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Global Women's Health Resident Blogger: Meagan Campol Haynes

January 15, 2016: Welcome to Accra

Welcome to the first installment of Meagan's travel blog, upon where I shall be scripting personal reactions regarding my brief global health experience in Accra, Ghana.

Disclaimer - this is herein forth a judgment free zone, and I'm planning to write as if the only reader beside myself is my mom. Hi mom! Miss you!

One of the reasons I love to travel is that it encourages me to pay attention to otherwise mundane details, both in the new environment and in my homeland. Traveling allows you to step away from your own routine and experience fresh surroundings from an anthropologic lens, as if you were Margaret Mead examining an untapped New Guinean tribe. How do they interact? How is their time spent? What do they eat? What do their homes look like? What is valued and what is discarded? The most fascinating aspect is how YOU intersect with this new genus – how do they react to seeing YOU? Are you lost among a horde of people anxiously crossing paths, apathetic to your presence, unabashedly unaffected by your race or language or appearance, no matter how bizarre (= the blissful yet indifferent diversity of NYC)? Or are you literally the first person a child has seen that doesn't look anything like his mother, face flooded with tears and horror and sweat and snot (= me in rural Uganda)?

This attention often starts on my trip to the airport, where the realization that you may soon be outside of your comfort zone begins to take hold. I notice details on the drive across Brooklyn: graffiti-adorned buildings, barred up bodegas blasting salsa music, traffic-jammed highways with nauseating cabbies who think they can drive. But then I glance back and, man, there's that good ole New York City skyline, romantically gesturing to come on in and stay for a while. The international terminal of an airport is another fascinating experience. I like to stroll through while imagining I am headed to the Olympic games. Stylish Russian teenagers stomp impatiently behind me at the counter, an Israeli family of 6 children with swinging Payot trail behind, an eclectic Parisian couple clutch a fur-lined backpack containing a tiny animal (dog?) at bag check, a line-backeresque security guard announces "NO shoes! Oh and no shirt, no problem" in the TSA check point to a full Argentinean soccer team stripping off their matching jumpsuits. Gateway to the games, for sure.

Anyways, I digress. The first Ghanaian I meet is in line to board the plane. She's a sweet girl named Sandra who has been living in Jersey City for the past 5 years and is headed home to visit her family. After learning that this is my first trip to her home country, she exclaims "Oh! How I wish I could just see your face when you first go into Accra!" I think her statement is 60% pride in her home, 35% genuine interest in my experience in it, and 5% morbid curiosity to the contrast. My flight is pleasant and after 3 movies and a swan-necked nap, I arrive in Accra. As the plane doors swing open, releasing the pressurized New York winter air, my body is suddenly dunk-tank dropped into the African humidity. Akwaaba!

With my NYC cab ride fresh in mind, I am able to note quite a bit from the taxi drive across this new city. Accra is the capital of Ghana and is an expansive metropolis of over 2 million people. It encompasses a mix of formal government buildings/embassies/banks with high concrete walls topped with barbed-wire icing and patrolling security guards ensuring you don't taste even the tiniest of slices, all alongside huge shanty towns. These are essentially brick walled rooms with a dirt floor and aluminum roof, smooshed together with needle-thin alleyways scattering from the core.

The streets are packed with a menagerie of personal cars, taxis, swerving motorbikes, and "tro-tros" (large mini-vans crammed with locals trying to get across town, often with backdoors tied closed with rope for additional space for small bags or persons in trunk). There is little greenery. The air is hazy and yellow from dirt and sand. The smells are of smoke, ash, diesel, trash, and car fumes. A persistent yet confusing honking schema fills your ears; it seems as if a car honk can be used for virtually any form of communication from taxi driver to other taxi driver/pedestrian/stray animal. So far I've noticed honking to represent the usual "get out of my way" or "what's taking so long" frustrations of heavy traffic on poorly maintained roads (NYC has trained me well for that one), to announce that the cab is open for business for ALL whom walk by (in addition to the obvious roof light), to announce that the cab is not? open for business for all whom walk by, to say the Twi equivalent of "yo dude, how ya been?" to other cabbie buddies, to drum along to the latest in Ghanaian reggae beats, or to get the Obruni's attention hoping for an ignorantly swollen fare (Obruni = also known as Gringo in South/Central America or Muzungu in East Africa or "white person" in translation). Concrete brick sidewalks are patchy and crumbling with huge gutters running parallel to the roads. You learn very quickly to watch where you step as you may very easily break your foot or just land ankle-deep in sewage.

