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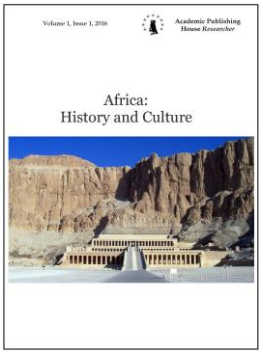

Editorial

Telling Our Story as Africa: Editor's Note

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"Africa has a story. Let's tell it with their history and culture"

Our team at Academic Publishing House Researcher s.r.o. began a new electronic journal, Africa: History and Culture to tell the story of Africans and Africa in 2016. Two years after, the journal has published papers focusing on the role of Africa's history and culture in fields like agriculture, arts, development, social sciences, health sciences, education, law, humanities, applied sciences, pure science, engineering, technology and other related disciplines.

Our focus is to have a multidisciplinary and transdisciplinary ways of telling the story of Africans and Africa as a continent. Africans share similar cultural specifics and some global evidence may just not work in our setting if not adapted to suit our history and culture. Previous evidence-based studies (Castro et al., 2010; Poulsen et al., 2010; McKleroy et al., 2006) have shared the importance of adapting scientific interventions to suit the existing culture and history of target populations. Consequently, until reports of scientific evidence focus on associating interventions and evidence with the African culture and history, imported evidence will be ecologically invalid and contextually irrelevant (Watt et al., 1996).

As a growing journal, Africa: History and Culture continues to encourage papers with primary focus on Africa and Africans from all disciplines. This is evident in our current issue, which looked at schistosomiasis in Ghana, kangaroo mother care in Ghana, internet usage in Africa, evidence based practice in Africa's nursing practice and education, and economic reintegration among African returnees. These topics are very vital for Africans, especially as we work towards achieving sustainable global development.

As per our commitment as editorial team, we continue to provide free article processing and submission charges. In addition, readers also do not need to pay for subscription fees in order to get access to published articles. Africa: History and Culture allows the author(s) to hold the copyright and retain publishing rights without restrictions. Submissions in all disciplines may include results of empirical studies, case studies, short reports, commentaries, correspondence, meta-analysis, and reviews. Please note that our main annual submissions are published on October each year. We are hopeful that you will consider publishing with us in 2019 to make this goal successful.

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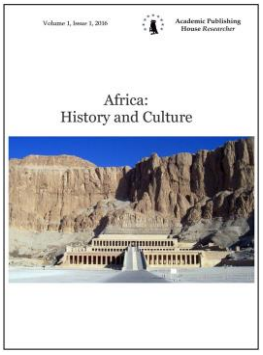

Articles and Statements

Schistosomiasis in Ghana: A Mini-review

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Abstract

Schistosomiasis is one of the neglected tropical diseases with infections often asymptomatic and, in severe cases giving rise to largely chronic and incapacitating manifestations. Ghana, like many tropical regions is endemic to schistosomiasis. This paper seeks to give a brief global picture of this parasitic disease and some historical events that have so far occurred in Ghana. Though in recent years, prevalence of schistosomiasis recorded in some parts of the country has decreased, it still remains a disease of major public health concern. This mini-review has implications for disease control, policy and research.

Keywords: Schistosomiasis, Neglected Tropical diseases, Intestinal schistosomiasis, Urogenital schistosomiasis, Control of schistosomiasis.

1. Introduction

Schistosomiasis is a neglected tropical disease which causes severe morbidities in tropical and subtropical regions (Inobaya et al., 2014). In terms of socioeconomic and public health importance, it is the third most devastating tropical disease globally (Ross et al., 2017). The disease is common in South and Central America, Asia and Africa but disproportionately high in sub-Saharan Africa. In Africa, Schistosomiasis is endemic in 42 countries (Barsoum et al., 2013; Inobaya et al., 2014). Globally, over 240 million people are infected with approximately 800 million people at risk of infection (World Health Organization, WHO, 2017; Ross et al., 2017). There are two forms of human schistosomiasis. These forms are urogenital and intestinal schistosomiasis. These are caused by digenetic trematodes which belong to the genus Schistosoma. Among the five species from this genus, *Schistosoma japonicum, S. haematobium and S. mansoni* are pathogenic to man, thus, of great public health concern (WHO, 2017; Inobaya et al., 2014). *Schistosoma japonicum* is the aetiological agent of intestinal schistosomiasis in South-East Asia (Sun et al., 2017). In Africa, the Middle East, the Caribbean, Brazil, Venezuela and Corsica (France), *S. haematobium* and *S. mansoni* are responsible for urogenital and intestinal schistosomiasis respectively (WHO, 2017).

2. Discussion

Schistosoma species are dependent on fresh water intermediate snail hosts (see Figure 1). A fundamental part of their life cycle is completed in these snails belonging to the phylum Mollusca

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(class Gastropoda). Three Fresh water snails, *Biomphalaria, Bulinus* and *Oncomelenia* species act as vectors or intermediate hosts for the disease transmission globally (WHO, 2017). As such, the distribution of schistosomiasis is determined largely by the presence or absence of these intermediate hosts (Opisa et al., 2011; Stensgaard et al., 2013). These snails are found in fresh water bodies that are subjected to fluctuations in environmental factors that impacts on their relative abundance (Amoah et al., 2017). *Oncomelania* species are vectors for *S. japonicum* while *Biomphalaria* and *Bulinus* species are vectors for *S. mansoni* and *S. haematobium* respectively.

Fig. 1. The three Fresh water snail hosts of schistosomiasis
Bulinus truncatus, Biomphalaria and Oncomelania species.
Image credit: Lewis et al., 2008

The schistosome species' life cycle begins with the release of eggs by sexually paired adult worms within the blood vessels (mesenteric venules of the gut for *S. mansoni* and venous plexus of the urinary bladder for *S. haematobium*) of the definitive host (man). In the case of human schistosomiasis when an infected person passes out the eggs either through the urine or faeces, they hatch into miracidia upon contact with fresh water. The miracidia then penetrate the appropriate intermediate snail host and develop into thousands of infective cercaria which are shed into the water. Transmission proceeds with the penetration of the skin of the definitive host by cercaria upon contact with a cercariae-infested water. Infections associated with schistosomiasis are often asymptomatic (Bruun et al., 2008; WHO, 2017). Even though most people in endemic regions generally have light infections with no symptoms, the effects of schistosomiasis on a country's health and economy cannot be overemphasized. Haematuria, that is blood in urine, is a classical sign of urogenital schistosomiasis. In some parts of Africa, this is considered as a normal phenomenon in adolescents (Aboagye et al., 2009). Ulcers, lower abdominal pain, bleeding disorders, and infertility are some of the common symptoms in women infected with urogenital schistosomiasis (Poggensee et al., 2000, Mazigo et al., 2012).

