REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING

AKWAABA:
Welcome to Challenge and Achievement in Ghana

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Akwaaba: Welcome to Challenge and Achievement in Ghana
Guest Editor: Brenda F. McGadney

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Child Labor: The Silent Thief of Children's Rights in Ghana

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The phenomenon of child labour is subtly destroying the future leaders of Ghana. This narrative describes the author's experiences with child labour, the nature of child labour, and the practices that promote it in the informal sector of Ghana. It also provides additional stories and experiences of victims of child labour and those who have identified with them. The narrative concludes with lessons learned and recommendations meant to ensure that economic prosperity is not gained at the expense of children. All names of children in this narrative have been changed.

Introduction

The phenomenon of child labour has existed for many generations in virtually all parts of the world. In 1998, the International Labour Organisation (ILO) estimated that around 12.5 % of children between the ages of 10-14 were engaged in some form of labour the world over (ILO 2006). In 2008 there were about 215 million children working illegally in the eyes of international law across the world. About 14 % of children around the world under the age of eighteen are engaged in child labour. An estimated number of 115 million children under age fourteen are engaged in hazardous work (Acheampong, 2010).

The phenomenon of child labour in Ghana is gradually becoming a threat to the lives of children. In 1997, the World Bank estimated that approximately 12.6 % of Ghana's entire labour force was made up of children, with over 80 % of children in rural areas engaged in some form of labour (Tedam, 2009). A study conducted by the Ghana Statistical Service (GSS) in 2001 estimated that out of the estimated 6,361,111 children in Ghana, approximately 20% of them were engaged in various forms of child labour; about 3.8% of this figure were engaged in activities classified as hazardous work, such as: head porters, domestic work, commercial or ritual servitude, small scale mining and quarrying, fishing, commercial agriculture, and commercial sex (Opare, 2007). The Western and Eastern regions, along with three regions in the North have the highest reported cases of child labour (Acheampong, 2010).

The Nature of Child Labour in Ghana

In Ghana, most child labour activities are confined to the informal sector. Children as young as seven years old work as domestic labourers, head porters, hawkers (selling items on the street and in open markets), miners, quarry workers, fare collectors, and in agriculture industry. The fishing industry on Lake Volta had a particularly high number of child labourers engaged in hazardous work, such as deep diving. Child labourers are poorly paid and subject to physical abuse. They receive little or no health care and generally do not attend school (Public agenda, 2005).

As a young boy, I was brought up in the rural forest belt of the Ashanti region of Ghana and thus witnessed the exploitation of children similar to my age. There is ample evidence to prove that the agricultural industry has been the main sector responsible for employing children in rural areas. It is a common practice in Ghana for cocoa farmers to engage family members (both young and old) in the production of cocoa. Adults see the involvement of children in farm work as a form of apprenticeship in the cocoa industry, but in many cases the reason may be because parents cannot afford to hire farm hands. It is also seen as a way of training children to take

over from their parents when they are old (Kuapa, 2009). However, what could have been a good practice and discipline is sometimes abused to the detriment of child's development. Children are often made to engage in farming activities such as handling dangerous farm tools and chemicals, and undertaking work which is beyond what they can manage. In some communities children engage in farm activities at the expense of their education and physical development, due to the fact that either there are no schools in the hamlets or the quality of education is poor.

Along the coastal areas of Ghana, fishing has been one of the major industries that employ children. In the Volta Lake region of Ghana, the "Tongus" regard fishing as an integral aspect of their cultural identity, and insist that their children inculcate the fishing processes and occupation, no matter the circumstances. Therefore, Tongu households of all social classes ensure that their members begin absorbing the knowledge, attitudes, skills, and values associated with fishing and fish processing as children. Children are trained from an early age to acquire skills in swimming, handling the fishing net, and diving through apprenticeship. Female children are not left out, and are also taught fish-processing skills. Thus, children from this ethnic group have to contribute to the household fishing activities whether in school or not.

Child labour in fishing and fish processing therefore becomes the socio-cultural mechanism or indigenous traditional practices by which the fishing culture is transferred from one generation to the next.

The migration of children is also associated with the fishing industry. By early adolescence, some of the children who have acquired enough skills and confidence in fishing migrate to other communities to engage in fishing and related labour. It is a common practice for children of the Tongu ethnic group to travel to thriving fishing communities during school holidays to engage in fishing and return when school re-opens. But in some cases the movement is permanent. There is ample evidence that children from other fishing communities in Ghana travel to towns like Yeji, Battor, Buipe, and Yapei, along the banks of the Volta River to pursue fishing as means of supporting their families.

Child trafficking is a phenomenon directly related to child migration in the fishing industry. Fisher-entrepreneurs actively look for young workers and, with the consent of parents or guardians, such children (both males and females) are taken away from their hometowns to work under a verbal agreement that lasts for as long as five years. When the term of the agreement is up, they are rewarded in cash or kind. Boys are usually rewarded with a cow, and girls may receive a sewing machine or cash. This transaction may or may not be facilitated by an intermediary.

Parents who are financially indebted to boat owners participate in another cultural practice that promotes child labour by releasing their children to work for their creditors, thus placing their children in debt bondage.

The Six-Year-Old Fisherman

Kete Krachi is a town in the Volta Region of Ghana and is adjacent to Lake Volta. Because of its proximity to the Volta River, most people living there engage in fishing activities. It is a common practice for children to be leased into servitude by their parents, guardians, or child traffickers. The narration below describes one young boy's ordeal under his master:

> *"Mark is 6 years old. About 30 pounds, he looks more like an oversized toddler than a boat hand. He is too little to understand why he has wound up in this fishing community, a two-day trek from his home. But the three older boys who work with him know why.*
>
> *"Like Mark, they are indentured servants, leased by their parents to Mr. Takyi for as little as $20 a year. Until their servitude ends in three or four years, they are trapped like the fish in their nets, forced to work up to 14 hours a day, seven days a week, in a trade that even adult fishermen here call punishing and, at times, dangerous.*

"Just before 5 a.m., with the sky still dark over Lake Volta, Mark is rousted from his sleeping spot on the damp dirty floor. It is time for work. Shivering in the predawn chill, he helps paddle a canoe a mile out from shore. For five more hours, as his co-workers yank up the fishing net, inch by inch, Mark bails water to keep the canoe from sinking. He last ate the day before. His broken wooden paddle is so heavy he can barely lift it. But he raptly follows each command from Mr. Takyi (his master), the powerfully built 31-year-old in the back of the canoe who freely deals out beatings. 'I don't like it here,' he whispered, out of Mr. Takyi's earshot. Mr. Takyi's boys are conscripted into a miniature labour camp. They are deprived of schooling, basic necessities and freedom." (www.cosay.com)

The Donkey Boy

The most impoverished regions in Ghana are the Northern, Upper East, and Upper West regions. The national average of poverty is estimated as 39%, but in the Northern region it is 69%, 88% in the Upper East region, and 84 % in the Upper West region (Abagali, 2002).

Savelugu (in the Northern region) used to have access to a regular supply of potable water. However, the supply is no longer able to meet the needs of a growing population. People living on the outskirts of the town are severely affected, and now rely on other sources, such as untreated dam water and hand-dug wells. Accessing water from these sources requires a 5-6 kilometre trek. Due to these long distances, young school aged boys use donkeys to haul drums of water from the dam and other sources to sell in the town centre. These water vendors are known as "donkey boys." In order to sell water, some of these children have either dropped out of school, do not attend class regularly. In any random group of ten vendors, only one or two are likely to be in school. One such drop-out is 23-year-old Sulemana:

"Sulemana has been a water vendor since he was 8 years old. He does not go to school. He had the privilege of enrolling in a basic school only to drop out at class one. He said: 'I was in class one when my father took my brother and I to farm in Walewale. After harvesting, my father sold his farm products and bought this donkey for us to cart water for sale.'

"Sulemana's day begins as early as 5:30 a.m. He carts water back and forth until 1 p.m. Sometimes, to keep up with customers' demands, he resumes working at 4 p.m. Since they have only one donkey for their business, his elder brother goes round the town to solicit customers whilst Sulemana carts the water.

"A drum of water often goes for 6.00 Ghana cedis (about 67 cents). On an average day, the brothers sell about five drums. All the money they earn goes to their father, who uses it to buy food and other necessities for the family.

"Even though Sulemana's wish is to be in school instead of carting water every day, he seems to have resigned to his fate because it doesn't seem to be achievable for now." (www.cosay.com)

The 11-Year-Old Head Porter

Accra, the capital of Ghana, stretches along the coast of the Atlantic Ocean and was originally built around a port. Its architecture ranges from large and elegant 19th century colonial buildings to modern offices and apartment blocks made of concrete, glass and steel (www.ghanaweb.com).

The majority of Accra's ever-expanding population can be found in Shanty towns at the edge of the city. The central business district of Accra houses most of the banks, department stores, and Ministries, where the government administration is concentrated.

The roads leading to the city centre are lined with people selling all manner of things ranging from food, pastries, clothing, and electronic gadgets to cast iron gates. Visitors to Accra for the first time would be greeted by women with their babies strapped at their backs selling all sorts of things by the road side (www.ghanaweb.com). Thousands of children live and work on the streets of this diversified city. Amina, an 11-year-old orphan from Northern region, is one such child:

> *"Amina, 11, is an orphan who works as a head porter in Nima, a suburb of Accra. Porters like Amina, known in local dialect as 'kayayei', carry heavy loads in a basin balanced on their heads. She said in an interview that she came to Accra in 2007, when she was nine, after her parents were killed. They were returning home from their farm on a bicycle when her parents were hit by a car and killed.*
>
> *"Although she has aunts and uncles, they not only declined to take in the orphan but they also accused her of causing her parents' deaths. Since she had no other family to run to, her only option was to head to Accra to find work and take care of herself. She now carries loads for shoppers in the Nima market for a fee.*
>
> *"She charges 70 pesewas ($ .50 U.S.) for a small load and one cedi ($ .68 U.S.) for a bigger load. After the day's work, she waits for shops to close so that she can sleep in front of one of them. She indicated that she has been robbed a few times of money she made that day.*
>
> *"She appealed to the government to come to the aid of child labourers like her and provide them with shelter and support. She asked that her full name should not be disclosed because she feared for her safety if her relatives should learn of her whereabouts." (Nyarkoh, 2009)*

There are many such children in Accra. They are deprived of basic needs such as shelter, education, and protection.

The Chop Bar Worker

> "Michael is a 14-year-old boy from Nkawie in the Ashanti region of Ghana. He is the third born of his parents, and has four other siblings. In 2007, the Nkawie District Social Welfare Officer found Michael in Bibiani a town in the Western region of Ghana working in a local restaurant (chop bar). His job was to pound 'fufu' (a local meal in Ghana). The activity involves using a wooden pestle to pound food substance in a wooden mortar. His wage was three Ghana cedis ($2.08 U.S.) a day. In addition to the wage, he was also fed twice a day from the restaurant. According to the District Social Welfare Officer, this activity is hazardous to his health, and can also negatively affect his future development since he does not attend school.
>
> *"Narrating his story, Michael claimed he dropped out of school because his parents were poor and could not afford to take care of his education. He indicated that even though he did not get the opportunity to have a formal education, he doesn't want his other siblings after him to suffer the same fate. As a result of this, he has taken to work in the local restaurant so that he can support his parents to educate his junior siblings. He sent part of the income he received to his parents to take care of the family needs and also the education of his siblings.*

The above narrations give credence to the problem of child labour in Ghana. There are a large number of trafficked children working in the fishing industry, quarries, cocoa and rice plantations, in most rural areas. In the cities, girls mostly work as domestic servants, bread

bakers, head porters, street hawkers, and prostitutes. Boys also work as construction workers, cart pushers, news paper vendors, street hawkers, and in mining towns, as scavengers in abandoned gem and gold mines (www.cosay.com).

There are some important lessons to be learned from the narrations. First, it is a fact that cultural practices and poverty are among the main factors that account for child labour in Ghana. Among the Tongus for instance, there is nothing like child labour. Even though children are made to participate in fishing activities, this is interpreted as apprenticeship; a process through which the knowledge, attitudes, skills, and values associated with fishing are inculcated in their children to sustain the family business. Cocoa and other farmers in the forest belt who engage their children in farming activities also have the same views about teaching their children the family business. Child labour in Ghana, to some extent, can be said to be rooted in cultural and indigenous traditional practices.

Second, the narrations have also amply demonstrated that parents who lease their children to servitude are compelled by poverty to do so.

A final lesson considers the protections of children against child labour. From the narrations, one wonders whether there are laws in Ghana that protect children and enjoins the Government to provide basic necessities to its citizenry. Ironically, Article 28 of the *Constitution of Ghana* provides that "...every child has the right to be protected from engaging in work that constitutes a threat to health, education or development." *However,* the enforcement of this provision has not been effective, thereby giving the perpetrators of this inhuman activity free reign to operate. To some extent the government and its agencies cannot also escape blame for the existence of child labour in Ghana.

The Way Forward

How can Ghana as a country curb the menace of child labour? The way forward is for the Government to show commitment to the fight by strengthening and giving resources to the Department of Social Welfare to rise up to the task and deal with the problem.

Parliament should review the penalty for the contravention of the *Children's Act* and make it more punitive. As it stands now, the penalty for the violation of child labour laws in Ghana is not enough of a deterrent. For instance, Section 15 of the *Children's Act* states that, *"...any person who contravenes a provision of the act commits an offence and is liable on summary conviction to a fine not exceeding GHc 500.00 or to a term of imprisonment not exceeding one year or both."* Offenders deserve a more stiff punishment.

Additionally, the government should institute measures that would ensure the seizure—in part or full—of any property acquired through exploitative child labour. For those executing government's projects, the state should, in addition to this seizure of property cancel their contracts and withdraw their license of operation. The seized property may be sold and the proceeds paid into children's funds to help educate victims of child labour.

In conclusion, it is evident that child labour is harmful and hazardous to the health and safety of the child. It affects the mental, physical, and social development of the children. In some cases it interferes with their schooling, while it completely deprives other children of the opportunity to attend school. Ghana cannot afford to mortgage its future by engaging her children in labour activities instead of schooling. The time to halt the phenomenon is now.

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Reflections On Sickle Cell Disease Research: Lessons Learned From An American Student's Collaborative Research Experience and Travel in Ghana

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This narrative describes the experience of an American student who traveled to Ghana in order to conduct sickle cell disease research. Intertwined with important lessons learned during the journey, are research experiences and reflections from a personal journal, a travel log, and insights gained through community service. The narrative discusses local barriers to accessible health care and encounters with limited resources. The aim is to offer insights into working effectively in Ghana as a foreign research assistant.

Introduction

In 2008, I traveled to Ghana to conduct clinical research through an internship with the Minority Health and Health Disparities International Research Training (MHIRT) program. The MHIRT program is funded by the National Institute of Health and allows faculty and students to engage in numerous health-related research projects in Ghana and many other countries. The University of Michigan and the University of Ghana are the collaborating sites for the "MHIRT Sickle Cell Disease Project." Sickle cell (SCD) disease is a significant public health issue in Ghana. One research aim is to investigate the clinical variability in the manifestations of SCD through studies involving twins and siblings with sickle cell disease.

Insights shared by past MHIRT interns facilitated more effective work on our part. I offer this narrative to students, researchers, advocates, volunteers, and helping professionals who may work or travel in Ghana. In addition to reflections on living and working in Accra (the capital of Ghana), and traveling to various regions in the country, I discuss the misconceptions of SCD. Of particular concern to me are barriers to accessible health care, disparity in the availability of resources, and education about sickle cell disease. I also describe the roles played by team members of the "MHIRT Sickle Cell Project."

A Perspective on the Cultural Transition

My senses were overwhelmed as I walked down the streets of Osu, a district of Accra, Ghana. Some women were carrying infants on their backs using traditional cloth. Many men, women, and children carried items neatly balanced on their head, such as mounds of fresh fruit, heavy bags of rice, sachets of pure water, *FanYogo* (frozen yogurt), stacks of T-shirts for sale, various artifacts, and much more. West Africa is notorious for its vibrant, crowded markets. Many Ghanaians make a living at the markets by selling a variety of things, such as food, clothes, household products, or by offering services such as sewing.

My research partner, Regina (a Ghanaian-American), and I lived in the International Student Hostel on the Korle Bu Teaching Hospital (KBTH) campus in Accra. I was quickly introduced to a lifestyle of occasional power outages, lack of running water, the heat of the dry season, and the fierce thunderstorms of the wet season. In response to the lack of running water, I adopted the method of taking cold, bucket showers. My daily routine involved taking malaria prophylaxis and spraying mosquito repellant. I happily adjusted to a significantly different pace in everyday life.

In addition to adjusting to a new lifestyle, I discovered a different system of racial

enculturation. "Obroni" is a Twi word that can be used as a racial or cultural term. Twi is one of over 49 ethnic languages spoken in Ghana. "Obroni" is often used to identify a foreigner from a Ghanaian perspective and is not derogatory. However, I was not thrilled by the attention given me as a foreigner because of the stereotypes that may be attached. On occasion, I encountered the belief that foreigners all have abundant resources. I developed a level of comfort in being asked: "Are you South African?" I would respectfully explain that I am from the United States and not South African, but a multiracial American. Memorable conversations often followed those encounters.

After viewing a historical display of the Atlantic Slave Trade and the "Brazilians of Africa" in Jamestown (another district of Accra), Regina and I chatted with a few local children. Two young children around the age of five captured my heart and my attention with their smiles. We all walked over to a sandy, trash-ridden beach and the children proceeded to play a game called Mancala. Ironically, the breeze from the Atlantic Ocean gave me a sense of calm, even though I was standing on land with a tragic, painful history.

Preparing to depart from Jamestown, Regina and I boarded a *tro-tro* (a passenger van). With the help of friends and locals, we learned to navigate the *tro-tro* system in Ghana. I peered out the window at a group of children making hand gestures near their mouths. Regina explained that they were asking for food. I had leftover food from lunch, plantains and *jollof rice*, a popular West African dish. Wasting food is often a tourist's habit, even in a country where children die of malnutrition and starvation every day. It was an inherent reflex to want to share this leftover food, but the *tro-tro* pulled away before I registered the meaning of their gestures. On the other hand, I did not want to perpetuate the image that foreigners have unlimited resources. My purpose in Ghana, in part, involved conducting clinical research on sickle cell disease and learning about life in Ghanaian culture.

Sickle Cell Disease in Ghana

The MHIRT Sickle Cell Project recruited participants for the study at the sickle cell clinic at Korle Bu Teaching Hospital (KBTH), where Ghana's first and largest sickle cell disease clinic is located. The University of Ghana Medical School is affiliated with Korle Bu Teaching Hospital and many medical workers live on the campus. KBTH is the primary health care facility in Ghana, and the only tertiary hospital in southern Ghana. The government supports a large portion of the nation's health care through the Ministry of Health (MOH). The MOH is responsible for providing public health services, as well as building hospitals and supporting the medical educational system (see http://www.ghana.gov.gh/index.php?option=com_content&view=article&id=332:ministry-of-health&catid=74:ministries&Itemid=224).