Men and women, dressed in both Western clothes and traditional African patterns fan out among the stalled cars selling a plethora of items I have trouble understanding, "yes, I really need to buy this [insert random item] during the 15 seconds I have until the light turns green." Said random items include: motorbike parts, Mercedes key chains, bibles, processed cookies, flashlight belts, coconuts, cleaning supplies, loaves of bread, sim cards, yams, and plastic bags full of water. Women balance baskets full of [insert huge amount of random items] effortlessly atop their braids,

a feat I hope to conquer at some point. Everyone is sweating profusely, dabbing salty beads off their foreheads with rags.

I drove by a hand-written, all caps sign tacked to a tree that read, “MASTER NATURAL GONORRHEA TREATER. 20 YEARS GONORRHEA. LOW SPERM COUNT. SEXUAL WEAKNESS. SMALL PENIS.” Go ahead, read it aloud. It’s pretty much a public health haiku.

The guesthouse/lodge where I am staying is quite decent, with a firm single mattress, a private bathroom with *advertised hot water (I have yet to experience warmth, yet coming home slathered in sticky dirty sweat permits cold showers to suffice), electricity with intermittent Wifi (dependent on frequent power cuts), and most importantly, A/C! It takes me about 25-30 minutes to walk to the hospital, or a $1.30 taxi ride. Breakfast is served daily, consistent of a hard-boiled egg, two pieces of white bread with butter, and NesCafé.

While there are a few city highlights I plan to explore, Accra is not as touristy as I expected. I did venture out on my first night to survey the “nightlife district” of Osu, which was crowded and underwhelming. It could be that I get enough unwelcomed personal contact with strangers living in NYC, or perhaps suddenly in my 30s I am morphing into a country mouse. Regardless, I think I shall prefer my sleeper side of town.

I’ve tried a few of the traditional Ghanaian meals, including jolof rice and plantains, fried rice with meat, waakye (rice and beans), fufu (mushy ball of cassava flour hand-dipped in stews or sauces), and banku (mushy ball of fermented corn hand-dipped in stews or sauces). I have yet to try the kenkey (another type of cornmeal ball often wrapped in banana leaves), red-red (black-eyed peas with red pepper and red palm oil), or koobi (salted dried whole tilapia). There are also street snacks of said mushy balls deep-fried into little doughy donuts. Overall, the food is, well, starchy. Good thing I brought fiber bars…

From within noticing details comes both comfort and adventure: comfort in recognizing similarities between this new exotic place to your own simple home, and adventure in witnessing activities or sights that are in stark contrast to what you are used to. I look forward to sharing my observations and experiences of both comfort and adventure with you during my time in Accra!

January 19, 2016: Korle Bu Teaching Hospital

My first week spent at Korle Bu Teaching Hospital in Accra was wonderful and informative. Korle Bu ranks as Ghana’s largest hospital and the third largest hospital in all of Africa! It is actually a large complex of buildings and services associated with the medical school, nursing program, public health school, pharmacy program, etc. Each service has its own building; the maternity unit is a freestanding 6-story building with a mixture of gynecology, postpartum, and antepartum inpatients and two separate labor wards, all run by 5 separate teams of doctors. They have about 12,000 deliveries a year! Each floor in the maternity hospital has been sponsored by a non-profit organization or a business for renovation. It’s quite nice compared to other international settings I’ve worked in!