Globally, some studies indicate that women infected with urogenital schistosomiasis are at a higher risk of attracting HIV, experiencing ectopic pregnancy and painful intercourse (Hotez et al., 2009; WHO, 2013). Intestinal schistosomiasis on the other hand present symptoms such as vague abdominal pains, diarrhoea, blood in the stool, splenomegaly (spleen enlargement) and hepatomegaly (liver enlargement) in advanced cases which (WHO, 2013). Mortality although low, may be due to non-functioning kidney, obstructive uropathy cancer of the bladder hematemesis, liver fibrosis and portal hypertension (WHO, 2013, 2017). Due to insufficient data, mortality related to schistosomiasis is complicated. Nonetheless, mortality associated to non-functioning kidney (caused by *Schistosoma haematobium* infection) and haematesis (caused by *S. mansoni* infection) are about 150,000 and 130,000 persons respectively every year (van der Werf et al., 2003).

Risk factors associated with schistosomiasis are likely to be location-specific. They may comprise of age, sex, occupation, water contact practices, socioeconomic status, and distance to safe and unsafe water sources (Kosinski et al., 2012; WHO, 2017). In rural areas, schistosomiasis is

often an occupational disease. Chiefly, it affects persons who are unable to avoid contact with water because of their occupation (agriculture, fishing). In other cases, rural dwellers are affected due to lack of a reliable source of portable water for drinking, washing and bathing. Hence, washing of clothes, water collection, swimming or bathing, and fishing have been identified as risk factors for schistosomiasis (see Figure 2).

Fig. 2. School-aged children fetching water from an infested water body in a schistosomiasis endemic community
Image credit: *L. A. O. Amoah*

Again, schistosomiasis has been connected closely to variations in the environment due to anthropogenic activities such as water resource development (Grosse, 1993; Opisa et al., 2011). Over the years, water resource development and management have had impacts on the diversity and abundance of freshwater snails and in some cases altered schistosomiasis transmission (Mazigo et al., 2012; Opisa et al., 2011; Zakhary, 1997). The constructions of irrigation schemes, small dams and larger hydroelectric dams for power production and irrigation-fed agriculture have resulted in the spread of the disease to formerly non-endemic areas (Fenwick, 2006; Grosse, 1993; Steinmann et al., 2006). The suitable freshwater bodies created by the water resources development attract intermediate host snails which prepare for the parasite to be introduced (Fenwick, 2006; Steinmann et al., 2006). Researchers believe that this situation is likely to be exacerbated by climate change (Yang et al., 2005; Zhou et al., 2008).

Brief History of Schistosomiasis in Ghana

Schistosomiasis turned out to be a critical public health crisis after the Volta River was dammed in Akosombo in 1964 (Danso-Appiah, 2009; Grosse, 1993; Yirenya-Tawiah et al., 2011; Zakhary, 1997). The creation of the Volta Lake resulted in a sudden occurrence and infestation of *B. truncatus* (an intermediate host of *S. haematobium)*, consequently leading to occurrences of urogenital schistosomiasis in several communities along the lake (Zakhary, 1997). Subsequently, the creation of the Kpong head pond, about 25 km below the Akosombo dam, also became another active transmission site of both urogenital and intestinal schistosomiasis (Yirenya-Tawiah et al., 2011). The construction of these two dams (Akosombo dam and Kpong dam) resulted in the upsurge of the prevalence of schistosomiasis in riparian communities. A 90 % prevalence rate of schistosomiasis was recorded in the south western shore of Lake Volta, two years after it was filled in 1966 (Grosse, 1993). Prior to the creation of these dams, a 5-10 % prevalence rate was recorded in those areas (Danso-Appiah, 2009).

Similarly, infection rates of urogenital schistosomiasis also increased in Bator and Mepe, two communities located along the Volta Lake. The infection rates increased from 17 % in 1963, 74.6 % in 1981, 26.5 % in 1963, and 88.0 % in 1981 respectively (Grosse, 1993). Generally, a number of children living in communities along the Volta Lake continue to suffer from schistosomiasis mostly

associated with *S. hematobium* (Danso-Appiah, 2009). Of the two forms of the disease recorded in Ghana, urogenital schistosomiasis was described to be far more prevalent than intestinal schistosomiasis due to its predominant and extensive distribution throughout the country as far back as in the 1950s (Hamed, 2010; McCullough, 1959). It is documented that about 20 % of Ghanaians suffered from urogenital schistosomiasis at some time in their lives between 1965 and 1973 (Aryeetey et al., 2000).

Among riparian communities from Kpong to Ada in the Volta estuary, prevalence rates of 7-52 % for intestinal schistosomiasis and 88 % for urogenital schistosomiasis were recorded in the early 1990s (WHO, 1993). Also, additional creation of the Vea and Tono dams (Northern Ghana), Nwabi and Barekese dams (Ashanti Region), Okyereko and Mankessim dams (Central region) as well as the Weija dam (Greater Accra region) for irrigational and domestic purposes also marked the extensive distribution of schistosomiasis throughout Ghana, a situation that affirmed the importance of a control programme (Yirenya-Tawiah et al., 2011; Zakhary, 2018).

Current Schistosomiasis Prevalence in Ghana

Presently, Ghana is still endemic to schistosomiasis (see Figure 3). The disease, per the World Schistosomiasis Risk Chart (2012), is present throughout the whole country including the urban areas (International Association for medical Assistance to Travellers, 2012). According to Biritwum (2017), endemicity of schistosomiasis mapped out in Ghana between March and May, 2008 showed that 119 districts out of 138 districts were endemic to the disease. A further survey in 2010 indicated an increase in endemicity from 119 districts to 141 districts.

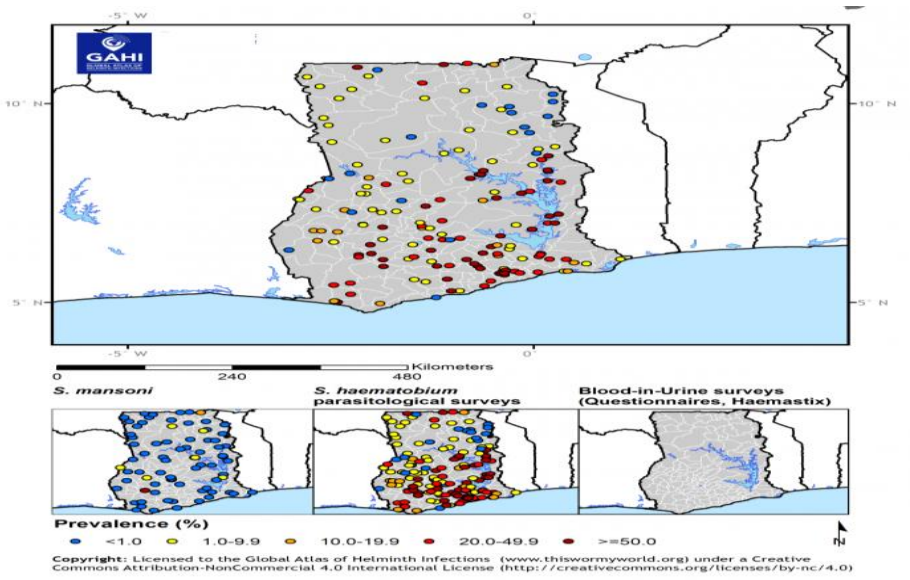

Fig. 3. Distribution of schistosomiasis survey data in Ghana
Image credit: Global Atlas of Helminth Infections via
URL: http://www.thiswormyworld.org/maps/distribution-of-schistosomiasis-survey-data-in-ghana

