Universiteit Leiden
The Netherlands

Ghanaian nurses at a crossroads: managing expectations on a medical ward

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Citation

Böhmig, C. (2010). *Ghanaian nurses at a crossroads: managing expectations on a medical ward*. Leiden: African Studies Centre. Retrieved from https://hdl.handle.net/1887/15028

Version:	Not Applicable (or Unknown)
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Note: To cite this publication please use the final published version (if applicable).

Ghanaian nurses at a crossroads

African Studies Centre
African Studies Collection, vol. 23

Ghanaian nurses at a crossroads

Managing expectations on a medical ward

Christine Böhmig

Published by:
African Studies Centre
P.O. Box 9555
2300 RB Leiden
The Netherlands
asc@ascleiden.nl
www.ascleiden.nl

Cover design: Heike Slingerland
Cover photo: Christine Böhmig

Printed by Ipskamp Drukkers, Enschede

ISSN: 1876-018X
ISBN: 978-90-5448-093-8

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Dedication

This book is dedicated to my late mother and my daughters, Juliane and Leonie, who provided my past, share my present and point to the future.

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Preface and acknowledgements

In March 1992, I travelled to Ghana for the first time to work in the Maternal and Child Care Unit in Cape Coast Hospital. Thinking my job was to weigh babies and give vaccinations in a health centre, I found myself in a different setting. After registering at the Ministry of Health, I was expected to greet the local chief and explain my mission. At the work site, clinical consultations were embedded in social gathering, praying and singing. While I taught young mothers about breast feeding and family planning, children would run though the gathering playing with a ball while old women sold minerals. On a rainy morning, I packed my bike and cycled the three kilometres to the health post, arriving in time but soaked. I was alone there. The community nurses would arrive hours later, after the rain had stopped and their children had gone to school. What was nursing about? My study of medical anthropology provided me with some answers and even more questions. More than ten years later, I arrived again in Accra to start my research on nurses in a hospital. The country had changed; its political system had stabilised, new roads now connected towns and villages and mobile phones and internet cafes had entered the daily life of the people. Before I settled in my room that would accommodate me during the fieldwork period, I greeted the local elderly and I was introduced to the community and encouraged to attend regular church services. And the nurses? As I would soon find out, caring and nursing is still embedded in singing and praying, in cultural events and the weather has an influence on the day's activities. But along side the colourful, noisy and adventurously fragrant scenery, I saw patients facing untimely death, families being overwhelmed by fear and financial burdens and outdated health facilities that could undermine appropriate health care delivery. And I observed nurses in white dresses trying to cope with the situation, caring for the sick and encouraging the dying.

When asked for a number between 1 and 6, a friend of mine said: 7! Is this a joke or deep wisdom? During this research, I had to learn that not everything can be planned; the unthinkable happens, new ideas appear and this opens new perspectives. The last few years have been an adventurous and exciting time. Since I started this research in January 2004, my path has taken several unforeseen turns. It has brought me to crossroads and it was not always easy to decide which direction to take. Sometimes, researching and writing seemed a lonely business. It was good to know I was not alone and I shared many joyful moments with family

and friends in Ghana, the Netherlands and Germany. When the road was rough and dark, I was grateful for their help and support. Below, I want to acknowledge some people whose guidance, co-operation and support have made this book a reality.

In Ghana, my deepest gratitude goes to all the nurses, nursing students and health care assistants on the ward where I worked. Thank you for allowing me into your midst, sharing your experiences with me and working together on the ward. Mrs. Barnes, Mrs. Hammond and Matron Elizabeth Menyah, it was a privilege working with you. You told me your stories and I took them with me; I am grateful for your trust. I also thank the patients for their patience and friendship. Elisabeth, Ethel, Martina and Rose, may you rest in peace – you are not forgotten. Thank you, Mrs. Owusu and Mrs. Richter-Addo for telling me about the beginnings of nursing in Ghana, the members of the GRNA and NMC who explained to me the principles and guidelines of their work, and the many nurses in the health posts and clinics in Accra and throughout the country where I visited and conducted interviewes. I want to thank the members of the Institutional Review Board of the Noguchi Memorial Institute for Medical Research of the University of Ghana for approving my research, and the administration of Korle-Bu Teaching Hospital for their support. Special thanks go to the staff and students of the College of Nursing at the University of Ghana, Legon, and the former dean, Ms. Mary Opare who helped me in the formal application of the research and with whom I share interest in the history of nursing, Mr. Al Hassan for his never-ending friendliness and patience and last but not least Mr. Osei Tutu for transcribing my interviews so accurately and well.

Research is one thing, but living in Ghana, away from my own family and culture is another thing all together. I am grateful to Rev. Abbey and his whole family in Madina and La for their support, patience and guidance during all those months that I stayed with them. Discussing and praying together and sharing food and thoughts nourished me in various aspects. Jonathan and Lisbeth, Auntie Joyce and Mrs. Regina Abbey, you helped me to manage on daily basis. May God bless you in abundance. The friendship with Derek and Vincentia Nikoi, Mr and Mrs. Aryee, Mrs. Joyce Duah, Rev. Lawson and his wife and the students of Trinity Theological Seminary, Legon, formed a solid factor during my Ghanaian months.

Supervising my research, my foremost gratitude goes to my supervisor, Prof. Sjaak Van der Geest. I still remember standing in front of your door in the autumn of 2003, knocking to start one of my biggest adventures so far. Writing e-mails and travelling to Amsterdam to discuss texts with you, exchanging ideas and trying to explain my thoughts have been valuable and important to me. I enjoyed your sharpness and support and your questions and critique encouraged

me to work consciously, sort out my ideas and to discover themes. It is a privilege to share your love for Ghana and life in hospitals. Spending a day with you in Accra's overcrowded streets, walking over 'my ward', visiting the mortuary together and finally sharing kenkey, dried fish and shito (pepper) was just one highlight. Thank you for believing in me. My gratitude also goes to Prof. Kodjo Senah, my supervisor and advisor in Accra. Being overwhelmed by work, you always had a smile for me and found time to meet, to discuss my findings and add your perspective. You helped me to look closely and understand the observed.

I want to express my thanks to AMIDSt, especially Prof. Isa Baud and Mr. Gert van der Meer for the financial and organisational support that enabled me to be a PhD candidate at the UvA. Benson, we started and finished together: Because both of us worked in hospitals, we experienced similar moments of excitement, doubts and perseverance, exchanged ideas and read each other's chapters. Thank you for your friendship and collegiality. I also thank the members of the PhD and hospital reading clubs, especially Fuusje, Joan and Diana, for sharing texts and exposing our research to critique and support. I owe a special debt of gratitude to Cate Newsom who carefully read and edited the manuscript. I am also grateful to Ellen van der Kemp and Gregor Bergdolt who supported me in translating the summary into Dutch and German.

This research could have not been carried out without the support and understanding of my employer. At University College Utrecht, I want to thank Paul Hermans and Dr. Hans van Himbergen for making the fieldwork period possible; Dr. Rob van der Vaart and Dr. Aafke Komter for their encouragement in the last years; and my tutorial colleagues for taking over some of my work and encouraging me to carry on.

Many friends lived along with me, listenend to my stories and knew when to ask for progress and when it was better not to ask. I thank you for your encouragement and for reminding me that life is more than just work. I am looking forward to enjoying life and friendship with you; we will return to laughter. Lucia en Maxim, bedankt voor jullie medeleven en vriendschap. Lieke, thanks for your suggestion that I should ask for a sabbatical; Lonia, indeed, sometimes 7 falls within 1 to 6! Ellen, without our adventures in Accra and Kumasi, this book wouldn't be here. Gregor, es ist gut.

No person lives by herself, but is part of a family. My whole family has been extremely supportive and agreed to carry the burden of this research with me. My parents followed me all along, when travelling the first time to Ghana, discovering my academic curiosity and returning to Accra 15 years later, wondering about my enthusiasm. Being hospitalised in September 2007 herself, my mother discussed with me the role of religion and cultural forms of dying peacefully, not

knowing this would be our last encounter. Danke für alles, ich trage unsere Gespräche in mir. Frank, thank you for your interest and help during all those years. You and your family's friendship and patience are special for me. From the very beginning, Ghana was my passion, not yours, but you supported me in my plans and their realisation. Our path was long and finally rough, but it wouldn't have worked without you. Bedankt voor alle hulp en steun. Liebe Juliane and Leonie, die letzten Jahre waren nicht einfach. Es war für euch und mich schwierig, immer wieder getrennt zu sein und wieder zusammen zu finden. Ihr habt meine Arbeit mitgetragen. Danke für eure Liebe und Unterstützung. Ich bin stolz auf euch und staune, wie ihr das Leben entdeckt und euren Weg geht. Dieses Buch ist für euch.

Christine Böhmig,
September 2009

PART I

INTRODUCTION

1

Setting the scene and theoretical considerations

Setting the scene

In the early morning, many nurses join *trotro*[1] in the direction of Korle Bu Teaching Hospital and cross the Korle Lagoon to reach their destination, not knowing what the day holds. The nurses come to work on the wards, most of them are still tired from the short night rest and already exhausted from the morning routine in their family households. They doze or chat with colleagues in the overfilled car, their white dresses prominent between the school uniforms of the children and the colorful dresses of the market- and washerwomen who also approach their workplaces in the nearby township. All know the poem about the Korle Lagoon: *"Come and listen to me ... Listen to my complaint ... I gave them vast land. For the construction of Korle Bu hospital ..."* It is famous in Accra, children learn it in school and recite the metaphorical cry for remembrance and respect.[2] The lagoon's water was crucial for the survival of the early inhabitants of Accra, and it was a place to meet before it turned into a stinking pond and its neighborhood into one of the poorest areas of the capital. Its meaning and importance seems underestimated and neglected today as modern and glamorous areas spring up elsewhere. Several nurses refer to it as a metaphor of their situa-

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1 *Trotros* are small vans transporting up to 15 persons. They form the cheapest means of transport in the country.

2 See Appendix E for the full text of the poem *Abooyo* by A.A. Amartey.

tion. Do they get the reward they expected when choosing this profession? They reflect on their current situation, feeling sometimes unnoticed on the work floor. Near the water, the billboard of a money transfer company advertises with a nurse working overseas suggesting that she makes money there to support the family back home: "Our sister is sending her support. Fast, reliable, worldwide money transfer." Leaving the country and the local working conditions appears tempting; many nurses have a friend or colleague abroad. Overseas, the conditions seem brighter, payments and recognition more adequate, but such option remains unreachable for most of them. Who hears their cry? A mix of expectations, dreams, hopes and worries accompany them as their vehicle turns into Guggisberg Street and delivers them in front of the new administration building of Korle Bu Teaching Hospital. They get down and rush to their wards; a new shift begins.

Passing the Korle Lagoon in January 2004, I did not know what to expect as I entered the hospital for the first time. I saw a colourful street life and people calling me to buy their food or attracting my attention. Poverty and dirt in the township contrasted with the impressive old hospital buildings. I did not yet know the poem with its meaning and call for remembrance. In the following years, my perspective became more focused and clear: Questions arose, connections were made and answers found. Working with nurses and aiming to understand their work, themes like recognition, neglect, pride and change turned out to be prominent. Stories were told, situations experienced, I was invited to listen and live along. Passing the water on a daily basis, I saw reconstruction work starting, seasons passing, and the nurses kept crossing the lagoon with me. They sometimes covered their noses with a handkerchief to avoid its acrid smell or sometimes they watch birds flying by to welcome a new day.

Since my first encounter with Ghanaian nurses in 1992, I became interested in their work and working rationale. I soon experienced tension between the image of nurses, the authority they radiate, and the powerlessness they face in their daily routine. Various forms of hierarchy, initiative and repression were visible on closer inspection. I want to understand how they manage their work and the quantum of resources available to them to regain energy and motivation. Being the most visible workers in the health sector, it is astonishing that relatively little has been written about nurses in general and in Ghana in particular. Writing on nurses in Ghana, my aim is to find answers to my questions and contribute to the academic discourse in medical anthropology.

"I am a nurse!" This seems to be a sentence with a universal meaning. Anybody hearing such a statement forms an image consisting of ideas, imagination, dreams and wishes. Some might think of the silent, obedient, ever present nurse who serves the patient on doctor's order; others of the independent health care

provider representing her own profession. Nurses fulfill tasks in the health posts, clinics and hospitals all over the world. Following the definition of the International Council of Nurses (ICN), nurses prevent illness, care for the sick and attend to the dying.[3] Their training follows international standards and many aspects of nursing procedures are regulated for the European, Asian, American and African nurse alike. But in reality, nursing differs from continent to continent and from culture to culture. Adapting the idea of Kapuscinski (2008), humans, and in this context nurses, are always incorporating several sides in their actions: Universal, culturally specific and personal aspects. Most nurses who work in a hospital or clinical setting, only represent universal biomedicine at first glance. Such locations have their own meaning and organisation, leading their workers into very different roles in different cultural and socio-economic settings.

Anthropology of nursing

Nursing is one of the oldest tasks of women. From ancient times through the reform and structuring of nursing by Florence Nightingale to today's debates, there have been discussions on what nursing as a profession should entail and how it is positioned within the organisation of the medical care setting (King 1991, Davies 1980, Garmanikov 1991). There are manifold perceptions and ideas about how a nurse should understand her work and this is often combined with ideas on female behaviour as such. The British 'Practical Nursing' guide mentions the following characteristics of a nurse: Be graceful, display integrity, intelligence, look fit, convey a sense of good health, well-being and happiness, avoid problems and conflicts. Other textbooks from this time mention their role as: relieving loneliness, attending to physical needs, being calm and dignified (Garmanikow 1991). Reforms and research in nursing carried out by nurses changed that perspective and called for a revised view on the profession (May 1992, Street 1995). Recent nursing theories shift their focus away from the obedient passive receiving nurse and research now focuses on the relationship nurses as representatives of an independent profession have with the medical profession and with patients (Armstrong 1983, Ceci 2004). The emphasis is on the process, acknowledging the emotions and power constellations of the doctor, the patient and the nurse. It is understood that interactions between parties influence the

[3] Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management and education are also key nursing roles (ICN).

behavior of all. Or, as Nancy Rooper has put it, "it is not enough to be a tender loving person" (in Armstrong 1983).

Also in anthropological research, nursing has long been perceived mainly as a service rendering profession on the margins of medical work. It took time to discover "that nursing is not subsumed by medicine (and this) is a point not widely understood in anthropology" (Dougherty & Tripp-Reimer 1985: 219). In the last decades of the 20th century, anthropology and nursing discovered and discussed natural alliances and differences (Dougherty & Reimer 1985, Mulhall 1996, Holden & Littlewood 1991). Two lines of co-operation and research started: The anthropology *in* nursing and the anthropology *of* nursing. The first, mainly carried out by nursing researchers in the United States and the United Kingdom created the awareness for nursing in multicultural societies. The focus is that patients and medical staff from different cultures have and need awareness of their different needs. Madeleine Leininger (1977, 1985, 1995, 1999) can be seen as the most prominent representative of anthropology *in* nursing. She developed the Theory of Culture Care Diversity and Universality in the mid 1970s and has refined it up to today. Being based on the situation in the US, her school calls for an increased knowledge of specific cultures among nurses and patients and a flexible interactive nursing process of patients from various cultures. The practice of nursing should build on culturally based care beliefs, values and practices to help individuals to accept diseases, regain or maintain health, face disabilities and deal with care in beneficial ways. It is a holistic approach to sensitise nurses to patients' needs and fears and make them competent mediators between patients and the regime of the hospital. Researchers developed models to approach patients in culturally sensitive ways and include specific needs in the hospital care, such as awareness of one's religion, cultural eating behaviors and gender roles (e.g. Evaneshko 1985, Glittenberg 2004). Such models have been under discussion whether it could be just another means to classify and label the patients and enable nurses to apply their power and reach social control (Mulhall 1996: 634). Other nurse researchers further developed it and use anthropology *in* nursing as a starting point for applied research and to look closer on the professional level what is happening in the training, socialisation and work of nurses (Dougherty & Tripp-Reimer 1985, Davis-Floyd 1987, Street 1995, Du Toit 1995, Brink 2001, Mill & Ogilvie 2001).

The anthropology *of* nursing researches the profession and its practice, focusing on certain aspects or culturally specific things. Nursing is a combination of a service profession, acting according to prescriptive orders, and a discipline, developing descriptive models and theories. Having been in the shadow of medicine for a long time, it is now unveiled and connections with anthropology are debated. Both disciplines apply methods of observation and aim at a holistic

view. Special attention is given to four elements in nursing that are fundamental in (medical) anthropology: Interest in the human nature, the role of the environment, concepts of health and nursing as a mediating role in the natural triad of patient, doctor and nurse (Doughterty & Tripp-Reimer 1985: 226f). Most studies focused on the socialisation of nurses and their training (Melia 1987, 1994, Du Toit 1995, Heikinnen *et al.* 2003, Mill & Ogilvie 2002). Davies' influential work on nursing history contributed to the feminist perspective, seeing modern nursing as still rooted in patriarchally constructed femininity (1980). Holden & Littlewood's edited volume on anthropology and nursing in 1991 marked a milestone in the anthropological research of nursing, highlighting various aspects of nursing though time and places and revealing the ever-present mixture of the nursing profession and the cultural perception of women. It shows "that while the content of the nurse's work might differ in different societies, her universal role, that of caring, is restating that particular society's cultural values" (1991: 6). Recently, more ethnographic research focusing on the position and role of nurses in the medical encounters has been carried out in Europe (Street 1995, Vermeulen 2001, Mesman 2002, Ceci 2004) and non-Western settings (Sciortino 1992, Marks 1994, De Regt 2003, Martin 2009).

Hospital ethnography

Having emerged over centuries in Europe, hospitals have a stable place in our society. They are found in cities, towns and even villages, offering health care and medical treatment. Konner sees hospitals as "our modern cathedrals, embodying all the awe and mystery of modern science, all its force, real and imagined, in an imposing edifice that houses transcendent expertise and ineffable technology" while Grossing suggests that they are regarded as enterprises that view patients as lucrative sources of revenues as well as institutions that function at various times as jail, school, factory or hotel (Zaman 2003: 10). Seeing them as places of modern technology, a stage for various medical professions to display their knowledge or space where interaction happens, they are a melting point where fears and hopes, rational behavior and religious conviction meet and decisions on life and death are taken (Comelles 2002, Nijhof 2002, Zussmann 1993). All these perspectives have in common the assumption that hospitals offer a stage for persons with their experiences and in their interaction and organisations with their guidelines and procedures. Early sociological researchers focused on the hospital as a clearly demarcated place outside society, where physical or psychological deviance and anomalies were treated (Zussman 1993, Hahn & Gaines 1985, Glaser & Strauss 1965). In his study, Parsons labelled hospitals as institutional systems; the sick person was assigned the sick role which legitimises his being taken out of his social place and reintegrated after recovery (1951). In

the 1960s, sociologists carried out pioneering work in hospitals. The most popular are the reports of Coser (1962) and Goffman (1961). They defined the wards as 'islands' and 'total institutions', understood as isolated from the 'mainland' of society.

Somewhat contrary to that view, Gellner & Hirsch claimed forty years later that "organisations do not exist in a vacuum. They operate in a wider context which both provides them with the aims they pursue and sets limits to the way they may operate" (2001: 4). Recently more research has been carried out in hospitals by anthropologists, applying ethnographic methodologies.[4] Hospitals are perceived and defined as non-identical clones in spite of their standardised biomedical features. Put more strongly, they mirror society and their actors remain in their social and cultural setting (Van der Geest 2001, Van der Geest & Finkler 2004). Zaman, who wrote an ethnography of a hospital ward in Bangladesh (2005), emphasised that hospitals are not isolated wholes but rather have to be understood as part of the society in which they are positioned. For the hospital, this means that its employees and patients represent society with its norms, values and limitations. It also implies that the hospital researcher needs to follow culturally and organisationally appropriate steps to achieve co-operation and permission. The concept of a hospital was exported to the African colonies in the early 20th century as a product of modern Europe, aiming at practising Western medicine. Initially opened only to the colonisers, it was a powerful place of determining and displaying differences; but soon it opened its gates to the indigenous population and with them, their culture, traditions and norms, which filled the wards (Curtin 1992). Hospital ethnography shows that and how local factors play an important role in the daily routine of the hospital, reflecting the culture in which it is embedded (Van der Geest & Finkler 2004, Van der Geest 2005, Gibson 2004, Van Dongen 2004, Mulemi 2008, Böhmig 2010).

Theoretical considerations: Assigning power and transferring knowledge

Several ideas and theoretical concepts form the basis of the research, and these are introduced in the following section In the chapters that follow, they will be applied to understand and interpret my observations. The aim of this book is to describe the development of nursing in Ghana and picture nurses at work on a medical ward of a big hospital in the Ghanaian capital. It will become clear how nursing is structured and according to which ideas and perceptions nurses operate. Through experience and skilful practice, professional beliefs and personal

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[4] See for example the special issues in *Social Science & Medicine* 47(9), *Anthropology & Medicine* 2008 15(2), *Journal of Contemporary Ethnography* 2008(37).

convictions, the power constellation within the nurses and with other actors are displayed, discussed and re-organised. They form the basis of the perceived reality and lead to a definition of the position of nurses. It is an oscillation between dynamic and fixed interactions, searching for balance and releasing tension, defining and redefining power and resistance in the daily working routine.

> It seems to me that power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation … Power is omnipresent because it is produced from one moment to the next, or rather in every relation from one point to the other. (Foucault 1978: 92)

Michel Foucault tries to find meaning and reason in facts and interactions. To understand what is 'normal' today, he applies an 'archaeological' perspective. Removing all current self-evident convictions, history and structure are unveiled; they appear and reveal those conditions that transform an idea into a reality. Immediately, the notion of power is introduced. Foucault sees power as a productive force; his concept of biopower, that manages the population and disciplines the individual, works not through discipline and violence but is a tool being successful through persuasion and appropriate thinking (Turner 1997, Gastaldo 1997). Power produces realities and structures relationships. It functions in a decentralised net-like form, operating on a micro, local and covert level. Persons simultaneously undergo and exercise power; they are subjects and objects trying to achieve equilibrium. In different contexts, people dominate or are dominated, oscillating between threat and supply of power. Following Street, the question is not "who has power?" but "how is power organised? How is power produced and functioning? How does power structure relationships?" (Street 1995, Riley & Manias 2002). Knowledge is an equally important factor. Knowledge means, next to the accumulation and reproduction of facts and beliefs, the practice of giving reasons for what one believes and whom one believes, it always involves social relations of power and can be displayed in rituals: Power and knowledge feed and imply each other, knowledge influences the actions of power and can therefore never be neutral. "Who can be and who should be believed is then based not on what one could be said to know but on who one is" (Ceci 2004: 1882). Thus, power creates sites of knowledge formation and exists through the disciplinary practices. Where power meets knowledge, truth is constructed, a specified truth that confirm and support existing power relations.

Another important concept is *le regard*, (translated as 'gaze'), exercised by powerful persons. It means both the perception but also the active mode of seeing. This brings social objects (like diseases) into existence, localises things, creates facts and develops a language for the still then unseen. The gaze is an act of realisation. Persons, situations and things become and are, obtained through

repetition and recognition (Riley & Manias 2002). Discussing the presence or absence of a nursing gaze sharpens the understanding of what is happening on a hospital ward. The question then is how to get into the gaze of a more powerful person, or how to escape from it, or how to use the gaze for personal advantage. The concept of power and knowledge is used to understand the functioning of medical systems and the interactions of actors in that system. In the modern hospital setting, the nature of the illness and disease decide on the status of a patient, hospitalised persons tend to become de-individualised and clustered in groups and series. Nursing processes can be recognised as those through which social processes come into existence and discourses start. Holden & Littlewood (1991) mention language, symbolic systems and identity-features as possible areas for such analysis. Some discourses turn out to be more powerful and influential than others, However, all operate under constant challenge. Summing up, this means that:

> Power produces knowledge; that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. These are 'power- knowledge relations'. (Foucault 1977: 27)

In the context of Ghanaian society and its health system, different points can be raised in which the above-mentioned mechanisms are employed: Ghanaian society is organised following a hierarchical structure: The displayed hierarchy clusters generations with unequal social authority, aspects of gender like the matrilineal Akan and patrilineal Ga and types of professions (certificate, diploma, degree). Within professions, a top-down organisation is found and enforced, if necessary by disciplinary measures. Social change and globalisation are leading to new groups such as businessmen, returning migrants, people who had been denied access to modern media (internet, mobile phone) and women to start to question their position; urbanisation is influencing the traditional functioning of the extended family system. The perception is that accepting the hierarchies is indispensable in order to become and remain a member of the group. As it is also a traditionally oral culture, the transfer of knowledge mainly used to occur through oral forms of story telling, acceptance and imitation (Müller 2005). An important aspect of socialisation is that of learning from the older generation and undergoing moral education through them. Researching the relatively new profession of nursing that was introduced by the British colonial power and taught through written sources, a possible friction with the traditional oral knowledge transfer could be expected. New forms of hierarchy and a shifting rule of assigning and accepting responsibilities were likely to be found.

Knowledge is used and spread within the group, but sharing it with outsiders requires time and trust, if not deals and negotiations. When adapting to new

situations or changed conditions, everybody tries to keep or heighten his/ her position. So if power is not stable but fluid, acting both 'bottom up' and 'top down', the existing hierarchy is challenged permanently. Power is then indeed productive, as it is exercised rather than possessed. On the work floor, this leads to shifting analyses of the situation and one's own position and role while maximizing one's influence and saving one's own face in negotiating compromises.

The structure of power and flow of knowledge can be found in respect to the work of nurses on the ward. "Nursing has failed to recognise the Foucauldian idea that the humanist discourse, like any other, must be perceived in terms of the inextricable link between knowledge and power" (Mulhall 1996: 634). They are a tool to understand what is happening. The reality on the ward for nurses can be seen as an oscillation between being an object and subject with regard to power and access and construction of knowledge. Both within the nursing body as also in interactions with other health professions and patients, power and influence is negotiated. As power is relational Lupton reminds us that "Foucault himself was careful to emphasize frequently that where there is power there are always resistances, for power inevitably creates and works through resistance" (Lupton 1997: 102).

Applying Foucault in the research on nurses in the hospital, several fields of power display and knowledge application are relevant and have to be discussed. Looking back in history, multiple determinants of today's situation of nursing will the unveiled. The role of women and the influence of social change in society will be examined to understand why girls choose this profession and in which position nurses find themselves in the interactions on the ward. Aspects like the hierarchical organisation of the hospital, the availability of working equipment, the influence of routine and the strictness of the dress code, the role of religion and language have to be discussed to understand the constellation of power and transfer of knowledge of nurses on the medical ward. Finally light will be shed on the perception of nurses and nursing, oscillating between internal and individual goals and external and social forces.

Objective of the study

Nursing in the Ghanaian context means balancing the universal concepts of nursing, individual hopes and aims, and everyday practice. Nurses are often the most visible actors on the floors of the wards and polyclinics; even so all the attention goes to the medical professionals and their evaluation of the patients' condition. This research project does put the nurses in the gaze and focuses on their work. Ghana serves here as a case study for the developing countries in sub-Saharan Africa, being the first country in the region to introduce its own nursing training in 1945. Contributing to the growing literature on nurses and hospitals, it

gives a voice to the Ghanaian nurses and looks at the state of nursing at the turn of the 21st century. The main questions are: How did nursing in Ghana develop? How do nurses manage their work under the given conditions? How do nurses perceive themselves? The working reality of nurses and the perception of nursing are examined using an ethnographic approach on various levels. The focus of this research is on nurses working on a medical ward in one of the academic hospitals, to some extent also including perspectives and perceptions from outsiders, doctors and patients, nurses' families and the larger society. This ethnographic method makes it possible to come to an understanding of the nurses' work as it "can mean all sort of things to different people in different situations" (Van der Geest *et al.* 1990: 1025). Shedding light on the entanglement and influences through time, professions, hierarchies and international linkages, nursing means balancing the concept of nursing as it is taught in the training colleges, nurses' expectations and society's perception, and the everyday practice. Nurses wish to be part of a coherent history, but the working reality uncovers breaks and complex interactions. The official history and the everyday experience do not always match.

After introducing theoretical considerations, chapter two discusses the ethnographic methodology, various roles of the researcher and ethical considerations. Part two gives the overall context in which Ghanaian nurses operate. It introduces the main social and cultural features of Ghana with a focus on religion, the notion of respect, and aspects of women's lives. It also describes the beginning of biomedical medicine and the beginnings of nursing up to present day nursing training, concluding with an insight into the motives and experiences of nurses working today on the wards. Part three presents the findings of the ethnographic study. It analyses in particular the work of nurses on a ward, their routine, hierarchical grouping, situations that are particular to the medical department. It also looks at the challenges involved, including their self-evaluation, resources and perceptions, working with and in contrast to the so called universal ideas of health care and culturally specific needs, that create the specific forms of nursing on this ward. Nurses appear as part of a universal profession in the globalised biomedical world while being rooted in a specific cultural context.

2

"Who are you and what is your mission?" Methodology and roles

> In January 2004, I visited the hospital in Accra for the first time and went straight to the nurses' department of the administration. Entering the secretary's room, I found myself among a group of nurses, all wearing white dresses and caps. They looked at me, invited me to sit down and asked: "Who are you and what is your mission?"
> It took me more than a year to show them who I was and could be, what my intentions were and which concrete plans had brought me to their hospital. "Now we got to know you, you are welcome; Tell us about your plans and ideas." I became a person to them and was allowed to do research on their work. Early in 2005, I was introduced to the ward by the director of nursing: "This is Christine, and she will conduct a research with us, so you will see her often. It is good she came, she can help us understand what is going on. She will also work with us, it is good you meet and get to know each other." I started my fieldwork and spent more than 10 months on the ward.

This chapter describes the methods I applied during my ethnographic research in the Ghanaian hospital and the writing of this study. After some general considerations, I will focus on the various steps I had to take in order to gain access, do my fieldwork, analyse the data and write the story presented in this book. Finally, ethical considerations and my role in the field will be discussed.

Doing ethnography requires several techniques and methods in order to gather data. Starting with Malinowski's classic text on fieldwork techniques (1922) up to Geertz' plea for thick description (1973) and recent textbooks, countless definitions have been provided for anthropological research. Bate distinguishes ethnography as an activity, a kind of intellectual effort and a narrative style: The process of doing, thinking and writing (Gellner & Hirsch 2001: 1). Silverman

mentions the range of sources of data collection, the concern with the meaning and function of social action and the use of everyday contexts in order to gain understanding (1993). For several years, the relationship between researcher and researched has received more attention and the awareness of this relationship as a valuable and important source of information and its possible influence on the study (Campbell 1998). These features are characteristics of qualitative research where the researchers are "guided by certain ideas, perspectives or hunches regarding the subject to be investigated" (Carr 1994: 716).

Considering how ethnographic research can be carried out in a hospital, three roles seem possible: Joining the staff, becoming a patient or playing the role of a visitor (Van der Geest & Finkler 2004).[1] Morse stresses the benefits of researchers being familiar with the medical professions: "Since they are certified to practise in a healing profession, they can operate … as practitioners as well as observers" (Morse 1989: 2). As will be shown below, my own background as a nurse and medical anthropologist was very helpful and made levels of observing participation possible. In addition, it became important and valuable to interact and mingle with the nurses and share personal stories and experiences. As Fetterman said "the ethnographer is a human instrument … relying on its senses, thoughts, and feelings, the human instrument is a most sensitive and perceptive data gathering tool" (Zaman 2008: 41).

In order to succeed in fieldwork, Evashanko (1985: 135) conceptualises four steps that should be taken: Preparation, initial contact or entrée, accomplishment and completion. These steps will be described in the following sections aiming at portraying the periods of data conceptualisation, gathering and analysis that took about four years.

Preparation

Preparing for ethnographic fieldwork in the organisation of a hospital required several steps. The first was a critical analysis of existing literature. Analysing the literature on West Africa and Ghana in particular, few written sources and descriptions could be found. There seem to exist only some historical accounts and handful recent articles on the beginning of nursing in the Gold Coast and its developments up to today's Ghana (Patterson 1981, Vaughan 1991, Twumasi 1975, Addae 1996, Akiwumi 1995, Anderson 2004). While the country prepared to celebrate its fiftieth independence day, what seems missing is research on the actual work and perception of nursing in Ghana.

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[1] Wind (2008) decided on a fourth role, 'doing the researcher'. She pleads for reconsidering the concept of participant observation and introduced the concept of negotiated interactive observation. See also Vermeulen (2001) on his role in doing ethnographic research on a neonatal ward in Belgium and the Netherlands.

My professional nursing background had brought me to Cape Coast in Ghana in the early 1990s working in the public health sector for several months. At that time, I was intrigued and became interested in the work of nurses and the understanding of nursing as an independent profession in the Ghanaian health care system. Planning a PhD research on that topic, the question was where to locate the study. Considering the few available sources, I saw much benefit in focusing on a public hospital and not on the private or church-related clinics and health posts. Even so, the majority of the Ghanaian population lives in rural areas (Songsore 2004) and the accessibility of hospitals varies a lot depending on the region. Each of the ten regions has at least one public hospital and an attached nursing training college. Looking at the reputation and professional understanding of hospitals, the two academic teaching hospitals in Accra and Kumasi, (Korle Bu and Komfo Anokye Teaching Hospitals) stood out without any doubt. The vicinity of University of Ghana on the Legon Campus with its sociology and nursing departments and personal contacts influenced the decision to choose Korle Bu Teaching Hospital as the main research site

Entry strategies

Of the three possible roles to be taken during the fieldwork, I chose to make use of my nursing profession and join the nursing staff. The knowledge would enable me to participate in the daily routines and be more than a pure observer on the ward. In January 2004, I entered the hospital for the first time and went straight to the nursing administration. Preparatory talks with the heads of the sociology and the nursing departments at the University of Ghana had encouraged me to approach the hospital and I had a letter of recommendation from Amsterdam with me. The scene described in the beginning of the chapter illustrates the limitations of my plans. A theoretical idea and the European concept of academic curiosity and enthusiasm opened the door but gave by no means permission for the research. Nobody in the hospital knew me, so why should I be supported? Other aspects of myself turned out to be of more benefit. Talking about my previous experiences in Cape Coast, my personal affiliations with the Presbyterian Church of Ghana in Accra and the fact that I stayed with Ga people in the outskirts of Accra gave the nurses an impression of my personal background and interest. Similarly, my social position back in the Netherlands as a married mother of two was important for them to form a picture. They could classify and link me to places and groups known to them, I became a person (Böhmig 2006). This rather informal aspect of entering the field opened the possibilities for me to establish a relationship with the nurses and influential members of the hospital organisation and to start working on the formalities of an ethnographic research.

During 2004 and early 2005, I stayed for shorter periods of four weeks in the hospital; I became acquainted with the ward and its people and they also got to know me. This brought us closer and helped me sharpen my research questions. In this process, I chose the female ward of the Medical Department as fieldwork site. There were two main reasons for this: Firstly, in order to research nursing activities, their routines and interactions with patients I wanted to be on a ward where patients stayed longer than just a few days. The patients' duration of stay in the medical department is generally longer that on the gynecological or surgical wards. Their illnesses represent the threats of daily life in Ghana, ranging from malaria and allergic reactions to hypertension, heart kidney and liver failure and the newer diagnosis of leukemia and organ cancer. Being interested in women's lives, I preferred the female ward to the two male medical wards. The second reason was a methodological one: For several years, the Medical Department was undergoing basic renovation and the medical wards were temporarily housed in another part of the hospital, mixing the nursing staff and specialisations anew. In order to get an optimal level of anonymity next to changing all nurses' and patients' names and to avoid simple recognition of persons and places, this temporary state of the ward helped to achieve this goal.[2] The director of nursing supported my plans and wrote me letters of introduction for the Medical Department. In addition, discussions with the Nurses and Midwives Council (NMC) and the Ghana Registered Nurses' Association (GRNA) took place. The latter were interested in the general aim of my study but reluctant to support my wish to work as a nurse in the hospital. I also realised that being there as a registered nurse would make it difficult for me to remain aside of professional dilemmas and difficulties. It was decided that I should remain on the background and only assist with smaller nursing activities.

In order to stay for several months as an anthropological researcher, I needed ethical clearance from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research of the University of Ghana (NMIMR). Obtaining such clearance required, along with the recommendation from my Dutch supervisor in Amsterdam, the support of the sociology and nursing faculties, help in finding a way through the bureaucratic features of the Institute, many copies of my research proposal and the consent forms, trust and patience. In the fall of 2004, the clearance was granted.[3] Informing the nursing administration at the hospital site, I could start the main fieldwork period, which lasted seven months, in the summer of 2005.

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[2] In 2007, the renovation was still going on and the nurses complained the temporary housing might become permanent.

[3] The ethical clearance was approved under the number FWA 1824 on October 25, 2004, and signed by the chairman of the NMIMR, Rev. Dr. Samuel Ayete-Nyampong.

Doing fieldwork

The initial positive welcome and support strengthened the plan to conduct the fieldwork as a participating observer. Helping the nurses with the smaller daily routines was thought to have two positive effects: I could help reduce the workload in the most practical sense of the word, participate in nursing activities and experience what it meant to be a nurse in this hospital. In addition, I assumed that 'just' sitting around and asking question would be less productive and limit the assertiveness and willingness of the nurses to cope with my daily presence. To make myself recognizable as (partial) member of the team, the nursing director decided on my clothing: A white coat over my trousers, a white shirt and white closed shoes. The white color distinguished me from nursing students who wear green dresses and black shoes and made it clear to outsiders that I was a member of the ward team. It took a little while till it became natural to meet the nurses every morning in the small rest room and change my clothes. The coat had two spacious pockets for my jotting book and pens. In addition, I received a badge from the main administration labeling me as staff member of the Medical Department.

While gathering data on all three shifts, my main presence on the ward was during the morning shift. Arriving on the ward around half past seven, the first hour gave me insight in the last activities of the night nurses before handing over. During visiting hour, the morning shift would arrive and take up duty after 8 am. Leaving after the afternoon shift started their work, I had witnessed the morning duties, washing, feeding and assisting the patients, joining doctor's rounds, collecting needed medication from the pharmacy, cleaning wounds, and distributing medication on the ward. Being on the ward during the night was complicated and asked for patience and perseverance. There were rumours about negligent nurses and patients being left alone on the ward, and I realised that the nurses on this ward felt uncomfortable about my presence. Finally I succeeded and was allowed to join a few night teams. In all shifts, a lot was to be observed and experienced. As Frank (2004: 439) writes, "getting yourself where the action is often means seeing that there is action wherever you are". During my study, I took a part in bed-making, feeding and bathing/cleaning of patients, assisted in wound dressing and catheterising patients. I also helped with the last offices of deceased patients and walked with the nurses on the doctors' rounds. In the less busy times and during the breaks, informal conversations took place when I could ask questions and procedures were explained to me. After a few weeks, my presence became normal and I was reprimanded when I arrived after 8 am. Two examples illustrate my presence on the ward:

> The nurses start their morning shift with a moment of devotion (prayer). Gathering around their table, they sing and pray, praising God for His mercy and protection and asking Him

> for support in their work. Unquestionably, I take part in that ritual, learn the songs and join the sharing of the grace. At a certain point, nurse Grace decides that it is my turn to lead the prayers and commands me to do so two days later. Feeling uneasy I still do it and receive thanks for it later on.[4] Nurse Martha says "You are one of us, you understand us. God will help you with your work."
> Matron Mary[5] saw me as part of her team and encouraged me to work. One morning she even pushed me: "Come here. Don't you also want to train your skills? Please, help with the making of beds, remove your wrist watch" Thunderstruck, I obey and start making the bed, feeling six pairs of nurses' eyes following each move I make and action I take. Apparently the result is accepted, the nurses smile at me and ask my assistance more often.

I took notes, made records to aid my memory, had informal talks, wrote down procedures and was allowed to take data from the report books and ward statistics. It soon became a habit to sit down and make notes. In the second part of my stay, I started more formalised interviews. Having gained the director's permission and starting off with her, I interviewed almost all the nurses, taping their stories openly and giving them the opportunity to read it. By that I wanted to create openness and avoid mistrust. Most nurses were happy with it and never asked to read my notes. I was rather teased with my notebook and my constant writing. At one occasion, nurse Martha uttered her understanding of my research:

> You want to know so much. We Ghanaians are brought up not to ask too many questions. Children who ask a lot are seen as troublesome. In the olden days we were asked to be silent. Today children are allowed to ask a bit more. You can interview us, it is a good idea. But only, we Ghanaians do not like to share secrets. If you ask something you might not get the correct answer, that is all.

It made me aware of my role, comparing me with a child asking probably obvious or inappropriate questions. To prevent major irritations, I increased my attempt to be cautious and avoid rushing. As Zaman wrote, I had to be patient: "Collecting data is like catching a butterfly; if you run after it, it flees, but when you sit quietly, the butterfly sits right on your head" (Zaman 2008: 148).

Reactions

The working staff and the patients on the ward reacted in various ways to my presence. The doctors hardly seemed to be aware of me. I was briefly introduced to the medical specialist and some doctors became interested in my work, but generally they did not take any notice. My clothing, primary interest and everyday presence with the nurses made me 'one of them' and not 'one of us'. Occasionally, the matron even asked me to stay off the medical round to avoid irritations and questions. Only one doctor asked me to assist him with certain medical

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[4] Chapter 13 analyses the role of religion on the ward, the function of the morning devotion and the consequences of participation or refusal in more depth.

[5] I use pseudonyms and not the real names of respondents in this study. In Appendix E, I have presented brief descriptions of the nurses and patients

procedures and to inform him about one patient's condition. When this very patient had to be readmitted to the ward months later and I informed him about a free bed for her, he smiled and said: "Oh, you did your trick and talked from nurse to nurse?"

The patients often took me for a doctor. They asked for my opinion on their medical condition and begged for efficient and fast treatment. The same reaction occurred when meeting their relatives, mainly the patients' husbands and brothers who asked me to "please look after her" and thanked me "for coming here and helping." Staying longer on the ward, they saw me making their beds and feeding the needy ones. One morning, an older woman asked me to come. She grabbed my hand and said: "Some people travelled and told me that you white persons do not like us blacks. But you came and even washed me. This is really being a person. I did not expect to be washed by a white person in my life." I became friends with two younger chronically ill patients and followed their stay both as a researcher and as a friend. With them, I could not always remain distanced but involved myself in their care, followed the doctors' rounds and visited them after discharge at home.

The nurses' group generally accepted me without problems. The nursing director greeted me on her regular rounds over the ward and occasionally asked me in her office to talk about my observations, findings and remaining plans. Her message to me had two aspects as she wanted to know about my research on the one side and see me work on the other side. Her opening questions would always be "How are you doing? Did you already render nursing care today or are you just observing?" The nurses in charge of the ward saw me as part of their team and assigned work to me. It was interesting to notice that they even felt the obligation to give me work to do. When the director came for her round, I was asked to stop writing and join the students with bed-making "Get up, do not sit down! Find yourself some work and be busy." As illustrated above, it seemed normal that I would join the devotion, do smaller nursing activities, pay every now and then to the ward fund ("you are one of us, so you also pay") and inform the matron about my presence and absence on the ward. Staying practically and emotionally distanced was difficult and I had to explain and negotiate my role as researcher on a regular base. This became especially difficult in critical nursing situations. On those occasions, the nurses were not sure whether I was one of them or if my presence formed a control or even threat to their working routine. For several weeks, two Scandinavian nursing students worked on the ward as part of their training. They had difficulties accepting their role as obedient subordinate nursing students with less autonomy and fewer responsibilities than at home and critically observed the routine on the ward. During that period, two patients died suffering from severe skin diseases. Their reaction was "Look at

them! They nursed another patient to death." While I also had my questions and doubts about the nursing care rendered, I forced myself to remain distanced and asked for the nurses' interpretation of the situation.

Leaving the field and writing the story

During the fieldwork I wrote daily notes on my ward activities and observations and conducted individual and focus group interviews that were recorded and transcribed.[6] In addition I spoke to teachers and students, attended classes at the nursing colleges in Accra, collected information with nursing organisations, visited a few hospitals and health posts in the rural areas, read newspapers and gathered accidental pieces of information by visiting friends and attending cultural and Christian meetings in Accra. After seven continuous months in the field, I left Ghana to return to Europe with my data. Leaving physically is just a matter of packing suitcases and catching a flight. Becoming emotionally and psychologically detached from the field turned out to be more complicated. The nurses had shared their professional and in several aspects private life with me and we had experienced life and death together on the ward not only as nurses and researcher but as human beings.

