Sustainable Change in Rural Africa Through Village-Guided Interventions and Global Partnerships

by

Cynthia Cupit Swenson, Ph.D.
swensocc@musc.edu
Professor, Psychiatry and Behavioral Sciences
Division of Global and Community Health
Medical University of South Carolina

Dr. Samuel Nkrumah Yeboah
powerfuldrums@yahoo.co.uk
Founder, Project OKURASE

Nana Ama Yeboah
nana.yeboah@projectokurase.org
Project Coordinator, Project OKURASE

Eve Garlington Spratt, M.D.
spratte@musc.edu
Department of Pediatrics
Medical University of South Carolina

Marguerite Archie-Hudson, Ph.D.
mjasper11@aol.com
Department of Political Science
College of Charleston

Dr. Ida Singletary Taylor
idastaylor@hotmail.com
Gethsemani Circle of Friends
Union Heights Community

Abstract

Economically disadvantaged communities in the United States and Africa have more in common than might be realized. In particular, determining interventions to set people in a community on a trajectory of long-term, positive change may be done through a set of shared principles. In this article we show how an inner city United States community of Black Americans of West African descent developed such principles and related interventions that were successful for changing their community. They then shared their ideas with Ghanaian artists and a rural community in Ghana, West Africa. The community in Ghana applied interventions based on those principles, taking into account their local culture to bring about positive changes to their community and shared their ideas back across the water with Americans. Together, in unity, these communities and others who crossed paths with both communities developed the resources needed for grassroots-level change.

Introduction

The entrenched issues of economic disadvantage and limited resources in rural Africa have created generations of vulnerable communities where the lack of safe water, sanitation, medical care, food scarcity, and educational opportunities are constant threats to survival (Appoh & Krekling, 2004; Hong, Banta, & Kamau, 2007; Nyonator, Jones, Miller, Phillips, & Awoonor-Williams, 2005; Scott, Curtis, Rabie, & Barbrah-Aidoo, 2007). Governments and philanthropic communities have responded to the presenting systems of these problems with major investment in aid, the nature of which has generally been defined by the contributors' analyses of the most effective solutions. This aid has generally taken the form of financial and/or programmatic investments. Over time, the inability to see major changes resulting from these investments has raised a serious policy question: are the historical and multi-generational effects of economic disadvantage in rural African villages so entrenched that traditional investments are ineffective?

This project asked a different set of questions: Will we get different results if we re-examine our assumptions about the most effective methods of providing aid to rural African communities? Is there a different model of sustainable change for rural African villages based on a village-guided intervention in lieu of a top-down approach from well-meaning government and philanthropic benefactors? Can we bring about sustainable change at a grassroots level through the use of principles from a community-based mental health intervention?

Based on knowledge shared by people from Ghana, West Africa and lessons we learned from a neighborhood-wide mental health intervention program in the United States, we started with the assumption that vulnerable communities, ravaged by economic disadvantage and limited resources, whether in inner city America or a rural village in Ghana, are made up of many adults who are intelligent, capable, and wish to create better lives for themselves and their families.

We also assumed that most vulnerable communities contained recognized leaders who understood and could articulate a vision of change even though they did not have access to the elements of support necessary to fund the vision. These assumptions mandated that our engagement included testing a bold hypothesis in Project OKURASE: the theory that a *village-guided intervention* would best define the critical elements needed to produce transformative, sustainable change and provide an effective vehicle for the participation of global partnerships in the venture.

In this article we describe Project OKURASE that is taking place in Ghana, West Africa as an example of the combination of sustainable village-guided interventions and global partnerships. Interestingly, this project grew out of a community violence prevention project that took place in a high-crime neighborhood in the southeastern United States and work that was occurring simultaneously with street children by local artists in Ghana. We begin by presenting the historical, social and cultural trauma that impacts the current context. Next, we describe Neighborhood Solutions, a community-based mental health intervention project. From this project, principles were developed that led us to successfully engage an entire community in an intervention process that produced positive outcomes for the community and its youth. These principles then were combined with the wisdom of local leaders and citizens in Ghana. The final set of principles became the basis for a sustainable way of sharing aid with a rural village in Ghana, West Africa and developing a significant global partnership characterized by equality and empowerment.

The Neighborhood Solutions Project: Historical, Social, and Cultural Trauma and the Current Context

Africa is a continent historically overflowing with natural wealth (e.g., diamonds, gold, cocoa, etc.). The historic nature of African culture was one of strong connection to the land and the view that these resources belonged to everyone and were to be shared rather than competed for (Asante, 2007). Counter to African ways of managing resources, the economic potential of this vast region led to European colonization beginning in the 15th century, first by the Portuguese and then by other European nations in their quest for control of these vast resources. The Portuguese invasions were carried out with the purpose of enriching the monarchy, promoting Christianity, and introducing plantation agriculture to meet European demands for sugar (Asante, 2007; Collins, 2010). The European invaders took land from Africans and imposed values and attitudes related to property, ownership, and culture that were fundamentally different from traditional African ones. This collision of two cultures was a shock for Africans and they did not have the power or resources to change the trajectory (Elkins, 1976). In addition, invaders brought diseases to Africa for which Africans had no natural immunity causing many deaths and increasing vulnerability of Africans (Collins, 2010).

Although slavery had been occurring in Africa for centuries (Collins, 2010), the impact of the Transatlantic slave trade beginning in 1526 fundamentally changed society within the African continent and impacted significantly greater numbers of people. After years of colonization, Africans were now viewed by Europeans as inferior and having potentially more economic than human value. Colonization set the stage and developed the widespread idea that Africans were property and less than human (Asante, 2007).