Sickle Cell Disease is a pressing public health issue in Ghana. SCD is an inherited disorder characterized by abnormal hemoglobin due to a mutation (see http://www.sicklecelldisease.org/index.cfm?page=about-scd). Hemoglobin is the iron-rich protein found in the red blood cells and is responsible for oxygen transport in the human body. When red blood cells containing abnormal hemoglobin are deoxygenated, they form a sickled shape similar to a half moon shape. Sickled red blood cells cannot flow through blood vessels as easily as normal hemoglobin and are prone to getting stuck. Such blockages can form in blood vessels and prevent oxygen from traveling to where it is needed. This often induces attacks of severe pain called a "pain crisis," a common complication for those with this disease.

In Ghana, sickle cell disease affects one in every fifty babies (see http://www.sicklecellghana.org/index.php?option=com_content&view=article&id=48&Itemid=55), and is the most common genetic disease in all of Africa; more than 400,000 babies are born with sickle cell disease per year. In comparison to the United States, for example, it is estimated that SCD occurs in one out of every 500 African

American births and in one out of every 36,000 Hispanic American births (see http://www.sicklecelldisease.org/). Sickle cell disease is considerably prevalent in sub-Saharan Africa and in African-Americans, but it is not a "Black" disease. SCD is also common among people whose ancestors come from East Indian, Caribbean, Arab, and Mediterranean countries. These regions tend to align with the "malaria belt," parts of the world where malaria is a common infectious disease.

Newborn screening allows healthcare workers to educate families about the needs of children with SCD. Early diagnosis and treatment is important because those with SCD are at an increased risk for infection and other health problems. Efforts of the Sickle Cell Foundation of Ghana, Ministry of Health, and international collaborative projects have helped launch newborn-screening programs for SCD in Ghana, and have helped develop psychosocial support programs. Additionally, Ghana has received financial support for the construction of a SCD diagnostic lab center in Kumasi, located in the Ashanti Region. This support was made possible through a partnership between the Ministries of Health of Brazil and Ghana (see http://www.ghananewsagency.org/details/Health/Brazil-commits-13-66-million-for-Sickle-Cell-Centre-in-Ghana/?ci=1&ai=22751).

MHIRT Research Experience and Clinic Days

At Korle Bu Teaching Hospital, we often shared the same space with doctors and medical students in the sickle cell clinic. However, we frequently had full use of a room to interview patients and families. When I was near KBTH for work or during my walks around the campus, it was heart-wrenching to observe long lines and groups of people seeking medical attention. Each person has a story and a history; I yearned to learn more about them. It is common for people to travel many hours in order to receive medical care in a clinic or hospital in Ghana. I had a strong desire to be in a position that would allow me to better serve those in need of medical care. Part of me felt inadequate as a student and merely a prospective health care worker. I wished that I had extensive medical training that would allow me the opportunity to directly help patients. For the time being, I accepted the role as a student-researcher. I also formed relationships with people that provided the opportunity to shadow health professionals in clinics and various wards at the hospital.

The partnership between the MHIRT research team and families affected by sSCD in Ghana allowed us to formally gather data that contributes to the greater knowledge of this prevalent issue, with the hope of improving health outcomes and quality of life for people with SCD. The MHIRT Sickle Cell Project collected data from patients on-site at Korle Bu between 2006-2009, and from May to August of 2011. Questionnaires were administered to participating sickle cell patients in the pediatric SCD clinic at Korle Bu on Thursdays (see http://www.korlebuteachinghospital.org/?pid=6&cid=40). The questionnaire in our study was designed to collect information regarding demographics, socioeconomic status, and a medical history of the patient. Other variables related to the severity of SCD were included.

Each child's medical history was obtained through review of medical records. Their medical histories were hardcopy notes, with test results in tattered, bright yellow folders. No medical records are kept online or are available through other sources. By contrast, in the United States most patient medical information has transitioned to electronic filing systems. Dr. Onike Rodrigues, a pediatrician in Ghana, gave the patients a professional physical examination. Finally, blood samples were obtained from each participant in order to acquire current laboratory data.

Jonas Tetteh, a worker at Korle Bu, coordinated the recruitment process of sickle-cell patients for the project. Patients were reasonably compensated in Ghana cedi for participation in the study. Gameli Adzaho assisted with the project while completing his required year of National Service in Ghana. Gameli was incredibly helpful with organizing the blood sample collections and managing the flow of patients between stations on clinic days.

Because many families in the region spoke Twi and Ga, Jonas Tetteh also served as a translator during the interview process. In any cross-cultural research project, the wording of questions must be carefully scrutinized in order to ensure that patients understand what is being asked.

My research partner and I used a password-protected laptop for data entry. The Department of Pediatrics Library at Korle Bu was where we could more reliably access the Internet. Although there are many commercial cyber cafés in Ghana, accessing the internet can still be problematic. Depending on the location, it can take a long time to upload documents and send e-mails. For example, one afternoon it took 30 minutes to send a short, one-paragraph e-mail at an Internet café near campus. Unpredictable power outages were also a factor.

A Reflection on SCD Research

Formal and informal information gained through the MHIRT Sickle Cell Project contributes to a greater understanding of sickle cell disease medically and socially. Data gathered through the research study is meaningful because it can be used to educate people with SCD and improve medical care. Data on over 200 patients has been collected since the project began in 2006. The majority of sickle-cell patients in this study lived in the Greater Accra Region and indicated Korle Bu Teaching Hospital as their primary health care facility. Most families reported that they rely on *tro-tros* as the primary means of transportation to get to the clinic. Very few Ghanaian families in this study owned a car; thus, one can imagine the predicament that a sickle-cell patient and their family may face when in need of emergency medical care. On average, the travel time to Korle Bu was nearly one hour.

Ideally, the questionnaire administration, physical examination, and blood collection were scheduled on the same day for a set of siblings. Multiple visits for families were avoided in order to minimize participants' travel time. Young adult siblings usually made individual visits without family members present.

In retrospect, we should have anticipated obstacles and prepared our materials prior to arrival in Ghana. Because we were not prepared to collect blood samples during the first four weeks of our research project, a few families were asked to return to Korle Bu after completing the questionnaire and physical examination phase of the study. During the first year of blood sample collection, tubes were ordered through a company in Ghana. The order arrived almost four weeks later. In retrospect, the tubes for blood samples could have been brought with us, along with the other materials (i.e., questionnaires, consent forms, flash drive, a 3-ring hole punch, manila folders, labels, pens, and markers). Adhering to airline guidelines for luggage, our team should have considered the space and weight of the research materials or found another means of supplying a site with necessary materials. Start-up time and research progress could be greatly enhanced by preparation in advance.

Student Sympathy: Invisible Nature of Chronic Illness and Accommodation in Schools

As a student-researcher, I pondered the issue of accommodations in the educational system for those with chronic health conditions in Ghana. I volunteered at Ministry of Health Basic School on the Korle Bu campus twice a week. Through this volunteer work and other conversations, I was able to glimpse the Ghanaian educational system and the learning environment in classrooms in a primary school. I also had the opportunity to meet a few students attending the University of Ghana.

As an American student, I struggled with other chronic health ailments throughout undergraduate school. I evaluated my understanding of accommodations for students in the States and my observations in Ghanaian educational institutions. Aspects of chronic health issues in a vulnerable population (such as children) often have an "invisible" nature, but represent real needs that should be of serious concern. Many Ghanaians hear about SCD and often share the popular view that people with SCD are doomed to an early death. It is a misconception that there is no hope for

a child born with sickle cell. It is true that SCD is a challenging, painful genetic disorder, and that people with SCD have a shorter average life expectancy and require continual medical monitoring. However, there is no firm data on the life expectancy of people with sickle cell disease in Ghana. The median life expectancy for people with SCD in the Unites States in 1994 was estimated to be 42 years for men and 48 years for women (World Health Organization, 2006). In sub-Saharan Africa, the estimated lifespan is considerably shorter. Some Ghanaians shared stories about people with SCD dying in childhood due to infections, malaria, or untreated sickle-cell complications.

There has been progress in raising awareness and developing forms of support for those affected by SCD. Public awareness of the disease must continue to increase, as most education on a societal level. The Sickle Cell Foundation of Ghana is a non-governmental organization formed in 2004. The organization strives to improve the quality of life and provide psychosocial support services for those with SCD (see http://www.sicklecellghana.org/).

There appears to be little assistance offered by educational institutions. For instance, if a student misses class for an extended period of time due to illness, there is no system in place to enable these children to catch up on coursework. This lack of support leaves these students susceptible to falling behind. Considerable progress needs to be made in medical and psychosocial support. The efforts on behalf of the Sickle Cell Foundation and other projects addressing the needs of sickle-cell patients are that the societal perception of SCD and health outcomes can continue to change over time.

Coda

Sustaining relationships and lines of communication between the collaborating research sites was crucial to the MHIRT Sickle Cell Project. It takes commitment and sustained effort for such collaborative work to be successful. As the lessons learned increased, communication between the teams of MHIRT students each year ensured that questionnaire administration, data collection, and analysis improved. The progression of projects will likely vary depending on the topic, location, and nature of the work. Our research team anticipated obstacles to the best of our abilities. Creative problem solving for mishaps along the way and adjusting our framework to adapt to a situation allowed our research team to successfully maintain a productive pace in data collection. In addition to our research mentors, Dr. Rodrigues, Dr. Campbell, Gameli Adazho, and Jonas Tetteh (Ghanaian research assistants) played fundamental roles in the project, particularly in the recruitment of patients. In addition, they helped the research team overcome barriers in language and cross-cultural communication during interviews with families and individuals affected by SCD in Ghana.

The understanding of SCD continues to grow, as does the identification of varying factors that affect SCD clinical heterogeneity. The overall goals in terms of the implementation of research findings is to further improve the outlook for sufferers of this chronic condition, and support those with SCD as valuable members of society. Socially lifting the burden of such chronic illness is a tremendous challenge. The desire to improve the quality of life for those facing chronic illnesses such as SCD is a motivating reason to engage in clinical research.

While working in a clinical setting, I observed the need for basic supplies. At Korle Bu Teaching Hospital, for example, they lacked medical supplies, such as latex gloves, cotton swabs, and sanitation materials. The same held true for a group of MHIRT colleagues working in a scientific laboratory in Mampong-Akwapim, a town in Ghana's Eastern Region. My colleagues conducted many procedures using cracked laboratory beakers, or the same latex glove (note singularity), which was recycled for several days. Materials are exhausted before they are deemed waste. At times I had deep concern for the sanitation safety of patients and medical workers. I was reminded of non-governmental organizations that recycle medical supplies from American hospitals to hospitals in other countries. This is an example of connecting one country's needs with another country's

excess, which still requires people to interact within a committed partnership.

Other valuable observations stemming from this travel-research experience involve identifying regional disparities in resources and living conditions that exist in Ghana. Nine out of ten people live below the poverty line in the rural north, and seven out of ten people live below the poverty line on average in the nation (http://www.wfp.org/countries/ghana). My travels between northern and southern Ghana visually highlighted Ghana's diversity in terms of development. There are regional economic disparities, with more economic opportunities in southern Ghana, which is characterized as urban in contrast with the rural north. In particular, Ghana's Northern, Upper East, and Upper West regions significantly lacked infrastructure.

The 10 administrative regions and 170 districts in the Republic of Ghana exhibit differences in infrastructure (see http://www.ghanadistricts.com/districts/). Access to resources and cultural features specific to a region are considerations in the development and implementation of projects. For instance, Nzulezo is a stilt village in the western region. Nzulezo is literally built on stilts over a body of water, and all materials are transported via canoes to the village. This example serves to illustrate the importance of preparing for what methods and resources may or may not be available to a research team in relation to the people or issue of interest.

Komfo Anokye Teaching Hospital (KATH) is in Kumasi, which is located in the Ashanti Region. KATH is the second-largest hospital in Ghana (following Korle Bu Teaching Hospital) and is the only tertiary health institution in the Ashanti Region. Komfo Anokye Teaching Hospital serves as the main referral hospital for the Brong Ahafo, Northern, Upper East, and Upper West regions in Ghana. Kumasi is located approximately six hours away from Accra, over dangerously rough and crowded roads via *tro-tro*. For someone traveling from Wa (the regional capital of the Upper West Region), it may take up to 36 hours or more to travel to Kumasi in order to receive medical treatment at KATH. In addition, the overcrowded wards and long wait-time cannot escape observation. For example, the obstetrics and gynecology wards at KATH are heavily crowded. Women are frequently expected to share a bed with one or two other women. Similar conditions can be found at Korle Bu Teaching Hospital.

Furthermore, reliable transportation between regions tends to be more time consuming and complex than traveling within a region. More roads are paved in the Greater Accra Region (in southern Ghana) than in the north, which is more rural and faces relatively harsher conditions than the south. Occasional violent disruptions between ethnic groups in Ghana may cause death or may halt the transportation of agricultural products between regions. While English is Ghana's official language, there are 79 ethnic languages, withe considerable variation in dialects between regions. Furthermore, the majority of Ghanaians are Christian. Christianity is the predominant religion in southern Ghana, but Islam is the predominant religion in northern Ghana.

As an aside, it is wise to carry a photocopy of your passport when traveling in Ghana. My fellow MHIRT colleagues and I were unexpectedly stopped by authorities while riding a *tro-tro* after a hiking trip to Mt. Afadjato in the Volta Region. (Mt. Afadjato is the highest mountain in Ghana and is located near the border with Togo.) Ghanaian policemen asked for all foreigners' passports, although their intent was never made clear. After holding a 30-minute conversation in a combination of Twi, Ewe, and English between the policemen and our Ghanaian friends, we were allowed to continue. When traveling, it is advised to remain mindful of one's inevitable identity as a foreigner, particularly when one is unfamiliar with the culture, regions within a country, and the unknown connotations attributed to daily behavior as it is perceived within a different cultural context.

My travel and research abroad through the MHIRT program was a classroom-without-walls experience. I encourage students and community members to seek opportunities to engage themselves in complex social issues through service and research projects. Actively engaging in the meaningful

work of service or research projects helps other people and facilitates personal growth beyond one's imagination. Mahatma Gandhi stated, "The best way to find yourself is to lose yourself in the service of others." It was my privilege to have met and worked with numerous sickle-cell patients and their families. For a lifetime, I will recall this firsthand experience in Ghana with gratitude.

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Addressing Mental Health Issues in Ghanaian Communities: From Personal Experience to Professional Obligation

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In Ghana, the struggle between traditional beliefs and modern medicine continues to leave mentally ill persons without proper treatment. Gaining an understanding of the role culture plays in Ghanaian beliefs about mental illnesses from a historical and current context encourages readers to assess how to best address this relevant and growing topic.

Introduction

My initial interest in the mentally ill in Ghana began as I overheard a conversation between two psychiatrists during my field placement at the Comprehensive Psychiatric Emergency Program (CPEP) at Stony Brook University Hospital in September 2005. The doctors were discussing odd diagnoses, and mentioned the term "incubus," a disorder associated with sleep terrors. Their conversation reminded me of a family friend who had a similar disorder, and believed that the family of her ex-husband had "witched her." Despite being educated both abroad and in this country, it never occurred to friends and family that she was experiencing symptoms of a mental disorder. Rather than pursue appropriate treatment by licensed clinicians, close family members collaborated monetarily and purchased a one-way ticket to Ghana so she could be treated by the only doctor that could help her: a fetish priest. This mentality is not uncommon in people from African countries. "In most parts of the continent, people's attitudes towards mental illness are still strongly influenced by traditional beliefs in supernatural causes and remedies" (Gureje & Alem, 2000, p.1). After she was "healed" and her symptoms were suppressed, she returned to the United States. Her symptoms recurred several years later, when additional forms of paranoia and hallucinations caused her to be hospitalized and given treatment. However, despite the physician's diagnosis, the family still insisted that spirits were the cause of the problem, not mental illness.

Pondering her issue made me wonder how many Ghanaians were walking around their villages with undiagnosed conditions, many of which could be treated with today's vast array of psychiatric medications and mental health services. Lack of knowledge about mental illness and proper treatment stems back to cultural beliefs about witchcraft, "juju," and other supernatural beings that are believed to be the cause of such disorders. As a result, a significant portion of the population is left undiagnosed, subjected to alternative treatment practices, and/or cast out by society.

This narrative was designed for professionals interested in international social work and related disciplines, policy makers, and practitioners. It addresses experiences of mental illness within the Ghanaian community. By addressing the challenges involved with providing culturally competent services to this unique group, practitioners can begin to give those in the social welfare arena a blueprint for ensuring proper treatment of all vulnerable populations.

Personal Background

Culture--a set of beliefs and practices amongst a group of people--often determines how a group thinks, acts, and behaves. These beliefs are passed down from generation to

generation despite outside influences and modernization. I am the child of two Ghanaian parents who were born abroad and came to the United States in their early teens and twenties with the goal of bettering their lives, the lives of family members back home, and the lives of the children they would eventually have.

Growing up in the suburbs of New York City and Long Island, I was very much caught between two worlds: one as a Ghanaian child named *Naa Aku* who ate jollof and plantains, wore braids wrapped with thick black thread that promised to make my "hair grow," listened to traditional highlife sung by my acclaimed Uncle E.T. Mensah, and sojourned to my parents' hometown in Ghana fully equipped with inoculations and filtered water to protect me from the diseases my American body could not handle. The other as an American child named *Lucinda*, who had an American passport, developed a passion for soul food from her elderly southern babysitter, who only spoke English (my mother claimed that when they tried to teach me Ga I got too confused), and went through most of my elementary and middle school years as the only African American girl in her class.

Experiencing life as a second-generation Ghanaian American— which seemed to be a blessing and a curse—has afforded me the ability to explore and view the world through two distinctly different social and cultural lenses. While I believe that all people are similar in their desire to advance their conditions and those of their loved ones, I cannot help but feel that growing up in a Ghanaian household instilled in me a world view that has expanded my values and beliefs far beyond those of my contemporaries who grew up without dual global and cultural perspectives. It is with this dual lens that I have found myself challenged when faced with addressing social welfare issues such as mental health.

Attitudes toward Mental Illness

Turn on any local broadcasting station in Ghana, or pop in any newly released DVD of a highly acclaimed Ghanaian film (think the Ghanaian version of "Bollywood," frequently referred to as "Nollywood" or "Gollywood") and you will find those who exhibit symptoms associated with mental illness portrayed as someone who has "gone mad" or has been "cursed." Since the beginning of time, spirituality has played an integral part in African culture. Therefore, most major life events are associated with something spiritual. "Religion has always been central to people's lives in Africa" (Dickinson, 2002). In addition to Christianity and Islam, several still practice African Traditional Religion (ATR). "Presently they are around 20% of the total population of Africa, which is estimated to be around 760 million" (Nnyombi, n.d.). ATR, often referred to as voodoo or juju, believes in spirits and the supernatural or magical powers of the seen and unseen.