Additionally, the two forms of schistosomiasis reported to occur in the country affect all ages and sexes with varying prevalence rates. Among 2,516 children surveyed in 51 schools in 2007, documented cases of schistosomiasis were higher than other helminthic infections. An estimated 6.6 million school-aged children were also reported to be infected with the disease (Biritwum, 2017). Occupational health risk is very high for fishermen and farmers as well as persons in constant contact with infested water.

Schistosomiasis Control Programmes in Ghana

Over the past century, countries with endemic schistosomiasis have undertaken control programmes with the aim of interrupting the parasite's life cycle with outcomes varying from little

effect to total elimination (Sokolow et al., 2016). Over the years, a number of strategies employed in controlling schistosomiasis include chemotherapy, improving sanitation, public health education and controlling intermediate snail hosts or a combination of these approaches. However, current global strategies employed to control schistosomiasis aim at reducing morbidity by decreasing worm burden and intensity of infection (Mazigo et al., 2012). Chemotherapy continues to play an important role in reducing morbidity and mortality associated with the disease burden. Praziquantel, which is endorsed by WHO as the "drug of choice" for treating schistosomiasis marked the turning point for the control of schistosomiasis in many endemic countries (Danso-Appiah, 2009). Many endemic regions undertake mass drug administration using praziquantel which is repeated over a period of years (WHO, 2013; Sokolow et al., 2014). An integrated control approach of praziquantel treatment, environmental upgrading or modification, sanitation improvement, control of the intermediate snail hosts and public health education activities have been documented to be highly effective (Mazigo et al., 2012; Utzinger et al., 2000).

In the case of Ghana, a national schistosomiasis control programme was initiated in the 1980s which started population-based treatment campaign programmes using chemotherapy (praziquantel) (Danso-Appiah, 2009). The Volta River Authority (VRA) also introduced Schistosomiasis Control programmes in the 1990 in communities along the Volta Lake to alleviate the disease burden of schistosomiasis. Measures employed by VRA involved mass drug administration, supply of wells and pumps, public education on observing proper sanitary conditions along the shoreline among others (Zakhary, 1997).

In recent years, the principal objective of schistosomiasis control under the Neglected Tropical Diseases Programme (NTDP) in Ghana is to bring down the prevalence of the disease using integrated approach. Through NTDP, Ghana hopes to attain schistosomiasis control to levels which will not warrant public health concern. The control programmes include regular mass drug administration to school-aged children, health education and training of health workers and community volunteers. As of 2008, about 802,561 school aged children in 46 districts were treated in a school-based programme. This number increased from 681,114 among 87 districts in 2010 and further to 1,383,831 among 65 districts in 2011 (Biritwum, 2017). Unfortunately, several challenges such as improvement in access to potable and safe water, funding to support control activities and increase in insanitary conditions have stalled these control programmes.

3. Conclusion

Ghana, over several decades has been grappling with schistosomiasis and its associated morbidity. Although the journey towards schistosomiasis control and its ultimate elimination has been a rather long one, significant successes have been chalked in some parts of the country leading to substantial declines in prevalence rates. The use of an integrated approach (mass drug administration, education, community involvement, improved sanitation and sustainable funding from government and external donors as well as strong political will) targeting the various stages of the parasites' life cycle is definitely the surest way to ensure sustainable schistosomiasis control and elimination.

4. Conflicts of interest

The author declares no conflicts of interest.

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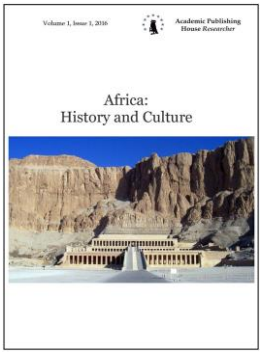

Ghana's Kangaroo Mother Care: A Historical Review on Eastern Regional Hospital KMC Excellence Centre

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Abstract

Ghana, which is part of sub-Saharan Africa is also noted for preterm and low-birthweight births. Following the inception of Kangaroo Mother Care in Colombia, this method has gained the approval of the World Health Organization as a standard approach for the care of preterm and low-birthweight infants. Though Ghana adopted this method in 2007, the standard Colombian approach was comprehensively introduced in Ghana after the 2015 training of 3 health professionals from the Eastern Regional Hospital. Consequently, the Eastern Regional Hospital has championed this care and trained several health workers and students. The centre has participated in several clinical and scientific meetings to share their findings.

Keywords: eastern regional hospital, excellence centre, Ghana, historical review, Kangaroo Mother Care.

1. Introduction

Kangaroo Mother Care (KMC) began in 1978 in Bogotá, Colombia by Dr Edgar Rey Sanabria, Dr Héctor Martínez Gómez and others at the Instituto Materno Infantil as an intervention to curb the overcrowding and inadequate resources in Neonatal Intensive Care Unit (NICU). This act decreased congestion in incubator space and number of care givers at the NICUs in those days (Almeida et al., 2007). Having gone through several scientific trials and validations, KMC has been accepted as a World Health Organization's standard of care to decrease morbidity and mortality rates among preterm and low-birthweight infants (Baley, 2015; Charpak et al., 2005; Nunes et al., 2017).

Today, KMC has the following key components:

"(1) early, continuous, and prolonged skin–to–skin contact between the mother or caregiver and the infant;

(2) exclusive breastfeeding or breast milk feeding;

(3) early discharge after hospital–initiated KMC with continuation at home; and

(4) adequate support and follow–up for mothers at home."

These key components form the basis of care within a typical KMC clinic and provide a focus for all multidisciplinary consultations. Experts of multidisciplinary consultations include paediatrician, nurses (all categories), psychologists, optometrists/ophthalmologists, ear, nose and

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throat specialists, physiotherapists, public health experts, social workers, and biomedical scientists. Globally, KMC has gained the acceptance of low- , middle- , and high- income nations alike (Charpak et al., 2005). In a randomized control trial among 28 neonates, babies via KMC increased in weight, breastfed, bonded and were discharged earlier compared to those offered standard care (Kadam et al., 2005). These benefits have been confirmed by several studies over 2 decades, making KMC an effective and safe method of care (Boundy et al., 2016, Charpak et al., 2005). In addition, a 20-year study by Charpak et al. (2017) revealed that KMC interventions positively affected children significantly vis-à-vis social and behavioural protective outcomes.