By 1650, the development of plantations on the newly colonized Caribbean islands and the American mainland led to the need for cheap labor and the brutal and inhumane capturing, kidnapping and selling of human beings as chattel and property, stripping them of all rights (Asante, 2007). Over eleven million Africans were enslaved from the coast of West Africa and sent to America (Collins, 2010).

Elmina Slave Castle in Ghana, West Africa sits on a beautiful plot of land by the Atlantic Ocean but the actions there were not so beautiful. Elmina was one of many slave castles in West Africa where Africans going about their daily life were kidnapped and held in abysmal conditions for the purpose of becoming a traded commodity to be dispersed to many countries. In the courtyard of Elmina Castle sits a church from which church members witnessed innocent people captured to be sold in trade being confined and forced to live in their own excrement, starved, killed, and physically abused. Women were raped and some impregnated by European men. The church members did not rise up against these atrocities because they followed what had been instilled across many years: “they did not view Africans as human beings” (Elmina Tour guide, 2017). Africans that survived the slave castles were taken through the dreaded “door of no return” to be put on overcrowded ships with below deck space that was normally five feet high by four feet wide (Collins, 2010), never to see their homeland, their families, their life as Africans again. They were confined in these conditions for 30 or more days. At least one-third of those who survived the untenable voyage were brought to places such as Sullivan’s Island, South Carolina where they were scrubbed, sprayed down with insecticides and made ready to be sold. These very enslaved people brought forward their skills in farming, engineering of water, brick making, building, music and other areas that added to the fabric of America. They were not paid for these skills and hard work despite now being African *Americans*. Laws prevented citizenship or personhood and they continued to receive abusive treatment similar to what occurred in the slave castles. They continued to be viewed as less than human and not worthy of rights or humane treatment (Hurmence, 1989). For 244 years, slavery in America was a legal, permanent and inheritable condition. Laws in America supported ownership of Africans and inheritability of descendants so there was no way for Africans to get out of the situation without breaking the law or losing their lives. Even after African Americans were supposed to have freedom from enslavement, laws and norms prevented them from being viewed or treated as equal human beings and they were, in effect, stuck in a caste system (Wilkerson, 2010).

It is in this context of historical, social, and cultural trauma of disempowerment, loss of land, family, and self that for over 300 years African Americans have been working to gain equal access to human rights, civil rights, education, jobs, and personhood. Coming from nonperson status to being valued as human beings is a long arduous journey and one of the most difficult parts of the journey has been being faced with those who carried forward the century's old engrained view that people of African descent are "less than" or as people whose lives, livelihood, well-being, families, and communities are unimportant. This is a view that is passed down through generations and that is based on the race of the person rather than personal characteristics as often times people who view a certain race as unimportant or "less than" may not even know people of that race personally. Moving from being a nonperson to being valued and having to overcome obstacles that were set in the way (e.g., laws) to prevent moving up in life is a struggle that leaves many people of African descent in poverty situations and ready to give up. This ongoing struggle belies the context of the Neighborhood Solutions Project.

Neighborhood Solutions

In 1998, the state of South Carolina commissioned several Healthy South Carolina initiatives. Within this initiative, the Division of Global and Community Health of the Medical University of South Carolina (MUSC) was asked to find a high-crime neighborhood in South Carolina and join with the people of that neighborhood; moreover, we were to ask them to prioritize the problems they felt were occurring with their youth and discover from them their ideas of solutions that would resolve these problems. The project was named Neighborhood Solutions and the overarching purpose of the project was to reduce costly out-of-home placements such as incarceration or institutional care for youth who were high risk of a formal out-of-home placement. Of the many high-crime neighborhoods in South Carolina, Union Heights of North Charleston was randomly selected.

The Union Heights community, populated by roughly 3500 people who are primarily Black Americans with an historical West African link, was identified as a high crime community based on city crime statistics. Families were faced with economic disadvantage (median household income = $13,583) and low educational attainment. School district records indicated that only 30% of elementary and middle school students met minimum standards for reading. Many youth in the community were involved in criminal activity. Of the seventeen youth who were the initial focus of the project, a total of 67 ($\underline{M}$ = 3.9) arrests representing 154 ($\underline{M}$ = 9) legal charges were in their history. Over 200 calls for police service per month occurred in this neighborhood.

Drug sales and drug use were part of the daily picture. Those who sold drugs were generally not hardened criminals but were young men, regular people, who had given up on the possibility of attaining education or job training and were selling drugs for survival or to make a living.

They were part of the continuing evolution of when people feel powerless and see no way to achieve power in life. Some young men in the community were not selling drugs but ended up in conditions of arrest when walking down the street at the time an officer arrived in the community. Our staff recalls a young man who had been working with us on a project and left the community center to get dressed for his job. On his walk home, he was arrested for "standing on the corner" (when police drive by it is the neighborhood norm to not walk or run but to stop and allow them to pass) and given a $400 ticket, which if not paid would land him in jail. Drug enforcement officers were in the community frequently and the more that people were arrested and served jail time, the more they gave up, lost their rights, and were at risk of moving towards a life of incarceration (Alexander, 2012). Little help was available to support youth in changing their situation. In addition, as observed by project staff, children who were never a part of the drug trade at times were arrested, slammed to the ground causing injury and then left to nurse their own physical injuries and psychological trauma when it was discovered that they were not the person the police were pursing. The trust of police was very low. Interestingly, Union Heights is 6 miles from the site of the murder of Mr. Walter Scott by a police officer that stopped him for a traffic stop. The murder was captured in a phone video and revealed the treatment of "less than personhood" that many people of African descent experience by some officers (New York Times, 2015). In the school system, the children were faced with the now well-known and documented school to prison pipeline (Heitzeg, 2016) that impacts primarily African American and Latino students. Our staff observed teenagers being arrested for disturbing school, which in reality was not getting into the classroom before the bell rang or maybe uttering a curse word. Based on the disturbing school charges, youth less than age 16 were sent to juvenile detention and youth age 16 and over were sent to adult detention center for overnight. For many this was a first arrest that created a record that followed them and led to permanent exclusion from school. A criminal arrest is grounds for school expulsion.