The second floor labor ward is for routine low-risk patients managed by the midwives and the first floor is for identified high-risk patients, more closely covered by the residents. In fact, the residents only deliver vaginal births if there is an intrapartum complication (shoulder dystocia, operative vaginal delivery, hemorrhage, difficult repair), otherwise the midwives do. The doctors are essentially reserved for cesarean sections. For a frame of reference, the World Health Organization has reported that a 10-15% C/S rate provides the best balance of both maternal and fetal benefits for survival due to necessary indications with minimizing harmful risks of unnecessary surgery. While the overall cesarean section rate in Ghana is very low due the lack of doctors in rural areas, Korle Bu’s rate is significantly higher as they are the largest referral center in the country, leading to a disproportionate amount of emergency cases. I’ve been told of an approximately 40% C/S rate at their hospital, compared to national average of 6-7% (vs. national ~30-35% in the US). For poor women in Ghana, the rate falls to only 1%, vs. 15% for the wealthiest. The disparities of access to care, for a plethora of socioeconomic and systemic reasons, lead to unacceptably high mortality rates; in Ghana the rate is 320/100,000. In the US the rate is 14/100,000, which surprisingly is among the highest of the developed nations compared to Canada/UK at 12, France at 8, and Italy and Sweden at 4. The highest in the world are in Southern Sudan at above 2000 (!), followed by Chad and Somalia with rates above 1000; the lowest is Estonia at 2 followed by Greece and Singapore at 3. Overall, 99% of all maternal deaths occur in developing countries, most contained within sub-saharan Africa and specifically among the rural poor. As you may guess, neonatal and infant mortality closely mirrors this pattern.

Here are some sad facts for those interested:

- http://www.who.int/bulletin/volumes/91/12/13-117598/en/
- http://www.who.int/mediacentre/factsheets/fs348/en/
- https://www.duo.uio.no/bitstream/handle/10852/29016/Prosjekt-Gulati-Hjelde.pdf?sequence=3&isAllowed=y

The path to become a physician here is slightly different, but equally as long, than ours. After medical school, they work for 2 years as “house officers,” rotating for 6-month periods among Pediatrics, Ob/Gyn, Surgery, and Internal Medicine. This is roughly equal to our “intern” year. They then are required to service local communities across the country for 1-2 years prior to starting a specialized residency training program. For Ob/Gyn, this is an additional 3 years, followed by an optional fellowship. Everyone has been extremely nice and welcoming to me. They are curious about my training and while sometimes confuse me for a nurse, or “sistah,” are happy to have me involved in their rotation. I’ve noticed a slight skepticism to my presence from some of the more senior midwives, but after friendly introductions and demonstration of my emphasis to work hard and help out, they have all warmed up. It’s nothing compared to the nurse-intern hazing at Bellevue!

In terms of the daily structure, the morning starts at 8am with a department wide “morning report” where all of the gyn and obstetrical cases over the past 24 hours are presented (similar to our morbidity & mortality conference, but a lot more morbidity and mortality…). They review indications for surgery, poor outcomes, and techniques for improvement. There are also intermittent journal clubs and power-point lecture topics. All of the teaching, notes, and formal discussions are done in English, while discussions with patients are often done in Twi or the other regional dialects. Provider conversations often include a mixture of Twi with English mixed in, like “Spanglish” (“Twinglish???”)

I enjoy listening to a few of the quirky English language differences in the field. For example, amniotic fluid is called “liquor,” attendings are “professors,” cesareans are performed “on account of” instead of “secondary to,” and the OR is called the “theater.” All spelling reflects the British system, like gyneacology vs. gynecology, and they pronounce it “Gyn-E” rather than “G-Y-N” as we say. Now put it all together in an Afro-British accent – so fun! After the morning report, the teams split to cover the various services, including the outpatient ob and gyn clinics, the reproductive health clinic, their booking clinic to schedule cases, the inpatient wards, and the labor wards. This week, I shadowed along one of the teams on the wards and in L&D; next week I hope to spend a day in the Reproductive Health unit to see how family planning services and procedures are provided here. They have a great emphasis on family planning, including long-acting reversible contraception (and even post-placental placement, just now becoming a hot topic in the US!).

The inpatient wards are large rooms with sequential patient cots grouped together. Each woman provides her own cloth linen and food during her stay, which can be months for certain antepartum diagnoses. They all wear cute little lacy white shower caps to cover their hair. They also function as wallets and cell phone holders. The formal teaching rounds are excellent; a large group of residents and medical students guided by the professor go from bed to bed to examine the patient, review current management, and highlight teaching topics relevant to the case. I actually think we lack on this structured, patient-centered teaching in our own department back at NYU. There is access to many specialist services if needed, including medical consultations, radiology services like MRI/CT/ultrasound (on a limited basis), and basic labs for both prenatal care and gynecology issues. The patients overall seem to have similar disease profiles to our own Bellevue patient population but in different amounts. Both hospitals have disproportionately high rates of pre-eclampsia, gestational diabetes, poor/non-existent antenatal care, and repeat cesarean sections. However, at Korle Bu, they see much more sickle cell disease (one of their leading causes of death), severe baseline anemia, malaria, and eclampsia (seizures from uncontrolled hypertension in pregnancy) while Bellevue more often sees issues related to morbid obesity. Due to the prevalence of anemia and hemorrhage, obstetrical patients at Korle Bu are strongly suggested to donate two units of their own blood to at the beginning of their care to help recycle the units that they eventually may require.