Saying farewell meant that my role as researcher had reached the next level. I had to transform the data into a story. Following Frank (2004), my research could turn into a detective story with a body to be discovered and an explanation to be delivered. What would be my body? "The practical qualitative research problem is how to see the action in situations where others see only life as expected … being where the action is, is necessary but insufficient by itself. Perceiving incongruities begins to turn action into a story" (Frank 2004: 434f). What had been going on? In the first weeks after return to the Netherlands I was still too attached to the nurses to be able to think of them other than as a group I was a member of. What could be written and what should remain unwritten in order to respect and safeguard the researched group and avoid unintentional misunderstandings?

Months of reading and re-reading the data illuminated key aspects, showed patterns and demonstrated possible results. The use of the qualitative computer programme MAXQDA turned out beneficial to (re-)discover observations and descriptions and to organise thoughts and findings. Going back to anthropological literature was necessary to construct frameworks and understand what was going on. Exchanging thoughts and discussing ideas with other medical anthropologists in Amsterdam was an invaluable benefit. Slowly, I was sufficiently

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[6] I want to thank here especially Osei Tutu for his excellent and precise work in transcribing the interviews for me.

detached to enter into the writing process. Two follow-up visits in 2006 and 2007 were used to fill gaps in the data, discuss findings and enrich the analysis of my research.

Ethics and the role of the researcher

> No matter how far 'participation' may push the anthropologist in the direction of non-otherness, the context is still ultimately dictated by 'observation' and externality. (Rabinow in Zaman 2008: 141)

The awareness of externality and otherness led me to questions concerning the writing process. Should I leave parts of my report blank? Could I deliver empty pages? These questions were and are constantly in my head. They touch ethical considerations that need to be taken in consideration when doing qualitative ethnographic research. There are two major aspects: Will my findings reflect reality and be true? And am I allowed to write about everything aiming at a balanced and objective presentation or would some observations need to be blurred?

There are as many realities of a situation as there are participants of that moment. Therefore an ethnography can only show a partial aspect of the complex whole. The moment the researcher is in one place and talks to one informant, other situations occur on the ward hidden from the researcher's ear and eye. "The idea that we collect data is a bit misleading. Data are not out there waiting for collection, like too many rubbish bags on the pavement. For a start they have to be noticed by the researcher, and treated as data for the purpose of his or her research" (Dey in Zaman 2008: 141). Personal interest or hidden agendas can influence statements or lead to misleading assumptions. Bleek reminds qualitative researchers of the fact that informants can be lying, having valid reasons to do so or being annoyed at the (often uninvited) researcher's presence and questions. "Not all informants are as enthusiastic about anthropological research as the fieldworkers themselves" who may "force polite informants into lying ones" (1987: 314).

The other side of the coin is the researcher herself who is involved in the process of data gathering. Campbell calls for continuous reflexivity of that role and analyses how "to put personal experience into the centre of trustworthy analysis" (1998: 56). It means that the presence of the researcher influences the research side and by doing so changes the supposedly 'original setting'. It raises the question of whether participant observation of a cultural entity is possible at all. In this case, I was aware of the partiality, grasping only fragments with my data. Next to limitations due to the language barrier and practical time constraints limiting my presence on the ward and understanding of all aspects, I experienced situations and moments when I was excluded. One example was the regular ward meetings. During these monthly meetings, all nurses meet and talk about current

events and information about the hospital is distributed and professional issues clarified. At least, this is one side. I understood that these were also opportunities when problems or mistakes were discussed and consequences drawn where necessary. Attending those gathering and observing the interaction of nurses there would have enriched my data, but I was never informed nor invited to those meetings. When asked about it, the matron told me: "We discuss our work, talk about problems and praise ourselves for good work done. No, it is not interesting for you to be there, we can tell you the results." Also the director of nursing shared that view: "Whatever is discussed and of interest for you, the matron will tell you. There is no need for you to be there." She promised to inform me when such meeting was coming up, but I never heard from her. I accepted those closed doors and my exclusion, respecting their professional privacy.

The second question was whether I was allowed to write about all I happened to witness and participate in. Before starting the fieldwork, I had been encouraged by the nursing administration to collect my data and write about it: "You be objective, write all you see. Do not choose a side, don't side with the nurses, it does not help your work. We are waiting for your book to come out so we learn form you. You can do a lot for us, we need your input. So write funny stories about the nurses." Towards the end of my stay, the same nurses adjusted their advice: "Try not to hurt people and make persons and things anonymous as much as possible. Please be careful with the writing, it is a delicate matter. You saw we are trying but we are few."

Discussing this issue with some Ghanaian friends, they explained: "Nurses know they are doing the wrong thing at times but they do not want you to write about it. We Ghanaians want to be cheated. They want you to lie and not say the full truth. So no matter what you write, there will be some who feel hurt. Everybody knows about the problems, so write about it. Write what you saw." I decided to discuss this matter openly with the nurses of the ward. For that matter, I got invited for one of their meetings. Explaining my study again and presenting first results and a rough outline of my study, I realised two things: Many nurses had become used to my presence and saw me as somebody who helped on the ward and made notes. By leaving them, they became again aware that they had been part of a research. In my own perception I had never hidden my research aim nor my writings or academic curiosity, but most of them were still wondering what I had exactly been doing. Appearing in a publication, they said, made them proud. Secondly, they became afraid of what would be published. Nurse Catherine said "We are doing our best, do not write any demoralizing facts. The job is already difficult enough." Matron Esther asked about possibilities of having a say in the writings before publishing. I explained my view, wanting to mention the hospital's name and ward's specialisation but hide nurses' individual

features. We agreed on the greatest possible anonymity of both nurses and patients. I changed all names and rearranged personal characteristics that would leave the persons less easily retraced but the message and statement unchanged.

My presence on the ward: Perception and reciprocity

Looking back, I understand that my presence in the hospital threw up questions: Being a woman and researching a female dominated profession positioned me in an interesting spot within the hospital organisation. As described above, the nurses saw me as one of them and accompanied my nursing activities and data gathering. The mainly male doctors defined me as 'one of them' and hardly took notice of me. This showed next to professional segmentation and also the existence of separated lifestyles. On top of that, younger nurses perceived me as representative of the West who could inform them about Europe and working possibilities there. The interest in migration increased, I was asked about visa-regulations, skill requirements and salary expectations. At the same time, their image of 'the West' was in many cases hazy and unrealistic. With the older nurses and the nursing administration, the distribution of power played a role. In some situation I was the researcher and presented like that to outsiders. At other times my role was that of the visiting nurse having to work along and give account of my participation. All participants in my research were aware that their cooperation and information was welcome and influenced the course and outcome of my research. The question of equality in research was unspoken but continuously present. The nurses had the power to conceal or hide information from me to produce enriching or misleading data. But they could not refuse my presence or prevent me leaving the ward and return to Europe to write about them. I was aware of the limitation of the research in time and space and the remaining distance. A nursing teacher said to me: "They will let you in for a while, but it is clear you will never fully get into the group and understand completely what is going on." My role shifted almost daily between my identities as researcher, nurse and person. My presence changed the reality, increased existing tensions and challenged nurses to reflect on the established routine.

Be a person

> It is not only the anthropologist who knows about the fundamental contradiction inherent in fieldwork; the informants know about them as well. (Bleek 1979: 201)

Following an anthropological question and doing fieldwork in a hospital outside one's own culture leads to methodological and ethical challenges. This is true both for the researcher and the researched group. The process of data gathering, analysis and writing is accompanied by open questions and closed doors. It is

impossible and also undesirable to bridge the gap between the anthropologist and the group. In my case, that led to three things:

During fieldwork I lost my innocence as researcher. Witnessing critical nursing situations, asking for the nurses' perceptions and trying to understand underlying convictions dragged me into the nurses' world and appealed to my subjective feelings. Reflecting my own actions and subjective feelings opened the floor to discussions with nurses and patients. Following Campbell's idea, I realised and understood the interconnectedness of my study and me and integrated my own experience and presence into the understanding of my data.

Secondly, this very involvement also showed me my limitations. Being a Western trained nurse who had worked in Europe, I was aware of the basic and general procedures of nursing on the ward. This made me partly '*native*' and withheld me from certain questions. I was not 'blank and ignorant' and the nurses knew that I knew how they were supposed to work. On the one hand, they felt extra critically observed and apologised for irregularities, even though it was never my intention to point on those. Also, they used my knowledge to have me join the team. Like Frank (2004: 437) said: "I did not have any new insights after all; I had only put into prose what everybody already knew. My preferred term for what social science can offer, *an articulate imagination*." I represented both the outsider and the member of the group. I was part of the imaginary worldwide professional nurses' network and familiar to the hospital routine at large and at the same a foreigner in the Ghanaian culture and emic realisation of the work.

Finally, I learned that I both chose and was given a role. The role I had chosen was that of a researcher, coming with my own background and curiosity. My identity of researcher was formalised through letters, the ethical clearance and my badge and uniform. I was interested and full of questions, hoping to understand what was going on. To bridge the gap and reduce the feeling of reserve, I added to my role that of the assisting nurse, aiming at making me more accessible. I soon discovered that I was also given a role. To the hospital staff I was a foreigner and by that both a threat and an opportunity. A threat as I took part in their daily work and was going to write about the successes and failures I had witnessed. And it was known that I would leave again and write about the observed. At the same time, I was perceived as a representative of 'the West' and by that defined as somebody with solutions, incorporating endless career possibilities abroad and financial solutions to daily problems. Several groups expected answers from me to questions I had never thought of and was unable to answer. In addition to that and, my personal life and social engagement in Ghana was of interest to the nurses. I could not remain the distanced researcher but they took part in my adventures and explained to me their culture. To achieve my research goals I had to constantly negotiate my roles, sharpening them through interaction

and finding a balance between work and free time, being a researcher and a person, being one of them and distancing myself. This is similar to Geurts experiences when she worked with the Anlo-Ewe on the notion of the senses. “What we write up, after extensive fieldwork, are historically situated texts concerning a set of people in a place during a time when we were present to witness and document the goings on - an admittedly strange blend of subjectivity and empiricism” (Geurts 2002: 25).

PART II

NURSING IN GHANA: HISTORY AND TRAINING

3

Respect and balance: Ghana's society and culture

> We Ghanaians are brought up not to ask too many questions. In the olden days, we were asked to be silent and obey. Still today, children who ask a lot are seen as troublesome. (Retired nurse)

In 2007, Ghana celebrated its Golden Jubilee remembering independence from Britain on March 6, 1957. After political unrest and several military regimes in the first decades, the political system stabilised in the Fourth Republic after 1992. At this moment, the economy is stable on six per cent growth, and the support from the Millennium Challenge Account in 2005 allows an optimistic view in the economic future. The influence of Western life-styles and trends through globalisation can be found in every aspect of public and family life, while also traditional values like respect and the cohesion of the extended family are still omnipresent and cherished.

Traditional society

Traditional Ghanaian society adheres to the principle that what was right in the past indicates action for today (Assimeng 1999). People form and sustain groups out of personal loyalty and respect to a leader whose authority is taken from an inherited status. Status and roles are derived from the position within the kinship group. Members of the family shape the individual who is socialised through a post figurative lifestyle (Nukunya 2003: 7). The territory of Ghana is inhabited by numerous ethnic groups and clans, each following its own traditions and organisational rules. The capital Accra is a melting pot of many groups, religions

and clans; English is often the lingua franca. The Akan group is the most dominant one and its language Twi spoken throughout the country. The Ga are the original inhabitants of the Accra area, they speak their own language Ga and follow principles contrary to the Akan patrilineal ones. All have in common that older members are honoured and listened to when decisions have to be made. Communities, villages as well as quarters in cities, are headed by chiefs whose influence enters manifold aspects of public life and who lead celebrations and festivals. Through the colonial era and since independence, the political, economic and legal systems altered their forms and some changes lead to significant redefinitions of the societal norms and values.

Soon after the Second World War, political parties were formed and ideas developed to end British rule. In March 1957, Dr. Kwame Nkrumah declared independence and was chosen the first Prime Minister of Ghana. Hereby, Ghana became the first colonial territory in sub-Saharan Africa to regain independence from colonial domination. In the next ten years, its economy grew, new towns developed and steps towards modernity were taken in all aspects of the society. The opening of the hydro-electric project at Akosombo in 1966 was and is till today a symbol of the technological and industrial improvements made. But the political system proved less stable. The years after Nkrumah's overthrow in 1966 can be characterised by political unrest and changing military regimes and, after a two-year democratic interlude under President Limann by the end of the 1970s, J.J. Rawlings and his PNDC gained power and ruled with his military regime over Ghana till the return to democracy in 1992. Especially in the 1980s, Ghana experienced a period of economic crisis leading to individual hardship and privation. Political enemies were repressed, a culture of silence emerged and many people tried to leave the country as refugee. This time can be seen as the beginning of the brain drain of young intellectuals and trained personal in all sectors of the labour market, leading to serious shortages in the various branches, a further decline in the country's economy and a pessimistic atmosphere in the society.

In 1992, Rawlings changed his political vision and led the county into its Fourth Republic. Serving two periods as elected president, he gave up his power and in 2000, John Kufuor of the opposing party NPP took over. Under his government, Ghana experienced political and economic stability. A process of reconciliation was started to end the period of oppression and silence. Creating a sentiment of unity and belonging, ethnic and religious differences could be held at a minimum. International organisation, global players and financial agencies supported the reconstruction and urbanisation of Ghana (Songsore 1999, 2003). Despite all efforts and economic successes, Ghana still faces serious problems. The departure of the educated middle class is still taking place and creates sensitive gaps in the social structure (Hagopian 2005). The new phenomenon of fami-

lies receiving financial support (remittances) from migrated members abroad and the rising social mobility within the country is influencing the traditional family setting. Modernisation and globalisation, the introduction of mobile phones and internet, are catapulting the society into a new way of life, having implications for the traditional values and the role of the individual. A nursing student phrases the problem in regard to the health sector:

> I think that as a nation in transition, our problems are so complex; it's difficult to predict whether things will return to normalcy. But to a very large extent, that will take a lot of political will power to redirect the way we go now. I don't think that within the next five or ten years, the health sector will be well resourced with regards to nurses. I don't, unless there's that strong political will power to be able to train people and retain them.

Today's Ghana: Urbanisation and migration

A conference organised by the British Council in 2006 discussed the role and influence of tradition on the modern Ghanaian society.[1] The speakers stated the problems of introducing modern ideas of management as it often conflicted with traditional norms and family obligations. One aspect discussed was the changing process when it comes to the influence of the extended family. It used to be the elders in the family who were consulted and stated which decisions to take or profession to learn, and marriages were often the outcome of family negotiations. The same was true for a case of illness, in terms of deciding when and where to consult a healer, pharmacist or health post. The individual was part of a bigger kinship group and its interests and was not expected to plan independently and take decisions by him/herself. Although society is changing and becoming more individualised and this traditional concept still has influence up to today. Professionals in all branches are found to have difficulties and face reprimands when it comes to taking decisions alone and adopting to a 'work outlook' and individualised work schedule (Twumasi 2005: 85). It can be expected that with the further segmentation of the family, the degree of influence of the traditional system will fade. But the success of any business or educational programme still depends on the community framework, and the engagement and co-operation of key groups like traditional leaders, churches and teachers.

Africa as a whole is undergoing a period of rapid urbanisation. As colonial policies and restrictions kept the growth of cities low, the worldwide urbanisation started later in Africa than in other continents. The number of cities with more than one million inhabitants and megacities with more than four million inhabitants tripled just in the last twenty years. Projection suggests that the percentage of the population living in urban areas grew from 15 in 1950 to 40 in 2000

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[1] This following section is mainly based on unpublished notes and memory records of the attending researcher.

(Songsore 2003). Although the process is rapid, Africa is still the continent with the least urban population. In Europe, urbanisation went along with social, health and economic benefits, stimulating general growth and development. The reasons for the growth of cities and the rural-urban migration are different in Africa. In Ghana, we can speak of a forced migration, or a "destabilisation-driven urbanisation" (Songsore 2003: 3). Up to the middle of the 20th century the main occupation was to work on the ancestral land or participate in fishing and other activities within the community. Ethnic conflicts, wars, draughts and famine were reasons to migrate to cities. These did not go with sustainable development of the cities leading to "urban settlements threatened by the poor quality of their environment with the associated negative impacts on human health and well-being" (Songsore 2004: 4). The WHO statistics indicate a rising level of urbanisation from 32% of Ghanaians in 1984 to 46% in 2006, of which half live in Accra, Kumasi and Sekondi (WHO statistics 2006), and up to 2.5 million Ghanaians are estimated to be homeless living, mainly in the cities.

In the booming urban centres the rapid general economic development created a demand for skilled and unskilled labour force (see for example Assimeng 1999). Working in the mining, timber or cocoa business or in industry became an option leading to rural-urban migration as well as the new professions in teaching, secretarial and administration work. Young people wanting to escape the influence of the family headed towards the towns and returned eventually uprooted from their families. While the formal education had been started under the colonial regime as a mean of control, it also formed the basis for a "rebellion against traditionalism" (Twumasi 2005: 52). After a first post-colonial economic boom, the economic crisis in the 1970s and 1980s stopped that development. Changing lifestyles and the economic crisis led to additional changes.. The man's salary alone was often insufficient to cater for a family, all family members needed to contribute to the family's income (Dolphyne 1991: 58). Mazzucato (2009) adds to this the influence of labour migration on the traditional family setting:

> It's not a problem in the Ghanaian culture to temporarily accommodate children with other relatives. It's even normal in rural areas, where child fostering is an age-old tradition. Children help out at home and work the land. It's perfectly normal for a grandmother to take part in the upbringing, or for a brother without children of his own to be sent a niece or nephew. But times are changing. The majority of the population lives in the big cities, where such childcare is hard to come by. If one parent leaves for Europe to find a job, the intention is for the family to join them as soon as possible.

By the turn of the millennium, Ghana had about 22 million inhabitants, of which almost two-thirds live in rural areas, but that is changing rapidly. With a population growth of 2.5%, almost half of the Ghanaian population is under 18

years old (WHO 2004).[2] The per capita income fluctuates around $350 and the adult literacy rate is 54%. The Greater Accra Region (GAR), including Accra and its harbour town Tema, is the most urbanised area in Ghana and the industrial centre and administrative and financial capital. A recent study carried out by the organisation UN Habitat put the population of Accra above 4 million people, including both inhabitants and daily commuters (Daily Graphic 1.11.2005). Low incomes and growing unemployment resulted in a group of urban poor whose condition is hardly better than that of the rural population. 10% to 20% of the population is poor as compared to 35-50% in the rural areas.[3] 46% of the population are linked to water supply and 12% to sewerage facilities. Dumping sites are breeding places of insects transporting malaria and other diseases. Direct risks like poor water supply and sanitation, crowded housing and insufficient drainage as well as indirect risks through air and water pollution constitute additional dangers of the health of the poor majority in the cities.

The role of religion

Ghana's population has to adjust to new developments while handed down ideas persist. Conflicting norms and the lack of a firm base can lead to anxiety and religion often takes the role of a socially controlling and reaffirming actor.

Religion plays an important role in the life of every Ghanaian. "Africans are notoriously religious. Religion permeates into all departments of life; it is not easy or possible to isolate it" (Mbiti 1975: 1). Traditional Ghana knows various forms of religion and worship. They include worshipping to a supernatural god, smaller gods, honouring the ancestors and the belief in forms of witchcraft, magic and sorcery (Nukunya 2003). Missionaries introduced Christianity almost 200 years ago in West Africa and Ghana has become a deeply religious (mainly Christian) country. Figures state that today officially 16% are Muslim (mainly in the north of the country) and 60 to 80% attend Christian churches, while only 10 to 20% follow traditional religions. Christian-Moslem frictions are limited to smaller conflicts in the Northern Region. The government, headed by a Christian President and Moslem Vice-President constantly appeals to the population to live together peacefully. The Roman Catholic, Anglican, Presbyterian and Methodist churches can look back on a long history in Ghana, but both Islam and Christianity have become "more and more indigenised" (Senah 2004: 61). In addition, countless Pentecostal and charismatic churches have started in the last twenty years. Their influence cannot be underestimated and reaches all aspects of life. Religion plays a role in all aspects of life, including perceptions of health and

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2 For more details, see the Appendix.

3 Poverty is defined here as an economic condition of ¢ 700,000-900,000 ($70-90) per adult per year (Songsore 2003: 14).

healing and the organisation of social relations. It is difficult to tell "where religion ends and politics begins" (Senah 2004: 62).

In regard to health education, Christian teaching calls on sexual abstinence as protection from HIV/AIDS and patronises scientific medicine as 'the right thing to do' (see for example Mill 2003, Takyi 2003). On the other hand, prayer camps offer guidance in a psychological crisis and promise healing for infertile women or those suffering from serious diseases like cancer or hypertension. Men and women from all ranks of life turn to these healing alternatives in difficult times or financial problems. This shows a parallel set of orientation and man's pragmatism to accept different systems and choose and take what each system has to offer in terms of help with daily problems.

Balance and respect: Being a mature person

One prominent feature of the Ghanaian cultures is the aim to achieve and maintain balance. Geurts (2002: 5) writes that

> … (P)eople grow up being encouraged to be in balance; they learn to balance their bodies as infants … and they grow into adult orientation in which balance s considered a defining characteristic of mature persons and the human species in general (hence an important dimension of their ethos).

This has implications for many aspects of private and public life. Normally, emotions should not be shown in public and regulated. Only in clearly defined situations such as funerals emotions are uttered and accepted if not expected. Signs of sexual attraction or affection between adults are not displayed in public. Parents are expected to reprimand their children, teachers severely punish disobedient pupils, but while shouting and punishing, parents or teachers have to control their anger and the child must accept the punishment.[4] Conflicts between adults are solved less by arguments than through mediation or consultation of older person. An 'even-tempered stance' and the 'aesthetic of the cool' are key characteristics for a life in social and physical well-being and stability (Geurts 2002: 202). This also applies to the researcher entering this field and aiming at understanding and recognizing main elements relevant for the research. The researcher's presence and own personal and professional background influences the setting (Müller 2005: 35) and can trigger unexpected reactions and might even challenge traditional cultural norms. In the Ghanaian context, balancing one's emotions, respecting senior generations and acting within the existing

[4] Informal talks with several parents in Accra indicated, that beating and punishing are perceived as normal and seem to be routine in raising children. One mother said, her child was too disobedient and she had to "beat the devil out of him." The idea of children's rights were laughed at and ridiculed as "one of your European ideas."

social hierarchies were crucial for me to be accepted as a person and succeeding in my ethnographic fieldwork (see also next chapter).

Van der Geest (1998) argues that respect is the basic moral value in both past and present Ghanaian (Akan) culture. Ghana's society is organised along lineages and clans forming ethnic groups. Different generations are living together in one household and the hierarchy is defined by the young obeying in respect and following the old. Giving respect and receiving respect are crucial elements that define and maintain the relationships between young and old, children and parents, workers and employers, poor and rich (Van der Geest 1997: 535). The elder is acknowledged for his/her traditional knowledge, experiences, life performance and wisdom; respecting old people strengthens and reconfirms the relationship, showing affection and reward for all the work and care old people gave to their families. It also compels reciprocity. Social developments and the introduction of money linked financial richness to respect and a good old age. Money regulates social relations and is a mean to show respect. The flow of migrating Ghanaians to Europe, America and lately Asia has to be understood as a possibility to enlarge the income of a family and raise its status. Returning migrants show their success in the financial means, building houses for the family and supporting younger siblings in their education and the old members in providing them goods, clothes and food. Disrespectful behaviour in private and public life brings shame to the whole family and will call the leaders for counselling and helping the individual to return to balance.

Women's life

Worldwide, children and women form the most vulnerable part of a society, and while the problems are the same everywhere and commonly known, it is a question of degree in how far they affect decision-making processes in the daily life. The International Women's Year (1975) and the following UN Decade for Women shed light on the customs that subjugate women and started educational programme and political discussions to bring this imbalance into the spotlights.

In Ghana, the life of women and men differ when looking at the distribution of tasks and behaviour in public and private places. In general, men dominate the public sphere and its discourse, taking decisions and determining interactions. Women can be seen as the dominating part when it comes to the private sphere, like the education of children and household duties. In many marriages, this distribution of influence and power is based on mutual respect. Traditional norms and values, religious conviction and duties and expectations from kinship form and determine women's activities and possibilities. It must be noted that there are differences between matrilineal (like the Akan) and patrilinieal groups (like the Ga), especially when it comes to decisions concerning marriage, child education

and lines of family solidarity (for details see Assimeng 1999: 75-79). "In many Ghanaian societies, the traditional position is that women are never wholly independent. A woman must always be under the guardianship of a man" (Nukunya 2003: 46). Modernisation and globalisation as well as the influence of the Christian religion introduced new concepts, also concerning the influence of parents and the role of women. This has led to more individual freedom, for example in choosing partners and initiating inter-ethnic marriages. Polygyny and extra marital affairs of man are not as seriously opposed and publicly disapproved of as when a woman engages in plural sexual relations. Dolphyne (1991) points at various aspects in the Ghanaian culture that influence women's life styles. Each woman is supposed to be married and bear several children.[5] While in modern times the choice of partner is no longer up to the family but to the individual, the agreement of both families is still necessary to have a successful married life and couples count on extended family support in case of marital problems and arguments. Both for the patrilineal Ga and matrilineal Akan, the continuation of the lineage is important. The status of motherhood is high and makes a woman a full member of the society. In childless marriages, often the woman is blamed and divorced for that reason.[6] The love for children is a female virtue and children are seen as a blessing and insurance against poverty in old age. Given the health risks and high mortality in early infancy, family planning programmes are important and promoted by the government. So far, smaller families are still an exception, but research still has to be done to produce explanatory models. From early childhood girls and boys are expected to help the mother in the household but it is clear that in married life the household chores are exclusively the wife's affair. She will have to make sure the house is clean, there is water supply and food is cooked. Women do have influence on the family life and their husbands but those pursuing a career are faced with fulfilling social, cultural and professional expectations.

Violence against women is a worldwide phenomenon and also observed in Ghana. Violence is hereby understood as any form of physical, psychological, socio-economic or sexual behaviour and injuries next to traditional practices deeming to degrading women. Domestic violence is the most common form as research indicates that one in three Ghanaian women experiences physical violence from her direct partner. Growing numbers of police reported cases[7] indi-

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[5] In my conversations with women of several age groups, having children seemed to be most important. A common reason was "who will bury you if you don't have children?" Unmarried women were encouraged to find a partner and, if this search proved unsuccessful, bear and raise children as single mothers.

[6] It must be noted, that also women can and do divorce men in case of childlessness. Bleek (1975) states that also men can and are made responsible for childlessness.

[7] The report shows an increase from 360 cases in 1999 to 3,622 cases in 2002.

cate that this problem undergoes an increasing awareness in the Ghanaian society (Amoakohene 2004). In searching for explanations, two reasons become apparent: Social control over women and the avoidance to talk in public about domestic violence. Women often downplay their experiences or try to justify violence by looking for mistakes in their own behaviour as caring and hard working wife and mother. Women seem to have problems of defining and fulfilling their role that includes traditional and modern expectations. As one woman in Accra mentions: "We all go to work, work full-time, come home tired and yet while he relaxes, I have to prepare the meal, tidy up the place, bathe the children … and after performing all these functions, he expects you to meet his sexual desires" (Amoakohene 2004: 2378).

Looking at daily life in one of the metropolises of Ghana, the struggle to manage family and professional duties forms a challenge to the well-being of women. Limited access to resources like sanitation and a clean water supply and the unpredictable and time-consuming transport system demand constant attention. Women themselves mention health problems caused by the pressure to be a good mother, wife and worker (Avotri & Walters 1999). Headaches, general bodily pains and psycho-social distress are mentioned problems when they say "I am so tired", "I think too much", "lose weight" or "am unable to sleep well in the night." Continuous financial problems and little support from the husband complicate the living situation of many women in the under and middle class of Ghana.

In the last twenty years many programmemes have been started to improve women's situation and create legal protection measures. Education is seen as the key to an economically more independent and healthier life. Primary education is free, while junior and senior secondary school request varying fees. The governments started campaigns to have each girl finish at least Junior Secondary School (at the age of about fifteen years) and complete a vocational or professional training to avoid early marriage and pregnancies. Typical female occupations are catering, hair-dressing, dressmaking, secretarial and administrative work, nursing and teaching. As the straightforward family planning goals could not be achieved, the spacing of children that was already practised in the traditional system is promoted to ensure the health of the mother. In 1985, the law to register all marriages and the Intestate Succession Law were passed regulating inheritance and offering a minimum economic standard security of the women. Before then the widow often inherited nothing due to the patri- or matrilineal order and was condemned to a life in poverty or be remarried to a sibling. Till today, this divided property system discourages marital 'joint ventures' or commonly financed houses. With this legislation the situation improved but it is only

as effective as the culture in the society is willing to support it (Oppong *et al.* 1975, Dolphyne 1991).

Having mentioned above that in many groups men dominate public life, a certain differentiation must be made. Today, three types of women are particularly respected in public life: Traditional rulers, professional workers and hard working market and businesswomen. Queens and queen mothers receive all due respect and status in the community and are approached for consultation (Müller 2005). In almost all professions, from lawyers and doctors to teacher and bankers, women are found and generally speaking given the same promotion and salary opportunities as men. They are admired for the work done and referred to as 'woman-man' (Dolphyne 1991: 43). Hardworking women in the market places or small businesses, who manage also without formal education to achieve a satisfactory standard of living, are equally accorded status. This indicates that education and professional training are key to increasing self-confidence and can create equality and social security in the long run. To achieve this, the support of the extended family will be needed as women try to combine modern and traditional life styles. Women find themselves in the dilemma of fulfilling the image of the perfect mother and wife, learning and working in a respected profession and participating in the modern society of Ghana. Successful role models are crucial for young women to show a way forward, gain self-esteem and voice their needs and wishes. This can and does lead to frictions and problems. Female successes challenge the male position. Support comes from the public discourse in form of printed and visual media. Programmes on television discuss family and educational issues, and weekly pages in newspapers (like the "Women's World" in the Daily Graphic) try to inform a broad public on women's affairs and start discussions. While these discussions take place in urban settings mostly, Dolphyne (1991: 84-102) observes that girls and young women in rural areas seem doubly disadvantaged as they often have limited access to formal education, their labour is needed on the farm from young age on and they encounter few role models in their immediate surroundings.

Despite increased effort in the last decades, the general participation of women in political policy-making bodies is still below the desired level. Under Nkrumah, the first woman was nominated for a post but it was not until 1969 that the first two women took seats in parliament. By the end of the 1970s, five women had been elected but none was given a ministerial appointment. In the previous parliament that was elected in December 2004 there were 205 men and 25 women (20 members of the NPP, five of the NDC), the women paliamentarians constituting about 10% of parliamentarians. There were just three female ministers (Women and Children's Affairs, Environment & Science and Fisheries), one

Minister of State in charge of the Tertiary Education and four Deputy Ministers out of more than 50 posts.

In conclusion, it is shown that the life of Ghanaian women is multifaceted. Fulfilling the different demands put before them by tradition, family, social relationships and professional work places them in a particular position. Being responsible and acknowledged for child raising and the organisation of the home contitute one side of their activities next to manifold duties and positions in the family, neighbourhood and church. More and more women are entering professional life, finishing university and working in their profession despite their home duties. Nurses, who form the focus in this research, experience these manifold responsibilities and try to find their way as wives, mothers, nurses among nurses and professional colleagues and the male-dominated doctors in the medical setting. More women in public office will be needed to create awareness and raise consciousness of their changing situation in modern society and lead to adjusted perspectives in society and policy-making. Ghanaians – and women in particular – face conflicting demands from tradition and modernity. Relating back to conference of managers in 2006, and also among young (male) managers, a search for change and thinking over social rules have been started.

4

Tradition and modernity: Concepts of health in Ghana

When it comes to defining health and illness in Ghana, we find the interplay of traditional beliefs, religious convictions and personal experiences with health facilities of scientific medicine.[1] This chapter will describe the beginnings of Western medicine in Ghana and its development up to today, while setting it next to the traditional medical system.

Traditional medicine in Ghana

Traditionally, Ghanaian society is an integrated one; illness is understood as a combination of social events and the supra-natural and health and illness are parts of the whole magico-religious fabric (Twumasi 2005: 8). Disease is seen as "a painful thing" (Ventevogel 1996: 15) reflecting a disturbance in the harmony between the elements of social and physical life. In this framework, the cause of diseases is sought in witchcraft, bad medicine, misfortune or spiritual forces and scarcely by natural forces alone. We can separate four types of traditional healers: Herbalists, spiritualists-diviners, faith healers, and traditional birth attendants, in addition there are bone-setters and modernised herbalists (neo-herbalists). Their explanatory model is based on physical and social causation of diseases and services provided include consultations, treatment and prevention. The knowledge of traditional medicine has evolved over generations, and skills are

[1] Many discussions have taken place on how to call the germ-based medicine that was imported into traditional societies during the colonial era. Terms suggested are Western medicine, scientific medicine, modern medicine, hospital based medicine, biomedicine and so forth. The same, there is a discussion how to call the traditional or indigenous medicine. As my main point is to distinguish this type from traditional healer-based medicine, I will use these terms interchangeably.

passed on through apprenticeship training. Traditional healers practise an individualised approach to diagnosis and treatment, and the small number of patients per healer is attractive to many Ghanaians. In 1964, the Ghana Psychic and Traditional Healers Association was founded to organise healers and to cooperate in the health care delivery in Ghana (GSS 1998, Ventevogel 1996, Oppong 1989). Today, the Ministry of Health estimates that between 60 and 80,000 traditional healers are practising in Ghana, providing care to about 60 to 70% of the population, especially in the rural areas. A relatively new phenomenon in this group is the healing sessions and prayer camps led by pastors of spiritual and charismatic churches and modernised herbalists.

The beginning of scientific medicine in Ghana

According to historical sources, Western medicine came together with the first European traders to the African continent in the 15th century. It is mentioned that medical men were "on duty around Accra in the late 18th century" taking care of the Danish employers (Addae 1996: 11). Health problems were those illnesses the Europeans brought along like smallpox, measles, syphilis and gonorrhoea, In addition, they had to face parasitic diseases like yellow fever and malaria. In 1844 the first British medical officers arrived on the Gold Coast to take care of the colonial administrators. In addition, mission posts and churches brought medical staff to the colony. In 1872, Britain became the sole European power on the Gold Coast and started investing in the country by expanding the administration and constructing infrastructure. This led to a rapid rise in the European population and a growing demand for Western health facilities. Hawe (1962: 15) summarises:

> The scant knowledge of tropical fevers and the crude form of surgical practice then known to the European doctors proved hopelessly inadequate. The forts and trading stations were decimated by disease, and the continued high mortality earned for the Guinea Coast the nickname of 'the Whiteman's grave'. Among the fevers were malaria and black water … With the planning of Christianity the missionaries brought a new and more philosophical approach to the nature of disease. In addition to preaching the gospel, they attended the sick and established schools and hospitals.

Parallel to the endeavour of the colonial administration, the various missions brought in doctors and nurses as well. The Basel mission, out of which the Presbyterian Church of Ghana evolved, sent their first medical doctors in the 1830s to the Gold Coast, but most of them died within a short time of fever or hepatitis. Around 1882, after a dispute over whether dispatching medical services showed religious weakness or displayed Christian responsibility to mankind, another group of missionary doctors travelled to and through the Gold Coast and built the first missionary hospital in Aburi, in the hills north of Accra, and later in Agogo (Schweizer 2000). Treating the sick was understood as part of the missionary

work aimed at converting the Africans to Christianity. Health conditions were still poor by the end of the 19th century, as Mary Kingsley describes in her West African Travels. She remembers an epidemic killing almost half of the European population in a few weeks and concludes: "there is another cause of delay to the development greater and more terrible by far than the labour problem – namely the deadliness of the climate" (Kingsley 2003: 41).

1878 can be seen as the official beginning of formal medical work in Accra, when huts were erected to serve as medical posts for the government forces (Twumasi 2005: 65). In 1880, the Gold Coast Medical Department was established to organise and supervise preventive services like vaccinations and sanitation. In 1899 the first British nursing sisters arrived and started nursing in Ghana. In the beginning, there was much resistance within the African population to consult them, let alone assist the medical doctors and nurses. The traditional system opposed the concept and practices of Western medicine that was so different from the traditional cosmological order. Patterson (1981: 15) writes: "The colonial physician was often a puzzling figure for Africans. He was usually a white male stranger who had to use an interpreter. He often asked impolite questions, demanded, for reasons unknown to the patient, samples of blood, urine and faeces; and sometimes cut open the bodies of the dead. On the other hand, he frequently had great power over sickness and injury." A few men were finally trained as orderlies to assist in washing the sick, dressing the wounds and in administering the drugs; traditionally women were not expected to work outside the family compound.

By the beginning of the 20th century, there were few hospitals, mostly in the bigger towns and almost exclusively for Europeans. Governor Clifford developed plans to restructure and improve the health care system in the 1910s, but the economic and social crisis caused by the First World War hindered its realisation. Sir Francis Guggisberg, Governor on the Gold Coast between 1919 and 1927, laid the foundations of institutionalised health care. He introduced a ten-year development plan for the Gold Coast and his impact on the sanitation and health improvements cannot be over-emphasised. In one of his first speeches he stated: "… I promise the people of the Gold Coast … I am sent out here to superintend the construction of a broad Highway to Progress along which the races of the Gold Coast may advance …" (Buah 1998: 111). There were two parallel developments that made improved health services more urgent: The European population rose, but the mortality among Europeans was still high and alarming. In addition, it was recognised that the success of the colonies depended on the health of both Europeans and Africans, leading also to an end of the segregation (Curtin 1992: 243). In addition, medical discoveries brought new insight in illness causation and disease prevention and offered new treatments. Understanding

the (economic) value of health, the needs of both groups became a major goal of Guggisberg's governorship (Addae 1996: 28). During his time, the country underwent political, social and economic developments. Next to the construction of the harbour in Takoradi and the expansion of highways and railways, the establishment of regulated formal education, his main accomplishments were country-wide steps to improve the sanitation and mass disease eradication programmemes. Guggisberg aimed at catering for the whole population and started to plan the building of hospitals in the whole country. Korle Bu became the model for a 'general' hospital for the whole nation. The government presented a public health policy and implemented large parts of it. The expenditure on health services varied between 15 and 18%, the highest ever (Addae 1996: 54). Indeed, this period can be seen as a golden age in colonial health policy, with the building of hospitals and improvements of general sanitation. The statue of Guggisberg in front of the administration building in Korle Bu Teaching Hospital and the naming of the street in front of the hospital are visible signs of the gratitude of the people for Guggisberg's work. Yet no more than 10% of the African population had access to those facilities.

The health problems by then can be described as mainly environmental. Poor sanitation, insufficient supply of clean water and malnutrition weakened the population and tropical diseases like malaria, worm infestation, yaws and tuberculosis were common (Twumasi 2005: 66). In the hospitals, the main diagnosis was pulmonary tuberculosis, lobar pneumonia, anaemia and epidemics of yellow fever, while malaria was the main cause of infant mortality (Hawe 1962: 16). Scientific medicine could offer successful treatment here and with time, acceptance grew. The parallel introduction of formal education and urbanisation had additional positive influence on that process. Educated young and urban people were more likely to use and accept modern medicine, being far away from their families and the traditions of their communities. As it used to be the head of the family taking the decision when and where to seek medical treatment, there were now alternative ways to choose from. In addition, local people working for the colonial administration had it as part of their job contract to seek medical treatment in hospital. These ideological and social changes led to increased use of scientific medicine.

Between 1920 and 1960, health centres were built all over the country, increasing the number of government hospitals from 17 to 40 but neglecting the rural areas. The worldwide economic crisis stopped further expansion but even so African confidence in modern medicine increased. There were insufficient facilities, resulting in overcrowded wards, an inadequate number of medical and nursing staff and a deterioration of sanitary conditions. Only one or two indigenes were sent to Edinburgh for medical studies per year. The first indigine to

be trained as a doctor had been Dr. William Benjamin Quartey-Papafio, who entered the government Service in the 1890s. Dr. Barnor (1962, 2001) who was selected in the early 1940s to study in Edinburgh gives a vivid description of his studies and work as a medical doctor these years of shortage. Like his fellow students, he received a basic training in the UK but had difficulties to enter the Colonial Medical Service due to lack of practice. This led to the situation that almost half of the doctors left the public service soon after return to the Gold coast and started private practice.

Reflecting on the introduction of Western medicine in Africa, it is necessary to touch on the underlying ideology. The 19th century was characterised by imperialistic politics, colonialism and scientific discoveries. This led to a shift in thought towards an objectification of the human body and individualisation of the person. Foucault analyses the rise of hospitals in France, its social implications and the construction of power between actors and the formation of the body as site of power relations (Foucault 2003). Those ideas were carried to the African colonies to meet a completely different thought-system. The first doctors and nurses in Africa saw themselves "armed only with faith and medicine" in their fight against wilderness and nature (Vaughan 1991: 1). The practice of Western medicine can therefore be seen as the stage on which the difference between the individualised Christian European and the traditional non-individualised African was located and enforced. Hospitals were places to maintain and control this difference. Public and mission hospitals transported those individualised and science-based ideologies on healing and defined 'the patient' taken out of his social group into the new system. Ideas of 'the other' and the thinking in dichotomies like 'black-white', 'nature-culture' and 'bad-good' carried the construction and imagination of 'Africa' and influenced economic and political decisions.

Health delivery in post-colonial Ghana

Ghana's first President, Dr. K. Nkrumah, stated: "We shall measure our progress by the improvements in the health of our people … the welfare of our people is our chief pride" (Buah 1998: 166). The young nation faced a poorly developed health system and the population faced many health problems, reflected in a life expectancy of 45 years. Following socialist and nationalist ideals, improving this situation became a priority of the first government. It led, among other things, to free social services like school education and hospital care. The Ministry of Health was created in 1953 to replace the colonial Medical Service Department. Under the first minister of health, Mr. Imoru Egala, the building of more health centres became a priority. Parallel to this, the number of medical doctors increased after independence from 330 to about 960 in the late 1980s while that of

nurses grew from 800 to over 5,000. The foundation of the medical school at Korle Bu in 1964 and the opening of nursing and midwifery training colleges were aimed at improving the situation further. But the economic decline of Ghana led to poor health facilities and an unsatisfactory supply of drugs and materials; patients seeking help in the hospitals had to cater for their own medication, bed linen and even stationery for their medical records (Senah 1997).

During the decades of political unrest and military regime, Ghana experienced an economic crisis that had implications on the health sector. The lack of maintenance in the health centres, especially in the rural areas resulted in deteriorated infrastructure and outdated equipment, and inadequate funding of the health sector worsened the already limited supply of drugs and necessary materials. Health professionals like doctors and nurses left the country in a mass exodus aiming to work abroad. This shortage of personnel had several implications: Along with the concrete lack of workers, the health service could not plan and organise the sector, and with those professionals, an important part of the Ghanaian middle class disappeared. Dugabay (1999) has compared the national health policies of several sub-Saharan countries between 1980 and 1990 and finds Ghana's health status in a critical stage. Weak economic development and low stage of policy development leads to systematic problems: rural areas are neglected while hospitals and urban centres are favoured, the constraints in manpower are reflected in numbers and allocation of workers. "A striking finding was the noticeable mismatch between policy pronouncements and actual implementation as related to decentralisation and resource allocation within the framework of PHC" (Dugabay 1999: 228). Key problems during this period are the absence of planning, poor procedures, and an unrealistic and unconvincing budget. The Alma Ata Declaration of 1978 for 'Health for All by the year 2000' aiming at 80% coverage of the population by primary health care was welcomed but could barely be implemented. Health care was either not available or of poor quality. Fosu (1989) confirms these findings in his research on access to health care in Accra. Uneven access to facilities and the concentration on hospital-based curative care instead of preventive and educational programmemes lead to continuous health problems. The disregard of the private sector, traditional healers and drug sellers through the official bodies intensify the situation. The political instability, socio-economic crisis and financial constraints increase self-medication and visits to traditional healers; the poorer health became, the more use was made of clinic services. Fosu concludes with a call for medical pluralism to improve the health status of the population. His call remains almost unheard, the exodus continues and in the 1990s, about 30% of Ghana's trained health workers left the country to work abroad.