2. Discussion

History of Ghana's KMC

KMC was first introduced into Ghana in the year 2007 as KMC Ghana initiative (Nguah et al., 2011). During this period, the KMC Ghana initiative was rolled-out in Central, Northern, Upper East and Upper West Regions. Much emphasis was placed on the early, continuous, and prolonged skin–to–skin contact position while little was done regarding the other components. Major hospitals like Korle Bu Teaching Hospital also adopted and included it as a protocol of care for preterm care (Bergh et al., 2013). By 2015, the concept of KMC had gained much acceptance in Ghana and most hospitals, regional and district levels started to practice this method of care. Skin-to-skin KMC became a popular thing in most paediatric care settings and one of such places was the Eastern Regional Hospital of Ghana.

Fig. 1. Participants and Director of Kangaroo Foundation
(From left: Psychologist, Medical Officer, Director of Kangaroo Foundation, and Nurse)
Photo credit: J.O. Sarfo

As concerns for newborn morbidity and mortality kept growing, the Colombian Government through the Embassy of Colombia in Ghana under H. E. Claudia Turbay Quintero initiated the first KMC specialist training of Ghanaians at the Kangaroo Foundation in Bogotá, Colombia. This initiative was also supported by Ghana Health Service, management of Eastern Regional Hospital, Koforidua and agencies like PATH. As a result, a three-member team comprising of Diana A. Apanga (Medical Officer), Jacob Owusu Sarfo (Clinical Psychologist) and Cynthia Yomor Martey (Nurse) from the Eastern Regional Hospital were selected and trained in KMC in Colombia between 2nd and 14th November, 2015. Their training included various sessions at the Kangaroo Foundation, San Ignacio University Hospital and San José University Hospital for Children (Sarfo et al., 2018). Following their training and certification in Colombia (see Fig. 1), the new KMC Excellence Centre was established at the Eastern Regional Hospital in the beginning of 2016 with the support of hospital's management. This new clinic took over the old KMC clinic that was adapted from the KMC Ghana initiative to implement the multidisciplinary Colombian model of KMC. Though the clinic was running in full session, the physical structures were not fully completed.

Fig. 2. New KMC Out-Patient KMC Set-up at the Eastern Regional Hospital
Photo credit: J.O. Sarfo

By the middle of 2016, the management of the Eastern Regional Hospital headed by Dr Kwame Anim-Boamah (Medical Director) constructed the new KMC Out-Patient KMC Set-up at the Eastern Regional Hospital following the Colombian 'Open Out-Patient KMC' Model (see Figure 2). Between 25th and 29th July, 2016, two experts (Silvia Fernadez Iriate [*paediatrician*] and Zandra Patricia Grosso Gomez [*neonatological nurse*]) from the Kangaroo Foundation came for follow-up visit to provide support in the process of implementation of the KMC programme in Koforidua (see Figure 3).

Fig. 3. New KMC Out-Patient KMC Set-up at the Eastern Regional Hospital
Photo credit: J.O. Sarfo

Eastern Regional Hospital's KMC Excellence Centre

Following the visit of experts from Kangaroo Foundation, the KMC Excellence Centre at the Eastern Regional Hospital was validated as one of the recognised sites in Africa for clinical care and training in KMC programme. The new centre expanded its training scope to train several health professionals and students in KMC (see Figure 4). Today, the Eastern Regional Hospital's KMC Excellence Centre stands as the first clinic model in Ghana to provide comprehensive In-patient and Out-patient KMC following the existing Colombian multidisciplinary model. Consequently, the clinic runs an in-patient Kangaroo clinic where caregivers are introduced to KMC and allowed to practice intermittent skin-to-skin method with their babies before discharge from the Neonatal Intensive Care Unit. Again, an Out-Patient Kangaroo clinic is organised to follow-up care after

discharge. The Out-Patient Kangaroo Mother Care clinic provides several multidisciplinary specialist services.

Fig. 4. KMC Workshop for Some Health Workers in Ghana
Photo credit: J.O. Sarfo

General set-up for the Out-Patient Kangaroo Mother Care programme at the Eastern Regional Hospital includes a section where nurses assess the vital signs and anthropometric assessment like temperature, weight, height and head circumference. The nurses also run an In-Patient Adaptation for families who are yet to begin KMC. Workshops on KMC position, feeding, massage and need for follow-ups are stressed at this section. The next section is the paediatric consultation where doctors consult together in an open space. This open review helps to provide peer support and motivation to KMC families as they see preterm/LBW babies of one another.

In addition to these two teams is the psychological unit attached to the Out-Patient Kangaroo Mother Care clinic. Psychologists and psychologist assistants assess the cognitive-developmental performance of babies at 6th and 12th month-corrected ages. Once a child passes the 12th month-corrected age assessment, the psychology team approve for their graduation. They also assess and manage psychological conditions like depression, anxiety and marital distress that KMC families go through. Also, the psychology unit provides group therapy sessions to both babies and their families to deal with both clinical and psychosocial problems.

Furthermore, physiotherapy referrals are made for babies with suspected developmental deficits while optometric/ophthalmological assessments are done concurrently for these babies for early identification of ocular pathologies in infants. Additionally, ear, nose and throat specialist assessments are also done for babies during this period to identify any problems. The social welfare and public health units are linked up to ensure follow-up visit for clients, especially those with social problems and other related issues like KMC defaulters. Finally, a WhatsApp group page managed by KMC staff brings together all families in the programme and specialists to ensure information sharing. Reminders for follow-up reviews, special programmes and issues related to care are shared on this platform.

As part of its achievements, the centre has seen over 800 babies and successfully trained several doctors, nurses, physiotherapists, psychiatric officers and psychologists in Ghana. Also, it has established 10 new KMC centres across Ghana between 2017 and 2018 (Sarfo et al., 2018). Ithas also hosted both general public and distinguished visitors including the Ambassador of Colombia to Ghana (see Figure 5) (Embassy of Colombia to Ghana, 2018), government dignitaries, officials from Ghana Health Service and Ministry of Health. The centre is also known for its research and policy interests. So far, it has participated in international kangaroo conference, workshops on newborn care and assisted in the development of the national KMC policy.

Fig. 5. Visit by the Colombian Ambassador to Ghana to Eastern Regional Hospital
Photo credit: J.O. Sarfo

Notwithstanding these achievements, the Eastern Regional Hospital's KMC Excellence Centre hopes to expand KMC coverage from 10 to 100 clinics in Ghana by 2035. It also hopes to access funding opportunities to provide technical and logistical support to all new KMC facilities in Ghana. Also, the centre is working to establish collaborations with researchers, KMC specialist and stakeholders to develop innovations in care.