On early trips to Ghana as a young girl, I recall being taught to believe in the existence of witches who presented themselves as different creatures (such as birds), and attacked people at night unless they prayed really hard. Although comical in retrospect, many people living in educated urban townships and in rural villages still subscribe to these beliefs. Therefore, fetish priests or witchdoctors exist yet today. It would not be uncommon for someone such as the homeless man I observed frequently walking around town unclothed and rambling obscenities to be sent to a traditional healer for treatment because he was a "crazy man."

Experiences with Symptoms, Diagnoses, and Treatment

"Traditional healers and religious leaders (such as priests) provide a significant proportion of the care received by the mentally ill" (Gureje & Alem, 2000, p. 3). In Ghana, a majority of the patients in psychiatric hospitals came to them as a last resort, despite the fact that all mental health treatments in Ghana—hospitalizations, prescriptions, individual and group therapies—are free. The patients are more trusting of the treatment provided by fetish priests than doctors who specialize in treating the mentally ill. "One goes to a church, a tabernacle or a mosque for worship, but one goes to the fetish priest of a secret cult to seek medical care, psychological cure, or religious comfort" (Kwabena-Essem, p.1). "For

example, in Ethiopia about 85% of emotionally disturbed people were estimated to seek help from traditional healers because there were only ten psychiatrists for the population of 61 million" (Gureje & Alem, 2000, p. 3). So the multitude of traditional healers available throughout sub-Saharan Africa helps tremendously with the treatment of the increasing number of mentally ill. "Ghana has about 45,000 traditional healers" (World Health Organization, 2007). Traditional healers are always available. "Traditional healers are in the neighborhood, and they're open 24 hours" (Lindow, 2006, p. 43).

The family friend mentioned at the beginning of this article was sent to traditional healers in the United States before being sent to one in Ghana. At the age of thirteen, I accompanied family members to the healer's house located in Queens, New York. The adults spoke quietly in a Ghanaian dialect I couldn't understand, while she was instructed to say certain prayers. For reasons still unbeknownst to me, my brother and I were instructed to drink a concoction of bay leaves boiled in water. Yet her symptoms never went away and, without notice, she was sent home a "healed woman."

Several years later, as a graduate student in social work interning in the psychiatric emergency room, I learned that the woman's symptoms had returned with a vengeance. Convinced that terrorists were going to attack her and family members, her hostile behavior once again became a concern to those in the community. Having witnessed similar cases in my field placement, I advised members of her family to seek psychiatric help. Experience and education in that area taught me that without taking appropriate precautions, failure to act quickly would result in an arrest, hospitalization, or harm to herself or others. Just as I anticipated, police were contacted for a disturbance in the household, and she was hospitalized for evaluation. After receiving medication and being discharged, I queried her son (also a second-generation Ghanaian American educated in the United States) about the diagnosis. Interestingly, he still insisted there was something *spiritual* attacking her.

Despite modernity and education, the majority of Ghanaians and others in similar cultures still resist accepting bizarre behavior as being symptomatic of mental illness. A study conducted in Liberia found that even psychiatric nursing students believed mental illness came from three major categories:

1. A punishment for wrongdoing
2. The result of being "witched" by another person
3. Illness that is passed down through the family (Hales, 1996, p. 3)

Performing unacceptable acts such as adultery, stealing, drunkenness, and disobeying elders can be viewed as wrongdoing and susceptible to punishment by the "gods." Offending these spirits will cause one to become mentally ill, and is only treatable by a fetish priest or zoe.

In addition to being punished by the "gods" for wrongdoing, being "witched" or having someone put "juju" on an individual are other ways Africans believe people can become mentally ill. It is not uncommon for beautiful or successful people who are mentally ill to believe that "others in their village went to the zoe to have a sign thrown on that person because they were jealous" (Hales, 1996, p. 5). One of the students interviewed in Liberia wrote:

> *"One man in our village took mentally ill when he was a young boy. He was the son of a rich man with over 20 wives. The boy was the first son of the head wife and was his father's most loved. All the other wives were jealous and decided to witch him to get him mad. They took a piece of his clothes to a zoe who used the clothes to make the boy go mad" (Hales, 1996 p. 5).*

Lastly, the concept of these symptoms being passed down through the family is similar to the medical theory that mental illness runs in families. However, in this case it is believed that illness can only be passed down from a birth mother to child for her wrongdoing, or the entire family is witched for one member's unacceptable behavior.

As an educated woman familiar with the field of mental health, I can come up with a logically academic rationale for the examples given above. But, as a second-generation American who understands the depths of Ghanaian cultural beliefs (some of which could be comparable to certain western spiritual beliefs), I can begin to address the challenge of providing culturally competent practices that will be accepted by individuals, families, and communities who belong to this immigrant population.

Implications and Recommendations for Social Work

Eager to understand the complexities involved in addressing the stigma toward mental health in Ghana, I consulted with social workers at a psychiatric hospital in Ghana during my visit in 2006. It was not easy to arrange talks with the employees at the Accra Psychiatric Hospital. Fearing I was a representative from a western media outlet, people either refused to talk to me, or knowledgeable personnel happened to be "out of the office." After pleading in the local language (with the help of an uncle who accompanied me), I assured them that I was just an inquisitive student eager to learn and was subsequently able to speak with an administrative aide.

Through our conversations, as well as several follow-up visits to Ghana, I witnessed a slow transformation in approaches to offset obstacles faced by the mental health profession. Today, Ghanaian mental health professionals are collaborating with traditional healers. Community nurses and doctors have been going into villages, educating traditional healers about symptoms, and pleading that they send their patients to the hospital instead of subjecting them to inhumane treatments that have not been proven to work. "Only very few traditional methods have empirical databases to support their effectiveness and safety" (Gureje & Alem, 2000, p. 3). Recently, although more patients have checked into hospitals, families still insist that the fetish priest is the only thing that will truly work. Routine bed checks have been deemed necessary because family members, at the instruction of the traditional healers, will sneak patients out to ingest special concoctions instead of the prescribed medications. This delays discharge time, which keeps the already doubled-up beds from newer patients who are also in desperate need of care. This is a clear indication that more collaborative work is necessary to educate communities about mental illness.

Additionally, there are only .03 social workers in Ghana per 100,000 people (World Health Organization, 2007). As with most countries, social workers are amongst the least paid in the helping professions, which discourages people who would be valuable assets to the field. Those sent abroad to study and conduct research often fail to return, depriving the country of knowledge that could be used for future developments. As is the case with other educational programs, social workers need to be provided with an incentive to practice in Ghana.

In the United States, collaboration with traditional healers is not as simple or accepted. Identifying traditional healers in Ghanaian neighborhoods here in the U.S. will pose challenges. As these immigrant populations increase, social workers will need to identify better methods for addressing mental health issues of those with this cultural background. These groups can now be found in metropolitan cities such as New York, Massachusetts, Maryland, and the District of Columbia. The 2009 NASW Center for Workforce Studies report indicates that the "nation will experience significant demographic shifts that will likely result in a population characterized more by its diversity than by any other factor" (NASW Center for Workforce Studies, 2009, p.2).

The Council on Social Work Education, along with curriculum policy listed in the Educational Policy and Accreditation Standards, now "requires programs to prepare students to recognize the global context of social work practice" (CSWE, 2001; Healy, Asamoah, & Hokenstad, 2003 p.V). Programs such as the Howard University School of Social Work specifically address the importance of educating students on strengths and challenges of immigrant populations in their mission statement guided by the principles

of the Black Perspective. The Black Perspective consists of six (6) principles stressing the importance of understanding the strengths and challenges working with marginalized and oppressed peoples, regardless of race, color, creed, sexual orientation, or national origin:

> Principle 6: *An international dimension with a special emphasis on Africa and the Caribbean area is intrinsic to the School's Black Perspective. The School of Social Work has a mission to educate international students for positions of direct social work practice and leadership roles in social welfare administration and policy in their home countries. A second aspect of the international dimension is our School's commitment to developing that area of social work practice dealing with refugees and other displaced populations — both those individuals displaced within their own countries and those displaced across national borders. A final aspect of the international dimension is the School's desire to foster in its graduates a sense of involvement and commitment to other parts of the world as an element of their professional identity. This is especially important for those areas where issues of social justice and social welfare for people of color are crucial.*(Howard University School of Social Work, 2002.)

As we seek to better understand the best approaches to working within the Ghanaian community and ultimately other immigrant populations around the areas of mental health, I revisit the examples from this article and pose the following questions to readers as food for thought:

1. As a social worker, what methods would have been more effective in suggesting the woman's family members sought professional clinical assistance during her psychiatric episode?
2. If the woman was *healed* because she believed she was healed, how can social workers utilize the strengths associated with belief systems to assist with treatment practices?
3. How can social workers utilize the role of familial decision making to better serve *their* clients?
4. As witnessed in Ghana, how can social workers in the United States best combine traditional beliefs with western practices to best meet the needs of the client?
5. How can the experiences of social workers from various cultural groups be best utilized to educate other practitioners about the unique strengths and challenges associated with corresponding groups?

Conclusion

This narrative concludes with the above questions to stimulate discussion about mental illness not only in the Ghanaian community, but in other diverse communities, as well. Discussion is the first step in finding resolutions to the dilemmas social workers face when serving such populations. Academic discussion has been lacking about the practices and beliefs that have strengthened and challenged these communities, possibly out of concern that groups will be portrayed as barbaric, or that painful family secrets would be revealed.

The experiences shared in this narrative are by no means a general portrayal of what happens in all Ghanaian households. However, while the scenarios may differ, one thing remains the same: we are a proud group of people who, like many other immigrant groups, encompass strength as a community. By discussing these issues as a community, we can shed light on the obstacles and construct practical services that are sensitive to the values of the groups being serviced, ensuring that their needs are being met.

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Abortion-Possible and Impossible: Stigma and the Narratives of Ghanaian Doctors Who Provide Abortions

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The following narrative describes the legal, financial, and social barriers that make access to abortion difficult in Ghana, where abortion is illegal, but accessible. Stigma is attached not only to the women seeking an abortion, but to the physicians who perform them.

According to World Health Organization (WHO) estimates, approximately 80 women around the world have an abortion each minute. Of these, nearly 39 per minute occur in unsafe conditions. Between 2003 and 2008, unsafe abortion rates remained unchanged, with 14 out of every 1,000 women between the ages of 15 and 44 experiencing an unsafe abortion (World Health Organization 2007). Though legal and financial barriers to safe abortion exist throughout the world, stigma is a fundamental cause of unsafe abortion and maternal mortality (Kumar, Hessini, and Mitchell, 2009).

As Kumar and colleagues describe, abortion stigma operates at multiple levels within society, from the socio-cultural to the individual. Abortion stigma exists across the globe, but its character and particularities can be "profoundly local," manifesting in varying degrees of intensity and consequence to the women who seek abortions and the providers who perform them (Kumar et al., 2009, p.3). In Ghana, we witnessed stigma operating at the intersection of law, policy, clinical abortion care, and the lives of women seeking abortions. We also came to understand the impact such stigma had on maternal mortality.

We began our work in Ghana as a group of researchers who, through our work with U.S. abortion providers, have documented the intensity and importance of abortion stigma in the lives and work of abortion-care providers. We have argued that U.S. abortion stigma is so pervasive and powerful that it creates dangerous situations, both for women seeking abortions and for the healthcare providers serving these women. Our work in Ghana began in the context of a long-standing institutional partnership between the University of Michigan and the medical schools at University of Ghana and Kwame Nkrumah University of Science and Technology. In 2009, one member of our team, a University of Michigan Obstetrics and Gynecology faculty member, engaged four Ghanaian physicians known for their commitment to safe abortion services in open-ended, semi-structured interviews.[1] The following year, our team participated in additional conversations in Accra and Kumasi with doctors, midwives, and administrators from nongovernmental organizations (NGOs) and university hospitals. Among other topics, we explored the culturally specific ways in which these professionals observe the effects of abortion stigma.

In Ghana, abortion is illegal, but accessible. Maternal mortality is high: a Ghanaian woman's lifetime risk of maternal death is 1 in 45, compared to 1 in 5,000 in the U.S. (UNICEF 2009). Unsafe abortion accounts for as much as 30% of maternal deaths (Lithur 2004). Few studies exist on Ghanaian women who seek

or have sought abortion services, and fewer describe providers' experiences (Morhe and Morhe, 2006). Therefore, stories from medical providers are vital in helping us understand the experiences of the high numbers of women who either attempt to self-abort, or seek the abortion services of nonprofessionals or poorly trained professionals.

Outside of the hospitals and clinics where abortion services are offered, talking about abortion seems almost impermissible. Frequently, when asked to comment on the status of abortion in Ghana, people winced, looked away, and said only, "It happens." When we asked a social-science colleague at the University of Ghana about abortion, she reflected on the meaning of maternity and its connection to the identities of Ghanaian women. She told us that the idea of a Ghanaian woman who would willingly forgo the chance to bear a child is unfathomable.

In contrast to our experience in the U.S., where abortion stigma is strongly tied to the idea of fetal personhood, in Ghana abortion is stigmatized because it challenges the idea of a woman's personhood. In Ghanaian culture, the very identity of "woman" is linked to "mother." Without children, her life is wasted and shameful (Oduyoye, 1995). Women attend religious ceremonies or healing camps in an attempt to "[secure] 'fruits of the womb'" (Asamoah-Gyadu, 2007, p. 439). According to one social scientist we spoke with, even in death in the cemetery childless women are buried in separate places. Well-known Akan proverbs capture the worthlessness of women who do not bear children: "A barren woman is like a leaking pot"; and the deep sorrow and social shame that attend childlessness: "A woman whose sons have died is richer than a barren woman" (Mbiti, 1988).

Our conversations in Ghana illuminated the complex intersections of gender, maternity, and abortion stigma, as well as creative ways in which Ghanaian medical practitioners, pharmacists, and women navigate fast-changing Ghanaian cultural, technological, and legal waters. This paper is an effort to give voice to the narratives of Ghanaian physicians on the front lines of abortion provision, and their colleagues in NGOs and universities, through the lens of abortion stigma. Their stories illustrate—in broad brushstrokes—the ways in which stigma operates in law, policy, clinical care provision, and in women's lives, as well as the impact of these manifestations of stigma on the incidence of unsafe abortion and maternal death.

Ghanaian Abortion Law

Ghanaian law states that abortion is illegal: "Abortion is unlawful and both the woman and anyone who abets the offence by facilitating the abortion by whatever means are guilty of an offense of causing an abortion" (Anon., 1999). However, the Ghanaian legal code then elaborates the many circumstances under which physicians may determine whether an abortion is permissible, including rape, fetal anomaly, or in cases where "the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health" (Morhe and Morhe, 2006; Dailard 1999).

Consequently, Ghana has what amounts to a relatively liberal abortion law. Women can obtain a legal abortion in a licensed and regulated facility such as a hospital or clinic, or with a trained, entrepreneurial private provider. Women also obtain abortions illegally with nonphysician providers of various sorts (including indigenous healers and spiritualists, community leaders, family members), and through self-induction via ingestion/insertion of toxic/caustic substances. Those with whom we spoke indicated that these illegal access routes are associated with nearly 90% of abortion complications in Ghana.

The ambiguity of the law is both a manifestation of abortion stigma, and a method by which such stigma is perpetuated. The legal code begins with a clear prohibition; it is only after that prohibition is crisply demarcated that the "extenuating circumstances" under which abortion is permitted can be listed. Several of the physicians we interviewed discussed that both physicians and women suffer the consequences of such ambiguity. According to their stories, neither medical professionals nor women often get beyond the first sentence of the law, and there is pervasive belief that

abortion is strictly illegal in Ghana. One physician stated:

> *"Right now, I think what we have to do is to create the awareness that there's safe abortion services in the country and make practitioners understand that safe abortion services can actually be provided within the confines of the law."*

Another physician, illustrating the intersection of stigma and the law, added:

> *"...healthcare professionals generally don't want to be associated with abortion. In my own view, I think that one of the ways which we can overcome that kind of social stigma is to liberalize the law, so that if it clearly stated that abortion could be provided without breaking the law, provided it is done within the hospital setting, then providers can go out and do it. For now, a lot of people in private practice in particular, engage in abortion services without keeping any records because it is a general notion among practitioners that abortion is illegal."*

Another physician described the way in which legal ambiguity can push abortion into shadowy corners of medical practice, where training and safety might be questionable:

> *"...Because most of the doctors think that abortion is illegal they don't record, and they don't undergo any formal training. It allows people to do it under [any] conditions, so people who haven't done training go directly to this clinic and do it off record. And that is why complications arise out of it."*

He went on to further describe how liberalization might improve safety and reporting:

> *"But if it is open...all of the health administrations can provide it...We make people walk to the hospital and it is done for them as one of the services. But as it stands, the practitioners will continue to hide."*

The ambiguous status of Ghanaian abortion law has both positive and negative aspects for providers. On one hand, this ambiguity creates anxiety about the possibilities for prosecution for all potentially culpable participants (providers, women, parents of adolescents seeking abortion); on the other hand, it allows physicians great latitude in providing care. In addition, the abortion statute empowers doctors to certify the necessity of the procedure. Some of the doctors we spoke to felt this placed doctors in an appropriate position of power, but others expressed that physicians worry over the amount of legal risk involved, should their judgment ever be called into question.

Reflecting on the risks of prosecution, one physician suggested that doctors are protected by the widespread belief that they are generally trying to do the right thing when they provide abortion services, particularly after complications have occurred with self-induced procedures and/or abortions started in clandestine settings. However, while current practices suggest that physicians are unlikely to experience legal challenges, the language of the law instills fear in some physicians who may otherwise be inclined to provide abortion services. Even physicians who understand that abortion may be performed legally continue to "hide" as a result of the wording of the law, taking protective measures such as not keeping any records related to abortion services.

The Tainted Economics of Abortion in Practice and Policy

Beyond these legal concerns, physicians also talked about the professional risks associated with providing abortion. Although Ghanaians typically have high regard for medical professionals, those who provide abortion services often experience both

professional and social marginalization. Abortion stigma perpetuates a climate in which capable, well-trained physicians are suspected of having base motivations for choosing to provide abortions. The physicians described how the association of money with abortion work could taint doctors' reputations. One administrator mentioned a common stereotype that the cost of abortions increased at later gestational stages not because of the increased difficulty of the procedure, but solely to elevate the abortion provider's income. Several providers referred to the snide comments and sidelong glances associated with "abortion money." Neighbors or colleagues often suspect that new cars or homes have been purchased with money earned from providing abortions. Similarly, doctors' wealth and possessions are sometimes assumed to be gifts offered from grateful parents whose daughters' "predicaments" were adeptly managed by accommodating doctors. "That Mercedes—they call that the abortion car." Abortion is ostensibly big business.