Health delivery in modern Ghana

The 2000 census counted more than 1,100 doctors and 13,000 nurses, of whom one third worked within the Greater Accra Region. These numbers indicate shortfall of 50 to 65% in the public health sector (Nyanotor 2004). Most health workers want to stay within the metropolis of Accra or Kumasi where there are better-equipped hospitals, higher living conditions and the patient-population is more educated; indeed while only about one third of Ghana's population lives in urban centres, more than two thirds of the health personnel work there (Twumasi 2004, Ventevogel 1996). This is in sharp contrast to the needs of the health service. In the rural areas, malaria and communicable diseases are still the main causes of illness and death and call for more medical and nursing staff in those remote areas. Horton (2001) details the inequality between the urban south (Accra) and the northern regions, with an infant mortality rate of 41 and 70 per 1000 respectively.

Today Ghana has two teaching hospitals (in Accra and Kumasi) in addition to nine regional, 92 district hospitals, 210 private or missionary hospitals and about 1,200 health clinics and posts, providing more than 20,000 hospital beds for 22 million Ghanaians (GHS 2005). There are 1,168 medical officers and 13,971 professional and auxiliary nurses working in these hospitals.[2] While these numbers represent an increase, the provision of health care facilities has not kept pace with the growing population, leading to a population-doctor/ nurse-ratio of 1:17,900 and 1:1508 respectively. These numbers have to be seen in perspective, as more than one third of all health staff works in the Greater Accra Region making it the best served region in Ghana. In term of access to care, about 40% of the population is estimated to live more than fifteen km from a health facility with rural areas being generally more deprived (Ghana MoH 2003, Arhinful 2003).

Health service and delivery is organised by two state organs: The Ministry of Health (MoH) and the Ghana Health Service (GHS). The MoH seeks to improve the health status of the whole population by providing policies, access to health facilities and supervise the quality of the service. It works to level out inequalities between and within regions and give priority to programmemes relating to HIV/ AIDS, malaria and immunisation. The government spent about 13% of the health budget in the recent years. While the MoH is the policy maker, the Ghana Health Service is the service provider. It was created in 1992 as an autonomous agency to implement national policies under the motto "Your health our concern."

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[2] Other sources report 3,240 physicians and 19,707 nurses for Ghana in 2004 (WHO 2004).

The Chief Nursing Officer is today part of the GHS. In an interview in the autumn of 2005, she expressed her wish to return to the ministry to be part of decision-making on all sectors concerning health delivery in Ghana. For now, all public nurses work under the GHS and are posted by it after graduation to a health institution somewhere in Ghana.[3] A problem nurses face is the centralisation of the organisation. Nurses from the whole country aiming for promotion must to come to Accra for interview. This has two major disadvantages: The paper work and travelling lead to delay and mistakes. The interviewers do not know the candidates, and cannot support objective assessment, while those superiors working with them in the field find it difficult to report accurately about the candidate's efforts and work experience.

Just as Ghanaian society is between continuity and change, so too is the individual when it comes to health-seeking behaviour. The choices for treatment are based on experiences and combining traditional and Westren treatment is not perceived as contradictions but a rather useful mixture. The complex formal and informal health facilities and the problem of accessibility given the urban bias of health facilities form together with cultural norms and post-colonial experiences, a continuum to which the individual looks for an explanation and therapeutic options in case of illness (Senah 1997, Ventevogel 1996, Takyi 2003). Bierlich (2000) describes the ambivalence towards biomedicine that is seen as attractive and powerful but also feared. Everyone agrees on the advantages that Western medicine has, such as the impressive reduction of high infant mortality rate[4] from almost 250 to 58 per 1,000 (compared to 76 in low income countries and six in high income countries; see Buor 2004), eradication and reduction of several diseases and country-wide immunisation programmemes leading to a rise in the quality of living and the longer life expectancy (57 years in Ghana as compared to 78 in Germany and 49 in Nigeria (WHO 2006).

But there is also criticism of the system. Next to the rural-urban discrepancy in service provision, the main problem mentioned is the service differentiation and impersonal approach. While the traditional healer works holistically, hospital care is split into several parties. The medical doctors relies on the results produced in a laboratory or examinations leading to an indirect diagnosis and patients find it more difficult to establish a direct rapport with the busy overworked medical officer while such a rapport is essential in the traditional belief system to regain complete health (Twumasi 2005). Fosu (1989) reports his findings from health-seeking behaviour in Accra, that both traditional and modern medical care was sought and requested by the urban population irrespectively of religious

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[3] Nurses working at the autonomous teaching hospitals are exempted from this rule and contracted directly.

[4] According to health statistics, 60% of the infant mortality is caused by malnutrition.

background, age or economic status. The field of psychiatry is another area where the limits of Western medicine can be seen. The individual approach and reaffirmation of the person are to the fore here. Families and individuals with psychiatric, psychosomatic and related health problems tend to seek help from traditional or religious healers first before turning to hospitals. In conclusion, in taking a decision, the individual is influenced by the rural or urban living, education and the availability and accessibility of medical treatment and the role of kinship

Health problems

During the initial period after independence, two health problems were prominent: High infant and maternal mortality. Medical field units, research and health education programmemes started to decrease the numbers, introduced immunisation campaigns and improved the general state of sanitation. According to the health survey carried out in 2003 and confirmed by official figures in 2005, the main health problem in all age groups is still malaria (35 to 55% of all consultations), followed by acute respiratory infections in younger age and hypertension in the group above 45 years (Ghana Statistical Service 2003). More than 70% of the disease burden is caused by communicable diseases like malaria and respiratory infections (Songsore 2004: 19). Akiwumi states the need to be forward looking and anticipating the signs in regard to changing health patterns and needs (1992). The most common disease is still malaria, and other preventable infections, like regional outbreaks of cholera, enteric fever and tuberculosis, return in waves due to insufficient hygiene. For 20 years, the incidence and prevalence of HIV/AIDS have increased, posing new challenges to patients and health workers. The prevalence is stated to be 2.1. The rise in health status and changing life styles have brought along new diseases like hypertension, diabetes, obesity, cardiovascular and behavioural diseases and various forms of cancer (Amoah *et al.* 2006). This is reflected in the main causes of mortality in hospitals in the Greater Accra Region, beside malaria cerebrovascular accidents, cardiopathy and anaemia.

In the urban centres, two diseases are increasing: Hypertension and diabetes. Hypertension is defined as blood pressure above 140/90 mmHg. Adoo (2006) and Duda *et al.* (2006) carried out research in the Greater Accra area and found about 25% of the women were suffering from hypertension. While this number corresponds with country-wide trends showing that the prevalence in in semi-urban settings is about 28%, some factors are worthy of note: There seems to be no correlation with age, income and education, but the rise of hypertension is linked with obesity and multiple pregnancies. A changing lifestyle leads to less mobility and physical work and the diet shows little emphasis on vegetables and

fruit.[5] The low level of awareness and treatment of hypertension is alarming; less than 50% of the already diagnosed women reportedly take regular medication and seek medical check-ups. Chronic and untreated hypertension can lead to ischemic cardio-vascular and renal diseases. Diabetes has not been a real issue in health education and policy strategies. Data on this are unreliable, suggesting a sub-Sahara prevalence of 0-2%. However, recent research with 4,700 persons presented a prevalence rate of 6.3% in the Greater Accra Region, involving mainly unknown or newly diagnosed cases (Amoah *et al.* 2006). Educational programme and the training of health workers across the country in the late 1990s show first results by diagnosing new cases leading to a tripling of the numbers. Older people and men are highly represented. As with hypertension, there is little awareness of the disease and its side effects. In addition the treatment is costly and forms a burden on the poor financial situations of most households. It is suggested that the trend of urbanisation threatens to bring bigger health problems alongside modernisation.

Ghana's Health Insurance System

Traditionally, Ghanaian society is based on reciprocity and solidarity within the (extended) family. In times of need, individuals turn to their family to mobilise (financial) resources in exchange for past or future investment in social capital formation. With the trend of urbanisation and migration, this system of social security is under threat and can fail to function. The colonial system introduced a new organisational model that was based on the market and the formal sector. Only few could participate initially, and from the beginning Ghanaians had to pay for the services rendered, be it directly or via poll taxation (Arhinful 2003: 34). In 1898, the Hospital and Dispensary Fee Ordinance was enacted, exempting only paupers and civil servants. This continued till 1954 when the new Ministry of Health recommended the abolition of hospital fees and charges, but keep prices for drugs dispensed. As there was no functioning tax system in the Gold Coast, the financing of the health system created an eternal problem. (Arhinful 2003: 47).

After independence, the President of the First Republic, Dr. Kwame Nkrumah launched a ten-year plan including the reduction and in most cases abolition of costs for users of the health service, leading to an escalation of the financing problem. The military regime that overthrew Dr. Nkrumah re-introduced fees and

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[5] The latter is also confirmed by my own observations. Vegetables are used to prepare stews and soups, but hardly consumed as food alone. Similarly, fruit is rarely eaten on a regular basis although several sorts (banana, oranges, papaya, mango) are available for a reasonable price. Independently, several Ghanaians stated that fruits are not valued, and hypertension is not seen linked to overweight or lack of balanced food.

enforced their collection. The Second Republic under Busia passed the Hospital Fee Act 1971. But the economic and social crisis in the country between 1975 and 1985 led to the collapse of many health facilities, and to problems in implementing the new Primary Health Care strategy. Necessary drugs were not available and many health workers, nurses and doctors, left Ghana to work abroad. In 1985 came a more specified Regulatory Law on that matter and both UNICEF and WHO purchased drugs and sold them at affordable prices. By 1992, the regulations were restructured and the 'Cash-and-Carry' system started to operate. This meant "a gradual diminution in the utilisation of health facilities because of affordability, resulting in 69% of the population being unable to attend/ use the health service. The majority resorted to self-medication, herbal or traditional medicine, or healing crusades or prayers or resigned themselves to their fate not by choice but purely because they cannot afford health care" (Akosa in Arhinful 2003: 54).

Figures show that about 20% of the population need medical help, but of these only about one fifth can afford the costs involved (Korle Bu Bulletin, November 2006: 8). Country Health Indicators from the WHO indicate that Ghana had in 2003 a per capita gross national income of $320 with almost 45% living under the poverty line, and the per capita health expenditure was $17. Under the last NPP government, the decision was made to end this injustice and introduce the National Health Insurance Scheme (NHIS). The NHIS, organised per communities and districts, is to replace the individualised out-of-pocket payment at service delivery points, which often puts untold burden on family resources. This was based on the notion of the authority of the state demanding a new form of solidarity built on the notion of a nation, in which all members, irrespective of lineage connections or tribal background must contribute. As in other sub-Saharan countries, this new insurance system met much resistance from the beginning. As Vogel showed in a study of 23 countries, only seven had a formal health insurance scheme and the percentage of registered persons ranged from one to 14% (Vogel 1990, Arhinful 2003). The government defined a minimum package of diseases that all schemes cover, comprising around 95% of all diseases in Ghana. This includes outpatient services like consultations, requested X-rays or ultrasounds, medications and physiotherapy and inpatient services like general care and accommodation, investigations and medication, surgical operations, cervical and breast cancer treatment and physiotherapy. Other services included are oral and eye care services, maternity care including antenatal check ups, deliveries, Caesarean sections and postnatal care, all emergencies (medical and surgical), and dialysis for acute renal failure. There is a list with drugs that fall within the NHIS. Among those things excluded are HIV drugs, prostheses, echocardiogra-

phy and angiography, dialysis for chronic renal failure, organ transplantations, heart and brain surgery, and cancer treatment.

The fees are graded according to one's income. After registering and paying for the first year, the papers are processed and after several months the card can be collected and be used. The registration fee is ¢ 20,000, and ¢ 10,000 for the card. The annual contribution is differentiated:

- Free for children under 18 as they are registered with their parents and for old persons above 70, the unemployed and "core poor" (adults being dependant on constant support from elsewhere)
- ¢ 72,000 for students, apprentices, and the "very poor" (who can just meet their own needs)
- ¢ 180,000 for the middle income workers and employed persons (who are able to meet their daily needs)
- ¢ 480,000 for the rich and very rich (who able to meet their needs and support others)
- Civil servants and SSNIT contributors will have 2.5% taken from their salary

As all users have to register with their address, Ghana faced the problem of non-existent or irregular street-andhouse-numbering. This had to be done prior to registration, leading to an additional delay in the introduction of the insurance scheme. Finally, all houses got a cluster of numbers for identification and the registration could start.

The promotion campaign started in the summer of 2005 with adverts on television and in the radio, posters and newspaper advertisements, regular reports and interviews in the news and public subscription exercises in the villages and towns. The main picture used is that of a young mother using a broom to clean her compound. The slogan was that just as one stick breaks easily, many form a sturdy broom. Thus, health costs will be carried by the whole group of registered Ghanaians in solidarity. The reactions varied and many doubted that the system would work. Traditions and cultural patterns influence how people cope with diseases and expectations concerning treatment. In a culture where illness (especially a serious condition) is seen as a punishment for misbehaviour or caused by magical powers, saving money for eventual health care costs would mean to create an illness. In addition, the payment structure in the hospitals was and is a strict one. While in the traditional setting, family members would negotiate treatment and its costs with the healer, Western medicine had standard and non-negotiable prices. Up to today, patients and their families face huge and sometimes inexplicable costs when sick relations are admitted to a hospital. The family is expected to assist in paying the bills, but that can create frictions and revive past conflicts. One relative visiting a sick relation on the ward said: "She (the patient) never contributed to family issues, so now, we cannot support her either", and a nurse commented: "Some time ago, the Ghanaian had the extended family. Now, we're all going back, falling back on our nuclear family in order to

help us. The extended family system is not working well because if you don't contribute to the coffers, you don't benefit." Once admitted to the hospital many patients fear the high costs and consider early discharge or a termination of the treatment in order to spare the limited household budget. But even so, this individual "cash and carry" system has problems, the benefits of the new scheme seem not to convince everybody easily. Patients form Korle Bu Teaching Hospital mentioned the following motives for postponing registration: There is the fear "They say that if you show the card, the doctors will not treat you as well as if you pay cash. I am not yet registered, maybe I will register later" (patient, 54 years). Others claim the annual fee is too high and the waiting period between registration and start of usage is too long. Others miss the coverage of treatment and medication for chronic ailments, or turn the idea down as they are not in favour of the NPP government. Nurses share some of these concerns, but most registered as staff of the hospital. Their fear is that "I can see already now that the patients will disturb us a lot. They will come and say that they have nothing to pay but wait for the card. They are poorly educated" (HCA, 20 years). Another joins in stating: "With the health insurance, you need personnel as well as human resources, and these things are not there. So how do we run the insurance, because you need to nurse the person or the patient perfectly in order for him not to complain? Because he has paid for it, so it becomes for us even more stressful. Because if he says I want a bed sheet and you don't have a bed sheet, I want this to be done for me, and we don't have, they will become very demanding because they've been taught their rights" (Regina).

By the end of 2005, only a very small percentage of the Ghanaian population had registered. Despite continuous promotion, the inhabitants of Accra especially seem resistant to the idea. The newspaper states that less than 5% of Accra had subscribed by November 2005 (Daily Graphic, 11.11.2005). In 2006, Korle Bu started to work with the NHIS card and the first patients attended the OPD or were admitted while showing the card. Other parts of Ghana, like Kumasi and Agogo, started earlier and could present the first figures and satisfied patients in the summer of 2006. Even so the organisation of the new financing system and the reimbursement for the hospitals need to improve to work smoothly. Both patients and health workers reported positively to the NHIS and expressed the hope that a greater proportion of Ghanaians would register in the near future.

5

From impropriety to acceptance: The history of nursing

> More than ever, it is essential to clarify and agree on fundamental issues: The who, what, and how of nursing. Nurses, other health workers and communities must move beyond the traditional stereotype and be flexible and forward- looking. This may sometimes be painful and difficult, but will enable us to create nursing and midwifery services that are appropriate for the third millennium (Dr. Hiroshi Nakajima, Director General WHO, 1992).

Nursing as female profession

To construct the beginnings of nursing, we have to look back in history. Writings by Hippocrates are seen as one of the earliest descriptions of the art of medicine and the beginning of separation of cure from care. In ancient Greece, the 'iatroi'[1] were male healers who were called to private homes in case of illness. They operated within the divinely established system of cause and effect of an illness; such connection between religion and healing can be found in many cultures up to today. The healing process was understood as a result of the iatroi's individual success as scholar, performer and actor showing intellectual competence within the divine system. The profession had no enforced standards; indeed, each iatroi developed his skills and performed the 'techne' (King 1991: 8). The presence and work of nurses are not mentioned in any of the early sources, but it can be assumed they were present. Looking through historical texts, the emphasis is on the curing aspect of the treatment and the actors were males. Before the advent of hospitals, healers visited the sick in their homes. The male healers would have required assistants to dress wounds, wash the sick and administer the prescribed

[1] 'iatroi' can be translated as healers, doctors, or physicians

drugs to support the healing process. It is also likely that it was women who carried out these tasks: Family members or (slave) household helps supported the treatment processes and performed caring functions. A source dating back to 1682 states: "It goes without saying that women, being so to speak born sick-bed attendants and nurses, have all the times carried out these functions" (King 1991: 11). Nursing as the assumed female activity is described in relations to and hierarchically subordinated to medicine (Sciortino 1995: 19). As we will see later, the domination of medicine over nursing and male over female continued to be the organising principle across time and space.

The origins of nursing in Europe date back to the Middle Ages. With the rise of Christianity, disease was perceived as a religious phenomenon and accordingly cure and care were religious acts. Caring was no longer seen as compulsory but as an act of Christian compassion and love towards mankind in need. In line with that, nursing slowly changed from an individual home-activity to an institutionalised vocation. Monasteries became shelters where everybody was welcome. They were an almshouse for the poor, hostel for pilgrims and the needed were looked after. Nuns and monks engaged voluntarily in this act of charity and their work was respected and held in high esteem. The places got the name 'hospital' or 'hospice' referring to the Latin 'hospes' meaning 'guest'. The first hospital in continental Europe, the Hotel-Dieu in Beaune, founded in 1443, was such a religious community. The nuns took care of the sick and dying. In her work Nelson analyses the relationship between deep Christian religiosity and devoted care from the 'Daughter of Charity' up to the 20th century (2001). The designation 'sister' has its origin in the monasteries and is used up to today to show respect to nurses. These early hospitals became often a last resort to the sick, as the means available for curing were limited. Bedside care was an act of religious worship to God, and included feeding and washing the sick and trying to relieve the suffering and pain with medicine and prayers.

Florence Nightingale is seen as the founder of modern nursing. Born into a British upper class family in 1820, she encountered little support to follow her divine calling to become a nurse. For a woman of her status, nursing was seen as a menial job for those without any prospects. But she persevered and got her training with the deaconesses in Kaiserswerth, Germany. Then she worked for several years in London before being sent as a nurse into the Crimean War. Driven by her experiences on poor sanitary standards when nursing the wounded, she returned to England and started to lobby for a reform in nursing. Her booklet 'Notes on Nursing', published in 1860, is seen as the beginning of modern nursing:

> I use the word nursing for want of a better term. It has been limited to signify little more than the administration of medication and the application of poultices. It ought to signify the

> proper use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of a diet – all at the least expense of vital power to the patient. (Nightingale 1969: 8)

She reformed the existing job and defined standards. Her rationale was to develop a profession including theoretical aims and practical work on the ward. Being hospital based, its implications were twofold: Within the group, it led to a formation of nursing hierarchy, but the relation to the medical profession also changed. Nightingale wrote: "it is the duty of the Medical officer to give what orders, in regard to the sick, he thinks fits to the Nurses. And it is unquestionably the duty of the Nurses to obey or see his order carried out." (in Garmanikov 1991: 116). Gamarnikov describes in her work convincingly how nurses understood this 'or', and the assumed complete control of doctors over the work of nurses was challenged. Nevertheless, nursing was understood and performed as a subordinate profession in relation to the medical group. As Worcester wrote, "it is the physician's function to discover the cause of his patient's illness and suffering and to prescribe proper treatment: It is the nurse's function to carry out that treatment" (in Garmanikov 1991: 117).

Following the definition of health and possible causation for illness in this time, health was understood as a sign of moral excellence and power to control dirt and disease. Sickness and disease symbolised a lack of control and the need to reinforce structure. Patients needed surveillance and a healthy clean environment. Nurses were to be the representatives of such good health. They were women from good homes, selected based on moral excellence, religious humility and sexually unquestionably behaviour. A good and healthy woman was a good and healthy nurse. Her devoted and God-fearing attitude made her suitable to support and enforce the treatment the doctor had decided upon. She also performed empathic care towards to patient. Where those nurses subordinated and just executing higher orders? In my view, nurses had power and were given power in several aspects. As we have seen, their relationship with the medical group was twofold from the beginning. Doctors were and are the main actors in the process of diagnosing and treating diseased persons. But in the process nurses are needed to carry out orders and they are responsible for establishing and maintaining a clean stage for the medical art to be performed. One can easily imagine how the hospital work would collapse if the washing, feeding, the wound dressing of patients and the administration of drugs was not done punctually and accurately. Doctors understood and accepted the nurses as part of the healing process. The nurses' continuous presence on the ward and their being pushed to the background during ward rounds is essential for the successful limited appearance of the doctors. Of course, it has to be kept in mind that the evolution of nursing into an active player did not mean equality in responsibility and reward. The distribution of power and control between nurses and doctors

remains negotiated and discussed in the health care at all times and places. With regard to the patients, nurses are displaying power in various forms: The actual work of nurses consists in supporting the patients in their handicapped condition. The punctual and permanent support in washing and feeding is essential for the healing process. Both subtle omissions and preference have an impact on the patient's well-being. The appearance of nurses is another powerful element. Their clean white uniform represents health, cleanliness and control over dangers like dirt and disease. Its importance is especially experienced in deprived environments be it deteriorating facilities or critical health conditions (Holden 1991). The Christian religious conviction supports the image of a powerful and controlling representative of a health institution. Nurses take the role of hope-giving persons, defying threatening elements, defending (eternal) life. This comes close to the image of the perfect woman, mother and wife.

As we will see later, these forms of displayed power can be found back in the work of colonial nurses in Africa and they form motives for Ghanaian young women to join the nursing profession.

Nursing in Ghana

There are no written documents on nursing activities in the traditional Ghanaian society. It seems that as the cultural patterns dictated, healers maintained the health of the people, being herbalists, spiritualists or fetish priests.[2] In accordance with the cosmological ideas of the society, they used divination, herbs, possession and evocation of the deities to achieve healing (Twumasi 1979: 349). It is assumed that women helped in the households to take care of the weak and sick. Docia Kisseih, the first Ghanaian Chief Nursing Officer who researched on the history of her profession, states: "The care of the sick had been the prerogative of the elderly female members of the community before the advent of the professional nurse. Their skill was not acquired in any school of nursing but through long years of housekeeping and child-bearing and practical experience gained in the care of former sick relatives." (Kisseih 1968: 205). Like in many societies worldwide, the division went along gender lines, men being the healers and women the carers.

Alongside colonialism and Christian conversion, European health care including its principles and convictions was introduced to Africa. The health hazards in the region claimed many lives and required improved health services for the Europeans there. In the early 19th century, the Basel Mission sent a medical doctor to evaluate the health situation in the Gold Coast. Like many men before,

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[2] For a description and categorisation of the traditional healing system see for example Twumasi 1979 and 2005.

he "succumbed to the 'fever' within six weeks of his arrival" (Schweizer 2000: 90). Only few European doctors withstood the challenges for a longer period and Europeans like Africans relied on traditional healers. In 1878 the first two European nurses arrived in the Gold Coast to care for the European officials, but it is not documented how successful their stay was. In 1892 a nursing organisation was founded to send British nursing sisters to India to care for the colonial workers. In 1895 the Colonial Nursing Associations followed, being renamed as Oversea's Nursing Association (ONA) in 1919. Already in 1896 the first nurses were sent to Madagascar and as second place to West Africa, where they reached Accra to find out how the conditions for a permanent posting were. The objective was caring for the sick and maintaining a healthy living environment for both Europeans and Africans. The journey was successful, and its objectives fitted in the parallel expansion of the curative hospital-based health service in the region (Holden 1991). More nurses arrived by the turn of the century to establish a permanent nursing service in the Crown colony from 1899 onwards. These nurses were carefully selected and given the order to represent their home country and its moral norms and symbolise this order and discipline in their working attitude and spotless white uniform. This 'right type of woman' was often compared to a soldier, as Tooley does: "No pace is too remote, no climate too deadly for the nurse to ply her ministrations. Like the soldier she obeys the call of duty and if need be gives her life for the cause" (in Holden 1991: 68). Their main duty was to work in the hospitals, assist the medical doctors and train local workers.

With the formal beginning of medicine in 1878, it became apparent that there were too few British nurses and that locals were needed to support the medical doctors, bathe and feed patients and dress their wounds. Most of the first Africans who were trained were male. Various reasons can be given to explain this fact. Firstly, women were supposed to fulfil the household chores and not expected to leave the compound for work other than farming or selling products in the market. Parents protected their daughters, since caring for strangers was perceived as unacceptable for girls in those days (Sumani 2005). In addition, this work required formal education in English writing and reading, and girls had not yet generally entered the school system. Sending girls to school was an economic risk, as they were supposed to be married and start child-bearing. Thirdly, men were seen as breadwinners to support their families. Sending them to school to acquire formal education was seen as a wise investment. But the nursing work in general had a low status. It is likely women took over the care of the sick and old in the families, but nursing was not yet perceived as a bread-winning lifelong activity. Working in these new institutions, the hospitals, where white doctors practised an unknown healing system appeared unattractive. Another new factor was the content of work, namely dealing with naked bodies, blood, faeces, and

smell; it was seen as menial work and not proper. The recruitment of candidates constituted a formidable problem from the start (Addae 1996, Kisseih 1968). Dr. Henderson, the then Chief Medical Officer, reports the same: "No native of intelligence would like to be a nurse because the pay is low and conditions of service are not good" (Owusu 1980: 1). Those few men who were curious and courageous to work in the clinics were to be trained by the British sisters. This took place in the hospitals in Accra (Korle Bu), Cape Coast, Sekondi and Kumasi. The in-service education given to those candidates were practical instructions on the ward and theoretical lessons in anatomy and physiology, surgical and medical nursing and first aid techniques. Tutors assessed the students on the ward. There were no general standards in the training school yet, and also the educational standard of the trainees differed from a few year of schooling to Middle School Leaving Certificate. After a successful training of three years, a certificate was handed over and the men were appointed as Second Division Nurses in the Civil Services. They worked in the 'junior service'; all senior posts like 'sister' and 'matron' were held by expatriates, and due to the limited training, there was no prospect of promotion for the African nurses (Kisseih 1968, Akiwumi 1994). In addition there were orderlies for simple tasks like cleaning the floor and carrying messages. The differences in expectations and the religious and cultural background of the medical doctors, British and African nurses led to regular conflicts and frustrations. A surgeon complained in 1901: "I would strongly recommend that some steps be taken to encourage a better class of men to join this branch of the service, for really the type of boys we have applying recently are too bad for anything. They are all 'bush boys' who have had little education, so called, in a way of book work, otherwise they are absolute savages and quite untouchable" (Owusu 1981: 2). The work was tediously divided in day and night shift with few free days and a strict disciplinary regime. This all resulted in difficulties in retaiing the trained nurses and recruiting enough new workers. At that time, the mining industry and cocoa farming had started to grow in the territories and many young men had migrated to those professions that promised a higher salary and less strict working conditions; the shortage of healthcare givers thus can be dated back to this very beginning. The British and African nurses worked together on the wards; while the British sisters supervised the work, dealt with the administrative writings and administered the medications, the nurses' work was to clean and feed the patients, wash the bandages and clean the instruments. Bedsores were an indication for poor care rendered and its cause had to be explained to the matrons. Punishments and warnings were given. Soon, plans were made to rethink the nursing activities and improve the training. The First World War delayed the development of the nursing education and reduced the number of British nurses from 64 to 15 by 1925, while there were

about 100 male Second Division Nurses. Under Governor Guggisberg, the health delivery regained importance and new plans were made to reform the training and also attract women into the nursing profession. At this time, there was also another supporting profession at the hospitals, that of the dispenser: He was to performe sanitary inspection, treat complicated wounds and administer drugs. Indeed the status of such dispensers was higher than that of nurses and many motivated men changed into that profession, creating a shortage. Parallel to this, health visiting nurses took up work in Accra to help in the starting health welfare clinics. They can be seen as forerunners to today's public health nurses (Otoo 1968: 79). The first midwifery school opened at the maternity block in Korle Bu, Accra, in 1928, and many girls who had passed through secondary education opted to enter into this considered female and accepted profession.

The growing demand for Western healthcare demanded more nurses and a solution needed to be found to meet the need. In 1944 plans were made to establish a nursing education in the country, standardise the training and establish recognition with the British Nursing Society. A retired nurse, who had been among the first Ghanaians to be trained in the country, remembers the development:

> Mothers didn't let their daughters go and do nursing, because it was such a strange sort of job. You must understand our nursing at the time. Clean chronic wounds and carry blood-stained sheet, rinsing them before taking them to the laundry. It was difficult to get girls as the women were supposed to be in the houses. We started with boys. And even with the boys, people from good homes were not encouraged to do it. So initially, the boys they got were just ordinary people who didn't care and they were trained on the job. Gradually as years went by, the girls were brought into the system little at a time and they were also trained on the job for about 6 months or so and given a special certificate. But that type of training was not regularised. It depended on how good the sister who was training you was. So, I mean, whatever they gained depended on the experience they had from the sisters. But slowly, it changed. We learned that being a nurse was a prestigious thing because the British women did it. We understood we were also allowed to wear the uniforms and have power. We could do the same work as the White, there was the possibility for promotion. This was attractive to our parents and us. It became necessary that they should start an SRN training school in Ghana. (Dora)

It is suggested that nursing started in most societies as a female activity, as caring for the sick family members in the houses was the duty of house-helps, wives and daughters. Healers and doctors needed assistants but organised the work distribution so that the glory of a successful healing was given to them, and the nursing activities were subordinate to them. In European hospitals, developing in the 17th century, the first nurses were nuns caring for the poor and sick brought there. Doctors emerged and displayed their knowledge there and the nurses were to support the medical treatment leading to healing or to give comfort to the dying with prayers on their last journey. Nurses were female and of unquestionable religious and moral status. Their devoted and endless commit-

ment symbolised control over health threats and they were seen as perfect women and Christians. The first British nurses transported this image and expectations to the African colonies at the turn to the 20th century.

Conclusion

The start of formal nursing in Ghana shows an interesting development. While caring in the homes and compounds was the domain of women, nursing in health institutions was a new phenomenon. Cultural barriers forbade women to join the nursing profession, and it was male school-leavers who were trained as first nursing assistants. The European perception of the good woman caring for the sick could not be translated immediately into this context. Although working outside the house was possible for women, for example as market women or traders, dealing with sick strangers was initially regarded as inappropriate. It took time till formal school education was introduced and girls were admitted to secondary education. Secretarial work, teaching, and midwifery became options for those girls, professions that were imported from Europe and labelled as 'typical female activities'. Nursing was added to that group of 'female professions' a slightly later. It underwent a change in perception and since it meant direct work under and with the colonial power, it was perceived as respected and venerable. The white nursing uniform intensified this idea. Some 45 years after arrival of the first nurses in the country, the nursing profession became attractive and accepted for women to choose after school education. It has to be seen that Western thought and standard dominated nursing in the Gold Coast. The rationale and practical work were copied from the British model without cultural adaptation. A similar approach was chosen in Uganda and Zambia (Andersen 2006, Schuster 1980). Schuster criticises this as a "cultural process of imitation … the perpetuation of colonial dependency" (1980: 78). There was little place for traditional healing practices in the Western hospitals, and the newly recruited indigenous nurses and medical doctors followed the imported Western understanding of healing and care. This is a difference compared to other countries under British colonial rule. Zaman (2005) explains in his research the situation in Bangladesh. The traditional and religious (Islamic) values remained strong and continue to influence up to today the perception of the work in the health services. Nursing in Bangladesh was and is perceived as dirty and nurses remain socially stigmatised. In the East Indies, today's Indonesia, Dutch traders and missionaries introduced hospital care and nursing. As was the case in Ghana, there was initial resistance to have indigenous women doing the caring job, and male guardians played that role (Sciortino 1995). Nursing was of low standard and reputation until the missions introduced the vocational model. An indisputable character and formal

education became intrinsic features of nursing and that is comparable to the emergence of standardised nursing in Ghana.

6

"We all have a role to play." Nurses' training and work since 1945

> Without a strong Nursing Service, a country's health programme is paralyzed. Every effort is therefore being made to establish an efficient Nursing Service and to maintain a high standard of Nursing in Ghana (D. Kisseih 1962: 23).

This chapter goes into detail about the training of nurses and the work situation in Ghana from 1945 on. The focus is on the development of the nurses training and the shifting in the taught objectives. The first and larger part explains the different stages and types of training in the country; the second part will briefly illustrate the working conditions. The quotations are taken from interviews with retired and elderly nurses who were trained or worked in Korle Bu. This chapter therefore places the ethnographic data in a broader historical perspective.

The early beginnings

A retired nurse, who was trained in the early 1950s, remembers:

> We started with this 3 to 4 months-course to grow into nursing and learned some basics. We were exposed to nursing to confirm whether we liked nursing. So at the end of the basic months, one or two said 'I didn't like nursing' and they left. Others who were intelligent and good enough but from middle school only, were selected for a one-year pre-nursing course before continuing with nursing proper by joining us. Everything was done to prepare our mind and us as to whether we've chosen the correct profession.
> So basically, from the first year of the SRN training, we did subjects like fundamentals of nursing, basic hygiene, environmental sanitation, including water sanitation and so on. And then we did first aid, and bandaging and wound dressing. And on the wards, we did certain

> jobs which we had been prepared for. Junior nurses have capabilities, so what we could do like patient bathing, we did. You collected his or her bathing articles, took her to the bathroom, helped her to wash down, dress her up and bring her back, made her bed nicely and made her comfortable. Now for bed bathing, you had your water and your bathing articles and so on. You had the extra-blanket to put under her so that the bed sheet didn't get wet, that sort you call "blanket bathing." And we learnt taking and recognizing the various temperatures. Now as basic students or beginners if you took a temperature, it is your responsibility to find who the charge nurse is and report it immediately. She being a senior nurse, she knew what to do and she would actually call you to work with you. So we learned on the job. Apart from classroom learning about all these things and then some of the things we were even made to use ourselves as patients. An example is giving injections. We learnt using oranges and old needles and syringes. At the very beginning, there was improvising. Then as time went on we used ourselves, not with drugs but with chilled water to learn the technique. So I will say these are some of the things we learnt in fundamentals of nursing. But what I said is that when we learnt the theory in the classrooms, during the first year we were exposed to patients on the ward and we worked under supervision. Whatever we did we had the seniors there to supervise them. And of course, when you had a good student and you saw the student was good at performing these procedures, then you had less supervision.
> Now, as I said, we learnt also first aid, fractures, sprains and then the various strategies of the various bandages. So after the end of the one year, you took the preliminary examination. Hopefully, a lot of the nurses passed and so they continued the training, went through the first year successfully, through the second and third year. We did also nutrition and dietetics. Then we learned the various diseases and if the patient was bedridden, we took more care of personal hygiene and pressure areas; we made sure they didn't occur. This was the programme up to the final examination by the Nurses Council. (Dora)

Nursing in Ghana started as a hospital-based activity by the turn to the 20th century. British sisters run the wards and supervised male nursing assistants. Their training was not formalised and depended on the skills and engagement of the colonial nurses leading to the rank of Second Division Nurse. They carried out junior activities and could be promoted to the First Division but continued working under the British. Their dress was a blue uniform, contrasting with the white uniforms of the senior British nurses. This on-the-job-training in human physiology, hygiene, medical and surgical nursing and first aid was of low standard, also due to the limited knowledge of English of the African apprentices (Kisseih 1968). All senior nursing posts were occupied by British nurses. The only standardised health care training available in Ghana was the midwifery school attached to Korle Bu in Accra. Since 1928, women were trained in the three-year course and worked on the maternity wards in the few hospitals. Some of those women were sent to Britain to follow a post-basic training in nursing, as there was no nursing training in the country. Alarming figures on maternal and infant mortality, the high morbidity of Africans and Europeans due to life-threatening diseases, and a growing acceptance of the hospital services led to an increasing number of patients. The Director of Medical Services, Dr. Balfour Kirk, realised the extreme shortage of nurses in the mid 1940s and called for an accelerated training for the supporting medical staff, to prepare higher calibre nurses with a standard comparable to the British (Addae 1996: 169).

The shortage of qualified nurses in the health service and the wish to standardise the training led to the establishment of a higher grade nursing training in colonial Ghana. In working out the curriculum, similar standards to those in the United Kingdom should be achieved. Isobel Hutton, who had been trained and worked in London as a nursing tutor, was appointed by the Colonial Office in London to lead this project. She arrived in the Gold Coast in 1944 and started the first nursing school for Ghanaian nurses.

> The formal nursing training began in 1945 with the establishment of the first State Registered Nurse (SRN) school in the country. The aim of the programmeme was to prepare higher calibre nurses of the same standard as the British nursing sisters, so that they could replace the foreign nurses later as supervisors and administrators in the hospitals. (Akiwumi 1992: 24)

The content and criteria of the training were regulated in the Nurse Ordinance that was established and maintained by the Nurses Board in 1946. It was organised and structured such that after completion of the programme, the SRN could register with the Nursing Council of England and Wales and be recognised as full nurses in the UK. The Nurses Board in collaboration with the UK Council of Nurses set the examinations of the first 3 groups. The examinationss were sent there to be marked and controlled. "All subjects compare favorably with an average standard in England and Wales, and the candidates passing through the Gold Coast examination, would compare favorably with a good student in the UK examination Centre for the SRN" (NTC 1995: 32). The level was thus decided to be high and 'full reciprocity' was established soon after in 1950.[1] Miss Isobel Hutton was the first Principal and functioned together with Miss Gladys Burton and Miss Kay Storrier as tutors for the SRN training. The first group of six students started at the Kumasi Central Hospital, which had about 150 beds at that time. Placing the first training school in Kumasi had a political purpose. The territory was divided into four parts: In the South the Gold Coast Colony, in the middle the Asante kingdom, then the Northern Territory and the East British Togoland. Positioning the first nursing school in the Asante territory was seen as an attempt to create unity in the territory and promote travelling between the regions (Buah 1998: 102). But soon it became apparent that the Gold Coast Hospital – today's Korle Bu – was better equipped than the hospital in Kumasi and the education moved in 1948 to Accra after housing facilities were built. In the early 1950s, the newly erected Komfo Anokye Hospital in Kumasi opened the second nursing training college with Miss Burton as principal.

Mrs. Owusu, who was among this first group of nursing students, remembers:

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[1] Reciprocity means that the nurses who graduated in Ghana as a State Registered Nurse had equivalent training and knowledge as nurses in England. The standard was similar to that of the General Nursing Council for England and Wales so "that locally trained nurses could be accepted for registration in Britain" (Kisseih 1968: 206).

> Getting to the end of 1944, some colonial sisters came to our school in Achimota, and talked about nursing. It was one of the few schools that could train girls up to the Senior Cambridge certificate. Those days they had plain midwives, that is midwives without nursing. First I wanted to become a midwife, not a nurse. But they said 'try and do nursing before we'll take you for midwifery'. So this is how I became a nurse. So they took my name and everything and added my name to the first set of six Ghanaian women to be trained as nurses. The nursing course started in February, 1945. We started in Kumasi and we were made to understand that we were there temporarily because no hostel had been built, but construction work was going in at Korle-Bu. After we qualified in 1948, we started working on the wards. Soon we had reciprocity with the Royal College of Nurses abroad. And that was very good because it gave us the opportunity to do post-graduate courses in Britain. If you finished as a nurse here, you walk into London hospital and you're still a nurse. At that time Ghana was the only West African country that started this training.

The recruitment of the first nursing students happened in the secondary schools. Blavo, a nursing tutor, confirms that the nursing tutors travelled through the country and held interviews in the middle schools, testing possible candidates on the spot in English and arithmetic. According to her, "there was a great shortage of work for these girls, and the nursing course had great prestige" (in Owusu 1995: 27), but statistics suggest that the needed number of well-educated and trained nurses could not be reached. The entrance requirement was a West African or Cambridge School Certificate, the O-level, in the field of English, General Sciences, and a third subject. Those candidates started with a 4-month preliminary teaching school course but they were also exposed to 'real nursing situation in the ward', and then assessed to be suitable for nursing and enter the three-year training to become a State Registered Nurse (SRN). In the first years, the intake of O-level holders was very low. This is why a second option was established to attract more girls. Middle School leavers who passed an entrance exam could follow a one-year pre-nursing course for additional coaching and join the SRN training after successful completion. Their intake was crucial and the survival of the programme rested on this category of middle school leavers. During the pre-nursing period, the tutors evaluated the student's "flair for nursing, her capacity for good practical nursing work, her adaptability to the hospital environment, her general conduct and academic ability – all were necessary for effective nursing care" (Owusu 1995: 19).

The objective of the SRN training was to give care to the sick in the hospitals through basic nursing and to carry out procedures supporting the treatment and diagnosis of surgical and medical as well as paediatric patients while obtaining the ward routine. In the recruitment of nurses, the qualities appreciated were honesty, kindness, obedience, truthfulness and neatness in person and work. Accuracy, cheerfulness and cleanliness in appearance and character were additional qualities of a future nurse (Akiwumi 1992: 32). The training was given by qualified British tutors, and combined theoretical lessons and practical training on the wards. But the focus was on the practical work as an apprenticeship, sup-

porting the few nurses on the wards. The students worked as part of the hospital staff doing both day and night duty and were placed in a monthly rotation system on all wards including the operation theatre and the out-patient department. "Responsibilities were assigned to them according to the level of the training" (Owusu 1995: 19). The students wore green uniforms with white aprons. After graduation, the nurses entered the midwifery school for an eighteen-month post-basic training, before start working on the ward. Here, they had the position of a ward sister wearing white uniforms and white shoes. When the first group entered the hospital in 1950, it was the first time indigenous nurses wore the same dresses as the British (Owusu 1995: 20). Discipline was controlled both during the work as well in the housing facilities on the hospital premise. The first nurses remember: "Discipline was rigid. The uniform and apron met specifications to reach the beholder's calf muscle. No student was allowed out of the college premises after 6 pm. Defaulting students were brought to book and their parents called for consultations. These disciplinary measures enabled the students to cultivate social values and have time to concentrate on their studies" (Akiwumi 1995: 6).

The low salary, strict discipline and rigid working times might have formed an important factor why the number of state registered nurses remained low. More workers were needed. So it was decided that next to the SRN, the training of Qualified Registered Nurses (QRNS) started in 1946. Middle School leavers followed after a three-month probation course a three-year training that was less detailed in sciences and specific medical areas than the SRN. The training was mainly based on apprenticeship. It could be offered in small hospitals with only 50 beds and be taught by nurses, not necessarily tutors. Finishing the training was understood as a certificate of competence and good behaviour. It was generally understood that this training was lower in status. Along with those (women) successfully following the training, the qualification of QRN was also given to nurses holding the Second Division Certificate or male nurses having served in the private or military services for five years. It is suggested that the work under continuous supervision and lack of possible promotion frustrated those male nurses and led to a high attrition. A nurse observed thus: "These nurses were good, I mean hard working. But they could not go for any course to upgrade themselves or to Britain, because their training was only recognised locally" (Alice).