Finally, the centre hopes to expand its training capacity with support from Government of Colombia, Kangaroo Foundation – Bogotá, D.C., UNICEF, PATH and other stakeholders to train professionals from other neighbouring West African countries like Liberia, Sierra Leone, Burkina Faso, Togo, Mali, Benin and Côte d'Ivoire.

3. Conclusion

Though Ghana's KMC Excellence Centre at the Eastern Regional Hospital is young, it is making key strides in promoting quality KMC for preterm and LBW babies and their families. It has also promoted national KMC training and capacity building. In future, the centre is hopeful of spreading KMC to other West African countries. This will not only enhance KMC coverage, but also improve the regional cooperation between Colombia, Ghana and these sister countries.

4. Conflicts of interest

The author declares no conflicts of interest.

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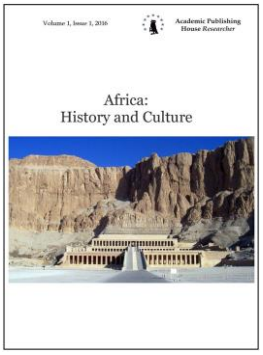

Economic Reintegration: A Look at African Returnees

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Abstract

Young people from Africa, like many developing places in the world, often leave their countries in search of better opportunities. Once they are involuntary or forced to return home, the problem of economic reintegration seems to reemerge. The purpose of our paper is to evaluate the economic reintegration of African deportees into their respective countries of origin. In this paper, we seek to enhance knowledge about the progress of the economic reintegration of forced-returnees and also add to the paucity of research on evaluations of reintegration.

Keywords: african, deportees, economic reintegration, migration, returnees.

1. Introduction

Many developing countries are confronted with a "youth bulge". This occurs when the composition of young people forms the highest proportion of the population. This creates some form of a demographic dividend. A demographic dividend refers to the increase in economic growth that tends to follow increases in the ratio of the working-age population – essentially the labour force – to dependents (Ssewamala, 2015). Also, the demographic dividend is projected to create a golden opportunity for economic growth and development. Amongst the young populations in the world, the African youth population has been increasing faster than the others (Population Reference Bureau, 2009). Additionally, African youth presents a promising possibility in the labour market participation (Agbor et al., 2012; Omoju et al., 2014). Nonetheless, this subject bursts the question – how has this opportunity been capitalized in Africa?

Evidence from recent developments has affirmed the increase of young irregular migrants from Africa to other parts of the developed world for greener pastures and refuge from wars (Kveder et al., 2013; Thomas, 2016). Unfortunately, irregular migrants from sub-Saharan Africa are often trapped in Libya where their dreams and aspirations of making it to the "promised land" are perforated. So what accounts for this mystery? The youth population bulge in Africa is not harnessed; several of those who leave their shores are stuck in transit and most returnees from transit zones risk facing obstacles when they return to their home countries (Brachet, 2016; Mensah, 2016). In this view, it is actually unrealistic for anyone to assume that the "risk-takers" forcibly repatriated will peacefully settle somewhere they do not want (De Haas, 2005). If so, what is the way forward? Or what is/are the way(s) to synergize policy initiatives and the needs of the young irregular migrants to avoid illegal re-emigration?

Notably, Libya has been a key transit point for people willing to embark on a perilous sea journey to Europe (Hamood, 2006). During the heightening of the 2011 political turmoil in Libya,

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thousands of irregular migrants from Niger, Sudan, Chad, Mali, Senegal, Egypt and Ghana were deported (Grange et al., 2015; Naik, 2012). Approximately, 18,455 irregular Ghanaian migrants were reportedly deported from Libya in 2011 (Kleist et al., 2013). Arowolo (2000) argues that a potential migrant was once an integrated member of his society and that the decision to migrate and return should not rob him/her as a formerly integrated member who needs to be reintegrated. Also, the study hypothesizes that the increased rate of forced returnees from Libya is likely to put pressure on any processes and resources aimed at reintegrating migrants. Thus, most deportees would possibly end up not receiving adequate economic assistance needed for successful re-integration. This is hypothesized because most publications on reintegration have failed to evaluate the economic processes to ascertain the extent of its sustainability and the supporting bodies behind the reintegration processes (Bob-Milliar, 2012; Dako-Gyeke et al., 2017; Kleist et al., 2013).

2. Methods

This research primarily uses both descriptive and explanatory approach to collect and analyze data. We attempted to assess all the indicators within the economic aspect of reintegration by the stakeholders in Africa. Moreover, two components have been delineated to underscore how sub-Saharan African countries can facilitate a successful reintegration programme. Online searches using keywords such as "migration", "refugees", "reintegration", "forced-returnees", "Libyan deportees" etc. were conducted. A systematic review was done to analyze each of the processes of economic reintegration.

3. Discussion

Reintegration: Concept and Framework

Also, owing to the problems associated with the need for a successful reintegration and limited literature on the evaluation of economic reintegration, this paper adopts the International Organization for Migration's (IOM) Reintegration Framework to answer the question; to what extent has Africa been successful in the economic reintegration process of undocumented deportees from Libya since the 2011? This framework was initially developed from an earlier study by Ruben et al. (2009). This framework has been at the core of "designing and delivering reintegration assistance" (Fonseca et al., 2015: 5).

For the purposes of the study, expressions such as irregular, undocumented and illegal migrants are used synonymously with deported or forced-return migrants from Libya. The study operationalizes that deportation of migrants by governments of transit countries, the government of origin and organizations because of political instability as forced-return and that it does not distinguish between the two scenarios. Though the IOM concept has limited detail account, for a clear understanding, this paper articulates a detailed account of the concept with secondary sources.

According to IOM (2015) reintegration is "the re-inclusion or re-incorporation of a person into a group or process, for example, of a migrant into the society of his or her country of origin or habitual residence (p.13)." In relation to the definition by IOM, the European University Institute (2008) in lieu spells out the definition of reintegration more simply as the "process through which a return migrant participates in the social, cultural, economic, and political life of the country of origin (p. 134)." Considering these definitions, particular parameters are necessary for the reintegration of migrants, whether voluntary or forced.

Notably, some researchers subscribe to the fact that reintegration is an important component for the successful return of migrants. Nevertheless, the procedure and administration of a successful reintegration has simply not been easy and remains widely contentious also. Central to reintegration is the fact that all nations, organizations and groups share a primary goal of reintegrating their returnees sustainably to minimize re-emigration and irregular migration (Dzinesa, 2007; Fonseca et al., 2015; Özerdem, 2006). As a fundamental process of socialization, the aim is to also preserve the rights of migrants to ensure their safety and well-being as well as their contribution to local and national development (IOM, 2015: 15). Through these processes, deportees are re-established, motivated and empowered to bring change and be able to participate in other areas of their social structure. Given this account, it is important that attention is given to these processes for successful reintegration of migrants to avoid possible illegal re-emigration.

