THEATRE OF HEALTH:

An Ethnographic Exploration of Female Physician Well-being and Applied Theatre in Accra, Ghana

by

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Abstract

This thesis brings together ethnographic research and theatre techniques to understand and confront the challenges - from gender barriers to professional burnout – faced by female physicians in Accra, Ghana. For three months, I shadowed three female doctors, conducted participant observation, interviews and focus groups and administered surveys in order to investigate local understands of well-being and its threats . I also worked with a local theatre group to design and implement workshops that allowed participants from the medical field to experiment with social theatre and embodied practices geared towards exposing and alleviating stress factors. Along with offering critical insights about gender politics and labor within the Ghanaian health workforce, my thesis offers a new global health theatre model , which is collaborative and interventional. Situated within the burgeoning health humanities field, this model as elaborated during my thesis project could serve as a well-being toolkit – not just for female physicians, but for members of different professional groups and social classes throughout Ghana and beyond.

Dedicated to Bridget.

For reminding me that interdisciplinary endeavors and collaboration will always change lives.

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INTRODUCTION

GENESIS

March 2017.

She sat at the edge of my bed, stroking the magenta sheets perhaps in an attempt to comfort me. I was grieving over the loss of a relative and overwhelmed by the intricacies and extravagance of a typical Ashanti funeral. Yaa's words were soothing. Her attempt to empathize with my loss and her suggested solutions for moving past death were typical of a doctor *and* a Ghanaian woman. However, the more my cousin shared about her own grief, the more she hinted at some hidden layers: fear, stress and a struggling well-being as a result of her personal and professional challenges. Our conversation suddenly metamorphosed into a physician's cry for help, and I could do nothing more than acknowledge her stress and precarious well-being. Although temporally, it felt as though our roles had switched: I, now the caregiver (listener), and Yaa, a helpless patient exploding in a range of emotions from the buildup of unaddressed problems met with an ingrained training to become a person for others (and not for the 'self') - true doctor style. This moment's reflection revealed for me a consequence of the inherent self-sacrifice of medical education and practice. Physicians are trained to put others first and in turn often neglect their own needs; a factor that has been attributed to high stress and burnout within the medical profession (See Deckard, Meterko, & Field, 1994; Gundersen, 2001; Linzer et al., 2001; Richardsen & Burke, 1991).

"Herh Maame! I am tired. I am so tired."

These final words floated in the still air of my room, along with seeds of what would become this thesis project on female physician well-being in Accra.

Since Yaa's emotional breakdown, I began to pay close attention to my cousin's words each time she visited, looking for more cues of fear, worry, hope and also signs of an improvement in her overall well-being. Further inquiries about her work, her physician friend group, her social engagements, and goals heightened my concern and led me towards a new wave of questions: Why was well-being such a poorly discussed topic among the minority female physician cohort in Accra? How were female physicians maintaining positive well-being, if at all? What impact does culture, society and medical work in Ghana have on female physicians? What are the consequences of poor well-being for these female physicians, their social groups and their patients? How could the issue be addressed?

While I acknowledge that there are other issues within Ghana's healthcare system, my conversation with Yaa led me to focus on a neglected patient population from whom so much is expected: the doctors themselves. Currently, the estimated doctor to patient ratio in Ghana is ~1:7300 (Ghana Health Service, 2018). Many physicians in Ghana thus find themselves working under stressful and resource-limited conditions which may affect their health and well-being. Doctors are at risk of similar illnesses as their patients, and they also experience higher than average levels of stress, burnout, anxiety and other health problems (Deckard et al., 1994; Linzer et al., 2001). I am particularly interested in female physicians in Ghana because of the unique challenges they face as both women and physicians in Ghana. They work hard to meet certain gender expectations in Ghana and are females in a male-dominated profession.

My conversation with Yaa in March 2017 now serves as the foundation upon which this thesis is built. It was and continues to be the guiding clue for this multi-dimensional journey to understanding female physician well-being in Accra, Ghana.

A MEDICAL ENCOUNTER WITH THEATRE

"So, what will we be doing? Are we going to be acting?" (Dr. Ofei)

As an arts enthusiast, I envisioned the numerous possibilities of utilizing the arts for communicating this problem and also as a therapeutic remedy. Since childhood, I have experimented with various art forms and over the years I have developed a strong inclination towards the intentional and purposeful practice of singing, drawing, and creative writing. In places like Ghana, various art forms play a significant role in the lives of many. From the constant radio plays of the "Malaria Free Future" anthem[1] in the early 2000s, to the current murals on community spirit that grace Jamestown-Accra, I began to see how in Ghana the arts carry an untapped potential to serve as an effective communicative language and avenue for creativity. While in the U.S. for college, I began to notice these same potentials and influences of the arts, as they were being used to facilitate health and wellness. Ultimately, my interests in the intersection of arts and health grew significantly, and I became far more interested in exploring

[1] Malaria-Free Future Ghana was a national campaign aimed at raises awareness at the national and community level around issues surrounding malaria infections, preventions and treatment. See http://www.comminit.com/content/voices-malaria-free-future-ghana

the dynamic nature of this arts and health relationship. The exploration of how the arts can intersect with healthcare and healing is now at the core of my undergraduate studies.

Organically, I experienced a personal concern for a minority group within the Ghanaian health workforce transmute into a two-pronged ethnographic investigation of female physician well-being and an exploration of the arts as a gateway for this project. The next step after identifying this well-being challenge was to decide on which artform could best serve as the intervention. After considering some art forms that have been used in the medical arena such as Narrative Medicine (See Charon, 2001) and music therapy (See Bates, Bleakley, & Goodman, 2013; Horne-Thompson & Grocke, 2008), I decided on theatre as my arts-based intervention.

Theatre has a long-standing relationship with Ghana; it is a cultural practice. From role-playing to music and dance, theatrical elements are essential to many Ghanaian rituals and festival performances. Similarly, the embodied drama in traditional cultural practices convey messages that are passed down from one generation to the next or to bring communities together. In "Theatre Space: A Historical Overview of the Theatre Movement in Ghana," Sophia Lokko – a senior lecturer and former acting head of the Theatre Arts Department at the University of Ghana, Legon - offers a rich historical account of theatre in Ghana. A central argument in her text is that theatre in Ghana has ritual origins and "has existed for centuries in the traditional dramatic expressions," many of which are characterized by music and dance, "which also happen to be important ingredients in Ghana's culture." (Lokko, 1980) According to Lokko, the "concept of theatre ultimately dates back to the time when the early tribesman, dressed in the skin of a previous catch, danced and chanted for rain or other benefits." Theatre was fundamental to social life in precolonial Ghana (Lokko, 1980, pg. 309). It was an element of

everyday living. It was not until the eighteenth and nineteenth centuries, when Europeans first arrived, that drama became formalized and scripted. (Lokko, 1980, pg. 314-315); thus shifting the focus of theatre from a cultural necessity to simply a commodified entertainment.

A particular form of theatre that sustained public interest and demand until the early 2000s was the Concert Party. It was popularized in the 1920s and delivered in various forms, including travelling theatre, street and set stage performances (C. M. Cole, 2001). It first began as "hour-long shows of European songs and vaudeville sketches" for educated Africans and foreign residents. It eventually evolved into an extended event with African pop music and "melodrama punctuated at emotional moments with well-known highlife tunes…" patronized by the ordinary citizens (C. M. Cole, 2001). Moreover, this type of theatre was not only for recreational purposes, but was also used as a platform to discuss cultural, social and political issues in Ghana.

Today the role of theatre in Ghana continues to evolve. Theater has been used as a an educational tool to explore accessing clean water as a basic human right (Madison, 2010), to highlight sexual and reproductive rights and for other socio-political endeavors (Bame, 1985, pgs. 46, 57) throughout the 20th and 21st centuries. However, its effectiveness in helping healthcare professionals has not been tapped.

While my choice to use theatre for this project was initially based on its historical relevance in Ghana, it was also greatly influenced by a theatre course I took in my junior year of college called "Medical Stories on Stage," taught by Dr. Jules Odendahl-James, a theatre artist and scholar. By exploring different techniques for conveying stories about health and medicine on stage, I came to appreciate the breadth of theatre. From writing scripts to constructing props

to utilizing movement and sound in various ways, we find that theatre is flexible; it offers opportunities for everyone to exercise their minds and bodies creatively. This accessible nature of theatre was also an important consideration for selecting theatre as the intervention for this project.

Over the years, the use of theatre within medicine and healthcare has gradually expanded; it is used for health education (Jackson, 2002, pg. 225-238), training doctors in performance skills ("Performing Medicine," n.d.; Willson, 2007) and for therapeutic purposes (Boal & Jackson, 1995; Jones, 1996). During my fieldwork, I came to appreciate that theatre and medicine actually share some similarities. Both utilize elements of technicality and subjectivity to varying degrees, and allow practitioners of their fields to embrace and envision the embodied qualities of 'self' and others. Perhaps, the performative nature of both medicine and theatre is what truly connects them. This discovery, while not a confirmation of my hypothesis, certainly gestured towards a promising future for the intersection of theatre and medicine in urban Accra. In this thesis, I seek to address the following: How can theatre as a historical and pervasive art form in Ghana be used as a communicative and therapeutic tool for well-being purposes? What theatre-based practices can facilitate female physician well-being in Accra? Later, in the final chapter, I will also discuss the future directions of using theatre-based models as sustainable well-being interventions.

EVOLUTION OF DOCTORING IN WEST AFRICA| The Female Physician

The art of healing is a fluid concept that has deep historical roots from the Middle Ages to precolonial Africa (Patton, 1936). There are a number of texts that detail the history of African traditional medicine and its evolution (See Abdullahi, 2011; Schoenbrun, 2006; Feierman, 1985). For example, M.V. Gumede's *Traditional Healers: A Medical Doctor's Perspective* (1990) details the history of traditional African medicine and its position in a developing modern health setting in South Africa. Historian Adell Patton's book, *Physicians, colonial racism, and diaspora in West Africa (1996)*, on the other hand, explores the history of Western medicine in Africa through the lenses of colonialism, racism, power and the role of the physicians in reinforcing the paradigm shift from traditional African to Western (Patton 1996). While both these authors do not explicitly analyze the role of women in health and healing in Africa, the presence of female traditional healers in ancient Africa offers questions of their historical relationship to contemporary female physicians.

The role of female traditional healers in pre-colonial Africa, and generally all traditional doctors varied by specialty and geography. Some of these specialties included practicing as herbalists (analogous to modern-day pharmacists), dealing with childbirth and reproductive issues (analogous to midwives, obstetricians and gynecologists), performing complex procedures (analogous to surgeons), serving as diviners and more (Good, 1987; Mokgobi, 2014). The roles women played in traditional medicine also varied across cultural environments. For example, among the Ga tribe of Ghana, priests/priestesses (who performed various physical and spiritual healing practices) if married had to leave their families upon appointment. However,

male priests, or "mediums", who had completed training could remarry if they chose to do so (Mbiti, 1990, pg. 169), thus allowing for more flexibility in the practice for males than their female counterparts. In the Fon and Yoruba tribes, the training period for traditional healers was much greater for males than females (three years vs nine months) (Parrinder, 1949). However, some ethnic groups put female traditional healers on a higher pedestal than men. Among the Kamba people of East Africa, for example, women traditional healers who practice divination are more common than men (Good, 1987).

Similarly, dating further back in antiquity are the likes of Merit Ptah. Merit Ptah was the chief physician of pharaoh's court circa 2700 BC and the first female doctor known by name in world history (Hurd-Mead, 1938). It has been recorded that before 3000 BC, medicine as a discipline had already been established in Egypt with women working as both doctors and surgeons with many of them specializing in gynecology (Herzenberg et al., 1991).

Certainly, women have had some significant part to play in health and healing in pre-colonial Africa. Perhaps and unfortunately, the shift to Western medicine and gendered ideologies that occurred during the colonial era in Africa impacted the presence and role of women in the healthcare field. Kofi Appiah-Kubi argues in his book, *Man Cures, God Heals: Religion and Medical Practice Among the Akans of Ghana*, that the introduction of Western Medicine as well as missionary churches impacted how African traditional medicine is now practiced and utilized, specifically its diminishing presence in Akan society (Appiah-Kubi, 1981). While there may be no exact correlation between the arrival of Western medicine or

Christianity and the evolving patterns of women in "healer"[2] positions in Ghana, it is worth looking into possible connections between these two colonial institutions[3] and the diminishment of female figures in healing. It may offer explanations for the lag in the production of female physicians in Ghana, as well their current low numbers.

In *History of Western Medicine in Ghana 1880-1960*, medical historian Stephen Kojo Addae[4] explores the development of medicine in former British colony, Gold Coast (which later became known as Ghana). Addae utilizes an ethnohistorical approach to highlight the threatened culture of Ghanaians when Eurocentric ideologies infiltrated their society, the racism that barred physician status mobility, and the development of medical services in the Gold Coast[5] overall. More relevant to this thesis is Addae's historical accounts of females in the medical service during the colonial era. He effectively captures the difficulties and barriers imposed on aspiring female physicians in the early to mid- 20th century in colonial Ghana (Addae, 1997).

Around the 1920s, high levels of maternal and child mortality and the drainage of medical labor from World War I forced British authorities in the Gold Coast to employ Women Medical Officers (WMOs). This pioneering enterprise stationed WMOs at infant welfare centers

[2] I use healer to broadly refer to agents of facilitating good health, be it from a traditional, holistic or modern approach. Healers here may include traditional healers, physicians, etc.

[3] Many scholars have argued that Western medicine, ideologies and Christian religion were introduced into Africa through the 18th to 20th century colonial architecture (See G. R. Cole, 2013; Houle, 2011; Owoahene-Acheampong, 1998)

[4] Professor S. K Addae is a medical historian and professor of physiology at the University of Ghana Medical School.

[5] Gold Coast is the name present-day Ghana went by prior to and during its period as a British colony.

to treat mothers and their children, as part of a colonial Health Branch Department initiative to curb the mortality levels (Addae, 1997, pg. 148-149). Moreover, many of these WMOs who pioneered the program such as Dr. Mary Magill (the first government WMO to be posted) were European and appointed by the British government. This preference of non-black personnel in running the initiative is reflective of the racial inequities Addae posits through his reference of the British educationist, David Kimble. Kimble writes in his book, *A political history of Ghana; the rise of Gold Coast nationalism, 1850-1928.*:

> …European personnel began to monopolize top posts. Africans in all branches of the colonial service, many of whom had been educated in the same schools and universities with their European counterparts, now found their careers blocked by rising racism. (Kimble, 1963)

This reference is not to undermine the impact of these pioneering foreign WMOs in paving a way for colored female physicians to practice over the next decades in Ghana. However, I touch on this idea of racism in medical service in colonial Ghana to bring readers' attention to one of the numerous obstacles that may have contributed to the lag in production of native[6] and African female physicians in Ghana. From the late 1800s until Ghana's independence, and even some brief periods after, Ghanaian and generally African physicians were marginalized in their own regions. There were limitations to whom they could treat and their qualifications were overlooked by colonial authorities, unless there were no European physicians available. (Patton, 1996)

[6] I borrow the term 'native' from Addae's 9th Chapter in which he explores the institutionalization of inferior positions for medical officers of African descent. The African medical officers were delegated "Native Medical Officers" (Addae, 1997, pg. 142)

Aside from race, the barriers to education for Africans and women during the colonial era is an equally plausible cause of the lag in female physician production in Ghana. Addae proposes in his text that the lack of secondary schools by 1915 could have explained the slow

Image 0.1. (Courtesy of Mercy Akman as seen in "...three pioneering doctors" (Ferry, 2018): Dr. Matilda Johanna Clerk

growth in Ghanaian doctors at the time. Similarly, prior to the introduction of government scholarships for medical education, only Ghanaian students who had the personal financial means to attain medical education did so. Susan De-Graft Johnson (nee Ofori-Atta),[7] for instance, was the first female physician in Gold Coast by 1949 (Tetty, 1985; Patton 1997, pg. 29). Her medical education at Edinburgh University Medical School was sponsored by her affluent father, Nana Sir Ofori-Atta I, Okyehene and Paramount Chief of the Akyem-Abuakwa area (Ferry, 2018).

[7] Dr. Susan De-Graft was the first female physician appointed in the Ghana medical service after attaining her Bachelor of Medicine, Bachelor of Surgery (MB ChB) in 1947. She was also the fourth West African woman to earn a university degree (Patton, 1993), and third West African female physician after Nigeria's Agnes Yewande Savage (1929) and Elizabeth Abimbola Awoliyi (1938) (See Ferry, 2018 and Anibaba, 2003, pg. 214).

Dr. Matilda Clerk - the second female physician in Ghana and first West African woman to earn a postgraduate diploma - also benefited from her father's respected position as a theologian and Presbyterian minister. Her father "persuaded the authorities to let her take a preclinical course previously closed to women"(Ferry, 2018).

Besides the financial obstacles medical education posed, after receiving the medical degree, female physicians then had to endure gender inequalities within the profession. In 1930, WMOs in Gold Coast protested against the gender inequities in the practice. They petitioned to be granted privileges for private practice just like their male contemporaries. After the intervention of the Medical Women's federation in London, the Colonial Office eventually came to a comprise and decided to offer WMOs who were in the West African Medical Service (WAMS) staff a stipend in place of private practice privileges (Patton, 1993, pg. 155). Unfortunately, this promise was contingent upon the availability of funds; funds which were unavailable due to the Great Depression of the 1930s (Patton, 1993, pg. 156). Female physician pioneers like Jamaican-born Dr. Cicely Williams, whom Addae notes, "became probably the most prominent of the women medical officers." (Addae, 1993, pg. 156). She was disappointed by the shallow offer being made by the Colonial Office and submitted another petition "by herself, protesting the continuing injustice saying medical training for a woman cost as much as for a man." (Addae, 1993, pg. 156). The resiliency and hard work as exhibited by WMOs including Dr. Williams and Dr. Helen Hendrie (the first woman pathologist in the colony) in fighting for equal gender rights and opportunities, certainly contributed immensely to the acceptance and growth of WMOs population in the Gold Coast, and more generally, female

physicians in the current West African region. As a matter of fact, Addae concludes his chapter on "Maternal and Child Welfare and Women Medical Officers" in an almost celebratory manner, by commending these pioneering WMOs for their contribution to incidence of female physicians to follow after them:

> Their presence in the country was a demonstration of the local Africans that women could be doctors also and that women doctors could do what make doctors did. It is not surprising that by the early 1940s, female African governments medical scholars began to enter the ranks of their male counterparts. (Addae, 1993, pg. 158)

Again, while there is not much said about the well-being of these pioneering WMOs, I anticipate that the processes involved in their struggle for female physician rights in colonial Ghana must have had some impact on their well-being. I envision that the feelings and thoughts they had are not too dissimilar from the sentiments I sensed from the female physician I interacted with in the field. I postulate that they are sentiments that arise from working to be seen, heard and accepted in male-dominated medical spaces.