In reality, doctors can lose money as a consequence of providing abortions. One pointed out how providers' fears over the ambiguities in the law can be exploited by family members who demand money in return for not reporting the provider to the police. One physician told a story of a time when a young woman's parents tried to extort him by threatening to report him to the police. While he knew the law well and ultimately did not pay, he noted that because of the ambiguity of the law, many other providers would rather pay a fee to the parent than risk being reported to the police.

While physicians deal with navigating the stigma associated with financial transactions for abortion procedures, the physicians we spoke with also acknowledged that regulatory constraints imposed significant financial hardships on the women who seek abortion. In particular, Ghana's recently implemented National Health Insurance plan does not explicitly cover abortions. The physicians we interviewed decried the implicit contradiction in government regulations which would permit national health insurance coverage for managing complications from self-induced or "botched" abortions, but would not permit coverage for safe abortions. One doctor spoke about the ways in which the widespread availability of Cytotec, an ulcer medication with abortifacient properties, has altered women's behavior in the face of regulations restricting insurance coverage for abortion. Women, especially those with limited means, will commonly use (or misuse) Cytotec to ensure that they present at the hospital with vaginal bleeding that appears to be a miscarriage, which *is* covered by insurance.

> *"...now we have Cytotec...this over-the-counter drug...they take it, they start to bleed, they come in. When they come in to be treated as [a miscarriage]...[then the abortion] would be covered. Once she is bleeding it [becomes] an emergency. But if she came in with an intact [pregnancy], not bleeding and so on, it would not be covered [by insurance.] So [women] are using that a lot now...[The pharmacists] that give [Cytotec] to them tell them, 'When you start to bleed, go [to the hospital.]'"*

The regulatory choice to exclude abortion from public health insurance funding is once again a manifestation of widespread social stigma against abortion, and reduces access to abortion care. Just as importantly, the separation of payment for abortion services from other services also *perpetuates* stigma, making abortion seem outside of the sphere of acceptable or legitmate medical needs. A vicious cycle is in motion here: abortion stigma leads to a national policy of not funding abortion, which further delegitimizes abortion, increasing the stigma. Furthermore, restricting access to funds to pay for abortion induces an illegal market for abortion services that are more affordable, but may be unsafe. Women often find themselves attempting to circumvent the system to access the services they need. Unfortunately, as the physicians we interviewed described, the avenues they use to bypass the system often lead them to engage

with clandestine, ill-trained, and unsafe providers.

Women's Experiences through the Lens of Physicians

Conventional wisdom suggests that a lack of economic resources and a lack of knowledge on how to access safe abortion services are the primary barriers leading many women to terminate their pregnancies through self-induction or in clandestine settings. While the physicians we spoke with felt that these barriers are present in Ghanaian society, social stigma is the true barrier influencing women's decision-making. One physician stated, "The local people know [which clinics are registered and safe]. The major problem with abortion in Ghana has to do with the social stigma."

The physicians hypothesized that some women may choose not to have their procedures performed in the safety of the registered clinics or hospitals as a way to shield themselves from the public eye. Protecting their anonymity is of the utmost concern to women seeking abortion services. However, as a result of limited hospital and clinic resources, patient volume in these settings is high, waiting rooms are small and crowded, and women wait for long periods of time alongside other people from their communities. Physicians reported that women have good reason to fear that they will lose privacy and confidentiality if they present for abortion at a public hospital. As one physician explained:

> *"The problem with that service [abortion] is that the people are labeled, anyone who goes to sit on [one particular] bench outside in a very busy part of the hospital. So once they see you sitting on the bench, you're female, they say, 'Ah, she's going for abortion.'"*

Social consequences to a woman who has an abortion may include loss of resources, public shunning, or divorce. Thus, if a woman is unable to protect her identity in the public hospitals and clinics, she has a strong incentive to seek out an abortion in more remote locations. Another doctor observed:

> *"Some doctors do it in very obscure areas and quite a number of people go there for abortions because they feel they have more privacy there than in the hospital."*

Ghanaian society's views on the unacceptability of premarital sex and importance of motherhood place extreme pressure on women to keep their unwanted pregnancies secret, often resulting in these women making unsafe decisions:

> *"They know that [abortion] is morally unacceptable. When they get pregnant, pregnancy outside marriage, they don't want people to know, and when they are very young they also hide it from their parents. So that leads a lot of people to hide, to have [their abortion] done in such a way that is, I don't know. They go to these quacks and some of them take all kinds of concoctions, they mix all kinds of things to take thinking they will cause an abortion. And those are the ones that lead to complications. We've had situations where people take naphthalene [moth] balls."*

Unsafe procedures have high rates of complications, ranging from incomplete abortion to perforations, potentially resulting in major blood loss or organ damage:

> *"Most of the complications, very bad complications [involve]...uterine perforations, cervical lacerations, and abdominal viscera [damage to abdominal organs]."*

Unfortunately, by the time many women arrive at the hospital from a clandestine abortion setting, it may be too late to preserve the woman's fertility, or even her life.

Stigma and Maternal Mortality

Abortion stigma drives women to unsafe procedures, and thus directly contributes to maternal mortality. Each of the doctors we spoke to could give an account of at least one harrowing tale of maternal death as a result of unsafe abortion. In one particularly disturbing story, a physician recounted how a teenaged school-girl had ingested an unidentfied toxic substance to end an 18-week pregnancy. She arrived at the hospital in a coma and died shortly thereafter.

Perhaps because of the high rates of complications with self-induced and later-stage abortions, abortion is commonly associated with infertility and death in women's minds. One doctor observed:

> *"Current work that I've done, [shows that] over 80% [of women] associate abortion with death, and the other 20%...think that abortion is associated with infertility...[but] they do it anyway [pursue unsafe, clandestine abortion]...so it means that people have been dying for abortion, and therefore they associate abortion with death. So...there is a lot that we need to do."*

Widespread perception of abortion as an incredibly risky undertaking (regardless of whether it is provided legally or illegally) disincentivizes women to seek safe abortion services, and increases risk of injury and death from clandestine abortion.

Furthermore, fear of social stigma causes delays in accessing care, leading to presentation at later gestational ages, which impacts the safety of procedures. The physicians we interviewed noted that for adolescents in particular, fear of the stigma and shame of admitting sexual activity to their parents leads to delays in care. These later procedures are more difficult, resulting in higher rates of complications, regardless of setting (though clearly worse in unsafe settings). One physician stated:

> *"With the first trimester terminations, they are not a big problem. Because even those who go for unsafe abortion in the first trimester, they come with sepsis and incomplete abortion, which you could easily work with. But in the second trimester, that is when the mistakes [occur], and [they use] sharp instruments to try to [remove the fetus]...so most of the time [the women] come to the hospital and the baby is already dead and there is damage to the uterus already, sometimes there is perforation, and then you see a real challenge of trying to bring out the dead baby when the uterus is perforated."*

Together, these two scenarios illustrate a second vicious cycle of stigma: abortion is stigmatized in part because of the perception that it is associated with infertility and death, but this stigma increases the likelihood that women will not seek safe care or will delay care, which increases the chance that women will die from abortion procedures. The perception of abortion as dangerous ultimately contributes to deepening abortion stigma.

Concluding Thoughts

The experiences of Ghanaian physicians with whom we spoke suggest that neither legality nor availability of safe abortion care is sufficient to prevent the tragedy of maternal mortality from unsafe procedures. Clarifications in the law, and increased awareness of the availability of abortion services in safe, public facilities are likely necessary. Regardless, these efforts may fall short of significantly reducing the burden of morbidity and mortality from unsafe abortion without a recognition that stigma is both reflected in *and sustained by* the current legal, political, and social climate.

Furthermore, the social sanctions imposed upon women who seek abortion must be understood and addressed through a lens that appreciates the misogynistic roots of cultural stigma against abortion. Efforts to address abortion stigma and its consequent maternal mortality and morbidity may require challenging traditional patriarchal culture, in which abortion

is often viewed as an affront to gendered power hierarchies and related practices (Braam & Hessini, 2004). A woman's choice to abort a pregnancy may be experienced as a rejection of familial and social roles as well as a dangerous expression of resistance to authority. Stigma serves to preserve and reproduce male/female power hierarchies by restricting women's freedom to determine the timing and place of their decision to parent. As we heard through the voices of the Ghanaian physicians, women bear the burden of intense social stigma against abortion, which stems from patriarchal, religious, and gendered social norms, and ultimately forces them to engage in secretive practices that often prove unsafe.

Importantly, we also heard that providers experience the weight of abortion stigma. They face a dangerously ambiguous legal situation and are marginalized in both professional and personal situations when their motivations and skills are called into question. Through the avenues of legal ambiguity and the moral outrage of the communities in which they practice, abortion stigma translates directly into stigma against abortion providers. The legal, professional, social, and economic consequences of working in a heavily stigmatized field may ultimately discourage providers from undergoing training in the procedures, or drive them to give up abortion work.

Abortion stigma ultimately acts as a double-edged sword to reduce access to safe abortion: it reduces women's ability and willingness to seek timely, safe abortion care, and reduces providers' ability and willingness to undergo training and offer abortion services in their communities. Furthermore, the prevalence of abortion stigma in law and policy acts in direct opposition to building women's health care services with an eye toward reproductive justice. Speaking about the separation of abortion services from the national health insurance law, one physician expressed his fear that the most vulnerable women in Ghanaian society will suffer most heavily from restrictive laws:

> *"Well, I've always said that health insurance should cover reproductive health as a whole from contraception to abortion care and all other (related services). I've always advocated for that...[The government] says that [reproductive health services] have been so much subsidized...that they think people should also pay for [contraception] themselves...[and] make reproduction really their own...In fact, we know that people in low-income groups don't contracept, they get pregnant, and they can't afford prenatal care. So they go to seek unsafe procedures..."*

This physician describes a belief by Ghanaian insurance authorities that requiring Ghanaians to put "skin in the game" (to paraphrase U.S. health economists) when it comes to contraception services might increase individuals' ownership and agency around pregnancy prevention and childbearing. As the physician points out, such ideas rarely work so well in practice. Requiring payment for contraception and abortion leaves poor women vulnerable to the consequences of unsafe abortion procedures. In his statement, the physician advocates for a more just application of reproductive health services across the spectrum; he calls for the re-integration of all reproductive health services under one umbrella, rather than separating abortion. Though not explicit, this physician's comments speak to the barriers abortion stigma erects to realizing reproductive justice.

Understanding the burden stigma places on women and on doctors is largely understudied around the world. The voices of Ghanaian doctors illuminate this issue, and have important implications for anyone who hopes to alleviate the burden of maternal mortality in Ghana or elsewhere. Their stories clearly delineate a role for eradicating abortion stigma in the pursuit of reproductive justice. Unless future efforts attend to legal, policy, and cultural manifestations of abortion stigma we fear that

efforts to significantly reduce maternal mortality from unsafe abortion will fall short.

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Footnotes

1 Each physician was independently interviewed for approximately 25 minutes, and a final 40-minute conversation was conducted with the entire group. The four physicians were asked to share their thoughts and observations on the following matters: stories about and managing abortion-related complications; reasons why women seek care in unsafe settings when safe care is legally available; barriers women face in accessing safe abortion and physicians face in providing abortion; and how to reduce serious consequences and death from unsafe abortion in Ghana. We did not ask specifically about abortion stigma. All interviews were digitally recorded, transcribed, and analyzed with the assistance of NVivo 8.0 (QSR International, 2008). Institutional Review Board approval for this study was obtained from the University of Michigan Health and Behavioral Sciences Committee, and all participants provided written consent.

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Personal Reflections of Resilience and Survival of Ghanaian Women with Disabilities: A Social Worker and Unemployed Study Subjects

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This narrative reflects the author's stories of resilience and survival as a Ghanaian woman with a physical disability, advocating for women with disabilities, and working for nongovernmental organizations in Ghana that provide services for persons with disabilities. In addition to profiling how she successfully advocated for herself, this narrative includes lessons learned from comparative personal stories of resilience and survival from disabled Ghanaian women, obtained from them during data collection for her dissertation. All names have been changed.

Introduction

Approximately 10% of the Ghanaian population consists of persons with disabilities. The term "disability" in Ghana refers to people with physical, intellectual, or sensory impairment and mental illness. The causes of disability are many and varied. Some occur through road accidents, amputation, blindness, deafness, birth defects, and diseases such as leprosy, measles, and polio. Negative perceptions about disabilities as well as the capabilities of such persons, combined with barriers (e.g., architectural, attitudinal, structural, information, and transportation, inadequate education and medical systems, few welfare benefits, etc.) prevents those with disabilities from participating fully in mainstream society, and propels them into poverty.

According to the National Disability Policy Document, many Ghanaians with disabilities are rejected by their families due to the stigmas attached. Many survive on the streets by engaging in petty trading and begging. In Ghana, the condition of poverty for women with disabilities is enhanced due to the biases that result from the intersection of gender and disability. The majority of women with disabilities are excluded from education and employment opportunities, aggravating their conditions of poverty.

Many of the women with whom I interacted were single parents and unemployed. To provide for their children and themselves, most of them engaged in menial jobs, earning an average of one U.S. dollar a day. Despite the multiple challenges they encountered, these women demonstrated positive attitudes toward life and hope for a better future. Their perseverance to succeed amidst the barriers that exist in Ghana reminds me of my own challenging experiences growing up in Ghana as a female with a disability.

My Journey as a Woman with a Disability in Ghana

I am the second youngest of ten siblings and the only one with a disability. I acquired polio at the age of two, which paralyzed my legs. As a result, I walk with the aid of braces and crutches. Although polio was a life-altering experience, through personal perseverance and the support of others throughout my journey, I achieved my educational and professional goals. However, I encountered many challenges growing up with a disability. Most of these challenges related to accessibility and societal attitudes.

The Ghanaian environment (rural and urban) has several access barriers to one's mobility. For example, in my high school there were several uneven steps leading up to most classrooms, dormitories, and dining halls. There were no ramps or elevators, so I maneuvered the steps with the use of my crutches. The

bathroom and toilets in the dormitory were also inaccessible. Bathing once a day, I awoke up before everyone else so that I wouldn't slip and fall on my crutches when the floor was wet. The bathroom was a big building without a roof; it had sinks but no showers or bathtubs. The toilets were holes in the ground, with no toilet seats. They were mostly untidy because the students squatted on them. I could not squat on the toilets, but sitting on them was unhygienic. Therefore, I learned to use the forest as a place of convenience, going once a day in the evening.

At the University of Ghana in Legon (a suburb of the capital city Accra), where I received my bachelor's degree, the access barriers were no better. I nearly gave up during the first semester of my first year. It was more difficult for me at the University than at my high school. A lot of effort was required to move from one classroom to another, due to the distance between the classrooms (lecture theatres/buildings) on the sprawling campus. With no campus bus, I traversed the campus on crutches, navigating open sewers, gutters, dirt paths, and the few broken and uneven sidewalks.

Furthermore, the streets on campus were a challenge for me, given the speed with which taxis drivers and other vehicles traveled. The streets were not well-lighted at night, and darkness descended promptly at 6 p.m. I sometimes attended night classes, often traveling solo without a flashlight on those dangerous roads. Yet I had no other option, because my parents could not afford to pay for any on-campus transportation such as a taxi or a powered wheelchair, which was virtually nonexistent in Ghana when I was growing up.

The architectural aspect of the classrooms was not disability-friendly either. I had to maneuver several concrete or marble steps before getting into the classrooms, while some of my classes were held in multiple story buildings with neither elevators nor ramps. Sometimes, when I was very tired at the end of the day, I skipped the last few classes held in these buildings. Besides, the classes were very large—some with as many as 200 students—but with a limited number of seats. Students had to get to class early enough to secure seats or they would have to stand throughout the one-hour class. Fortunately, other students often reserved a seat for me so I would not have to struggle for one.

The library had more steps than the classrooms, and hence presented more challenges for me in terms of regular usage. I went there only to borrow books, and made copies of books I could not check out. Until recently, I was not used to studying in the library due to my experience with that particular library. Thus, while working on my master's and doctoral degrees in the U.S., I always studied in my apartment.

Being forced to overcome accessibility issues taught me the need for patience and perseverance to help me move ahead in life. I learned of "Bethany Projects," a nongovernmental organization (NGO) formed in 1986 by Rev. Fr. John Thebault from the Society of African Mission (SMA) to promote the dignity and rights of persons with disabilities. They gave me a tricycle to help with movement, which significantly reduced the time it took for me to get to classes and appointments (http://hopeforlifeghana.org/aboutus/whoweare.php). My family's support and motivation during these struggles were invaluable. They did not have much money, but they gave me what they had: love, moral support, and motivation--which are essential life elements that everyone needs, regardless of their disability status.

My parents were in the lower-income bracket and had difficulties caring for me and my nine siblings. My father was a policeman and my mother a petty trader, selling food on the roadside and sometimes in elementary schools. My father retired from active employment and relocated to our home village when I was in elementary school. From then on, my parents have been subsistence farmers.

Three of my siblings and I lived in East Gonja District, capital Salaga, in the Northern Region of Ghana, about 45 kilometers (28 miles) away from our parents. We visited them every vacation. When I was in high school, I engaged in petty trading wherever I went to the village. I mostly sold candies, biscuits, and soft drinks. I made and sold items woven from

wool such as hats, belts, and bracelets. For Christmas, Easter, and other important occasions, I also braided hair. That extra money supplemented what my parents gave me for school.

Traveling was always a challenge because, at that time, there were neither existing roads nor motorized transportation to the village from the district capital. My father carried me on a bicycle for the 45-kilometer journey. Bad weather presented challenges to riding a bicycle, as some of the streams overflowed and covered the bicycle path. These incidents challenged me to work harder in order to achieve my goal of reaching the top of the academic ladder. I was also motivated to pursue a meaningful job to help my family.

My parents and siblings gave me much support, love, encouragement, and motivation. Despite the negative perceptions and maltreatment persons with disabilities experienced while I was growing up, my parents treated me with the same dignity and respect as my siblings. Because I was treated as an equal by my parents and siblings, I grew up with the idea that I was able—academically and socially—to pursue whatever interests suited me.

The attitudinal challenges I encountered from others included negative perceptions, prejudices, and stigma against those who are disabled. The situation was made worse because I am a woman with a disability. In Ghana, certain cultural practices discriminate against women in general, and exacerbate the situation for women with disabilities. In most cases, women with disabilities are even denied the second-class citizen's status as women, because they are seen as asexual and incapable of performing the traditional roles assigned to women in society, such as being nurturing mothers, wives, and sexual partners.