Economic Dimension of Reintegration

Ruben et al. (2009) expound that for successful reintegration to take place; three elements are to be considered. These include: (1) the prospect to become self-sufficient or independent, (2) the accessibility of social network in one's community of origin and (3) the consideration of one's psychosocial health. Generally, reintegration is thought to be sustainable when all facets of the economic self-sufficiency of returnees, their social stability with and acceptance into their communities as well as their psychosocial welfare are considered together at all levels without isolation. These processes are considered to allow returnees especially those stranded because of deportation to cope with migration drivers.

In the words of the Graviano et al. (2017):

"*[T]he complex, multidimensional process of reintegration requires a holistic and a need-based approach: one that takes into consideration the various factors impacting an individual's reintegration, including economic, social, and psychosocial factors across individual, community, and structural dimensions*" (p.1).

Though the above exposition demonstrates three main dimensions necessary for reintegration of forced-return migrants, this paper focuses only on the economic reintegration of deportees. This is necessary because economic reintegration has not received enough attention with respect to African returnees. Correspondingly, economic reintegration is stipulated to consists of the transportation (and travel expenses), income-generating assistance, work materials and educational support (Fonseca et al., 2015). Nevertheless, unplanned and sudden deportation of migrants from countries of transit or destination often has financial implications for the deportees and their family. The difference between the prepared and the reverse as Cassarino (2013) explains is that migrants who wish to return voluntarily make preparations for their homecoming through resource mobilization and activating social networks. This claim is supported by the IOM's projects that returnees are likely to be more sustainable in their communities if the resolution to come home is premeditated, voluntary and complemented by suitable reintegration support (IOM, 2015). As indicated in a study by Kveder et al. (2013) involuntary returnees who were forcibly repatriated back to Senegal had difficulties reintegrating into the labour market and consequently wanted to re-emigrate.

The first stage of economic reintegration regarding undocumented returnees has to do with their transportation. It is necessary for migrants to receive support right from the transit countries to the countries of origin and to their various homes. The transportation stage could possibly include "movement coordination, transit assistance, escort assistance, unaccompanied bags, documents and formalities" (Reyntjens et al., 2010: 8). In Kleist and Bob-Miller's report (2013, p. 2), mass deportation took place from countries in the global south including Libya and Morocco where irregular migrants were arrested, dumped elsewhere and left to their own faith without direct deportation to their respective countries or with any kind of support to rescue their helpless situation. Deportees in this situation became extremely stranded and vulnerable to the volatility of the conflict. They further discuss that some undocumented migrants died while trying to run from the country of expulsion. We argue that the situation indicates how the relationship between war and forced return represent a high-risk migration-management tool that always needs first-hand attention when the processes of economic reintegration are taken into consideration. Taking a critical assessment of the Assisted Voluntary Return system in Europe, emphasis on financial assistance - particularly travel expenses for returnees is fundamental. Travel assistance varies depending on the country of the return. Though it is known that some forced returnees navigate their way through to come home, in the case of deportees stuck and stranded in countries of transit, governments in collaboration with the humanitarian body such as the IOM are the agencies that come to their aid by facilitating their movement back home through coordinated activities with the officials in the transit zones. This is the first relief stage for deportees wherein the burden of moving to their respective homes is also sorted out.

Furthermore, most deportees particularly from countries of transit who could not reach "the promised land" unlike voluntary returnees, end up losing all impetus to find good conditions for themselves after their return. Dako-Gyekye et al. (2017) recognize that most returnees come back home virtually with empty hands; placing them in a difficult position to start a new life on their own. Similarly, Peña et al. (2017) argue that in most instances deportees suffer hardship and angst-ridden problems mainly because of financial instability. Even if the enthusiasm to start any

business-oriented activity is rekindled, the urge to propel this desire is obliterated by financial constraint. Attention should be drawn that not all repatriated migrants are unskilled. Before the Libyan conflict, some migrants had already stayed in the country for a considerable period of time. For that matter, their involvement in certain jobs has earned them valuable skills and innovations which can be harnessed to benefit the deportees' families, communities and the countries of origin at large. This is part of the reason why the need for an income-generating assistant is prudent. This mode of assistance could be in the form of giving money to individual returnees for start-up or group with joint economic activities. In the sub-Saharan region of Africa (SSA), poverty reduction strategies have not seen many manifestations at the grassroots level of their economies. Calls for the reintegration of deportees through financial and income generating assistance has become an additional burden for governments. A study on migration and development by Laczko (2005) maintains that reintegration assistance schemes are missing in most parts of the emergent nations where they are needed the most. This is expressed in the lack of reintegration policies and programs in these countries for returnees especially the deported individuals who could not make fortune overseas. We, therefore, argue that the pragmatic actions by the African governments in playing a leading role can facilitate a better economic reintegration process for sustainable return.

Another element notable for the augmentation of the economic assistance of forced-returnees is the provision of working materials (Kuyper, 2008). This is mostly the second phase of the financial assistance. It is believed that some returnees and in similar cases deportees, return back to their remote, marginal and poor communities where their lives began with foreknowledge in subsistence agriculture methods (Jallow et al., 2004). Importance, as scholars argue, should be attached to the provision of work materials such as agricultural supplies (livestock, seeds, tools) necessary for the development of agriculture and reintegration into their communities. They continue to argue that emphasis must be placed on the fact that in an urban location, different skills, and working tools may be required where vocational and commercial tools are prudent. According to Aghazarm et al. (2012, p. 19) "states have the prime responsibility to protect their nationals, even when abroad", and therefore, once they have been forcibly returned, it is the obligation of the state to show strong interest in a move towards a good economic reintegration process to avoid possible re-emigration. Apparently, this situation has seen a reverse action between governments and organizations in sub-Saharan Africa. Humanitarian bodies and organizations including the IOM, United Nations Development Programme (UNDP), and Japanese International Cooperation Agency (JICA) etc. are some of the agencies playing key roles with indifferent posture from most governments (Bob-Milliar, 2012; IOM, 2013). In addition to providing deportees and returnees with working materials, there should be educational initiatives to build their capacity.