By independence in 1957, 211 Ghanaian women had been trained as SRN and worked in the hospitals, as compared to more than a thousand QRNS stationed in the hospitals and health posts (Otoo 1968: 86). Dynamic changes and developments in nursing characterised the first years in independent Ghana. The first government of Ghana wanted to refresh the education and saw the need to train

more nurses. As well as the hospital-based nursing, it was also aimed to train more specialised nurses in public health and administration and reach a better spreading of nursing services over the country. In addition, there was the wish to start post-basic education to offer Ghanaians to rise in the hierarchies and replace the departing British sisters. Therefore, a commission was established to review the educational system and advice on improvements. Dr. Brachott, a medical doctor, drew up a ten-year "Plan on Health for Ghana' in 1961. He noted, "it would be unsatisfactory to apply the accepted pattern of health services in other countries to the newly-independent Ghana. Much more knowledge about … disease in the specific physical, biological and social environment of Ghana is needed." (in Akiwumi 1995: 26). He stressed the implementation of a new nursing programmeme as crucial to adapt system to the needs of Ghana. To support the public health nurses, he suggested training auxiliary nurses: The community health nurse. The consultant also advised the strengthening of prevention aspects to avoid overloaded hospitals due to lack of health education. To implement the suggestions, the Nursing Division of the Ministry of Health was advised by Miss Houghton, a WHO consultant and representative of the General nursing Council of England and Wales. She encouraged nurses to do public health training and raised interest in the social and preventive aspects of nursing. Another innovation was to include obstetric training in nursing to make nurses competent to deal with obstetric emergencies when they were working independently in remote areas.

Soon, plans were made aiming to bring unity in the nursing training. These recommendations resulted in the termination of the QRN training in 1968 and the introduction of a new nurses training course called "comprehensive nursing care" (CNC) in 1970. As well as Accra and Kumasi, nursing schools were opened in Sekondi, Cape Coast, Tamale, Koforidua and Agogo, where the Presbyterian Church runs a hospital. This new comprehensive nursing training focused on recognizing the total health needs of a patient and include preventive and educative aspects to care. Subjects like midwifery, psychology and psychiatry, sociology and community health were taught, understanding 'comprehensive' as a reflection of this broader knowledge. The apprenticeship status was changed into a student status as in the USA, giving the students more rights and strengthening the objective of learning instead of working. A nurse who was trained in that programme describes her experiences:

> When I was in training, we went for an initial period of three months to the classroom just to get the basics. Vital signs, what to do, where you do what and all those things. So that when you go to the ward, you are not a nuisance. Bed making, serving bedpans, feeding, you know a few basic things, that will make you beneficial to the nurses you're going to meet there. And then, during the three years, you go to the ward. If you're put on the medical ward, you're there for one month throughout, full month, Monday to Sunday and you're given one

> day off. And you come to the classroom for another month for the theory to continue. At that time, there were nurses on the ward and you go in after having done what we call professional adjustment here. That is the rudiment of the qualities of a nurse. So you go and you know you've been taught something. The hierarchy is there so you go and fit in. You know where you belong. Those you meet because you're showing some respect for them, they are willing and provided you and you also avail yourself. There were times we even have to run or hide. We were so tired. We go we don't wait for someone to call you. Your set up should be clean so we go and we started despite the fact that the ward assistant was there. (Kate)

Students were prepared to work in hospitals, including psychiatric and obstetric wards and participate in community health services. This new emphasis on preventive health education was conceived as a response to health needs of Ghanaian population to strengthen the prevention and consolidate the curative services. The nurse should be prepared to face all situations she might encounter. But the reality in the hospitals required for a working force. Newly graduated nurses were mainly posted in the hospital wards; the emphasis remained on curative care and the wider concept of health was not implemented.

As the QRN training had been stopped and the workload increased, new auxiliary nurses were needed. Another effort to fill the shortage was to train assistant or practical nurses, called Enrolled Nurses (ENs). Their training was shorter and less detailed. Enrolled Nursing was to meet the needs on wards until sufficient trained nurses were available; each hospital could train them according to their needs. Those girls entering this in-service training were often from villages or poorer families, and their grade was below the level needed to enter the nursing training. Halfway the 1980s, this training was also stopped. Both QRNs and ENs were offered the possibility to upgrade their knowledge by returning to school later to become a full nurse, but only a few decided to do so. Most expressed sufficient satisfaction from the work and limited motivation to return to school books.

By 1980, there were seven training schools for SRN in the country, producing about 3000 new nurses annually. Plans were made to establish additional schools in Ho, Sunyani and Bolgatanga to raise the number to 600. There was only one public health school and two for mental nursing. In addition sixteen hospitals trained enrolled nurses and they outnumbered the SRN in several places (Owusu 1980).

The contemporary concept of nursing

In the 1970s, the WHO and UNICEF adopted the concept of primary health care. During the conference in Alma Ata in 1978, all nations agreed to work on the project 'Health for All by the Year 2000' trying to achieve the highest possible level of health for its population. In 1983 the World Health Assembly recognised nurses and midwifes as crucial in providing health services and in mobilizing the

public opinion for an effective implementation of the primary health concept. In a reaction, the WACN defined the nurse as "a polyvalent nurse at the SRN level" (Akiwumi 1992: 30). In 1991 nursing training underwent another reform, and the competence-based nursing training was established. It was to strengthen the various tasks a nurse could and should fulfil both in the hospital and in the public health sectors. "The answer to the challenge of preparing nurses best suited to function well was a polyvalent nurse. The term suggests a nurse who is able to perform several roles. It is another way of describing the multi-purpose nurse as opposed to the unipurpose nurse, a generalist as opposed to a specialist" (Akiwumi 1995: 30). While these intentions are stated, they are not specifically spelled out in the curriculum in term of skills to acquire. To give more practical experience, a one-year internship was added to the training, called a rotation year.

Since 2000 the training course has been called the "registered general nursing diploma programme." Students with a Senior Secondary School Examination Certificate and an aggregate of 24 or higher can apply for admission. Good health, the absence of a criminal record and an age between 18 and 35 are additional requirements to be invited to a selection interview. The curriculum is divided into six semesters with continuous assessment through tests and practical examinations. General and specialised nursing, social studies and medical anatomy are included as well as nursing administration, public health, research and care studies (NTC 2005). Clinical work is limited during the semester and strengthened in longer posting during the long vacations. Students gain practical experiences in the hospital, a psychiatric ward and polyclinics. Most students receive a state allowance during training and automatically enter a bond to serve the Ghana government for five years after successful training.

Another improvement in the professionalisation of nursing was also implemented: There was no post-basic training facility in Ghana. All nurses wanting to pursue tutoring or teaching in nursing had to be sent abroad, mainly to the UK. In the same way, the position of ward sister, matron and administrative nurse could only be achieved after a course abroad. The plan was to offer continuous education in the country. Therefore the Nursing Department was established at the University of Ghana, Legon. In 1963, the first post-basic nursing training was started there to produce nursing teachers. Rae Chittick, who headed this training course, states: "The establishment of this programmeme in the University of Ghana is a history-making event, for it is the first university programmeme in tropical Africa to prepare tutors for schools of nursing … There are high hopes for these students, not only in nursing education but in providing leadership for the advancement of all aspects of nursing" (Chittick 1965: 39-41). These first 20 students were carefully selected. It was a major step towards professionalism of

nursing in Ghana by offering post-basic education in nursing administration, management and education. Until the 1980s, nurses aiming to promote into specialised nursing had to search admission for overseas courses. Since 1980 students have been able to pursue a Bachelor programmeme in Arts or Sciences at the Nursing Department. This degree programmeme is more theoretically oriented than the diploma courses at the NTCs. Two groups can register for it: normal students coming directly from Senior Secondary School, and diploma-holding nurses with some years of practical experience aiming at a degree level.

The working reality today

During the first decades after independence, the work of nurses was for the most part situated in the government, private and confessional hospitals and health centres. The hierarchy within the profession was strict. In 1947 the Nurses Board was set up and a Principal Matron appointed to head the nursing service in the whole country. This first Principal was Miss Hutton who was succeeded by Miss Luscombe in 1951 and Miss Agnew in 1958. Miss Martin was the last European on that post and the title changed to Chief Nursing Officer. All these British nurses had served the British colonial power as a nurse in Ghana and had climbed through the ranks before assuming this highest post. Most of them had worked in Korle Bu as hospital matron, emphasising this position in the country. In 1960, Miss Dr. Docia Kisseih was the first Ghanaian to hold this position. She had been trained as a midwife in the country and specialised further in the UK. Mrs. Mary Owusu took over in 1971 being the first Ghanaian nurse trained in Ghana to head the nursing service in Ghana. There was one Chief Nursing Officer with one Deputy. Working under them were the Regional Matrons and then the hospital matrons. Ward sisters headed the wards. The older nurses were respected and obeyed "because when we came into nursing we loved to do the work. The senior nurses were there to work along with us. So how do we go and sit down to relax? You will not sit down but work" (Ernestina). In the early years, discipline was rigid similar to the situation during the training. Regular check-ups were made by the ward sisters to control the hygiene of the ward and condition of the patients. Also the uniforms were regularly checked on neatness and cleanliness.

> They (the British sisters) were very strict. Going on strike like they do today did not occur to us. They believed in supervision, going round and seeing what we do. So if we were on night duty we could not fall asleep, so much I know, you had to stay awake. (Alice)

The work on these wards was from the beginning characterised by a shortage of nurses and a high workload. This shortage, described by several writers, put limitations on the work and led to frustrations (Akiwumi 1971, Opare & Mill 2000). The young nurses were placed on the wards and gained experience and

practical routine by working with the older and more experienced nurses. Naa says, "the freshly graduated nurses came on our wards and did not know anything, they had not had the same hands-on practice as we had in our training. So they even invented the rotation year for the fresh nurses to get them gain experience." The enrolled nurses worked under supervision of the state-registered nurses. Until the 1980s, nursing service was mainly curative, with few elements of health education in the outpatients departments and maternal health care programmemes (Owusu 1980, 1995). Most nurses returned to school briefly after the nursing diploma to follow the one-year midwifery training. That was on the one hand an important addition to their training, especially for those working outside the bigger towns, but a waste of resources and time for those nurses interested in normal nursing. In addition, the midwifery training remained a prerequisite for climbing in the nursing hierarchy. A nurse trained in the early 1980s recalls: "During our time, for instance, after the SRN, automatically you are called back to do midwifery. Every SRN was there, it was compulsory for you to do midwifery. Some did it also to relax from the ward work. But it was a prerequisite for you to do midwifery before you can do Public Health Nursing. Actually, at that time, it was a prerequisite for a lot of the post-basic courses. So if you don't do it, you could not go for any promotion" (Evelyn).

The working reality of the nurses must be seen in relation to the general development and situation of Ghana. The initial period was characterised by a feeling of freedom and a general emergence into independence. The hospitals were high in standard and equipment, and the workload manageable. Political unrest led to various military regimes from the mid '60s up to the early 1990s. The socio-economic conditions aggravated and the conditions of the health facilities impaired. Ernestina observed thus: "I started working around 1970. All was still ok. We had sterile trays and trolleys to dress the wounds. The care was free and many patients came without paying. Slowly, it got worse because of the coups and bad management. There was even a time we had to send patients to buy the soap for the nurses." The nurses tried to keep up the standard with rigid working schedules. "During our time (the 1970s), the working schedules we used were strict. If you were on night duty, you worked for a whole month before you could get one night off. This is how we managed the wards" (Liz).

The 1980s were determined by the military regime under J.J. Rawlings. The working facilities were decreasing; the government budget allocated for health fell to 8% (Twumasi 2005: 111). Many health workers, doctors and nurses decided to leave the country, intensifying the shortage of health personal in the hospitals. The economic and political instability resulted in retrograde steps professionally. One nurse describes the working conditions at that time:

> The situation worsened so they were really using us. It was the Rawlings time when there was a curfew so most nurses who were still in town by 5:30 pm must return to the wards. In the night everybody had to be in a house. Rawlings came in ’79 when I was in first year. The curfew was very brief at that time but then he came back in ’81 for good, I remember the curfew period, it was until about ’82. When I qualified, I quickly assumed the role of in-charge for night duties because I was living on Korle-Bu campus. On Korle-Bu premises, there was no curfew, so we were asked to take care of the night duties. You can’t believe it, inexperienced as we were! I remember one night I was on duty left alone with some student nurses and we were all afraid, we didn’t know how to go on rounds. So we locked ourselves up. It was sad so then that period too was over and then there was the serious hardship time, money was not available, things were not available. It was the ‘80s. There was what people were calling ‘the Rawlings’ chain’, people had slimmed, you know money was hard to come by, people cannot buy drugs. You have to use one needle for about ten patients or more. I tell you if AIDS was to have been transmitted by using sharp instruments … it was then. We would all have been dead. But God is so good and because I was an SRN those days I used to give medication. I used to go about making sure everything was in order, you had to go and boil needles over and over for a long time. But in the morning the needles were black. It was a difficult time to be a nurse. (Naa)

During that period and up to the turn of the millennium, nurses were generally respected for doing the caring work in the hospitals. “Everything was done by the nurse – washing, bed bathing, feeding and so on. I finished in 1993 and as far back as ‘93 and even ’96, nurses were still doing these things. Do you get me? There was not so much cry for materialism or greener pastures. Today is different. The trend started maybe ten years ago. It’s because of the enormous shortage today that we cannot do all and the relatives need to assist us” (Cecile). Along with signs of gratitude expressed by patients on the ward, all nurses in this research recall situations of public appreciation and expressions of respect. They were taken along in public transport for free, had respected positions in their communities or given food and other materials in the markets. “With your uniform on, you never have to queue in the line. One car would always stop. And in the markets, I am given food for free. They call me ‘auntie nurse’, even my mother is treated with more respect” (Evelyn). The nurses tried to fulfil their roles and do all work. The relation to the medical profession appeared biased. While some nurses experienced the reality on the ward as a harmonious co-operation (“we used to meet and discuss matters; we respected the doctors and they respected us” (Dora)), others felt stuck in an ongoing struggle for recognition (“we are not walking behind the doctor, but next to him. We are no paramedicals, we are nurses!” (Ernestina).

Professional associations

Two organisations play an important role in the set up of nursing in Ghana. The Nursing and Midwifery Council (NMC) and the Ghana Registered Nurse Association (GRNA).

The NMC was established in 1972 by bringing the former councils for nurses and midwives together into one council. Its main task is to guarantee the standard of the training and processing of official diplomas and registration. Its vision is "to produce trained nursing and midwifery personnel who would provide safe, prompt and efficient service that will lead to a better cost-effective health care."[2] All nurses (and midwives) practising in Ghana must be registered with the NMC, which has its seat in Accra. As well as establishing training courses, supervising schools and setting admission requirements, examinations are developed and controlled by this agency, and diplomas produced here. Generic degree nurses (studying for a BA degree at university level) need to pass a NMC licential exam first before being fully registered as SRN. After school, nurses are registered and have to work for five years in public hospitals before the official transcript, also called verification, is given out. Through this form of bonding, the nurses work for the country that invested in their training, and it is also an attempt to avoid immediate attrition to private hospitals or overseas. Breaking the bond attracts a fine of ¢ 50 million cedis[3]. In reality, nurses leaving Ghana to work in Europe or America before that time have few problems in paying that fine and receive their verification. Recently, a PIN (personal identification number) has been introduced for each nurse after qualification and renewed every three years, if she can prove she atteded training courses and workshops. All these are an attempt to strengthen the professional understanding of nursing and guarantee a high level of nursing care delivered. Even so evaluating and upholding a high standard of nursing in Ghana is supposed to be the main job of the NMC, a lot of energy goes into the certification of nurses when they wish to work abroad.

The GRNA's motto is "Unity is strength!" and understands itself as the mouthpiece of all nurses in Ghana in order to promote the socio-economic well-being for its nurses. Their official website states that "(T)he GRNA is the exclusive mouthpiece for all nurses in matters that affect them. Membership of GRNA is open to all nurses in Ghana, registered or enrolled by the Nurses and Midwives' Council of Ghana" (GRNA 2009). Its beginnings go back to the situation that two training programmemes were offered, the QRN and SRN, each with its own association. But awareness grew that one single training course would provide the nurses with more strength. The amalgamation of those two into the GRNA in 1960 meant the firm establishment of nursing as an independent profession in the country. Since 1961 the GRNA has been affiliated with the ICN and the Commonwealth Nurses Federation (Addae 1997). The organisation is hierarchical: Its president has her seat in Accra, where the GRNA just finished a

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[2] The information in this section was given to me in two interviews with NMC officials in November and December 2005.

[3] In 2005, ¢ 50 mio was the equivalent to $5,000.

new representative building, including a hostel for visiting nurses. She is elected for four years and fulfils this work part time while also working as a nurse in a polyclinic; her motto is to 'Empower nurses to provide quality care' (The Ghanaian Nurse 2005 (1): 20). The council exists as the national executive and representatives from each of the ten regions in Ghana, meeting regularly alone or as part of the bigger assembly. Each region has its own organisation down to district and local branches in the health care institutions. The Association is financed by its members through a one per cent deduction from their monthly salary. Today, it pursues four goals: Protecting the nurses by negotiating with the government on salary and logistical support for all nurses; protecting the clients by giving workshops and training to update the nurses' knowledge; establishing a welfare system by having funds for the members. They get a benefit when they retire, when they marry or their spouse dies as "we mourn with you when you cry and enjoy with you when you laugh." Finally the GRNA maintains a high professional standard by offering workshops to all nurses for continuous education. The GRNA is accepted by the government and Ghana Health Service as partner and negotiator when it comes to discuss salaries, working conditions and affiliated standards.

In Korle Bu, the association holds office a few hours each week, but the resonance is minimal. Many nurses see its benefit when it comes to salary negotiations but as of little influence in the daily problems and struggles. The building of the new offices is criticised as a waste of money serving only representative goals while they need practical assistance in their work. One nurse even confessed that she "was the secretary of the GRNA in Korle Bu at a certain time, but I resigned on principle. I think that what I thought the association to be doing they were not doing. And I wasn't the type who would hang in there and pretend all was well." A student is disappointed about their influence: Some of us have lost faith in them because at the end of the day we don't see them as protecting our interests. The GRNA has outlived its usefulness. And to tell you the truth, there's this general practice that people don't really have any faith in them." Others do like the idea of being organised and able to make a stand. During the elections of the new branch of the hospital in 2006, the nurses agreed to wake up the dormant group and stand up for the rights of the nurses and make their voices heard. The journal of the association, "the Ghanaian Nurse" appears irregularly but is circulated over the wards, informing them about new developments, remembering the principles of nursing and advertising workshops and training. In addition it boosts the moral of its members by informing them about plans and actions in the Ministry of Health and Ghana Health Service, reporting about achievements and strengthening group solidarity.

Conclusion

Analysing the development of the nursing profession in Ghana in the past 60 years, one trend becomes clear: Both the training and the working reality has had to continuously adjust. External constraints have reshaped the programmeme and dictated the conditions of the workload and the level of equipment. On-going education became a reality, but the work satisfaction decreased. Thus, Twumasi (2005: 81) concluded in 1975:

> The nursing field, like other fields in the health profession is engaged in a struggle for status and prestige as an emerging profession … It is often hard to distinguish how the unique character of Ghanaian values and beliefs have significantly altered the models of nursing educations brought to the country. Even in future nursing may continue to develop along core universal lines which are established outside of the country.

The economic dilemma in the 1980s resulted in unsatisfactory working conditions, and the exodus of nurses led to increasing shortages. A changing society and the rise of new professions have shaped the reality of the training and work in the health setting. This had an impact on the perception of nurses about their work. Akiwumi (1995) researched the nurses' ideas on their role and competencies. Freshly trained nurses stated insecurity and lack of practical routine when entering the work floor. Insufficient supervision and outdated equipment are additional factors to feel less optimally prepared. Qualities of the nurse were defined as observant, responsible, punctual, accurate and patient. These are attributes generally labelled as female and Christian, confirming the existing gender perception. Characteristics like being humble and submissive were seen as negative features. This shows that the nurses working on the hospital wards in Ghanaian hospitals today have different way of seeing themselves from those women who introduced nursing to Ghana 60 years ago. Some attitudes are transported over time and remain important for nurses, while others play a subordinate role today. Nursing had to continuously adapt to new situations.

7

Attrition and attraction: Motivation to become a nurse

> I have confidence in you all and believe that you are all "CARING" dedicated people who are challenged to give best nursing care (President of the GRNA, 1997).

Regina, 59 years

> At that time, in our family, it was your parents or somebody very close to the family who'll say 'you go and do this, you go and do that'. Be a doctor, be a nurse, go and do teaching, go and do this. So it was my senior brother who said: 'She can be a very good nurse'. He brought me to the nurses' training college. Whether I liked it? I was not asked but I said OK, because at that time, they have to tell you what to do. Your daddy can even tell you, you 'I'd like you to be a nurse'. So we worked towards it. This is how it's been. I'm the last born of my family. So they said, 'oh, let's have a nurse'.
>
> We were committed because we have said that we're going to take care of the sick. So you should feel happy, work happily and lovingly, make sure your patients get well. They said in "the Girls' Guide", you should smile at all your difficulties and they'll go. But any difficult thing that you have, you squeeze your face. And most of our patients they like smiling, so you should smile to them so that they get well. In our time, we had no say. We were so much interested in the work, we were not talking about working schedules or salaries, we just worked. They put us to a ward because our services were required there. So this is how it is. Oh, I'm happy that I've been able to work to save lives. It's only by the grace of God. I don't have any ill feeling at all, and I'm grateful to God for what he has done for me during more than 35 years in the job.

Susan, 27 years

> I wanted to do Science. I can do chemistry well; I tried the university. But my biology wasn't too good and made my aggregate too high.[1] I applied several times but they didn't admit me.

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[1] The aggregate is composed of 6 grades from the Secondary School Final Examination: the three main courses English, Mathematics and Integrated Sciences, and three electives from their profile. The grade A counts 1, B is 2 etc, this means a low aggregate reflects a good overall result. To enter Medical School, an aggregate of 7 or 8 is compulsory.

> You know, also to get into a Nursing Training College is also very competitive, it is not easy. They take up to aggregate 24, I had 18. I had to write an exam. Then I had an interview and another exam. This is how I got in, but when you know somebody it helps and goes easier. I did not really know what nursing is, I never knew. The only thing I knew was drugs and injection. When I asked some nurses, they wouldn't tell me the real thing. It's difficult. Nobody advised us, nobody, some of us thought the nursing is just a matter of coming, just give injection. We didn't know that there's other things behind, serving of bedpans, wound dressing, doing this bathing and caring of the mouth, do you get me? I never knew. I knew only injection. But what else can I do? At least nursing has got a science field. Should I go and do business or start with something like accounting? I can't start. It'll take me some time. And I can't stay in the house everyday doing nothing. So with the nursing, I am OK. And by now, I started to like it, caring for the sick, making them feel better.
> Some people are in the nursing field, they are not there for the profession, they are there just for money or to say, "I'm a nurse." They don't want to do the filthy job. They want something that is glamorous. Do you get me? When you don't have the skills and develop the love, you don't make it. So I do not advice anybody to join us. You know, in Ghana, the profession and situation is not good. It's only the higher people who're enjoying life.

Both Regina and Susan are nurses on the medical ward in the teaching hospital. While Cynthia is higher in rank and supervises the work on the younger colleagues, Susan started her professional life not long ago and is still trying to gain routine. Most nurses are in their early twenties when they start to work, and the official retirement age is sixty. Given the current situation with many nurses leaving Ghana to work abroad, most nurses on the wards are either as young as Susan or older than 50 years, and many hospitals depend on retired nurses to return to work on contractual base. This means job starters and experienced nurses meet on the wards for the daily work, but their motives and generic expectations differ. The above examples are representative for nurses of these two age groups. We may recognise various motives for women to start training: Within the elderly, the influence of the family and the experience of a religious calling are prominent, whereas the younger nurses mention mainly financial attraction and vague expectations of the nursing reality. There are also motives found across all generations, like the function of role models. They will be analysed below.

The first generation of Ghanaian nurses

In the older generation, the prominent motives for becoming a nurse are decision-making processes in and by the family, and a religious calling. Most older nurses who were interviewed mentioned the family. In the example above, we see that it is the elder brother who decided; other nurses mention their parents: "My parents took good care of me, and they were very strict. After JSS, I went for the SSS to Wesley Girls in Cape Coast. That is one of the best schools. I finished school in 1960 and immediately my parents sent me and I joined the nursing training at Accra. I am grateful to my parents" (Liz). The family looked at its needs, aiming

to have within the extended family doctors, lawyers and teachers to cover various aspects of professional life. The woman herself had no or very limited say. In the first decades of the 20th century, nursing had been regarded as a low profession. Whereas caring for sick family members was seen as a primarily female duty, working outside the house and outside the supervision of an elder male family member was inappropriate. A retired nurse of 82 years said that in the mid-1940s that perception still existed: "Eventually, when I told my mother, she cried. She cried, "nursing, no, my daughter to go into nursing, no." You youngsters will not know but people were surprised also in Britain that Nightingale, being from a good family touching these people. So I went and saw a senior nurse to come and talk to my mother before she agreed for me to go and do it. But it wasn't easy for her to swallow it."

With time, this view changed and "working with the Whites and wearing their white uniforms" gained status, both for families and the educated girls. Alice: "a colonial sister from England came to our school. She was an Anglican nun and told us that they would like us to go and do nursing. She told us about nursing training, what is going to happen and that we're going to replace the white people. They told us." Working together with the British helped make nursing attractive in the 1950s and '60s. Young girls started engaging in smaller nursing activities, and helping the community at an early age led to nursing: "In secondary school, I was a member of the Red Cross Society. And in my school, we were supposed during the weekends to go to the nearby villages and we go and dress wounds. And on Sundays, we also organised Sunday school for the children. And so it was something that I was doing. So when I came out, it wasn't difficult for me to decide whether I want to be a nurse or not" (Ernestina). In addition, those young women who had gone through secondary school education had few professions to choose from. The only other options were teaching and in a more general way catering. "I was always happy in my profession. In the beginning I did not know what to do. I was good in school and could do both teaching and nursing. I filled in the forms for both and was about to choose. I was always interested in health, so I chose nursing, I never regretted it" (Dora). Nursing became a wanted profession and gained status; this made it attractive for families and their educated daughters. "My father was a teacher and a strong catechist. So after school, he told me the options: Teaching and nursing. He asked me to choose one. And by nature I liked health issues so I decided to do nursing" (Naa).

The second main motive for entering into this profession is Christian faith. All older nurses state that nursing is a calling and not a mere profession. The nurse quoted in the beginning of the chapter mentions "gratefulness to God" for being able to work a whole life as a nurse. "Serving God", "humbling yourself like

Jesus" and "following your religious calling" are reported sentiments. One nurse puts it: "Some nurses have this calling, you recognise them immediately. Me, even on Sundays, I get my blessing when I come to the hospital. I sacrifice my worship to nurse my patient. Any given time of the day, I've nursed Christ. Our motto is 'nursing Christ in the patient'; whoever is sick, He is there" (Mary). This religious motivation is manifold: It serves as a frame of reference for the nurses themselves. Praying on the ward in the morning and reading the Bible during breaks are recurrent activities by all older nurses on the ward. Secondly, their strong religious conviction serves as encouragement for the nurses themselves to manage the workload and challenges in the daily routine: "It is not easy to work here, this ward is ruled by the Satan, you have to pray hard" (Martha). Thirdly, displaying the religion publicly is a symbol of support towards the patients. Patients calm down when seeing the nurses pray, seriously ill ones are encouraged to pray ("Keep praying and He will glorify His name in you") and relatives of deceased ones comforted to "give it over to Him."

Looking back, all those interviewed experience 'gratitude' for having learned nursing, describing it as a good and a useful profession. The support from the family is rewarded and the acknowledgements from society compensate for long working hours and low salary. "I am happy in my profession. I like nursing and I will always nurse, even if I was married to a millionaire. Once you learn it, you always stay one; you are 24 hours on duty. The family and neighbours see the nurse in you. You are respected and you help everybody, the family, church-members, and friends" (Martha).

Today's motives

If we compare this to today, other topics arise. Younger nurses and current students have quite different motives. They state unanimously "I chose nursing because I like to care for people" and "we were called 'auntie nurse' as children already". One student nurse recalls: "there was a time, my grandmother was very sick. I was very young and I was left in the house to care for her. And I felt like helping her but I wasn't having anyway, but I did it. So since then, I've felt at least I have to help. As people needed my help, may be sick or well. So I had that one from infancy that when people are weak or something I have to go near them" (Gloria). When pressed, it proves difficult for the younger generation to illustrate those statements with examples. Unclear expectations about the profession and financial reasons dominate.

Secondary school leavers in today's Ghana have a wide range of professional training options, and the school aggregate decides on the entrance into degree and diploma programmes. Apart from studying at one of the universities, women may choose to go to teacher training colleges, follow secretarial, administration

or computer courses. As a young nurse said, nursing is often started as second choice given the competitiveness of university courses. “When I was young, I thought nursing means that you have already settled for the mediocre, you always pay heed to what people want you to do, go and do this … so I saw nursing to be like an apprenticeship in some work places. But I got to know that going into nursing does not mean that you’ve settled for the mediocre. You can still be good. It is not like you’re an apprentice to somebody” (Cecile).

Being denied their first choice courses for various reasons, the young women stay at home for some time and then apply to Nursing Training Colleges. Their age group claims not to have been advised about what nursing really is, feeling shocked when they enter the ward. The public perception that school girls share, is that of nicely dressed women in the outpatient departments or clinics, calling names or giving injections. The hands-on care when washing and feeding unconscious patients, or dressing wounds was not what they expected. The same unawareness of what nursing entails is valid for the amount of theoretical knowledge. Many students complain about long lectures and complicated exams in anatomy, pharmacology and nursing theories. As one put it: “I didn’t know the magnitude of what nursing entails. Nobody advised us before starting the training. Because if you know and you love it, you still want it, you go for it and you will be good. But if you don’t know that, it is like somebody who’s getting married. She doesn’t know that in the night, the husband would approach her to have sexual relations with her. And all of a sudden, in the night, this man jumps on her. Reality, it’s another thing. I think it would have been better, had they advised us before” (Evelyn).

Most young nurses deal with this initial shock alone and without advice. Too much has already been invested by the family to allow the student to enter the college, there is no possibility to drop out of the training. Several students voice more general frustrations and problems. One is explicit: “Nursing is not what I thought. I was interested but it is so depressing. Every week when I have to get to the hospital I get almost sick. But there is no way out” (Eram).

One reason to come to terms with their professional future is the financial aspect of nursing: This profession offers a job guarantee, the salary is, compared to other professions, reasonable, and it opens the chance to travel abroad and become financially independent. “The young ones, they do it for nursing gives them immediate job opportunities here or abroad. You see, with secretarial work or accounting, it is difficult to get a good job, but as a nurse, you can always work. And you earn well, so it is attractive to most young girls” (Vicky). The whole of Ghana experiences a shortage of nurses; this means that all graduated students will be taken into service either by the Ministry of Health (and placed in a small hospital or health post in the country) or the autonomous teaching and

private hospitals. Getting an education is a stepping stone to a respected and materially successful life. The old fear that knowledgeable and clever girls are unattractive to men has gone. “In the olden days it was difficult for educated girls to find a husband. When you know a lot it seems you scare them” (Vicky). Making a living and acquiring access to modern media like mobile phones is within reach as is the chance to find a good marriage partner. “Many become nurses because this profession makes chances outside. And then you get a husband too because if you go, your husband will follow. I mean now because the men are aware that if you go you have a work permit so when they come, their children are safe and then they also get work. Nurses are now wanted marriage partners. Initially we were not, because they think we are fat, but now we are wanted” (Naa).

Joining the group of working migrants to the UK, Canada or the USA is another appealing motive. There are high expectations on earning money that cover up possible fear about the unknown abroad. Stories from nurses outside Ghana or returnees seem to verify this chance without critical questioning. Training colleges and professional bodies seems unable to stop this drain of health workers. “A teacher at the NTC told me, out of the class 60% leave immediately. Some even only become nurses to travel” (Regina).

Older nurses have their children or elder family members to look after; travelling is not an option for them. When they see the younger ones leaving, some are jealous, some judge harshly: “Young nurses are often only after the money. They enter the job for the salary, and the moment they think it is not enough, they decide to travel and leave for greener pastures In one year outside you make so much money that you can come home and just set up a house. Nobody manages that by staying here, so they all go” (Araba). On the other hand, working abroad may be understood as a modern form of paying respect to the family. Families see their influence increased with a nurse in the family. Indeed, a nursing student today is seen as a possible family member abroad tomorrow supporting the family with euros and dollars. Many members invest in the training of younger siblings by paying fees and doing without assistance in the household during those years. Once registered as a nurse, they are expected to “give back what was invested.”

Nurses staying in Ghana mention the satisfaction of having learned nursing, “suffering small abroad” is accepted as the money sent home monthly is wanted and needed. But also working in Ghana implies being there for family members in need: “My primary aim of becoming a nurse was to acquire the skills to care for my family members. Because, you know that we live in a country where it is difficult to even get people to take adequate care of people, when they get sick. And so looking at the number of nurses in the system, at least if I’m a nurse by

profession, my immediate family members will have that benefit of getting me at their disposal" (Stephen). This implies that also for the younger generation, the family has influence on the professional choice. With the interviewed nurses, all families either stimulated them to choose nursing or reacted positively to the decision. One nurse said: "My daddy said he wouldn't waste more money on me to do the accounting thing. I decided to look for another job so that I can finance myself. And initially it was my mum that wanted me to do nursing. She encouraged me to do nursing" (Susan). It is interesting to note that both female and male nurses are supported by their families. The parents react "very happily", the nurses "cannot recollect anybody discouraging me."

As explained in an earlier chapter, nursing by Ghanaians started with young men being trained as assistants to the British doctors and nurses. After the regulated training started in 1945, it was mainly women who were selected, and very few men entered the profession. Today, there are hardly any male nurses working on the wards. Those in the system, work in the psychiatric hospitals or on administrative positions in hospitals or governmental institutions. In the research setting, there were no male nurses on the ward.[2] But among the nursing students, following the degree programme at the university, a few were male. In interviews, five explained their motives. They were similar to those of their female colleagues, and also their families reacted comparably. Kofi, a second year student said: "My main goal to become a nurse was to acquire the skills to help my family, as it can be difficult in the country to get adequate care. I try to help other people, like caring for the sick. We have a doctor in the family, but I am the first male nurse. My family was happy, my grandmother said: 'Hurry up and take care of me before I die'. I can't recollect anybody discouraging me." This suggests that the male studying and working nurses do not have different motives for choosing this profession than their female colleagues.

Shared ideas

Even though nurses from different age groups do have different motives for joining the profession, they share in their motives two features: The vagueness about concrete nursing work and the presence of role models. Older nurses seem to have fewer problems with bridging the gap between expectations and reality of the work: "I didn't know. So I went into nursing and I think when I got in, I liked it" (Naa). Younger nurses continue to question the choice and consider alternatives: "So in fact, when I was starting my training, I was reading my prospectus when something just went through me. I was asking, 'What do nurses learn at all

[2] In the whole hospital, there are 40 male nurses working next to more than 1000 female nurses (Korle Bu 2006).

that we need a note book and text books?' It was a different issue altogether. Nurses also go through a lot" (Kate). Also other nurses mention that they were not aware what nursing entailed. One student asked her mother, a nurse, but received no information. "She kept saying, 'Oh are you sure you want to, I wish you could do something else'. And I asked: 'Why?' Then she turned away and never told me what was involved, until I came into the training" (Evelyn). This example shows how the vagueness pertained even when clarification was asked. In addition, we see that a family member was taken as role model and inspiration even when the actual content of the work remained unclear and was revealed only during the training.

The presence of a role model is mentioned through all generations of nurses. In the 1950s and '60s British nurses visited secondary schools and recruited actively for the training colleges. Pupils felt attracted to the uniform and working in the new and unknown territory and working with British nurses. In recent decades, it is a nurse they met accidentally in the hospital who motivated them. "Honestly, I was inspired by a nurse while I was in senior secondary school. Together with a friend, I visited a clinic and saw the nurses in their uniforms. So I also wanted to be a nurse" (Esther). An aunt, mother or woman in the neighbourhood may be a nurse, and their appearance, patience or direct advice influenced the decision. "Actually, my mother happens to be a nurse. So I sort of took inspiration from her" (Evelyn). The vagueness about the nursing reality and the advice from an older person are intertwined: Having finished secondary school, young women look for a profession while fulfilling the family's expectations. Respected female members of the society like nurses attract them and make them curious to join and share in the authoritative appearance and knowledge of caring. Similarly, nobody tells them about the full scope of nursing. Like in other jobs, there is the outside perception, and it seems impossible to give newcomers an insight before entering the training schools.

The 'wish to care', a religious calling and 'following the family's plan' cannot be combined with experiences until the course has started. Once in training, attending lectures and gaining first experiences on the ward, the novices see what nursing entails and adapt their expectations. They learn the 'rules of the game', socialise and become a member of the nursing group.

In the Ghanaian society, there are several prejudices about present nurses and their real motives. A regular reproach is that many girls finished school with a bad (this means high) aggregate and are not qualified enough for the university. Nursing is then a second or third choice. Similarly, people accuse nurses of choosing the profession only to abandon it and migrate to earn more money abroad. 'They want to be called nurses but they don't want to do the nursing' is often said by persons outside the hospital. Some older nurses join this view and

criticise the younger generation. “It might be that it is the parents’ idea to train them, so that they send them abroad later. And these students have no alternatives and no clue; they come to the ward and are shocked. There is no motivation and no love for the job. But they will not tell you. Most tell you lies and not the real motives” (Esther). Such expressions are part of an ongoing discussion between the generations. “The attrition is our main problem. So many leave, and even those who stay, most are young and not motivated. They are less committed and may see the time here only as stepping stone to leave” (retired nurse in KB). The young girls see themselves caught between the dream of finding a well-paid job and gaining independence on one hand and the tradition to honour their family on the other. They feel glued to such a step, rather than having opted for it on purpose. One nursing student phrased the situation for herself and friends: “I look at it that I didn’t find myself into nursing by chance but by choice” (Faustina).

Conclusion

When asked about their motives for becoming a nurse, the current group of nurses brought up various motives. There is a clear difference between the generations: Older nurses mention mainly guidance from the family and religious convictions, while financial pressure and vagueness about the future crop up in the analysis of younger nurses. As in many other professions, the longer women are in the job, the better they seem successfully to match reality with their expectations. The decision of respected family members was followed up without hard feelings, although surely romanticising and idealising the past plays a role here. They feel like the pioneers in the profession, copying and fulfilling the role the British sisters had: Be a convinced Christian and a well-educated woman with a spotless reputation, represented in the neatly ironed white dress, the symbol of ‘the good woman’. The younger ones being trained by Ghanaians, have less linkage with such role expectations of the woman: They see nursing mainly as a profession that should pay well. Confronting criticisms from outside, nurses from all generations join together and call for more respect and acknowledgement from the society. Nurses are there in the hospitals, clinics and health posts all over the country, working under pressing conditions with inadequate manpower and equipment. Those nurses, that do not leave the country or job, want to be acknowledged for their daily presence and work. During the research period, nurses all over the country went on strike several times. Their main objective was to earn higher salaries. In their view, the long working hours and regular weekend and night duties should justify better remuneration. They verbalise this claim by stating that they are “not being motivated enough.” Using the term ‘motivation’ is unanimously interpreted as ‘sufficient money’. This money

should come in the form of enhanced salaries and additional incentives like 'extra hour allowances', preferential treatment in renting housing nearby, buying a car or purchasing land, etc. From their direct superiors, nurses expect them to treat them to 'minerals' like coke or fanta and cookies after a hard working day or at the weekends. Their claim is that raising the financial reward will guarantee more satisfied workers. By this, nurses try to cope with the pressure of an unfriendly working environment and a growing demand from the society and the desire to (re)gain control and influence over the processes in the health service.

The older generation received power and status while they were working with and replacing the British sisters, the younger group is attracted to nursing as it guarantees a job and opens the possibilities to travel. It seems that even so the core work has only been slightly modified, their motives have changed over time. We can find a generation difference in the reported ideas, feelings and memories of nurses of different age cohort and working experience. This can be explained by historical changes and individual convictions. Historically, nursing was introduced by the colonial regime as one of the few professions that needed formal education. Like teaching, secretarial work or driving, it was carried out my British women and men and represented the European way of life and standard of organisation. In addition, nursing and teaching were understood as a profession in which high Christian standards and values were portrayed and transmitted. Indeed, most mission posts had small clinics attached to their churches. As a result, nursing gained a high respect and became attractive to educated young women and their families, as can be appreciated from the quotations. On a more individual level, it is shown that the nurses who were trained in the 1940s and 1950s passed these ideas on and functioned as role models for the younger generations. We can assume that a certain level of idealisation took place now that they are looking back on their professional life. As Ghana became independent and the economy developed, more professions arose and the uncontested status of professions like nursing, teaching, and driving tottered. In addition, the profession underwent several reforms and introduced new specialisations. Also the society passed through changes and with the rise of individualism and globalisation, the traditional respect of the elderly and their views was disputed. Today, nursing is experiencing an extreme shortage of personal and a decline in the availability of equipment. Dealing with the decrease in status and experiencing the shortcomings can be difficult to handle by the older generation resulting in romanticizing the pioneering period. The younger nurses find themselves between transmitted values, the remaining influence of their families and modern wishes and they are struggling to find a balance.

It is clear when one looks at the statements of the professional bodies that caring for the sick (still) forms the focus of nursing. In 1997, Mrs. Emma Banga,

the president of the Ghana Registered Nursing Association (GRNA) wrote: "Colleagues of the noble nursing profession … I have confidence in you all and believe that you are all a "CARING" dedicated people who are challenged to give best nursing care … We must be compassionate, tolerant and empathic. However, we must understand also that the best of our efforts requires a structure for skill at making decisions." (The Ghanaian Nurse 1997: 4). The slogan of the GRNA does not seem powerful enough to form a stable basis within today's nursing body. Career perspectives, higher and stable financial compensation and satisfying working conditions are pressing issues of today's generation and are necessary to become and remain attracted by the nursing profession.

8

Being green on the ward: Nursing training experienced

> After taking up from the night shift and having a moment of Christian devotion, the nurses start their morning duties. Six students are ordered to make beds. Each starting at one row of the ward, they work in pairs straightening bed sheets and refreshing the dirty ones. Some wear gloves but there aren't enough for all. Two of the students feel uncomfortable touching soiled sheets and skip the bed of a restless unconscious patient. Later that morning, they check the vital signs of the patients. One takes the temperature, one the heartbeat and a third one checks the blood pressure with the only machine available. Then they document the results in the nurses' notes. After that they relax in the resting room. One student complains: "In school we learn all things on dummies in the demonstration room and they tell us that on the ward things might be different and you will have to improvise. Look here, there are not enough bed sheets and machines, how can I do the right thing?"

This chapter illustrates the perceived reality of student nurses who come for their practicals in the hospital. After briefly introducing the two different styles of nursing education, the study will focus on shared experiences, namely the theory-practice gap, the lack of supervision and the dreams and expectations of neophytes. Finally those aspects will be brought in discussion with the support of existing literature.

The Nurses Training College (NTC) is located on the ground of the hospital. For three years, students learn and work here before going to take their examinations and obtaining their diploma as State Registered Nurse (SRN).[1] Stating that "the rewards of nursing are many but perhaps not as great as knowing you are making a difference in the world", the goal of the school is to "produce qualified professional nurses through excellent teaching, research and dissemination of

[1] In 2007, the title changed to Registered General Nurse RGN.

knowledge" (NTC 2005: 3f). The classes are full to capacity. The principal explains:

> There are currently 230 first year students in our school; in the second year 130 and in the third year 124 students. More than 600 apply each year. It is highly competitive and we do our best to select the best. There is no bribing or anything, these stories are made up by those who did not get in. We realise it is often not their own choice but more the decision of their families. So they have to become nurses for the family to have somebody abroad. We are aware of that situation. They will not tell you in the interviews. We do not find those candidates till they are in the system. Some do not know what nursing is till they are inside. Then some are shocked or disappointed but cannot stop the training because the family pressures them.
> Our current problem is that we have too many students. It is difficult to find wards for them to practice. Imagine this, 33 students for the emergency room and ten on a regular ward. They are too many and won't learn a lot. Some will shy away from their work.