For example, I experienced employment discrimination, as employers still doubt the capabilities of persons with disabilities, especially women. After receiving my master's degree in 2004 from the University of Chicago, I returned to Ghana. I applied for nine jobs, and was short-listed and interviewed for all but one. An organization whose focus was on disability issues interviewed and eventually employed me. Although the other organizations granted me interviews, none of them contacted me afterward. In each interview, the panel specifically asked me how I would handle the job, given that the much travel would be required. Keep in mind that prior to coming to the U.S., I had worked in Ghana for several years as an advocate for persons with disabilities. I refused to let these incidents change my attitude toward life, which is that everyone has the potential to contribute to the socioeconomic development of their nation, and must strive to achieve that goal in the midst of whatever obstacles exist.

Working with Persons with Disabilities: Macro-Level Practice

My undergraduate degree is in economics, because I thought I would not be able to work outside of an office. However, my passion for working with and advocating for the human rights of persons with disabilities grew while I was in college. There were only a few persons with disabilities in the college, so I wondered where the majority were. It dawned on me that they might be at home doing nothing, or on the streets begging because they were not given the opportunity to maximize their potential like myself and the other students. This compelled me to begin my activism while in college.

As the secretary of the Campus Association of Disabled Students, I advocated for services for students with disabilities at the University of Ghana and created awareness about disability issues. After college, I worked for four years as the Assistant Program Coordinator for the Ghana-based, nonprofit organization that I mentioned earlier--Bethany Project: Hope for Life Ghana (http://hopeforlifeghana.org/projects/bethanyhouse.php). This organization provided start-up capital and income-generating sustainable programs, acquisition and repair of mobility aids, formal and vocational education, and two-week yearly respite services for persons with disabilities. Their motto is: *Disability is not an inability!* In this capacity I served approximately 100 persons yearly, taking them from the streets, getting

them formal education and vocational training, and supporting them to establish their own businesses. I also advocated for their human rights and socioeconomic and political development. Their resilience and perseverance were encouraging, given the myriad barriers existing in Ghana that make it difficult for people with disabilities to participate in mainstream society. They seek to be self-sufficient and able to care for themselves and their families. I was happy that I could impact the lives of our clients at Bethany Project, helping them to stand up for their rights and responsibilities.

After four years of working in that environment, I decided to combine the practical skills I had obtained with appropriate knowledge and theory. Thus, in 2002 I pursued a master's degree in social work at the University of Chicago with a scholarship from the Ford Foundation International Fellowships Program (http://www-news.uchicago.edu/releases/04/040608.convocation.shtml). The program aims to equip people from developing countries with leadership skills to improve their communities. To be eligible, a candidate must possess community development and leadership experience, and must be committed to returning home, for at least two years, to continue working for social change.

Due to my development and advocacy work for persons with disabilities, I was one of seven students awarded the fellowship (from nearly 1,100 applicants) to attend graduate school at a University in the West. In 2004, I returned to Ghana after successful completion of my master's degree and secured a job with Action on Disability and Development (ADD).

Experience Working with Women with Disabilities: Macro-level Practice

ADD is a British-based, nonprofit organization whose objective is to build strong leaders of persons with disabilities, as well as influence policy and practice in order to end the social exclusion and poverty among persons with disabilities in Africa and Asia. I worked as the Gender Programs Officer for ADD-Ghana from November 2004 to October 2007, serving approximately 500 clients yearly. During that period, I worked with leaders from organizations such as Ghana Society of the Blind, Ghana National Association of the Deaf, Ghana Society of the Physically Disabled, and the Ghana Federation of the Disabled, to mainstream the issues and needs of women with disabilities in their programs, and to increase their representation among the leadership of the organizations. The greater part of my work focused on working with women with disabilities--empowering them to advocate for their human rights and their socioeconomic and political development. I also advocated for the inclusion of their needs in the programs and activities of both governmental and nongovernmental organizations. I assisted them with developing funding proposals, and raised funds for their small-scale, income-generating activities. Access to funding was very important for the women, the majority of whom were unemployed single parents with no regular source of income.

The women judiciously used the little money they received—grants/microfinance—to establish small businesses, and raised additional funds to feed and clothe their children, pay their school fees, and provide for their homes. For example, Ayi, a blind single mother of four, started a small trading enterprise with six Ghana Cedis (nearly 5 U.S. dollars). She purchased sugar, divided it into smaller bags, and sold them for 0.5 Ghana Peswas each (nearly 5 cents). With the accumulated profits, she expanded her business to sell matches, candies, and other goods. Ayi was delighted that she could provide food for her children with the proceeds from her small entrepreneurial venture.

Other women started businesses through their own funding initiatives, such as a credit venture where each woman contributed a small amount of money at every group meeting. The collection of money (also about $5) was given to one member at the end of each meeting. The process continued until every member received their turn. The women were able to start small businesses with the amount they received from the credit venture, and were also able to provide for their families. Those two funding strategies not only helped the

women generate their own incomes, they provided opportunities for social participation and stronger support networks.

These women gained visibility within the organizations of persons with disabilities. Their representation in the activities/programs of the organizations improved. As of December 2006, my annual report indicated that they held 19% of the leadership positions—such as president. These previously invisible, powerless women also became active participants in other mainstream organizations in Ghana, including Orphans and Widows Ministries, Single Mothers Association, and Knights and Ladies of Marshall of the Catholic Church. Working with these women, who were so determined to take care of themselves and their families, was an amazing experience.

Although I am a woman with a disability, who grew up poor and engaged in petty trading, I still learned much from those women. My "insider" position made them more receptive to me and my ideas, as well as allowed me to devise better strategies to help them. I felt fulfilled that I was able to help women with disabilities take greater control over their lives.

While I worked with ADD, I had the opportunity to serve in the local government of my area as a government-appointed representative with expertise to help develop the area. As the only person with a disability among 70 assembly members (only five of whom were women), my ideas about mainstreaming issues of persons with disabilities and women were often restrained by the men. Oftentimes, when I tried to contribute to discussions, there was loud shouting from the assembly members who did not like my ideas. Thankfully, one of my brothers, who had always supported my efforts, was part of the same assembly also offered support. Two of the male members and the few women offered support. With their help, I was able to get several issues about persons with disabilities and women mainstreamed in the development of the district.

For example, I developed a resource booklet for the district assembly about making buildings accessible. My interaction with the district planner revealed that the district lacked the designs to retrofit the buildings. The newer buildings in the district should have been made accessible, but I realized that they had not been properly designed. The few ramps that existed were either very steep or too narrow, so I developed the booklet to guide the planners and other parties involved in designing and building new structures in the district.

As I mulled over my work at ADD, I realized that the lack of adequate opportunities to engage in academic research was impeding attempts to examine issues emerging from practice. Additionally, I thought that engaging in doctoral studies would open avenues to further participate in academic debates and discussions on issues about which I was passionate. Doctoral-level preparation became critical and integral in enhancing my analytical capacity to understand and interpret issues about public policy, social development, and interventions across the life span for persons with disabilities in Ghana and the world as a whole. As a result, I sought a degree program and was admitted in 2007 to the doctoral program at the University of Utah (http://www.alumni.utah.edu/u-news/may09/spring-awards1.html; http://www.alumni.utah.edu/u-news/april09/?display=achievement-scholars.html).

Experience as an MSW and Ph.D. Student in the United States

Studying in the U.S. was both rewarding and challenging. The first time I came to the U.S. I was excited to see the wonderful place everyone talked about. My family and friends were both happy and sad, and so was I. During my first trip to the States in 2002, my mentor and friend Dr. Brenda McGadney-Douglass (whom I had met a year earlier in Ghana) drove nearly four-and-a-half hours from her home in Pinckney, Michigan, to pick me up from O'Hare International Airport in Chicago because I didn't know anyone. Not knowing the lay of the land, I had no idea that she did not live just around the corner!

Brenda had already informed the administration of the School of Social Service Administration (SSA) of the University of Chicago (where she earned her doctorate) about my arrival on Friday evening. The

Director of Admissions had picked up the keys to my apartment and waited at the school to give them to me.

After more than 16 hours of flying and transit, I was eager to get to my apartment, which was just a block away from the school. However, Brenda was dismayed when at first sight we could tell that the apartment building was not disability-friendly. There were two heavy doors to the building that I had to pull open with crutches under my arms, and six huge marble steps up to the first floor (no elevator) where my small apartment was located. A few weeks later, I was given an electronic device with which I could open the doors. I wondered why I had been assigned an apartment in an "inaccessible" building because, when I applied for housing, I indicated unequivocally that I needed accessible housing closer to SSA. The dean of students of SSA and the Office of Disability Services worked together with the Office of Student Housing to modify my apartment and make it more accessible, since there were no more accessible single-room apartments closer to campus. I could not share a room; I wanted privacy and a peaceful environment for studying.

Although I was most grateful that the Office of Student Housing made my apartment more accessible, the six steps could not be taken away. I thought I would be able to manage them given the access barriers I had encountered in Ghana, but it was not easy; especially carrying my groceries up those steps. The School of Social Service Administration worked in collaboration with my insurance to get me a beautiful scooter to ease my mobility. This gave me a lot of freedom to get back and forth to classes and the grocery store in Hyde Park.

The laundry room and the garbage bins were located in the basement of the building. The entrance to the basement was at the other end of the building, about 30 meters away from my apartment. My problem was walking that distance to the basement while carrying garbage and clothes. When I was busy and too tired, I left garbage in my apartment for two-to-three days at a time because of how difficult it was to carry a load of garbage to the basement. The janitor sometimes disposed of my garbage when he saw me carrying it. My second year, I was given the option to move into an accessible building, but I had become accustomed to my apartment and chose to remain there.

In 2002, Brenda introduced me to her friends while she was with me in Chicago. I instantaneously bonded with one of them, Dr. Carrie Wicks, a retired University of Chicago nurse practitioner, whom I affectionately call Mom. Carrie had been to Africa several times before we met. Carrie, like Brenda, knew the challenges a person from Africa was likely to face in the U.S. and was prepared to help me. Not only did she assist me with finding my way around (e.g., finding African grocery stores and a place to worship) and with understanding the culture of my new environment, she also mobilized donations for me from friends, family, and members of her sorority, Chi Eta Phi.

Carrie has become my lifelong friend and has visited my home village in Ghana almost on a yearly basis since 2004, bringing medical and school supplies to the people (http://www.thechicagocitizen.com/community-focus/good-citizenship/carrie-wicks-rn-phd/). The people of Lonto have dubbed her *Queen Mother of Development* due to her commitment to the development of the village (http://articles.chicagotribune.com/2011-05-02/news/ct-met-trice-mission-0502-20110501_1_medical-supplies-clinic-babies).

Life in the U.S. was like "everybody for him/herself, God for us all." It was so lonely. I come from a country where we believe in the extended family system and community bound in love. In Ghana, it is possible to know and have meaningful interactions with one's neighbors. It is not unusual to find neighbors and family members knocking on one's door to check on them without prior notice. While I was a student in the U.S., I hardly knew my neighbors. I felt lonely, especially since I have a big family of nine siblings (one deceased) and over 100 nieces, nephews, uncles, aunties, and cousins. We are very close and see each other often through family reunions and other events. I adopted and educated two of my nieces, who lived with me and helped with

household tasks. Apart from them, several other nieces and nephews visited me during vacations and other occasions. It was difficult to stay in touch with my family, especially my aging parents, due to the cost involved with phone communication as the majority did not have access to the Internet.

There is no doubt that graduate school education is more rigorous than undergraduate education. When I first received the syllabi for the master's program, I was overwhelmed about the workload and the number of assignments that I had to type, (I was not very good at typing). Most of my academic assignments at the University in Ghana were handwritten on long paper; there were few computers. While I was wondering about how to adjust to my academic and social situation, I met two Americans at SSA from different states who also felt overwhelmed. I could not believe it because I thought I was experiencing challenges because I came from a different country, but I was wrong. (Those two ladies became my friends and we walked through the challenges together, encouraging and helping each other.)

Language was a problem, given the differences not only in the accent, but also in the differences between British and American English. I found my professors crossing out certain words from my assignments simply because they were British. I also realized that my professors and classmates had difficulties understanding me when I spoke, just as I had difficulty understanding them. When I made contributions in class, people asked: "What did you say?" or, "Can you people speak up?" At first, I was frustrated that I always had to repeat things I said in class when no one else was asked to do so. But, I could not give up participating in class, because participation was a requirement.

My two-year experience in Chicago made it easier to adjust to social and academic life in Salt Lake City, where I pursued my doctoral degree. I understood the accent better, and I had learned to slow down when I spoke so people could understand me. I had a better idea of handling academic work, which was still overwhelming. I had the opportunity to learn to ride trains and buses for the first time. In Chicago, I mostly used my scooter and/or the para-transit to get around. It was much easier using the para-transit services in Chicago than in Salt Lake City. It took me over two months to obtain eligibility for the service in Salt Lake City; by then I had already learned to ride trains and buses. Also, one must wait for the para-transit where it could be seen when it comes for pick-up and return trips, while in Chicago the drivers buzzed at the door, except at shops, hospitals, and other public places where customers could wait where they would be visible.

The housing issue was different at the University of Utah. My faculty mentor, Dr. Hank Liese, who is also the Director of Doctoral Studies, stayed in touch with me while I was in Ghana. He negotiated my travel and followed through to see that my accommodations were met. Upon arrival in Salt Lake City, I stayed with him and his family for a week while he worked with me to obtain accessible housing. I could bring my scooter (which my mentor helped me obtain) in and out of my apartment with ease. Even though the laundry was on the 14th floor and I lived on 1st floor, I was able to carry my laundry on my scooter and use the elevator. The garbage bin was in a room next to mine, which was convenient. My mentor also helped me find my way around campus and Salt Lake City, especially where to find food and other important necessities.

I am happy that I completed both degrees on schedule. Faculty members and staff of both universities willingly and selflessly supported me throughout my education in the U.S., and I am thankful for that. My master's degree in Social Service Administration, with an emphasis on community organizing, planning, and development, deepened my mastery in both theory and practice in my field of study. The program sharpened my analytical and critical thinking, and the ability to make social change happen. My master's education placed me in a better position to effect change in the lives of women with disabilities. The doctoral program equipped me with more tools to contribute to scholarship by teaching the next generation of social workers, and engaging in research that could influence policy and

practice interventions for persons with disabilities.

Employment Situation of Women with Disabilities in Ghana

Upon successful completion of two years of coursework and a qualifying examination to ascend to doctoral candidacy, my next task was to complete a dissertation in order to obtain a Ph.D. degree. Thinking about the women with disabilities in Ghana, I wondered about what to investigate. As I reviewed the literature, I realized that unemployment rates in general were high, but were even higher among persons with disabilities, with disabled women being at greater risk. Disability and gender operate to perpetuate the vulnerabilities of women with disabilities in developed and developing countries. Poverty, negative cultural beliefs and practices, and perceptions about the capabilities of persons with disabilities could further complicate the employment situation of women with disabilities in Ghana. In developed countries, there are "safety net" programs to support persons with disabilties. But in emerging and developing countries like Ghana, these supports are nonexistent, exacerbating the condition of these vulnerable women.

The literature elucidates the various forms of oppressions women with disabilities encounter in society and their unpleasant consequences, which in turn perpetuate their employment situation. The literature is explicit about the consistency of employment and income disparity between men and women with disabilities, with women experiencing lower rates of employment. Although studies portray the inequality, oppression, and exclusion that women with disabilities encounter, little research is available on the impact of unemployment on women with disabilities. Thus, I sought to understand the daily experiences of unemployed women with physical disabilities in Tamale, Ghana.

Personal Experiences of Unemployed Women with Physical Disabilities

Similar to my personal experience and that of the women for whom I worked in Ghana, the women I interviewed with physical disabilities experienced numerous challenges in their daily lives. In addition to architectural, transportation, information, and attitudinal barriers, they were poor and could not provide for their basic necessities. Welfare benefits such as Social Security for persons with disabilities in the U.S. are nonexistent in Ghana, compounding the dire situation for these women. Their experiences dealing with the above-mentioned challenges have given them the opportunity to develop resilience. Resilience refers to individuals functioning beyond what is expected of them, despite adversity/ vulnerabilities, because of personal strength and skills developed in adversity. To code the narratives of these women, I used 15 factors that researcher Grotberg (1995) identified and divided into three categories of resilience to overcome adversity: *"I have," "I am," and "I can."* Some of these elements are mentioned in my discussion about the resilience of the women I interviewed.

The participants for my qualitative dissertation study consisted of two focus groups comprised of stakeholders from governmental and civil society organizations (N=6, 8 persons respectively), and individual interviews with unemployed women with physical disabilities (N=10). For the purpose of this paper, I concentrated on narratives from interviews with the women with physical disabilities, who were between 20 and 45 years old.

Study participants had different types of disabilities, including polio (50%); stroke (10%); and a lame hand (20%) or leg (20%). They reported an average income of one dollar a day and two children (60%). Also, 80% of the participants were Muslim, while 20% were Christians. Additional demographic findings indicate that nearly 50% were married; 20% of husbands had disabilities; 20% were old men, retired from active employment with second wives, mostly able-bodied. The married women noted that they did not receive enough financial support from their husbands, but stated that they received love, attention, and help in times of need; factors from the "*I have*" category of elements necessary to overcome adversity, which, according to Grotberg, reinforce resilience. An example of

these factors was given by Muna, one of the study participants:

> *"He's fine, but because we are all disabled we don't have jobs. As for love, my husband loves me, but the money is not there. That's our entire problem...The money isn't there. Your husband goes to work, but doesn't get any money. Do you fight him? No, you try to manage whatever he gives you so that people don't hear you fighting. So, if I tell you the money I get is enough for me, then I am not telling you the truth."*

Zara, who was single, identified similar elements of resilience identified by the married women with disabilities, although her experience related to her familial relationship. She stated:

> *"We [referring to her family and her] have a good relationship. They are helping me because they know they are the only people I have and hence the need to help me. But they don't provide me with all my needs. Not all of them, because they don't have money."*

On the other hand, some of the research participants narrated negative familial experiences in spite of the Ghanaian culture, which entreats families to support members incapable of providing for their needs, irrespective of their disability status. One study participant, Ninash, claimed her family did not pay attention to her needs even when she personally requested help. She reported how she sought help from outside her family saying:

> *"I live in my father's house with my siblings. My relationship with them is not good at all. If I need food and I ask them, they won't give me. I have to go outside and ask for food...When my dad was living, it was much better, but now that he is dead, my siblings don't care about me...Eh, no one helps me when I am in need. No one in the house helps me unless they are outsiders. They don't even give me emotional support...I don't even ask because, if I do, they will not pay attention to me. And I am afraid they will insult or become angry with me when I ask."*

Despite the importance of love and support in promoting resilience, the majority of women, like Ninash, do not receive these elements. However, they demonstrated the attitude of: "I can find ways to solve problems that I face," which according to Grotberg, is an important element of resilience (1997, p. 37). For example, due to the fact that study participants have no means of earning regular income, many struggle to provide for themselves by engaging in menial jobs for survival. Gina exemplified this fact when she discussed how she made ends meet by occasionally sewing people's tattered clothes:

> *"Sometimes three to four months I don't get any job, I just get up, go and sit there [referring to under a tree] and come back home without doing anything. But sometimes when I go there people give me their tattered clothes and they will give me something 'small, small' [referring to few Ghana Cedis or small change]. But I can't stay in the house doing nothing. So I will get up and go there in the morning and come back in the evening."*

Others, particularly those residing in family houses (where all family members from multiple generations reside) at times stayed home all day to provide free labor, such as cooking for family members in return for food and other basic necessities, as with Muna:

> *"Sometimes I don't go anywhere because I don't have pocket money. I have to stay in the house so when they cook in the house I can have*

something to eat. Because when I go out I don't have the money and, by the time I come back, there will be no food. But if I am in the house, I will help my in-laws to cook and I can have some food to eat."