The labor ward is a dimly lit, steamy hot rectangle consisting of a laboring area, procedure rooms (used for difficult repairs, etc.), two operating rooms, a recovery unit, and a washing/sterilization station. The women all labor in unison, moaning without any anesthesia or labor support. No epidurals or doulas here! Due to limited space, family and husbands are not allowed to accompany the mothers. There is virtually no privacy: they deliver in the communal room with temporary sheets strapped to metal wires hanging overhead in an attempt to divide the space from her neighbor. The first thing I noticed about the mentality approaching labor and delivery is what I would describe as the “tough love” approach. A poor woman was shrieking in pain, uncontrollably tossing in the rolling rusty cot, knocking over buckets of cleaning solution, breasts swinging, feces flowing, bearing down uncontrollably. In order to calm her down, her midwife LITERALLY slapped her across the face and scolded her to get back in bed. Like, pitcher’s arm wind up back open-fisted smack. My mouth dropped in both comedy and horror; minutes later all was well with a cutie baby boy swaddled in her arms. Tough love for sure.

The cesarean process and set-up is very similar to what I do in the US. Obviously the procedure itself is the same, with trivial variances in layer closure, suturing technique, and materials used just as we have among providers at home. There certainly are some differences though. The patient consent can be either signed or fingerprinted, reflecting illiteracy. “Sterile” seems to be interpreted more loosely here: while the operative field is kept “sterile,” the OR/theater itself certainly is not, with anesthesiologists often without masks, nurses eating plantain chips and sorting through their purses in the corner, and windows open with mosquitoes actively buzzing about. It’s actually a new form of torture – have a pest buzzing in your ear or in front of your face and not be able to swat at it because you’re hands deep in someone’s uterus. Nightmare scenario. I helped to “prep” a patient by scrubbing her abdomen with sponge sticks and cleaning solution – the resident with whom I was operating jostled me, “Hey, we are in AFRICA… Scrub like you mean it!” as the white sponges promptly became brown. The rust-covered suture scissors simply do not cut – the scrub tech teased me for struggling and I quickly abandoned the “proper” technique for a crude push-and-saw method to get the job done. All that harping on the US medical students and I’m back to square one!

Almost everything is reusable. The surgeons wear tall rain-boots designated for the OR instead of boot covers, which I love. The drapes and surgeons gowns are cloth not plastic, there is no suction tip but rather the open end of a cut-off plastic hose, and the laparotomy pads are thick absorbent cloths that are washed, not tossed. In fact, they actually ask the patients up front if they want disposable items included for an additional cost, like the Bovie electrocautery. I do appreciate the reduction in medical (and financial waste), although the lack of a proper sterilization autoclave makes me a little nervous. In addition, the up-front payment occurs for almost everything in the hospital: tubes for blood collection, IV fluid bags, all medications, and more expensive operating room and anesthesia fees. Their family members serve as the transport team, taking their fees to the pharmacy to purchase the drugs or to the blood bank drop off specimens and deliver blood. As you might imagine, many patients who come in unexpectedly for labor or an emergency may not have the necessary funds on them, and if their family is not present (or if they simply have no money), the procedure is generally not done. The residents told me that the hospital overall cannot allow the patient to be billed for services, as payments would often be unremitted without reliable way to track people back. I described our own healthcare issues in the US, with patients often clueless about the outrageously inflated costs of services until their insurance receives the bill, and if no insurance is had, the bankruptcy that wipes them out. We debated which was worse. We both decided to move to Canada.