During the training, students live in hostels attached to the college and receive an allowance of about ¢ 400.000 (in 2005), the training itself is free.

The dress code of these students is a dark green uniform with a white apron worn over it. On the sleeves, between one and three small white stripes indicate the year of training. To complete the appearance, they have to wear black shoes that are closed at the toes to avoid injuries and infections and have a rubber sole to be quiet when walking over the floors. By this they differentiate themselves from graduated students on rotation (who wear white shoes to their green uniform and indicate the graduation with one broad white stripe on their sleeve) and the regular nurses who wear white dresses. The material to make the dresses is provided by the school and sufficient for two or three uniforms that are tailored in town or by befriended seamstresses. Being recognizable in their uniforms, they form a group of young woman on the wards on their way to being disciplined and transformed into good nurses and well-educated women, following the established role models and expectations of the good nurse being the perfect and indisputable woman.[2]

After having passed the exam, the students need to complete their National Service. In the health sector, this year of duty is called 'rotation'. It is divided in three months each in psychiatry and public health and six months in the teaching hospital. During that period, students receive an allowance. On completion, students either are either posted via the Ministry of Health to a clinic or hospital in the country or apply straight to the independent teaching hospitals or private clinics. Some students try to influence their posting: "I started the rotation outside. The first six months were in public health and psychiatry, so I finish here. This means automatically I will stay in Korle Bu. I also opted to be placed alone and not with other students, I like it like that. And my chance is that I will

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[2] The chapter on motives portrays and discusses this aspect of the good nurse and woman in more details.

be asked where to be placed, as I am alone. If you are in a group, they just put you somewhere" (Lisbeth).

In the 1980s, the University of Ghana established the possibility to study for a four-year Bachelor in Nursing within the Department of Social Sciences. In 2003, it was turned into the School of Nursing, with a strong affiliation with the University of Alberta, Canada in developing an MPhil programmeme. By this they reacted on the growing demand for further professionalisation of nursing and followed similar developments in Europe and the USA. Compared to the training colleges, the programmeme is more theoretical and the students are less exposed to the work on the wards. During the semesters, students attend classes three to four days a week and go to the ward only one or two days. To compensate the lack of practical work, they have long placements in the summer breaks when they work full time on a ward or a public health post. 'Generic students' arrive straight from secondary school, choose nursing as their main subject and are enrolled in the first year. Others start in their first year in a different field and move to nursing in their second year. After receiving their bachelor degree, all students need to study for one additional year gaining work experience and then passing the license exam before being registered as a SRN. About 150 students start this study each year with the introductory semesters. In 2005, 330 students followed the year two through year four to gain the BA or BSc degree, and less than ten students followed a masters' course.

Degree students wear white uniforms and black shoes. This uniform makes them easily recognizable on the wards as university nursing students. Their rather theoretical training impedes their acceptance on the ward. Nurses complain that the degree students lack practical experience and are sometimes unwilling to learn and obey. Students mention to feel "this whole stigma of the white ones being those not willing to work" (Cecile). Her friend knows of similar experiences: "It seems that some of us were very rude to the nurses because their course was the certificate course and ours is the degree, so they were very condescending to them. So there's this stigma in our time and it will take a very long time for the perception to be changed. One consequence is that nurses on the wards do not really want to teach us." (Nora) One nurse verbalised her problems with the degree students on her ward thus: "You see, they come and we have to teach them all. They know nothing and need us. And then, after two years or so, they return to my ward and are my superior all of a sudden. They do not remember it was me who taught them. So I am not too willing to work with them" (Agnes).

The theory-practice gap

Both types of training teach nursing according to international standards. The books used in the lectures are mainly imported from the United States and introduce Western style nursing theories and care perceptions and ideas. Even though there are lessons on African studies, cultural heritage and cultural values, the nursing concepts remain international. The demonstration rooms are relatively well-equipped and serve as first training place. After that, the students experience the practicals as exposure to a reality they feel not prepared to. The confrontation with severely ill people, the working conditions with suboptimal equipment and the limited number of available nurses on the wards lead to feelings of insecurity or even shock. Many students feel overwhelmed by the orders they do receive from the nurses and have personal inhibitions about doing the actual work. They feel unprepared and insecure. Several second and third year students report that they managed to continuously avoid challenging nursing procedures like the placing of an urethral catheter, the washing of an unconscious patient or the carrying out of last offices after a patient dies on the ward. In addition, students are repelled by the state of available equipment. Gloves and bed sheets are constantly unavailable, but also the materials to dress wounds or give a bed bath are limited and often incomplete. Linda observed thus: "We learn how to do everything well in school, like oral hygiene and treating pressure areas. You use the right material. Here on the ward you have to improvise. For the pressure areas we fill gloves with water as we do not have the pillows. [3] But when you have your exam, you have to do it right and organise all the original material from somewhere."

When the work leads them to practical situations on the wards and they are expected to do basic nursing care, some students are stressed. One third year student had to wash a semi-conscious patient who had soiled herself. It took her more than thirty minutes. Even so, she was assisted by two friends. After they finished, she was exhausted and blamed the set-up of the training for her inability and shortcomings:

> I have never before changed diapers, not even those of a baby. I did not even know how to open those diapers. I am in my third year, but today was my first time doing that and seeing it all together. On all other wards I have worked so far, nobody needed to be assisted in washing, or other nurses did it. We just learned about all that in the demonstration rooms in our school, but were never forced to do it. Our training is too theoretical. When we are placed on the wards, we do not get any specific goal.

Reality shows that the students from the university are even less prepared for the work and also they experience problems in fulfilling nursing duties. The day

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[3] Pressure areas are bed sores, pressure-induced ulceration of the skin occurring in persons confined to bed for long periods of time. They are also called decubitus ulcer or pressure sore.

on the ward often starts late for them, given transportation problems.[4] They often arrive when bed making and taking up is already done. This means that their main occupation is watching, assisting wound dressing and checking patients' vital signs. One morning, three young students were asked to assist in the last offices of a patient who had just died. They did not really know what to do and tried to avoid the work. With the help of a nurse, one managed to set the tray with the needed materials to prepare the body before being taken to the mortuary and went with her to the treatment room where the last offices were carried out. Afterwards, she expressed her feelings:

> We in Legon are now in our third year, which is the second year in nursing. Last year we were mainly in school to do sociology, psychology, anatomy, pathology, pharmacology and all. We were not really on the wards. This summer I did the long practical assignment, but I had no real goal, I was just there and I worked. This third year is more or less our first year on the ward. So we heard about the last offices in lectures and read in the textbook, but I have never done it before. Those of us who are already nurses can do it, but I have no real idea. Today I felt uncomfortable, it was too confronting, I never did that before. All the practice comes in the last additional year, when you prepare for the SRN licential exam.

All students, from the NTC and university, experience the gap between the theoretical teaching syllabus and the practical working condition in the hospital that are representative for the condition of most public hospitals in the country. This becomes especially apparent in concrete learning goals the students arrive with on the ward. The most obvious is the care plan. This nursing tool was introduced through various theories into nursing worldwide several decades ago aiming at defining individual patient's needs and describing individualised care aims and measurements. Ghanaians students are expected to practise it from their second year onwards and write care plans based on their practical experiences. With the shortage of staff and a heavy workload, no ward seems to be using this model. Nurse Catherine observed thus: "The care plan is a good thing, but we are just two nurses for thirty patients. How can we also sit down and write this plan? It might be good for the seriously ill, but we do not have the time. Students do it now and then; maybe they can implement it." All students perceive the writing of such plan as a merely theoretical and artificial exercise. A student observes: "It is just theory, nobody uses it. I think the nurses tell each other the most important care issues during taking up. Sure, things get forgotten or are neglected, but this is how it goes." Gladys, a nursing student in her third year, says: "This care plan is just routine for the exams; then it disappears in the cupboards, it does not live." Her friend adds: "We just do it so in case you are placed on a ward where they do it, you cannot say you never did it before." Rachel, a mature nursing student from university, is more critical: "We are in an explosion of knowledge, so much is

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[4] The students live on university campus in the North of the capital. In the morning, the school bus brings all students to their various placements, but given the traffic situation this leads to delays.

happening in nursing. We have to give the patient more care; he also has his rights. If we do not learn and apply it well, nursing is going down." While this student sees advantages in the theory, she also feels limited in her possibilities to practice it. "Maybe we can do it for training, but the nurses will not listen to us when we want to implement it. They won't listen to the young ones." This statement also illustrates that next to the theory-practice gap, there is also the intergenerational conflict on the ward. A mature student from the university remarks: "We see things going wrong on the ward but we have to accept them. You can't go there and tell an older colleague she is doing something wrong. It is impossible to do." Her colleague, also an experienced nurse back at the university, adds: "You just have to try to do the right thing. Work alone and do your thing. Just make sure you are OK with it and it doesn't affect the patient." A third said that, "I haven't got enough skills to deal with certain situations (on the ward). I just try to do my best."

Limited supervision and the lack of preceptors on the wards

The set up of training in the college is in a block system: Three to six weeks of schooling alternate with several weeks on the ward. Four weeks in total are spent on night duty. The aim is to combine the theoretical and practical topics, but given the limited places on the ward, this is not always possible. The university education focuses more on the theoretical learning and schedules fewer days on the ward. Both schools try to work with clinical tutors (also called preceptors) who are supposed to supervise and guide students on the wards and teach the practical part. In reality, few wards have this offer and given the personnel shortages these nurses do not always have the time or energy to instruct and coach the students. The students miss the constant supervision of those clinical tutors. Tyra, a final year student lamented: "One of the nurses is supposed to be teaching us, she is trained for it. As tutor, she is supposed to come and work with us and see how we do procedures and discuss situations with us. But look at the ward, they are all busy with themselves."

The school seems not able to solve this gap between the constructed learning situation in school and reality on the ward. Teachers share the assessment of the students, mainly focusing on the lacking support from the wards. "I used to tell the students that 'if you go, ask questions'. When we were students, the staff nurses were eager to teach us. They would even give us assignments to go and do and come and check on us. These days, the staff nurses there, they don't care. So if you don't ask questions, you won't know anything. So it is up to the students to find out things for themselves. It is difficult" (Evelyn, teacher).

This mismatch of expectations on each side is reinforced by nurses on the wards. A matron complains about the short period of their stay: "In some cases,

they are only here for one or two weeks. The moment you have taught them something, they leave already." Generally, the students are assigned to concrete nursing actions but often not supervised, guided or corrected. Only few nurses function as tutors on the ward. During the research, one of them impressed the students in trying to teach and motivate the students on her ward: Right after morning devotion she would tell them: "We have here two mottos: One is 'a clean and tidy environment!' and the second is 'Touch a patient before you go home'.[5] So all move and make the ward tidy and clean. After that, start touching the patients! Don't leave the ward like that to meet your boyfriend, but report to me all the time, clear?" The students generally appreciated her approach and followed her through the day asking her advice and reporting the completed work. The atmosphere with her was one of learning mixed with friendly and strict remarks.

On the wards, nursing students meet the 'mature students'. These women are already registered nurses, have worked for several years and have gained a certain status on the wards; some are in the position of matron. Now they enter the university to obtain a degree to deepen their knowledge or qualify for administrative and management positions in the health system. Joy, being in her final year, likes the level of learning at the university: "It is very interesting. You learn so much more. In the SRN we learned all alright, but now it is much more in detail, like in anatomy and physiology." While most mature students enjoy the more theoretical approach of the school, they have problems with the practical placements. On the wards, they are regarded as students low in the hierarchy and have to make beds again like the generic students straight from school. Several of them feel undervalued in their knowledge and see practical exposure as a lost time. To make up for the lack of supervision, they are often paired with fresh students on the ward who teach them. Comfort, a mature student observed: "With us, the mix of mature and genuine students is working fine; one learns from the other. The older ones teach the younger, and they themselves get more background knowledge to what they are doing. They know it is a journey, and they are on it." But other mature students are less satisfied with this solution and miss appropriate challenges in their practical weeks. Kate observed: "We asked the authorities of the school not to let us go to the ward because making beds we know; giving injections we know. Let us go into the community maybe to do some research. Coming everyday just to come and give injection and roam about. For the long attachments they should let us go to a district and write a vision for nursing for that district. That would be useful work."

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[5] The term 'touching' refers to the idea that the nurse should try to render personal and individualized care by talking to the patient and assisting in his/her needs. By this, the general well-being is stimuated and the healing process supported.

Managing dreams and expectations

While the gap between taught theoretical knowledge and the reality on the work floor creates tension in many professions, nursing students seem to enter the profession with various expectations and dreams that are often scattered by the reality. Some students feel misinformed before entering the schools; others try to cope with the years of training before resetting their professional goals in life and probably leave nursing completely.

Students who start the training straight after secondary school are often frustrated with the workload and the impossibility to apply acquired knowledge. Improvisation and justification for carrying out certain procedures seem to prevail. Almost all students mention that "in school we learn all the proper ways, but on the ward you need to improvise." Some blame school for lack of information and transparency during the application processes and its initial period of training. Common complaints are that the school "does not motivate us enough", "does not prepare or guide us" or even "makes you hate nursing when you get out." One student says, "Our system is such that the real fact is not out for you to know till you have come inside. So once you are in, you see, but you are stuck." The lack of necessary equipment and the shortage of the most necessary material frustrate nurses most. As many of them entered into the training with unrealistic expectations, the shock is more immense and leads to feelings of depression. One student expressed her worries thus: "On ward days, I really have to drag myself out of bed." Some nursing students are unable to cope with the experiences and try to minimise their presence on the ward. Coming late and taking long rests is one way to avoid practical work. Others volunteer to go to the pharmacies to collect medication and use that time to stay away from the ward. A final year student still struggles with her choice: "I am in my third year. Actually, I wanted to go to medical school, but things did not work out for me. I somehow do not like nursing. This is too much for me. Every morning when I have to go to the ward, I feel sick" (Bridget). It seems that this woman represents a larger group of students who feel out of place in nursing. They do not dare to openly criticise the training or discuss their wish to stop this programme with their families or teachers. To cope with the situation, they try to avoid stressful nursing activities and limit their presence on the ward to a minimum. Their hope is to move to administrative functions after graduation or take courage, face family disapproval and change study programme.

With students in the university programme, the expectations take a different form. It seems many of them consciously prefer the study approach and the high status linked to it. A second year student observes: "I also applied to Korle Bu Nursing Training College. I had my admission there and I had this one also (at university). But because the training college is a diploma course and this is a

degree course, I decided to do the degree which is higher than that course." Her friend emphasises the influence nurses with a degree programme have within the profession in Ghana: "I think that here is the best. When you come out of the university and you're talking, they (doctors) look at you and know your background. They will understand and take you seriously. You'll have influence. Your starting level from that place is nursing officer, but if you have to go through SRN, it takes you five years till you'll be promoted to senior staff nurse. From senior staff nurse, before you go to nursing officer. So it's about 15 years difference in status, if I'm not wrong." These statements reflect nurses' dreams and future plans but do not equip them with sufficient energy and motivation to deal with the nursing work during training.

As the bachelor programme is perceived and set up as a more theoretical approach to nursing, the generic nursing students are not registered straight after receiving their degree as full nurses with the Council. After graduation, they need to follow one year of practical work. During this year, they are placed on different wards in the hospital, are loosely supervised by tutors from the college and school and go through the practical licential examination of the Nurses and Midwifes Council (NMC). Maureen, a teacher from the school explains: "After their BA with us, they go to the wards for practical experiences. We assist them and also the NTC supervises them. Most of them do fine and pass the licential exam without problems." Passing this, they become registered nurse and will be placed by the Ministry of Health. Given the frustrations students have with the actual nursing work, many of them decide not to do the additional year but turn to health education, apply for administrative work within the health service or leave the health sector altogether after graduation.

The mature nurses either return to their hospitals and wards or become teachers in the various training colleges of the country after graduation. But they also meet obstacles when planning to move on to a masters' degree or equivalent higher education. The bonding also applies to them and the state wants them to work for several years before aiming for more specialisation. As Tyra knows, "if you apply right after the training, the university won't take you. They have liaised with training colleges and the hospital and the government bond and you should serve – it was three years but they've made it five years. But that's why most of the young ones who aim higher are leaving the system and going abroad. And the place is filled with old ones."

As many students leave the country after the exams to work abroad, the Nursing and Midwifery Council NMC decided to introduce the bonding system. Newly registered nurses have to work for five years before receiving the definite registration with the board. Leaving earlier and for that purpose requesting a quick registration leads to high costs and paying the bonding fee of Gh¢ 5,000.

This amount represents the cost the school and the country made to train a nurse. In reality, the bonding fine does not constitute a serious hindrance to those intending to leave. Salaries overseas are often sufficient to enable early payment of the fine. The principal of the training school expressed the irony of the situation and her sense of despair thus: "It seems we are training our students for the developed world. About 80% leave within the first two years after the training to work abroad. What can we do?"

Conclusion

The feelings expressed and the questions raised are not typically Ghanaian. Since the late 1950s, sociologists have looked at the relationship between professional expectations, realities on the work floor and the experiences of workers in the hospital. Merton *et al.* (1957) saw medical schools mainly as socializing agencies in which the students were passive recipients. Olsesen & Whittaker (1968) stressed in the same way that the aim of studying is 'about becoming'. Becker *et al.* (1961) followed an interactionist approach in which students can be and are active players who react and negotiate their role in the educational process. Melia did an in depth study of Scottish nursing students and illuminated various aspects of the tension, "which exists in nursing between curriculum needs and service demands" (1987: 3). According to her understanding and finding a response to this tension leads to a successful transformation of professional socialisation of novice students into practising nurses. In this process, Ghanaian students experience problems on interpersonal, structural and emotional levels:

Firstly there is the gap between theory and practice. College teaches the correct way of nursing, but on the ward the main principle is 'to get the work done'. Planned educational goals and needs in service delivery do not always go together and students sometimes have to break with learned procedures, learn new rules and experience that the correct way "is modified to suit the prevailing situation on the wards" (Melia 1987: 54). Martin (2009) found similar gaps and ways of dealing with them in Ugandan nursing schools; there too, formal and informal knowledge needed to be accessed, organised and put into practice. In the Ghanaian setting, the students need to find a way on the wards and in the work. Most of them do that by copying older nurses and internalizing what they see. In addition, they need to learn about unwritten rules one example being to 'appear busy always', towards both patients and their relatives and to superior nursing staff. In practicing this, they adopt the permanent staff's attitude and start using their explanations. This is intensified by the inter-generational hierarchy. Following cultural norms of respect, younger nurses hardly see a chance to correct older nurses or implement ideas they learnt at school. The only solution seems to optimise the copying behaviour.

Secondly, research in European settings shows that the school's attitude plays a role in whether and how well students learn to cope with the professional reality. Heikinnen *et al.*, writing about nursing education in Finland, stress the learning process both in educational and social regard: "Students will learn to care for patients if they themselves are cared for in the educational community" (2003: 260). Well-thought through supervision by the school can enable students to deal with their emotions and learn to reflect on their actions. In the Ghanaian reality, it seems impossible to organise and offer these structural supervisions and reflections. The consequence is that students oscillate between school's needs and the ward's demands, being armed with theoretical knowledge and the idea of 'how it should be done', but being employed as mobile workforce (Melia 1987) improvising and trying to get the daily work done. Martin, following Schön, speaks of a "hierarchy of knowledge in which the formal knowledge … was considered the 'correct way' of nursing while the informal knowledge … represented an unfortunate digression" (2009: 85). Such a dichotomy leads to frustrations and many students begin to doubt the appropriateness of their professional choice. As a consequence, this can hinder a successful socialisation into the profession.

Thirdly, the students experience difficulties in recognizing, accepting and managing their feelings. Concluding from the observations and experiences in Accra, many students do feel left alone facing situations they are not prepared for. Thus, anxiety, fear for unexpected situations, feeling of inadequacy and failure, seem overpowering. Beck found similar emotions with American students who went through struggles to identify their role in the nursing process (1993). Following Du Toit, the socialisation into the profession depends on the transported values that link person and profession. "The novice enters the school with a set of values, which may change during the socialisation process to reflect the values the profession holds in high esteem. When values change, behavior will change accordingly" (1995: 165). This implies that the above-mentioned aspects must be combined to lead to a successful socialisation into the profession. The current Ghanaian situation is one of large number of students, with limited teaching personnel and suboptimal staffing on the ward in combination with Western style teaching theories in schools and improvising practices on the wards. Only very few students find a way to verbalise their feelings and deal with their individual emotions and try to reach a deeper understanding of themselves and their vocation. Fulfilling duties and managing the workload set the rules of the daily routines of students and hardly leave space to reflect on actions, adjust expectations and set individual and professional goals.

In conclusion, it seems difficult for Ghanaian nursing students to find their place in their future workplace. Several problems and challenges they encounter

are not particularly Ghanaian phenomena; many student nurses all over the world face the practice-theory gap and have to manage their emotions when facing seriously ill patients for the first time and getting physically and psychologically involved in nursing. But several cultural and organisational constraints, like the existing generational hierarchy and the idealised role model of the obeying and humble nurse, seem to make it impossible for the students to apply Becker's interactionist approach and be an active and co-determining actor during their training. Fifty years after having started the training of nurses in the country, the novices still struggle with the code of conduct to link themselves to encouraging role models and to finally develop a nursing identity that carries them through the three years of training and introduces them into the profession.

PART III

NURSING IN THE HOSPITAL

9

"Miŋya Korle Bu!": Korle Bu Teaching Hospital, Accra

Since early morning, patients have been arriving by public transport trotros or taxis, accompanied by family members. The vehicles find their way through one of the poor neighbourhoods of the metropolis, cross the Korle Lagoon to finally turn away from the sea and stop directly in front of the entrance of the hospital. For about a year now, a new administration block has been built to form the border between the hospital ground and the adjacent street. Passing this new, fully air-conditioned building and turning left, old buildings dominate the scene. The inscriptions on the former administration block read: "C.R. MCMXX" and in front stands a statue of Sir Gordon Guggisberg, the governor of the Gold Coast in the 1920s in whose administration the hospital was built.[1] How many nurses have crossed this building heading towards their duty and how many patients have passed here hoping for treatment and cure for their ills?

History

Around 1878, a series of wooden huts were erected for the Government Forces in the centre of Accra to cater for their health needs marking the beginning of organised bio-medical treatment in the British colony. A few years later, the facility was moved to Usher Town to herald the beginning of the Old Colonial Hospital. It had four beds for the European ward, and twelve beds for the native ward. In addition there were a dispensary and nurses' quarters. In 1916 the British realised the need for an expansion and looked for a suitable location that would meet all needs concerning water supply, fresh air and easy drainage. A

[1] In 1916 the land was acquired to build the hospital. In 1920 the construction started and the hospital was officially opened in 1923. The Roman number marks the start of the building activities. (Information by a staff member of the hospital)

land was acquired measuring about 170 acres and the permanent structures of the hospital were built on it. The hospital is situated away from the central business district of the Accra metropolitan area and is separated by the Korle Lagoon.[2] It took several years to agree on a construction plan and when the foundation stone was led in 1921, Governor Guggisberg had continuously adjusted the plans to enlarge the hospital to 192 instead of eighty beds for inpatients and enough space for about 200 outpatients.

On 9 October 1923, the Gold Coast Hospital was formally opened. It consisted of a two-storey administration block decorated with a colonnade and led to the four wards on the left and right side, the ablution block, an operation theatre and wards, disinfection facilities, medical store, kitchen and laundry and to the mortuary. In addition, there were nine bungalows for the fourteen members of the European Staff and permanent quarters for the 57 African nurses and additional health workers. The entire hospital was lit by electricity and there was a lift installed to reach the second floors. The water and drainage system followed the latest principles of sanitation. In his speech, Governor Guggisberg mentioned six branches of work to be done in the health sector: The general education of the people in modern methods of sanitation and care of the sick, the provision of sufficient medical and sanitation staff including training of Africans, the maintenance of a research department, the provision of water supplies, the improvement of towns and villages and the care of the sick in hospitals and dispensaries. This new hospital, together with the other six in the colony, was to improve the health status of the population (Korle Bu 2003).

Till then, all medical doctors and nurses had been trained in the United Kingdom, but there was a wish to offer at least partial training in Africa. While midwives had been trained at Korle Bu since the late 1920s, the Nursing Training College (NTC) opened only in 1945, starting in Kumasi but moving permanently in 1948 to the grounds of the hospitals. There was also the plan to start medical training in the country. The reason was twofold: "Newly qualified African doctors in the United Kingdom were unable to get the required clinical experience in British hospitals as a result of racial prejudice … The raison d'être was not only to shorten the residence of African doctors overseas, but also to provide them with the necessary clinical experience in diseases of their environment" (Korle Bu 2003: 5). However, the Medical School of Ghana admitted its first students in 1964 and the hospital was subsequently renamed a teaching hospital. Since 1969, the school has been graduating medical students. Twumasi confirmed the lack of clinical practice for doctors who studied in the UK and pointed out that in addi-

[2] The name 'Korle Bu' refers to the Korle Lagoon nearby (see also the poem in Appendix F), while 'Bu' means well or pond. Korle Bu can then take the meaning of "source of water" which is essential for life.

tion, doctors trained within the country showed more understanding of the cultural needs of the patients than those trained abroad (2005: 78).

The hospital was an instant success for, the number of patients seeking treatment increased rapidly. It was soon realised that the hospital needed to expand. By 1954, more than 300 outpatients visited daily from within and outside the metropolitan area and in that year almost 10,000 inpatients were treated, with a male-female ratio of 2:1.[3] There was need for additional space and modernisation of the existing structures. The government saw the need for reforming and extending the health sector and started a development programme. Included in this programme was the establishment of seven nursing training schools, modernisation of all nine hospitals including the extension of the hospital, the construction of a new mental hospital, and plans for building 15 new health centres and bungalows and flats for doctors in the country (Addae 1996: 77). In 1962, work began on the new wards, including new operating theatres, the children's block and a new Isolation hospital (called "Fevers Unit"), as well as extension of the nurses' quarters and Training College. As a retired nurse remembers, the construction of the maternity block was completed alongside the other wards and formed a separate unit in the first years. In the next wave of expansion, the maternity unit and the general hospital were joined and the hospital's capacity grew up to 1,135 beds on 54 wards (Korle Bu Teaching Hospital 2003). By 1967, Korle Bu had treated 358,297 outpatients and 11,293 inpatients (Twumasi 2005: 106). As explained in Chapter 4, the rise in patient numbers represents, among other factors, the growing acceptance and attraction of Western medicine in the urban centres of the country.

The hospital today

In the 1990s, the two teaching hospitals in Ghana (in Accra and Kumasi) were given semi-autonomy and have since been run by a management boards, albeit subject to the general direction and strategies of the Ministry of Health, "as they relate to the nation's general health needs" (Strategic Plan: 5). The Board Chairman is assisted by four board members. The Chief Executive together with six directors, including those of Medical Affairs, Nursing, Administration and Finances form the management team, exercising management control of the hospital.

Today, "Korle Bu is the premier and leading national referral hospital. It serves as the teaching hospital of the College of Health Sciences. It has grown to a 1,600 (bed capacity) with a staff strength of 3,000." (Korle Bu 2003: 10). There are seventeen (17) departments and three centres of excellence: The National

[3] Twumasi gives the number of 95,213 outpatients and 9,810 inpatients for that year (2005: 106).

Cardio-Thoracic Centre, the National Radiotherapy Centre and Nuclear Medicine, and the Reconstructive Plastic Surgery and Burns Centre. The Mission Statement of Korle Bu Teaching Hospital reads: "Working in partnership with other sister institutions, Korle Bu aspires to provide the highest quality of patient care within available resources, deliver excellence in teaching and research, engage and develop staff and operate in an effective and efficient manner" (Korle Bu 2003).

The Department of Internal Medicine

The Medical Block is positioned on the back right side of the old administration. It is a concrete five-storey building, and for several years now it has been undergoing complete renovation. Only the nursing administration and the consultation rooms for the medical staff of the specialised units are still located on the ground floor of the renovated building. In the meantime, three temporary wards have been established at the end of the colonnade: downstairs, the female ward, K, and upstairs the two male wards, L and M, providing 85 beds for inpatients (30 female, 55 male). Both health workers and patients express the hope that the renovation would be completed soon and that everyone could move back to the more spacious and newly equipped medical block. The Annual Report of 2004 mentions as challenges the limited working space on the congested wards, lack of the required staff members to ensure quality care and the wish for improved supply of drugs.

The female medical ward

Coming from the outpatients department, patients and visitors pass the emergency, the physiotherapy and X-ray departments before entering the ground-level colonnade. Behind the surgical and orthopaedic wards at the end of the corridor is the wing with the three medical wards, the male ones upstairs, the female one on the ground. Many visitors of all ages are waiting outside for the visiting hour to be allowed into the wards. As they wait, chat or sleep, they are filled with anxiety about the condition of their hospitalised family members. As one passes by the female security guard, one enters a corridor about twenty metres long. On both sides are doors. Those on the left side lead to the matron's office, two consultation rooms for the medical doctors, and the treatment-room used for the "last offices" after a patient has died. On the right side corner of the corridor, two men run a small office behind a small table: One is the clerk, responsible for payment of patients' deposits and bills while the other is the 'lab-man', who collects blood specimens for the laboratory. Then there is one room for the orderly to wash. This room is also used for ironing hand towels. The nurses' toilet, and resting and changing-room are also located here. There is a small passage that leads to

two showers and three toilets for the patients and the sluice room in which bedpans and dirty laundry are kept. Straight on, one passes through folding doors that enter ward K. The ward consists of one main room divided into four units. Those units correspond with the following specialisations:

- Unit 1: Dermatology and thoracic;
- Unit 2: endocrinology, neurology and general medicine;
- Unit 3: Nephrology, thoracic and general medicine;
- Unit 4: Nephrology, endocrinology and general medicine.

Each unit consists of seven beds, bringing the ward capacity to twenty-eight beds. In the sideward at the far end of the room are two additional beds, separated by a door. Next to each bed stands an iron bedside table with the personal belongings of the patient, water bottles, a cup and a spoon and a Bible. Under each bed is a bucket and towel. At the foot-side of the beds is another iron heart table on which the patient's medical record and a plastic box for medication. On the ceiling are big fans, four per unit and florescent tubes. The walls have huge open windows covered with mosquito nets.

The hospital staff and patients

According to the hospital's annual statistics the hospital's situation for 2005 is as shown in Table 1.

Table 1 General information on the hospital's capacity

Bed capacity	1,397 (1,600)[4]
Total staff capacity	3,946 (40% male, 60% female)
Medical doctors in service	ca. 400
Nurses in service	1,057 (1,017 female and 40 male)
	(867 professionals, 190 auxiliaries)
OPD	339,580/year (65% female) = ca. 1,500 daily
Inpatients	52,369/year (63% female)
	ca. 150 admissions daily
Absconders[5]	322/year (involving an amount of ¢ 280,000)
Births	11,552/year (6% Stillbirth)
Operations	20,071/year
	9,800 major and 10,271 minor)
Deaths	4,485/year

Source: Korle Bu 2006

The average period of admission is 11 days. Most cases are referred from regional hospitals or clinics for specialised treatment here. More than 4,000 patients were admitted to the Accident Centre having been involved in road or

[4] The official capacity is 1,600, but due to renovation activities on the medical bock and elsewhere, it is temporarily reduced.

[5] Absconders are patients who left the hospital secretely without paying their bill and can't be retraced.

domestic accidents or street violence. The main causes for for outpatient attendance are malaria (30%), diarrhoeal diseases (10%) and hypertension (7%). HIV/AIDS, for which there is a specialised Fever's Unit, ranks almost last with 1.4%, comprising 560 new cases for 2005 (216 male, 350 female).

As the newly created National Health Insurance Scheme was yet to start operating at the time of the study, most patients had to pay medication and hospital bills under what is known in Ghana as the "Cash-and-Carry" policy (see Chapter 4). Only civil servants and workers in big companies and institutions are eligible to request a refund from their employers. As an autonomous referral and teaching hospital, the government's policy directive to render free services to children under 5 and patients above 70 years is not applied. Patients unable to pay their bills may be referred to the Social Welfare Department. The Director of Medical Services declared that between 2001 and 2005, the hospital paid ¢ 3.1 billion as bills for 1,614 pauper patients and 1,977 absconding patients (Daily Graphic 18.12.2006). In 2005, the Social Welfare Department decided on the cases of 1,120 patients who could not pay their bills. Most of the cases were resolved by asking patients to pay in instalments. However 120 patients were declared paupers and their bills amounting to ¢ 77,000 were absorbed by the hospital.

Nurses in Korle Bu

Since the opening of the hospital, it has experienced understaffing in almost all sectors. A careful analysis shows that the hospital runs on 50% of the staff strength. The target, as explained by the Director of Nursing, is to have 2,000 nurses on the work floor, but this number has so far not been realised. Even a more realistic figure of 1,500 nurses has not yet been achieved. Table 2 shows the number and rank of nurses in the hospital.

Table 2 Number and rank of nurses in the hospital in 2005

Rank	Number	
DN	1	Director of Nursing Services
DDNS - SNO	317	Deputy Director - Principal - Senior Nursing Officer
SN - NO - EN	736	Nursing Officer (Staff Nurse) - Enrolled Nurse
Midwifes	64	(figure from 2004)
Newly contracted	107	
Attrition	98	Reasons: retirement, schooling, resignation

Source: Information given by the DDNS in Autumn 2005

While there is still the need for between 500 and 1,000 nurses, the age distribution of the working nurses indicates an additional shortage in the coming years. Almost half of the nurses are aged 45 year or more and will have to retire at 60. Table 3 shows the current age distribution.

Table 3 Age distribution of nurses in the hospital in 2005

Age	Number at post	
20-35	223	(including most auxiliaries)
36-45	169	
46-55	461	
56-60	102	
On contract (>60 yrs)	42	
Other	60	

Source: Information given by the DDNS in Autumn 2005

Nurses work in three shifts: The morning shift is to report latest by 8:00; in reality, however, those in the higher rank start work by 7:30. The latest in the morning shift arrive by 8:30. The afternoon shift starts at 14:00, overlapping one hour with the morning shift nurses. The night shift arrives by 19:00 and leaves the next morning after handing over around 8:00. The general duty rooster gives two days off-duty a week. The Principal Nursing Officers, (called "matrons" by most colleagues), work daily from 8:00 till 17:00 with the weekends free. All staff nurses run night shift for two or three months a year (four nights on duty, three off). The health care assistants (HCAs) are also assigned all three shifts. Each year, nurses can apply for annual leave of 32 working days.

Nurses and patients at the medical ward

In 2005, the medical block had 52 doctors, 67 nurses and 32 health care assistants (HCAs) and 72 orderlies. This compares with 19 nurses of different ranks and ten HCAs for the female ward. Table 4 shows the distribution of nurses in the medical department and on the female ward.

Table 4 Distribution of nurses by rank

Rank	On female ward/at medical block	
DDNS	1	
PNO	4/13	(3 'matrons')
SNO	2/8	
NO	3/13	
SSN	1/6	
SN	5/13	
Sup. EN	4/13	
HCA	10/32	

Source: Interview with the DDNS in Autumn 2005

During the research period, there were mostly two matrons on the ward, three nurses and two to four HCAs per day shift, while two nurses work with one HCA in the night. This stands for a nurse-patient ratio of 1:7 during the day. Comparing this with the workforce on other wards suggests a standard situation in this hospital.

In 2005, the ward was full to capacity (the Annual Report states a bed occupancy of 99%). Newly admitted patients were detained up to 72 hours in the Surgical and Medical Emergency (SME) department as that place is chronically overfilled (in November, the SME with its capacity of 37 beds catered for up to 80 patients daily). New admissions came on the medical ward as a daily routine. There was never an occasion that more than thirty patients were on the ward or had to sleep on the floor. It is difficult to estimate the average duration an inpatient stayed in the ward; most stayed for between one and two weeks and a few died within a few days. However some twenty patients remained for longer than one month on the ward. This corresponds with the average stay of eleven days. Table 5 shows the number of patients per month.

Table 5 Number of patients on the female medical ward in 2005[6]

Month	Inpatients on 1st of the month	Admissions	Total	Discharge	Death	Death within 24 hours
June	25	74	99	46	26	-
July	26	87	113	58	23	3
August	28	85	113	41	17	2
September	27	75	102	52	21	2
October	30	71	101	51	16	4
November	26	63	89	41	16	1
December	30	45	75	32	9	-

Source: Ward statistics and data collection of the researcher

Officially the three medical wards with 80 beds reported 465 admissions, 595 discharges and 222 deaths, which amounted to 47% of the admissions. The patients form a cross-section of the population in regard to age, profession and diagnosed disease. Tables 6 and 7 present an overview on the patients on the female medical ward.

The decades of economic hardship and shortage of health workers have left their fingerprints on the hospital. In 2002, ex-President Kufuor urged health professionals to accept the challenge of staying to build the country in a selfless effort. He added that the lack of maintenance culture is noticeable in most hospitals in the country and "the state of our premier hospital, Korle Bu, remains a disgrace to us all."[7]

Three points run through the comments of both patients and personnel: An unsatisfactory quality of service, deteriorating structures and the congestion on

[6] These numbers were collected by the researcher herself during the research period and have to be treated as unpublished material.

[7] This quote is taken from his Presidential speech delivered in Korle Bu and reported on www.newsinghana.com, 4.11.2003

Table 6 Patients on the ward by diagnosis (2005)

	July	August	September	October	November	December
Diagnosis:						
Hypertension	12	7	10	6	9	12
CVA	8	8	25	10	5	2
DM	7	7	10	9	3	5
Heart failure	10	6	5	9	15	6
Steven Johnson	-	2	3	-	-	7
Nephritic Problem	9	5	10	5	5	2
Malaria	7	5	4	6	4	7
TB/pneumonia	10	8	10	8	13	3
Liver problem	7	5	4	3	4	4
Anaemia/ALL	7	3	5	6	8	6
SCD	2	3	-	-	4	2
Other	16	7	11	5	12	5

Source: Ward statistic and data collection of the researcher

Table 7 Patients on the ward by socio-demographic characteristics (2005)

	July	August	September	October	November	December
Age						
15-35	27	23	18	19	26	16
35-50	21	17	14	14	12	14
50-70	24	22	23	20	14	11
older	7	7	12	7	12	5
Professions						
Trader	32	25	25	21	23	12
Unemployed	14	12	15	8	17	13
Shop	12	6	7	4	2	4
Seamstress	11	10	10	13	14	6
Student higher educ.	4	7	11	3	6	6
Other / old age	7	8	3	8	12	4

Source: Ward statistic and data collection of the researcher

all wards. The hospital's Strategic Plan 2005-2009 states: "Patients perceive it (the hospital) as the best and last resort in Ghana, where one gets the best treatment/ care. In spite of the general acknowledgement … there is a growing perception of it as a hospital for the 'poor' due to the preponderance of people in the lower socio-economic status groups in its patients population. The 'rich' tend to seek care in private medical centres. (Another) major challenge KBTH is facing is that too many patients who do not need tertiary care are accessing service at its facilities, leading to unbearable congestions. Many of these patients could perfectly be managed at non-tertiary health centres" (Korle Bu 2005: 23, 24).

Perception of the hospital by health workers

"We are the eye of the health sector; everybody looks up to us and we see everything. If we sneeze, the country gets a cold." This statement by a senior nurse demonstrates the pride of most health workers about working in this hospital.

Nurses like working here for two reasons: One is the broad variety of the patients' diseases and the specialised care that they need. A young nurse puts it thus: "Here, you see all cases. Not the normal ones, they are dealt with elsewhere. But the special ones, they are brought here." Several nurses agree and plan to work here for some time before moving to another hospital. This suggests that working in such a tertiary institution offers the possibilities to practise and deepen the knowledge acquired in the training, leading to the other reason: Using your expertise elsewhere. "Once you have worked here, you can work everywhere."

There are also critical points of nurses when reflecting on their working conditions at this place. "Korle Bu is biting more than is can chew." They complain about the high workload ("the workload doesn't match the workforce") and the low standard of equipment ("as premier hospital, it should be better equipped; it is a village compared to some private clinics."). One nurse summarises this point more aptly: "This hospital has a big name. But when you come, it is completely different. It is not so special after all." Another concern is the perception from outside. A matron says: "Most people know that this is the best hospital. But there is the notion that it was a Government hospital for the poor, so Ghanaians still think they do not have to pay when they come." Her colleague adds: "People are afraid. The media is not helping. It is written in funeral announcements, (that) about 90% of all death occur in our hospital. It is dignified to die here. You say 'Go to Korle Bu and die', and our Medical Block is often called 'mortuary annex'. It looks like we are not doing anything but just helping the dead people." While the nurses feel proud to work here, they are also aware of the twofold perception of this place. Taking the advantage to be part of this known hospital, to see and learn a lot, they seem to accept the downside of working with outdated equipment and a sub-optimal workforce.[8]

Perception of the hospital by patients

In the streets you hear "*Miŋya Korle Bu* – I am going to Korle Bu" as a general expression for attending a hospital or clinic. This expression comprises the respect Ghanaians have for this hospital and its medical care. Most patients come as referred cases from other hospitals, having fallen sick with a severe form of malaria, allergic reactions or CVA, being newly diagnosed of a chronic disease like renal failure, diabetes or heart disease, or suffering from sickle cell disease or forms of cancer including leukaemia. Korle Bu is "the last resort", their "last hope." A patient observed thus: "This hospital makes people afraid. They don't

[8] An elaborated discussion on the nurses' perception of patients follows in a later chapter.

want to come here. They know when they are referred here, it is serious. Nobody comes voluntarily. When you have to attend this hospital, you think you have to die." All patients are admitted and as indicated earlier, there is a welfare department for those in financial problems, and both medical doctors and nurses are highly qualified. Patients come hoping for adequate treatment and their general impression is a positive one. A patients' survey carried out by the hospital showed that the courtesy of and confidence in doctors, the response time to patients, the attitude and courtesy of nurses and general staff attitude are rated high, while explanations given to the patients on their medication, condition and treatment are assessed low (Korle Bu 2005). Individual comments unveiled sentiments of fear and uncertainty. The mother of a young patient said: "This hospital is so big, I had to get used to it. I was once sent to the X-ray Department and had to look for it by myself. Since we arrived (eleven days ago), I haven't spoken to any doctor again. I just meet the nurses and they inform me." This covers the fear some have of unfamiliar examinations and painful treatment, medical terms they do not understand, high medical costs beyond their means and the fear of being confronted with an worrying diagnosis.

This ambivalent perception is also mirrored in the media like radio, television and newspapers. The hospital is regularly in the news; events like the shortage of blood in the blood bank (300 units instead of 500), individuals' encounters with doctors and rude nurses and annual reports and statistics are reported on in the media. The Chief Executive of the hospital is a prominent person in Accra and is often praised for his achievements for this hospital and his general commitment to the country. Under his leadership, the Cardiothoracic Unit was built and recently a new MRI centre was opened. The gynaecology theatre has been renovated and laparoscopic equipment bought. To motivate the health staff, 1,000 plots of land were bought and auctioned and the building of 200 additional flats and nursing quarters has started. The accidental death of three urologists from Korle Bu hospital while returning from an outreach programme in the Brong Ahafo Region in August 2005 was a national catastrophe. The tragedy brought two general national problems to the fore: The dangerous condition of the roads in the country and the shortage of specialised doctors. The newspapers reported that the death of the specialists had reduced the number of urologists to seven (of which six work in Accra), while more than 35 would be required for the need of the hospital. The various strike actions of doctors and nurses during 2005 for a higher and regularly paid salary were a front page story and those working in this teaching hospital were often referred to and interviewed. This enforces the perception that Korle Bu is "the eye and the ear of the country."

10

"Tidy and touch!" The working routine of nurses on the medical ward

> "Nursing at Medical is special. You see all conditions and learn a lot."
> (Edith, senior nurse)

While taking a break in the morning, nurses talk about their work on the ward:

> *Martha:* "I am happy to be at the Medical (ward) now. Here nursing is really done well. You learn a lot, as the people are really sick. I will not move to another ward, but stay in Medical."
> *Grace:* "But with all this dying, there is no job satisfaction here. You work hard all the time and in the end, the patient still dies. Maternity and other wards are nicer; the people are not really ill there and everybody is happy. Even at Surgery, they do not die as they do here. You know they are not really ill. There is life and colour, but here on Medical, the colour is black and people are sick."
> *Ama (an HCA):* "The Medical ward is hard, people are really sick. You need to do everything for them."
> *The matron:* "Yes, the work is very tedious. But in the end, at least you do something, because most of the people are very weak and they need your care – total nursing care. Though you're tired, you know you have helped so many people, maybe by bathing, feeding and doing other things, because they all depend on you. Medical nursing is not easy but rewarding."