Others, like Maliya, begged on the streets for their survival, even when they were faced with sexual harassment and scorn:

"Because of my disability, if I don't beg no one will take care of me...Sometimes, I can get about 5 GH Cedis. Other times I get about 2 GH Cedis. Once I go out, I get money. But there are times I don't get money, especially on Sundays...However, sometimes the guys disturb me. Some of them tell me they want to marry me and when I say I am married they get angry with me, insult and make fun of me...They say things like, 'Look at how she is and she doesn't want to marry.' Sometimes they make a lot of fun at me and that makes me angry such that the only thing I do is to cry. They will laugh the more and make more fun when I cry."

Additionally, the majority of study participants reported living in family houses. The married ones, especially those married to disabled husbands, also reported living in their spouses' family houses. Through this arrangement, participants did not pay for rent, water, and electricity bills. Other participants, like Gina, lived in rented houses with their husbands. However, they chose to live in houses without the basic amenities of running water and electricity because they claimed they could not afford to pay for them. Gina stated:

"We live in a house my husband rented...Even where we are staying, we do not have electricity or pipe-borne water because we cannot afford to pay for them."

The various means of survival discussed previously did not yield much income for the women. Study participants earned an average of one dollar a day, which is demonstrated to be below the poverty line. Thus, they are unable to take care of their basic necessities, including food, soap, and clothing. In line with the *"I can find ways to solve problems that I face"* element of resilience, the majority of the women have become "managers," managing the little money they get from menial jobs as well as what they receive from family and friends, as demonstrated in Fati's comment:

"I have to try to manage. Sometimes, if I buy food, I can't buy meat because I have to keep some of the little money in case there is a problem in the house. For example, if my son is sick or needs something urgently...Though the money isn't enough, one has to manage... Despite the fact that I have been in this situation for a long time, I still feel sad about it most of the time...It really bothers me."

Because they must be managers of the little money they receive, they cannot participate in simple social and recreational activities, such as eating out at chop shops, going to soccer games, movies, and concerts, and visiting family or traveling to funerals or naming ceremonies for newborns, as well as doing things women would normally do, such as maintaining good hairstyles and buying nice clothes.

Participants also demonstrated *"I am willing to be responsible for what I do,"* another element of resilience identified by Grotberg (1997, p. 37). Despite the love they have for and the help they receive from their children to complete household tasks, some study participants reported giving their children to both relatives and non-relatives who could provide for them. The women asserted that it was a difficult decision, but it was better for their children to live with other people who could provide for them. As Joy pointed out:

> *"One [lives] with my mother, one with my husband's brother, and the other one is with my sister...The main reason why I gave them all out is because I can't take care of them. I don't have the money to do so. If they are with someone, they may get food to eat. So I will then struggle [refer to struggling for survival] for myself."*

In the midst of all the challenges previously discussed, the women with physical disabilities I interviewed demonstrated the attitude of *"I am sure things will be all right,"* another important element of resilience Grotberg identified (1997, p. 37). They remarked that life could be tough for everyone, whether disabled or able-bodied. However, they believed that they sometimes handled difficult situations better than their able-bodied counterparts because they often faced difficult life situations. The only thing they consistently reported praying for was a better future and long life. As Muna remarked:

> *"I feel okay, what else can I do, I have to manage. In this world, there are times you won't get what you want. Other times, you get what you want. I thank God I am healthy, and if I get a long life, I know things will get better."*

Even though I have a disability and have had similar experiences as my Ghanaian "sisters," I had an "out-of-body" experience listening to them and, was personally thrilled by their resilience. Often their stories were so emotional that I occasionally fought back tears. They willingly and eagerly shared their stories with little emotion.

When asked what they wanted the government to do for them, it will surprise you to know that, though poor, they did not request monetary support. Rather, they wanted the government to provide them with sitting space (e.g., kiosks, malls, and stores). They claimed they cannot afford to buy/rent these facilities and their inability to obtain them affected their small businesses, a reason why some of them were unemployed. They stated that customers can easily locate them if they have stores. They could also sell finished products, as well as accessories. The women deemed these facilities more important for their businesses than monetary support. They noted that monetary support without these essential business elements would not be beneficial, because they would be more likely to spend the money on food and other necessities. Yaa stated:

> *"If we could also get seed money and a sitting place, we can buy materials, sew, and sell them. We can also sell sewing accessories so we can get some money to live on. If the government gives us money alone, it will run out [referring to spending the money on food and other necessities], because you can't do business without having a place to sit. For example, if I am given 20 GH Cedis for business, that money can't do anything, because I don't have a place to sit, I don't have something to sell, but if I get the sitting place, and say, materials to start business, it will help."*

Conclusion

In conclusion, the women I interviewed have developed resiliency as a result of the challenges they encounter in Ghanaian society, parallel to my own experience. I persevered and achieved my goal of a higher education and an academic job, and am currently employed as an assistant professor in an American university. Similarly, these women continue to persevere, hoping for a better future, that would include sustainable employment through a hand-up, not a handout.

From my own experience as a person with a disability and from working with persons with disabilities, I know that persons with disabilities want to work like everyone else. They do not want to depend on others for their survival. However, many barriers continue to exist in Ghanaian society, preventing the majority of them from accessing both formal and self-

employment. In the absence of welfare benefits, the majority are compelled to depend on their families and other people for basic necessities. Poverty and negative perceptions about disabilities affect the quantity and quality of support people with disabilities receive from these sources. Subsequently, some unemployed women with disabilities survive by engaging in menial jobs or begging, and the income they receive falls well below the poverty line.

My experience indicates that economic empowerment is a crucial element in helping people break out of the cycle of poverty. Other important factors to economically empower women with disabilities living in developing countries include the opportunity to: (1) have a formal education; (2) learn vocational skills from experienced trainers who also live within the community; (3) have income-generating projects financed through a micro-credit programs; and (4) be taught basic business management and saving skills to ensure sustainability of success. Assertiveness and confidence-building skills are also important to help them advocate for their basic human rights, and have access to resources that could better their overall livelihood for themselves and their families. Equally important is to create awareness in families, communities, work places, and public policies about the capabilities of women with disabilities and the contributions they can make toward development that will benefit everyone. Therefore, it is my goal that I and other professional helpers can make a difference by effectively advocating for persons with disabilities, especially women, regardless of whether the professional helper has a disability or not.

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The Krisan/Sanzule Refugee Who inspired a Ghana Ministry

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This narrative recounts the origination of a nine-year ministry in Ghana led by the author, the former pastor of Webster United Church of Christ, in Michigan. The focal point of the ministry was Ghana's Krisan/Sanzule Refugee camp funded by the United Nations High Commissioner on Refugees (UNHCR). It follows the development of the ministry through the travails of a Liberian refugee who lived in the camp from its inception in 1996 to the beginning of its phaseout in 2006. During the course of the ministry, over fifty Americans traveled to Ghana and hundreds of others provided financial support stateside. The narrative also addresses the bonding between the author and the former refugee who inspired her. All names have been changed.

Introduction

I met Kadeja in 2001 at the multinational Krisan/Sanzule Refugee Camp in the Western region of Ghana. She has been a part of my life ever since. Little did I know that such a brief encounter would change her life, define my nascent ministry, deepen my faith, and launch a ministry that would span nearly a decade. That year marked the end of my second full year of ministry at the Webster United Church of Christ (Webster Church) in Webster Township, Michigan. Webster is a small farming town west of Ann Arbor, the home of the University of Michigan. The town was settled by farmers, many of them Germans, who had received or worked on farms resulting from federal land grants given by the U.S. Government in the 1800s to settle the then-frontier. Webster Church was still housed in its original white-framed clapboard, historic 19th-century building. I was the first African American and the first woman to pastor the nearly 200-year-old church.

In July 2001, I received a call from the Africa Office of Global Ministries, a joint overseas mission of the United Church of Christ and the Christian Church Disciples of Christ. Unlike other overseas church missions, their goal is not to establish churches, but rather to support existing economic, social, or religious programs run by indigenous people. In short, Global Ministries does not dictate, it facilitates.

Global Ministries invited me to join other African American clergy and lay leaders on a trip to Ghana in order to acquaint us with their work in the country and to meet their Ghanaian ministry partners. While this would not be my first trip to the continent—I had spent time in Senegal and Zimbabwe and later would spend a month training teachers in Ethiopia—it would be my first trip to Ghana. It would be the beginning of a ten-year commitment which would result in the establishment of a church ministry that included: micro-economic projects for refugees, scholarships for secondary and senior secondary school students, as well as funding of 11 hand-pumped wells and a partial water system. Most of all, it would be the catalyst for the development of foundational relationships that spanned the two continents.

My Introduction to Ghana

The 12-person delegation headed for Ghana in August, following a briefing by the Africa Office of Global Ministries, at which we were encouraged to get involved in and be supportive of their African missions. We landed in Ghana at Kotoka International Airport, and were greeted by what I have come to know as the normal crush of Ghanaians offering everything from a request to carry luggage to a proposal of marriage. Of course, our guides had planned our transportation in advance. After cautioning us to stand in one

place until we were summoned, they went in search of our waiting driver.

Our itinerary—one which I would replicate with varying degrees of alterations over the subsequent years—included: a visit to the Accra office of our host, the ecumenical Christian Council of Ghana; the Evangelical Presbyterian Church of Ho (EP Church); the slave dungeons in Cape Coast; and the Krisan/ Sanzule Refugee Camp in the Western Region. After two days in Accra, the Christian Council of Ghana staff took us to EP Church, where we stayed in their campus dormitories. Our sparse rooms overlooked a well-manicured court yard, had cement floors, twin beds, and indoor showers—replete with a bucket in the event the plumbing failed—which it did.

Each day at EP, we shared in the early morning devotions held in the head office. The devotions were conducted in Twi (the local language) and English. We then adjourned to the office of the Moderator. In a very formal, British-style presentation, we were greeted with salutations as each of us identified ourselves, our affiliations, and stated our purpose. Afterward in Ghanaian-style hospitality, we were each given gifts of cloth.

EP Church provided a major social safety net for Ghana. In Ho, we visited the EP-run leprosarium, a place that housed about 800 people who had been cured of leprosy, but because of the stigma attached to their condition, could not re-enter the general population. This resulted in many of them living at the leprosarium for more than four decades. Many had established long-term personal relationships. The several hundred offspring of those unions were housed on an adjacent parcel of land, where they wove kente cloth for tourists and local use.

We visited a newly built EP-run regional hospital that was virtually empty because most of the health professionals—who remained in the country after training—moved to the major cities to practice. One lone Cuban doctor served the hospital, with nursing staff providing the bulk of the support. One of the most moving visits was to the residence of a husband and wife who had opened their small home to street children, providing them with housing, food, clothing, and a respite from the streets. Global Ministries gave funding to support these and other EP programs.

The Startling Encounter with Kadeja

Our last official stop was the Krisan/ Sanzule Refugee camp, located in a forest about an hour's drive from the trading port of Takoradi. That year, we were told the camp had a population of approximately 2,000 refugees from wars and political unrest in Cote D'Ivoire, Liberia, Sierra Leone, Togo, Chad, Sudan, Darfur, the Congo, and Rwanda. The refugees lived in cement cubicles with dirt floors, corrugated tin roofs, and no electricity. The leadership of the camp had our 12-person delegation sit on a stage in an open-air pavilion while they gave a presentation about the camp and how well it was working. In the midst of this planned, upbeat briefing, a woman emerged from within the crowd of refugees. The young woman, whose age was 26, was Liberian.

She spoke in a deep, gravelly voice: "The women and children are dying in this camp. The women are being raped and the children are dying of hunger. Please help the women and children."

We were silent because the well-orchestrated presentation had just taken on a different tone. My heart ached, listening to her petition.

"Can you people do something?" she pleaded.

It was not our habit during these presentations to speak, but I could not refrain from saying something. What I should have said was*: I have no idea what I can do; I have no idea if I will ever get back to Ghana.* Instead, I said: "I don't know what I can do, but I *will* do something."

After the session ended, I met privately with the woman who had spoken out so courageously. Her name was Kadeja. I told her I would come back, and I gave her a ring to hold until I did. In an interview with Kadeja in March of 2011, she reflected back on the day we met:

> *"I was tired of people coming and hearing the same things from the camp management, feeling sorry for us, but never returning. The*

women in the camp wanted me to go and to tell what was really happening to them. I didn't want to go, but the women kept begging me. It was dangerous, but I spoke up."

Kadeja's Odyssey: Warring Liberia to the Krisan/Sanzule Refugee Camp

My promise to return haunted me all the way home. I vaguely remembered the other meetings with church officials and other organizations, because my thoughts were with Kadeja. I remembered her face--drawn and weary far beyond her years. She wore a sleeveless grey-green dress similar to one that I owned. When I returned to the States, every time I looked at that dress in my closet, I thought of Kadeja and her seemingly hopeless condition.

Kadeja was born in 1974 in Liberia, a year after my oldest son. By the time she arrived at the Krisan/Sanzule Refugee camp in 1996, she had lived nearly half of her life in a country engaged in one war after another. From the overthrow of the Americo-Liberian President William Tolbert by Samuel Doe, to the rebellion by Charles Taylor, Kadeja knew nothing but war.

As a teenager, Kadeja became pregnant and, because of the conditions in the war-torn Liberia, she was afraid to leave the house to go to the hospital. She delivered her daughter at home. The baby, Rebecca, was in a coma for three months. Kadeja told us of her miraculous recovery and her growth into a normal little girl. In addition to what we could read about in the newspapers in the West, Kadeja spoke of numerous culture wars between feuding tribes. Better known to Americans, however, was the Charles Taylor invasion, which lasted the first time until early in 1995. It ended in fragile, short-lived peace.

In April 1996, a savage and bloody resurgence of the Charles Taylor rebel forces known as the "Easter Terror" produced the next big wave of Liberian refugees and initiated the second half of the Liberian Civil War. Kadeja remembers the date, even to this day. As she was heading home with her six year-old daughter, she was swept up with the crowd of people running toward a Nigerian Freighter known as the Bulk Challenger Lagos. She was a 22-year-old single mother finishing her last year of school, studying computer science. By that time, almost all of her young life had been defined by coup d'états and violent civil war. Kadeja and Rebecca would be among the 4,000 Liberians to board the Nigerian freighter. In 1990, another ship had carried thousands of Liberians to Ghana. They eventually settled in Buduburam, a refugee settlement on the outskirts of Accra, populated primarily by Liberians.

The 4,000 refugees aboard the Bulk Challenger Lagos became a part of an international cause. The freighter had no place to anchor. Initially it was thought that the freighter would go to Nigeria, but the Nigerian government refused them. Other West African countries had been swamped with Liberian refugees, and Ghana refused to allow the ship to dock on its shores for fear of a stampede of refugees. Consequently, the Bulk Challenger Lagos stayed in the waters for over a week with no safe harbor. When the Liberian Civil war was over, it would produce nearly half a million refugees.

Kadeja recounted how the people were packed into the ship, which had only one toilet. People had diarrhea, two people were shot, and one woman died of internal bleeding. Then the Ghanaian government ships fired on the vessel. With horror still in her voice, Kadeja recalled:

> "I was there with Rebecca and we were huddled on the ship when the Ghana ships started firing at the refugees. We kept raising and waving white rags, but they didn't care. They later stopped and somehow talked with UNHCR (United Nations High Commissioner on Refugees) and let us into the camp."

The Early Years at Krisan/Sanzule Refugee Camp

The *Voice of America* reported that the European Union and the United States had negotiated with Ghana officials, which resulted in a relationship with the UNHCR and the designation of the Krisan/Sanzule region as a

site for a new refugee settlement. When Kadeja and her daughter disembarked in Ghana, she was stunned at what would be her new home. A decade and a half later, Kadeja was still emotional about the first years in the camp:

> *"It was a forest! There were crocodiles, scorpions, and snakes. We lived in tents and, during the rainy season, the water would flood the tent and come up to our waist. A lot of people died in those early years."*

One incident that she recalled from those early days was the time when one of the refugees came out of his tent to find a 25-foot snake eating one of his chickens, while his baby son stood next to the other chickens. Kadeja said:

> *"We would say, God put the chicken there to save the baby because the snake got to the chicken before he came to the baby. That's what saved the baby."*

Over the years the story would be retold throughout the camp, accompanied by a time-worn picture of several men holding the huge, dead snake.

In 2001, five years after the 1996 opening of the camp, the refugees no longer lived in tents. Kadeja was one of the early refugees who helped build the cinderblock houses. While cinderblock dwellings allowed some degree of protection, there were still children being killed by snakes and scorpions, and there were still crocodiles in the waters. But Kadeja felt that the noise in the camp kept some of the animals away, at least during the day.

A Promise Kept: The First Webster Church Delegation to Ghana

I returned to Webster Church and told the congregation that, when I took my vacation the following year, I would be going back to the refugee camp to do something, even though I wasn't sure what that would be. Slowly, individuals from the congregation came to me and said that they wanted to go with me, and that they would pay their own way. It was amazing! This predominately white, Midwestern church had produced people who wanted to take their first trip to Africa, in some instances their first trip outside of the country; for one or two people, it would be their first trip outside of Michigan. Our first delegation included a lawyer, a psychiatric social worker, a municipal supervisor, a business executive, a management consultant, a college student, two former missionaries, a retired professor, a former Peace Corps volunteer, and a child care professional.

The Global Ministries Office and the Christian Council of Ghana provided the travel arrangements and the logistics for this first trip. The delegation turned out to be that ecclesiastical number of twelve. The schedule would be the same as the one provided by Global Ministries--at least that was the plan. The first change of plans occurred on the third day of our two-week trip, as we were being escorted by our guide to visit EP's Peki Seminary. Following breakfast, we headed for the Seminary, but our guide rearranged our schedule, which resulted in our visiting an EP-run clinic in Gemeni village.