The centuries old dehumanizing views of people of African descent that were carried forward and became normative, the current context, and advice of local people from the community made it clear that to "fix" a high-crime community, there must be respect for race and culture and the interventions must be based on the knowledge and ideas of the residents. Interventions would need to be those that help people have equal access to education, job training, jobs, and healthcare. Importantly, significant work would be needed to develop positive relationships between community members and families and the schools and police. Intervention would require work to bring unity to various groups of people who were separated and divided.

The problems that were occurring in the neighborhood were vast and implementation of an intervention would be complex. The first step was to use community wisdom to consider how to begin.

Implementation of Neighborhood Solutions

The literature on implementation is clear: stakeholder recognition of problems, buy-in, and involvement in the program through all stages is important (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). Virtually no studies have been conducted that indicate the best approach to successfully attain buy-in for a community-based project (Fixsen et al, 2005). Direct and significant involvement of the community members appears critical. Studies from the business world show that employee inclusion in the planning process for implementation of programs decreases stress (Korunka, Weiss, & Karetta, 1993). According to Adelman and Taylor (2003) the early stages to prepare for adopting innovation include: (a) understanding the context; (b) understanding the efforts that have already been made and how the interventions can help beyond what has been done; (c) mobilizing interest and consensus among stakeholders; (d) identifying champions and through them mobilizing a greater number of supporters; (e) determining if the program is feasible; and, (f) developing a long-range strategic plan. Even the most highly feasible, acceptable and effective programs can fail if there is no sustainability plan.

To properly implement a community-based program, it is critical to implement interventions that are developed, owned, and guided by the leadership and residents of a community. For a program to succeed, the plan to sustain the program must be considered in the initial planning. Implementation of the Neighborhood Project followed several steps. First, an initial contact needed to be made with a community champion. A cold call was made to the director of the community center, the hub of neighborhood activity. She agreed to link MUSC with the other community leaders, though she had little faith that a project would come to fruition, based on past negative experiences with researchers, grants, and programs. The second step was to meet with key neighborhood leaders to discuss their change priorities related to concerns about their youth. After several meetings and discussions, the leaders reached consensus that the problems of greatest concern were youth substance abuse, youth crime, and youth suspension/expulsion from school. Next, a community-wide meeting was held to discuss the change priorities of the neighborhood residents. Throughout all of these meetings, the most critical advice to follow was listening and understanding that people in marginalized African American neighborhoods have the knowledge of solutions to resolve their own problems but may not carry them out due to lack of resources. Project staff had to prove they could be trusted and were there to work with and help the community rather than to take something from the community or impose their own solutions on the community.

To understand the community resident's priorities on a more formal scale, the community directed project staff to work with a cultural guide. This individual was a leader in the neighborhood and was knowledgeable of the community and culture and pledged to teach project staff about the local culture. The cultural guide agreed to facilitate meetings conducted individually with adults, children, teens, business owners, teachers, police, the Mayor, community elders, and drug dealers to attain the opinion of all regarding interventions that would help youth develop more positive behaviors and reduce involvement with criminal activity.

Following six weeks of formal individual meetings, a second community wide meeting was held and an intervention based on community consensus of need was developed jointly by MUSC staff and community members to include three parts: 1) interventions for youth and families to reduce substance abuse and criminal activity; 2) interventions to keep youth in school; and, 3) positive, violence free activities delivered in the community to attract youth away from drugs and crime. The basis of the intervention was a family and ecologically-based treatment model called Multisystemic Therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). This treatment model, supported by 30 years of research, became the underlying structure for all interventions in the neighborhood (Dopp, Borduin, Wagner, & Sawyer, 2014; Johnides, Borduin, Wagner, & Dopp, 2017). MST was explained to the community and they decided that they wanted this intervention for their youth and families because it is a family-based intervention and is conducted in the home and community.

Multisystemic Therapy

The Multisystemic Therapy model and the Neighborhood Project are described fully in a text (Swenson, Henggeler, Taylor, & Addison, 2010) that had significant contributions from the Union Heights community members. Multisystemic Therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009) was originally developed to meet the clinical needs of youth experiencing serious antisocial behavior and their families. The theoretical foundation of MST is rooted in systems theory (Haley, 1976; Minuchin, 1974) and social ecological models of behavior (Bronfenbrenner, 1979). From these theories, behavior is understood to be multidetermined by factors within the many systems that youth live (e.g., family, school, peers, community).

Regarding treatment, MST interventions are tailored to the specific strengths and needs of each individual family and intervene in problems occurring in each system. A key part of MST is engagement of the family and this is the responsibility of the MST therapist and clinical team (Cunningham & Henggeler, 1999; Tuerk, Cunningham, McCart, & Henggeler, 2008). In the United States, the typical dropout rate is high for a clinic providing outpatient mental health services. Rather than waiting for a family to engage and closing a case due to lack of response, with MST the therapist must discover how to engage the family and others in the ecology in treatment. In fact, this is the first step in treatment. Engagement requires a solid understanding of the culture of the families being served. For example, if a therapist knocks on the door of an African American family in Charleston, South Carolina and doesn't start the conversation with, "good evening, how are you", that therapist will not be allowed in the door and will have to work hard to undo the damage of cultural disrespect. Until the family is engaged, treatment can neither begin nor progress.