This conversation is typical for the feelings of nurses working on a medical ward. Nurses experience the work as very exhausting; the daily routine is seen as tedious work and nurses express feelings of despair and being overloaded. In the same breath, they define their activities as 'real nursing and caring' as it is supposed to be. This chapter portrays the daily work on the ward, highlighting both the routine observed and the perceptions voiced. The morning shift is followed

while taking up from the night nurses, bed making and wound dressing to admissions and discharges, writing reports and giving medication, until the afternoon shift arrives to take over from them. In the evening, the night nurses will return and start their shift till the next morning. It concludes with a discussion of how nurses' work on this particular ward can be understood.

Taking up and starting the shift

At 7 am, the janitor opens the doors to let in relatives and friends visiting the patients on the wards. They have been waiting outside, hoping to find their mothers, daughters or sisters in a good state. The ward is soon filled with voices, colours and smells, Christian and Muslim prayers and songs can be heard, food is given and some patients receive a bath. A woman walks over the ward selling items for the patient's; soap, deodorant, toothbrushes, towels and food. Two nurses and two health assistants are on the ward. Their table is on the very right of the four rows of the ward. During the night they have been sitting there chatting, taking a nap and watching television in between making rounds. The table is filled with patients' files, charts and the report books. The television is on, but its volume is lowered and the nurses try to finish their work. They need to complete the medication round, record body temperatures and blood pressures in the charts, attend to visitors asking for new prescriptions and write their last nursing notes. The assistants check the vital signs and heat water for patients to make tea or wash down.[1] By 7:30 am, the visiting hour is over and the orderlies order visitors out of the ward by ringing a bell. The first nurses for the morning shift arrive. Most come dressed in their white uniform, but others change into their uniform in the small resting room just outside the ward. Officially, the shift starts by 8:00 am and the nurses are supposed to be in by then. All nurses, students and assistants sign the attendance book at the entrance, indicating the time they arrived. Per shift, two to four nurses are scheduled, assisted by two HCAs and occasional nursing students. The matron has already arrived around 7 am;[2] she greets some patients and their relatives, talks to the night nurse and goes to her office outside the ward.

By 8 am, the nurse highest in rank in this shift (normally a PNO) starts with the 'taking up' procedure. Accompanied by some nursing students and younger nurses, she walks from bed to bed examining the files, checking the medication chart, the documentation of vital signs and the nurses' notes. The morning medi-

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1 Vital signs refer to the patient's pulse, blood pressure, respiration and bodily temperature. All are to be checked at least four times a day. The results are documented in a special chart.

2 The name 'matron' is outdated. The official title is Principal Nursing Officer. The reality on the ward is that all nurses and patients refer to the highest nurse in charge as 'matron'. This is why this terminology is adopted here. A description of the various ranks follows in the next chapter.

cation must be given and signed in the charts; the same must happen to the charts reporting on the fluid balancing of a patient.[3] Incomplete notes, unfinished charts or forgotten medication are regularly discovered. The night nurse is warned to work more accurately. She laughs and defends her negligence: "Oh, here is my signature, I did all but I am hot this morning; we are so busy. Please, it is OK like that." Unfinished balance-charts are objected to and the night- assistants are asked to calculate it. Discussions arise over whose responsibility it is: Incomplete forms from the previous day shifts prevent correct balancing and the plea for careful and responsible work of the shifts is repreated. In some cases, nurses try to retrieve information from the patient about the previous day in order to complete the charts.

Patients are addressed with questions either in Ga, English or Twi: Auntie, how are you today? Have you taken your breakfast? Have you had your bath already? Did you go to the toilet? The patients hardly react to the questions, their reply is brief: "Sister, thank you, yes, I am fine." If the night nurse accompanies the group taking up, she gives information on the patient's condition, tests that are scheduled and finished medication requiring a new prescription. Empty beds indicate that a patient died since last afternoon. Given the seriousness of the medical conditions and the late admission of some patients, many of them die on the ward. The statistics give almost 50% mortality for the Medical Department. During the research period, about one third of the patients admitted on the female ward died, meaning 17 to 26 patients a month.

After the round is finished, one more action has to take place before the night nurses can leave. It is the handing over of certain monies and objects. Nurses sell disposable nappies to incontinent patients. Most patients rely on the nurses' supply. Nurses buy them outside the hospital and sell them for a small profit. A list is kept on 'nappy debts' and are recovered during visiting hours. Similarly, blood sugar strips are sold.[4] New patients and diabetics have their blood sugar level checked regularly. Those strips for blood sugar control are not provided by the hospital and very few patients bring them along but buy them on the ward. This money, strips and nappies are kept by the nurse in charge and handed over to the following shift team. It is a conscientious responsibility of the nurse in charge to guard everything and hand the correct amount to the following shift team. Once this handing over is completed, the matron calls all nurses and nursing students to gather around the table for a short moment of devotion. A nurse says a prayer or starts a song followed by reciting of Psalm 23 or the Lord's

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[3] Some patients are on input - output control. This means all fluids a patient drinks (like tea and water but also soup) or receives as drip over 24 hours must be documented in a chart; the same all output in form of urine, diarrhoea or vomit must be written down.

[4] Nappies and blood strips are both sold for ¢ 15,000 a piece.

Prayer together and finishing the devotion with the sharing of the grace. Occasionally, a doctor joins the group, but on most mornings, nurses gather alone while the ward is getting busy with doctors arriving and orderlies distributing breakfast. After that religious moment, the matron orders the nurses, nursing students and health care assistants to start with the morning routine.

All mornings have one thing in common: There is no central handing over of information between the shifts. Both factual and possible confidential information is exchanged in English while walking over the ward from bed to bed.[5] Nurses hardly take notes but remind each other during the days. If time allows, they read the reports in the books. This leads to the situation where different nurses have different level of knowledge, the matron having most and the junior nurses least.

Tidy the ward

> Cleanliness of the ward and the patient area is very important. The patient is untidy. But if the place is tidy and there's a lot of fresh air, you see a change. The patients should look neat in their beds. (Regina)

All nurses on the medical wards share this conviction by the deputy director. Making beds in the mornings is part of the tidying process. Nursing students and HCAs form pairs to make the beds of the patients. If there are not sufficient students and more hands are needed, nurses join in. Fresh bed sheets are supplied each morning from the central laundry and distributed by the matron or nurse-in-charge. Given the unpredictable and often insufficient supply, the order in which beds are changed varies each day. Generally, nurses react to the matron's plan: "Today we have enough bed sheets. You use them both for the bed and to cover the patients. Please, hurry up and make the beds so we finish before the doctors arrive. Form pairs always a young and an old nurse to learn from each other, go!" With this instruction not only bloodstained or faeces- stained but also crumbled and sweat-soaked sheets can be replaced. "We do not have enough sheets to change all beds. Change only the really dirty ones. Look at the bed sheets and top sheets, maybe you can switch them." This means that whenever possible, no change should be done. In addition, some days are special: On Fridays, the matron keeps sheets in stock for the weekend. Extensive changing is required on Mondays to prepare a tidy ward for the extensive doctors' rounds that take place. Mobile patients are asked to leave their beds while the bed sheet is changed or straightened. Bedridden patients are rolled from side to side by two nurses who inspect and, if needed, change the sheet; experienced nurses take that moment to check the body on pressure areas or sores. Any pillows, Bibles, mobile phones or

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[5] The use of English as the language of nursing will be discussed below.

money are rearranged and the top sheet is placed to serve as cover. Nurses regularly complain about the shortage of supply. Not being able to change sheets when the patient's situation requires this and being hindered in presenting the ward in a uniform white colour, leads to frustration. Different sises of the sheets form an additional constraint to smooth working; not all are big enough to cover the whole mattress while others can be tied together on the top to avoid excessive crumbling. Hence while some beds have short sheets and patients lie partially on the plastic, other beds present colourful sheets from materials brought by the patients themselves. Blue, red and green motives and prints change the face of the white ward. Family members bring them washed and ironed and cover their mothers, daughters and wives with it when visiting the ward, as if leaving their care and love for them in the materials. Neither the matrons nor the nurses support the use of these private sheets though. Their aim is to have a uniform look of the ward and the white colour represents cleanliness and order. The following statement from a matron illustrates this principle: "We don't want these house cloths. I do not like all these colours, different colours make the whole place dull." Only in situations of extreme sheet shortage or with specific conterminous diseases these private sheets are accepted, otherwise they are immediately removed and hidden in the lockers.

Tidying the ward also means clearing up the lockers and spaces around the patients' beds. Nurse Grace explains it: "Do you know the slogan of the day? Create a tidy and clean environment and touch the patient. Let's tidy up the place, make the beds, straighten the sheets and clean the lockers. Yesterday, we changed most of the sheets, so today you only change the dirty ones and clear the place. Go and work."

While the female orderlies wipe and dust the beds, lockers and public spaces on the ward, it is the nursing students' task to tidy the lockers. They check for old food attracting flies and throw it in the dustbins, clean the spoon and cup of the patient and arrange other belongings properly. Food-related items are to lie on the top of the locker, preferably covered by a white cloth, articles used for washing, toilet paper, creams and alike are put on the second layer. Nurses mention that it is easy to conclude from the state of the locker whether a patient is poor or wealthy. Poorer patients have fewer belongings on their lockers and in their beds; sometimes they don't even bring a spoon or a cup and hardly have water to drink; richer patients display their belongings on the lockers in the form of cookies, fruit juices, bottled water and occasionally cards from well-wishers. The table at the foot of the bed also has to look neat; the patient's file, new prescriptions, a box with the needed medication and freshly taken samples of blood or urine are the only things kept there. Every now and then, empty pill-strips are removed, old blood samples that were not sent to the lab in time are disposed of

and outdated prescriptions thrown away. Finally, the metallic trolleys used for the wound dressing and medication rounds need to be cleaned every morning. This is a job for the HCAs and they start with it even before bed making has started. There are three trolleys on the ward; two are normally empty and ready for various procedures and the third contains a pre-arranged medical set for inserting an infusion, consisting of cotton wool, plaster, spirit and a box with gloves. The HCA puts on a glove and cleans all wiping them with parazone. Then the needed materials are rearranged on the trolley and put back in its position in the ward.

Making the beds and tidying the ward are crucial elements in the daily routine of nurses. A superior nurse inspecting the ward says: "Now your ward looks tidy. A tidy ward is a white ward. Even more as this is a female ward. You know, we women have all kind of things to keep with us; it is difficult to keep a female ward tidy."

Admitting and discharging patients

Elizabeth Kwasie, an elderly woman of 59 years living in a village in the mountains, has difficulty in breathing. As her condition worsened over weeks, her family decided to bring her to the city and have her checked in the hospital. She was immediately admitted and she spent three days in the Emergency Unit. Then the doctors defined a therapy and decided to have her admitted to the ward. She is sitting in a wheel chair pushed by a male orderly. Nurse Catherine is unfriendly to the man, as this case had not been announced, and she returns to the nursing table not saying a word to the new patient. Elizabeth looks up disturbed, she breathes heavily. On her right hand is a drip and she is holding the infusion in her left hand. Two young relatives accompany her carrying a small suitcase, a bucket (an old margarine container), the patient's file, an envelope with X-ray pictures and some food. Nurse Joyce walks over and brings her to an empty bed that she quickly covers with a sheet. Before Elizabeth is placed in the bed, the drip is hung on a stand. Then she stands up from the wheelchair and lies down on the bed in her clothes. She looks exhausted. Joyce covers her with another sheet; the relatives place the belongings on the floor and follow the nurse to the table. There, several forms and papers are filled and information is exchanged.

The ward has 30 beds, divided into four rows that function as specialised units, dermatology and thoracic, endocrinology, neurology, nephrology and general medicine. The ward has two additional beds on a side ward at the end of the four rows. This small room is used for special patients, so called VIPs. Such women are staff members (sometimes retired) of the hospital (nurses, doctors or physiotherapists) and their direct relatives, or rich patients. They prefer being separated from the main ward with its noise, sight and smell. The room has a

small bathroom attached giving additional privacy. The health condition of these patients must be stable as nurses come to this room less frequently and moving beds there is difficult given the limited space. Unless the nurses or doctors are on strike, the ward is filled with 25 to 30 patients each day. In 2005, 465 patients were admitted to this ward staying on average ten days.[6] The relatively high turnover of patients and the fact that almost one third of the patients die on the ward put emotional stress on the nurses working there.

In the morning, a nurse from the administration checks the numbers of empty beds and gives this information to the emergency unit. The doctors there decide during their morning round which patients from the emergency or polyclinic should be admitted to the ward. The telephone system in the whole hospital broke down several months ago and this means that most admissions are not announced but they just appear on the ward around noon. It happens occasionally that a patient is brought in but no bed is available. In such situations, she has to return to the emergency unit, and the nurses complain that the communication between them and the doctors is unsatisfactory. While it is aimed to keep the four units classified, doctors 'lend' beds to their colleagues. Martha explains it this way: "We used to have only patients for unit three lying in this row. But now it is different. If a doctor needs to admit somebody or the emergency unit has to bring a patient and a bed is free, we admit the one and shuffle the beds later."

The relatives play a role in making an admission smooth. They provide information to the nurse about the patient's name, address, telephone number of a close relative, tell about the patient's illness history and receive information from the nurse about the routine on this ward. They are supposed to bring a few articles for the patient: A towel, soap and a sponge with a bucket, a toothbrush, toothpaste and toilet paper, a cup and spoon, completed with drinking water, sugar, tea and milk powder. Given the inadequate supply by the hospital, it is important that each patient has her own things to make the nursing process smooth. While sitting together at the nurses' table, they learn that this ward has two visiting possibilities a day, thirty minutes in the morning (7 till 7:30) and one hour in the afternoon (16:30 till 17:30). Apart from these times they are not welcome on the ward. Checking quickly in the morning whether new prescriptions were written and medication needs to be bought brings about exceptions to this rule. Others manage to enter the ward bringing food to the patients. Generally nurses are not supposed to give information about the health condition of patients, but they appreciate if relatives talk to them regularly and find out about changes in the treatment, making appointments for examinations like X-ray and ultrasounds, and paying debts resulting from nappies, blood sugar tests or alike.

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[6] These numbers are taken from the annual report 2005.

All patients have their blood sugar tested on admission and the relatives are asked to voluntarily pay ¢ 20,000 into a ward fund. From this fund, nurses buy soap, towels, cotton wool and the like which are needed to supplement the equipment on the ward. After that, the relatives are sent to the administration to pay a deposit of ¢ 300,000.

Admitting a patient means entering her in the documentation system of the ward. While the patient rests in her new bed, the nurse has to follow a defined set of actions to make the patient a full member of the ward. The official file provides information about the patient's medical history, her social background and previous admissions and therapies. Nurses use the information from the medical file to form a first picture about the patient, talking to the newly admitted woman hardly takes place. Several forms and charts must be started: The 'front index' gives the name, address, contact information, family status and diagnosis. Much of this information is retrieved via the file and from relatives. For the nurses' and doctor's daily check, vital signs' charts are started for pulse, blood pressure, temperature, respiration and bowel movement, a cost sheet is added to document all supplies used for this patient, the treatment sheet for oral medication and infusions is prepared to be filled in by the doctors and in some cases the balancing form for 'fluid intake and output' is prepared. The nurses' notes indicate the name, age, and diagnosis of the patient next to the name of the ward and the date. It is set up without having talked to the patient. The illness history is taken over from the medical file and standard phrases are written. They read like: "… was admitted at the given time from the SME under Prof (following the name of the specialist) with a history of … she is a referral from polyclinic … (or she is a known patient). She was well until the above mentioned symptoms started (two) days ago. Several investigations requested to be done. She is currently on … (followed by a listing of the medication prescribed so far). Her condition on admission is fairly ill (ill)." In very few cases the patient or her family are asked to tell what happened leading to the admission; this can give a different picture and lead to various versions of the illness history.[7] The general perception of nurses about their patients' condition is that they "came too late", they "are afraid of the place and do not tell us the truth" or "are ignorant of diseases and need to be educated well". After the individual file is completed, the patient's particulars are written in the admissions book and finally the name and medical condition is written in the 24-hour report book. This book contains next to the admissions and discharges, reports on those that are seriously ill (SIL) and deaths within 24 hours, and read and signed each day by the nursing director of the department.

Once this is done, the nurse or HCA approaches the patient to check the vital signs, measure their blood sugar and look after the medication. It is in the course

[7] Examples will be presented and discussed below.

of the first day that patient and nurse start building up a relationship, and this depends on the condition and age of the patient. Many patients are admitted for the first time and do not know about the routine of a hospital ward. They remain silent in their beds, hardly asking anything and answering briefly to questions posed to them. One nurse explains her role towards these patients: "I have to make the patient comfortable and also make the relatives comfortable. I give the patient a bed. Then I talk to the relatives and orientate them on visiting hours, what they're supposed to do. You know, people have some anxiety when they are coming to a hospital. I make them understand that there's nothing to worry. I release their tension and make them feel comfortable. We talk to the relatives; only when a patient comes alone we talk to her directly."

Some patients suffer from chronic illnesses like leukaemia or sickle cell disease and return to the ward on repeated occasions. The nurses know them and their families well and feel for them when they are admitted. They are welcomed in a friendly manner and are given special beds. Often these patients are young women who appreciate the contact with the nurses and they prefer beds near to the entrance and nurses' table. Their admission is often announced by rumours and gossips nurses and HCAs bring to the ward when returning from the pharmacy, OPD or their break. "Do you know that Akosua is back? She is at the emergency." "I saw Mandy at the lab; she will come to the ward later." Their admission procedure is characterised by informing each other of what happened since the last discharge. Their file is complex, containing reports of repeated hospital admissions, therapy efforts and extensive bills. If their health condition is stable, they sit with the nurses to chat or watch television.

Most patients stay between one and two weeks on the ward. Generally, patients are discharged when the doctors define their health as improved or stable during their ward rounds. The following example illustrates this:

> During their round the doctors attend to some patients. Cecilia, a young patient was admitted with malaria and possible meningitis a week ago. They look at the X-ray film, glance through the charts and examine her neck. 'She is doing much better. We can discharge her today. She should come for check-up in two weeks. OK, so we have one free bed. That is good, more patients are waiting at the emergency.' One doctor writes a discharge summary and places the file on the nurses' table with a sticker attached 'for assessment'. Then they continue their round.

Whenever time allows, one nurse follows the doctors on their rounds and thereby is informed on discharge decisions. In reality, nurses are often too busy with other nursing activities to participate; then they depend on accurate reports by the ward doctors. In most cases, the files of discharged patients are collected on the nurses' table. A sticker is attached 'for assessment'; this means that the clerk of the ward can calculate the final bill. The patient is informed about her discharge either during the medical round or later by the nurse, and she will in-

form her relatives about the good news and pack her belongings. The most important requirement to make a discharge final is the settling of the bill. Given the length of stay and the large number of medicines administered on the basis of the paid deposit, such a bill can be high.[8] Organising the needed amount can be a burden to families and the patient may have to stay a few days longer. This means that doctors pass by the patient and the nurses do minimal care for the patient. Finally if everything is done, the relatives bring the bill-receipt from the administration and the patient can leave. The nurse calls the patient and a close family member to the nurses' table. She checks for possible outstanding debts with the nurses for strips, nappies and the like. Then she explains when the patient should return to the OPD for a check-up (normally within two weeks) and educates her on the regular use of medication. Then they leave. The nurse writes a discharge report in the specific nurses' notes and in the 24 hour-report book of the ward. The discharge date, the amount of the bill and the receipt number proving its settlement are documented in the admission/discharge book. Then she archives the file in the cupboard and strips the bed. The orderlies will clean the mattress with a disinfectant before a new sheet is put on and the next patient arrives.

Admitting and discharging patients is in the first place administrative work. Many forms and charts must be filled in, relatives have to have the rules on the ward explained to them and money has to be collected before the patient becomes a member of the ward. The nurses play a crucial role towards the patients and their relatives. They are the first they meet on the ward and present both day and night. They give structure and take away the anxiety of a hospital admission. During discharge, they educate the patient on the follow-up and check the financial aspects. Constraints prevent them from realising their nursing plan in approaching each patient individually: A lack of communication about expected admissions and decided discharges, a shortage of sufficient bed sheets to present an empty bed clean and white, patients staying longer due to unsettled bills and busy routines aggravated by a shortage of nurses per shift, force the nurses to improvise on the learned routine. Given the high number of admissions and the shortage of nurses, patients cannot always be given the necessary attention but remain almost unrecognised. Relatives are sent to buy needed medication or pay the bills without having provided all needed information and the file does not always inform the nurses sufficiently to anticipate and provide the needed nursing care. The interplay of nurses, patients, and relatives at the concrete moment

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[8] In case a deposit was paid, this amount is deducted from the final bill. Only in few cases of a short stay, patients receive a refund. Depending on the medication prescribed and examinations undertaken, a two-week admission can cost between ¢ 400,000 and ¢ 600,000.

of first encounter has influence on how a patient is perceived, informed and integrated in the flowing routine of the ward.

Medication

At 12 pm, Martha gets ready to distribute the medication. “I am alone today, I have to start early so I finish in time.” She prepares the trolley with syringes, needles, a spoon, a stone, a small tray, gloves and a pen. She also adds the small heparin and insulin bottles from the fridge. The patients’ medications are in small plastic boxes on the trolley at the foot side of their beds. Pills are in their original box or in small plastic sachets on which the pharmacist wrote the name of the medication. The doctors prescribe the treatment, the dosage and duration on the ‘treatment sheets’. Martha checks the medication; some patients have to swallow up to five pills. She puts the correct number of pills on the small tray and pours it from there in the hand of the patient. She makes sure the patient (chews and) swallows them while she is there; in some cases she hands them their bottle with water. One patient is unconscious and has a feeding tube, she takes the pills and moulds them with the stone in their little sachets, dissolves them in a bit of water poured in a cup and astringes the pulp with a syringe before applying it via the tube. Only few patients get intravenous medication. Martha either applies it directly with a syringe through the drip, or makes a small infusion connected to the drip. Another patient is admitted with a thrombosis in her left leg and is prescribed heparin. Martha looks through the heparin and insulin bottles on her trolley but cannot find hers. It is either finished or not yet bought. Martha makes a dash on the day and time on the treatment sheet and reminds the patient that this important medication needs to be bought soon. “We and the doctors reminded her several times that she needs this heparin, but her family does not buy it.” After giving the medication, Martha signs the ‘treatment sheet’ and writes in the nurses’ notes “Rx given according to plan.” She moves on to finish distributing medication to 30 patients within one hour.

Medical doctors prescribe oral and intravenous medications. They specify the type and mode of intake on the treatment sheet. Some medications are provided by the central pharmacy to patients who paid a deposit, the larger part has to be bought by relatives. It is the nurses’ duty to administer the medications to the patients two, three or four times a day and the unwritten duty to both inform the doctors on finished medication and press the relatives to buy the prescribed drugs. There are three main times when medication is given: At 6 am, at noon and in the evening around 6 pm. Most medication is given twice a day or three times a day (every eight hours). Distributing medication is one of the main tasks of the nurses. Nursing students in their final year assist them at times, but HCAs are not allowed to do this work. Under the current health system, patients are

supposed to buy their medication themselves. This is likely to cause a delay, as a medication might be considered too expensive or is unavailable, or the families are not informed about its urgency. Such challenges make the medication round a daily search and ongoing discussion with patients. The most important aspect is to make sure the patient swallows the pills well; in cases of doubt, the nurses check the mouth. Injections and infusions form another part of standard medication. Depending on the supply, nurses wear gloves while injecting insulin and heparin or connecting an antibiotic drip.

Writing and documentation

Documenting the nursing work is an important aspect of the daily routine for nurses working in the hospital. It happens on various levels and degrees, depending on its purpose. The most direct and concrete writing is in the individual nurses' notes. Each shift is supposed to write down what they did with and for the patient, including the exact time and closing it with their signature. Reading through those notes, standard phrases appear like: "6 am: Slept well nocte, vital signs checked and recorded. 8 am: Breakfast taken and fair amount taken. 10 am bed linen straightened, patient washed and made neat in bed. Noon: Wounds dressed, Rx given. 4 pm vital signs checked. 6 pm Rx given, diner served and well eaten, made neat in bed for the night." Given the functional care aspect, it is often a higher rank nurse writing those comments and not always the nurse who carried out the action. She also goes through the medical file after the doctor's round looking for a change in treatment or a special examination requested; such changes are mentioned in the nurses' notes under 'WR' (ward round). Asked for an explanation, a nurse explained thus: "By this we make sure the nurses get to know. Not all do read the medical file, so we give them the important facts." The separate sheets are filled in by several nurses. The vital signs are charted when taken, the cost sheet is supposed to be filled after every cost-involving nursing activity. Here, supply is listed and added to the patient's bill on discharge. Typical items written down are plaster, cotton wool, syringe and needle, disposable and sterile gloves. Special and more costly items are urinary catheter and bag and the NG tube. While some nurses neglect filling in this cost sheet regularly, others are stricter. Vivian explains: "We need to fill it in properly. If we lack behind, the patients will not pay and the hospital has less money and will give us less supply. It is in our own interest to fill it in well. With poor patients, I am a bit lenient, but in general, we use for a patient daily four cotton balls, two pair of gloves and two needles and syringes." The balancing chart for patients on strict intake and output must be calculated every day. The ward doctors look at this chart regularly and fault these mistakes. The day shifts have to remark what they gave the patient as fluid intake (including infusions) and collected in urine bags, diapers or in the

toilet as output. The night nurse will make the balance. The balance is often uneven and reflects thoughtlessness. “Helena has a urethral catheter; she is on a balancing scheme to check the functioning of her kidneys. During the doctors’ round, the balancing sheet reads: Intake 450 ml, output 2000 ml. The ward doctor calls the matron in and asks for an explanation. He urges her to be more precise in the following days.” In other situations, the morning shift recognises an imbalance in the chart and tries to recollect information form the previous day to make it more fitting. The treatment sheet is filled in by the medical profession and nurses just sign the given medication. This is done consciously and accurate and the nurses’ shorthand symbols given an overview of who was on duty which day. The admissions and discharge book lies on the nurses’ table during the day; the responsible nurse having done the admission, discharged a patient or carried out the last offices with a deceased woman will fill in the particulars in the book.

While this documentation is done by several nurses, the 24 hour report book is the domain of the matron and nurse-in-charge. Each day, the morning, afternoon and night shift reports on admissions, discharges and death, the condition of the VIP patients and the seriously ill ones (SIL). The full names are given, vital signs reported and information mentioned on the patient’s condition, special treatments and her night rest. In case of a blood transfusion, the pre-transfusion treatment is written down, supplemented with the badge number, exact time and the patient’s (non-) reaction to the fresh blood. The daily report closes with a statistic on occupied and empty beds. The matron, night nurse, supervising night nurse and a member of the main nursing administration sign it. Comparing the nurses’ notes to the reports in the book, the description hardly differs. In both notes, the information is short and factual. Specifics like wound dressing and its healing process, critical health incidents and specific nursing matters (like extensive vomiting, diarrhoea, refused medication or delayed examinations) or views on the emotional well-being of a patient are non-existent. Standard phrases recur on ‘patient reassured and made neat in bed’, ‘patient’s condition is weak and therefore declared SIL’. Most deaths happen ‘suddenly’, a patient ‘was observed to have stopped breathing’ or ‘the condition remained poor and the patient died’.

Writing and documenting is seen as an important part of the work of the nurses. They spend a large part of their time at the table writing the notes and reading previous reports. Asked for an explanation, the foremost reason given is the legal aspect. Nurses of all ranks and positions mention, “The records are our justification. What is not written is not done. If something goes wrong and a patient sues us and we cannot prove having done something, we are lost” (Matron Hilda). Stories about legal complaints against hospitals or nurses make the round. While specifics were difficult and delicate to retrieve, the main concern of the nurses is to be blamed for carelessness. Other reasons are to exchange informa-

tion and guarantee the continuity of the given nursing care. Regular workshops at the in-service department are offered to discuss the need to document clearly and reliably and nursing students are taught in the college to use the writing as a reflection on and justification of their work. The exchange of information also concerns the aim to control nursing. The matrons and nurses in the administration use the report book to get an impression on their nurses' work and in case of lack of clarity, specific nurses are called to explain their actions.

Routine work

Depending on the situation on the ward, the nurses carry out several activities. In the following section, some of these activities are highlighted.

Feeding

After beds are made, patients are served breakfast. Female orderlies bring porridge, 'Tom Brown'[9] or rice water with bread. Some patients prepare additional tea. All patients are supposed to have their own cup and spoon ready, and use their own milk and sugar, as these are not provided by the hospital. The same is true for the lunch and dinner when warm food is served. Food served varies between kenkey, yam or agido with stew, fish or light soup. Some patients refuse to eat this food and rely entirely on their family for food provisioning. Diabetics are asked to wait till they have been given insulin injection. Younger nurses, students and HCAs are ordered by the matron to feed those patients who are unconscious or not mobile enough to eat independently. They stand next to the bed, stir the fluid food, and spoon-feed the bedridden patients; there is hardly any communication between the two. Unconscious patients are fed through a tube; students have less experience in feeding this way and learn from HCAs or nurses how to fill a syringe and slowly inject the fluids through the tube into the stomach. They learn to flush the tube thoroughly with water to avoid blocking the tube with cold sticky porridge. In addition, they give the patient the needed fluid intake. The patient's toilet paper is used to clean both tube and cup. Depending on the amount of supply the nurses wear disposable gloves. With patients on a balancing scale, they note down the intake.

Bathing

The nurses have to assist several patients in cleaing themselves or bathing either by accompanying them to one of the two showers or cleaning them in bed. This happens every morning, and sometimes may be repeated in the afternoon. Occasionally family members wash the patient. The nurses have biased opinions about

[9] A mush made of moulded corn.

this. Phyllis says “We are not enough so we ask the relatives to wash them. We talk to them and explain all to them. Only the seriously ill ones are exclusively washed by us.” But Ernestina, a senior nurse, states: “Relatives just wash, they don’t know what to look for. The patients are under our care. The private parts and oral hygiene, the relatives do not do it, so we have to do it. It is our responsibility.” In reality, it is mainly the nursing students and HCAs who are asked to wash bedridden women. These patients are unconscious, too weak or old to stand up or have wounds or bedsores that prevent them from moving freely. The young students prepare a trolley with cold water, warm some water in the electric kettle and look for towel, sponge and soap in the locker. A folding screen is placed around the bed to create minimal privacy. If available, a plastic sheet, called a ‘Macintosh’, is put under the patient to keep the mattress dry. Starting from the face, moving down the body and rolling the patient from side to side, the body is washed, dried, creamed and powdered. This bath can take up to half an hour, especially if the woman is incontinent, has soiled herself and needs to be washed extra carefully.

Students are hardly prepared for this work. Josephine, who is in her final year, exclaims after a bed bath: “I have never before changed diapers, not even with a baby. I did not even know how to open them. Today was my first time of doing such a bath and seeing it all together. It is a shock to do it. On all other wards, nobody needed to be assisted in washing. We just learned about all that in the demonstration rooms in our school; our training is very theoretical. I am exhausted.” The HCAs have more routine already, but sometimes forget certain aspects. The senior nurses regularly chastise them: “Hey you, you forgot to place a screen. Where is the privacy, here or there? Is this the privacy you would want? When you stand at the table you can see everything. Place the screen well!” Matron Mary explains to new incoming students: “Do not give them a ‘top- and-toe’ bath. You know what it is? It means you just dip the towel in water and then you clean the patient; ey, the patient feels sticky. They might think you also do it shallow. They call this ‘Korle Bu bath’, but now you learn to add enough water to clean a patient well. You do it and do it well. It’s only when you come into a hospital bed that you are called a patient. There’s nobody called a patient when they are walking - but when you come into a hospital bed, then we recognise them as patients. Sometimes, you see patients who are even dirty, they haven’t even got a napkin to clean up their bed. You watch out, those are the patients that you should care for. Walk closer to them or they think ‘is it because I haven’t been washed that’s why they are not coming to me?’ Do proper nursing care for them.” In the routine of the day, there is hardly any communication with the patient; it is rather the two nurses who talk to each other. Special wishes or the use of specific cosmetics are not made known to the nurses and patients do not

dare to speak up. Having finished, the screen, trolley and bath utensils are cleared up and the patient is bedded either on her back or side. The involved nurses wash their hands and leave.

Wound dressing

Angela is 37 years old. She is suffering from diabetes and has developed gangrene on her right foot. Rosemond is in charge of wound dressing today. She has prepared the trolley and has just dressed a sterile wound for another patient. She wears a facemask and disposable gloves. "Actually, you should use a forceps for the sterile wounds, but we do not have it. I use two gloves. With the first, I remove the old plaster and gauze, then I remove the gloves and clean and dress the wound. For the sterile wounds I use sterile gloves, but for this I do it with normal disposable gloves." She places a screen around the bed and looks for dressing material bought by Angela. Then, she opens the package covered in green paper, the sterile kidney cup. Rosemond tears the paper in two, puts one part on the trolley to post sterile cotton balls on it, the other part serves as bed cover under the wound. After removing the old gauze, she pours hydro-peroxide over it to clean the infected flesh. It is a deep wound of about 5 cm, the edges are necrotic. Then she cleans the wound with cotton balls dipped in normal saline. While doing this, her face mask slides off her face and hangs on her neck. Finally, she dips the gauze in iodine and places it on the wound. To cover the wound she uses a bandage and fixes it with a strip of plaster. The dressing was painful to Angela; tears are rolling over her face. There has been no communication with the patient during the procedure. Rosemond says later: "When it comes to dressing, there is no mercy. We have to do it and do it well". After the dressing, she writes in the nurses' notes: '11 am: Wound dressed and cleaned'. Then she brings the trolley back to its place; the used dressing material is thrown away in the rubbish bin. The dressing package is collected in a reservoir to be cleaned before sending it again to the sterilisation department.

There are few patients with fresh scars on the ward. Wounds to be dressed stem from gangrenes (possibly a consequence of badly managed diabetes) and bedsores (due to long lying and/or reduced mobility) or are the result of drainages (e.g. in the lungs to run off fluids) or infected punctures from drips. This means there are sterile and non-sterile wounds to be dressed. Normally, it is one nurse with an assisting student or an HCA who does all dressings on the ward alone. She prepares the trolley with two or three sterile dressing packages (a kidney dish with two Galli-pots and a set of forceps) that are supplied by the hospital, sterile and disposable gloves, face masks, scissors and plaster, non-sterile cotton wool and cleaning liquids like saline and spirit.

Nurses learn during their training how to dress wounds according to the hygiene standards, for example how to treat sterile ones first. On the ward, they face conditions that challenge the realisation of the learned procedure. It has mainly to do with the shortage of the needed material. The ward has about five sterile dressing sets. After one use, it needs to be cleaned and brought to the CSSD (Central Sterilization Service Department) for renewed sterilisation. This means in practise that no more than two or three sets are available. In addition, the supply in sterile and non-sterile gloves, plaster and cleaning liquids (saline, mercurochrome, spirit) is limited. Given the cash-and-carry system of the Ghanaian health system, patients are supposed to buy dressing material themselves.[10] Sterile cotton wool, gauze and special articles like hydro-peroxide or Asmisol, a liquid disinfectant, have to be acquired by patients. This means a successful wound dressing depends on the cooperation and financial strength of the patient. 'No money' can lead to 'no wound dressing'. Only in urgent cases, are nurses willing to borrow these necessities from other patients or decide to buy it from the ward fund or out of their own pocket. The high workload on the ward in combination with the low number of available nurses is another challenge nurses mention. There are days when wounds are dressed without folding screens, and sterile gloves are used instead of sterile forceps. On other days, students and HCAs carry out the work without supervision. The only exceptions are excessive wounds caused by pressure areas or allergic reactions like the Steven-Johnson's Syndrome.[11] These wounds are deep and often inflamed and are dressed daily by more experienced nurses in a long procedure.

When asked about the proper performance of the dressing procedure, the nurses express the need to deviate from the learnt standard and improvise. Probing further, knowledge gaps were also disclosed. Only few can explain the difference between a sterile and non-sterile wound and its medical implications for the dressing. "We are a medical ward. Over there at surgical, they have more experience" is the opinion of a nurse, while a HCA says: "I learned dressing here on the ward. I watched it and now I know it." Nursing students practise dressing on the ward but feel uncertain about the right way. "At school we have had teachers teaching us the cleaning of wounds. We were told that in cleaning of wounds we clean the inside before outside, and when you get to the wards, they clean outside before they clean the inside." Another student agrees and solves the problem her own way: "They do things really different here. They dress wounds

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[10] As explained above, Ghana introduced the National Health Insurance Scheme in 2005. The support of this scheme based on yearly contributions is still low, many patients doubt its benefits. The hospital plans to implement the system by 2007.

[11] This condition is caused by an allergic reaction to sulphates containing medication or herbal treatments. Approximately two patients, mainly young women, are admitted per month on this ward. Given the degree of the reaction, the mortality rate is above 50%.

with non-sterile gloves and do not have the correct instruments. I do not feel really happy doing it that way. So when I am on the ward, I avoid being asked to do this work by moving away quietly." Next to these uncertainties, there is no quality check over time. Different nurses dress the wounds every day, and neither the nurses' notes nor oral information give any specifics about the development of the wound.

Vital signs

Around 10.00AM, a group of nursing students is sent to check the vital signs. They are not sure where to start, and finally split up. Each starts at one row of beds, checking either blood pressure, pulse, respiration or temperature. While one student measures, the other records it in the chart. With one older woman, a student cannot find the pulse: 'I cannot find it, it always disappears again'. She looks around, asks her friend to help and together they search for the best way to do this work. After some minutes, they turn to the paper, note down a pulse and move on. A few minutes later, another student approaches this patient to check the blood pressure.

Each patient on admission in a hospital has his or her vital signs checked. This means the pulse is controlled next to the blood pressure, body temperature and respiration. This happens four times daily with hypertensive, feverish or seriously ill patients. In addition, the movement of bowels is enquired into each morning. All this information is then documented in the 'vital charts' and examined by the medical doctors during their round and by the nurses when taking up their shift. On normal weekdays, nursing students or HCAs are asked to check the vital signs; at weekends or when more nurses are on the ward, they will join them. They split up in two or three groups, one taking blood pressure and counting respiration, the other checking pulse and temperature. The needed instruments are a blood pressure gauge and a stethoscope, a thermometer with cotton wool and spirit, a watch and a red and blue pen. The ward possesses three gauges, but one is dysfunctional due to a broken tube. There are two stethoscopes and two electronic thermometers. All nurses use their own watch to control the pulse. Checking and documenting these signs take a long time and is often characterised by uncertainties. The young nurses lack the experience to use the gauge easily and so lacking self-confidence and feeling uncomfortable they often ask for help. This can lead to a situation commonly known among nurses as 'free charting': "A doctor wants to examine a patient and asked nurse Catherine: 'How is she doing today? How are her vitals and how often did she pass any stool?' Catherine responded: 'It is better today, but I cannot tell you more. I was not there when they changed their diapers.' They go to the bedside to see the patient. The woman is lying in bed, weak and silent. The doctor wants to know the actual

blood pressure and asks for a blood pressure gauge. He does not hear anything. Agnes tries and her result is 60/40 mmHg, very low, especially for a woman of her age. The doctor jokingly remarks: 'Women have better ears. But look at the chart: yesterday and this morning it was charted 120/70 mmHg. This must be a blind check and free charting.' The nurse agrees that it is likely that the vitals were recorded wrongly. She charts the just measured results and the doctor makes a remark in his notes and leaves."

Such occurrences can be explained by a lack of practical experience and motivation of the students, minimal encouragement and poor supervision by experienced nurses and by the set up.[12] The ward follows a functional care approach in which one nurse does the same treatment or action with all the 30 patients on the ward. Unlike the individualistic care, when one nurse does all caring aspects for a few patients from taking up to bathing, feeding, medication and documentation, the functional approach leads to less attachment with and knowledge about one patient's specific condition and needs. The shortage of nurses, time pressure and the wish to appear knowledgeable increase the stress. Abnormal and extreme results in blood pressure, temperature or pulse have to be reported to the nurse-in-charge in order to decide on nursing or medical actions like medication, sponging and repeated control. Given the different tasks carried out during the shift, a regular exchange of information is often omitted. Nursing students and HCAs finish their round and wait for the next order from the nurses.

The personal hygiene of patients

The ward has two water lavatories for the 28 patients and one additional toilet for the two patients in the side ward. The male orderlies sweep and clean these rooms several times a day, starting in the early morning and stopping in the evening. This means that the toilets are clean and emit little miasma during the day, while in the night the smell increases and the condition of the place deteriorates. Sustaining one's personal hygiene is an important element in adult life and subsequently needing assistance is perceived as shameful. Ambulant patients go to the toilets themselves; the preferred moment for moving the bowels is in the morning before the visiting hour. The nurses ask for regular bowel movement daily. Urinating is done either in the toilets or on the ward into a small bucket the women keep under their bed for regular use, and emptied either by them or a family member. When a patient needs help, it is mainly the students' or HCAs' task to assist her. They either push them in a wheelchair to the place or place a screen around the bed and provide a bedpan. Immobile patients are prescribed a urethral catheter and they wear nappies. Matron Mary observed: "It is our duty to

[12] Nursing student complain about a missing practical experience and lack of supervision on the ward. This aspect will be discussed in the following chapter and in the chapter on training.

recognise when a patient needs a catheter or diapers. It is a shame when a doctor has to tell us; we are responsible for it." The patient is not asked but informed about the decision. A qualified nurse using gloves and a catheterisation-set does the placing of a catheter. While catheters are supplied in several sizes, some experience is needed to choose the correct one and avoid inflicting unnecessary pain on the patient. Insufficient supply means in this situation to borrow the needed catheter from another ward (preferably the gynaecology ward that has the biggest and most varied supply) or delay its placement. Catheter bags are emptied by HCAs three times a day. Diapers are changed when bathing a patient or if she has soiled herself. Nurses do not like to do this job. It is time consuming and can be physically and psychologically challenging. In various situations during the research period, nurses either delayed it till the next shift arrived, commanded students to do it or waited for relatives to come for the visit.

Other regular activities are the attaching of infusions or blood transfusions, collecting medication from the pharmacy and sterilised medical instruments from the CSSD and a spontaneous chat with a patient.

Being there in the night

In addition to the normal work in the day, each nurse has to work two months during one year in the night. Most nurses do not like that period. Recently, this period had to be prolonged. Nurse Joyce explains: "Actually, each nurse is supposed to work two months a year in the night. But this work is stressful. There are nurses who say they will not do it due to health issues or family problems; so I have to do four months. I also do not like it but have no choice." Only one nurse stated that she likes the night work as she follows courses during the day to eventually go to university. Working in the night enables her to follow that plan.

In the night, the work is different: There are no doctors around, visitors have left, and the major nursing activities have been carried out. Night nurses work in pairs for four nights and have three nights free. The main task is to comfort the patients and enable a quiet and serene atmosphere on the ward for the patients to rest and recover. Nurses look after the patients, check their medication and current health situation and encourage the worried ones. Asked about it, most night nurses perceive the work as 'busy and tiring'. Nurse Doris observes thus:

> This night was OK; only one patient that was admitted yesterday afternoon and died in the early morning, for the rest it was not too busy. We had to check the files. Whenever one sheet is finished or about to be finished, like the treatment chart or the chart for the vital signs, we have to renew it in the night for the coming days. Next to this, we look after the patients, give them the night medication and look around. When a patient has soiled herself, we change the diapers and wash her in bed. Otherwise, the washing is done by relatives in the morning; we do not wash standard in the evening. Some patients are troublesome and do

> not want to sleep. She will say 'sister come and give me water' or 'sister come and do this or that for me.' They keep us busy and running.