Upon entering the clinic, we saw a father holding a listless child of about a year old. The child was suffering from a fever and some other malady that was not easily determined. The nurse, who was the only staff at the clinic, was administering medicine through a large hypodermic needle. She needed a doctor. A trip to the hospital was out of reach for the mother and father. The $20 entrance fee to the hospital was prohibitive for the family, and the one-hour drive to the hospital required additional funds to pay someone in the village to drive them there.

The delegation decided to take a detour and drive the family to the nearest hospital, pay for the cost of care, and provide money for the family to return home after treatment. Following a prayer with the mother and a brief discussion with the doctor, it was learned that the mother was fearful for the life of her child, because another child in the village with similar symptoms had died the day before.

When we arrived at Peki Seminary, we were greeted by a huge sign that read: "Know Who You Are; Where You Are; and Why You are Here." After such an experience, some tearful delegates read the sign with a poignant sense of purpose and humility. About ten months later, I received an envelope at the church that was only addressed to "Webster Church, Michigan, USA." I cannot imagine how it was delivered with such an incomplete address. It was from the baby's father, who wanted to thank us and to let us know that she was doing fine.

On day three, we visited the EP Leprosarium. The day had already been emotionally and spiritually full, but nothing prepared us for that evening's visit. There we were, mesmerized by the stories of the residents (most cured from leprosy, but still bearing the scars and deformities of the disease). These stories told of people who had not had any relatives, children, or spouses visit them for more than 30 years. Abandoned by family, they were also shunned by the outside world. The residents sat on one side, the medical staff on another, and the delegation on the third side of the seating triangle. One member of the delegation rose up and approached the leper residents and reminded them that we were all children of God—sisters and brothers—and that we loved them. She then went over and hugged them all. The other members of the delegation followed her lead. The delegation donated money for the purchase of special shoes to be used by the lepers whos feet had become deformed.

The Delegation's First Encounter with the Krisan/Sanzule Refugee Camp

The Webster Church delegation finally reached the refugee camp. The bus was welcomed into the camp by singing and dancing refugees who were glad to see us. Unlike the large Buduburam Refugee Camp outside of Accra, Krisan/Sanzule had very few visitors due to its remote location. Our delegation was one of the few that had ever visited. When we gathered with the members of the refugee camp, I saw Kadeja. She gave me a necklace that she had made and spoke these words:

> *"People say they are coming back, but they never do. You came back. I have been praying for you to return. Thank God."*

Once again, the camp manager organized a meeting and the refugees came forward under his leadership. He began to tell us the story of the progress made in the camp and the effectiveness of the governing model that he had structured, where each of the nationalities had a representative on the camp's welfare council. The delegation separated into small groups with individual tasks. To the consternation of the camp manager, three of us met with the women only. He wanted a representative to be present in the meeting, but the women objected. I asked the women to share their stories. Most were not unlike Kadeja's story—lost families, parents, brothers, and sisters dead or missing, rapes by rebels, witnesses to mutilation of family members and worse. The following narrative from one woman in the camp is typical of the stories we heard:

> *"I am a Liberian who lived in Liberia from the day of my birth. However, since the war started in 1990 up to now, my parents and the entire family was hunted. My father was part of Doe's Administration as a police officer. He was killed. In April 1992, I try my possible best to try to travel out of the country, but while at the last gate or border point in Yekepe Nimba country, I was arrested by the officer who knew my father very well...they immediately took me to prison, and I was there for six months. While in prison, I experienced a lot of inhumane treatment which I cannot explain to you. After two months, the commander of the prison came with his friend and took me to another room and raped me. I cried for help, but there was no one and they also took off one of my toenails and stabbed my foot with a knife."*

The Sanzule Women's Sewing Circle—"With Every Dress a Story"

The Webster Church delegation returned to the hotel, shocked at the litany of violent stories and the plight of the women. As we reflected on the future and what was possible for our involvement with the women, I suggested that we start a micro-economic enterprise that would provide them with some independent resources for themselves and their families. Many of the women were seamstresses. That night we gave a structure to the plan: we would form the "Sanzule Women's Sewing Circle," and they would make dresses, handbags, and aprons that we would sell in Michigan. We would purchase manual sewing machines, material, thread, and supplies for them to begin the project. We would include with each dress a story about the plight of one woman so that their circumstances would be made known to a larger audience. The theme would be: "With Every Dress a Story."

Excited and hopeful about the prospects of the project, we returned to the camp and shared the plan with them. The women, whom we had left looking forlorn and rejected because we had promised that we would return with a solution or some hope, returned that morning with brightly colored dresses, their hair beautifully done, and some even wore make-up. They were smiling and ready to hear our ideas. We shared with them our vision of the Sanzule Women's Sewing Circle, with the theme "With Every Dress a Story."

They were so excited; they joined with us to put the particulars to the plan. Members of our delegation accompanied by several of the women went into Takoradi to shop for supplies. Other women stayed behind and worked out a budget and pay scale for the project. They would pay someone to type the stories, as dictated by the various women. The photographer at the camp would be paid to take pictures of the women and their families to attach to the narratives. The women in the sewing circle would be paid per dress, and Kadeja, along with another woman, would be our liaison in the States. When the women had finished 50 items they would ship them to Webster Church. We would establish an account with a shipping service and pay for the shipments. Women who could not sew would be paid for ironing, folding, and packing the dresses (to press clothes, the irons were placed on hot coals).

The Initial Success of a Micro-Economic Enterprise in the Refugee Camp

We gave them the first order for fifty dresses. They delivered them as planned, earning the sewing circle an estimated $1,250. In a country where a good salary was $30 a month, these funds would put money in the women's pockets to use to provide food for their families. At that time, their monthly rations amounted to a quart of oil, two cans of tuna fish, a pound of rice, a pound of maize, salt, and a pound of beans. Families with infants received additional rations, but not much more.

Of course, the introduction of that kind of money into a system where people had so little required someone trustworthy. Kadeja was one of the most trustworthy, God-fearing women I had encountered in the camp. My confidence in her integrity proved to be well placed. She distributed the money to each of the women in the agreed-upon amount. She had them sign for the money, kept a roster of the recipients, and also requested that they give her a thumb print next to their names when they were paid.

Kadeja later told me that the camp manager and the men in the camp had tried to get her to turn the money over to them. She knew she had to get the money to the women without letting the management know it was being distributed. So she gathered the women together and paid them, after retrieving it from a hiding place in her house.

The Second Webster Delegation Returns to Ghana

Before the second visit, Kadeja warned me that the men wanted something, as well. A businessman from the congregation facilitated organizing the men into forming a craft circle. The men made carvings, necklaces, and other trinkets that we sold.

The delegation provided school supplies for students in the camp, and we purchased

large quantities of rice, beans, fish, canned milk, maize, and oil. During this trip we were successful in getting the food to the refugees directly. Our first attempt to bring additional food into the camp almost caused a riot, because the women refused to allow the Red Cross to take the food and store it. They said that much of the food designated for refugees ended up in the Ghana market to be sold to Ghanaians. The women sat on the bags of food and surrounded the Red Cross truck to keep the driver from loading the food onto the truck. The welfare council finally decided that the food would be distributed directly to the refugees, instead of putting it in the storehouse with the rations.

As they had done the year before, the clinic nurse gave us a list of medicines to purchase, and accompanied us into Takoradi to the pharmacist, where we purchased what was needed. We later find out that much of the UNHCR-funded medicine designated for the refugees found its way into the marketplace as well. That year, we learned of the death of a child from malnutrition. While it startled us, it was common for refugee children to die of hunger. Even though natural resources such as fishing waters were within reach, we learned that refugees could work for Ghanaian fishermen by hauling in fish, but they were forbidden to fish for themselves. If caught, they could be shot or jailed.

Kadeja seemed to possess a degree of hope, even though the conditions in the camp had deteriorated for Liberians. Refugees had three options available to them, according to the UNHCR: they could repatriate to their home countries if the war or unrest had ended; they could naturalize in the country of their asylum, if permitted; or they could be resettled in another country, which in most instances meant the U.S., Canada, or Australia. In 1996, with the election of Charles Taylor as president of Liberia, UNHCR support for Liberian refugees ceased. This meant that rations for them would be discontinued and they would be encouraged to return home. However, most did not. According to the UNHCR 2002 Statistical Yearbook, the Liberian refugee population in Ghana had grown to 28,298 by the end of 2002. Kadeja, like many others, was still afraid to return home. For those women and men who had married spouses of other nationalities, there was still the possibility that they might receive rations, and still the hope that they might be resettled in another country.

Going from a Mission to a Spiritual Pilgrimage

The one message that the delegates took back to the church was that the people in the camp possessed an indomitable faith. Whether Christian or Muslim, the refugees were faith-filled to the point of inspiring and strengthening all of us. As a result, the trips were renamed "spiritual pilgrimages" rather than mission trips. For middle-class Christian Americans, the experience of being with people who had lost home, family, and country--yet still harbored a strong spiritual core--was transformative. The 2003 delegation experienced the refugees' spirituality even more profoundly than others.

When the delegation arrived, we were met by two women led by Kadeja. They had been fasting and praying for three days for our safe arrival. They met us in Accra and stayed with us during our trip to Ho and Cape Coast. They did devotions every morning with whomever their roommates happened to have been. They slept in beds for the first time in a long time, and used the facilities of the dormitories and hotels in which we stayed. They marveled at how much we ate: three meals a day, snacks, and large portions of rice. One woman cried when she saw so much food. She was reminded of how little food they had in the camp.

When we finally arrived at the refugee camp, the other women had prepared a lunch of fried chicken, plantains, soft drinks, and rice. We were ashamed to eat knowing that so many had so little, but of course we could not refuse because it would offend them. That night at the camp there was a church revival, and members of the camp used a local church-owned generator to produce light in the open-air pavilion.

I was asked to preach. I had no sermon; we were all tired and sweaty because we had been going all day. Nevertheless, I preached from the Gospel of John about the woman at the well who encountered Jesus and about how

she, too, was a refugee - a Samaritan. Jesus took the time to talk with her, giving her the status of being "somebody," and that even though they were without a home, or a country, they too were "somebody."

One woman left the revival singing a song she had made up about being somebody. She confessed that she had been beaten by her husband (not an uncommon occurrence in the camp, where domestic violence was prevalent). She was determined that she would not allow him to continue to beat her. However, we were made aware in subsequent visits that the domestic violence continued.

Six months after our return to the States, movement began to take place in the camp. Eight hundred refugees were resettled, after years of very few resettlements. The story in the camp was that the revival and the sermon brought about the change. In actuality, UNHCR started implementing its resettlement plan more vigorously.

2005 Delegation Met by Despondent Refugees

The refugees were calling it a miracle. Following the first wave of resettlements, Webster Church started a resettlement ministry. After years of hopelessness, refugees were going back home, or to Australia, Canada, or America. The Sierra Leoneans were the primary beneficiaries of this first wave of resettlements. Some were placed in Lansing, Michigan, an hour's drive from Webster. The resettlement ministry helped with housing, hospitality, life skills, clothes, and food. A few of the new arrivals joined Webster Church.

By 2005, the Ghana Ministry commitment had expanded to include a fully developed scholarship program that provided financial support for more than a dozen young people in secondary school, scholarships for the EP School, medical supplies for the camp, and school supplies for the street children and the elementary school at the camp. We also provided toiletries and financial support for the leprosarium.

The refugees looked forward to our yearly visits as much as we anticipated seeing them. Unfortunately, the camp had become more anxiety-ridden than before. A new group of women had taken over the leadership of the Sanzule Women's Sewing Circle. These women not as transparent and honest as Kadeja's leadership team. Kadeja had stepped down because she had gotten wind of the dishonesty. The camp management, the UNHCR, and the Christian Council of Ghana seemed to have had problems with the income being generated by the Sanzule Women's Sewing Circle, which made them a little more independent than before.

Now in her tenth year as a refugee, Kadeja had witnessed infant deaths, endured food shortages, watched as later arrivals were resettled in other countries, and had survived different political movements in the management of the camp. The 2005 delegation included an 83-year-old African American woman who had dreamed all her life of going to Africa. After her trip, she decided that she wanted to pay for a water well for the country. She went into her savings and gave the church $6,800 to pay for the construction of a hand-pumped well.

A matching grant allowed us to have an additional well constructed along with the first one. Both wells were completed in 2007. That same year, we expanded the Ghana Ministry to include building wells. The "Living Water Well Ministry" was documented by the Office of Proclamation and Identity of the National office of the United Church of Christ. This two-part video can be found on YouTube (www.Youtube.com/Webster/Ghana).

In 2005 we felt the tension in the air. People were restless with so much movement, resettlement, and repatriation. The remaining refugees were weary and ready for a change in their own circumstances. Friends were leaving each day, and the remaining residents were depressed and distressed at their condition. Kadeja had aged and was now married to a Sierra Leonean. They had two children--a boy and a daughter that she named after me. Each week the UNHCR officials would post the names of refugees on a bulletin board in the open-air pavilion. These refugees were to report to the resettlement office to schedule physicals and prepare for trips to their new homes. It was the dream that they all harbored. In some instances, refugee

identifications were sold to Ghanaians, resulting in some losing any chance of resettlement.

The Krisan/Sanzule Rebellion

That year we returned from Ghana in mid-March and in November, I received a call from Kadeja. She was desperate and hiding from the Ghana military and police. There were 30 people with her. She wanted me to send her money so that she could rent a bus and carry them to safety in Accra. They were fearful that if they returned to the refugee camp, they would be arrested, beaten, or killed.

There had been an uprising in the camp. The genesis of the unrest was dependent on who was reporting the story. One version blamed the Togolese for the disturbance. According to this account, the Togolese were upset because they wanted to be resettled outside of Africa, but because they were not refugees from a war and were there because of political deal making, they were not eligible to be resettled. They led a large group of people to the border Ghana shares with Cote D'Ivoire, but were met with force by the Ghana military and police.

Kadeja's account in later years was that the police had badly beaten a female refugee and her son, who eventually died. Kadeja took pictures of the two and encouraged the residents to send letters of protest to UNHCR along with the pictures. She thought this would be better than trying to demonstrate and risk their personal safety. Others chose a different route. When the unrest began, residents turned over UNHCR cars and burned the food storage shed that held the rations. Kadeja fled along with her husband who had previously incurred a leg injury that caused him to limp and their three children. Kadeja explained:

> *"We ran to a Ghanaian friend who let people stay in his house. We were sleeping all over the house. Then I called you."*

When she received the wired money, Kadeja rented a bus, loaded the 30 people onto it, and headed for Accra. When she arrived in Accra she called me again so that she could get money to rent a house for herself and the others. The money was sent, and Kadeja rented housing in Accra.

Kadeja is Resettled in America

Several months later, in 2006, I received a call from Kadeja saying that a friend had informed her that her name had been posted on the camp bulletin board. Because the police were still looking for her, she waited until one day before she was supposed to take her physical and leave before claiming her resettlement package. Kadeja and her family would be resettled in Lansing, Michigan. It was a dream come true. It had been seven years since I first met Kadeja, when I thought her plight was hopeless. Now she would be an hour away from me. She would no longer live in fear of snakes, scorpions, and crocodiles. Her children would no longer have to fear malnutrition or malaria. After a little over a decade in the refugee camp, years of wars and political unrest, Kadeja would be coming to America. She was almost 33 years old.

Church members met Kadeja and her family at the airport, and gave them coats, gloves, and hats. The housing that the official refugee resettlement service provided seemed adequate initially, but turned out to be otherwise. The landlord would house the refugees until their resettlement funds were exhausted, and then would devise a pretense to evict them. Fortunately for Kadeja and some of the other former refugees, we had a developer in the congregation who had townhouses to rent in the Lansing area.

In those early days, I would invite Kadeja to stay overnight at the parsonage with the kids on the weekends. They were not used to cold weather and thought that they needed to keep their coats, sweaters, gloves, and hats on even indoors at night. I told them that it wasn't necessary, that we had heat and blankets; but it seemed as though those first few months were much too cold for them. I explained the seasons to them. I told them about fall and how the leaves fell off of the trees, but that in spring new leaves would return. They were incredulous because, in the abstract, this seemed impossible.

Kadeja moved ahead, enrolled the children in school, and began to take classes to become

a licensed practical nurse, (while working part-time at a bargain department store. (She wanted to work full-time but her employer kept her part-time so that she would not be eligible for benefits.) Her husband had a little more difficulty getting work. She visited the church when we drove to Lansing to get the others; however, our services were no match for the spirit-filled African worship experience. I understood her need to settle into a church that was much more expressive and evangelical than our Reformed worship tradition.

A Military-Controlled Krisan/Sanzule Refugee Camp

When the delegation visited Ghana the spring of 2006, the atmosphere was different. We were not allowed to go into the camp as usual. Crowds did not greet us, and many of the women we knew stood behind trees as if in hiding. The one thing we did notice was that several of the teenage girls were pregnant. Their pregnancies could be traced back to the time of the unrest and the subsequent occupation of the camp by Ghana police and military. They were silent. I had to negotiate with the new camp manager, a former military officer, to get access to the camp. I assured him that we would not disrupt anything, but this was our annual visit and we wanted to spend some time and resources on the clinic, the school, and the food.

Our micro-economic enterprises had dissolved. When we were finally allowed in the camp (under strict scrutiny), we saw a lot of new faces. We took two of the young girls with us to Takoradi to get food and medicine. Both were pregnant; one was having morning sickness and fell ill in the van. We later took the two of them to a restaurant.Unlike the normal morning sickness, when the teenager vomited she spit up only sand and water. It was clear that she had not had any substantive food.

I was glad that Kadeja had been resettled in America, but I was saddened by the condition and the spirit of the camp in 2006. When we returned to America, I spent some time with Kadeja. It turned out that she was having marital difficulties with her Sierra Leonean husband and they were on the verge of separating. In the meantime, Kadeja had learned from another Liberian woman in the States that it was possible that her mother was alive and possibly living in New Jersey. Kadeja thought initially that the woman was talking about her stepmother, but later found out that it was her biological mother, whom she had not seen for sixteen years. Kadeja had matured into an extraordinary woman in the refugee camp. Now she would find out that she would lose a husband but gain a mother.

Expanding the Ghana Pilgrimage to Include Water Wells

Our 2007 pilgrimage started off on a high note with the dedication of the first two "Living Water Wells" in Dambai and Akaa in Northern Ghana. We had doubled the number of delegates for this trip to about two dozen. Another highlight was a ceremony at the W.E.B. DuBois Museum in Ghana honoring the work of Webster Church and its delegations from 2002 to 2007. The plaque included the names of over 50 people who had participated in the mission over that period of time, some of whom had returned several times.

Ghana had changed. The decision was made to close the two refugee camps. Bududuram residents protested their closure, but the Krisan/Sanzule refugees were in a state of despair. The camp had become dilapidated. The refugees that were left were unlikely to be resettled and the rations had been cut drastically. The medicine in the clinic was practically nonexistent. Once again, the children were dying of malnutrition at a more rapid pace. Children who received scholarships were thriving, and some of the individual relationships established by the members of the church were at various levels of success and failure.