MST uses an analytic process as a road map to take the family from referral behavior to intervention implementation. Importantly, the analytic process provides a mechanism in which the therapist takes key referral behaviors (e.g., substance abuse) and determines risk factors driving those referral behaviors (e.g., low parent monitoring, low school-family connection, association with peers that abuse substances). MST applies interventions to these risk factors and these interventions are those with research support, such as the cognitive-behavioral therapies, behavior therapies, and pragmatic family therapies.

MST has been delivered via a home-based model of service delivery in all the MST research studies and across all the MST dissemination sites in the United States and internationally. The home-based model removes barriers to service access and promotes the capacity of interventions to alter the youth's ecology. In the Neighborhood Solutions project, the MST team was comprised of 3 therapists, a family case manager, an activity director and a supervisor. Clinicians on the team carry low caseloads of four to six families, which allows intensive services to be provided to each family. Treatment occurs daily to several times a week, with sessions decreasing in frequency as the family progresses (i.e., titrated to family need). Treatment is time-limited and generally lasts four to six months, depending on the seriousness of the problems and success of the interventions. Treatment is delivered at times convenient to the family; thus, therapists work a flexible schedule. Therapists are available to clients twenty-four hours per day, seven days per week through an on-call rotation.

Several published studies (Henggeler et al., 1997; Henggeler, Pickrel, & Brondino, 1999; Huey, Henggeler, Brondino, & Pickrel, 2000; Schoenwald, Henggeler, Brondino, & Rowland, 2000; Schoenwald, Sheidow, Letourneau, & Liao, 2003) have demonstrated significant associations between therapist fidelity (i.e., adherence) to MST treatment principles and outcomes for youths (e.g., rearrest and incarceration) and families (e.g., improved functioning). In light of the importance of treatment adherence to MST outcomes, considerable attention is devoted to quality assurance aimed at assuring that the clinical team provides treatment in the way it was provided in research trials. The quality assurance system includes an orientation training week; quarterly booster trainings; weekly on-site MST supervision; weekly telephone consultation from an MST expert; and, feedback to therapists on monthly adherence ratings completed by parents.

MST clinical supervision provides therapists with an understanding of the MST model, facilitates adherence to the MST nine treatment principles, assists in determining ways to engage families and professionals from other systems, assists in learning and implementing evidence-based techniques, and helps identify barriers to the success of interventions. To fulfill these goals, MST provides a high level of weekly supervision (i.e., average two hours of face-to-face contact with each therapist) along with supervisor availability that matches the therapist schedule—twenty-four hours a day, seven days a week. The clinical supervisor is available to consult with the therapist when needed and even to visit the family with the therapist to address safety concerns or for clinical skill building.

Weekly supervision sessions, held in a group format, are structured and goal oriented. Each therapist becomes familiar with every case. Such familiarity is important when a therapist responds to an after-hours crisis call for a family that is not on the therapist's primary caseload, as it increases both the family's and therapist's comfort in interacting.

Outcomes and Sustainability for the Neighborhood Project

Neighborhood Solutions Project outcomes indicated significant reductions in criminal activity, substance abuse, and school exclusion among participants. Youth referred for treatment due to criminal activity averaged 3.9 arrests in their history – 59% had been arrested on drug charges, 71% for violence, 29% for theft, 35% for property destruction and 35% for other charges. Of these youth, only 29% were rearrested during MST treatment and none of those arrests were drug related. Youth referred for treatment due to marijuana and cocaine use showed reductions in use of both drugs and maintained abstinence for cocaine in particular. Among students referred due to being at risk of school exclusion, 94% (15/16) remained in school. The one excluded student was rapidly enrolled in an alternative program. Calls for police service in the neighborhood were reduced by 80%. The Union Heights community notes that the development of a positive relationship with their community-based policing team was critical (e.g., police calling our on-call staff for intervention when concerned about a youth instead of arresting him/her, police showing up on a holiday to build benches for a basketball tournament). In fact, crime in the community became so low that the community policing team was moved to another community.

In the second year of the project, active steps were taken towards sustainability. The neighborhood leaders began to consider what activities they could sustain on their own and what methods might make sustainability possible. It was determined that the neighborhood could sustain the prosocial, violence free activities. However, to do so would require resources. Towards preparing for a future of resources, the Neighborhood Solutions staff worked with the leaders to develop a neighborhood-based 501 (c) 3 nonprofit organization. Doing so allowed the community to apply for small grant funds and donations to resource their activities. At this time, the nonprofit and prosocial, violence free activities have been sustained for twenty years.

The Link with West Africa

As noted earlier, between 1717 and 1803, Charleston, South Carolina was the site of the landing of ships carrying enslaved people from West Africa. In 1860, over half the population of Charleston consisted of enslaved people from West Africa. The children and adults from the Union Heights neighborhood have a strong heritage link with West Africa and today are known as Gullah Geechee people.