Educational initiatives complement economic support for a successful assisted return of deportees (Graviano et al., 2017; Jallow et al., 2004). Certainly, while some deportees are labour-skilled, others may be less skilled or unskilled. Therefore, it is important to absorb all these concerns in the quest to reintegrate them. Likewise, the need for educational assistance is vital for job training, information on the labour market, and deportees' knowledge and skill enhancement. As Schuster et al. (2013) note in Afghanistan, the IOM was engaged to offer little financial assistance to improve skills needed to set up businesses. Rather, it provided for deportees the opportunity to "enroll in qualification training courses to learn computer skills or English, or undertake vocational training programmes that will teach them a specific technical skill in just 6 months". The knowledge acquired will certainly enhance the reintegration process. Nevertheless, the lack of funds has usually been the main hindering factor that stalls this process of reintegration in SSA. While organizations and agencies are willing to help, the large numbers along with no formal support from governments mean that successful reintegration will continue to be a herculean task for all stakeholders especially in Africa.

Component of Reintegration

As economic reintegration remains a vital issue in global development, important considerations must be attached to the components that determine the fruition of overall re-inclusion program. According to the Fonseca et al. (2015), essential factors like sustainability and measurability are required for successful readmission and development of returnees into their

communities. In this regard, they admit that sustainable return should encapsulate: (1) all the dimensions of reintegration and the ability of the returnee to handle factors that push them to migrate, and (2) any subsequent legal re-emigration that occurs based on acquired skills from the reintegration after deportation. Furthermore, measurability allows for monitoring right from the on-set and evaluations of different stages of every project. This is because evaluation is not a one-time incident, but assessments of differing scope and dimensions undertaken at various points in time to cater for the developing needs for evaluative knowledge and learning with the aim to achieve an outcome. Cherti et al. (2013) argue that long-term monitoring and evaluations of reintegrated beneficiaries will reveal the contribution of the support to a sustainable return. Additionally, long-term evaluations provide analysis of the different stages of the processes of reintegration and this could help identify possible gaps of the entire programme (Fonseca et al., 2015) and appropriate responses for subsequent projects. Based on these measures, the international community and migration scholars can ascertain the migration trend, the role of economic reintegration and how to address gaps that arise.

4. Conclusion

We evaluated the economic reintegration as a vital issue for African deportees' from Libya into their societies. Since deportees were already active members of their societies, the need for their reintegration into their various communities should be treated with alacrity. Economic reintegration has several stages beginning from the transportation of stranded migrants to and within their country of origin, provision of income-generating assistance, working tools and educational support. If the processes are to yield valuable fruition, essentially sustainable and measurable factors are not only sufficient but necessarily indicative. In the case of the African deported migrants from Libya, organizations and humanitarian bodies are the agencies that play a leading role in such reintegration programs. Governments often show a posture of mediocrity with disinterest to formulate cogent reintegration policy for their returnees. In addition, forced repatriation of migrants has great knock-on effects for development. Based on this notion, we consider the issue of deportation as a complex system which must be understood in a holistic outlook. We, therefore, suggest future studies to assess the other dimensions of reintegration in the context of social and psycho-social processes for which we acknowledge as a limitation of the study.

5. Conflicts of interest

The authors declare no conflicts of interest.

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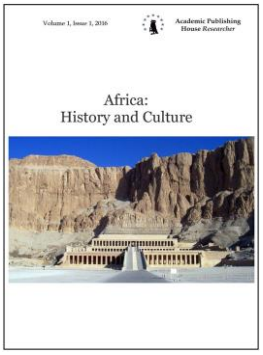

Short Communication

Why Evidence is Not Always Used in Nursing Practice and Education in Africa: The Place of Organisational Culture

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Abstract

Globally, Evidence-Based Practice is most preferable for care of patients and training of nurses. Nonetheless, organisational culture in most developing African countries may serve as an impediment to its success. This paper seeks to explore some organisational cultural factors that can impact on the use of evidence in Africa among nurses. As Africa seeks to raise the quality of nursing practice and education, much has to be invested into the organisational culture frame of the healthcare environment.

Keywords: Africa, education, evidence-based practice, implementation, nursing, organisational culture, practice.

1. Main

Knowledge acquisition is a vital concept in professional nursing education and practice. As studies get refined in a pyramid, the quality of evidence-based knowledge increases (Figure 1). Evidence-Based Practice (EBP) is currently one of the foundation principles in nursing education and practice (Koehn et al., 2008). EBP is "*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient*" (Sackett et al., 1996). EBP allows nurses to utilise individual's unique characteristics and research findings (Van Achterberg et al., 2008).

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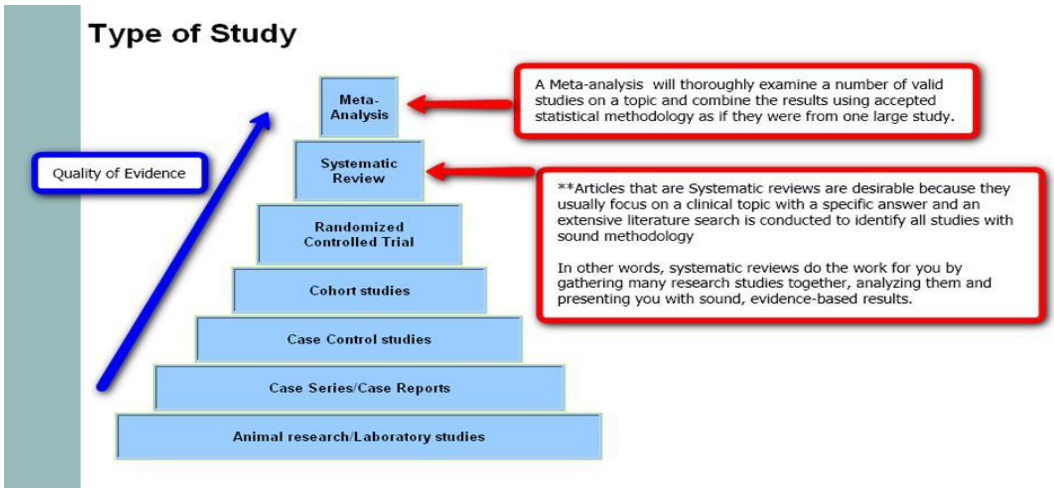

Fig. 1. Evidenced Based Practice Pyramid (CSUN Library, n.d.)

To observe EBP in principle is very beneficial to nursing practice and education. It helps decrease cost of treatment because '*trial and errors*' as well as 'mere assumptions' are often avoided through the implementation of EBP. The exact medications and procedures are given to the individual using the right standards (Colorado Mesa University, 2017). Subsequently, there is there is reduction in the length of patient's stay at the hospital because there is early and right implementation of interventions with less risk for complications. Additionally, health care providers gain job satisfaction when their clients/patients get the best of care outcomes (Bradywood et al., 2017; Ouslander et al., 2016; Veeramah, 2016). With EBP, there is a decrease in the geographical variation of care. This means the care given for a particular condition will be the same globally if all clinicians adopt interventions based on evidence. For example, managing the cord of the newborn in developed countries will be the same as in the developing countries because it is evidenced based.