I am impressed by how similar many of their management schemes and techniques are compared to our program in NY. They have the same tools for induction of labor, including misoprostol, cervical balloons, AROM, and Pitocin, although since no drips are available, the Pitocin is infused into the maintenance fluids at increasing amounts. Dexamethasone is given for fetal lung maturity as indicated. Magnesium (for seizure prophylaxis) is given as a loading dose of IV fluid, followed by intragluteal injections every 4 hours. One big difference in labor management compared to the US is the lack of routine continuous monitoring of the fetal heartbeat. Instead, a fetoscope (little audio-funnel placed on mother’s belly and your ear) or a hand-held doppler is used to listen intermittently every 30 minutes when in latent labor (or 15 if active). If they identify a problem, there is one CTG (cardiotocography) machine available (without printer paper) to use for additional evaluation. This is often how diagnoses of “fetal distress” are made, though more often than not, seems to be an overcall due to the intermittent nature of the monitoring. They were interested to learn that while continuous fetal heart rate monitoring is practically universal in the hospital setting in the US, it hasn’t led to improvements with our own neonatal morbidity or mortality rates, but only to increased cesarean deliveries. New take on first-world problems…

Unfortunately, on only my second day on the labor ward, I experienced my first intrapartum fetal death. I've delivered numerous intrauterine fetal demises back home and it remains one of the most harrowing experiences of our profession. Even after 3.5 years of training, however, I have not yet experienced delivering a baby in an emergent setting presumed to be alive at the time of birth and in fact delivered a stillborn (nor have I been involved in a maternal death, which I am dreading). The patient was a 30-something year old woman at either early term or late preterm gestation (estimates in her scanty prenatal records said either 35 or 37 weeks). This was her second pregnancy – her first was a C/S for presumed cephalo-pelvic disproportion (baby didn't fit out of her pelvis) and also wound up a stillborn. She went into spontaneous labor, attempting to have a vaginal birth after cesarean. On referral to Korle Bu, she had been in the second stage for a number of hours (fully dilated and pushing) with no progress. On arrival, there were suspicious red flags, including a high fetal position not engaged in the pelvis (-1 station), bloody urine, and a very obvious Bandl's ring, signifying a thinning of the lower uterine segment on a previously scarred uterus and worrisome for uterine rupture. Fetal heartbeat on Doppler was for the first instant severely bradycardic at 70, but when repositioned lower in the pelvis was 130 (normal, phew!). Thus, she was set-up for an emergent (but not stat) repeat cesarean for arrest of descent, taking the time to place spinal regional anesthesia. On entry to the peritoneal cavity, the placenta was visibly bulging out from the uterus, and on palpation of a thin membrane, the fetus was exposed through a ruptured area of the old scar of the uterus. I helped the resident extract the limp baby girl, who was essentially pronounced dead on birth. There were no pediatricians in attendance. I was horrified. We repaired her mangled uterus. Stopped the bleeding. Stabilized her. She was awake during the procedure and likely overheard the doctors talk about the situation, yet left the OR without anyone explaining what had happened. Eventually, when she asked to see her own baby, a nurse was instructed to inform the patient the sad news. The empathy was minimal, the situation overall without anxiety or urgency.

I do not mean to portray a lack of sympathy on behalf of the Ghanaian physicians – everyone here is extremely compassionate at the core. I imagine they just see SO much more death than we are used to. Provoking the entire staff to sprint through the halls and intubate and rush for blood and slap instruments in the surgeons hands and mobilize all teams may just be too exhausting for a group of people who witness death frequently. There seems to be urgency but not emergency, an unspoken understanding that certain situations are futile.

In our narrative medicine sessions at NYU we talk about how death affects us in medicine, as both professionals and people. We are simultaneously expected to be professional/strong/mature for our patients while balancing our own emotions as human beings. When death surrounds you often, it is only natural for it to become less taboo, less disturbing, more accepted, more understood, more complacent in the day-to-day. But I couldn't help but imagine the same situation but in the setting back home. It would have been chaotic, shocking, desperate, tragic. We would have debriefed as a group. We would have comforted the mother; her family allowed to be by her side. We may have cried for her. I still don't know if this situation at home would have ended up with a live baby or a dead one, but I do know that the emotional state and sense of urgency among all involved would have been very different. For better or worse.

January 27, 2016: Exploring Accra and Cape Coast

After almost 3 weeks in Accra, the streets and pace and sticky-hot sensory-overload has settled in. I have a neighborhood.