This statement shows the various aspects of the night work. Many tasks are supportive to the day shifts, like the renewing of charts and sorting of files. In addition, they have to control the vital sign charts and copy results to report books. Caring for the patients is kept to a minimum since they want them to rest and sleep. The anxiety of many patients about their admission and the general fear of darkness turn the night into a difficult period both for nurses and patients. Patients are afraid that death may come in the night and so they ask that the lights are kept on and to have regular contact with the nurses; indeed some patients try to avoid sleeping in the night and are restless till dawn, when they finally sleep a bit. The nurses do not admit openly to that fear but they show dislike for being responsible for so many patients. In the late evening and early morning, they are busy with the medication and making of balances. The morning shift sometimes complains that patients were not washed or their nappies not changed during the night, but generally it seems the night work is done sufficiently. As they form one group of nurses who 'go in the night' several weeks each year, they come to appreciate the pressure and learn to cope with it.

Rumours circulate among patients and in the streets that nurses do leave the wards in the night and lock themselves up and sleep in the resting rooms for some hours. During the research period, the researcher had difficulty in getting approval to staying on the ward overnight; probably the nurses felt uncomfortable having an outsider with them in those hours. Arguments used were that the workload was relatively lower, uncomfortable resting possibilities and supposed boredom during the night; "It wouldn't be of any interest." Finally, a few nights were granted for participation. During those nights, the nurses worked as described and explained earlier, but they also spent several hours per night to rest outside the ward, leaving the sole HCA behind. The patients were mainly left to themselves. Although most slept, some were clearly uncomfortable with the darkness. They expressed their fears and were worried about themselves and the condition of their fellow patients. In addition to this, patients who die during the night seemed to cause more confusion and troubled the patients.

Conclusion

The activities give a picture of the nursing routine. One feature becomes open to view: The presentation and the appearance of the nurses and of their work. This presentation can be divided into three parts: The ward, the work and the team.

The nurses see the ward as their territory. Presenting it in a clean and tidy way to visitors and doctors means that they take good care and show their sense of responsibility towards the patients. Until the completion of the renovation, this

old part of the hospital has to serve as a ward with all its described limitations. Achieving cleanliness here is hindered by the deteriorating structure of the building and insufficient equipment. It is a momentary activity interrupted by medical and nursing activities, emergency situations and visitors crowding the ward during permitted times. But it is an important element in the nurses' understanding of 'good nursing' in the hospital. Roots of this can be found in the historical beginnings of Ghanaian nursing. British Colonial nursing sisters had imported ideas on external hygiene suggesting both their dominance over natural challenges and provocations and the presentation of undoubted moral integrity (see for example Akiwumi 1992, Blavo 1995). Cleanliness as a concept of successful nursing confirms also what Schuster (1980) and Holden (1991) report on present day nursing in Zambia and Uganda respectively. A tidy and uniformly white ward symbolises cleanliness and a supporting environment for the patient to rest and recover. Replacing the colourful sheets also demonstrates the power nurses have over the patients; they decide how the ward has to look and there is no space for discussion.

The hospital is the working place of the nurses. Their understanding of nursing is that of a responsible and a busy profession. It encompasses bedside nursing, writing and documentation and various forms of communication with patients and other medical groups. Nurses communicate in clearly defined styles with patients and among each other. While private conversations are conducted in Ga, Twi or Ewe, nursing talks and written forms of communication and documentation are in English. All medical and nursing terminology is English. By this nurses show a form of professionalism and educational level, both in speaking and writing. The nursing administration supports and confirms this by checking the written reports on grammar and spelling. Talking to patients is done in English when medical issues are concerned while some of the Ghanaian languages are spoken when shorter questions are asked or the proper use of medication is explained on discharge; the style is plain and determined. Patients who do not speak English are often regarded as less educated and poor. Towards them nurses show their authority in talking English and also mention a diagnosis or treatment only in this language while knowing the women will not be able to understand it (fully). Doing this, nurses display authority and alienation from the (less educated) patient and its embodiment of daily life in the streets of the capital. Patients reply to questions asked calling the nurses 'sister', 'or 'auntie', a respectful and dignifying naming even when the nurse is much younger than the patient. In documenting the work, it is noticeable that most descriptions and reports and brief contain limited details. The nurses themselves display by the writing process their control over the patients and the work on the ward as a whole. While the training schools teach a more individualistic and personal

approach to nursing and caring, the reality on the wards shows the functionalistic approach to nursing. Personal specifications on a patient's condition or her psychological state of mind remain blank in the notes. Patients are labelled as cases that are 'fairly ill', 'ill', 'ill but conscious', 'weak' or 'weak and restless', describing the condition as a whole. While the first term refers to less severely ill persons who are mobile and improving, the latter indicates a serious health threat possibly leading to death. This is never mentioned aloud, indeed there is no structural communication about the patient's well-being and psych-social position either with the women or among nurses. This reflects one aspect of a social and cultural norm in Ghana. When asked about one's health, everybody is 'doing fine', 'we are managing'. Depending on the level of intimacy, more detailed information might follow at a later stage of a conversation.[13] By speaking in English and remaining distanced and emotionally withdrawn from the patient, the relationship stays superficial and the courteous reply 'I am fine' remains the only option.[14] Emotions like fear, uncertainty, grief or doubt are not expressed publicly. Such display of emotions is labelled as 'childish' and 'inappropriate'. Such emotional detachment can also be understood as an attempt to advance the goal of the hospital as a quasi-bureaucratic institution such as to enhance the nurse's power in the medical encounter. It is difficult to estimate whether a patient is aware about the type and severity of her illness and prognosis and how the nurses assess the situation. Following doctor's instructions and praying constantly are perceived to lead to improved health. Deterioration in health is hardly pronounced. "It will be well"; "we are praying for you" and "the condition is weak but stable" are attempts to describe it. Consequently, nurses follow this unwritten rule in their recordings and do not indicate health aggravation.

In carrying out the work well and handing over a clean and well-ordered ward to the next shift, nurses show responsibility towards their patients. The nurses are aware of their position. They define themselves as knowledgeable and educated and their role is to guide the patients through their stay on the ward in a directive way. Discussions or extensive questioning of their orders and activities through the patients is neither expected nor appreciated. The patients respect the nurses. Being authoritative to them is also the professional role nurses are expected to take on. They often call them 'auntie nurse', even when the nurse is younger than the patient, reflecting the high position they are given. Gibson (2004) analyzes the role of nurses in catching the doctor's attention for a special patient in the South African context. On this medical ward, the risk of 'falling out of the gaze'

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[13] This emotional neutrality is also exhibited in Europe and North America.

[14] While this seems the standard reaction and behaviour, nurses do create an emotional band with some patients. These are often younger women suffering from a chronic disease like leukaemia or Sickle Cell disease, return regularly to the ward or stayed for a longer period. Richer patients can form another group.

of both doctor and nurse starts during admission through the nurses. As Anderson analysed about a hospital in the north of Ghana (2000), nurses do not treat all patients the same, claiming that many of them, mainly the poorer ones, are less educated and ignorant. The degree of integration and 'focus in the gaze' is often determined upon admission and hardly changes tilll that patient is discharged. Too knowledgeable patients are seen as difficult and destructive for the ward's routine and patients' well-being. Senah (2002: 58) explains this perspective with the cultural background: "From early childhood, the Ghanaian is made to understand that knowledge is acquired in stages of biological maturation and precocity is evil. Authoriy is said to be sacred." Only few younger or wealthier patients can influence and negotiate their position on the ward and positively catch the regular attention of nurses and doctors.[15]

The irregular supply of equipment and the unforeseeable order of events during shifts require the nurses to improvise in their work. Procedures learnt during the training need to be adjusted to the reality. This is a process typical for all professions and places (see for example Melia 1987 or Du Toit 1995). Shortcomings must be managed and creatively solved, be it insufficient laundry, understaffed shifts or a large number of seriously ill patients asking for elaborate and individualised nursing care. Being very visible in their white uniforms, nurses represent a shelter in all uncertainties and display control and order. They radiate authority and power. This is also valid for the team of nurses. The role of the matron is important both as a controlling ward manager towards the medical doctors and patients, and as a listening ear motivating and encouraging the nurses. Her appearance and working attitude shape the whole group of nurses. The work is distributed according to clear lines and this strengthens and confirms the hierarchy of the nursing profession on the ward and in the hospital as a whole.

The nurses talk about their work, discuss the appropriate form and amount of reward due them, finish their shift and return home to their families. The next day, they will come back to their ward to fulfil their duties. Some perceive the work as tedious and frustrating; others face the challenges and the needed improvisation declaring that working on the Medical Ward means learning a lot. Sister Grace concludes while addressing the nursing students: "We have here two mottos: One is: 'A clean and tidy environment!' And the second is 'Touch a patient before you go home'. Don't leave the ward like that to meet your boyfriend, but report to me all the time when you have a question. Now move and make the ward tidy and clean. After that start touching the patients. That is nursing on our Medical Ward."

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[15] See Chapter 14 on doctors and patients for more details.

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"We are a decent profession." Hierarchy and differentiation

On a Wednesday, the deputy director of nursing in the Medical Block invites all matrons for a meeting. During that meeting, she shares her recent observations with them: "Most of our nurses are working fine, but sometimes I see them sitting with their phones and the students do all the work. Please, encourage all to work hard. I know it is not easy. But it is your responsibility that the patients get the best care. Last week, I saw a chart that was not filled in a proper way. Go and check your group." The matrons leave to their wards and call in ward meetings. During those meetings that take place on monthly basis, only the staff nurses are present. Students, rotation nurses and HCAs remain on the ward, no outsiders are welcome. They discuss the current situation, the matron evaluates her group, praises and criticizes the nurses and explains her goals for the next weeks. Returning to the ward, nobody speaks about the outcomes of the meeting; they continue with their work. Asked about it, those meetings are labeled as 'just a get together' and 'a repetition of what is known'.

When one arrives on a hospital ward as a patient, family member or visitor, nurses are in most cases the first persons to meet. Their presence in numbers, their white uniforms and the work they are doing with the patients and on the workfloor easily catch one's attention. In another direction, nurses often actively act as guards over the ward or even function as representative of the hospital in general. In the previous chapter, the routine of their daily work was described and analyzed as a whole. Looking closer, the group can be split into subgroups, each fulfilling different functions and carrying out different responsibilities depending on their hierarchical position.

This chapter describes the nurses in their particular positions and their perspectives on nursing. It starts with the clothing rules and then discribes the various ranks in the nurses' hierarchy. Beginning with the Director and Deputy Director of Nursing (DNS and DDNS), the focus turns then to the matrons, nursing students and finally health care assistants (HCAs) and their specific tasks

and vision. It will be shown that the various groups represent both in their appearance and their actual work, different aspects of the power balance on the ward. This balance, based on clear hierarchical structures, is a delicate one and varies depending on the available actors and the nursing situations that occur.

The nurses' uniform: Green girls turning into white women

Traditionally, nurses in Ghana wear dark green dresses, separating them from the doctors in white coats. This is still the case in most public and faith-based hospitals and the health posts in the rural areas of the country. Recently, a shift took place in the university (and several private) hospitals. Nurses in Korle Bu now wear white dresses. The explanation given is twofold: One argument is linked to the recently implemented autonomy of the hospital and its revised direct recruitment structure for nurses. The special status of the hospital is thus made visible in the white dresses of the nurses. The other argument is the status attached to white dresses. White used to be the privileged colour of the powerful medical profession, and by 'allowing' the nurses to wear white also, this shift aims at attaching more status and authority to the profession.

Nurses wear white dresses with a white cornet and shoes. The rank and position of a nurse is visible in the presence and color of her belt. Like the number of borders on cornet, both show immediately and underline the position a nurse has on the ward and within the hospital. Most nurses dress at home and come with their dresses on to the ward; they only change their shoes. Many nurses tell about the prestige and status their appearance evokes.

Students from the training colleges still wear green dresses with a white apron; the band on the sleeves indicates the number of years in training which ranges from one up to three. The cornet is plain white; the shoes are black and closed. Students from the university wear white plain dresses and black shoes. This means also that mature students who worked as nurses before entering the university have to change their clothing and wear black shoes and a simple dress again. Table 8 gives an overview of the differentiation in clothing within the nursing profession in Ghana.

The appearance of a neat and clean dress is of high importance to the nurses. They regularly check their dresses for stains, and the night nurses change their dresses in the morning into well-ironed ones before the new shift arrives. The matrons as well as senior nurses check the appearance of their junior colleagues and students regularly. Dusty shoes, a badly-fixed cornet or dirty fingernails are disliked and the (student) nurse gets a warning. The following examples illustrate

Table 8 The dress code of nurses
(*Source*: Data collection of the researcher)

Name	Dress and shoes	Belt	Cornet	Apron and special features
Health Care Assistant (HCA)	Blue and black	None	None	Assisting nurses on the ward after a short training
Student Nurse from NTC	Green and black	None	Plain	White apron, 1-3 white small bands on sleeve indicating year of training
Student Nurse from University	White and black	None	Plain	Also mature students have to wear a simple dress and black shoes again
Rotation Nurse (RN)	Green and black	None	Plain	White apron, 1 broad white band on sleeve
Staff Nurse (EN and SRN)	White	None	Plain	Starting work after graduation, mainly placed on a ward via the main administration
Senior Staff Nurse (SSN)	White	None	Plain	Promotion after 5 years of working in the health service
Nursing Officer (NO)	White	white	1 border	Position reached after interview, exam and positive recommendation
Senior Nursing Officer (SNO)	White	blue	2 borders	Includes regular trainings e.g. in administration
Principal Nursing Officer (PNO)	White	green	2 borders	Formerly called 'Matron', she is in charge of the ward
Depute Director of Nursing Services (DDNS)	White	purple	3 borders	Responsibility of a unit e.g. medical or surgical department
Director of Nursing (DNS)	White	purple	3 borders	The highest position in a hospital

this: The DDNS of the unit makes daily rounds in the wards; one morning she meets a student on the hallway wearing a short dress that stops above the knee and is tight. She calls her: "Give me your name and I will check that this uniform is changed soon. Such a dress is not decent. I do not want to see that on our ward." She explains the importance of a neat appearance to students and young nurses when they start their work in the department. One morning she checks students: "Your nails are painted. We do not do that. Why? Because we are a decent profession. You will be married, you do not need such dressing and painting. We do not want to be too attractive to the patients, but we care for them. So make sure your dresses are long enough, not showing anything. You must be comfortable in them. And wear closed shoes on the ward. I do not care what you wear in school, but here you work and must protect yourself. We have short and cleaned nails here and well combed hair. Care for the patient and leave the rest to God. We are a decent profession!" Doris, a nurse working regularly in

the night is often reprimanded about her negligent appearance; her cornet is most of the times missing and her dress shows old stains. She is an enrolled nurse and remains low in hierarchy. When spoken to, she feels uncomfortable and says she lends the cornet to a friend and blames the busy work schedule. Her superiors state that by this she is not representing nurses well.

All nurses subscribe to this image. But the white dress and their subtle attributes demarcate much more than just a professional group dress. They mark their position as representative of an accepted profession. Three aspects are important here: Firstly, the white dress acts as a visible characteristic of the group. Registered nurses in the hospital wear white uniform and fulfill an important position in the hospital organisation. This makes them recognizable and respected even outside the hospital walls. In translation, it represents the idea of a decent, well-educated neat woman and trustworthy member of the society. Secondly, the uniform depersonalises and makes the individual invisible. Putting on the uniform turns the person into a member of the nurses' group. Clean nails, an unobtrusive hairdo and a humble manner support the aim to desexualise the nurse and potray her as a devoted and dedicated caregiver. Finally, the concept of the uniform pronounces the hierarchy within the group and underlines the different ranks. The pure appearance shows the position of a nurse within the hierarchy and makes discussion about power and influence superfluous. Controlling the neatness of a dress of a younger nurse in a lower position underlines and strengthens the top-down hierarchy. This shows self-discipline of the group and authority both within and to doctors, patients and the outside world.

The Directors of Nursing Services: Supervising and motivating

The Director of Nursing Services' (DNS) main task is the general overview of the nursing activities in the whole hospital and the setting out of general rules and standards. She is less visible on the wards and more involved in the main administration and management. That is reflected in the fact that her office is located within the main administration block and she is a member of the board of directors of the hospital. She is assisted by a group of senior nurses (SNO and PNO), who take care of the nursing statistics and planning of recruitment and training.

The DNS is the liaison between the nurses and the hospital management, which is headed by a medical doctor. Her main duty is to staff and equip the wards sufficiently and to keep her workers motivated. She summarises her duties thus:

> As a Director of Nursing Services, my vision for the hospital is to have a fully-staffed hospital. A staff that is very motivated and giving quality service to the patients. I want the nurses to be really happy and work for our patients. Also I want them to be satisfied; that

was my vision for the hospital. But I guess it is ambitious. In the last years, we had between 1,000 and 1,050 nurses here. We need up to 2,000 to deliver quality care.

The nurses on the wards perceive her as occupying a distanced position; they expect her to stand in for the nurses' rights and to provide them with better working conditions, equipment and salary. Being careful with criticism, the nurses define the current situation among nurses and medical staff and administration as "not very cordial" and the DNS as being worried about the situation and feeling responsible but being "not the type to face a discussion". One nurse observes thus:"You can't run Korle Bu when you are a silent person."

Most concrete supervision and motivation are delegated to the Deputy Directors of Nursing Services (DDNS) who head the departments (e.g. surgical, medical, pediatrics). The deputy director supervises the work of the nurses, keeps record both of their working schedules and patients' statistics and takes care of the nursing work in her unit.

In the medical unit, the DDNS is assisted by one or two senior nurses (PNO). She makes regular rounds over the wards to meet the nurses during their daily work, supervises care situations and gets an overview of the patient population and their health conditions. Along with those rounds, the work consists of administrative and management tasks, co-ordinating workshops and training, supervising and evaluating the work of the nurses and having regular contact with the medical doctors of that unit. During the weekends, the DDNS is free, and one of the matrons takes over her duty. Having worked as a nurse for several decades before rising to this rank, she knows about the daily worries and achievements. Her perspective on the work is clearly motivated by her Christian conviction and professional will to deliver high standard nursing care. Asked about her professional life, she says: "It is only by the grace of God. Through all these diseases, I have been able to go through. It's solely by the grace of God that I am still standing here."

Towards the nurses, the DDNS is both motivating and controlling. As mentioned above, it is important to her to present a united group of nurses underlining the decency of the profession. She knows the situation of the medical unit for a long time and sees that 'her' nurses work hard: "The work here is very tedious[1] given the seriousness of diseases. And the work here is still unpleasant because of the very limited privacy we can provide for the patient."[2] Given the high work pressure, she tries to be understanding towards the nurses:

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[1] The word 'tedious' is used by nurses to describe their work as tiring, exhausting and hardly manageable. It has a different and even opposing meaning to the regular one that means 'boring' or 'monotonous'.

[2] With this statement, the DDNS refers to the temporary housing of the ward in the old part of the hospital during the renovation of the original medical department.

> They are very hard working. I know some take long breaks by noon or leave early. But the fact is, since you have few nurses, you should be very flexible and be a bit more lenient than you would like to be. Otherwise, it will push these off the hospital that you have. Aha, they will just say, why can't we leave and have our peace? And by the time you realise that you had a dictator leadership, you'll not have anybody to work with you. So you should be very dicey and understanding. Open criticism will drive them away.

Arriving around 7 am, she listens to the reports of the night nurses, reads the nurses' notes and supervises the updating of the statistics on seriously ill patients (SIL), the death rate and the number of available beds. Her assistant reports the number of empty beds to the emergency unit to enable new admissions in the late morning. Then she makes a round over the wards to meet the nurses and greet the patients. She also checks the attendance of the nurses and the cleanliness of the ward and nurses' tables. Taking her time to talk to the patients, she greets those she knows from previous admissions, consoles the seriously ill and encourages them to be patient and sustain the suffering and uncertainties during the admission. Her main partner on the ward is the matron whom she consults. Talking to the matrons in one of the regular meetings, she stresses the need to have a feeling on the current workload and motivation: "You have to set your priorities. You have to know when to start, how to start, where to start and how to finish." The nurses acknowledge and respect the authority of the DDNS and are engaged when she is around. Some check the notes and charts, others finalise reports or start nursing activities. They also encourage the students to work hard: "Quick, get some work, she is coming. Do not sit down, but find something to do." Indeed it is not appreciated if nurses or students sit or relax on the ward, as "your place is at the bedside, go to the patients and care for them. If you take a break, leave the ward."

The DDNS defines it as her task to teach the principles of nursing and she expects nurses, students and assistants to live up to the standards. She makes clear that she expects motivated, decent and accurate nurses in her unit. Asked about the growing numbers of HCAs, she says: "We have too many HCAs, they engulf all. These young girls crowd the ward but are non-professionals. We will need well-trained nurses to keep the standard up. What can we do? We do need them. We try to train them to guarantee a certain degree of standard, but we are lost. Those fresh from school do not know anything." She also encourages the nurses and matrons on the ward to supervise and teach the students as they form the future of the profession.

> You go round and you correct all those things that your children have done which are not good. If possible, call them and teach them. Say that 'this is not how to chart', 'this is not how to go about it' like writing down 'dressing done!' What does it mean 'dressing done'? I mean you make a comment on those things. Some of them seem to not even read the thermometer properly when they come. That's why you should be therefore helping them. If you come alone with a student, you yourself, the in-charge do the seriously ill patients and leave the rest to the student. But while you work, help them to learn and do the work well. Make

sure you go round and they do their chart well so that when you're handing over, there won't be any problem and patients will return home healthy and grateful.

Asked about her perspective on nursing, she confirms her motivation to improve the work and keep nursing on a high standard. "I personally think, it's not money that matters, but the job satisfaction. This is why I try to improve the situation, organise better equipment and keep the nurses motivated. When they like their environment, they will work better and the patients will respect us even more. I am using Jesus Christ in my leadership to motivate them."

The matron: "Our mother on the ward"

Having risen to the rank of Principal Nursing Officer (PNO), a nurse can function as a matron on the ward. This old name is still used and applied respectfully. The matron normally arrives before eight o'clock on the ward and works till afternoon, meeting night, morning and afternoon shifts. The weekends are free for her.[3] The matron on the female ward is responsible for the staff, the nursing work and the general atmosphere regarding job satisfaction, patients' well-being and smooth cooperation with the medical staff. The aim is to present and sustain a white clean ward on which the patients can recover well and not be disturbed by noise, smell or uncontrolled working procedures. Being in charge of the supply of fresh bed sheets, she controls the making of beds and distributes the sheets in such a manner, that patient's own colorful covers are kept to a minimum and sufficient sheets are in stock for unforeseen circumstances.

In the morning, she starts with taking up, making rounds with the night nurse. At each bed, she greets the patient in one of the local languages followed by "How are you today? Have you had your bath already and could you go to the toilet? Have you taken breakfast?" She reads quickly through the notes of the evening and night shifts and goes on to the next patient. When she realises an incomplete note or remark, she calls the nurse on duty in front of her colleagues and the patients: "Hey, a balance wasn't made and here, the medication is finished. You night nurse, come! You always give it in the morning. What is our duty? You have to realise it on time and announce it to the day shift. Don't just wait till all is finished." Her tone is determined but friendly, and the nurses rush to correct their mistakes or omissions, apologising and laughing.

Before the official start of the shift, the matron calls the nurses for a moment of Christian devotion. Although the style of the matrons differs, all take care that the nurses come together, form a group, pray and share God's grace before splitting in smaller groups, turning to the patients and their different duties. She

[3] At the weekends, one of the nurses in charge takes over her position supervising the nurses and taking care of the equipment and supply.

further distributes the work and sees to its completion. In addition, the matron supervises the use of nursing equipment and hands out the daily supply of disposable gloves, spirit and plaster, needles and syringes which she keeps locked in her office. Depending on the number of available nurses, she orders them to work in pairs or individually, supervising students or teaching them on the bedside, distributing the medication in time and accompanying the doctors on their round. To make the duty schedule and supplementary writing work, the matron retrieves to her office. There she is regularly interrupted by nurses asking her advice, students or HCAs being sent for fresh sheets or gloves or other colleagues dropping by. On one occasion, the matron was disturbed again and again. "I want to work in peace. But they will not let me go, I cannot leave the ward even to drink some tea. They want to destroy me." A young nurse, laughing: "Yes, you are our only mother, so we need you." "You see, I cannot leave the ward."

The ward is operating with three different matrons and their characters vary. As described in the previous chapter, these three women represent different styles of managing the ward and supervising the group of nurses; two work in a more more distanced and corrective manner, one mingles with the nurses and is respectfully called 'our mother'. Matron Mary arrives each morning before the day shift checking on the situation on the ward. Around 8:00 she makes sure that nurses and students follow her on her round over the ward and pay attention to the information given during the handing over. Her communication style with the nurses is jovial; she invites students to ask questions and talks to each patient individually while passing the beds. A patient not wanting to drink is encouraged by her and gathering for a moment of devotion is important for her. Her approach is known to the nurses: "All come for devotion. Hurry up it is already late. Why do I always have to call you? You know when the round is made we gather for devotion before starting the work." To a student: "Hey, why are you hiding behind others? Are you allergic to prayers? You will lead us today." Matron Mary often works alongside with the nurses. She likes the practical bedside nursing, demonstrates procedures to students and checks on their work. Her appearance and attitude make her a central point on the ward. Both nurses and patients show their appreciation and give her respect.

Matrons Hilda and Esther are more reserved and work individually. While they also arrive before the day shift, they spend more time in the matron's office and at the nurses' table and call nurses to give report. They regularly make the round alone after the day nurses have already started work. This can lead to situations where the night nurse has to explain specifics twice, moving between the nurses' group and the matron. Their general approach towards their colleagues is more controlling and less informal. For them, the devotional moment is equally important as they join in but hardly ever take the initiative; this means

that on mornings where they are in charge, the prayer is occasionally omitted. Nurses and patients appreciate their knowledge but they start conversations less spontaneously. Nurses recognise these styles and act accordingly, they know the work must be done in time, but the atmosphere and tone are different.

Matron Mary defines her position mainly as a motivating one. Her motto is "Know what you do and do what you know". In her own work and function as role model, she realises this motto both in the nursing care to patients and her cooperation with doctors. Introducing new students to the work on the female medical ward, she says, "Make sure what you're doing is the right thing. So you know what you're doing and what you're doing is this all the same." Towards the medical profession, she acts as a colleague representing a crucial independent profession and requesting respect and collegiality.

> Be very proud to be a nurse. I don't think any doctor will step on my shoulders, I'll throw him out. You can only do that when you know what you're doing and you do it well. I'm not saying you should be rude to the doctors, but in playing back your coin on the music of nursing.

Reflecting on her work, she is critical: "We try our best, but it is not good enough. I believe in delegation and give responsibility to my nurses, but in the end, I am accountable for what is going on. I have the love for nursing, but at times it is stressful." Matron Hilda explains her duty as matron this way:

> The duties of a matron are doing the correspondence with outside, filing the requests for supply, ordering the patients' meals. I also have to write and give confidential reports about the nurses on the ward for promotion. I have to evaluate and ensure quality on the ward regarding nursing and the proper use of the equipment. Then also I do the schedule. We do not have many nurses, but I have to make sure there are enough in each shift, and they also have free days to recover. The nurses are working hard and know the work well. I have to check their work and keep them motivated.

In addition to the ward routine, the matrons meet on a regular basis with the DDNS to inform each other about the situation in the wards, share experiences and discuss improvements or new nursing ideas. Towards patients, they represent the ward and form an authority when it comes to dealing with individual anxieties and worries. They talk to the women, explain procedures, encourage them to eat well and rest, or read the Bible for consolation. One matron says, "I am their mother; I have to make sure they eat and drink well." The matron is also the first contact point for patients' relatives who have questions about their hospitalised family member or want to inquire about possible costs of treatment. Indeed, the matron keeps some patients' monies to pay for special treatment like chemotherapy, medications or examinations. In severe cases, she will take time to counsel patients or their relatives or explain planned procedures to them, trying to convince them of its necessity. Whenever possible, it is also the matron who informs

relatives about the death of a patient, inviting them to her office and consoling them during the first period after she had delivered the bad news to relatives.

The matron is respected by the nurses. Even so the style of the three matrons differs and one is more directly involved in the work than another, and nurses, students and HCAs accept and treat them as their role models and points of reference when it comes to the standard of nursing care. They all try to do their work accordingly and satisfactory. Students mention that they like to be taught by her for "she is supportive and sees us like her own children." Nurses appreciate her for "bringing good spirit on the ward" and for motivating them. "You see, even when we make a mistake, the way she will go about it, you don't feel like you are nobody." Also, nurses like their standing with regards to the medical staff. "Our matron is so strict that doctors accept her and do not want to mess with her. She is a good matron and does not make any differences."

Nurses: Present day and night

The group of nurses is in itself divided into senior and junior nurses. The younger ones learn the daily procedures from the more experienced ones and have only limited influence on the routine and set up of the work. Innovations through new nursing ideas and adaptations to the situation are difficult to implement. Most nurses interviewed said that they had not opted for work in the medical unit. The work is seen as extremely exhausting, and nurses perceive it as offering little reward given the high mortality rate. Some older nurses mention that they now like the work as "you learn about all conditions," but younger nurses seem to experience the situation as challenging and depressing. Changing wards or even units can be done by making a request to the matron, and is decided on a few times a year. Given the negative perception of the unit, very few newer nurses opt to come and replace those who want to change. Regular promotion takes place about every five years, depending on the individual's work and evaluation by the senior nurse and matron. The DDNS and matron try to encourage nurses to attend workshops and improve their skills, leading to higher motivation and promotion chances. Their hope is to keep the nurses on the ward so that they will not entertain the desire to leave for other units, private clinics or work abroad where the workload and emotional burden are thought to be less heavy and the pay is more.

The group of nurses differs by shift. During the morning, between two and five nurses are present; in the afternoon two or three work a shift before two nurses take over for the night. On the medical ward, there are nurses who arrived shortly after their graduation, nurses who were trained under the old program of enrolled nurses, and nurses who reached higher ranks through promotion and years of experience. They form a group of various ages, levels of nursing experi-

ence and routine on that specific ward. Their work distribution changes according to their number and the seriousness of the thirty patients' diseases. When students and HCAs are around, they are asked to make the beds and check vital signs; otherwise the nurses do that work. Clearly the dressing of wounds, caring for seriously ill patients and completing the written documentation is the nurses' duty, next to handing out medication and accompanying the doctor's round. As the table below shows, there are regular tasks to do, but the individual patients' conditions demand adjusted working schemes and changing priorities.

Depending on the number of seriously ill patients, some nurses specialise in caring for them while others remain in charge of the ward and supervise the work of the students and HCAs. Generally, there are no differences within the nurses' group, but the work is redistributed every shift. Much functional care is carried out and not individualised; the care plan is hardly used. Martha says: "Everybody here can do every kind of work, whoever has time does it, and there is no division of tasks." Looking closer, it appears that the distribution of work is organised top-down. Cleaning the trolleys and tidying up the lockers are almost exclusively done by the HCAs and students. Simple nursing tasks like making beds and assisting in feeding are done by students whenever they are available. Tasks that are clearly carried out by nurses are the medication round, dressing of wounds and assisting the medical staff in rounds and examinations. One nurse is specialised in care for patients with severe wounds like Stevens-Johnson syndrome, another one followed courses on patient counseling and social care aspects, and two nurses are assigned as preceptors to students on the ward. Nurse Grace says, "We are just encouraging each other. It is a very nice atmosphere. We are one in everything, that's what keeps us going."

As described in the previous chapter, working in the night is a special challenge to all nurses. In the night, there are fewer nurses to do the work and no matrons to oversee the work or take decisions. At the same time, the medical staff is absent and can only be called in for emergency situations. Patients are expected to sleep. Nurses and patients alike often feel uncomfortable in the darkness on the ward. Insecurity, pain, and the fear of death approaching in the night keep patients awake and restless. Nurses are to comfort and console suffering patients and to handle their own anxieties. At the same time, working in the night gives the nurses more freedom though the absence of higher authorities.

Generally, the atmosphere on the ward is supportive and encouraging. Even so, working conditions are challenging. Coherence and solidarity among the nurses is high and they endeavour to complete all work and avoid mistakes or sloppiness. Nurses who are friends try to work in the same shifts and help each other out, when private issues (like family reunions, funerals or church activities)

Table 9 Regular working duties on the ward

Time	HCAs	Students	Nurses	Matrons
7-9	Shift starts at 8, HCAs clean the ward, feed patients and make beds	General start at 8, degree students arrive around 9. Duty of bed making and feeding	Night nurses write reports and do medication, inform relatives during visiting times, day nurses arrive Morning shift takes up	Arrive around 7:15, talk to nurses, patients and relatives, call in devotion and distribute the work
9-12	HCAs assist nurses, clean trolleys and lockers, collect medication at pharmacy	Students assist nurses in wound dressing, vital signs, bedbath, admission, collect medication at pharmacy, make care plans	Nurses carry our care activities, wound dressing and supervise students and HCAs, do documentation, admission and discharges, go on doctor round, do medication round	Matrons do general supervision, check reports, supply equipment, have contact with doctors, attend meetings with other matrons, return to their office for specific work
12-15	HCAs go to pharmacy, CSSD, empty urine bags, do tube feeding, take a break, are on call till the afternoon shift takes over	Break, they assist in medication round, finish work before afternoon shift takes over	Nurses do medication, take a break, welcome new admissions, discharge, finalize reports and notes Afternoon shift arrives and takes up,	Matrons are on and off the ward and in the office, talk to relatives, supervise staff, break
15-18	HCAs assist nurses, care for patients, clean the ward and sluice room, empty urine bags	They assist nurses, check vital signs, learn procedures, practice care plan	Nurses care for patients, react to special situations, supervise students, do writing, medication round, have contact with visitors	Matrons finish the work, supervise and motivate nurses, react to nursing situations
18-20	Finish work	Finish work	Nurses finish day tasks and hand over to night nurses	Matrons leave the ward
Night	HCAs assist night nurse, make balances, care for patients	Students spend only few nights on the ward during their training	Nurses care for patients, give night medication, finish writing and day documentation, react to specific care situations	Matrons are not on the ward, there is one SNO in charge for the whole unit

Source: Data collection of the researcher

demand a change of shifts during the week or on the weekend. Some nurses attend workshops or additional training to enhance their further specialisation. Each nurse has about one month of vacation a year. They sign up on a list, and it is then the matron's responsibility to be fair with the regulation of it.

Students: Exposure to reality

Nursing students stay relatively briefly on a ward. This means they are there for several weeks before moving either back to school or to another ward. As a consequence, the wards are sometimes well-staffed with three to seven students, some almost inexperienced in their first year ,and others close to writing their final examinations. At other times there are no students at all. This makes planning and regular work distribution difficult. As extensively described in the chapters of Part I, many students are not aware of what nursing entails till they arrive on the wards. Exposure to severely ill patients poses a serious challenge to most students. They hardly talk about their experiences. In their work, they appear insecure and often reluctant to react appropriately to upcoming nursing situations.

The main task of the students is to do the work that is given to them. After arriving on the ward, they look for trolleys to be cleaned or beds to be made before the official duties start, when the matron calls for devotion and then distributes the work. Regular tasks are making beds, checking vital signs, cleaning the ward, and assisting nurses in dressing wounds and making rounds. It seems also unclear to them what their task on the ward is; some see it as exposure to the ward reality and others use the practical days to learn or practice procedures like hair washing or oral hygiene.

Depending on the years of training, students may lack factual knowledge about diseases and symptoms. This regularly leads to misunderstandings and wrong evaluations of situations. Given their age and the tasks to perform, they seem to feel more attached to the health care assistants, learning from them and taking breaks together, not mingling with the nurses. They hardly dare to ask nurses for explanations or concrete supervision, or to discuss procedures that have been carried out. The nurses sometimes check the work of the students, check vital signs or look after procedures that have been carried out. Generally, the students report to them when they finish their work and leave the ward when their shift is over.

The DDNS meets all students before distributing them to the wards and explains the main features of medical nursing to them. She encourages them to ask questions and involve themselves in the work, and she also stresses the importance of self-motivation and eagerness to learn.

> If you're not too sure – ask a nurse for clarification. You are here to learn. And you have to show a lot of respect on the wards. Some of you try to run away, we don't like that. Ask the matron 'can I go? I'm going home'. This is what you are supposed to do. Some even decide not to come because you are many and hide in the crowd, but we will see it. You understand. You are now starting your occupational life. So you need to devote a lot of time.

Asking the matron about her view of the students, she says:

> The students keep on coming. There's a period in the year when students come in for only one week. You have just one week to teach them. By the time they are able to do something, they move to another ward. Then another batch comes. So you remain in the same cycle… so you end up exhausted. You can see immediately who is interested and will be a nurse; with many of them, I have my doubts.

Both quotes show that the nurses in charge of the work in the department have their doubts about the students' motivation. Given that the students always come in bigger numbers, the individual student remains unnoticed; they are perceived as one group. In many situations, the nurses do not know the name of a student. In daily work, students are seen as workforce that helps to do all routines and finish the work on time. They are reminded to be humble and obedient, to dress neatly and cleanly, to reflect the well-educated nurse and woman.

Health Care Assistants: The blue helpers

For several years, the Ghana Health Service has tried to find a solution to the shortage of nurses. In 2002, the Ministry of Health introduced health care assistants (HCAs) as helpers on the wards. They are young women (and some young men) in their late teens or early twenties. Having finished secondary school they were not able to continue their education or study straight away due to financial problems or unsatisfactory grades in their final exams.

The training of these assistants is organised by the hospital itself. At Korle Bu Teaching Hospital, it took initially six months in school (at the in-service-department), followed by two months of practials in various units before being posted on a ward. In 2005, the shortage of nursing staff on the wards had increased and it became necessary to train the assistants for a shorter period and post them on the wards faster. The training was shortened to seven weeks in school followed by a two-week practical experience. A teacher at the in-service department explains:

> In the last two years, we have trained more than 60 HCAs. This year (2006), more than 200 have been trained already. We train them here only for three months; we cannot go into too much detail. We make it very clear to them that this is not a real profession but they should use the time to better their grades, develop an interest in medicine or strengthen their interest in nursing.

In the medical unit, each ward has three to five HCAs and they work in both morning and afternoon shifts. The older ones also work in the night. This group

is itself divided into the older, more experienced ones and the newly trained girls. Since the former have gathered practical experience and routine, they are more respected by the nurses and are involved in nursing activities. The freshly-trained ones are mainly given orders, as their knowledge of medical diseases and nursing standards is generally limited. Working under the supervision of nurses, their tasks are supportive, like making beds, cleaning nursing utensils and the sluice room, and assisting the nurses. As mentioned above, many student nurses relate more to them than to the nurses and work with them.

Asked about their work and motivation, most HCAs claim they are aware of their position on the ward and see this job as a temporary period before starting a proper training or study either in the medical field or in a completely new area. Rose was part of the first group and has been working on the ward since 2003. She knows the routine and sees herself working alongside the nurses. In her view "We are doing all kinds of work. I know a lot and the nurses do give me tasks with responsibility, like admitting patients. Also, when I am on night duty, I work hard, like a nurse. But yes, there is a hierarchy, the nurse is above me." At the same time, she is not aiming for a nursing career: "I applied to a school but they didn't take me. I think they do not like us assistants; we are critical as we know the reality. I am now following courses in tourism and will leave soon." Lisa is a recent arrival on the ward and is overwhelmed by the work. She tries to avoid intense contact with patients, volunteering to go to the pharmacy or do paper work instead. Regularly, she feels ill and reports sick. Nurses and assistants alike assume that the work is too heavy for her and she should quit. Peter, one of the few male assistants is confident and knows his position: "We know what we have to do on the ward; we do not wait till the nurse tells us what to do. In the morning you can start feeding and it is our responsibility to prepare the trolleys for wound dressing. We do the same things as the students – check the vitals, dress wounds, make the beds, wash, serve the bed pans and feed. Only if there is a new dressing we have not seen before do we ask a nurse or the matron, and then they teach us. You go and do your work alone and do not wait till you are told to work."

Nurses are critical of the health care assistants. Even though HCAs help with basic nursing, nurses see them as a burden and a threat to the nurses' status. Some accuse them of being lazy and of running away from work, while others see them as threat to the prestige of the nursing profession. During the breaks, they rest at different places. Sometimes a nurse orders an HCA to buy her food at the streetside or do other small jobs for her. The matrons assign them work and evaluate their activities but are not enthusiastic about the HCAs: "These young girls crowd the ward but are non-professionals. We will need well-trained nurses to keep the standard up. What can we do? We try to train them to guarantee a

certain standard, but we are lost. Those fresh from school do not know anything." Also the DDNS is critical and sees negative consequences for the nursing profession:

> These HCAs are a new thing. I am not too happy with them. They do not know a lot and are not supposed to do any important work but assist the nurse with basic tasks. We have to talk a lot to them and explain everything to them. So it is not only a help. We have to take care they are not taking over and lowering the image of nurses. In the end there will be only one examined and experienced nurse with all the HCAs, and she has to take the responsibility and give medications and do the superior tasks. We have to take good care and protect our profession.

The self-evaluation of the presence and influence of health care assistants contrasts with the perspective of the nurses and is an essential part of the power balance on the ward. They see themselves as necessary helpers to manage all the nursing work done but receive little respect from the nurses. Some end up going into silent resistance by hiding from work, prolonging the break or slowing down in their activities. Others respect the hierarchical structure and perform their tasks obediently, hoping for recognition in the form of compliments or a rise in responsibilities. They hope the work they do is seen as a crucial and essential part of the daily routine. The latter hardly happens and the nursing body forms one white group in which they include some green nursing students while the blue helpers remain outsiders.

Conclusion

Analysing the scenario described, three aspects become apparent: nurses on the ward fulfill and reshape forms of hierarchy, display and embody levels of differentiation, and balance the distribution of power.

Each profession is organised according to hierarchical classifications. Working in a hospital where various professions meet and have to collaborate, the logic of differentiation seems vital for its survival. Appearing as one group to the outsider, the nurses are divided in subgroups and each member shifts her position and influence on a daily basis. The health care assistants see themselves as crucial workers in daily health care management, but have to accept their subordinate position. Nursing students are socialised into this organisational principle mainly during their work on the various wards. Innovations are difficult to introduce, the shifting and sharing seems to work best within a strict top-down hierarchy in which freshly-examined nurses fulfill the obedient and serving role. Senior nurses are in charge, carrying responsibility and receiving most of the credit. Higher-ranked nurses distribute the work and reprimand nurses in public in case of negligence. Statements on the unity and decency of the 'noble profession' serve to encourage all members but also call for internal unity and prevent conflicts. Criticism within the group can only be uttered in undertones. The Di-

rector of Nursing is respected as the highest representative of the profession and is expected to improve working conditions. Dissatisfaction with her management style is evident but not openly discussed. Being embedded in a culture of respect for and obedient to the older generations, this hierarchical order is not challenged.

Differentiation within the group is mainly displayed in the uniform. The white dress symbolises the decency of the profession and is at the same time an indication of discipline as a distinctive feature of the profession. Through her pure appearance, each nurse- including assistants and students- is categorised and expected to know her place. A neat dress is appreciated and confirms her position. Higher-ranked nurses use their own uniforms to demand respect and display authority. They derive from it the power to correct and discipline younger nurses and students. In this way, the white uniform acts as a mean of inclusion, excluding all caregivers wearing other colors.

Hierarchy and differentiation serve the goal to balance power distribution. This power is daily challenged by the flexibility nurses need to manage everyday duties. The profession and its working conditions are marked by insecurity and incalculability. The limited and changing staff number, the fluctuating health status of the patients with their specific needs and demands brought from outside require nurses to react and reshape their work as an individuals and a group. At the end of the shift, the work needs to be done irrespective of those unpredictable factors. In times of manpower shortage, the matron will help with basic nursing care and students are given more responsibility. At other times, roles are fixed without any question. Defining and redefining the resources and aims leads to a balance; its success influences work satisfaction and solidarity among the group. Nursing directors and matrons are careful about controlling and demanding too much from the nurses, as the nurses have ways of resisting their power. Hiding from work, prolonging breaks, having the uniforms sewn in a slightly provocative style, are a few examples of this resistance and both sides know and recognise these actions. In addition, most nurses feel proud to be working in that academic hospital with its high reputation in West Africa. They feel being part of the nursing profession that represents Western medicine and modernity. All participants in the health service – caregivers and care seekers alike – have expectations about appropriate health service. In order to manage the unpredictable and keep up appearances, control and power is displayed openly and covertly alongside statements regarding unity and cohesion.