Overall, the themes of colonialism, religion, gender and culture, that have characterized the history of female physicians in Ghana may have crept into the 21st century. Whether they are still prominent or not, they inform our understanding of the current state of female physician practice and lifestyle in urban Accra. Later in this thesis, I offer readers some perspectives on how the aforementioned social, cultural, and political factors that survived the colonial era, as well as new ones that have emerged in the 21st century, impact female physician well-being in Accra.

THE ISSUE | WELL-BEING

Although there is a plethora of literature on physician well-being[8], little focuses on female doctors. When it does, the literature fixates on female physicians in the Western world, Europe and sometimes Asia, but rarely in Africa. By taking on this research project, I will not only be contributing to research in the medical anthropology field as it pertains to physician well-being, but I also get to spotlight a group of whom little is written – female doctors within the African context.

Undoubtedly, well-being is a broad yet important concept within health care and human development. Many scholars have faced challenges in defining and measuring well-being due to its multidimensionality (Parrinder, 1949). It has also been mistakenly thought of as many things including the "absence of mental illness," (Ryan & Deci, 2001) or as a synonym for health (Fuller, Atkinson, & Painter, 2012). In *Well-being and Place* (2012), the authors attempt to negotiate this definition problem by arguing that "Defining…wellbeing requires the specification of components that operate largely independently from one another" and also deciding whether those components are "best captured through objective or subjective assessments" (Fuller, Atkinson, & Painter, 2012). They also affirm that some of these components that must be assessed are aspects of human life such as "social relationships, health, safety and financial security," variants of control and meaningful purpose in life (Fuller, Atkinson, & Painter, 2012).

[8] See West et al., 2014, Dunn et al., 2007, Shanafelt and Noseworthy 2017, and Wallace and Lemaire 2007.

Two major perspectives in well-being studies through which scholars better understand and assess this pervasive concept is the hedonism and eudaimonism philosophies. The hedonic view of well-being relates to pleasure, comfort and happiness whereas the eudaimonic well-being deals with a fulfilling a sense of purpose and meaning in life. (Ryan & Deci, 2001). Some studies indicate that these distinct yet overlapping views, when combined can yield the greatest well-being. An empirical inquiry in both these paradigms will, therefore, yield a more holistic understanding of well-being and how to assess it. (See Henderson & Knight, 2012; Huta & Ryan, 2010)

In this thesis project, I investigate the well-being of female physicians in Accra by identifying the internal(personal) and external factors that impact their happiness, their goals, their physical and psychological health. I argue that while well-being broadly relates to holistic health, for female physicians in Accra, well-being is not only multidimensional but it is perceived differently based on each individual's unique set of experiences. The multideterminant nature of well-being in this social and cultural context thus beckons a multidimensional response, which I argue is theatre.

THE PROCESS | THEATRE OF HEALTH

The Process: The Anthropologist

"But you'll get here soon. You'll see how it's like" (Dr. Agyeman)

During my time in the field, my interest in the arts and health changed from a purely intellectual one, to a personal journey of understanding what my life could look like as a Ghanaian female physician in the future. I have taken on this project from a unique position as a Ghanaian-American and aspiring physician. I was born in the U.S. but I grew up in Ghana. While my familiarity with the people, places and the culture offered me an insider perspective, my passport and a few years away from home for college positioned me as an outsider. Even though I was able to cross the 'foreigner' barrier and connect deeply with my target population through our mutual understanding of local languages and culture, some preliminary views I had in mind sometimes felt out of left-field to the reality I was observing. My attention was brought to the elements of non-nativity I possessed (and found hard to accept).

I always felt connected to my target population until I had to immerse myself into their lives. Our identities were detached not just by our current geographical residences, but by education and experiences. My tertiary education has and will continue to be in the U.S. whereas my research subjects were trained in Ghana. Although I could envision and understand typical events of locals in Ghana, I was no longer experiencing the everyday events of these residents. I did not feel the ubiquitous tension and concern that choked Accra as a result of the devastating effects of the tumultuous floods the previous year. I did not vote in the last election nor could I contribute extensively to conversations about the best *waakye*[9] spot in the city. Ultimately, these female physicians and I were different; it is these differences that have fueled the investigation to know them better than I initially presumed.

[9] *Waakye* is a Ghanaian dish made with cooked rice and beans. It is typically eaten with meat sauces and/or *shito* (a pepper sauce)

The Process: The Field

I began my research this past summer by conducting fieldwork over a period of about three months (late May – August 2018) in Accra, Ghana. However, prior to this study, I wanted to analyze the arts-health relationship using market women working in Kejetia[10] - Kumasi, Ghana as my target population, but maintaining theatre as my lens of exploration. The idea was first suggested by my aunt, who is a retired artist. She always shared in my belief that the arts have a powerful way of communicating messages, engaging our senses, and fueling social change. Upon retirement and moving back to Ghana from the United States, she helped established the Pre-Nkwa Market Health Clinic as a way to address the immediate health concerns of market women in the Kejetia Market.

One of her major concerns after setting up the clinic (amidst the many logistical challenges of non-profit work in Kumasi), was the depth of health illiteracy in the market. I also volunteered at Pre-Nkwa during many school breaks and those experiences corroborated the concern my aunt had, especially when it came to hygiene. My initial plan for my senior project was to use theatre as an intervention for hygiene education among these market women. However, the memorable moment with Yaa peaked my interest; Yaa and other female physicians were likely caring for these market women (when they did visit the clinic/hospital) other working-class patients, and not themselves. My decision to focus on female physicians was partly logistic and partly of self-interest (since it is related to my own professional

[10] Kejetia Market, also known as Kumasi Central market is an open-air market in the Ashanti region. It is considered as one of the largest market in the West African region.

trajectory); but most importantly, female physicians although an elite group, still suffer and need to be cared for.

Although I switched my focus to study female physicians in another urban Ghanaian city for this thesis project, the preliminary fieldwork I did for my hygiene education project was not in vain. I discovered through conversations with the market women that although doctors are seen as a source of knowledge and guidance, gender (be it of the physician or patient: the market woman) might impact what is believed and who is taken seriously. The woman's position in the patriarchal Ghanaian society could be challenging; and I discover later during my fieldwork that medical spaces are no different. This extra information shaped how I thought of women and labor in Ghana, and in turn informed some of the questions I asked while in the field.

For this thesis, I set out to do two things: learn about female physician well-being and how effectively theatre could serve as an intervention for this specific population. My fieldwork was therefore shared between investigating factors that may impact female physician well-being, planning the theatre workshops that these female physicians would attend, and most importantly observing and analyzing the outcomes of the theatre workshops.

Firstly, using participant-observation, interviews, surveys and some newspaper content analysis as my primary ethnographic methods, I identified some cultural, sociological, financial and personal factors that impact female physician well-being in Accra. I shadowed three female physicians in their professional settings and sometimes, in their personal spaces including their

homes and cars[11]. Occasionally, I had debriefing sessions (15 -20 minutes in length) to discuss the day's work with these physicians. These sessions became a useful alternative to the personal diaries I had initially proposed, which I abandoned very early on in the study when I realized they would only add to their workload. Again, many of these sessions were impromptu. I had to feel out the physician's mood before requesting a session; a skill although not as weighted not unlike the improvisation these female physicians use in their everyday work. When these sessions did not happen during their lunch breaks or after work, I would call them at a time of their preference (often at night) for a similar session. I could best describe these phone sessions as a vocal diary; symbolically I was the diary and their voices were pens in action.

I also interviewed three other female physicians: a Nigerian general physician, an older obstetrics and gynecology resident, and a psychologist. Occasionally, I had brief informal conversations with other female doctors that worked in the clinical spaces I shadowed in. I approached most of them when I noticed they were less busy during my spontaneous walks around the hospitals or clinics. Others were introduced to me through the three physicians I shadowed. And of course, I got to interact with the physicians who participated in the theatre workshop portion of the study.

Electronic surveys served as another useful tool for data collection. I sent out two survey links; one administered to female physicians through the contacts I had established during the course of my fieldwork and the other to female medical students through some friends. Social

[11] The idea of the car as a personalized space for some female physicians is an observation I made during my fieldwork. I shall explore this more by chapter 1, when I connect well-being to the spaces these physicians inhabit.

media platforms like class group chats on WhatsApp, Facebook Messenger and Instagram were helpful in reaching the target populations. In total, forty female physicians and fifty-seven female medical students completed their respective surveys. These survey results were particularly helpful in conveying the nuances in the female physician lifestyle in Accra. They also offered detailed opinions that allowed me to compare female well-being during medical training to practice, and how the nature of medical training could inform the well-being of future female physicians.

I also interacted with affiliates of female physicians (by way of casual conversations and formal interviews) to get secondary perspectives on the female physician image in Accra and how others thought about her well-being, if at all. These included two interviews with male physicians in a private clinic and public hospital, informal discussions with nurses and other hospital/clinic staff in both private and public sector. I also had conversations with family and friends living in Accra.

For the other premise of my research which explores theatre as a well-being intervention for female physicians, I organized four theatre workshops in conjunction with a couple of theatre and performing arts experts in Accra. These workshops were aimed at exploring, contextualizing and facilitating well-being for the female physician participants using embodied practices from theatre. The workshops altogether form the *Theatre of Health* - that is using theatre to experiment with certain embodied practices as it pertains to holistic health and well-being. The participants were mainly recruited by word of mouth and social media platforms. Each theatre workshop included five to nine physician participants and was facilitated by the performing arts experts. The idea was to create a comfortable, non-judgmental space where the

female physicians could express themselves freely and creatively, explore their goals and challenges, and most importantly consider theatre-based solutions to improve their well-being.

With regards to assessing the effectiveness of these workshops, I varied methods between participant-observation, informal interviews, taking pre-and post-workshop heart rates, administering pre- and post-workshop questionnaires and focus group discussions. Preliminary preparations for these workshops required that I also delve into the history and sociocultural functions behind the theatre techniques to be used in the workshops. This prepared me to better understand and appreciate their mechanisms of action while making informed hypotheses. Moreover, each workshop's focus was largely inspired by my observations in the hospitals/clinics, my conversations with the doctors, their colleagues and generally, findings from my fieldwork. The feedback from preliminary workshops were also used to inform the structure and content of the subsequent ones.

This thesis, all together, assembles ethnographic data that provide evidence that female physicians in Accra have unique experiences that impact their well-being. The thesis also raises arguments in support of the use of theatre and arts-based practices as well-being interventions. In Chapter one, I will describe the issues female physicians face in Accra and how these issues affect their well-being. Chapter two explores the impact of the theatre workshops on the female physicians. In this chapter, readers are introduced to the embodied practices used in the workshops. They will also observe snippets of theatre in action and find an analysis of the effectiveness of these embodied practices in facilitating female physician well-being. Finally, the conclusion envisions the future of these theatre workshops in Accra; their sustainable use by

female physicians and also the possibility of these workshops serving other groups of people in Accra.

Ultimately, by committing to this study, I have expanded on my knowledge of the health system in Ghana and the complex female physician lifestyle in urban Accra. The process has also further enhanced my appreciation for the role of female doctors in society and the potential of theatre (and the arts in general) to serve as avenues to discuss and facilitate health, healing and well-being. Finally, this research project offers a theatre-based workshop model for facilitating well-being that could be utilized by female physicians in Accra like Yaa, other doctors (in similar situations) and generally different groups of people facing well-being issues.

FEMALE PHYSICIAN WELL-BEING

INTRODUCTION: First Day

I walked into the Lekma Hospital lobby and immediately noticed how packed the multipurpose space was. The cashier's office was a few feet to the right of the large glass doors that welcomed visitors; and the small pharmacy that catered to the entire outpatient department was situated in a corner, left of the entrance. The nursing station, on the other hand, was directly in the center of the lobby. With this open-structure, all activities were on display: vitals checks, nurses leisurely re-arranging patient charts, others attentively following the telenovela playing on the mounted TV screens, and lots of chatter. I chuckled at the intricate and compact arrangement of the metal chairs in rows and columns; a classic marker of public healthcare spaces in urban Ghana. Individuals also skillfully maneuvered through the tightly packed space with ease and familiarity.

Two dim corridors connected the lobby to the rest of the congested outpatient department; I walked into the left one. It was lined on opposite sides by patients (some seated and others standing), many of whom stared at me as I walked further down the narrow hall. Their gazes were piercing, yet everyone sat still and only stared without confrontation. Was it the white coat I wore, or did I just look unfamiliar to most of these people whom I would later learn were regular patients? Did I look too young to be in a white coat? These and other questions flooded my brain. The mild heat coupled with the mix of unique sounds suddenly become apparent and intensified my growing discomfort: wailing babies, loud conversations, cacophonous sounds from old fans and very often, the dragged footsteps of both patients and nurses.

I walked into the third room on the left past the previous green doors. I thought it looked familiar. I was, however, surprised to find another female physician that I did not know (but later learned to be a physician assistant) with a younger female patient, and student nurse. All three women stared at me blankly. I quickly asked the older female lady in the white coat if she knew Dr. Ankamah's consulting room. "Room 10!" she sternly replied. I thanked her and quietly closed the door.

On my way out, I bumped into a young female who asked me if I needed anything. She wore a green uniform with a single white band around the arm of the dress like the other nursing students. She probably noticed the embarrassment plastered on my face or sensed an aura of confusion. "I'm looking for Dr. Ankamah. What consulting room is she in today?" I asked. She seemed very enthusiastic to assist me in a way that felt almost forced, but made me feel special. We engaged in brief conversation until we parted ways at the mystery Room 10.

Room 10

Dr. Ankamah asked me about any challenges I had in getting to the hospital. It was my third time ever driving to the Lekma Hospital that day. The route felt familiar from my visits the previous year, but the unpaved roads that led to the hospital - and supposedly under construction- seemed to have gotten worse.

Dr. A: "Ah, Maame is it a nurse that brought you here or Janet told you which room I'll be in? Dr. Ankamah began.

M: "Nah a nurse brought me. I thought you were in Room 6 like last time."

Dr. A: "No o. We don't have our own rooms. It's based on what's available. Wait! Did the nurse ask you questions?" she inquired.

Dr. A: "A little. She was just saying that she hasn't seen me around before. I told her I'll be working with you and a couple other doctors. But she didn't get to ask more questions because I came straight inside."

M: "Ah. Some of these nurses! Instead of them actually doing their jobs, they just want an opportunity to chat and gossip. I'm sure it was one of the lazy ones. I've asked them not to assign me any nurse again because they don't know anything. They come and s---"

Our conversation was abruptly interrupted when a patient barged through the door of the small room, sending in a surge of hot air and a wave of riotous chatting from the hallways into the cool air and loud humming of the consulting room. The patient had not yet been called. Dr. Ankamah asked the middle-aged man in a T-shirt and khakis to wait outside till his turn.

"Everyone wants to be seen when they want." She checked her phone and sighed, "And it's only 10 a.m."

•••••

The patient to physician ratio in the Ghana[12] has a serious impact on how physicians must work to accommodate these demands. This ratio is moreover exacerbated in public healthcare, thus, physicians like Dr. Ankamah must cater to an overwhelming number of patients at a rate that sharply contrasts to that of private clinics and hospitals in Accra. Most of the public hospitals in Accra which are already understaffed, operate under the Ghana National Health Insurance scheme. For a subsidized annual cost (typically ranging from 7.2 GhC [$1.45] for the "very poor" to 48 GhC [$9.64] for the "very rich") (Blanchet et al., 2012), the insurance plan allows patients to receive most forms of care including medication, consults with specialists, and some surgical procedures[13]. The Lekma Hospital in Teshie, where Dr. Ankamah

[12] The nationwide physician to patient ratio in Ghana is 1: 7,374. In 2017, the doctor to patient ratio for the Greater Accra region was estimated to be 1: 3,052 (Ghana Health Service, 2018).

[13] See Ghana National Health Insurance Scheme Website: http://www.nhis.gov.gh/Default.aspx

works part-time, also operates under this policy. Teshie is a coastal town in the Ledzokuku-Krowor Municipal District, in the southeastern Greater Accra Region of Ghana. The hospital caters to a large number of people from the Ga tribe[14], as well as residents of Teshie, neighboring suburbs in the district and the nearby fishing communities. This government-owned health facility was built in 2010 by the Chinese Government as part of efforts to strengthen the collateral ties between the two nations.

From my very first encounter on the field, I observed how the structures of the public health system, and the relationships embedded in it may facilitate or inhibit the female physician's well-being. My visit illustrates many of the themes of this chapter: the overburdened healthcare system, the complex interactions and relationships within clinical spaces, the unpredictability and improvisation of such healthcare spaces, and the palpable sense of tension and exhaustion of female doctors trying to practice medicine within these institutions. This chapter will also discuss the female physician's experience outside the clinical setting and overall how all these elements impact her well-being. I will moreover highlight snippets of the lives of Dr. Ankamah, Dr. Mantey and Dr. Ofei – the three young doctors I closely shadowed. This, together with information shared by other female physicians like Dr. Agyeman who contributed immensely over the course of this research, I attempt to present a ethnographic view of the female physician in Accra and most importantly, her well-being.

[14] The Ga ethnic group resides in the Southeastern part of Ghana including Greater Accra, Eastern and Volta regions. They speak the language, also called Ga – a dialect of the Kwa branch of Niger-Congo languages.

