in a large boost of confidence.

The variety of conditions and diseases within the Ghanaian hospital resulted in an understanding of how to care for patients with tropical diseases, such as malaria. Although malaria is not prevalent within the UK, the disease affects 3.3 billion people across the world, thus equating to around half of the world's population (WHO, 2012). With the increase in migration of nurses across the world searching for new learning opportunities (Kingma, 2001) the knowledge gained will remain useful beyond registration.

These conditions were discussed and taught during the daily ward rounds. The medical team would teach and question the nursing staff on the conditions of the patients. As this was a daily occurrence new conditions would be explained to the nurses and then they would be quizzed the following day; this proved a valuable positive learning opportunity and improved my medical understanding of conditions and reasoning behind investigations alongside my confidence in my own knowledge.

In conclusion my elective placement has been the largest learning opportunity of my nursing practice so far. The extremities between the facilities and attitudes of the hospitals and nursing staff of the UK and Ghana pushed my nursing knowledge and increased my confidence in the nursing ability I possess. The experience of nursing patients with tropical diseases and other conditions uncommon within the UK has broaden my depth of nursing knowledge and this continuum of learning will continue into and beyond registration. With the limited resources and reduction of technology available my confidence in observing symptoms and listening to my gut response when spotting the sick child has developed. All 4 objectives despite being broad were achievable during my placement; I feel I matured greatly during the opportunity both professionally and personally. The experience of travelling and nursing in sub-Saharan Africa was out of my comfort zone, yet I loved the entire experience and would love to use my nursing registration to pursue this in the future. Through negative experience have realised the value of communication, taking time to talk to the parents and child, even if they have no concerns, due to the language difference I have developed my confidence in providing non-verbal communication; this will be particularly valuable for patients who speak limited English to build a relationship when an interpreter is not present and provide quality care. Seeing the difference in the children's response to treatment between the UK and Ghana reinforced the importance of treating children as children. Most importantly I have learnt to appreciate the NHS, seeing the consequence of poor health service on a population put into perspective any previous criticisms of the NHS.

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