Moving south from the hospital, towards the Atlantic shore, is a grid of sandy dirt residential streets. The roadsides are lined with tin convertible storefronts – little transformer shipping boxes that swing open with the daylight and retract locked up late at night. These countless bodegas each sell a disproportionate amount of random but identical goods: bottled beverages (including Guinness's Malta, a chocolate malt drink that sounds better than it tastes), processed snacks, canned foods and condiments. At first I thought, "How do all these tiny shops stay in business selling the exact same things?" but then I remembered NYC has just as many *tiendas* selling the same junk who have to pay thousands of dollars in rent... There are also service oriented shops: seamstresses stitching away making fabulously crazy African dresses from local fabrics, mechanics fixing motorcycle parts, and "restaurants" consisting of a single hot plate/fry pan serving up the local [enter starch here] fare. The "bars" tend to be clusters of plastic tables and chairs in the dirt, centered around a large amplifier blasting rap or a boxy TV set tuned into fútbol matches or, ironically, American wrestling. Behind each "shop" are the owners' tiny homes plunked on dirt plots. People seem to be out and about at all hours of the day. Children skip along the roads in their formal school uniforms, women tend to the shops actually doing work, and men gather in groups to play "Draughts," a British checkers that is mesmerizing to watch. There is actually a Men's only "Draught Club" on the main corner of the hospital complex centered under a big shady tree with tacked up clocks and a large announcement board. I watch a match everyday on my walk back to the guesthouse. They whizz and flip and slap morphed and melted plastic pieces across the board, grunting and glaring for dramatic effect. At first the group was protective and skeptical of my inquisitive and obviously foreign eyes, but soon they warmed up and invited me to sit and watch. One man even asked me to rub his bald head for good luck. I did. They all laughed. He lost.

Walking south through the dusty, sweaty hustle, you arrive at the shore. Well, first you need to crawl through a dilapidated motel with knocked out ceilings and rusty nails. Then you arrive at the shore where the familiar Shangri-La of the Atlantic Ocean greets you. Salty air, cawing gulls, crashing waves – things seem perfect to balance out the heavy heat. That is, until you actually step out into the sand and walk down the beach…. Here you swiftly discover that what was once held sacred in your heart as a place of unspoiled relaxation, of peace and solitude and romance and nature and ever-more-rare-stress-free-moments, promptly ignites down to the ash-stricken sand. The beach is rancid. In central Accra, the beach is used not for tourism or for play, but as a dumpster and a toilet. I mean this literally. Trash is everywhere; bottles swish out to sea, plastic bags sprinkle the sand in huge constellations, burning garbage mounds soot up the sky, sand dunes of decomposing food and broken glass and human waste greet your feet. There are signs posted along the decrepit beachfront concrete-block shacks exclaiming "DON'T SHIT HERE" while nearby, grown men and little boys and dogs alike do exactly that, trousers dropped in plain sight. I gather my strength and muster my determination in an attempt to stroll along the water, skipping from clean sand patch to clean sand patch like a game of childhood "lava." I find a few brave souls along the way, mostly children playing in the waves or teenage couples making out in the shallows. But by and large, the beach is a dumping ground, a squandered opportunity for tourism, local real estate, and recycling! I learned that back in June 2015, the Odaw drain, which carries runoff water from the city through the Korle lagoon into the ocean, overflowed its banks during a heavy rainfall because it was so choked with garbage. Massive flooding and fires killed over 150 people in the

nearby slums. There obviously is a dire lack of political commitment to invest in the engineering and city infrastructure to support the huge number of people living here. Big shame.

I spent the first of my free weekends exploring the “sites” of Accra. While I wouldn’t describe the city as a hot spot for tourists, there are a few interesting places within the capital. The Kuame Nkrumah Memorial is a small landscaped park and mausoleum in honor of their late leader of the Ghanaian independence. Next to this is the monstrous Black Star Square, a Soviet-inspired concrete slab built to hold over 30,000 people. According to Wikipedia, it is the second largest city square in the world after Tiananmen Square in China. I prefer green spaces to barren concrete, but that’s just me…

A local teacher led me through Jamestown, the poor fishing village on the seaside. He showed me the school where his pupils are mostly orphans and the fishing boats carved out of huge tree trunks the size of school buses. Little clay ovens formed from the muddy ground were used to cook the fish, lured in by hardworking men at sea. There I discovered the popularity of boxing, for which Ghana is world-famous. Punching bags hang from abandoned building rafters, super-fit men jog along the shoreline, and elaborate gyms are constructed from junkyard scraps and old tires amoung the village’s many boxing clubs. Jamestown alone has produced some of the world’s top fighters.