Based on this heritage and interest in the arts and in line with one of the major Project goals (positive, violence free activities delivered in the community to attract youth away from drugs and crime), the Union Heights leaders wanted their children exposed to traditional West African dance and drumming. What started as an expected six weeks of lessons for exposure purposes turned into a children's dance company called Djole that sustained for fifteen years. In the second year of Djole, the children needed professional drums. The project staff was introduced to a drum maker and master drummer from Ghana, West Africa named Samuel Nkrumah Yeboah (also known as Powerful). The group purchased drums from Samuel and in so doing forged what was to be a long-term link with Samuel and Ghana. Djole performed around South Carolina, at the United Nations in New York City, and in 2006 traveled to Ghana to work with Samuel and local performing artists to conduct education related to HIV through dance/dramas in multiple sites, one of which was Elmina Castle. Some of the children had never been to the Charleston airport but gathered the courage to fly to another continent that they referred to as Mother Africa. While in Ghana, Djole visited a drum carving village called Okurase where 70% of the drums carved in Ghana originate. The group from Union Heights accepted the invitation from Samuel to partner with the village to help address key problems that village residents had prioritized (i.e., no safe water, no sanitation, limited education, limited job training, limited health care). Similar to the neighborhood project, Okurase's leadership prioritized their children and youth. However, the problems to be addressed were not violence or criminal activity but instead related to health, well-being, and prolonging life.

Work with Orphans and Vulnerable Children in Ghana: The Beginning Stages of Project OKURASE

At a similar time frame as the beginning of the Neighborhood Project in Charleston, Samuel Nkrumah Yeboah was working with orphans and vulnerable children (OVC) in Ghana through arts-based initiatives. In Ghana drumming, dance, and singing are a part of everyday life and are common ways to disseminate information. Samuel used this forum to teach OVC about important topics such as HIV/AIDS, violence, environmental cleanliness, and girl child education. To promote the sustainability of the work with OVC and to encourage other artists to address the needs of the more than 160,000 children living on the streets, Samuel founded a non-government organization (NGO) called Nkabom Artiste and Craftspeople Association. Today more than 100 artists are members. Growing up in a village where arts and music were daily events, Samuel began making drums at an early age. On a regular basis he visited a village called Okurase where drum shells are carved and he supported the work of the carvers. He noted that drums went out all over the world from Okurase but little came back. The people in the village (like many villages in Africa) faced great challenges to survival. He was determined to help change the plight of people in Okurase and to use the strategies developed in Okurase as a platform for other villages in Ghana and elsewhere in Africa.

Project OKURASE

Global partnerships can often come from unexpected places. It is almost counterintuitive that through children on two continents, an MST-based neighborhood project in inner city North Charleston, South Carolina, and an NGO formed by an artist in Ghana, a partnership would form to transform a village, bring change to rural Africa and greatly impact the lives of American youth. Project OKURASE (named for the village) was formally named early 2007 following the Djole trip to Ghana. The naming of Project OKURASE occurred simultaneous to the opening of an NGO in the village. The NGO was started by Powerful, Dr. Cynthia Swenson, and Neighborhood Solutions leaders from North Charleston and led on the ground by Nana Ama Yeboah, Ghanaian Project Coordinator. Other than the link through drum making, the village of Okurase was chosen because of the dire situation the people face.

The Village of Okurase

Okurase is located in the Upper West Akyem District of the Eastern region of Ghana. Like Union Heights, the population of Okurase is roughly 3500. People representing seven different ethnic groups[1] live in subcommunities, creating a context of vast cultural richness. The majority of people are subsistence farmers of maize, cassava, plantain, cocoyam and yam. Okurase is also known for drum carving and the production of gari – a starchy cereal made by grating, drying, and roasting cassava. The village lacked a source of clean and safe water, toilet facilities, and an infrastructure for waste disposal. In addition, medical care was limited. In this municipal, malaria was the leading cause of death followed by anemia and heart failure.

Method and Results

Intervention Development and Implementation in Okurase

Establishing change priorities through formal evaluation of village needs. Identical to the Neighborhood Solutions project, the first step in Project OKURASE was to establish priorities for change. As the early stages of Project OKURASE were taking shape, a formal qualitative study of village needs was implemented through focus groups and individual interviews with key informants. The study was funded by the Department of Psychiatry of the Medical University of South Carolina and approved by the University's Institutional Review Board and by the village Chief and Elders. Participants were randomly selected from groups that included village elders (formal leaders), male and female youth, male and female adults, small business owners, teachers, HIV/AIDS orphan case workers, and child welfare caseworkers.

The consent forms were translated to the Twi language. All interviews were conducted in Twi and audiotapes of interviews were transcribed and translated to English. The exception was with caseworkers who requested consent forms and interviews in English. Coding and analysis was conducted through Atlas ti.

The ultimate goal of the study was a needs assessment to formally understand village priorities and to advise the development of public health interventions. Prior to initiating the study, a field guide was developed containing questions to assess village residents' needs with regard to health, mental health, substance abuse, dental care, environmental conditions, education, job or skills training, and OVC.

The primary concerns expressed by interviewees related to health care, lack of environmental cleanliness or clean water, low food security, education and job training. One of the most concerning problems expressed was lack of health care and the greatest health care problem reported was malaria. Residents identified unclean water and lack of toilets as the cause: "right now, the disease that is very prevalent in this village is malaria…the toilet and the water have mixed up, it brings a lot of organisms to us in this village. And so this village, we don't have strength – we and our children … By the time we get back from the farm, the feces have entered the water and that's the same one that we'll fetch to do what? To drink … to bath with … to cook with. It really troubles us … every day we have headaches, our waists, our knees, we are very sick in this village". A second health care concern is maternal death: "a lot of pregnant women will go into labor but the home delivery attendant tried to help her deliver, eh, but it didn't help and she died".

A strong desire for a school and formal education was expressed. Adults generally hoped that their children would attain jobs but expressed that education was a better investment for boys. Whereas "girls would become pregnant and the school money would have been wasted, boys can impregnate someone and still continue". Regardless of gender, the consensus of most interviewed was that generally people in the village could not afford to educate their children.