In the meantime, the Webster Church Ghana Ministry became involved in raising funds for "The Living Water Wells." This phase of the ministry—inspired by the aforementioned octogenarian—raised about $100,000 for the construction of wells in Ghana. The wells were dedicated during our 2008 pilgrimage. In all, we constructed eleven wells and a partial water system.

My Last Spiritual Pilgrimage to Ghana

That year, I returned from our annual pilgrimage to Ghana and made good on my letter of resignation that I had written 18 months earlier. In May, I resigned from Webster United Church of Christ and began serving as the Chaplain Administrator at The Chautauqua United Church of Christ Society, Inc., in Chautauqua, New York; a summer religious, arts, and educational retreat center. During the remainder of the year I remained home in Reston, VA.

When I returned to Ghana in 2009 to finalize the well inspection and to visit the refugee camp, I knew that it would be my last trip for awhile. I was experiencing major health challenges. When Kadeja found out about my condition, she called and sent cards from her home in East Orange, New Jersey She was praying for me and sending forth petitions in her home church for my renewed health. In one email she offered to come to Virginia and take care of me until my health was restored. Her prayers and those of others were well placed and produced the desired healing.

Re-Uniting with Kadeja in New Jersey

In March 2011, my first road trip following my illness was from Virginia to New Jersey, to visit with Kadeja and her kids. She had moved from Newark where she had lived with her mother. It appeared as though too many years had elapsed for them to recapture the mother-daughter bond. When I climbed the stairs in the two-story garden apartment Kadeja called home, I remembered that first image of her in the dust and dirt of Krisan/ Sanzule; her face weary, her children neatly dressed, even in the worst of circumstances.

When she opened the door to her apartment, we just embraced. My namesake was now six years old, smart and feisty, and her brother was seven or eight and already had the bearing of a little man. I looked around the apartment, which was neatly decorated with pictures, comfortable furniture, and plants; it had the warmth of a real home. Rebecca, Kadeja's oldest daughter was in her first year at state college. She had wanted to come home to see me, but she had to stay in school. I couldn't stop snapping pictures and marveling at the progress that this courageous woman had made in spite of the adversities. She was now sitting before me, healthy and strong, as spiritually centered as she had always been. She held devotions every morning with the two children and cooked meals at home because eating out was too expensive. Most of all, she said that she was enjoying the peace and serenity of her new life.

Kadeja was now working part-time at a nursing home as a nurse's aide. She had purchased a second-hand car that she used to drive to work. Her plan was to return to school and study to become a radiology technician. As we began to talk, Kadeja went back into the bedroom and came out with something in her hand.

She sat next to me and said: "I still have it." "What?" I asked. "The ring," she said as she held out her hand. "This is the ring you gave me and said to keep it until you came back."

We just stared at each other—it had been a remarkable journey!

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Economically Empowering Ghanian Communities through Patchwork Quilting

Mariah Landrum Childs, LCSW, Celestial Enterprises Unlimited, Inc.

This narrative is to inform social workers, students, and other professional helpers how an appreciation of creativity and an understanding of the African tradition of Ubuntu can aid in the empowerment of people and their communities—especially young women—in emerging countries. It is a narrative that "stitches" together the development and implementation of a cross-Atlantic, intergenerational, income-generating quilting project between older African American and younger Ghanaian women from my social work perspective as an organizer and storyteller.

Ubuntu – n. (oo-BOON-too) an ancient African word, meaning "humanity to others."

Introduction

I have been a clinical social worker for over three decades. Throughout my professional career, I have been an activist for the rights of the abused, the disenfranchised, and the socially and economically deprived; in particular, women and children. As an avid quilter, I always look for opportunities to enrich the lives of vulnerable populations by teaching them the art of quilting as a means of becoming empowered and self-sufficient. Most recently, I have done this by facilitating the sale of quilts in the U.S. and Ghana. I am a firm believer that nothing happens by chance: that God divinely connects people and orchestrates situations for the betterment of society. I believe that unpredictable situations or experiences can lead to new and different patterns of creativity. Thus, this narrative is an account of how The Celestial Heritage Quilting Project, an income-generating venture, came into physical manifestation through the providence of God.

The foundation for this project was laid by my eldest son, Christopher Lake, MSW. Chris made his first trip to Ghana while in high school, and went to Ghana a second time in 1995 as a senior at The University of Pennsylvania through Temple University's Study Abroad program at the University of Ghana. During this trip, Chris met Mr. Kwabena Osei Bonsu, a native Ghanaian who was actively involved in making the sanitation conditions better for the people of Madina, a town in metropolitan Accra. Chris contributed some financial support to help move the effort forward, and the two men became friends. Before returning home, Chris formed an import/export enterprise with Mr. Bonsu, a relationship which they have maintained to this day.

Upon my son's return to the U.S., I became acquainted with Mr. Bonsu via phone and email. I was impressed by the excellent quality and workmanship of the products he sent over, particularly the garments made from beautiful batik fabrics. I pondered the potential marketability of a business venture--maintaining an import/export business of African products, especially clothing, that would help young women acquire income as a result of their sales.

Quilting and Business Experience

I believed that I could pull off this cross-Atlantic project with the help of God, and my training as a quilter and entrepreneur. I have been blessed to not only be a social worker but the founder and CEO of Celestial Enterprises Unlimited, Inc., a 501 (c) (3) not-for-profit organization in the U.S. was dedicated to helping educate and empower

disenfranchised and economically disadvantaged young women. In fact, out of my passion for quilting, I established and operated The Calico Giraffe, a small in-home quilting business that was successful during the 1970s and 1980s. I have always had an affinity for African textiles, and have incorporated batik textiles into many of the quilts and wall hangings that I've sold. My social work background and sensitivity toward humanity was expressed in some of my work. I designed personalized baby and children's quilts, as well as the "Comfort Quilts" that were intended to provide comfort for those suffering from loss and grief. These quilts and wall hangings were embellished with scriptures, sentiments, and phrases of comfort. I never imagined that God would "stitch together" my gift of quilting with my social work and business management skills, but this unique skill set enabled me to make a difference in many lives.

Getting the Project Off the Ground

I met Mr. Bonsu in 1999 during my first visit to Ghana. I remember how excited I was to finally stand on the soil of my ancestral home. As I looked into the faces of the people, I recall thinking that they looked familiar, like the faces of my family members and friends at home in the U.S. It was an unforgettable experience. Throughout all the challenges that visit solidified my belief that maintaining the import/export exchange was well worth it. Mr. Bonsu and I shared a common commitment to train and empower young women to become more productive economically to improve their standards of living. Because of this, we came together and pondered how we could use our gifts to be a blessing to the disenfranchised in his community. After time spent in discussion and prayer, we decided to create a Non-Government Organization (NGO). That July, we completed the necessary paperwork to legally form and incorporate The Celestial Needy Children's Program (CNCP) in Ghana.

The Role of Young Ghanaian Women

The initial entrepreneurial enterprise of CNCP was The Celestial Stitches Heritage Quilting Project. It was established to teach the art of patchwork quilting to young women, thus aiding their social and economic development. Ten young women were recruited and trained, and made up the core group of seamstress working for CNCP for more than four years. To be a part of the quilting initiative they had to live in Madina and be between16 and 21 years old.

The specific nuts and bolts of this entrepreneurial operation are relatively simple. I emailed designs for clothing to Mr. Bonsu, and locally trained seamstresses assembled the beautiful garments. As for the quilts, batik fabric pieces (remnants, often discarded) were stitched together by an intergenerational group of Ghanaian seamstresses into beautiful patchwork-quilt tops. The quilt tops were then shipped here to the U.S. to be sewn into finished quilts by volunteer quilters (including myself). After the products were sold, the proceeds were sent to Mr. Bonsu via money wire transfers. He then distributed the earnings to the women. We could not do this without him!

Intergenerational Connection – The Role of Older African American Women

I proposed to the Board of Celestial Enterprises Unlimited, Inc., the notion of collaborating with the Celestial Needy Children's Program (CNCP) in Ghana. I wanted to help move the quilting project forward by helping them to raise the needed funds to support the program and to aid with marketing. The Board unanimously voted to partner with CNPC, believing that the partnership would be a good entrepreneurial enterprise to help young women and the local community. I was elected to oversee our involvement with CNPC.

The Board agreed that Mr. Bonsu would arrange to have the patchwork batik quilt tops sent to me in the U.S. The quilts were completed with the assistance of experienced elderly African American female quilters (between 60 and 80 years old) who participated in a quilting class I instructed in Savannah, Georgia, where I resided.

Once finished, the quilts were marketed by Celestial Enterprises Unlimited, Inc.,

through church-sponsored events, conferences, festivals, and word-of-mouth. The funds from the sales were collected by Celestial Enterprises Unlimited, Inc. and wired to The Celestial Needy Children's Program in care of Mr. Bonsu, the CEO. During the time of our engagement, I have insisted on maintaining quality control so that funds are not misspent. Fortunately for all involved—especially my U.S. seamstress and investors—Mr. Bonsu has proven himself to be honest and responsible as a businessman based on his professional dealings with our import/export business. He, in turn, distributes the funds to the workers; submitting records regularly to validate how and to whom the monies have been allocated. Through The Celestial Heritage Quilting Project, the lives of retired senior African American were joined together with young women from Ghana to form an international partnership, bringing lives together cross-generationally, geographically, culturally, and economically.

The elder quilters from the U.S. maintained internet communications with the young women, which allowed them to share stories, quilting ideas, and pictures. The women established caring relationships with each other during the time they worked and interacted with one another. Eventually, the quilters from Savannah yearned to go to Africa and meet their younger counterparts face-to-face, and began discussing the possibility of sojourning to Ghana with me the next time I went.

Older Mentors and Young Mentees

I planned my second trip to Ghana in 2001 as a member of the Enyimnyam Study Development Project. The project, which has been operational since 1996, is co-directed and guided by Dr. Na'im Akbar, and my cousin, Dr. Wade Nobles. Dr. Nobles, a tenured professor at San Francisco State University and the Executive Director of the Institute for Advanced Study of Black Family Life & Culture, is a prominent theoretical scientist in the fields of African Psychology, cross-cultural and ethno-human functioning. The project's concept comes from the Akan (Ghanaian ethnic group) belief that every person is endowed with a "gift of splendor" from God. According to Dr. Nobles, this gift of splendor is called "enyimnyam" and is translated as the "radiance of the face." It is believed to serve as a blueprint of one's soul's capacity for success. Participants of the Enyimnyam Study Development Project are encouraged to find and use their gifts from God, and to help others by sharing their gifts in some form of skill, talent, or ability to fulfill their purpose in life. When I shared this information with the volunteers in my quilting group, they thought it would be the perfect opportunity for them to go to Ghana and share their wisdom with their younger counterparts. So arrangements were made for them to accompany me as participants of the Enyimnyam Study Development Project.

These elderly African American women—all natives of Savannah—had never thought in their wildest dreams that they would ever have the opportunity to travel to the "motherland." They were filled with enthusiasm as they applied for their passports, planned and received the necessary shots, and made payments toward the cost of the two week trip. A woman who was in her 70s shared, "I always thought about going to Africa, but I never, ever believed that one day I would really be planning to go." She went on to say with a chuckle, "Just goes to show you that 'nothing is impossible with God'."

In July 2001, six women from the quilting group accompanied me to Ghana. Plans were made for them to meet with Mr. Bonsu and the young women who made the patchwork batik quilt tops. While there, the women would exchange quilting ideas and techniques. It would be a life-changing experience for the African American and African women to meet face-to-face and have the opportunity to get to know and learn from each other.

When the women arrived in Ghana, they were amazed at how modernized Accra was. They were also pleased to finally meet Mr. Bonsu and to have him take us to the town of Madina. Oh, how we laughed and held our breaths as he drove us over roads that seemed totally impassable. Yet, somehow he maneuvered around the huge potholes and narrow red-clay pathways and got us safely to our destination! When we got to the African-

style gazebo where the young women were busily cutting and stitching together beautiful fabric squares into patchwork quilt tops, we were all amazed that they were able to produce such beautiful pieces in what seemed to be a primitive outdoor environment.

After exchanging cordialities, Ms. Brown—a woman in her 70s and our most experienced quilter—quickly pulled out her fabric, measuring tape, and scissors and began teaching the young women how to make a "pillow quilt." The young women were very interested, paid close attention, and freely shared ideas and asked questions. Then they, in turn, made a "pillow quilt" effortlessly and with precision. Ms. Brown was amazed that they learned how to make them so quickly. She remarked, "You young women sure are good!" This global quilting initiative was a wonderful conduit for uniting the two groups of women of different ages and from different cultures together to share their collective wisdom and resources with each other. A good seamstress/tailor in Ghana (and there are many) can make a western or traditional outfit perfectly simply by looking at a photo of the item; no pattern needed.

The young women were overjoyed that the elder women were impressed with their workmanship, and in turn praised them for their sewing skills. The radiant smiles that spread across the faces of the young women signaled their appreciation of the compliments they received. This encounter served as a mechanism to help elevate the young women's sense of worth and increased their self-esteem.

One young woman participant in the project pulled me aside during this visit and commented, "I never thought that these little pieces of fabric could ever be turned into such beautiful bed coverings that would be sold and help us earn money." She gave me a hug and said, "Thank you, Ms. Childs, for all you do." This young woman's comments reinforced the idea that it often takes social workers and other helping professionals with vision to work with marginalized populations, teaching them how to turn their natural resources into marketable assets.

The older women had a variety of experiences and adjustments. For example, one asked to use the bathroom. One of the girls led her to a door, opened it, and bid her to go in. She came out and quietly whispered to us, "There was no toilet, only a hole in the dirt floor." This situation reminded me of how important it is for social workers and other helping professionals to be aware, flexible, and sensitive of cultural differences when traveling internationally so that the people that they are interacting with will not be offended by their reactions to unfamiliar situations.

Eugenia Morris, an 80-year-old quilter, shared one afternoon, "I never thought that I would ever be blessed to come to Africa, and not at my age. This has been the most exciting experience of my life! I have really enjoyed meeting Mr. Bonsu and him taking us to Madina to meet and share quilting techniques with the young women there."

All in all, the trip was a once-in-a-lifetime helping opportunity for the Savannah women and me. I had the opportunity of developing and implementing an international, intergenerational, and cross-cultural quilting initiative from the ground floor. I believe that as a result of our project and opportunity, young women without skills or jobs can care for themselves and their families (parents, siblings, etc). Most likely those vulnerable young women felt discarded in their communities; much like the remnant batik textile fragments. Hopefully they no longer have such feelings since gaining a purpose for life and a marketable skill. The benefits of this venture are far reaching. In addition to providing support to these young women, other monies earned from this business enterprise are used to pay for school uniforms and supplies for the community's needy children.

As time has gone by, The Celestial Heritage Quilting Project has flourished, and the quilts are in demand by tourists and U.S. patrons. The young women became so adept with the quilting process that they began designing and making the quilts entirely under the keen and creative eyes of Mr. Bonsu and Ellen, a young Ghanaian woman who began with the project at the age of sixteen. Through her participation in The Celestial Heritage Quilting Project, Ellen is now an experienced seamstress who is proficient in teaching other

young women the necessary sewing and quilting skills. Ellen remained with the project for four years, completed her education, improved her living conditions, married, and started a similar business of her own in another Ghanaian community, and continues to maintain contact with Mr. Bonsu.

The quilting enterprise advanced to include quilted patchwork bags and other quilted products, which were enthusiastically received in the U.S. for their beauty, workmanship, and uniqueness. The sales from these products were used to not only help empower the workers economically, but also helped to provide educational supplies, fees, uniforms and to meet other needs of disadvantaged youth and their families through The Celestial Needy Children's Program.

The Celestial Heritage Quilting Project has continued to prosper on a micro level under the auspices of The Celestial Needy Children's Program. In 2006, the program's vision expanded to include the Medicinal Plantation Project, in collaboration with Government Plantations, which distributes seedlings for planting. The aim is to raise medicinal and other seedling plants to combat malaria and help the reforestation effort. In 2007, out of concern for environmental waste, the Keep Ghana Clean Project, aka the Accra Trashy Bags Project (Plastic Waste Bags Initiative), started with the aim of clearing the environment of plastic waste (especially pure-water sachets) and recycling them into purses, toiletry bags, tote bags, and handbags. This creates employment and educates people on environmental sanitation and degradation.

In 2008, The Celestial Needy Children's Program turned its focus to the prevention of malaria with its Kick Malaria Out of Africa initiative, whose mission is to drastically reduce the incidence of malaria in the rural and urban areas of Ghana and other countries in Africa in collaboration with local and international organizations. This initiative utilizes funds acquired from the sales of African batik quilted products from The Celestial Heritage Quilt Project to help purchase and distribute treated mosquito bed-netting and repellents to African communities and to move the malaria prevention project forward through literacy programs.

Lessons Learned

In conclusion, through my involvement with The Celestial Heritage Quilting Project, I have learned not to take any of my skills or life experiences for granted, and to remain open to unexpected possibilities that lead to helping others. I have also come to realize that the role of a social worker to help others obtain a better quality of life does not have to be so narrowly defined as clinical practitioner, community organizer, or researcher, but that it can be all-encompassing in the role of generalist (use of all knowledge, resources, and skills) practitioner. Additionally, incorporating one's God-given talents or passions into the role of social worker can be a tremendous benefit in working with diverse populations, facilitating their empowerment and improved quality of life. Finally, I have learned as a social worker in the 21st century to think "outside the box," and to enlarge the borders of my practice through collaborating with groups and organizations nationally and internationally to improve the lives of disadvantaged people and empower communities.

In this changing global world, social workers can play a major role in collaborating and working with other people, communities and societies. The philosophy of "ubuntu" emphasizes team work and collaboration, and enables the social worker to use their interests, gifts, skills, knowledge, creativity, and most of all spiritual nature to undertake leadership in uncertain times.

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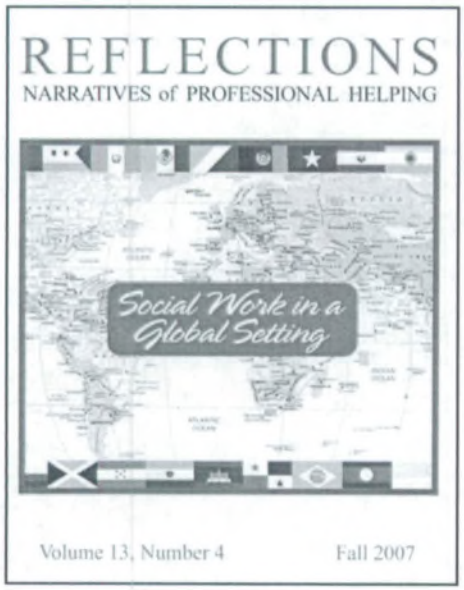

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