HEALTHCARE IN GHANA | The New & Complex

As a child, I remember visiting the Holy Trinity Hospital for basic health problems: fevers, blood tests, sprains and generally any health issue my parents deemed necessary for a hospital visit. The hospital was in walking distance from our home, so services were generally accessible for me and others who lived in the area. Holy Trinity Hospital catered to a wide demographic of the North Kaneshie[15] community, which in the late 1990s to early 2000s ranged from upper middle-class professionals to low-income hawkers. It was also one of the first private hospitals to be founded by Ghanaian(s) and as such, was highly regarded by residents of the area and neighboring suburbs. I often found this reverence for the hospital ironic. The low numbers of clinical staff, especially during the weekends and nights was one of the many problems that dampened its glory in my eyes.

Today, a lot has changed about the Holy Trinity Hospital. First, the facility has expanded to include more departments and medical services. The medium sized billboard at the front of the small hospital that used to read, "Holy Trinity Hospital", was changed to a larger one that now displays "Holy Trinity Medical Center". Similarly, the hospital's website shows pictures that advertise the modern labs and technologies that the hospital uses in attending patients. These changes are indicative of general improvements in the Ghanaian healthcare system.

However, not all residents may share in this appreciation of advances in Ghanaian healthcare. Other natives like my grandaunt, Ekua Budu, who served as a nurse practitioner in Ghana, U.K. and U.S.A for forty years often critiques the system and believes the developments,

[15] North Kaneshie is a suburb within the Accra Metropolitan district. It is also connects to the North industrial areas of Accra.

while necessary, have taken too long to arrive. It also common to find callers on local radio talk shows complaining about the healthcare system. Generally, there is the view that the advancement and new climate of healthcare in the country still struggles to address an increasing demand for care. These same progressions and challenges of the evolving healthcare scene in Ghana has arguably had an influence on the training and practice of female physicians in Accra.

Training

Since the inception of the University of Ghana Medical School, the pioneering institution has tried to maintain its pledge for gender balance in its admissions process. At least 25% of each incoming class is made up of female students, but this ratio is still very low[16]. In a survey[17] (See Appendix) I administered to female medical students across the country, a few of them believed that the lower numbers for women were probably due to the fact that "more [men] applied for the program" or as postulated by another student in her third year, "many ladies are intimidated by the rumors about the stress in the medical course and for the majority, they hate blood related stuffs." Another reported that, "Generally in every institution in the country more men are given opportunities cos it is assumed that they will be better at things."

Nonetheless, there was a popular view in the survey that the female to male ratio for medical students had drastically improved in the past few years. In the same survey, a

[16] See History of Medical School | School of Medicine and Dentistry for statistics: http://smd.ug.edu.gh/about/history-medical-school

[17] I administered an online survey to female medical students across the country through some friends. Fifty-seven respondents completed the survey.

participant noted that her class had a record number of 99 women vs. 111 men. Others explained these gradually balancing ratios with reasons including but not limited to, "Female empowerment and redefinition of self actualisation of women", "The medical system is now open to the idea of female doctors and as such the numbers are starting to even out" and "more opportunities are being created for females to become professionals."

Furthermore, the majority of the participants (22.8%) rated their stress level as an (8/10) as a general medical student, but a (9/10) as a female medical student. When asked about factors that could account for this minor difference, participants gave reasons alluding to some biological, cultural and social factors: putting in extra work to look presentable and composed; painful menstrual cycles; contemplating a "future life, juggling marriage and kids"; having aspirations for being in more competitive specialties like surgery; harassment and general lack of respect for women.

When I first looked at survey responses, the one-point difference in stress level ratings for general medical students as opposed to female medical students did not seem significant. It was only after reading the detailed explanations that I was able to appreciate the reasons behind the marginally varying reported average for stress levels. A particular participant's response was:

> As a female, you're still required to master a number of things in catering for a home thus juggling that with academic demands can be rather stress inducing (Student X, 5th year)

Another shared that:

> For me personally, I always have to strike a balance between being a student on weekdays, travelling home to the eastern region in order to take care of my dad since my mom passed, helping him out with house chores and cooking for him for the on weekends while at the same time, making time to learn either on the bus to and from Koforidua and sleeping for shorter hours even on weekends. Lastly I have

to make time for my fiancé and church activities as well. (Student X, 3rd year)

The survey showed that the female medical students attributed the varying social, cultural and biological demands of being a female in Ghana to factors impacting their well-being, stress and time. There was also the underlying theme of working the 'double shift'. The respondents felt that they take on more roles as a female, both in the educational setting, as well as at home than their male colleagues.

In an interview with Nancy[18], a friend and third-year student at School of Medical Sciences- KNUST, she emphasized the lack of educational facilities and poor structure in the medical school as one of her biggest challenges:

> Not only is it stressful to be in med school but sometimes, the professors and administration seem not to care. How can you not have gloves in the lab for a dissection? Common basic gloves must I provide those too myself? And some professors can feel so big. It's like they can't be challenged. Honestly, I'm so tired. (2018)

The financial challenges of the education system have been a recurring theme since the 1960s when the medical school first opened. The limited infrastructure and resources (both housing and educational) poses a challenge for the medical students. It hinders their progress in training and poses a barrier to their meeting of curriculum learning objectives. This further augments the stress and uncertainty of being in a medical program. Additionally, the intense hierarchy in the Ghana Medical system places these female physician in a double status of inferiority. For female medical students, the idea of being a second-class citizen in the medical

[18] Nancy is a pseudonym given to the interviewee to protect her identity and respect her wishes.

education realm is further heightened when they have very few women as professors or in positions of power.

It also became evident early in my fieldwork that the concept of well-being, while very familiar to these female medical students and physicians, was not a subject of priority unless it was their patients'. Dr. Mantey explained it best: "What time do you have to even think about your well-being when you have people to take care of ?" (Dr. Mantey, 2018) Recently, medical training in the U.S, Canada and other Western nations has gravitated towards the inclusion of seminars and courses that explore wellness and stress management in an attempt to curb the burnout that comes with medical practice (Lee & Graham, 2001; Dyrbye et al., 2005; Drolet & Rodgers, 2010; Haight et al., 2012). While the Ghanaian medical education does not prioritize this as much, attempts have been made to introduce the idea. Dr. Nana Ama Agyeman, for example, mentioned that at one point during her time in medical school, the school organized a talk about stress and wellness for her class. She added that although it happened just once, she still recognized the effort.

Students like Nancy and the participants of my survey have ways to deal with stress and ensure positive well-being while in medical school, even if it is not formally explored within the confines of their education. In the same survey for female medical students, participants said music, church events, sleep, cooking, watching television/movies and engaging in some social activity (just to a name a few) were their ways of dealing with stress from school and/or maintain positive emotional and mental health.

Dr. Agyeman also re-echoed this sentiment about the commonness and variability in maintaining well-being amidst the stress and frustrations of medical school:

> I mean, back then everyone found a way of dealing with the stress. I mean you have to. Like, the guys would play soccer on Fridays, some girls too will just hang or do something to chill. Some people liked catching up on series as a way of relaxing. It really depends. I know some people who were really into church will go for programs. So, yes, even though it wasn't formally incorporated in the curriculum, they tried to with that one talk. But, besides that everyone had their own way of de-stressing. (2018)

Practice

A lot of the infrastructural and financial challenges hinted above do not end at the educational stages of the medical journey. As a matter of fact, all medical graduates are likely to face these challenges as they navigate their way through the different stages of physician levels (see Appendix for Physician Progress Chart). However, the more levels these physicians attain, the more the challenges become gender-nuanced.

Money, for example, is an issue for most of these doctors. The average salaries of doctors in Ghana is about $GHS 41,561 [~ $8,500[19]], though specific salaries vary with specialization, seniority, and place of practice. A medical officer will make ~ GHS 24,000 [~ $12,250], whereas as an anesthesia specialist could make GHS 281,000 [~ $57,350] ("Ghana | 2017/18 Average Salary Survey", 2018)[20]. Besides the level of training that can influence physician salaries, other factors that can impact a physician's finances include full-time vs part-time opportunities and working in the private vs public sectors. Locum is a term (usually an abbreviated form of

[19] The dollar to Ghana cedi exchange rate as of December 2018 was $1: GHS 4.9

[20] The lucrative professions in Ghana are now in finance and business. However, private practice healthcare can be financially rewarding. Also, although physician salaries in Ghana significantly fall below the global average, the M.D. title holds cultural capital.

locum-tenens) often used in healthcare for persons that work in place of other staff due to staffing issues, sabbaticals, furloughs and employee shortages. In Accra, locum has become a very common approach for doctors to make ends meet. The male medical officers I briefly interacted with had two or three locum jobs. One of them said he had some non-health related side business. Typically, these 'other' ventures range from owning a mini supermarket to serving as consultants to pharmaceuticals or some type of trade they could use to supplement their financial stores. Locum-tenen medicine in Accra could thus be viewed as a side-hustle and a way of survival.

I discovered during my fieldwork that female physicians were less likely to engage in a couple or more locums as compared to men. Only two of the female physicians I interacted through the research process, participated in locum. "Typically the men do more locum. They are able to [work] straight for 24 hours to raise money for cars, marriages etc." (Dr. M, 2018) Physicians who do multiple locum jobs, trade in long hours of work, for better salaries despite the fatigue associated with managing the additional roles. During my fieldwork, I had conversations with different physicians some of which were family and friends who shared similar views about why I should never practice medicine in Ghana, should I continue on the pre-medical path. The main reason being that the financial returns of practicing medicine in Ghana are unsatisfactory and well-below the global standards.

Again, there are base-line challenges like limited infrastructure and resources that all physicians in Ghana deal with. However, the more levels these physicians attain post-medical school, the more the challenges become gender-nuanced. I had an interview with Dr. Adjoa

Ofei[21] that captures the general challenges of most young physicians in Accra, but especially affect female physicians.

Dr. Ofei decided on Anesthesiology while in medical school because she wanted a work-life balance but also a specialty that would allow her to be in the operating room. Unfortunately, she had to go through many bureaucratic processes to ensure that she would be placed in this trajectory of medicine. Firstly, It took her a year to get her medical officer Anesthesiology posting approved; an administrative procedure that should have taken at most a month:

> Maame, the first issue was that Anesthesiology wasn't even an option to check on the M.O. [Medical Officer] posting form! Can you believe? When I went to the head office, the secretary, front desk lady, or whoever she was, told me that they had a printing issue and that I could have just written Anesthesiology on the bottom [she said as she passionately acted out the scene] (Dr. Ofei, 2018).

This organizational problem Dr. Ofei faced is rather common for many new physicians in Ghana. Her experience highlights the inconsistencies within healthcare administration and management for the public sector in Accra. In that same interview, Dr. Ofei compared the disorganization of the placement office that handles the medical officer postings to a similar problem she was facing in her Anesthesiology department.

Dr. O: "All these people who handle administration for medical stuff, I don't understand why they can't just do it right. There is always one problem or the other. I hadn't been paid for the last three months, and each time I went there they would have an excuse. You didn't complete a form. Go here, go there. Meanwhile when it's exactly 5 o'clock, they'll be packing that they are going home. Some of us have to be here all night sometimes."

M: "Wait, so what did you do?"

[21] Dr. Adjoa Ofei is a third-year medical officer planning to specialize in Anesthesiology. She was also one of the main physicians I shadowed.

Dr. O: “Ah, I went to get my money. There was one guy who actually explained the backlog to me. It had something to do with how anesthesia is basically under the surgery department, and all departments are handled by the main administrative [office]. This back-and-forth is one of the main reasons why cardio decided to be on their own, and they are thriving. Sometimes, the politics is too much, because the department… and the department heads want to be heard and recognized”.

Dr. O: “And it seems every time, you need to ask for a favor to get things done. This particular guy who helped me figure things out, at first when I would come to the office he would make flirty remarks, ‘Obroni Kooko[22]’, ‘Ahuofe[23]’, those annoying things. Like, how is my beauty … where does it factor into the fact that I am still not getting paid. And obviously too you have to play along a bit or else they will make things more difficult for you, because you’ll be seen as tooknown[24] I think someone in the office also knew my dad. You know how these things are… like how the nurses were asking, ‘How is Prof?’ So that one too may have made it easier. I don’t even know. But this guy, I don’t know if he thought I’ll give him my number or what.”

Figure 1.1. Dr. Ofei expressing her frustrations with some aspects of her job

Female physicians may find themselves in unsafe and challenging positions when they inhabit spaces with men who use sexually provocative language around them, make grossly

[22] Obroni Kooko is a compliment in Twi given to light-skinned people. The words translate to ‘Fair White Person’ in English.

[23] Ahuofe means ‘Beautiful’ in Twi.

[24] ‘Tooknown’ is Ghanaian slang for arrogant or pompous.

inappropriate actions (i.e. fondling thighs), give inappropriate gifts or have expectations of them beyond their professional duties (Phillips & Schneider, 1993). In some cases, as hinted by Dr. Ofei, they may be seen as arrogant when they do not give into these expectations and demands. It becomes even more frustrating to work when the female physicians are harassed by co-workers and patients who make suggestive gestures and pass sexually inappropriate comments. The normal hierarchy (where administrators defer to the doctors) is thus often overturned when the doctor is a young female. I argue that the harassment female physicians in Accra experience invalidates the power inherent in being a physician; it negates their achievements and unfairly relegates them to an identity that is limited to their biological makeup and gender constructs.

Another challenge of working as a female physician in Accra is the ability to network. Their access to opportunities and likeliness to be respected is significantly affected depending on who they know. A male colleague of Dr. Ofei argued that in some cases women were better at networking because they could use their beauty to lobby. He also, however, noted that women "may not be taken seriously" (Dr. Ansah,[25] 2018) merely because of the associations of fragility made with the female gender. The networking scene within Ghanaian medicine can to a large extent mitigate some barriers to well-being because it is deeply rooted in favoritism and nepotism. Dr. Ofei noted during our conversation that if she knew the head of the organization in charge of the medical officer postings she could have avoided the stress from the bureaucratic demands or inappropriate treatments received during the process. Dr. Ofei who is

[25] A pseudonym was used to protect his identity.

also a second-generation doctor actually admitted in the interview that the process to securing her medical officer position in Anesthesiology may have taken longer, or not have happened at all if she had not asked her father, a revered pediatric doctor and former dean at the University of Ghana Medical School, to make some calls.

Above all this, I observed that the conversations I had with Dr. Ofei did two things; it gave her time and space to vent. It also pushed her to relive those events and situations that have impacted her emotional, mental and physical well-being. When we finally got to talking about her well-being, Dr. Ofei mentioned that sleep was a frequent issue for her. She had gotten used to not getting enough sleep to the point where she was no longer concerned about how it will affect her performance at work. She did, however, point out that there had been a couple of times when she got dizzy and had to go home. She also related the sleep challenges to having a lot of things on her mind, (both personal and professional).

Generally, physicians in Accra, especially those who work in the public sector or high stress specialties, must find a way to mitigate the potential consequences of the stress, demands and uncertainty of the profession. Moreover, female physicians like Dr. Ofei must also deal with the expectations and perceptions of females in this male-dominated field. They must find ways to navigate advances from men in and outside the hospital, and they must also deal with repercussions when they do not succumb to the demands of such men. There also seems to be an added responsibility to respond well to multiple roles, even if it makes them feel uncomfortable. These expectations are often related to beauty, the traditional view that they should stay at home, and that they should show submissive and endearing traits. They are

likely to face distress in their emotional and mental well-being if they find it hard to reconcile these expectations with their own desires.

GENDER, SOCIETY & CULTURE

In the patriarchal Ghanaian society, women are commonly viewed as caretakers of the home. However, with the increasing modernization and commercialization, gender roles within households in Ghana are evolving. Some women are now breadwinners of the home and/or self-providers, be it by circumstance or choice(Ardayfio-Schandorf, 1996). Traditionally, women were expected to cook, clean, raise the children, while the men labored to provide for the household (Randriamaro, 2006; Momsen and Kinnaird, 1993). Using data from Ghana Living Standards Survey, Haddad (1991) argued that on average women in Ghana spent ~20% more hours in contributing to the home. The multiple roles played by women in supporting the home could explain their longer work hours (Oduro 1992). Scholars like Agyeman-Barwuah could, however, argue that women with resources to hire *househelps*[27] actually significantly reduce their household responsibilities and could therefore focus their energy in other personal ventures (Agyeman-Barwuah, 1983). Nevertheless, the role perception of female dynamic is variable and changing in the urban Ghanaian setting.

For many of the young female doctors I interviewed (most of whom were single and in their late 20s to early 30s), many of their worries both professionally and individually were tied to traditional expectations of women; expectations they had for themselves and also those that society imposed on them. In the paragraphs to follow, I analyze three conversations: a dialogue between a male worker (at my family house) and my cousin, an interview with a young male

physician at a private clinic and finally an end-of-work debriefing with a female physician. I use these ethnographic anecdotes to highlight how despite the evolving perception of women's roles in Ghanaian society, the typical view of them as caretakers, submissive, emotional and dependent (Shapiro, 1981:448) still remain at the core of gender ideologies in 21st century. Moreover, by breaking down these conversations, I extrapolate potential factors that affect the well-being of female physicians.

*****

July 22nd, McCarthy Hill-Accra

It was a sunny Sunday afternoon but the breeze through the McCarthy Hill (a suburb, west on the outskirts of Accra) masked the intensity of the intense July heat. I was in the backyard of my house with my cousin who was preparing fufu[26] with twenty-five year old Philip (one of the male staff) male *househelp*[27]. Philip pounded the fufu dough with a consistent, rhythmic force whilst my cousin, Jewel, skillfully turned the fufu while simultaneously maintaining a conversation with me about the influence of churches in decision-making about marriage and domestic abuse. Philip, who pretended to concentrate on his fufu pounding, was in fact paying keen attention to our conversation. My cousin passionately proclaimed that she would beat her husband back if he were to ever lay his hands on her. A declaration that caused

[26] Fufu is a staple Akan dish made by pounding a variety of root tubers and starches including unripe plantain, cassava, cocoyam, etc and is often served some type of soup. Although it is originally an Akan dish, it is eaten by people of other ethnic groups.It is also eaten by various tribes across West Africa.