Other concerns related to shortage of food, especially in the Harmattan (dry) season and lack of access to food varieties due to poverty. "If it happens that maybe rice, or something like that, store-bought food, if we want to eat that, getting that is often difficult for us because we are farmers; we don't really have a lot of money … Everyday we eat the same food. It's made our children not get a lot of nutrition from our food. And so it's made their growth not very good".

A third priority was job training and this need was expressed by men and women: "the women, we need some work like vocational jobs which would bring a little bit of money to us for us to take care of our children so the children's lives can get to a good place". In sum, the qualitative study of change priorities matched with the goals of the village leadership and indicated that a comprehensive, village-wide intervention would be needed.

Six project objectives were established: 1) health and nutrition; 2) water and sanitation; 3) education and technology; 4) economic self-sufficiency; 5) cultural exchange; and, 6) building the Nkabom Centre. Addressing these objectives would involve building a center through which the village and partners would develop: 1) a model for job and skills training for youth, young adults, and women; 2) a model for family and village-based formal education with special emphasis on female children; 3) a family-based model of caring for OVC; and, 4) a model for the use of sustainable architecture.

Early attention to sustainability. After initial project goals were set, the next step was to begin work towards fundraising and sustainability. The people of Okurase had not carried out their solutions because they could not develop resources to do so. As noted earlier, an NGO/formal charity was established in Ghana and the nonprofit in the Union Heights neighborhood committed to helping from America. A nonprofit called Project OKURASE was later opened in the United States to help support provision of resources to the Ghana project.

Further delineating the overarching goals. The Centre to be built was officially named the Nkabom Centre for Skills Training and Formal Education. Nkabom is from the Twi language meaning bringing people together in unity. The community decided on the function of the Centre and number of buildings needed. They determined the need for a vocational school for job and skills training, formal school for children, a performance training centre, administration building with health education seminar rooms, a dining building for school children and guests, a medical centre, three accommodations buildings, a recording studio to teach sound technology and to support the work of musicians in Ghana, and six homes for families to live in to be able to foster OVC. In support of the project, the village Chief provided land on which the Centre would be built.

Steps to achieve the major goal. The architectural design had to be developed. Project OKURASE volunteers in South Carolina contacted professors and students from Clemson Architecture Center in Charleston and they accepted the challenge of developing the design as a service project. The students researched Ghanaian culture and building styles. Two students traveled to Ghana and studied the land in the village and the cultural context. Architectural design reviews were held every two weeks over a four month period and each step was approved by leaders in the village. While the design was being developed, Project OKURASE staff in Ghana were actively working to register the land, which proved to be a 3-year process. This registration and structural drawings by a Ghanaian architect were needed to attain a building permit.

Program start-up. While the land and building documents were in process, Project OKURASE began job skills training. As with the Neighborhood Project, nonprofit and NGO status created a portal for accepting funds. Through private donations and a small grant from United Support of Artists for Africa, the first program, compressed earth brickmaking, began to support the building of the Centre and honor the goal of environmentally friendly building.

Nine men and nine women were trained to make these bricks on a manual machine that made one at a time. They completed 60,000 bricks and the machine that was on loan had to be returned. Clemson became involved again and designed a brickmaking machine that produced two bricks at a time. They built four machines with the help of funds from the Church of the Holy Cross of Sullivan's Island. The Medical University of South Carolina shipped them to the village. The bricks were used to build the first building, a vocational school that was completed by hand with all local labor and no machines. Importantly, during the brick making and building process, skills were learned and sustained. The first building was 18,000 square feet and was built over an 8 year period. At no time did the village consider giving up.

Through other partnerships in Ghana and America, small business ventures were started. In particular, women have been supported to start businesses through small loans that have been paid back regularly. Pedals for Progress, a nonprofit in New Jersey donated over 100 sewing machines and over 1000 bicycles. The sewing machines supported the startup of a sewing centre, the initial supplies for which were donated by a women's public service organization, The Charleston (SC) Chapter of The Links, Incorporated. Women quilters from the Union Heights community spent a week in Okurase teaching a quilting class, and the women quilters have sent many lightweight quilts to Okurase for children to have something to sleep on. Through a small grant with the African Women's Development Fund, women in the village started a gari making operation. The grant provided space for much needed storage so that production could increase.

In addition to job training, health and nutrition programs began. A grant with Opportunities Industrialization Center (OIC) International supported a feeding program for village OVC. The feeding time was used to share cultural stories and talk about the importance of hygiene. At the behest of the village, once a year a village health outreach (VHO) has been held, now in its 10th year. The first was held by local medical professionals and all subsequent VHOs have been a partnership between Ghanaian professionals and people from many countries. To date, over 10,000 people in Okurase and surrounding villages have been served through the VHO free medical clinic to address physical and mental health. A significant program aimed at supporting nutrition and food security was the building of a ½ acre organic garden in partnership with the Medical University of South Carolina Urban Farm and Miami Valley School of Ohio. This garden has been run for 1½ years by a village resident and now plans are underway to help farmers convert to village-wide organic methods.

Education programs started through Project OKURASE include scholarships for school fees to allow children to attend school and in partnership with Country Day School in La Jolla, California, building and opening an electronic classroom that brought computers and internet to the village for the first time.

Towards the objective of water and sanitation, a safe water system for the village was an important first goal. This system was created through a deep drilled well that reached an aquifer and water is now pumped to a tank for treatment. Prior to this system, in the Harmattan (dry) season the village had very little water. Now there is safe water year round. In addition, a biogas toilet system that converted waste to gas for cooking was installed in one of seven subcommunities, which reports the elimination of open defecation and cholera.