I wandered aimlessly through the Makola Market, a cluster of city blocks and buildings littered with people selling all sorts of items for daily life. While there are fancier malls on the outskirts of town in nicer suburbs, this market is the main shopping area for the urbanites. Women and men enter carrying large aluminum bowls full of their specified goods on their heads, then plunk down on the dirt sidewalk or in a vertiginous alleyway to sell for the day. The most popular items tended to be shoes (mostly used and totally random styles), tomatoes, hair extensions, fly-covered fish, and cleaning supplies. They also sell reused multipurpose plastic bags – it’s really amusing to see how many women are strolling around with Lulu Lemon bags. One off-putting mannerism to be warned about is how people call to get your attention; rather than whistle, here people “hiss” at you to draw you in. Like a cat. I continued to stroll by the parliament buildings modeled after European architecture and slurped down fresh coconut water/pulp from a large man with a machete. While the streets are named, nothing has an official address; everything is marked by obnoxious-yet-super-helpful roadside signs pointing the way at each bend. I took a cab to the nightlife district for a beer. This taxi was the only one I’ve ridden in with a working seatbelt. Unfortunately, I must have been the only one to ever use it because on exit, I noticed a dirty brown slash across my white top branding me as the lame American who tries to stay safe in taxis. Silly me.

One of the noticeable cultural differences here compared to home is a funeral process. In Ghana, funerals are a HUGE deal. If you pass one, you might mistake it for an African quinceañera; music blasts down the road from a live electric band, heapings of catered food satisfies the crowd, and people clamor into the streets actively recruiting onlookers to join, all while the open casket remains in site. The formal dress is color coded: red for close relatives to signify their loss, black for distant relatives and well-wishers, and white when the deceased is elderly, highlighting having lived a full life. Ghanaians are both religious and spiritual and funerals seem to have taken priority as the most important life event (beyond weddings and childbirth). Families spend huge amounts of money on the ceremony process, which can last over a week, and while attendants donate for the deceased, often the financial burden is stiff. Ironically, Ghanaians spend more on a casket (which are elaborately gaudy handcrafted pieces of art) than they do on their beds.

I was exposed to the Accra “high life” briefly; a visiting attending from NYU has a friend who works as a psychiatrist for the US embassy in the West African region. She invited us to her home and out to a dinner with other Americans working in Ghana affiliated with different aspects of health, finance, and development. The housing was spectacular (a 5-bedroom, swanky apartment that instantly transports you to the states) and the steak restaurant equally as posh (imported beef from South Africa). Most of the visitors stayed at the Mövenpick hotel (5-star classy). I later learned that the local real estate market is surprisingly expensive; an anesthesia resident informed me that a 2-bedroom home in a safe neighborhood could cost over 500k! Essentially only bankers, successful entrepreneurs, and professionals are able to afford decent housing. Goes to show that if you can afford it, there are very different ways to live in a single city … not unlike NYC projects vs. NYC penthouses, however.

After my initial Accra beach trauma, I researched the “swimmable” beaches in the city and was led on a balmy Sunday afternoon to “Labadi Pleasure Beach.” Intriguing name, right? There is a small series of fancy private beach resorts (one proudly hosting Queen Elizabeth II in its heyday) in addition to a public beach area just outside of town. I would describe this public beach environment as the Ghanaian South Beach – thousands of young fabulous people in their 20s and 30s dressed to kill, packed rows and rows of tables, parked in the sand, smoking hookah, drinking beer, eating shish kebob, blasting R&B, and flashing their finest accessories and tattoos. Acrobats entertained the crowds with flips and fire breathing, while people went on horse walks on the shore, with adolescent boys kicking sand over the horse poo trails. It was quite a scene!