[27] It is common to find house staff in many homes in Accra who help with cleaning, cooking and/or gardening. Typically they will be referred to as "househelps" and may live in the homes or commute daily to the homes in which they work.

Philip to giggle and gave him entry into the conversation. Philip who claims to have been a pastor prior to working at our house had some opposing views.

J: So, I should sit there for him to beat till I die.

P: If he beats you its ok. Maybe you have upset him and the husband is supposed to lead the *home.*

J: So why should an educated woman like myself sit down for a man to beat me. In most cases, these woman can probably even be the ones providing income for the household…. Why should she stay in a home where she is abused.

P: No…. You see the Bible says you have the man is the head of the house. So you have to make him also happy. Men should love their wives but wives should submit. So, maybe you've done something to make him upset, that is why he might hit you. But you shouldn't leave or fight him back.

J: Wow, so you would hit your wife?

P: No, but maybe if she's done something to upset me and that happens, we have to look into why that happened and work it out…

J: [giggles] Wow. Ok. As for me I won't sit down for any man to come and abuse me. The Bible also asks the man to lead the household and protect the wife, and not beat her if something is wrong.

Philip's response was very upsetting to both my cousin and me, yet it was not entirely surprising considering many domestic abuse cases have been backed by a misinterpretation of religious scripture or the cultural reverence of male figures in Ghanaian society. This particular situation was reflective of a common and unfortunate view that religiously and culturally, women must be submissive to men even at the expense of their emotional and physical well-being. We find these broad strokes of patriarchy not only in social spaces but also professional ones as well. In an interview with a male physician at a private clinic in Accra, he admitted that he preferred working with female physicians because they were more likely to be receptive to his treatment plans when group decisions had to be made about a patient's diagnosis. Even at

the hospital, there is still the expectation that women must be dependent and have an opinion secondary to the male figure.

May 28th, 2018 in Dr. Aja's (male physician) Consulting Room at a neighborhood clinic.

M: As someone who works with female physicians and has friends that are female physicians what do you think affects their well-being, emotional , physical…?

Dr. Aja: I mean we all have work stress so that one it varies from person to person. So the women they can just work their six hours for the day and be done. They normally have to deal more with the home stuff… so if they are married and stuff that takes a lot of their time…. Also, first of all, I think they always have that whole relationship stress. It's a stress. You know….They'll probably be thinking that this person is coming to date me because of my title… and those I know who are married, sometimes marital issues and stuff… [Also] the most I always find with female physicians is that at some point in time they are not sure if they want to go [abroad] or stay. Especially because they are not sure if they go outside they are gonna start a whole new life there… you know meet someone to marry… or [if] they are [already] dating someone here….

M: So male physicians, don't have these thoughts?

Dr. Aja: [laughs] Oh men. At the age of 50 they can even marry… you know what I'm saying? So for the male doctors it's not a real stress… because for a man anyone he gets, once he gets a good female to suit him. He's good to go. But for a female, she can't just make those decisions unless you have an accommodating partner.

I noticed during my fieldwork that external views (from men like Dr. Aja referenced above) on female physician lifestyle and well-being followed a trend; most external subjects assumed sociocultural factors, like marriage, familial duties, etc. were the main factors that impacted female physician well-being. These external views often took for granted the gravity of occupational factors on the well-being of female physician. In some cases, female physicians

were assumed to work less than male physicians on the basis that they had some kind of family demands or were being taken care by a husband or father figure.

Most men in Accra assume that female physicians are less stressed out by their jobs since they have less responsibility or work less then male physicians. Even in the medical arena, the idea of a "female doctor" is still unsettling to some Ghanaians. It is as though women only practice medicine as a hobby on the side to their domestic roles as wives, mothers and daughters.

While some, certainly not most, of these external perceptions of female physician well-being aligned with the opinions of female physicians themselves, the professional factors such as the work atmosphere and colleague relations were equally as significant in impacting well-being for these female physicians. Below, I analyze the factors that impact female physician well-being from the stance of a female physician.

June 28th 2018 in the Hospital Parking Lot with Dr. Ankamah.

Dr. Ankamah had just ended her morning shift. This debriefing session began outside her consulting room as we walked outside to her car:

Dr. A: "Oh yes. People always ask? Am I getting married. Even my patients. There's this pressure to get married from everyone, my family, everyone….They like to say the whole time is not on your side, your biological clock is ticking….Sometimes I get sad ...I'm like ei am I a failure? I've always wanted to do public health …. but I don't really have anything going on now. My plan was by now I should be in a program … so I'm either in a program in Ghana or I'm doing my masters [abroad] .I'm not doing both, me aaa I'm not married, so what am I doing …. I don't know… it makes me very sad and I overthink. Sometimes, I just fall into some temptations bi that I regret. It makes me very sad but I've realized that I can't help it, the things that I can't do anything about, I just pray to God about it. Well, because I've

realized that prayer works, so that's what I'm doing about it. [But] God said we should trust Him so I'm trusting him..[giggles]"

In the excerpt above it can be observed that marriage carries significant weight in the lives of younger female physicians. For those who are already married, having children and serving as a good wife became the sociocultural milestones they hope to achieve. Generally, the pressure to meet societal and personal goals for female physicians in Ghana, in addition to the high stress work environment can negatively impact their mental and emotional well-being. Like Dr. Ankamah, other female physicians can spend a substantial amount of mental and emotional energy worrying about the cultural expectations of women, in addition to the professional goals they have set for themselves. All the while they must navigate how gender sometimes works in Ghana; one aspect of which is being viewed as a nurse in the hospital.

M: "Do you always not wear your white coat?"

Dr. A: "We wear the white coat. So you might want to ask them [patients], have you seen a nurse in a white coat before? They'll call you a nurse. Till [this day] when I walk around the wards they call me a nurse. So I don't like wearing my coat unless I'm in wards. Well not even that, I get hot so I don't like wearing it."

M: "How are your relationships in the hospital like? I noticed the nurses are nice. They're always saying hi to me. I'm not sure if it's because they think I'm a doctor."

Dr. A: "Yes, the nurses and the PA's they are nice. They can be nice. However, I don't like the nurses here because they are not smart…Most the nurses assigned to me, I fight with them. So they are supposed to come and assist you because you know this hospital has a lot of patients… The nurses who are supposed to assist us are not smart. They cannot spell… this particular nurse I had today, I sent her back to the nurse station. She's not serious. She came without a pen knowing very well that she has to write down the medication as I type up the charts."

In his book, *Women and Development in Africa: How Gender Work*s, economist Michael Kevane argues that labor is stratified based on gender and in many African societies, it is rare for a man or woman to cross occupational boundaries (Kevane, 2004). The presence of female physicians in 21st century Accra in some situations can be considered as the "rare" Kevan (2004) mentions in his book. Certain social classes and or cultural groups in Ghana place great value on the gendered stratification of societal roles. Female physicians working in environments with such people are likely to be referred to as nurses, even when they are wearing their white coats. In such cases, the woman in health service must be a nurse, a cleaner or anything but a doctor, because doctors are typically men. Also, age does not seem to be factor in this gendered association; older female physicians who are specialists also report occasionally being called nurses. Female physician assistants who also wear the white coat are equally not exempt from the nurse title.

I suppose that many of these gendered identity mistakes are likely to be made by patients who are staunch supporters of traditional gendered ideologies rather than others who taken on more liberal view on gender and labor. Usually, younger generations and individuals who have attained higher levels of education are more likely to acknowledge that female physicians and women in white coats are not nurses. This misconception bothers some more than others. Dr. Agyei-Smart, who specializes in Obstetrics and Gynecology noted that even as a senior specialist and director of a OB-GYN department, she occasionally gets called 'nurse'. At this stage in her career she added that it does not irk her as it used to when she was a younger physician mainly because she associates the mistake with ignorance.

Others, like Dr. Ankamah, carry a lot of anger and irritation from these instances throughout their working day. Not only does being called a nurse upset them, but it may also affect their relationship with patients and other staff. The title, "nurse" applied to them triggers a range of negative emotions, including anger, disappointment and resentment that are unhealthy for a work environment. I anticipate this may create and/or reinforce tension between female physicians and their nurse counterparts. Dr. Ankamah's frustrations on being called a nurse stems from her dissatisfaction of having the length and rigor of her education unacknowledged. When nurses (like the one she was assigned to in the excerpt above) act below her expectations, she is more likely to enhance her associations between nurses and poor work.

Indeed, when some staff members fail to complete their tasks, the workload must be taken up by other staff to keep the system running. This system of inefficiency accounts for one of the many professional factors that influence female physician well-being. At the public hospital, Dr. Ankamah works with a patient records and accounting system that is meant to be paperless but requires medication prescriptions to be written on paper. She, therefore, uses both an electronic and paper-based system when working and this makes her job more tedious and cumbersome. Some nurses are assigned to the consulting room to ease the physician's work by taking charge of the prescription writing. However, when these nurses cannot spell certain drugs, as implied by Dr. Ankamah, or lack knowledge in that area, the physicians in such public hospitals end up diagnosing, typing up charts, and writing prescriptions - all under a time crunch.

> The [nurses] here like speaking Twi[28]. That's what I don't like about them… they can be unprofessional. So yes, they also add to my stress. (Dr. Ankamah)

On the other hand, nurses and other staff can be very helpful for many of these female physicians by acting beyond their professional duties. They sometimes run minor errands for the physicians or serve as local language translators between physicians and patients when the need arises. They therefore also help minimize the intensity of some stressors of these physicians, which otherwise would negatively impact their overall well-being. Moreover, depending on the type of clinical facility (public vs private), the social dynamics of the place and individual personalities, female physicians and nurses can have supportive relationships and work as allies.

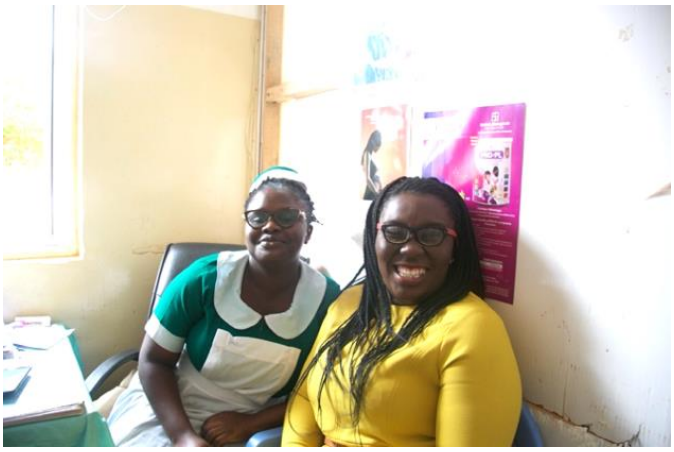

Image 1.2. Dr. Mantey posing with one of her favorite nurses at the public hospital she works at.

[28] Twi is a dialect of the Akan language in Ghana. It is considered as the most widely spoken language in the country.

STRATEGIES

Female physicians have developed individual ways of coping with their challenges. I observed during my fieldwork that sociocultural and personal expectations when not met could induce doubt, fear and a general dissatisfaction in their lives. However, meeting such goals improved the female physician's sense of satisfaction and could induce positive moods. Since spirituality and religion play an important role in Ghanaian society, it was common to find many of these female physicians of varied ages referring to their religious faith as an element of hope, peace and an instrumental part of their well-being.

Another interesting approach female physicians use in re-affirming their positions in life and expressing gratitude for the their physical, emotional and mental states is by making a schadenfreude comparative analysis with other women in their environment.

> There's this girl at the private clinic I work at and when I listen to her story, I know that my situation is even better. She's the branch manager actually. She's in her 30s. She had fibroids which degenerated in her body. She was also dating some man bi that likes koloms [a man that likes messing around]. You know, she thinks she's also growing old, so any man that comes she'll just take them. She also said she's been having unprotected sex and never gotten pregnant. So that's something we also have to look into in case conceiving is going to be an issue. (Dr. Ankamah, 2018)

This schadenfreude comparative approach seems to occur at different stages and levels of female physician-ship. In a conversation with Dr. Agyeman who was in the process of planning her wedding that summer, she noted that many of her married counterparts often joked about how they [single and/or unmarried female physicians] "had fallen behind because they had not yet married nor had kids." This web of comparison, therefore, serves as a transient antidote to

self-doubt and unhappiness. It enforces self-positivity by acknowledging the failures of others in similar social, gender and cultural classes; an unfortunate reflection of the tension and doubt within female relations as influenced by this web of comparisons.

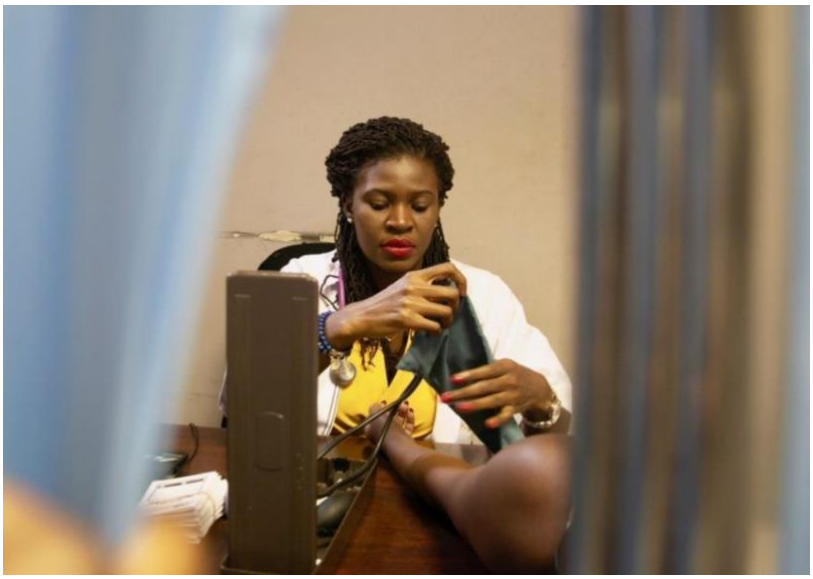

Image 1.3. Dr. Ankamah attending to a patient at a private clinic.

Another challenge female physicians have to deal with, as noted earlier in this chapter, is the disconcerting romantic advances and pressures from others asking for favors. Physicians in Ghana are perceived to have the capacity to support others, be it financially, emotionally, and of course, medically. As a result, patients may request the personal numbers of their doctors. Doctors might give in to this request if they see it as having a transactional benefit for the future, or simply out of compassion and care. Dr. Ankamah for example has a personalized system of on how to control the distribution of her personal cell phone number.

Dr. A: Yes, some patients have my personal number. Maybe I'm being biased but I just look at you and decide…. Mostly for the [public hospital] patients, no I hardly give out my number. But for the private clinic I work at… you know there are polished people and all that, so sometimes I give my

number. Some of them, you know know … maybe in the future they can help…Some patients also just call to show appreciation or to have an idea of when I'll be working. So calling isn't really a problem because I can block you…. [M: Do you block people sometimes?] Oh yes I block people. How can you be calling me twice, three times, at dawn? I'll block you especially if it's for unnecessary things.

She also added that some patients who crush on the female doctors could go as far as getting their numbers from other staff in the hospital or clinic. The harassment some of these female physicians may receive could make their work very difficult as they try to maintain a balance of a healthy work and personal environment. Setting professional and personal boundaries has, therefore, served as an effective tool for managing these professional and personal spaces that in turn affect their overall well-being.

Despite some of the socioeconomic challenges explored earlier in this chapter, motivation and a desire to help others remains at the core of medical work. In the survey filled out by female medical students, the most popular reasons for pursuing medicine pivot around ideologies of service and compassion. 70.2% of the participants chose "Help others" and 47.4% chose "To support my community" as the primary reasons to pursue medicine. Some strangers I briefly interacted with during my time in the field alluded to a feminine compassion that many Ghanaians associate culturally to woman. I witnessed this same compassion and care during a consult between Dr. Mantey and older female patient (~ sixty years old). After reviewing her lab results, Dr. Mantey uncomfortably broke the news to the patient that she had HIV. She gently rubbed the patient's back as she wept all the while reassuring of the possibility of a stable future.

As described by Dr. Mantey, "sometimes the job gets so stressful. How do you tell someone something like this…but you have to be that person for them [patients]", perhaps even before their loved ones can take on those caretaker roles. Many of the female physicians I interacted with gestured towards how a recollection of the benevolence within medicine, through their work experiences cushions professional tensions and restores a psychological balance. For Dr. Ankamah she believed that it was important to remember that she was helping people, or else "[she'll] go mad" from the unpleasable aspects of the job. Similarly, a moving moment like the one between Dr. Mantey and her patient may every so often equilibrate negative thoughts and feelings for these physicians.

SPACE: A WELL-BEING FACTOR

In her article "Analysing wellbeing: a framework for development practice" (2010) Sarah White, a sociologist of international development and wellbeing, argues that space is fundamental to well-being (pg.166). According to White, "People's understandings of and [their] capacities to achieve wellbeing depend critically on the geography of the space they are in" (pg. 166) although this occurs in variable ways. By also recognizing that different places have multi-dimensional cultural, historical and political influences (Rodman 1992: 641), we can also appreciate that the embodiment of these places are dynamic.

The kind of professional setting in which the female physician works can contribute positively or negatively to her well-being. Hospitals attend to more patients than clinics and are likely to have physicians working more hours and/or doing more tasks to accommodate the number of patients. Similarly, the privatization of medical institutions, including the policies

and infrastructure within them could impact the female physician's well-being. In Ghana, public health institutions particularly cater to a tremendous amount of patients as opposed to private health institutions (which are often clinics). Dr. Mantey who works in both the private practice and public service describes a notable difference in her day as she navigates between both environments:

Dr. M: I start my shift at 7am at Lekma (the public hospital) and end around noon. Then I head over to the private clinic in my area I work out. The first difference is the numbers. At Lekma I see so many patients. Sometimes I don't even get a break to pee or take a breath before my shift there ends. So by the time, I start my shift at North Legon clinic I can be so exhausted. Because the clinic is also in a good neighborhood and is less busy, I kinda use that time to gather myself a bit, because it's also a long shift. Also because I live in [that same] area, even when my shift ends at 9 in the evening, they can call me after hours if there's an emergency…. even though they don't pay me extra. But what can you do? When it happens you just have to go and it can be so annoying, coz I feel like they take advantage of [the fact that I live nearby]… But my worst days are when the clinic also gets busy because I don't even get to take a look at my phone till it's like 8pm...Yes, it can be that bad. These past couple of weeks have been so bad. I don't know if there's something going around but so many people have been sick.