Discussion

As noted in descriptions of Neighborhood Solutions and Project OKURASE, similar processes that foster community ownership with regard to community development have been followed. These processes are based on the following principles:

1. A community champion should be identified and designated to lead the project.

2. Key community leaders should initiate the process of determining priorities required to facilitate desired changes.

3. A formal assessment with a sample of individual community members will facilitate an understanding of change priorities on a broader scale.

4. There should be an acknowledgement that people in rural African communities have the knowledge of solutions to resolve their own problems but may not carry them out due to lack of resources.

5. To conduct a project or program in a community anywhere in the world, trust must be established. It must be proven that those who come in to provide assistance are there to work with and help the community rather than to take something from the community or impose their ideas on the community.

6. Formal strategies for sustainability should be determined early in the planning process.

7. Interventions should be carried out only after the nature of the interventions is understood and approved by the community leadership.

8. Knowledge and understanding of the culture and context of a community are critical factors in successfully working in that community.

9. Never underestimate the importance of every community member to the success of a program.

10. Heavy reliance on local social and human capital are key ingredients for project success.

Though the structure and implementation of the Neighborhood Solutions Project and Project OKURASE was virtually identical, the American project started with some resources and Project OKURASE had to attain resources through global partnerships. In America the infrastructure for the community existed (i.e., community center, neighborhood services from the city) but in Africa the infrastructure had to be built (e.g., a school, clean water, sanitation). Both projects addressed very serious clinical problems with youth that placed them at risk for loss of life. In America, youth were at risk of violence and incarceration. In Africa youth were at risk of death from highly treatable diseases.

The American project brought about significant changes that reduced crime and serious community problems. Project OKURASE to date has been instrumental in saving lives and creating an economic base for many men and women. The interaction of the two projects has also been significant. The American children who conducted the arts-based HIV/AIDS education in Ghana have become more cognizant of world affairs and some have engaged in international studies in the college context. A children's dance company called Nkabom Children's Cultural Troupe was formed in the village of Okurase and these children offered instruction in traditional dance and drumming via videotape sent to the American children. Recently, a Montessori school called Sundrops Montessori in Mt. Pleasant, South Carolina partnered with Project OKURASE and Okurase village to open a Montessori primary school called Nkabom Sundrops Montessori that is highly valued and popular throughout the district. Montessori education in Ghana has typically been reserved for families of privilege. Through this partnership, people with very little in the material realm now have educational privilege that they would not have had before. Finally, students from all around the world have come to Okurase to be involved in community-based projects. They have experienced untold benefit. People from each community (Okurase, Union Heights, and others around the world) have sent their own version of bidirectional aid across the ocean. Okurase residents have given as much as they have received.

Conclusions

Project OKURASE is a demonstration that transformative and sustainable change in vulnerable communities ravaged by economic disadvantage, disease and lack of resources can be achieved by a community-based bottom up approach where the elements of change necessary are defined by community leaders themselves, in consultation with benevolent interests. It also demonstrates the abundance of valuable human capital available in African communities including leadership, planning capabilities, labor, volunteerism and local resource development – factors that help to maximize the impact of scarce funds from public and private sources. Additionally, the global partnerships created are extraordinarily effective because they support and facilitate change based on a community consensus about the elements necessary to create long-range, sustainable and empowering change. Finally, community-based interventions provide the opportunity to identify and promote the indigenous leadership that can promote sustained change.

Steps for Further Research

Through the Neighborhood Solutions Project and Project OKURASE, we have shown how people of African descent can bring about sustainable positive changes in their communities through empowerment to use their community's human capital, resource development, and global partnerships. Community buy-in is essential. Future research to understand what it takes to maintain long-term sustainability of such widespread changes is critical. One particular challenge is how to keep goals and achievements on track with changes in leadership. In both of our projects, over time, key leaders died. Communities must have a strategy to prevent successful programs from being stopped or changed in a negative way due to differences of leader priorities. A second area of study is financial sustainability or how an economically disadvantaged community can sustain important community changes that require financial resources. A third area for research attention is understanding the capacity that is needed to conduct long-term follow-up of vast community-based interventions. Determining how an intervention impacts people and an entire community years after the intervention starts and through the changes that take place can help with an understanding of long-term health and economic benefit. Finally, if a community-based and community-wide intervention is successful, determining how to get other communities or government to uptake such an intervention will be critical to change in more than one spot in the world.

References

Adelman, H.S., and Taylor, L. (2003). On sustainability of project innovations as systemic change. *Journal of Educational and Psychological Consultation, 14 (1),* 1-25.

Alexander, M. (2012). *The new Jim Crow: Mass incarceration in the age of colorblindness.* New York: The New Press.

Appoh, L.Y., & Krekling, S. (2004). Effects of early childhood malnutrition on cognitive performance of Ghanaian children. *Journal of Psychology in Africa,* 14 (1), 1-7.

Asante, M.K. (2007). The history of Africa: The quest for eternal harmony. New York: Routledge.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature.* Cambridge, MA: Harvard University Press.

Cunningham, P.B., & Henggeler, S.W. (1999). Engaging multiproblem families in treatment: Lessons learned throughout the development of multisystemic therapy. *Family Process*, 38, 265-286.

Dopp, A. R., Borduin, C. M., Wagner, D. V., & Sawyer, A. M. (2014). The economic impact of multisystemic therapy through midlife: A cost-benefit analysis with serious juvenile offenders and their siblings. *Journal of Consulting and Clinical Psychology*, 82, 694 –705.

Elkins, S.M. (1976). *Slavery: A problem in American institutional and intellectual life*, Edition 3. Chicago: University of Chicago Press.

Elmina Castle Tour Guide (2015). Personal communication.