For my second weekend off, I ventured to the nearby city of Cape Coast. As usual, the journey is half the fun (at least for me!) While it should only take about an hour and a half to get from Accra to Cape Coast, the trip actually takes upwards of 3 hours due to heavy traffic on a single-lane paved road for buses, trucks, cars, taxis, and cows alike. I took public transportation via the “Ford mini-bus,” a 12-passenger van (with A/C!) that departs when all seats are purchased, even if for one’s luggage. Both while sitting at the station and along the entire route, “hawkers” approach the vans and tro-tros with blistering intensity, weaving through oncoming traffic, chasing after moving vehicles in order to sell their head-adorned goods. Here is a comprehensive list of the items for sale I noticed along the way: portable fire hydrants for your taxi, loaves of bread and gallon containers of fake butter, lottery scratch off tickets, bandanas, Malta Guinness, palm-sized bags of drinking water, USB drives, sling shots, English textbooks, board games, jeans, air fresheners, firewood, and an assortment of gum/candy/plantain chips/peanuts/Pringles/cookies/baked snacks galore. Along the roadside, further from town. women guard personalized selling tables branded proudly with their English names: “Florence, Gifty, Peace, Comfort, Grace, Philomena… ‘s mango/banana/X stand.” The highway truck window treatments declared, “God is good” and “thank you Jesus” similar to East Africa. Petrol stations were the most completed structures along the drive.

Cape Coast is a seaside fishing town famous for its port and infamous for its castle. I greatly enjoyed the slower pace, relaxed beach-side vibe, and hilly landscape compared to Accra. Kids play fútbol barefoot in the dirt while adults play card games in clusters. Goats and chickens roam everywhere, navigating traffic like pros. I was confused how the animals’ ownership could be ascertained (no visible tags) or their whereabouts (didn’t need to return “home”

to feed since they just eat trash). I later asked a co-resident who informed me that the owners are mystically aware of their branded animals' location (GPS chips?!) and if you were to steal one (or hit one with your car as she accidentally did), they will swiftly appear for collections.

I stayed at a beach-side hostel; there was yellow tap water and lots of Germans. The Sunday morning wake-up call consisted of the surrounding churches (loosely defined) bellowing unsynchronized and off-key gospel songs alongside crashing waves on the coast. The nightly bar was a hot spot for both international backpackers and local college students. A DJ spun local and American top 40 and mostly men danced aggressively until their button-downs soaked through. My favorite thing about the hostel was the morning fisherman routine. Along the beach, groups of 20+ fishermen/fisherboys hoisted nets in vast U-shaped configurations along the current while singing beautiful songs in unison. It was impressive to watch and lovely to listen to. Nearby the hostel was a small collection of Rastafarian shops blasting Reggae and selling Djembe drums, beaded jewelry, and African masks. I made friends with one of the Rasta families, who invited me for a vegan breakfast (hand-ground porridge and pineapple!) in the back of their store, which served as an overnight room. They lent me Marcus Garvey's autobiography, shared CDs of their favorite reggae stars, encouraged equality and love for all living things, called me Empress, and instantly convinced me that the Rasta life is a good life. It probably didn't hurt that due to the humidity and salt, my hair was starting to form little dreads themselves… Actually, after just having chopped off over a foot of my own hair, I began to appreciate how significant hairstyles are in African/black culture; within a few hours, I heard three separate strangers (a Rastafarian with dreads, a hip hop kid with a wide Mohawk and patterned sideburns, and teenage girl with an afro instead of braids) lament their hair woes, being dismissed as irresponsible or dirty or silly or unpolished or unattractive or lazy, etc. by their mothers. Hair dilemmas span the world.

I spent an afternoon touring the infamous Cape Coast Castle. This white-washed British fort, originally built in the 1600s by the Swedes for trading along the "Gold Coast," was transformed into a notorious slave castle during the Trans-Atlantic slave trade in the 1800s. Here, many thousands of African slaves were crammed into infinitesimal underground dungeons without light, food, water, or toilets for 2 weeks to 3 months. Those who survived this torturous prison passed through the "gate of no return" and were carted onto slave ships on the Middle Passage to the Americas. Not exactly the best tour for lifting your spirits on the power of humanity (much like visiting the concentration camps of Eastern Europe). Thankfully, it now serves the community as a strong tourism site, visitors include the Obamas, and is a humble reminder of the destructive power of man against himself. Rasta life for all, please.

In personal news, I am no longer worried about the starchy food overload. With my steadfast demand for authentic street food, the "Ghana Gut" has officially taken effect. I am told it is similar to the Benin Belly or the Togo Tummy. For those of you who plan to do this elective in the future, I highly recommend bringing a slew of stomach meds and extra toilet paper…

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