Although medical work in the private sector is typically seen as the less stressful option compared to the public sector, they can both present different demands as that have varing impacts on Dr. Mantey's well-being.

Besides the clinical setting, social spaces can have varying impact on these female physicians. An older female physician I spoke to who works at a major public hospital in Accra credited her success in managing life as a mother, wife and doctor to support from family. She noted that she tries as much as possible to separate work from home, and such being at home and spending time with family has become a relaxing atmosphere and avenue for happiness. On the other hand, a younger female physician I spoke to mentioned that she had to move out

from her parents' home because she was being given household chores that she didn't like and would add to her stress from work. Typically in Ghana, younger women live in their family homes until they get married. Some women who may have the financial means to live on their own, like these physicians, may choose to still stay at home to save money.

Overall, I found that many of these female physicians were significantly affected by their spaces: spaces with an absence or presence of a group of people, spaces that embodied a mood or had specific artifacts. Dr. Ofei, for example, is a fan of artistic work and so loves to indulge in creative activities for fun. Dr. Ankamah, on the other hand, views her car as a safe space that allows her to "escape the troubles of her life and unnecessary stress". Space for these female physicians is crucial because the different environments they inhabit, contain elements (people, objects, rules, energies, etc.) that improve or hinder their well-being; and most of my female physician participants were well aware of the impact various spaces had on their well-being.

The female physician well-being is variable and multidimensional as illuminated in this chapter. Now, having explored how historical, sociopolitical, and cultural factors affect female physician well-being, the next chapters of this thesis will examine the more formal and collective approaches to coping using theatre as the avenue for exploration.

THEATRE WORKSHOPS AS WELL-BEING INTERVENTIONS

INTRODUCTION: A New Theatre

Workshop 2

Crystal: Te te te te te te te ta

Audience: Te te te te te te te ta

Crystal: Ge ga ge ga ge ga ge ga

Audience: Ge ga ge ga ge ga ge ga [a participant giggles as the voice exercises continues]

We were 20 minutes into the workshop (way past the warmup exercises), when Dr. Olusegun[29] joined us on our multi-purpose stage. Normally, I would have taken part in the activities but on this day, I did not. I was engrossed in the laughter and excitement that filled the air. My intention was to take notes. However, I was fascinated by the scene that opened before me: a theatre-based game had turned young women into little girls gleefully hopping and skipping around in repeated loops. The mood of these *big girls* had completely changed from when they first came in. Fingers that had tightly held on to handbags as they hurriedly walked in were now loose and moving fluidly. Fatigued faces turned into silly expressions. The aura of irritation that surrounded Dr. Ofei seemed to have dissipated into the light Accra nighttime breeze. Moreover, I was even more fascinated by how quickly Dr. Olusegun picked up on the game.

[29] This doctor has been given a pseudonym to protect her identity.

The encounter above embodies much of what this chapter is about: exploring creativity, experimenting with theatre-based interventions, varying emotional moments, unravelling truths, and an unspoken desire for change.

This chapter analyzes the theatre workshops and their effectiveness in promoting well-being. Most workshops, if not all, manifested laughter, intimacy, courage and relief. Yet, the same feelings of uncertainty and discomfort that characterize the clinical and social spaces these female physicians inhabit, were also present. The workshops, moreover, did not only have a therapeutic goal but also initiated conversations about stressors that impact the participants' well-being. The workshops thus became an embodiment of the lives of the participants. While the intention was to devise the perfect workshop model, in retrospect it was an impossible goal to attain. We were faced with numerous social, cultural and personal variables that could not all be addressed. Nevertheless, I would like to think that we came close enough for the purposes of this study. Our intention was to create a non-judgmental space that welcomed honesty and provided creative challenges to foster well-being. Most importantly, these theatre workshops offered female physicians the opportunity to engage their bodies and minds alongside colleagues.

If the first two chapters of this research project illuminated female physician well-being in Accra and introduced the argument that theatre is an undervalued apparatus for health and healthcare, then this chapter connects those components. The chapter investigates the outcomes of female physicians using theatrical and other therapeutic interventions. It also assesses specific techniques within theatre that could be useful for well-being in this setting. In doing so,

the thesis could inform similar efforts to integrate the arts and health in sociocultural and geopolitical environments similar to urban Accra.

Finally, the workshops I analyze throughout this chapter served two purposes: 1) to act as an avenue to promote female physician well-being using theatre-based solutions 2) to test the therapeutic and communicative parameters of theatre. Although I refer to these workshops as "theatre workshops," they included non-theatre specific practices such as breathing, stretching and movement activities. I hope to spotlight theatre as a dynamic avenue which encompasses other art practices including producing sound (as with musical theatre), movement (as with dance theatre) and creative writing (as with playwriting).

The use of the arts for healing purposes is far from a new phenomenon (See Vick, 2012). In his chapter on "Music Therapy in Antiquity" in Peregrine Horden's anthology *Music As Medicine* (Horden, 2000), Martin West explores the connection between music and medicine from ancient perspectives by highlighting relevant examples from Paleolithic times and perspectives from philosophers from the Classical Era. For example, he notes that Shamans and traditional healers were called to cure sickness often using singing, chanting and dancing– a time when the idea of healing equated to driving away evil spirits that possessed the body and manifested through recognizable ways which we now call symptoms.

Today when we think of the arts as having healing properties, the term 'therapy' might first come to mind. In their article, "Routes to Interiorities: Art Therapy and Knowing in Anthropology" art therapist, Susan Hogan and visual anthropologist, Sarah Pink, define art therapy as examining "issues surrounding knowing about, and bringing to ''surface,'' interior feelings" (Hogan and Pink, 2010, page 159). Their definition does well to capture the use of art

therapy for exploring internal feelings. However, the definition also fails take into account the physical impact of art therapy. Art therapy does not only engage and bring to 'surface' interior emotions and feelings; it also creates an awareness of the corporeal. Art therapy can connect the physical qualities of the body with the same issues (be it social, cultural, spiritual or political) that Hogan and Pink refer to in their definition.

Theatre is one of the main art forms that engages the corporeal with direction and intention. In addition to theatre's historical connection to Ghana (See Introduction), the inherent combination of corporeal, mental and emotional engagement in theatre practice is a major reason I chose to work with theatre for this project. The medical arena is one filled with an embodiment of health-related and social experiences. Theatre provides many embodied techniques thus making it a suitable intervention for this well-being exploration project.

EMBODIED TECHNIQUES

This study is unique in that it focuses on a relatively elite social group in Ghana; a group that works with people living in precarious situations (such as the market women I introduced in chapter 1); a group that benefits from a relatively higher income and social respect. However, this social status and privilege does not protect these female physicians from also experiencing suffering. On the physician side, female doctors must empathize with their patients' struggles in order to understand their needs and effectively care for them. They must provide this support amid working in a high stress environment. Likewise, female physicians in Ghana must live through the sociocultural demands of women in a male-dominated profession and also in a patriarchal society (See Chapter 1). Who then supports these individuals whose professional

and sociocultural roles demand that they support other individuals? The physician well-being in this professional and sociocultural context is multifactored and thus beckons a multidimensional response: Theatre. Theatre in its expansive capacity offers numerous embodied techniques and in the broader view, theatre is an art of embodying experiences. I argue that to effectively support this unique group, embodied techniques from theatre are most effective because they can be used to mirror the experiences these female physicians live out.

The embodied techniques we used were pulled from various literature including the works of Augusto Boal, the Alexander method, and Jacob Moreno's psychodrama. Augusto Boal's material was particularly helpful in this project because of its underlying goal to influence lifestyle changes. As the founding father of Theatre of the Oppressed[30], Boal (a Brazilian theatre director, writer and activist) revolutionized the use of theatre for legislative work, social justice and community healing in (Babbage, 2018). Many of his techniques are intended to expose the oppressions people internalize, liberate people and in turn transform lives (Boal & Jackson, 1995).

The unique feature of globally-acclaimed Theatre of the Oppressed is the purposeful engagement of the audience as 'spect-actors'. 'Spect-actors' or spectators/actors can suggest changes to the scenes and offer solutions for the protagonist in distress, as opposed to just being

[30] Theatre of the Oppressed is a community-based theatre formed in the 1970s that seeks to empower people to combat social oppression and issues surrounding inequality using theatre-based tools. Theatre of the Oppressed was inspired by the Pedagogy of the Oppressed, by Paulo Freire – an educationist and close friend of Boal. (See Freire, 1970)

passive viewers. Boal believed that theatre could serve as a means to create the future rather than passively wait for it (Boal & MacBride, 1979). The therapy therefore in Boal's techniques is analogous to the art therapy Hogan and Pink describe in "Routes to Interiorities": Boalian theatre offers a similar capacity to "rehearse and explore strategies of resistance, [and] explore and reconcile contradictory discourses (contradictions that create stress and "dis-ease")" (Hogan & Pink, 2010, pg.166).

Furthermore, Boal has a plethora of games and theatre forms that offer participants the avenue to relive, discuss and affect change to their situations. Some of the practices we used in the female physician theatre workshops from Boal's techniques were (See Appendix for detailed descriptions):

Forum Theatre

In this participatory theatre form, participants enacted scenes inspired by their lived experiences, with spect-ators (spectator/actors) offering suggestions for scene changes during and after the scenes, on the command of the joker/moderator.

Image Theatre

This embodied technique utilizes the body as a tool for creating still images/tableaus and moving images to convey experiences, emotions and attitudes (Boal & MacBride, 1979, pg. 126).

Boal's Arsenal of Games and Exercises (MacDonald & Rachel, n.d.)

A set of Boalian practices that allow participants to change narratives where they lack power that are compiled in a report written by Susie MacDonald and Daniel Rachel.

Besides Boalian theatre, other theatrical practices we experimented with were:

Psychodrama

Psychodrama is a therapeutic model created by Jacob Moreno in 1921 that utilizes role-playing to gain insight into the lives of participants(s) and consequently address their issues (Moreno & Moreno, 1946).

Playback Theatre

Playback theatre is an improvised drama in which participants share personal stories and see these acted out by other audience members (Rowe, 2007).

In addition to these drama-based practices, the participants also practiced non-theatre specific practices including the Alexander method, explorative writing, Butoh Ash Walk, Progressive muscle relaxation breathing and stretching exercises:

The Alexander Technique

Created by Matthias Alexander, this technique is a process or (series of activities including chair work, table work, etc.) intended to retrain habitual posture and patterns of movement. It is also practiced for pain/tension relief and overall well-being. (See Williams, 1990)

Butoh Ash Walk

This Japanese dance theatre movement technique is intended to increase a self-awareness through a directed walking process. The walk (also known *Hokotai*) is walking as if you were a "pillar of ash". (See Fraleigh, 2010)

Progressive Muscle Relaxation

This two-step process of tense and release was developed in the 1920s by American physician Edmund Jacobson. It is often used for deep muscle relaxation to alleviate stress and tension in the body. (See Jacobson, 1987)

DESIGN & PLANNING

Finding a theatre group to work with was harder than expected. A significant hindrance was that I was searching remotely from the U.S. I had planned to work with a drama group that focuses on using performance to promote women empowerment. Unfortunately due to a scheduling conflict, the group backed out a month before I entered the field. On the other hand, the communications director of the group graciously offered to help me with the search. She eventually connected me with the director of another local theatre group called the Accra Theatre Workshop (ATW), which eventually became my team. After exchanging a few emails

about my thesis project, the ATW team agreed to step in as my supporting performing arts group.

ATW seeks to support a variety of artists. Their vision as stated on the website reads:

> Theatre. Lab. New work. New voices.
>
> Accra Theatre Workshop [established in 2012] supports artists at different stages of their careers by providing opportunities for training, experimentation, showcase and performance.
>
> ATW also creates a community of artists who can support each other, forming a forum where artists can receive critical and useful feedback in a supportive environment…ATW seeks to present Ghanaian stories in new and interesting ways. ("About | Accra Theatre Workshop," 2013)

ATW epitomizes theatre in Ghana in the past decade. The group serves as advocates for a burgeoning experimental theatre in Accra while maintaining important elements of historically Ghanaian theatre which incorporates music, dance and performing predominantly outdoors. During the project, ATW operated predominantly at Terra Alta - an idyllic hub situated within the bustle of Dzorwulu (a partly residential/commercial community area in the Accra Metropolitan Area') – even though they occasionally work at other art spaces across Accra. All the theatre workshop design and planning thus happened at Terra Alta.

Terra Alta is in some a sense a green space with a unique aesthetic appeal. Besides the abundance of trees and greenery, there are also objects like colorfully painted car tires and kiosks all over the 500 square meters of land; an intentional and purposeful approach ATW uses to advocate for recycled materials as decorations and design tools.

An interesting fact to note is that Terra Alta is also part of a larger piece of land that served in part as the home as well as the creative grounds for Efua Sutherland (1924-1996) -

a pioneering dramatist, teacher, author and cultural activist in Ghana. For about four decades she led "literary and theatrical movements" in Ghana ("Founder - Mmofra Foundation," n.d.). Adjacent to Terra Alta is the Mmofra[31] Park. Mmofra Park was established also by Efua Sutherland as one of the first public children play spaces in Accra. It was also the central location for the theatre workshops. With the exception of a few minor structural changes, this playtime wonderland has maintained its serenity and greenery amidst the developing high-rise buildings that now surround the park. Dr. Agyeman remembered her childhood days at Mmofra Park, making the theatre workshop experience even more personal for her:

> Ei this place I remember coming here after school. All the Dzorwulu and Abelenkpe[32] kids. They'll come and drop us off here, and we'll be running around. [She giggles.] And there used to be some pond where Marvels [a mini golf and recreation center] is right now. (2018)

In addition to the historical significance of the workshop location, Ms. Elisabeth Sutherland (director/co-founder of the ATW) is also Efua Sutherland's granddaughter. The connection here is not merely fascinating. I believe her familial background in African theatre complements her Western education in the arts and theatre. It is a powerful combination that was useful in the design and planning process.

Elisabeth and I primarily planned the workshops, including organizing the structure, activities involved and making decisions about how long the workshops would

[31] Mmofra means 'children' in the Fante-Twi language.

[32] Abelemkpe is a neighborhood and community area also known for its commercial activities that adjoins to Dzorwulu. Both areas are considered to be inhabited by mainly middle and upper-middle class groups.

last, providing refreshments, etc. Each week, we had an in-person meeting at her office in Terra Alta and we also frequently communicated via a WhatsApp group chat. Our first in-person meeting was dedicated to laying down the groundwork and expanding on the information we had shared over email. I shared my vision with Elisabeth: to use theatre and/or arts-based approaches to facilitate well-being for female physicians in Accra. Much of this vision was inspired by Augusto Boal's use of theatre to initiate difficult conversations and develop practical solutions.

Elisabeth was vaguely familiar with Boal's work; she noted that some smaller theatre groups in Accra, in conjunction with some international advocacy groups, had used Boalian techniques in the past to discuss social issues like gender violence and female empowerment ("How We Do It | Theatre for Change," n.d.). On the other hand, she was well-versed in theatre practice and more generally the arts. She has used theatre and arts-based techniques like the psychodrama and the Alexander method in her works as an artist, choreographer, playwright, and director, some of which we incorporated into the workshops. Crystal Mercer - a performance artist, poet and activist completing her MFA project in Accra - also joined us a couple of weeks into the workshop series. Her experience in theatre studies and dance were helpful in not only the selection of these embodied techniques, but also how they were implemented. Both Crystal and Elisabeth led the workshops. For workshops 1 and 4, we invited guests to lead sessions on a 'Work & Well-being' discussion and a psychomotor therapy activity (See Table 1.0. in Appendix).

Most of the activities that went into the theatre workshops emerged from a selective literature guidance and a great deal of experimentation. We decided on techniques that we

felt were simple to do and/or required minimum to no special talent/skills and would be easy to incorporate in the female physician lifestyle[33]. The selected exercises were also similar to the ritualized and performative practices of Ghanaian social theatre like the Concert Party (See cole, X) and cultural festival displays . Borrowing practices from these socio-historical contexts - practices that are not about formal performance but rather about shared cultural expressions - offered the physicians opportunities to intervene in everyday life-bound experiences.

We also deliberated the different ways to test the outcomes we wanted to observe. The options for doing that eventually narrowed down to my participant-observation, workshop feedback, interviews and the one-time we measured changes in participants' heart rates during workshops (See Table 2.0 in the Appendix).

Along with my role as a researcher, I served as a mediator by translating information between the arts experts - Elizabeth and Crystal - and the female physicians. Where Elizabeth and Crystal were well-versed in theatre and arts techniques, the female physicians were experts on their well-being needs. As the mediator, I traversed these boundaries between theatre and medicine to better understand how these workshops were impacting female physicians. My role was to identify the factors that impact physician well-being, while connecting with the female physician narrative in order to share their perspectives during the workshop design process. I also worked to offer my external

[33] This broadly refers to the professional, social and cultural demands female physicians face (refer to Chapter 1) and how they plan their schedules around these demands.

perspectives as well as suggest solutions as a third-party (non-arts expert, non-female physician) member.

Ultimately, the four workshops followed a basic structure: warmup, theatre and discussion, speaker/experimental activity and closure/reflections. Feedback from the female physicians after each workshop was used to improve the subsequent one. Table 1.0 in the Appendix summarizes the structure and content of all four theatre workshops.

Image 2.1. Early participants getting a head start on warmups in our working area/stage (located exactly at the center of Mmofra Park).

EVALUATIONS | Improvisation, Embodiment & the Individual

"Theatre is the art of looking at ourselves" (Augusto Boal, n.d.)