Notwithstanding the benefits of EBP, nurses share various perceptions about it. A study among nurses in the United States, for example, showed time and knowledge as barriers when it comes to EBP implementation (Koehn et al., 2008). According to Melnyk (2016), organisational culture is a serious factor when examining the effectiveness and efficacy of EBP though many factors like organisational politics, knowledge and skills of nurses and inadequate investment in EPB. As Africa is predominantly occupied by developing countries, the culture of healthcare organisations ought to be reviewed for successful EBP implementation. One cultural barrier to be met in implementing EBP is poorly supporting work environment for EBP. In a qualitative study by Sarfo et al. (2013), ehealth implementation among Ghanaian nurses was challenged because junior staff nurses were not offered access to computers in some wards.

Another challenge within most healthcare work culture is poor job satisfaction leading to high turnover. In a study among 90 healthcare workers in Sierra Leone, "67 % were dissatisfied with their jobs (71 % rural vs 52 % urban) and 61 % intended to leave their post (75 % rural vs 38 % urban)" (Narayan et al., 2018). This finding is not different from studies most African countries like in Ghana, Kenya, Nigeria, Tanzania, Malawi, and South Africa (Blaauw et al., 2013; Boafo, 2016). With this in mind, implementing EBP may not be successful in such a culture.

Additionally, EBP as part of the culture should be seen as part of personnel morale and overall commitment. As factors like workload, turnover, job satisfaction and management support deteriorate, nurses are more likely to have a decreased level of morale and overall commitment to implement EBP. An example is seen in a study among 256 health workers in Ghana. Results indicated that personnel motivation at work was affected by increased workload, burnout and intentions to quit job (Bonenberger et al., 2014). Correspondingly, 60 % of 453 South African nurses in a study by Ehlers et al. (2003) were willing to emigrate based on similar factors.

In conclusion, EBP is very important to ensure quality nursing care and training globally. To ensure that evidence is always used successfully in nursing practice and education in Africa, the healthcare organizational culture must be examined carefully. There is a need for political support

and joint collaboration of stakeholders to promote the quality of culture in healthcare organisations. Furthermore, nurses need to develop their intrinsic motive for EBP. This will enhance their aptitude to adopt and adapt evidence.

2. Conflicts of interest

The author declares no conflicts of interest.

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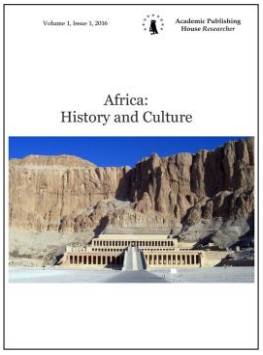

Is Internet a Family Divide Tool in Africa?

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Abstract

Historically, African societies are communal and value family bonds. Thus, anything that seems to impair the function of communal bonding is traditionally classified as a 'taboo' or 'nuisance.' With the inception of technological means of communication like social media, little is known about how these technologies affect the family bond in Africa. This paper seeks to briefly identify possible gaps in Africa vis-à-vis the concept of technological means of communication and how they have affected existing human communication and psychosocial health. This paper has implications for research and psychosocial health of Africans.

Keyword: Africa, communication, family, history, psychosocial health, social media, values.

1. Main

Africa values human relations, communal living, family, parenting and personal interactions (Ofori, 2016). In the past, African families and communities serve as places to provide love, security, belongingness and identity (Avoseh, 2001). Globally, the invasion of current and new technological gadgets, applications and software in the society have had a drastic turn, both positive and negative on the life of the people. One of the major areas to be affected is the pattern of communication among families (Kaplan et al., 2010; Williams et al., 2011).

Communication in the family is a very essential tool that keeps the family bonded. Families that have very good and structured communication system, who are able to express their feelings, opinions and ideas well, enjoys healthy and stronger relationship among themselves (Grotevant et al., 1985). Communication has been under many transformation and development over the years as the inception of internet has increasingly paved way for more recent methods of communication despite distance, location and time.

The Internet Users Statistics (2018) reveals that among 1,287,914,329 people in Africa, internet users as at the year 2000, accounted to 4,514,400. However, this figure in 2017 increased to 453,329,534 people. Similarly, the trend is comparable to specific countries in the continent. Ghana for example, with a population of 29,463,643 recorded in 30,000 internet users in 2000 while increasing to 4,900,000 people in 2017. Also, Kenya, with a population of 50,950,879 in 2018 has a fast growing internet penetration of 85 % with 7,000,000 Facebook users in 2017.

According to study by Drago (2013), modern technology has gradually become a basic way people communicate. In effect, it has progressively taken the place of face-to-face communication that takes place between individuals which is most preferable in indigenous African cultures. According to the study's results, approximately 92 % of respondents agreed to the assertion that technology negatively affects face-to-face communication. However, 1 % of them disagreed while

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the rest neither agreed nor disagreed to this idea. Consequently, regarding the use of modern technology among family members, divergent views have been reported by several authors.

Among Chinese families in Hong Kong, traditional methods of communication were seen as the most preferred for family communication and better family happiness. Though 94.85 % of 1,502 adults preferred face-to-face communication, younger people were more accustomed to the use of mobile phones and social media sites (Wang et al., 2015). Like modern day Asia, the scope of preferable communication route might be changing with respect to age cohorts in Africa. Correspondingly, other demographic changes apart from age may also affect the likelihood of Africans opting more for technological routes of communication, instead of traditional face-to-face method. For example, among 1,322 American parents, ICTs for parent-child communication was more likely to increase as children grow up (Rudi et al., 2015). Bolton et al. (2013) expounds that one may feel like they are communicating physically even though, in reality, they are a distant apart.

Notwithstanding the benefits received from the use of technology and social media in communication, Tillema et al. (2010) argue that face-to-face communication seems to be no longer vital in maintaining social contacts in these virtual arena. What is troubling is the fact that cultures with value for communal living and physical presence during communication like Africa may need to be sacrificed in the process of recent technological advancement. Again, the question still remains; how much of face-to-face communication is valued in Africa, especially among young people? According to Madell et al. (2007), young people preferred social media to direct face-to-face communication due to the greater control it offers them. Although this may sound positive, the notion of losing control in face-to-face communication could also be an indication of dysfunctional self-esteem, self-awareness and assertiveness (Bianchi et al., 2005; Sheldon et al., 2016).

In conclusion, technology has come to stay in Africa and its benefits in relation to communication is numerous. However, the traditional face-to-face interaction among families and friends cannot be sacrificed. In addition, as concerns about mobile phone addiction and cyber bullying becomes alarming globally (Bianchi et al., 2005; Wang et al., 2009; Yahner et al., 2009), much has to be told regarding current causal relations among psychosocial health, social media usage and Afrocentric values in Africa (Asante, 2017).

2. Conflicts of interest

The author declares no conflicts of interest.

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