Fixsen, D.I., Naoom, S.F., Blasé, K.A., Friedman, R.F., & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* University of South Florida, Louis de la Parte Florida Mental Health Institute.

Haley, J. (1976). *Problem solving therapy*. San Francisco: Jossey-Bass.

Heitzeg, N. A. (2016). *The school-to-prison pipeline: Education, discipline, and racialized double standards.* Westport, CT: Praeger.

Henggeler, S.W., Melton, G.B., Brondino, M.J., Scherer, D.G., & Hanley, J.H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, 65(5), 821-833.

Henggeler, S.W., Pickrel, S.G., & Brondino, M.J. (1999). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research,* 1, 171-184.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic therapy for antisocial behavior in children and adolescents.* New York: Guilford Press.

Hong, R., Banta, J.E., & Kamau, J.K. (2007). Effect of maternal HIV infection on child survival in Ghana. *Journal of Community Health,* 32 (1), 21-36.

Huey, S.J., Henggeler, S.W., & Brondino, M.J., & Pickrel, S.G. (2000). Mechanisms of change in Multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of Consulting and Clinical Psychology*, 68, 451-467.

Hurmence, B. (1989). *Before freedom, when I can just remember: Twenty oral histories of former South Carolina slaves.* Winston-Salem: John F. Blair Publisher.

Johnides, B. D., Borduin, C. M., Wagner, D. V., & Dopp, A. R. (2017). Effects of multisystemic therapy on caregivers of serious juvenile offenders: A 20-year follow-up to a randomized clinical trial. *Journal of Consulting and Clinical Psychology,* 85, 323 – 334.

Korunka, C., Weiss, A., & Karetta, B. (1993). Effects of new technologies with special regard for the implementation process per se. *Journal of Organizational Behavior, 14 (4)*, 331-348.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Nyonator, F., Jones, T.C., Miller, R.A., Phillips, J.F., & Awoonor-Williams, J.D. (2005). Guiding the Ghana community-based health planning and services approach to scaling up with qualitative systems appraisal. *International Quarterly of Community Health Education,* 23 (3), 189-213.

Schoenwald, S.K., Henggeler, S.W., Brondino, M.J., Rowland, M.D. (2000). Multisystemic therapy: Monitoring treatment fidelity. *Family Process*, 39, 83-103.

Schoenwald, S.K., Sheidow, A.J., Letourneau, E.J., & Liao, J.G. (2003). Transportability of multisystemic therapy: evidence for multi-level influences. (2003) *Mental Health Service Research*, 5 (4), 223-239.

Scott, B., Curtis, V., Rabie, T., & Barbrah-Aidoo, N. (2007). Health in our hands, but not in our heads: Understanding hygiene motivation in Ghana. *Health Policy and Planning*, 22 (4), 225-233.

Swenson, C.C., Henggeler, S.W., Taylor, I.S., & Addison, O. (2009). *Multisystemic Therapy and Neighborhood Partnerships: Reducing Adolescent Violence and Substance Abuse, reprinted paperback edition.* New York: Guilford Press.

The New York Times (2015). *Walter Scott Death: Video Shows Fatal North Charleston Police Shooting.* https://youtu.be/XKQqgVlk0NQ.

Tuerk, E.H., Cunningham, P.B., McCart, M.R., & Henggeler, S.W. (2008). *Engaging families in treatment.* Family Services Research Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina.

Wilkerson, I. (2010). *The warmth of other suns: The epic story of America's great migration*. New York: Random House Inc.

Authors' Note:

Cynthia Cupit Swenson, Department of Psychiatry, Medical University of South Carolina, Samuel Nkrumah Yeboah and Nana Ama Yeboah, Project Okurase, Ghana, Eve G. Spratt, Department of Pediatrics, Medical University of South Carolina, Marguerite Archie-Hudson, Department of Political Science, College of Charleston, Ida S. Taylor, Gethsemani Circle of Friends, North Charleston, SC.

The qualitative study noted in this article was supported by a grant from the Department of Psychiatry, Medical University of South Carolina (Cynthia Cupit Swenson, PI). The analysis of data via Atlas ti was supported by a grant from the National Institute of Mental Health (K23MH064111; Eve Spratt, PI). The biogas research project was funded by The Medical University of South Carolina Center for Global Health. The authors wish to thank Dr. Thomas Uhde, Chair of the Department of Psychiatry at the Medical University of South Carolina and Former University President Raymond Greenberg for support of our global health work. We would also like to thank Baffour Ampofo, III, Chief of Okurase village (ancestor) for leadership and Dr. Basant Singh for data assistance. We thank Todd Chas for making our initial U.S.-Ghana connection and Iris Poole, Fred Taylor, Toby Smith, Linda Norton, Shelley Kawamura, Dr. Linda Plunkett, Oliver Addison, and Daniel Scruggs for their ongoing work with Neighborhood Solutions and Project OKURASE. Finally, a great deal of gratitude is offered to Scott Henggeler for a significant contribution to the world in developing and disseminating Multisystemic Therapy (MST).

Correspondence concerning this article should be addressed to: Cynthia Cupit Swenson, Division of Global and Community Health, Department of Psychiatry, 176 Croghan Spur, Suite 104, Charleston, SC 29407. Email: swensocc@musc.edu. Website: www.projectokurase.org.

Notes:

[1] The authors engaged in discussion about whether in Ghana the word tribe or ethnic group should be used. Tribes was determined to be the most appropriate description. The word ethnic group was considered out of a desire to prevent stereotyping African people as tribes with spears running through the jungle and fighting. The authors hope that as the strengths of African people come to light in this article what is written will dispel such stereotypes.