In *Ghana's Concert Party Theatre*, Catherine Cole writes that performativity and theatre in Ghana, just like Akan culture "do not merely reflect reality: They create it." (Cole, 2001, pg. 106) The theatre workshops similarly did not just reflect the realities of these

female physicians, they were intended to influence it. In the case of *the Second Model* from Boal's Arsenal of Games & Exercises (See Appendix), the activity served this purpose very well.

For this activity, Dr. Mantey volunteered to share her experience with some demanding patients that led to her frustration. She was then asked to re-enact the scene and create the 'image' with a few other participant volunteers.

In this preliminary 'image', a patient walked into Dr. Mantey's consulting room and immediately started talking about her sleeping issue. There were no salutations; the patient just bombarded Dr. Mantey with concerns and complaints. Just as Dr. Mantey was about to respond, another patient barged into the room:

Patient 2: "Doctor! It's an emergency. Eh doc."

Dr. Mantey: "Madam can't you see I'm with another patient. Please step out and the nur-

Patient 2: "Doctor help me. I'm dying. Doc! "

Dr. Mantey: "Madam, do you want the wom---"

Patient 2: "I'm dying. The woman can wait. Ei Doc can't you see I'm dying?"

Dr. Mantey: "Are you kidding me? Do you want her to---"

Patient 1: "Hey! Wait you wai. [Patient 2 talks over Patient 1 and Dr. Mantey]"

Dr. Mantey: "Oh my goodness [she says in an exasperated tone]. You people should just keep quiet so I can sort you out individually."

Right before the moderator called out "Freeze," the scene depicted a chaotic environment with the patients yelling at each other. A nurse who saw a defeated Dr. Mantey leaving the room, asked if the doctor was leaving because of her delayed income from administration. A third patient waiting outside the consulting room who heard the nurse's comment, then became outraged by the doctor's exit thinking that the doctor chose

to leave because she had not been paid. The doctor out of frustration sarcastically yelled back at the third patient, "Yes salary! How do we transport ourselves here?"

I was particularly intrigued by this 'image' and how well it was depicted; I have actually seen it occur a few times in the public hospitals. In such overpopulated healthcare settings, patients are likely to become more irritated or demanding of immediate care after waiting long hours to be seen.

At the end of this 'image', Dr. Mantey was the most frustrated. Even though it was just a simulation, she looked rather drained and dejected. The other participants merely laughed at how accurate and typical the 'image' was.

During the discussion that followed the scene work, other participants offered suggestions to help remodel the 'image' and transition into the "Ideal Image" (MacDonald and Rachel, n.d.) – an image where the problem no longer exists. Dr. Mantey also noted that normally when she finds herself in such challenging situations, she finds an internal mental space where she can remain calm and patient. However, if this same situation happens during a long day at work, she is likely to vent at the patient. During the discussion, the moderator focused on Dr. Mantey's desire to have a breather during such situations. Finding a point to catch her breath and recuperate became the goal of the remodeled scene. The challenge was for Dr. Mantey to identify an appropriate moment in the chaos to dissociate and utilize one of the breathing techniques the participants had learnt so far.

The scene was acted out again to remodel the 'image'. However, other participants had the liberty to add their own flare in order to heighten or subdue tensions from the

initial 'image'. When asked how it felt to take time to herself during a chaotic situation after the remodeled image, Dr. Mantey expressed that, "It felt really good. You don't even need to speak." Dr. Olusegun also affirmed this feeling of relief and controlled calmness by adding that she often takes multiple moments "to reset" during hectic situations at home and work. In that same discussion, Dr. Agyeman shared how the role play activities had become useful in dealing with stressful moments. Since the very first workshop, she had been incorporating some of the relaxation and breathing techniques into her work schedule:

> Like I said, in my consulting room there is literally no break once I sit down. One person comes and one goes out; just like that! But what I realized is even if the patient in front of me is upsetting me, once the person is still there, I really can't take the break. In my mind or wherever, I am fixated on the person. So, I just sort of want to be done with them. I just tell myself we'll be done in a few minutes. And then I keep pushing. But now… right after a patient, I tell my nurse to kindly tell them [other patients] to hold on just for a minute..… by the time she takes that walk and tells the person, I get to just breathe in. Then after, I now tell her, 'You let them come'…Then I feel better. I feel like it's [the frustration] all gone... And I think it has been really helpful. (Dr. Agyeman, 2018)

Again, working towards the "Image of Possible Transition" (MacDonald & Rachel, n.d.) taking the 'images' from their daily lives and putting them on stage presented these physicians with an opportunity to change narratives where they often lack power. They also got to relive and change experiences that have already transpired *and* envision/embody new experiences that were likely to occur.

Image 2.2. A scene from Image Theatre: Second Model from Boal's Arsenal of Games & Exercises

Theatre - An Embodiment of Experiences

Embodiment is a "concept in constant motion" (Harris, 2016). It is an awareness of the physical, emotional and mental parameters of the body and how these bodily aspects change, temporally and spatially to situations. The various theatre exercises explored during the workshops shared a common goal in that they brought participants' attention to physiological changes and how any contextualized space could impact mood, feelings, psyche and general feelings within and of the body. Theatre, therefore, offered participants a diverse set of tools and practices that allowed them to experiment with certain embodied practices; embodiment that is focused on breath and movement, and embodiment that is focused on relationships through scenario building. Unlike traditional theatre, which is often scripted for the purpose of representations and/or storytelling, these embodied techniques were intended to work through

experiences and ongoing moments. The theatrical practices in these workshops were not being served to make a play, but were adopted to make a Theatre of Health.

Embodying the situation

Using scenario-based theatre practices such as playback theatre, forum theatre and activities from Boal's Arsenal of Games and Exercises (MacDonald & Rachel, n.d.), the female physician participants had the opportunity to simulate situations and discuss factors that impacted their well-being. A very interesting scenario that we re-enact was an issue that many of us had experience: dealing with romantic advances from men. Except for Dr. Agyeman, all participants agreed that in most cases ignoring the advances from these men until their persistence waned was the most feasible approach. When Elisabeth first introduced this topic about harassment from men, different experiences were shared. In particular, Dr. Ofei briefly shared an experience that triggered Dr. Agyeman:

Dr. O: I try to [ignore them] also, but they end up doing what they did. [They say] ok firi ho[34], you think you're beautiful. Ok. Firi ho!

Dr. Ag: That's where I think I flip, like why does it have to be insulting? How did we get to this. You were telling me something , I've not responded, does that mean you have to insult me? Like at that point…. No! I get angry. I'm telling you. Coz I'm reliving that experience. [murmurs and laughter in the background]

Elisabeth: Ookay. So let's take a moment like that and imagine maybe this happens to you on the road and you're going to a nice cafe to have a drink by yourself. And you walk into the cafe and you sit down. And the driver in the car who was yelling at you sits down in the same cafe…[participants: ei!, he follows?...]... ok so let's try that. Who wants to….

[34] *Firi ho* means 'Get Away' in the Twi language.

This scene was enacted a few of times with Dr. Agyeman as the protagonist and Dr. Ofei, who volunteered herself as the driver. Dr. Agyeman's task was to prevent or control her frustration and avoid retaliating with insults should the driver become verbally aggressive. At the end of the final run of the scene, she was still angered but she possessed an enhanced level of control over her emotions.

Through this practiced embodiment, the physicians' relationships with stressors and factors that impact their well-being evolved. They were not just able to locate the core issues, but they also devised and tested solutions for themselves.

Connecting with our bodies

Other theatrical activities such as the breathing exercises, Alexander method, Butoh ash walk, etc. were useful in creating awareness of one's proprioception and physiological areas of stress. The Alexander method sitting chair work and the butoh ash walk activities, for example, brought the participants attention to their habitual movements.

"I allow my neck to be free so that my head can release forward and up. So that my torso can lengthen and widen. So that my knees can release forward and away from my torso. So that my heels can release up and down. So that my neck can be free." – Instructions for Alexander Method led by Elizabeth Sutherland

Following these activities, many of the participants noted that their bodies felt awkward. Although they now had better walking and sitting postures, they felt misplaced. This

phenomenon where our senses deceive us due to our habitual routines is what F. Matthias Alexander noted as "debauched kinesthesia." It explains how "our sensations are not necessarily reliable indicators of the body's knowledge." (Nicely, 2005). For actors, the Alexander method helps with displacing one's normal embodiment to prepare for the embodiment of a character. Dancers similarly utilize the technique to release poor habitual movements they tend to fall into.

When participants were asked to think about changes in their bodies after the activities, a couple of participants mentioned that they suddenly noticed tensions in their lower back, shoulders and neck. The participant group hypothesized that these stressed muscles were a result of poor sitting postures at work. For the participants that worked mainly in clinic, sitting in the same position for extended periods of time intensified the muscle pains.

Where some embodied techniques like Alexander technique revealed tensions in the body, an activity like Progressive Muscle Relaxation turned out to be a potential remedy for these tensions. In this two-step process, developed in the 1920s by American physician Edmund Jacobson, the participants were instructed to clench/squeeze a group of muscles as they took in deep breaths. After holding this tension for ten seconds, they slowly released the muscles while breathing out. They reported feeling "lighter" and "activated" after the activity. Those feelings of relaxation and rejuvenation they experienced in that moment were converse to the moods they embodied at the beginning of almost every theatre workshop. These embodied exercises facilitated the release of habitual movements, giving participants time to re-align in ways that were useful for their full bodies.

Moreover, I observed that Image theatre served a dual role: to create a physiological awareness and to generate images that symbolize situations that impact female physician well-being. A volunteer was asked to consider a gesture, movement or situation that represented her day. After creating this image, the moderator spontaneously called out "Freeze!" and the volunteers fixed position becomes an image for discussion. The 'image' which depicted the volunteer in an awkward position and strained expression stirred up conversations about navigating the fast pace of Ghanaian public hospitals. After these initial discussions, the moderator asked all participants to envision another narrative that this image could metamorphose into. The first volunteer went back into her still 'image' and then another walked up to manipulate the image to reflect this new narrative by moving body parts and introducing a new character. The modified image, however, brought a volunteer's attention to the tension in her neck and lower back after having her body shifted to a different position to create the new 'image'. Again, theatre here did more than just reveal a professional issue; it also accentuated how bodies interact with these issues.

Image 2.3. Participants exploring muscle tension in their bodies.

Image 2.4. Participants experimenting with alternate nostril breathing led by Elisabeth Sutherland (far right).

Overall, embodiment during the theatre workshops was a dynamic process. They first and foremost required an awareness of the what was happening and how it was manifesting temporally and spatially. Subsequently, that same awareness prompted decision-making about whether to change or maintain the form of embodiment. Elisabeth would occasionally remind the workshop participants that, "No one can change [your situation]. It's only you." Did this affirmation impact their engagement with the activities? Perhaps. Ultimately, I believe the workshop activities sustained Harris' proposition of embodiment as "concept in constant motion" (Harris, 2016). Throughout the workshop series the physician participants discovered and challenged ways to inhabit their spaces and act during various situations. I argue that by engaging themselves and one another (mentally, emotionally and physically) through these embodied techniques, they could uniquely assess their visceral reactions to a wide range of situations that are typical to females and physicians (or a combination of both roles).

Improvisation

Improvisation is embedded generally within medicine and also in urban African culture. These female physicians experience the uncertainty of many situations that characterize everyday bustle of living and working in urban Accra. From a sudden power outage during a patient checkup to dealing with incessant catcalls from male drivers in traffic, I draw parallels between the cancer wards that Livingston describes so vividly *in Improvising Medicine* (2012) and our Mmofra Park stage. The spontaneity and vulnerability of these theatre workshops, while very different from the cancer wards in Marina Hospital, could be equally considered as "a powerfully embodied social and existential space." (Livingston, 2012:8) Space, specifically Mmofra Park, for these women, became a constellation of physical and social experiences as well as the intangible thoughts and emotions that conveyed their fears and dreams. The opportunity to discuss many of their worries/ victories in a group setting fostered a sisterhood and encouraged group strategy. Drawing from the works of Sarah White, I agree with her proposition that well-being is a social and collective process (White, 2010). Perhaps, the collectiveness of the theatre workshops is how the female physicians experienced well-being. Mmofra Park became a space where they could exist in their multiple identities, as and how they wanted to; a space that characterized a social and communal improvisation.

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Laughter, like improvisation was also integral to our theatre workshops. Laughter is a tool used to socialize pain and suffering in both Livingston's cancer ward and the frustration on our Mmofra Park stage. Using the oncology narratives in *Improvising Medicine*, Livingston

argues that "laughter is a form of social expression,"(pg. 148) and in the cancer ward, laughter is sometimes the response that pain demands (pg. 121). The female physicians also utilized laughter in a similar way: to make light out of the stressful situations they recreated and re-lived during the theatre workshops. A joke made by a participant about another's lack of control during simulation could easily catalyze a cascade of giggles and eventually a ubiquitous laughter in which we all participated. Certainly, laughter as a response to another female physician's burden can be perceived as rude or insensitive, but it in this case it reveals information about the complexities of lived experiences in Accra. Laughter at the theatre workshop yields a communal and social embodiment.

Laughter is also a "cultural artifact," (Livingston, 2012, pg. 146) and ingrained in the way of life a group of people. Likewise, the application of laughter will vary across various settings. An example is the use of laughter for improvisation in the face of uncertainty and vulnerability. In *Laughter Out of Place: Race, Class, Violence, and Sexuality in a Rio Shantytown* (2003), anthropologist Donna Goldstein, illuminates laughter as a tool to navigate the harsh realities of the social underclass and their suffering, which is fueled by race, sexual exploitation, an economic and physical violence in favela, Felicidade Eterna (eternal happiness). The surreal humor captured in the stories in Goldstein's book actually carries a liberating power for the residents of the favela to disengage or rather uniquely engage their challenges. Laughter in this part of Rio is not only a way to cope with the physical and social pain, but also bear witness to the suffering. I argue that laughter during the workshops was also used as tool to improvise, cope and bear witness to each other's pain and suffering.

The improvisation at Mmofra Park was unique. Unlike the day-to-day realities of these female physicians or the stories of Princess Marina Hospital cancer ward, the female physician participants possessed a significant measure of control although they were immersed in situations that demanded improvisation. The pre-planned theatre activities gave room for mistakes without consequences or concern. The all-female space embraced uncertainty and offered a power to re-invent oneself spatially (e.g. as with the physical adjustments made to the body through image theatre or Alexander method) and temporally (such as with the timed activities breathing exercises, progressive muscle relaxation or Soldier's and the Skipper from Boal's Arsenal of Games). To better explain this unique improvisation (i.e. a model with built-in control), I will use ethnographic descriptions from a psychodrama activity from Workshop 3.

Psychodrama is a therapeutic model created by Jacob Moreno in 1921 that utilizes role-playing to gain insight into the lives of participant(s) and consequently address their issues (Moreno & Moreno, 1946). Typically, for group psychodrama, one person remains the protagonist of the scene without changing their identities (Kipper & Ritchie, 2003, pg. 17) even when the original scene is tweaked. Dr. Amoah volunteered to be the protagonist for the psychodrama activity using an experience that had occurred that same week.

She had a rude and stressful interaction with a store manager after she had been sold the wrong cell phone. After sharing the story in detail, she was asked to re-enact the situation with Dr. Agyeman playing the role as the store manager and Dr. Ofei acting as a sales attendant. Following the role play, the audience gave their feedback on what they thought Dr. Amoah was feeling. They particularly stressed the palpable tension and irritation in her face as their main observation. Correspondingly, Dr. Amoah admitted to having the same frustration (but not the

confusion) she had when the incident first occurred. The scene was tried a few times with varying levels of conflict, with a discussion following each set of scenes:

- First Set (Mild Tension)

Moderator: "What's going on here. How do you feel in your body? Dr. Agyeman: Well, I was getting a bit angry because I thought it was going to be straight-forward."

M: Think about your muscles. Is anything tense. Where are you carrying that? Think about that.

Dr. A: uh, maybe in my shoulders. And in my thighs…

- Second Set (Moderate-high Tension)

Moderator: Ok great! How are you feeling now?

Dr. A: Extremely angry.

M: What do we think about this situation?

Some participants: Typical Ghana…You know the usual. Unfortunately th-- [murmurs in the background]

M: Of course we can't always control what happens outside of us. We can control how we're feeling in the meantime. We're going to continue. Are you feeling it in your body right now?

Dr. A: Yes!

M: Alright I know this feels silly, but go back to the situation and check in with yourself on how you'll approach this…

- Third Set (High Tension)

M: Alright great pause. I saw you take that big breath [laughter from the audience] How was that?

Dr. A: Well… that like….hmm…it makes you feel a little lighter and then it gives you a moment to think so that you don't speak [back at the offender].

M: Exactly it's that moment that you're thinking off.

Image 2.5. Dr. Amoah improvising a role play with other participants.

From the excerpt above we can appreciate this kind of controlled improvisation that occurred in the theatre workshops. A certain level of spontaneity is maintained but with enough capacity and freedom to make changes. At the core of psychodrama is what Moreno describes to be "spontaneity-creativity" (Schacht, 2007). Moreno believed that by responding on impulse, the participant is likely to develop various creative solutions to their own problems. With the psychodrama approach, the participants got to practice how to react to situations that require patience, quick thinking and extemporization.

The Individual

These theatre workshops could be considered as individual psychotherapy in a group setting. The female physicians focused on particularities of their own lives as it relates to the

different roles they assume in society. Most activities were thus targeted towards an individual mode of existence and overall all participants benefitted from the workshops in some way. For example, the results from our one-time heart rate measurements before and during workshop 2 supported our hypothesis that the female physicians were leaving the theatre workshops more relaxed than when they first arrived. All participants who took part in the pulse check had lower heart rates than their initial readings at the start of the workshop. The female physicians also manually checked their heart rates against the pulse oximeter readings on Elisabeth's smartphone, and found almost matching results[35] (See Table 2.0 in the Appendix).

Participants also had their unique benefits. In an exit focus group discussion at the end of the final workshop, participants reported different views on the activities. Where the breathing exercises were useful as long-term relaxation strategies for some participants, the role play theatre activities were most helpful for others who needed to vent. Dr. Ofei, for example, said that she enjoyed the stretches and complementary massages. Dr. Mantey, on the other hand, had been trying to incorporate the breathing practices and the Alexander Technique chair work (a practice intended to improve upright balance, movement and self-awareness) into her schedule because she had so far found them helpful.

[35] Although though the pulse measurements were statistically unreliable (i.e. they were not replicated or indicative of statistical significance), it was interesting to observe a numerical drop in their heart rates.

Image 2.6. Dr. Ofei (right) sharing her thoughts during a discussion after an activity.

A couple of participants disclosed to me privately outside the exit focus group discussion that they did not understand the point of the Progressive Muscle Relaxation. One of them added, though, that she probably did not connect with the activity as she had with other exercises because she was extremely fatigued that day. This goes to show that the different workshop activities had varying impacts on the female physician participants. By experimenting with a variety of tools, they could also explore different embodied techniques, targeted at improving different aspects of the well-being. However, considering that we only had four theatre workshops, some activities like progressive muscle relaxation and the Alexander method were tested just once. The female physician participants, therefore, found it difficult to give well-informed and sustained feedback beyond the limited timeframe for exposure. This is the obvious drawback of this pilot study.

In the concluding chapter, I will explore what it means to have these theatre workshops as a sustainable program: what these embodied methods might do for female physicians in the

long-run, how to continue to modify the workshops to account for their needs, and how this pilot study can inform similar projects for a broader population.

CONCLUSION

WHAT NEXT?

Overall, the workshops helped these female physicians to relax and connect with their bodies. I discovered that although the female physicians were receptive to all workshops activities, their preferences and use of the embodied techniques varied. Dr. Ofei, for example noted that the body stretches and Alexander chair exercises allowed her to "become more aware of [the] problem areas" in her body. She added that developing that intentional awareness of her body has improved her sleep; where previously her poor sleep hygiene impacted her mood and energy at work. Dr. Agyeman, on the other hand, mentioned that she enjoyed the breathing exercises most because she could apply them to many stressful situations.

Additionally, during our exit focus group discussion the participants felt the acting-based activities like psychodrama and playback theatre better served long term goals including learning to control one's reactions to various situations, whereas the breathing techniques were helpful for short term interventions such as relaxing during moments of distress. Despite these benefits, the workshops also had limitations. Dr. Mantey mentioned that she had some difficulty in attending workshops due to fatigue from a long day's work:

> You know the number of people that say *oh I will come* [to the workshop], but see the number [other participants in the background murmur in agreement]. You know it's like a lot of things are pulling you. It's like I knew I have to be here, but [then it feels like] *oh my god, I'm tired too. I just closed. Let me sleep a bit*. I took a nap today and when I like woke up, I was like *did I just miss it*? So yeah stuff like that….(Dr. Mantey, 2018)

For many of these participants dealing with a combination of social, professional and other demands (like attending these workshops) could sometimes feel burdensome. Their commitment to meeting some of these demands often required them to forfeit other necessities like rest. Incorporating new *and* additional practices from these workshops into their schedules was therefore more difficult than anticipated. Even when the workshops helped these female physicians to relax and connect with their bodies in the moment, integrating the practices into the rest of their lives proved to be challenging.

In spite of the identified limitation, the workshops (together with this pilot study), is a promising model for utilizing the arts to teach and support physicians in similar settings. I therefore postulate what it would look like to have these workshops as sustainable programs. I will also briefly explore the possible effects of expanding these workshops to reach a wider subset of individuals within and outside the healthcare arena such as nurses, workers in precarious situations, and generally anyone whose health and well-being goes ignored.

Firstly, these theatre workshops will have some benefits but also significant limitations should they become a regular activity for the female physicians. More frequent workshops will allow us to test different theatre and arts-based interventions. In doing so, the female physicians will have a broader set of tools to utilize. They would also have more time to become acquainted with strategies they may have initially not liked. In the same vein, through repeated practice, they may develop different opinions about the activities they originally preferred.

On the other hand, the logistical challenges we faced while planning and executing these workshops must be taken into account when deliberating how to develop a sustainable workshop series. Uncertainty and improvisation were recurring themes that characterized not

only the theatre-based interventions we tested but the workshops as a whole. From delayed food deliveries to late arrivals of participants/workshop speakers, we all found ourselves improvising too many times. This was largely influenced by the dynamics of urban Accra living: unbearable traffic jams, unanticipated *light-off*[36] and the incessant beeping of physicians' phones. While many of these factors were out of our control, a sustainable workshop series will benefit from buffers such as having a generator in the event of a power outage and enforcing workshop rules including following strict start/end workshop times or silencing phones during workshops.

Moreover, a suitable workshop series will benefit from the direct input of female physicians themselves. I was often the mediator between the physicians and the art experts, communicating to both sides each other's expectations. This offered me a parallel appreciation of the theatre-based interventions and the female physicians' well-being needs. However, it also meant that a lot of information could have been lost in translation, overemphasized or diminished. The presence of female physicians on the design team would have alleviated many of the communication loopholes: some of which were about crucial decisions like how often to take breaks during workshops to more trivial details such as food options for post-workshop refreshments.

Likewise, female physician counsel in the design and planning process will help the theatre experts better tailor the workshops to their non-professional demands. I mainly shadowed these physicians in their clinical environments, as such, many of the well-being issues targeted during

[36] Light-off is a Ghanaian slang for power outage.

workshops were skewed towards their occupational challenges. I hypothesize that the direct contributions of female physicians to the design process could catalyze the revelation of more nuanced well-being factors that did not come up during my fieldwork, and thus not addressed during the workshops.

Furthermore, besides the logistical challenges for planning and implementing the workshops, we were also concerned about how well and easily the female physicians could retain the embodied strategies (breathing techniques, psychodrama warm-ups, Alexander technique chair exercise, etc) they had gathered from workshops. An ideal outcome would be female physicians forming habits from the workshop practices. Typically, habits are formed through a "repetition of a behavior in a consistent context" (Lally, Jaarsveld, Potts, & Wardle, 2010). Unfortunately, many of the female physicians - with the exception of a couple - found little to no time to consistently practice or use these strategies. Both Dr. Mantey and Dr. Ankamah (two of the three physicians I shadowed consistently) admitted to forgetting to use the techniques. Their reason being that they were occupied with work or personal demands. Again, deciding on strategies to improve habit formation around these embodied-techniques cannot *and* should not be done without the input of the female physician perspective. They will know how best these practices could be incorporated into their lifestyles.

Nevertheless, I propose that spreading the theatre workshops over a longer period of time can facilitate this habit formation. With the extended timeline, the female physicians will have the opportunity to better align these practices with their already-established schedules and with time, the practices will become automatic body habits. From the exit focus group discussion, the physicians who participated in all four biweekly sessions acknowledged that it was challenging

attending all the workshops. Moreover, they could have used the time for other responsibilities. Their decision to be present at the biweekly sessions came down to two main factors: their dedication to remain committed to what they had started and a fear of missing out on pertinent information. A well-designed long-term theatre workshop series will minimize what I call "*attendance burden.*" Attendance burden here comprises the stress and burden of having to attend all workshop sessions for reasons like the ones brought up in the exit focus group discussions.

Dr. Agyeman shared during this exit discussion that while she enjoyed the workshops, it would have been easier for her if they were monthly commitments. In that way, she would not have to worry about missing a session. She added that it would make the workshops feel more like a "fun, de-stressing" block in her schedule than "another thing to worry about". Dr. Ofei echoed this sentiment by explaining that:

> … in Ghana, there's always something happening. One weekend there is a wedding. The next funeral. Sometimes you don't even want to do any of these things because if you're on call for example you'll be tired. So there's always something that requires your time. So I also think for me, if it was like a monthly thing, I can plan ahead. Cuz it also gives us [her and her participant friends] something to do things together. (Dr. Ofei, 2018)

Not only will spacing out the workshops make it easier for them to attend and reduce "*attendance burden*", but it will also give those on the design/organization team significant time to develop more effective workshops.

DIVERSITY

We could also consider diversifying the female physician participant pool as a way to improve these theatre workshops. The female physicians that participated in the theatre workshops were between the ages of 27 to 35 years old. Many of these physicians were therefore medical officers or deliberating what specialties to pursue to advance their careers. An improved workshop series could otherwise bring together women from all stages of their medical journey, including female medical students and veteran[37] female physicians. I hypothesize that the diverse range of participants would enhance the complexity of activities like role-playing. This will in turn enrich the suggested solutions that come up during the workshops. It will also provide an opportunity for younger female physicians and female medical students to learn from their older counterparts. They will be informed and become better prepared to deal with those professional and sociocultural experiences in Accra that are likely to occur with age: choosing a medical specialty, navigating gender biases in the medical profession, ensuring work life balance as a mother and/or wife.

In a similar vein, an expanded participant pool could present drawbacks. Deciding on techniques that can cater to the nuanced needs of a diverse female physician group may pose a challenge; especially if the well-being issues are significantly differ. Life experiences, household dynamics, and personal goals are some factors that can account for differing well-being issues beyond the medical field they share. If there are indeed considerable differences, how do we avoid prioritizing the needs of one group over another during workshops? A potential solution

[37] I use veteran here to describe female physicians generally above 40 years old and those who practice as specialists.

is to have separate workshops and collective ones where they can convene and share their experiences. I believe many of the techniques used in the theatre workshops will still be applicable to dealing with a diverse range of situations.

Additionally, my fieldwork revealed that while female medical students showed interest in attending the workshops or having their own specialized theatre workshops, older female physicians may not be as receptive to the idea. I postulate that participants with varying degrees of interest and enthusiasm in the workshops could have an impact on the collaborative atmosphere of the workshops.

The varying receptivity to the workshops between medical students and the older female physicians stemmed primarily from the following factors: flexibility in schedules and personal commitments. Generally, medical students must face the rigor and demands of an arduous medical education. However, they often have weekends off. Depending on their respective schedules, female medical students can carve out time for leisure and rest, unless some extraneous circumstances coincide. Older female physicians, on the other hand, have a broader range of professional and personal responsibilities including working for longer hours and taking care of the home.

Besides being mothers and wives, older female physicians usually occupy senior medical positions in hospitals and clinics that demand a substantial amount of their time. They can have clinical, administrative or teaching responsibilities in the medical setting or a combination of these. They are also likely practicing specialists; this niche of doctors is limited in Accra and may work longer hours to accommodate a large patient population within the city, as well as patients coming from other cities and countries in the West African region.

Ultimately, these demands can affect the well-being and ease of older female physicians in making it to the workshops.

Furthermore, the idea of intersecting the arts and health in a practical and embodied way is fairly new and unknown concept in Ghana. As we have seen previously in the introduction, the arts and more specifically theatre, have a long standing relationship with Ghana. Theatre has been used as a recreational tool, for cultural practices and as public education tool in Ghana. However, it's therapeutic qualities and connection to health and the body have not been significantly explored, if at all. When I presented this project to people (some of whom I knew, but many of whom were strangers), their reactions ranged from an excitement about what seemed like a novelty intervention to a mix of skepticism and confusion about the intended outcomes of the theatre workshops.

In my interview with Dr. Agyei-Smart, an obstetrician/ gynecologist and department head at a major public hospital, she mentioned that she would consider attending a theatre workshop or an arts-based workshop only if she knew someone it had worked for, or if the workshops had been proven to have some benefit. As a middle-aged Ghanaian woman, her view of theatre (or the arts) is simply recreational. And so, she is unfamiliar to this interdisciplinary concept my thesis project characterizes. It also deviates from her medical knowledge and understanding of the body. Dr. Agyei-Smart, like many other veteran Ghanaian doctors, will seek out empirical evidence – which is at the core of Western biomedicine - to validate the use of theatre-based interventions for well-being purposes.

Doctors are trained to use an empirically-based approaches to identify symptoms, gather relevant information from the patient and recall medical knowledge to make their

diagnosis (Djulbegovic et al., 2014). Often, evidence-based treatments are corroborated by studies like large repeated randomized control trials (RCT). These RCTs are intended to test the reproducibility of treatment outcomes and validate the efficiency of such treatments (Spieth et al., 2016). Interventions and treatments that are not backed by such 'evidence' tests are often overlooked, even if they are effective for a smaller subset of people.

In "Theorizing Global Health, medical anthropologist Joao Biehl calls out how "'evidence-based medicine' has become the default language" for many global health issues. He argues that interventions that bring about useful change in global health have become secondary to the "development of reliable methodologies and the generation of comparable data." (Biehl, 2016, pg. 129). Biehl's argument here is not only reflective of the realities of health work. It also suggests that medical communities' have developed a narrowed focus on producing statistically significant data to an extent that may neglect the potential power of interventions (like these theatre workshops) in effecting change. Dr. Agyei-Smart is also perhaps so fixated on the evidence-based medicine she practices that it blinds her from envisioning the similar healing effects that may come from arts-based interventions like the theatre workshops.

On the other hand, where veteran doctors like Dr. Agyei-Smart are conditionally receptive to the theatre workshops and broadly an intersection of arts and health, the survey administered to female medical students[38] (See Appendix) told a different story. In the survey which was completed by fifty-seven female medical students in Ghana, 10.5% reported as

[38] I administered an online survey to female medical students across the country through some friends. Fifty-seven respondents completed the survey.

'Always' engaging in the arts, 19.3% as 'Often', 35.1% as 'Sometimes', 28.1% as 'Occasionally' and only 7% reported as 'Never' engaging in the arts. When asked why, the majority of the participants who engaged in the arts - gave answers similar to "It helps me relax and rejuvenate," "It destresses me" and "These are things I enjoy." Most of the survey respondents indicated that using the arts-based approaches for stress management and wellness exploration would be "great" or "helpful.". However, the responses that went into detail offered nuanced perspectives in how some of these female medical students were thinking about arts-based interventions:

> It is a good option. However the extent of its effect depends largely on the personalities of the target audience and it wouldn't be safe to assume that this method will work for all. (Student X)

> I think it's a good idea if you are interested but I believe there are also many other ways such as exercise or meditating or just plain Netflix and chill. (Student Y)

> It's a good way to manage stress as long as you find it relaxing and it doesn't take too much of your time. I think it's fun, educative and relaxing to engage in. It may even serve as an alternate means of income generation. (Student A)

In my interview with Nancy, a friend and third-year student at the School of Medical Sciences-KNUST, she noted that she would like to have theatre workshops like the ones I was organizing with the Accra Theatre Workshop (ATW) or some form of arts-based engagements incorporated into their medical school curriculum. Nancy believed that arts interventions could serve as opportunities to learn medicine in a new and exciting way.

When I asked Dr. Ankamah for her opinion about the differences in receptiveness to the arts-based interventions between my friend Nancy and Dr. Agyei-Smith, she argued that it was based on age. According to Dr. Ankamah, the socio-cultural associations of age and lifestyle in Ghana largely influence how people perceive things:

> honestly they won't even have time. And if they did you know they were born and trained in a different time… so these things they see it as like young people stuff. (Dr. Ankamah, 2018)

Dr. Ankamah's comments signal the importance of considering various social, cultural and political factors when planning these workshops for a diverse participant group. It would be useful, for instance, to consider how the structure and content of the theatre workshops can accommodate participants who may be (i) concerned about the time commitments, (ii) skeptical about the effectiveness the workshops (iii) new to engaging the arts in an intentional and embodied way. In the same way, consideration has to be given to balancing the needs of medical students, young female physicians in the workforce and older female physicians during these workshops. Such considerations are useful for the design process, should this program expand to older female physicians and females in the medical training process.

Some questions to consider when planning workshops for a more diverse female physician group therefore include: How can the workshops be tailored to accommodate the needs of individuals with different lifestyles and interests? How does one publicize theatre workshops to female physicians that may be skeptical about using theatre as a well-being intervention? What strategies can workshop moderators employ to ensure that if not all, most needs are met within a varied participant group?

ENVISIONING THE FUTURE

This pilot study explores factors that inhibit or promote well-being among female physicians in Accra. It also illuminates the embodied and multifaceted nature of theatre and its suitability as a tool for improving well-being. While mining for the therapeutic potentials of theatre in this sociocultural context, I discovered the social impact theatre has had historically in Ghana, and the collaborative power theatre yields when health professionals engage art experts and vice versa. Similarly, this thesis extends a new global health theatre model. It conveys a potential yet necessary paradigm shift from a global health theatre that has typically been didactic and unidirectionally, to one that is collaborative and interventional. By developing an ethnography of what Theatre of Health could look like and by also offering suggestions in this concluding chapter as to what Theatre of Health must certainly include, the study offers a framework for crafting other interdisciplinary global health theatre projects; projects that do not shy away from experimentation and are developed in close proximity to the populations who will participate in and benefit from them.

Beyond the discussions about the sustainability and relevance of these theatre workshops, it is relevant to consider how a Theatre of Health could benefit others who do not fall directly within the female physician pool. Many of the lessons derived in this project could be translated into similar well-being projects for other groups. I hypothesize that theatre workshops can also serve in a similar way other professionals in the healthcare arena or the very patients the physicians care for. A Theatre of Health tailored to professionals, patients, and generally all kinds of people, could empower them with similar strategies in dealing with well-being issues.

In a similar vein, the female physicians could glean many of the embodied practices they have gathered from the theatre workshops and share them with their patients. In this regard, the collaborative nature of a theatre workshop model situated in the global south, challenges models that privilege the dissemination of knowledge to certain social classes (i.e. doctors vs patients or even the wealthy vs impoverished). By taking the embodied practices from the workshops and sharing them with others, the benefits of Theatre of Health may felt all over.

Additionally, physicians and patients could be placed jointly as participants in the same the workshops to further expand the collaborative boundaries of Theatre of Health. The possibility of this combined endeavor particularly opens up for me a new way of thinking about how the Kejetia Market women I initially planned to work with (as noted in my introduction) and the female physicians I worked with for this project could support each other. Both groups of women share similar burdens and their experiences offer insights about women, labor and the body in the Ghanaian context. I shall introduce a typical day in the life of a market woman to illustrate my conviction:

At Kejetia Market, Mamounatu[39] opens her *apata*[40] by 7am to setup for the market day ahead. As one of the older vendors on the market line, she is well-respected and maintains cordial relationships with the other neighboring store owners who sell a variety of things; some of them selling secondhand clothing just like Mamounatu. At Pre-Nkwa Market Health Clinic, I learn through her conversation with the nurse that "her boy" - who is on a school break- is watching over the store while she's here for her check-up. She also adds that she will be away

[39] The woman has been given a pseudonym to protect her identity.

[40] *Apata* means market stall in the Twi language.

for a couple of days the following week to retrieve new stock for her business. Even though the nurse does not ask, she shares about how the handkerchiefs (and other items I cannot recall) are not selling as fast. They joke about how brand-new items (unlike the used clothing) have low returns in what they describe to be a growing recession in Ghana. A few minutes into the check-up, the nurse commends Mamounatu for her consistent blood pressure. It had been relatively high in the past few months; a situation Mamounata plans to keep under control by monitoring her diet and stress.

Market women at Kejetia face stressful situations like the female physicians who might very well be their primary care providers. Many of these industrious women are breadwinners or they largely contribute to the upkeep of their homes. Their additional domestic responsibilities combined with social expectations and occupational demands might augment their stress and well-being challenges as seen with Mamounatu's blood pressure problem.

A joint workshop for both groups of women may yield a unique application of the embodied techniques explored in Chapter 2. The commonality of the double burden in both their lives - demand of the home, and the demand of the professional place - will inform the development of such collaborative theatre workshops since the embodied techniques would target similar issues. Moreover, it may also offer a unique way for physicians to better communicate and understand the needs of market women (and similar patient populations) and likewise, an opportunity for market women to support physicians in unprecedented ways. I envision that this type of partnership will highlight theatre workshops as interventional tools and platforms that can bridge socioeconomic and professional gaps by placing different professionals on the same creative platform.

Besides these market women I am personally invested in, I believe collaborative theatre workshops could serve other working class populations or generally all those who are equally at risk of well-being issues. More broadly I propose that these theatre workshops, and generally a Theatre of Health provides practical resources that could potentially influence preventative and therapeutic models of care in Ghana.

This conclusion highlights many questions and conjectures that come out of this . Some of these postulations will remain in my academic and everyday conversations beyond my undergraduate journey. Some of these ideas may also inform the next steps in my journey towards becoming a physician and how I reflect on the role of theatre and arts engagement in my own health and well-being. More importantly, these questions and ideas are not only representative of possible follow-up studies for this project, or other new projects in the arts-health discipline. They are also intended to spark further thoughts for readers about what Theatre of Health could offer the future of Global Health studies. My hope is that issues raised in this concluding chapter will contribute to conversations on the intersection of arts and health, interdisciplinary studies, global health theatre and ethnography, and challenge how readers might think about the breadth and depth of using theatre in facilitating their own health and well-being.

APPENDIX

SUMMARY OF WORKSHOP PRACTICES

Forum Theatre

This is participatory theatre form, which reflects the democratic forum with actors, audience and a moderator. The scenes enacted in the play represent the group/community's lived experiences and an issue(s) for discussion. After observing the play, the audience is invited to stop the play through the 'joker' or moderator. They can offer suggestions to change the situation and replace characters and in so doing they become 'spect-actors'. They therefore control the change they want to see in the experiences enacted before them. The spect-actor "intervenes and changes the vision of the world as it is into a world as it could be"(Boal & MacBride, 1979, pg. 132). Some benefits of forum theatre include team learning and developing solutions as a group (Boal & Jackson, 2002, pg. 242), having the capacity to observe clearly, analyze, reflect and change one's reality.

Image Theatre

This embodied technique utilizes the body as a tool for creating still images/tableaus and moving images to convey experiences, emotions and attitudes (Boal & MacBride, 1979, pg. 126). By forming these corporeal representation, participants can identify the crux of issues but also identify how these issues affect their beings by forming the images. In doing so, images become powerful tools for exploration. For the female physician theatre workshops, a participant would share their issue or message, and then would proceed to create a moving image for it. The

process of creating the image allows the participant to develop an awareness of their bodies in connection to the issues and also think about different possibilities of how these issues could become a reality. The joker/moderator would spontaneously call for a stop during the image exploration; allowing the moving image to become a still one. The audience then discussed the image, offering solutions to change the image or replacing the spect-actor on stage to create the own renditions of the image.

Boal's Arsenal of Games and Exercises (MacDonald & Rachel, n.d.)

These specific Boalian practices taken from a report by Susie MacDonald and Daniel Rachel at the 2000 Theatre of the Oppressed Athens Conference were used in the theatre workshops:

1. *Soldiers & the Skipper*:

In this game "volunteers are asked to march in a line from one side of the room to the other. Their objective is to keep marching at all costs. [Another] person, the skipper, begins to skip and dance around the marchers after they have been marching for a couple of minutes. As the skipper gets in their way, the marchers beat her onto the ground, and, leaving her for dead, continue their marching. The marchers represent the oppressors and the skipper, the protagonist." The audience then discusses ways to prevent the oppression from being repeated and roles are switched with audience members. (MacDonald and Rachel, n.d.)

2. *Two Models – Second model*

The model used for the female physician theatre workshop was a rendition of the second model in MacDonald and Rachel's report:

Firstly, an oppression is agreed upon by the group. An individual creates an image of the oppression, sculpting spect-actors into a group image. This may then be discussed with the audience to agree upon the "Real Image" of this oppression. The joker/moderator then asks the spect-actors within the image to change their positions, be it verbally or physically, in order to represent an "Ideal Image" whereby the oppression is no longer there. This change from "Real Image" to "Ideal Image" – also known as Image of Possible Transition - was done in a slow motion to allow the spect-actors appreciate changes in the body and make the transition as realistic as possible. (MacDonald and Rachel, n.d)

Psychodrama

Psychodrama is a therapeutic model created by Jacob Moreno in 1921 that utilizes role-playing to gain insight into the lives of participants(s) and consequently address their issues (Moreno & Moreno, 1946). Psychodrama has been used in both clinical and community-based interventions to help individuals and groups work through their challenges (Blatner, 1996; Kipper & Ritchie, 2003).The different techniques under psychodrama usually include role reversal, doubling, and role-playing enactment. These may be used individually or together (Kipper & Ritchie, 2003).

Playback Theatre

This is a form of improvisation theatre founded in 1975 by Jonathan Fox, Jo Salas and the Original Playback Theatre Company in New York (See Fox, 1994; Salas, 1993). Playback theatre is "a form of improvised drama in which members of an audience are invited to tell personal stories to a 'conductor' and see these improvised by a company of actors and musicians." (Rowe, 2007) Because of the flexibility of playback theatre it is can be used in numerous situations including psychodrama activities. Playback theatre is unique because unlike psychodrama or theatre of the oppressed, it does not necessarily demand discussion or sharing or as the founder Jonathan Fox writes, "there will be no….search for a solution or a cure--just another story."(J. Fox, 2004)

The Alexander method

Created by Matthias Alexander, this technique is a process or (series of activities including chair work, table work, etc.) intended to retrain habitual posture and patterns of movement. It is used

for training performing artists and also can also be practiced for health and well-being purposes or relieving pain/tension. (See Bloch, 2004; Williams, 1990)

Butoh Ash Walk

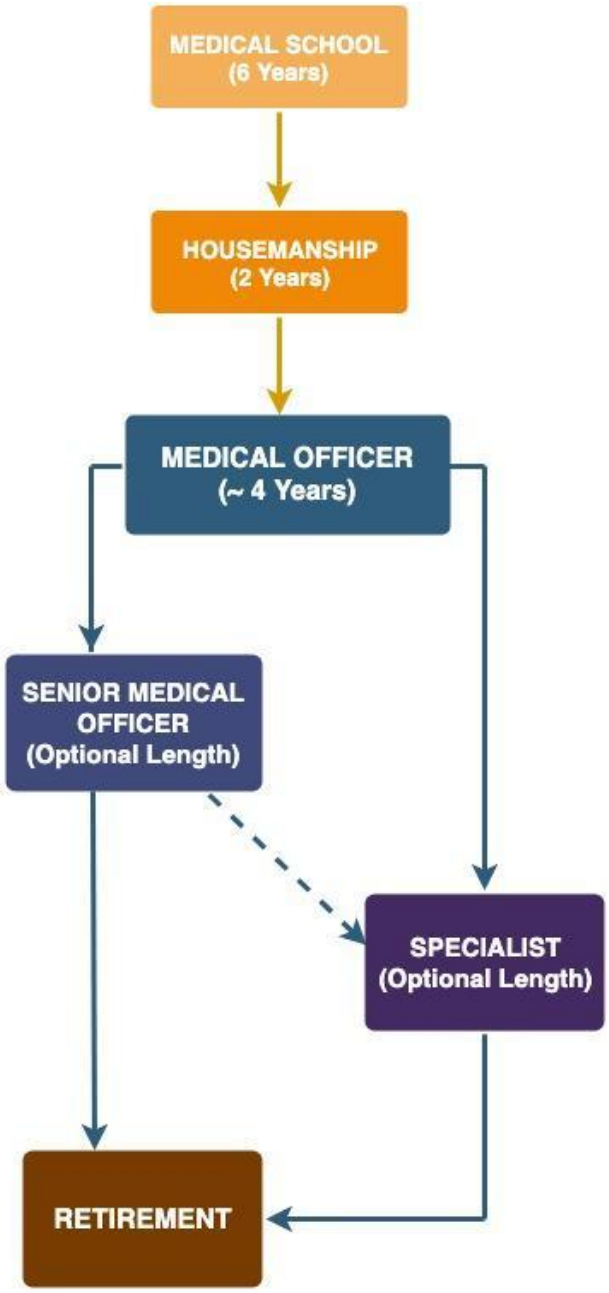
This Japanese dance theatre movement technique is intended to increase a self-awareness through a directed walking process. The walk (also known Hokotai in Japanese) is walking as if you were a "pillar of ash". (Fraleigh, 2010)

Progressive Muscle Relaxation

This two-step process of tense and release was developed in the 1920s by American physician Edmund Jacobson. It is often used for deep muscle relaxation to alleviate stress and tension in the body (See E. Jacobson, 1929; E. Jacobson, 1987). Step 1: Clench/squeeze a group of muscles as while taking in a deep breath. After holding this tension for ten seconds, slowly release the muscles while breathing out.

CHARTS

Physician Progress Chart in Ghana



TABLES

Table 1.0. Theatre Workshops Summary by Date

WORKSHOP 1	WORKSHOP 2 led by Crystal Mercer
Date: June 29th 2018 Duration: 2hrs 30 mins No. of Participants: 9 Schedule: ● Introduction ● Presentation and discussion by psychotherapist, Laurita De Diego Brako ● Skit and Role play with external actors ● Guided discussion using tennis ball ● Breathing exercises ● Alternative tension/ relaxation exercises and quick stretches ● Closing Remarks & Refreshments	Date: July 13th 2018 Duration: 1hr No. of participants: 5 Schedule: ● Introduction ● Vocal and breathing exercises ● Standing and mat stretches with timed interval breathing exercises : 1min each (30 secs breath, 30 secs stretch) ● Heart Rate Measurements ● Name + Gesture activity ● *Soldiers and the Skipper* from Boal's Arsenal of Games & Exercises ● Image theatre: *Second Model* from Boal's Arsenal of Games & Exercises ● Playback theatre ● Closing Remarks & Refreshments
WORKSHOP 3 led by Elizabeth Sutherland	WORKSHOP 4 led by Elizabeth Sutherland and Crystal Mercer
Date: July 27th 2018 Duration: 1hr 30 mins No. of Participants: 8 Schedule: ● Introduction psychodrama warm-up activity : Connecting with your inner protagonist – dreams and goals ● Ash walk by Butoh ● Alexander technique: Chair exercise ● Forum theatre	Date: August 10th 2018 Duration: 1hr 15 mins No. of Participants: 7 Schedule: ● Introduction ● Warmup with Breathing exercises and Alexander technique ● Playback theatre and role play ● Progressive muscle relaxation by psychomotor therapist Alina Veseer ● Closing Remarks and Refreshments

• Jacob Moreno psychodrama action activity • Setting Affirmations : psychodrama sharing activity • Alexander Breathing Exercises • Constructive rest exercises • Closing Remarks and Refreshments	

Table 2.0. Heart Rate Measurements taken during Workshop 2

	Pre-Workshop		During Workshop	
	Smartphone Pulse Oximeter	Manual Self-Check	Smartphone Pulse Oximeter	Manual Self-Check
J	80	84	-	77
A	92	90	82	82
O	84	82	76	-
N	88	86	-	78

SURVEYS

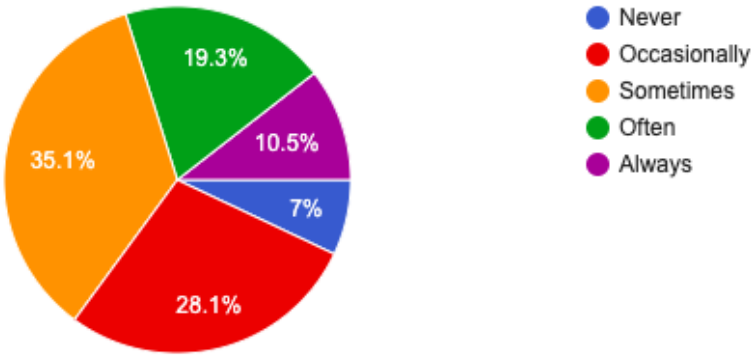
A. Female Med Students - What does the Future Bring?

1) What year of medical school are you in?
2) Why medicine? Choose all that apply.
    - Help Others
    - I like or I'm good at science
    - My family/friends want me to become a doctor
    - To revolutionize healthcare in Ghana
    - To support my community
    - Other…
3) Roughly, how many female medical students are in your class vs male medical students?
4) Why do you think the female to male medical student numbers are so?
5) On a scale of 1 to 10, rate your stress levels as a medical student
6) On a scale of 1 to 10, rate your stress levels as a FEMALE medical student.
7) What factors could account for the difference/similarity in ratings between the previous two questions? Consider cultural, gender, social, economic, etc. factors.
8) On a scale of 1 to 10, rate your wellbeing as a female medical student. Consider physiological, mental and emotional parameters.
9) What are some specific stressors you anticipate facing in the future as a female physician? Consider cultural, social, gender, financial, religious, etc. factors.
10) How often do you engage in the arts(music, dance, creative writing, theatre, photography, etc.?
11) How do you feel when you engage in the arts? Select all that apply.
    - I don't know
    - Relaxed
    - Energized
    - Tired
    - Overwhelmed
    - Other….
12) Kindly elaborate on your answer(s) above?
13) How do you feel about using arts based approaches for stress management and wellness?

Sample results from female medical students survey

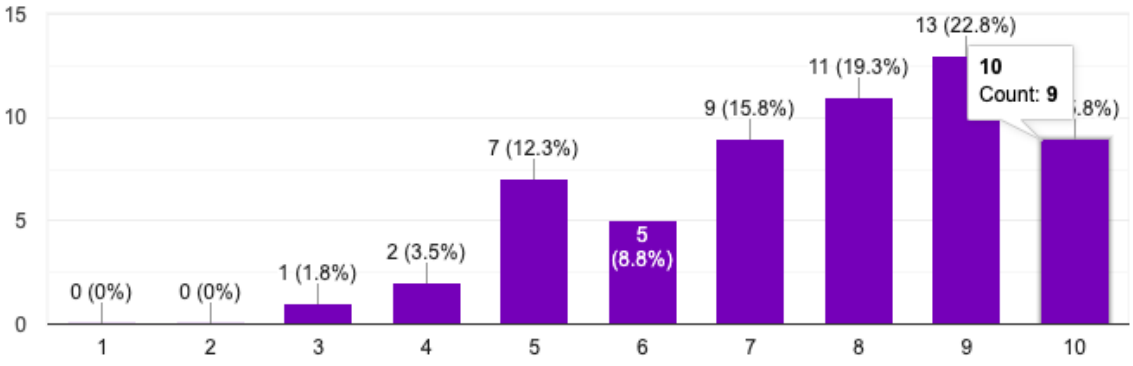
How often do you engage in the arts(music, dance, creative writing, theatre, photography, etc)?

57 responses



On a scale of 1 to 10, rate your stress levels as a FEMALE medical student.

57 responses



B. **Female Physician Survey**

Intro Message: This short survey is designed to collect information on the lifestyle and stress-inducing factors of female doctors in Ghana as part of Margaret Darko's senior research project on exploring female physician wellness in Accra using theatrical approaches.

1) How old are you?
2) Why did you choose to pursue a career in medicine?
3) Roughly how many students were in your graduating class? How many of these were female?
4) What type of doctor are you?
5) On a scale of 1-10, rate your stress levels as a female physician
6) What do you think are some challenges, obstacles or limitations you face as a female doctor in our Ghanaian society? Consider sociocultural, financial, family gender, etc. factors...
7) What are some benefits of being a female physician in Ghanaian society? Kindly provide personal examples if possible.
8) What does good wellbeing mean to you? What do you personally do to ensure good wellbeing?
9) What are your thoughts on using arts-based approaches for stress management and wellbeing practices? These can range from breathing exercises for singers and actors to writing for stress relief. What are your thoughts on including such practical approaches in the medical school curriculum?
10) If you would like to be contacted for further questioning, or know more about the study as a whole, kindly leave your email below.

Sample results from female physician survey

What does good wellbeing mean to you? What do you personally do to ensure good wellbeing?

- Being financially sound. Being satisfied at my workplace and having that work/ family balance I would like. Personally I take occasional trips to relax. I try to have a social life outside medicine and family too.
- Taking breaks. Vacations during my leave period
- Spend time with my family
- Good wellbeing entails ensuring complete care for your health and life. I try to get good sleep when the opportunity presents itself, good nutrition and take some time off for entertainment
- I dance or try to relax with music or go out
- sound mind and good body. I try to take long walks occasionally and eat at least a fruit a day.
- A state of well-balanced emotional, social, psychological and economic life
- Having a sound mind, being in good physical health and resting well despite daily struggles. I exercise.
- Good mental and physical health. I take time off during the week to take myself out to relax
- Financially spiritually, emotionally sound and balanced .
- Exercise regularly, eat well, sleep well
- Being at peace with ones self and environment. Rest, vacations, spending time with family
- Sleep

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