12

"You are not supposed to cry, it does not help." Death as a daily companion

> When they cannot do anything again, they refer them to Korle Bu. So this place becomes like a graveyard. (Matron Mary)
> You come alone into this world and you go alone, that's all. You have to take the good times and also accept the bad times. We nurses have seen so many dying that after some time, you get used to it. There is nothing you can do. You learn to deal with it. (Susan)

Sophia, the young health care assistant enters the ward to start her afternoon shift. She addresses her colleague Joy: "Good afternoon, how is the ward?" Joy replies: "It's bad. Oh, we were very busy; today I am not happy." "What happened?" "This morning, two patients died on the ward."

Agnes, a young trader arrived a few days ago as a referred case from a smaller hospital. She suffers from gum bleeding and she is fairly ill on admission, though a concrete diagnosis could not yet be given. At ten o'clock this morning, she becomes restless. Oxygen is applied through a small tube to ease her breathing difficulties and as she starts sweating. Nurse Grace removes the thick blanket and places a bed sheet over her. Agnes gasps for air. A young doctor takes blood for a blood transfusion 'to fill the system'. It is difficult to find a vein. Suddenly, the patient becomes motionless. Doctor Boateng, a young female ward doctor and Nurse Grace get busy. The nurse goes for Atropine while the doctor checks the patient's pulse at the carotid artery. She starts a heart massage. No folding screen is set up, so other patients observe the scene from their beds while a group of ten medical students is busy with a lumbar aspiration at the neighbouring bed. The doctor exclaims: "She is coming back, I will go on. As long as she is here, I have to go on, I cannot stop, help me." Grace arrives with the medication and passes it

to the cannula. The doctor calls a colleague to look after the blood transfusion. A few minutes later the doctor stops the resuscitation attempt and takes a step back, looking disappointed and sad. "She is gone." Grace: "This morning she swallowed the medication. It was very sudden. She leaves behind a small child. Her brother is outside, I will look for him."

They put off the oxygen and leave the bedside; Agnes lies on the bed uncovered. The other patients remain silent in their beds; some start reading the Bible. The medical students finish the lumbar procedure, chat and leave the ward. Grace writes the report of this death in the nurses' notes and informs the mortuary. Then she asks two younger nurses to prepare everything for the last offices to be done. They push the bed over the ward to the treatment room outside, making noise as the bed-wheels are not turning properly but leaving marks on the floor. A trolley is prepared with gloves, a syringe, three strips of gauze and cotton wool. One nurse wears a plastic apron on top of her uniform. Both put on disposable gloves and face masks. Agnes' body is undressed, the cannula, gastric tube and urethral catheter aret removed and thrown on the floor together with the diaper and her clothes. Then the eyes are closed, the ears and nose filled with cotton and the jaw is tied up with one piece of gauze[1]. After that, the hands and feet are crossed and bound together with gauze. Two strips indicating her name, hospital number and date of death are placed on her wrist and foot. Finally Agnes is covered with her bed sheet and left in the room. The nurses have not spoken during the procedure. They finish the work by packing the patient's belongings in a plastic bag. One hour later, the workers from the mortuary arrive to collect the body, an orderly cleans the mattress and pushes the bed back on the ward for the next patient to be admitted later.

On the ward, the routine work continues. The nursing students start to check vital signs. They arrive at Dora's bed; she was admitted last week diagnosed with liver failure. Two days ago she became semi-conscious and confused. This morning, she was taken to the computer tomography and returned sleeping about 30 minutes ago. The students cannot find a pulse and ask nurse Joyce to come and assist them. She checks at the wrist and neck, then takes the blood pressure machine and tries to find the blood pressure. She looks at the students and says: "She is gone." Joyce returns to the nurses' table and convinces the doctor relaxing there to certify the death. The students are asked to push the bed to the –just emptied- treatment room and another student packs her personal belongings in a plastic bag.

Death in the Ghanaian society is seen as part of life. A high child mortality rate (112 per 1,000 according to the WHO report 2005) and a life expectancy of 58 and 59 years (male-female) lead to a situation where death is omnipresent in

[1] This is done to prevent an open, yawning mouth when rigor mortis sets in.

daily life and regular funerals become part of the social organisation (De Witte 2001, Van der Geest 2004). On Fridays and Saturdays, small streets, compounds and churches regularly become places for extensive family gatherings, wakes and funeral ceremonies. Funeral announcements are posted along the streets, shops and on vehicles and videos and photographs of the funerals are willingly shown to visitors and friends.[2] In contrast to this, dying is supposed to happen alone and in a secluded space (Van der Geest 2002). Public opinion is such that dying is a personal and intimate affair and no other person should interfere. This does not mean that a dying person should be lonely, but surrounded by the care and prayers of family members. Having reached old age and being firm in the Christian belief that "I will return to my maker" defines the framework for a peaceful and good death. The phenomenon of being given water to drink on the moment of dying has been researched and is mainly understood as a symbol of a final intimate act of family care or a preparation to greet the ancestors. Indeed, as an elderly member of a Ga family explained: "Death to the African is not the end of one's life but rather, it is a transition from this physical world to the ancestral world. It is believed that if you die, you just leave this world to stay with your ancestors."

Dying and death play an integral part of the routine in the medical department. During the research period, between 16 and 26 patients died monthly on the 30-bed ward. This chapter describes the processes around dying patients and analyses their impact on nurses. It starts with the nurse's observation of a dying patient, carrying out the last offices and completing the written documentation. Then it turns to the reactions of patients and the notification of the deceased's relatives and finally it sheds light on the nurses' own emotions. It will become clear that the activities around dying and death in the medical setting both follow and compromise cultural and traditional norms in Ghana, leading to social and emotional dilemmas. As it is a universal conviction that people should die after a long and fulfilled life, serious diseases and unforeseen complications can lead to life-threatening situations that challenge this idea; people die young and before their time. Both the individual and the group around him or her have to deal with this and find an appropriate reaction. The introduction and omnipresence of biomedical care gives hope but also has to deal with limitations and the feasibility of its medical claim in the Ghanaian culture.

Nurses' work

Dying on the ward happens in most cases suddenly and is not immediately noticed. The above examples illustrate that in cases of some younger patients like

[2] In Kumasi, funeral notices are mounted on giant billboards and banners along or across busy streets.

Agnes, resuscitation efforts are made and are later mourned when these are unsuccessful. However, most older patients like Dora die unnoticed. Many patients arrive at the hospital in a condition labelled as seriously ill and weak, but neither the medical staff nor the patients and their relatives ever discuss an imminent death.[3] Only a few patients are aware of their deteriorating health as a consequence of terminated treatment. In such cases, the financial burden due to necessary medication or technological examinations becomes too much for the family and the patient remains on the ward with minimal treatment. Stopping dialysis or chemotherapy results in a death. Such a decision sometimes comes from the patient herself mentioning her wish to spend the money on the family instead or 'just happens'. It is never a discussion including medical and nursing professionals on the remaining quality of life. A sudden death refers to situations when nurses label the death of a patient as unforeseen. Nurses recall such situations as when a woman "was fine in the morning, she talked to her visitors and had her breakfast; then her mood changed, she lay down to rest and died all of a sudden, it went fast.' Another patient was remembered as 'she was ok, I spoke to her yesterday. She might have aspirated some food because when we looked she had vomited all over; we did not expect this." This is different from an unnoticed death that seems to have occurred while nobody was aware of it. In the written documents it reads thus: "she was observed to have ceased breathing." Others are found dead when nurses approach them for an activity like checking the vital signs or to wake them up in the morning. All situations have one thing in common: That patients die alone. Even with those women whose health slowly deteriorates and whose death is imminent, nurses decide not to take any action but leave them alone. This became explicit when a 43-year old women diagnosed with pneumonia and suspected tuberculosis became weak and unconscious. She was washed and tube-fed by her mother and sister who then sat at her side praying with her. Two nurses asked her relatives to leave and then checked her pulse. It was weak and hardly palpable. One nurse squeezed her finger and noticed a slight reaction. "Oh, she is not yet gone. Let's give her more time, we will wait for a while." Both nurses went to do other work and when they returned fifteen minutes later to check again, there was no reaction. "She is gone, let's call the doctor to certify her death." Only on a few occasions is death seen as a condition that should have been prevented and fought against as described in the beginning. During the research, two similar events happened when a young woman died suddenly and both nurses and doctors started resuscitation. Sucking machines were connected, heart massage started and medication was administered. The women died several minutes later.

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[3] The cultural norms of avoiding discussing medical conditions and expressing emotions were analysed also in Chapter 14.

After a patient is declared dead, nurses have to fulfil two duties: execute the last offices and document the passing of the woman in several files. Two nurses normally carry out the last offices in the treatment room just outside the main ward. Nurses do not like to do this work and try to avoid doing it. Younger nurses and nursing students express fear of the dead bodies, and the physical effort adds to the work labelled as tedious. The deceased uncovered woman is brought in her bed to this place, passing other patients. Asked for an explanation, nurse Edith says: "The patients that we push out and prepare for the mortuary are many in number. These days when patients die, we don't cover their faces. Some time ago, as soon as you died we would cover your face before pushing you out, but now we just push them out. The other patients got scared. We would sometimes say they are being taken for an examination or something like that. The other patients do realise somebody has died and might tell the relatives. In such cases, before the relatives are informed officially, they will have been told by other patients, 'Oh they pushed her out'. It should be a nurse who informs the families about the death, not a fellow patient. Patients are the first people to make noise, so we try as much as possible to stay silent."

Nurses hardly speak to each other while removing the clothes and (para-medical) devices in order to prepare the dead body for the mortuary.[4] There are no common prayers or sayings to mark this transition; at best a remark is made about an untimely death, a patient's last physical condition or the difficulty of doing this work with insufficient equipment and gloves. Used sheets are thrown on the floor and the deceased is finally wrapped in a cloth, preferably one of her own. Edith explains: "Otherwise, we lose too many of our own sheets; they are never returned. And there were several reasons that made us stop using the body bags. One is that it did not look nice. Another reason was that they only had one size, and many fat people did not fit in it. Finally you know our climate. The bodies in plastic seem to start rotting in the bags due to the warm weather and insufficient cooling. There were just too many negative points, so we do not use them any longer. We got used to seeing the dead bodies." The dead women are left there till the mortuary workers come to the ward. They place the body on a stretcher and bring it to car, collecting bodies from all the wards. There are days they have to come twice.[5]

The second duty is to do all the paperwork involved. Before closing a file and bringing it to the administration for bill assessment, the cost sheet is completed by adding cotton balls, gauze, a syringe, gloves and facemasks to the list. While

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[4] During this procedure, jewellery like earrings and wedding rings are removed and kept aside to be given to the relatives. Traditional strings of beads wrapped around the hip or neck remain on the body.

[5] For the role and function of mortuary workers, see for example Van der Geest (2006).

reporting in the medical file is the responsibility of the doctors,[6] nurses document procedings in their nurses' notes and in the 24-hour report book. The nurses' notes often read like those in the following case of a 50-year-old woman:

> 6 am: Slept fairly well. Is very ill and weak.
> 8 am: Breakfast given and little amount taken. Assisted with her personal hygiene and made neat in bed.
> 9:45 am: Oxygen inhalation started as patient was observed to have difficulties with breathing.
> 10:30 am: She was observed to have ceased breathing. Dr. Mills called to certify the death. Last offices done. Body collected at 1 pm. RIP.

The report in the 24-hour book resembles these notes; there are no indications that the situation changed or became life-threatening. The only variation is whether "she was observed to have ceased breathing", "her condition deteriorated and she ceased breathing" or "her condition changed suddenly and she stopped breathing". It is, as mentioned before, very rare that a patient dies under acute circumstances that ask for resuscitation and medical emergency. The files do not give account of any nursing activities or reactions concerning the death. The style is factual and short. For statistical and administrative purposes, the name, age and diagnosis of the woman is listed both on the daily ward-state paper (translated into an 'empty bed') and on a monthly poster hanging on the wall, joining those who had died earlier. Finally, announcing the day and time of her death in red ink completes the woman's entry in the ward's admission book.

By then or the next day, the assessment of the bill is done and the relatives are informed of the amount to be paid when they come to take the belongings away. They take the file to the accountant and return with the file and receipt. The death certificate is written days later, long after the body has been taken to the mortuary and the bereaved family has paid the outstanding bill to the hospital. The doctor has to fill in two copies of the death certificate form. One remains on the ward in the book and the other is given to the relatives once they bring the receipt of the paid bill. They write their name, address, date and relationship to the deceased on the back of the part that remains on the ward. Thus, the bill receipt and death certificate are exchanged. With the death certificate, relatives can now go to the mortuary to collect the body for the funeral. If the doctor decides that a post-mortem (PM) should be done, collecting the body takes longer, sometimes up to a few weeks. In such a case, the deceased's relative takes the file and the postmortem request to the mortuary, identifies the body and returns with the file. Nurses play an informal but crucial role in this process. Next to the obvious

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[6] The medical files report on the daily doctors' rounds, the treatment plan and the patient's condition. The dead of the patient stops this report. It mainly reads; 'was called to the ward to see that patient who was reported to have ceased breathing at … Examinations done, death certified at … RIP. Signature.'

control of exchange, they are the main contacts for the relatives who have come to request the death certificate. Busy days prevent the medical doctors from filling in this form quickly; sometimes it takes days. It is up to the nurses to negotiate the conflicting schedules of the doctors (and their wish not to be reminded of their duties) and the desire of families to handle the papers, organise the funeral and come to terms with the death.

The following situation is characteristic of this dilemma: A man came to the ward early October to collect the death certificate for his deceased wife. "She died three weeks ago and we are planning the funeral in November. I want to see her. I am chasing up the paper. Yesterday, a young nurse told me I should come today. But I do not see my folder. Without the folder, I do not get the body and burial certificate. You have to understand that it is not easy. My boss will not allow me to leave my work everyday to come here and look for the things. Why is it still not done?" The nurses remain friendly and start looking for the file while asking the man to be patient. "It is not our fault if the certificate is still not written. We tell the doctors to sit down and fill out the forms, but this is all we can do. We are not in the position to force them. And you do not need to visit the dead body. They keep it well there, nothing will happen to the body till the funeral. They use formalin there to preserve them; you cannot enter the place anyhow. Once you have the certificate they will show you the body. She will be ok." Finally the file is found and the widower is relieved. He decides to wait outside till the doctors come for their round and ask them to write the certificate. Nurse Catherine expressed her joy: "Thank God we found it. Losing such a file is really a problem. They can sue you for losing it. Without a file, there is no death certificate and no easy and fast funeral. In cases where the cause of death is not completely clear, the doctors request a PM (post mortem). This is especially meant to avoid accusations later. You know, sometimes the relatives are outside when the patient dies, and later they come and enquire after the cause. They will come with all kind of ideas like food poisoning and so forth. In such a case, it is good if you have a clear PM. It not only protects us nurses, but also the relatives." This example repeated itself often, and the nurses have to manage the various expectations.

Patients and relatives

As has been explained, dying happens openly on the ward and other patients are witnesses. They are afraid and doubt their own fate while hospitalised. After one young woman died during the night, a patient tells me in the morning:

> This night I could not sleep. This girl died; she made so much noise. She was breathing strangely and then she died. They pushed her along past my bed. I saw her, her eyes were still open, like she was looking at me. Oh, I could not look at her and then it was impossible

> to sleep. It happened around half past three in the morning. I was afraid. Her relatives were outside. I heard them crying and shouting.

This remark expresses both her insecurity about her own health and the general fear of the night. It is widely believed that death comes at night. Therefore, many patients try to convince the nurses to leave some light burning and they remain awake, resting again during daytime. Another woman expresses her disbelief: "Why is she dying? I am much thinner than she is, so why her?" Another adds: "I am not better than those women, I could also lie in the fridge. So I pray, I pray God will save me and bring me home again." Younger patients are particularly vulnerable to what they witness. A father of a young sickle cell patient is concerned because "during her admission, she saw too much. The people were dying and she saw it all, she suffered a lot." Normally they do not speak about what they have seen but remain calm and prayerful, reading their Bibles or trying to rest. The nurses do not inform other patients of the death of a woman; they simply wheel out the deceased's bed and clear her locker.

Relatives are hardly ever present when their loved one dies. Nurses justify this with the disturbance of their work and possible 'misbehaviour' of the family members, as nurse Grace states:

> Dying patients do get our care. We look after them; it is just that we are understaffed. But relatives at the bedside will disturb us and we can't do our work.

An older nurse shares her experience:

> Some people cannot control themselves and will start crying. And this will disturb the other patients too much. And then the other patients will ask themselves 'Will I also die here?' So we normally do not ask them in. But when you ask the relatives to leave, they know what is happening and start getting used to the idea outside the ward.

Nurse Maggie adds:

> Yes, when they are about to die, we ask the family to go out. Some people cannot control themselves. They will cry and shout and disturb the whole ward. In Europe, you cry silently, but here, some people make noise or even fall on the floor or collapse. Also Christians or even nuns can collapse. I do not understand it, at least they should be calm, but they also cry and shout.

In general, the matron or one nurse who has had a special training will try to counsel the relatives, preparing them to anticipate the passing away of an admitted family member.

The nurses' perception of the relatives is biased. Traditionally, people are to die at home, cared for by female family members till the end. Death in a hospital is a recent development. Nurses see the driving force behind this in the changed perception of death, and also in several practical reasons. Death in the house can shed a dubious light on the family; suspicion about the cause of death might arise and old conflicts may be revived. Nobody wants death to enter his house. Vivian elaborates:

> They will wait in the house till the last moment and then rush the patient to the hospital. The same applies to the private clinics: Too many deaths give them a bad name; they refer their hopeless cases to us as a last resort. This is why so many people die here in Korle Bu. These are the reasons: People do not have enough money to come on time, are too sick and then they cannot buy all medications or do all the needed tests. Some have chronic diseases. You can see them tired after taking medications for 20 years. They decide to stop and just die. In other cases, it is the family that decides to stop buying the medications. Over here, it is the family that decides on your health. And then they wait till you are dead and they will spend a lot of money on the funeral.

Lydia adds: "People do not want their family member to die at home. In such a case, they have to report to the police and it becomes a coroner's case[7]. So they bring the women here when it gets critical and leave them." Another reason is a financial one. In today's Ghana, funerals often take place weeks to months after the person has died. In the meantime, the body is stored in a mortuary, referred to as 'the fridge'. These are linked to hospitals. The cost of the mortuary is lower when the person died in the hospital after being 'brought in through the OPD' instead of 'brought in dead'. Nurses are therefore not happy about the new role they are given to participate in the dying process. In their opinion, relatives withdraw from their duty to provide financial and emotional support when health deteriorates. They may do this by delaying the supply of necessary medication and reducing their visiting frequency. While relatives are kept out of the ward when a patient dies, nurses also feel left alone.

Breaking the news to family members is the duty of the nurse in charge or the matron. This is done preferably outside the ward in the matron's office or at the table. They ask the visitor to sit down. "We let them cry." In most cases they know already the poor outcome of their relative's health. The following situation is typical:

> Mary, died in the early morning. At only 48 years of age, she had suffered from various medical conditions, including diabetes, a peristaltic ileus and severe hypertension. She had been unconscious the last day and was on oxygen support. Her daughter arrives with two friends at 7:30 am to visit her. She notices the empty place and walks slowly to the table. Nurse Joyce is sitting there writing.
> "What happened to my mother?" she asks anxiously.
> "You sit down first."
> "I want to know what happened to her, tell me." She starts crying, looking at the nurse in hope and despair.
> "I am sorry, we lost her. Sorry."
> The young woman starts crying aloud; she stands up and starts walking to the place where her mother's bed stood. Then she stiffens and throws herself on the ground. Some patients look on, they know what has happened, but nobody speaks to her. Her friends also cry and help her to stand up. Joyce walks over to her and guides her back to the chair. She tries to make some phone calls informing the family of the death. Joyce talks to her: "Listen, this is a time of challenge. Today, your mother has joined the Lord in heaven. So let your life be a

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[7] A sudden and unclear death is labelled as coroner case. It is reported to the police who will then send for a post-mortem examination to exclude an unnatural cause like murder or poisoning.

> memorial for her, so she can be proud of you. The Lord will guide you through the days to come. Let the champion in you arise and stand up. Let your young life be a joy to our Lord. These challenging times are to show your strength and belief. You know that your Redeemer liveth, God is in control. Yes, you will weep and cry, but you will also live. Do not look down, stand up and rise, the Lord is with you. Now go home and inform your people. Come back later for the bill."

The nurses appear calm and sober in such exhortations. They refer to the correct procedure, the sudden death that could not be prevented, and the shared belief in God who takes care both of the beloved deceased and the bereaved family left behind. Such commiseration with relatives and patients is rare.

Nurses' emotions

How do nurses deal with their own emotions? Are they touched or indifferent, frustrated by their unsuccessful efforts or sad about another life lost? Being faced with death in such regularity poses the question as to how they manage their feelings and to what extent they can intercalate this in their perception of nursing. Two ways are followed here: nurses have their professional attitude leading to ideas and explanations of the patients' conditions that lead to death, and they have their personal convictions trying to find a way to show or conceal their emotions.

It is the nurses' general conviction that patients lack sufficient awareness of their health conditions and come too late to the medical centres. Veiling one's health problem, resorting to religious or traditional healers and being afraid of excessive costs at the hospital prevent timely hospital admission in many cases. The matron is firm in her condemnation of this attitude:

> All say: 'go to Korle Bu and die.' That is the Ghanaian attitude. So people come here when they have exhausted all their resources. They go round, round and when there's nothing for them to do, they come and if we can't do anything, the patient dies. And because of that I call Korle Bu 'last stop', or the medical block 'mortuary annex'.

Many nurses share this view and blame a traditional mentality when patients do not come in time. In their perception, managing seriously-ill patients is within their capability, but complications and lack of medical resources can lead to an untimely death. A nursing student captures it this way: "They won't come in their early stage, they come in their chronic stage. They wait till the thing has developed complications. They've gone to seek treatment from some herbal centres, prayer camps, other things. So most of the time, when they come, they come in their terminal stages. Nothing or little is done and they pop off. But those who come in their early stages, they are managed and they go home again." Relatives also play a role here. They are seen as the main religious, emotional and financial support to sick family members. It is supposed that when such support fails, the patient gives up. The death of a young girl suffering from

symptoms of paraplegia is explained by the lack of maternal support. The matron explaines:

> Her mother was very sad, she had given up. I saw her on Friday and she had no more power. I tried to talk to the mother to prepare her, but she was so fragile and tense, so I decided to leave her. There was nothing more we could do and the girl died two days later.

The reaction of the nurses to these situations is mainly to give nursing care. One of the nursing directors explains:

> What can we do with all these problems? Why should they start dialysis or chemotherapy in a chronic or complicated case? Let Thy kingdom come! We don't want to give false hope. All we can do is TLC – tender loving care. You see, again and again, death is laying its icy hands on our wards.

All nurses and nursing students express that 'empathy' is the attitude nurses have to show towards patients and relatives. The students repeat what they learned during their training, that "if you have this patient on a ward dying, the parents come weeping, crying and all that, you should not join them in crying. That's not professional, though we should be with them help them and help. We should empathise with them, we shouldn't get emotionally involved." Nurses explain that "those relatives are already stressed out because they also have other problems, so we should rather be there for them than joining them in their expressions of grief." Indeed even the health care assistants say that "if you're very emotional, you can't do this work; you should go and do something else."

On the personal level, coming to terms with death is not easy for the nurses, especially when a patient with whom they had established a relationship dies. This is particularly true in the cases of several young patients who died of leukaemia after years of repeated admissions and therapies. The death of one of them was one of the few occasions when nurses felt sad and cried. One expressed how all felt: "today is a sad day on the ward, there is no life in me." Susan summarises the situation:

> You are not supposed to cry; it does not help. You come alone into this world and you go alone, that's all. You have to take the good times and also accept the bad times. We nurses have seen so much dying, after some time, you get used to it, and there is nothing you can do. You learn to deal with it.

Martha adds her religious conviction combining it with her professional attitude:

> I am telling you, this ward is ruled by Satan. There are diseases you do not understand. It is wonderful. Things do happen here, am I telling lies? You sometimes work hard and think the patient is exaggerating and before you realise it, the patient is dead. There is nothing we can do but pray to the Lord to glorify His name.

The emotional burden of being faced with death in such regularity puts stress on the nurses. Students and nurses alike mention that they had not expected to see so many patients die and be overwhelmed by it. As most nurses did not opt to work on this ward but were posted there by the main administration, their appar-

ent emotional distance can also be understood as a mechanism to protect themselves and keep the level of frustration low.

Conclusion

Nurses on this ward are confronted with suffering and dying patients on a daily basis. They experience the dilemma that their hospital is known as one of the best places for medical treatment and cures, while at the same time it is associated with hopeless situations and death. Their profession teaches them to care for patients and support their healing processes, but many patients arrive (too) late or are brought in to die in the hospital instead of at home. Following this, conclusions can be drawn on three levels, concerning a dilemma between culture and medical practise, challenging practical issues and the concern for the hospital's reputation and showing an increasing medicalisation of death and dying in Ghana's metropolitan centres. Nurses have the task to bring together the contrasting views of the omnipresence of death and the unspokeness of the act of dying.

An untimely death is defined as a 'bad death' that can lead to suspicion and conflicts in the family. Certain forms of diseases and social behaviour are clustered as causing problems and can lead to a death that manoeuvres both the deceased and her relatives into a complicated social situation.[8] Nurses are aware of this but find themselves exposed to possible reproaches and accusations. They try to avoid being involved in such a 'bad death' and its circumstances, or turn it into a 'good death'. Two features contribute to this behaviour: In verbal communication and statements, nurses strengthen the apparent well-being of the patients, while on the ward they are content with the 'suddenness' of death. This also corresponds with the attitude to keep illness, and dying secret and secluded. While nurses might make judgments on the patient's behaviour and (unsatisfactory) compliance with the hospital treatment during admission, this stops with the death of the patient. It is only with aged patients that it is said that "they were old; it is good they died, there was nothing we could do for them in this world." Otherwise, the death of each person is labelled as 'sudden and unexpected'. In addition, the standardised ways in which nurses' notes and reports are written do not reveal the concrete circumstances of the death, nor do they give any individual assessment of the last moments before death. Reading the files, the patients were weak, received bodily care and feeding. It is up to the medical doctors to define the cause of death or request a post-mortem examination.

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[8] Death as the consequence of undefined or untreated diseases and the consequences of accidents is in many cultures labelled as 'bad' or 'bothersome death'. See for example Lerer *et al.* (1995) on infant mortality in South Africa.

The Christian belief both of patients and medical staff plays a crucial role in helping them to place death in their lives.[9] Praying in front of the patients, reading the Bible (both patients and nurses) and affirming one's trust in God's ultimate plan are regular expressions of individual belief. Death is labelled as a transition to eternal life in the absence of pain and suffering.[10] A common expression is: "If it is her time, she should go meet her Maker and rest in perfect peace. If it is not her time, God should glorify His name and make her return home so that our work is not in vain." Nurses mention their religiosity as one motive of choosing the nursing profession, and say it supplies them with mental support to cope with the situations on the ward and organise their own emotions. Giving 'tender loving care' is inspired by the Christian view, and nurses say, "It hurts but we have to be strong to support families. It does not help when you break down. You need to support the relatives and let them cry. With some patients, you know there will come a day they come and do not leave again." By holding on to their religion, nurses are able to manage their emotions and do their work on the ward. Mourning is the task of the family in preparation of and during the funeral rites, and nurses do not normally attend funerals of their patients. Individual moments of grieving and sadness do occur among the nurses but are preferably kept secret. Christian hope and cultural norms dictate self-restraint and form the base of their facade.[11]

Most researches on Ghana emphasise the importance of dying in one's own house, preferably in one's own room and after being served some water to drink. The phenomenon of dying in the hospital occurs more and more often and challenges this ideal. It can be understood as an indication of the increasing role Western medical care is given by today's society. The patient and her family decide on a hospital admission despite its costs hoping for therapy and a cure. Most patients expect to leave the hospital cured and a deteriorating health condition anticipating death is not openly discussed. At the teaching hospital, roughly two groups of severely ill patients can be met: Chronically ill patients suffering from a severe form of hypertension, diabetes, liver and kidney disease or cancer, or acutely ill persons admitted or referred after an uncontrollable disease outbreak. As life-threatening diagnoses are often hidden to avoid emotional breakdown, discussing the possibility of an early return home is not encouraged. In addition, family members seem to have an interest in a hospital death. When their

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[9] Most patients and all nurses were Christians of various denominations, ranging from established churches to Pentecostal congregations. Only few patients were Muslims, therefore my analysis focuses on the Christian group.

[10] See Spronk (2004) on a Biblical understanding of death; its core message was also told or even recited to me during interviews and conversations with Christian Ghanaians.

[11] Van der Geest (2002) describes the construction and display of cultural norms with regard to death. Geurts (2002) explains the concept of 'balance' as a major characteristic of adults in Ghanaian culture.

health conditions deteriorate, patients express the wish to return home (to die), while family members might prefer them to stay in the hospital and out of the house. The brother of a seriously ill patient formulates the problem: "Look at her, she is not walking any longer. I don't know what to do. She remains in bed and the hospital costs pile up. But at home we cannot help her, as we do not know when she is dying. We do take people home to die, but only if there is somebody to take care of them. There is nobody in our house, so she has to stay here." The dilemma often remains unresolved as the patient is too weak to force her way home, and in the end time decides. As described above, organisational and financial reasons also play a role here, namely the complicated police investigations if a person dies unexpectedly at home and the reduced mortuary fees for in-patients. Relatives want to avoid accusations of having caused the death of a family member or having been negligent. By admitting her to hospital, it is shown that all has been done to try to save her, and neither trouble nor expenses were spared. Mentioning the hospital as the place of death on the funeral announcement can be understood as a supporting aspect of this idea. Tijmstra (1987, 1989) also found such behaviour among relatives of transplant patients in the Netherlands, calling it 'anticipated decision regret'.[12] This term explains the behaviour of relatives who try and support medical treatment in order to avoid an anticipated feeling of regret ("we haven't tried everything") later. The Dutch context of course differs from that of the Ghanaian by, for example, working within the framework of a health insurance system and allowing for a more open discussion of possible options and the risks of a given therapy with patients and their families.[13] Therefore, the idea of an 'anticipated decision regret' is only related to the decision of the families to admit a patient and leave her in hospital to die.

The reasons given above do offer an explanation as to why so many patients die on the ward. The question remains as to how nurses deal with this and, maybe more prominently, why patients are left alone in this situation. It is against most cultural codes and convictions to die alone and this is avoided whenever possible. On the ward, however, the patient is left by herself to die, and relatives are asked to leave. Nurses do not take additional action to emotionally support or soften the dying-process. The concept of palliative care and pain-reducing medication is absent on this ward. The line between being left alone and being abandoned is hard to draw in this situation. It was also suggested during this research that such behaviour creates a legitimate way for the dying to send all relatives out of the

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[12] The original Dutch term Tijmstra introduced is 'anticiperende beslissingsspijt'.

[13] The high costs of therapy and medication are in the Ghanaian situation rather a cause for late admission and delayed treatment. Families find themselves in the dilemma of choosing between desired medical intervention and practical financial problems. See also Chapter 14 on the relations between patients and their families.

room (to get the water) and die peacefully and alone. In doing this, the dying person can keep her dignity and show neither fear nor emotional agitation. An older woman in Accra confirms that "people here want to die alone. When you are with them, they cannot go. You have to give them some space to leave this earthly place. This is why they ask for water or other things, just to send you away." In that light, the apparent negligence of nurses concerning dying patients can be understood as a way of establishing an atmosphere of dignity and seclusion for the person to die. A Ghanaian Christian minister suggests that "In hospitals or at home, when people are going to die, we believe that the soul/spirit moves out of the body. It is a moment of struggle, and sometimes it is a bit difficult for the soul/spirit to move out of the body when there are people around. So in hospitals, the relatives of the dying person are driven out or kindly asked to go out. The period or the moment of death is a critical moment which many people in Africa are not able to withstand." The nurses seem overwhelmed but display a professional attitude, appearing knowledgeable and in control. The individualised and emotional care for the dying person that is so crucial to Western nursing theories is not (yet) practised in the Ghanaian culture. The predominant goal seems to be having a quiet and well-ordered ward with patients resting in their convalescence. Each death forms a threat to that goal and challenges the nurses.

Finally, it is clear that there is an increasing medicalisation and professionalisation of dying and death in Ghana. Similar to developments in America, Ghanaian narratives of the dying become increasingly medicalised stories (Rubinstein 1995, Long 2004). Sick and dying persons are admitted to the wards. The patients surrender and try to comply with the medical system, their relatives hope for successful treatment through Western biomedicine that will be within their financial means. The building, the machines and the pharmacy as well as the medical doctors and nurses represent this last hope, but sometimes turn out to be part of a fictional feasibility. The dying patient and the nurses meet on the ward and remain distant. The clash of religious, financial and family obligations with the medical, laboratory-based, individualised system leads to intricate, interwoven dilemmas. All this makes dying on the ward an awkward and undesired situation displaying the problems of the current state of the Ghanaian health system.

13

"By the Grace of God, we are fine." Religion on the ward

> We are all Christians. Don't let God ask you, 'When I was sick where were you?' because He manifests in the patient. I get my blessing when I come to the hospital. Any given time of the day, our motto is 'nursing Christ in the patient'. Whoever is sick, He is there. (Matron Mary)

The morning visiting hour is over. Just after 8 am, the night nurses have finished their nursing documentation and have administered oral medication to all 30 patients on the ward. The morning shift has arrived and is getting ready to take over. Matron Mary calls all nurses to the table. Four nurses, three assistants and three students gather and form a circle. "All come for devotion. Hurry up, it is already late. Why do I always have to call you?" She calls a student: "Hey, why are you hiding behind others? You will lead us today." They start by singing a short song, and then the student prays in Twi, asking for healing mercy and support for the work of the nurses, accident-free transportion for the night nurses back to their destinations, a cure for the patients, and strength for all. Some nurses confirm by calling out "Yes, Jesus come", "Amen" and "Soak us all in the blood of Jesus!" Then the group says the Lord's Prayer together, followed by the sharing of grace. The nurses form a circle holding hands. "Let's close the circle, let the chain not break. 'The grace of our Lord Jesus, the love of God and the sweet fellowship of the Holy Spirit shall be with us now and forever more. Amen!' So now, let the work start, form pairs and start making the beds. We have some bed sheets, take them with you. Hurry up!"

This religious ritual takes place every morning on the ward. In case the matron is absent, the nurse in charge takes over and calls the group together. On most occasions, a young nurse or student is asked to lead the prayer. It is a crucial moment in the morning routine and sometimes it happens even in a jocular way,

like sister Grace who calls, laughing, "Let's come and pray. Don't be so shy, or are you allergic to prayers? Or do you worship any Buddhist tradition? Let's pray together before we start insulting each other. Let us be together and 'one' today, ok?" On some mornings, older nurses start singing a hymn, clapping their hands and even dance around the table. The patients see and hear this prayer going on, but none of them joins in. The medical staff arrives during this worship, but they continue with their own work or look for files on that table; only in very rare situations would a doctor participate in the prayers. It is clearly the group of nurses forming the circle, sharing the grace and asking for blessings over their work. When asked, the nurses give their explanation. Sister Edith says: "It helps us in our work. We pray also for the doctors and patients." Her young colleague adds, "This prayer will also encourage the patients as they see their nurses are serious Christians and do their best to care for them. It will help in the healing process."

Hospitals are often seen and perceived as areligious and secular places, identical clones following scientific criteria worldwide. Norwood (2006: 8) speaks of a space as an 'insulation from the outside world' in which religion has been given a marginal position both structurally and ideologically. The contrary is true in Ghana. The medical ward is, just like other wards in Ghana and elsewhere, a space where the scientific diagnosis of a situation and the complex needs of an individual including personal belief – be it that of the patient or of the health worker – meet. Following Geertz's (1973) comprehensive definition of religion as a cultural system, Christianity delivers perspectives to individuals and groups who face the extreme situation of life-threatening diseases. The following chapter shows what the role of religion is and how religion can be observed as an unconsciously, natural and self-evident part of the nurses' and patients' personality on the ward. Describing the views and actions of nurses and their relationship with patients, it will be shown what role belief and religion play in the daily routines of nurses and how the perception of God as the almighty power influences the acceptance of and dealing with disease and death.

The omnipresence of religion

Nurses, doctors and patients alike confirm that Ghana is a religious country and "if we talk about all things and don't add the religious part, it's like there's nothing inside" (Cecile). Unlike experiences in Europe, where different Christian denominations challenge and dispute each other's beliefs and dogmas, the Ghanaian reality is tolerant. The most prominent goal is to be a Christian and go to church regularly and lead a life according to the Bible's principles. Whether the person attends a more established church (like Roman Catholic, Anglican, Methodist or Presbyterian) or one of the countless Charismatic and Pentecostal

churches, is of less concern, as the individual belief is what counts. Since 1992, following the state's liberalisation of the media terrain, television and radio stations continuously report on religious developments, telecast or broadcast Bible studies and church services. The churches play an important role in and regulate the daily lives of Christian Ghanaians. Church welfare committees help to manage health expenditures and prayer groups support sickly church members during their time of ill-health. One example is often recalled when expressing the religiosity of the staff in the hospital: Lighthouse Chapel International, a charismatic Christian ministry, started on hospital grounds about 20 years ago. Its founder and current bishop was a medical doctor at the hospital before becoming a full-time reverend. Many nurses remember the beginnings in the hospital's canteen. They still attend this church and recall miracle healings. It is within that reality of prayer meetings, funeral announcements, broadcast divine services and individual counselling that nurses and patients organise and understand their daily lives.

As is already visible in the women's motivation to enter the nursing profession, Christian religion and personal belief form an important aspect of many nurses' personalities and is suggested to be one of the motives for entering the nursing profession through the generations. Several nurses mention the calling they had. One matron reveals thus: "When I get up in the morning, my prayer is to bless my hand that I'll bring healing to the sick. I have the calling to be a nurse. I said, 'God, if you want me to be a nurse, let me come out with good grades so that I can go into nursing.' And fortunately, my results were good" (Matron Mary). Matron Regina believes that "it is God who's keeping us here; otherwise you won't come and be here." Nurse Evelyn, who is about 15 years younger than the matron, shares this conviction. In her view, "as the Good Book says, we'll give account of all these little things on the Judgment Day. And so for us nurses and doctors, we really need to sit up and do what the Lord expects from us." Nurse Martha brings in her struggle using her belief to defeat illness and death. "I am telling you, this ward is ruled by Satan. I chose nursing because I like to care for people. I attend to them when they call me. We have to pray as we live in the end of the days."

Being a Christian has implications for the understanding of the nursing work, it means for them 'doing good'. The Sunday shifts are justified in the conviction that:

> Jesus is in the same dress as the patient. We sacrifice our church and worship to nurse God in our patients. At any given time of the day, you nurse Christ in the sick. (Matron Mary)

Some say "be grateful to God to work and safe lives". Sister Catherine explains that religion is and should be the main motivating factor for all nurses. "Treat all patients well, by this you serve Jesus best. And when you are a

Muslim? Then you have Allah to serve well. We have to give our service to the patients; this is where you meet your creator." They are aware that God is powerful and are grateful for their lives. As Matron Regina puts it: "I am happy that I've been able to work in Korle-Bu to save lives. It's only by the grace of God. So I don't have any ill-feeling at all and I'm grateful to God for what He has done for me." But they also anticipate that nothing can be taken for granted.

> God is real and His word that has spoken is real. He sent His word to heal us, so if you believe in Him it will work but when you just believe in the formula it won't. You see, God is not like a computer, when you press certain things and certain numbers come up. I'm going to seek the face of God and when I pray to him, He'll heal me. But if you just believe because everybody does and you don't believe in your heart, it won't work, it won't work. (Nurse Cecilia)

The older and more experienced nurses serve as a role model in their expressed religiosity to the students. On their first day in the Medical Department, nursing students learn and recite with the departmental director the maxim 'Service done to mankind is service done to God'. The next step can be seen in the example in the worship to begin the day's activities: young nurses and students are chosen to lead the morning prayers and they practise that ritual; the older nurses correct and guide them in the process of openly displaying their Christian conviction. Also in the schools, students are prepared to pray with patients in need whether they are Christians or Muslims. "You just share a few words with them. Talk about Christ to them. Even if the person is not a believer, you help the person to accept Christ." Her friend adds: "It's like we help the patients with their religion. Like for instance, we are told that when you're about to prepare a patient for an operation you prepare the person physically, emotionally and then spiritually too, in terms of the person's faith. So that if the person is a Christian and you're also a Christian yourself, I mean the nurse, you pray with the patient and assure him that God will take care of everything and all that. It helps calm the patient down a bit so that when they go in there, they come back." Another student says: "We are taught that if the patient is maybe a Moslem and you could help, just say, 'Oh Allah will be with you'. It helps the patient to realise … you know he's not kind of … let's say foolish or mad believer, but Allah will help. The nurse taking care of him is even assuring him that Allah will take care of him. You know it helps."

Religious patients

In the nurses' interaction with patients, religion is omnipresent. It is known that some patients will have gone to traditional healers or spent time in prayer camps before coming to the hospital in search of a cure and healing. Surrendering exclusively to religious or traditional healers is generally disapproved of by the

nurses and is given as one the reasons for a patient's arriving too late at the hospital, but strengthening and holding on to one's own belief is everybody's goal. Just as patients have their Bibles readily available in their beds, nurses read the Scriptures during their breaks and listen (together) to broadcast services on the ward's television. Nurses encourage patients to pray and they promise to pray for them. On her regular rounds over the wards, the department director talks to the patients, asking how they are doing: "Oh it is good that you are doing fine; we are also doing our best. We keep on praying for you" and encourages another to pray: "If you want to say something to God, you say it in the air, and He will hear for sure." But on the ward, there were only a few concrete occasions observed when nurses would actually pray with the patients. One morning, a severely ill young woman moves hectically in her bed. She says: "Sister, please pray for me, pray for me!" Two recently graduated nurses look at each other, feeling uncomfortable. One says she only prays in her head, the other does not want to do it. Finally they hold hands and one prays asking for God's blessings over this woman as "we are only human beings but You can do miracles." She asks for mercy and healing power and finishes thus: "It is ok now, drink some more and then relax." The patients generally appreciate the Christian position of the nurses. One older woman thinks that:

> If you ask me about nurses, they must be called by God. If He does not call you, you cannot be a good nurse. You deal with human beings. So you have to have this calling. Most here have it.

During visiting hours, relatives and friends enter the ward, bringing in addition to food and hygiene products their anxiety about the patient's condition and their religion with them. They regularly pray with and for their ill family members. After having washed and powdered the patient and put down the food, they form a circle around the bed. In the case of a male visitor, he will lead the prayers and start a song, while all hold hands; when only women are around, one of them, often the oldest, prays. During these visiting moments, the ward is filled with sounds and cacophony. After all have left, the patients rest in their beds and read the Bibles that nearly all of them keep under their pillows. They appear more relaxed after a restless night, being comforted by the supportive faith of their families and trust in the healing power of their God. Nurse Cecile says: "We see relatives praying for the patients. It is good, it helps them psychologically. It helps to cope with the situation, solving problems and getting better."

Occasionally, priests or representatives of charismatic churches come to the ward to visit patients and pray with those who request it. Most patients on this ward are too ill to attend services in the hospital chapel and depend on visits on the ward. This happens mainly on Sunday afternoons and in the evenings at the weekend when the medical doctors are absent. Clergymen are the only visitors

allowed on the ward outside visiting hours. Nurse Martha is particularly keen on having them on the ward: "The patients do not go to church, they are too ill; this is the medical block. I think a priest or reverend minister should come to the wards more often. It is when you are ill that you start looking for God. Some think they got ill because they did something wrong and God is punishing them for it. They should come and pray with them." One morning, a Catholic priest is on the ward praying with several patients. He pours olive oil from a small bottle like those sold on the market over the patients' foreheads and gives benediction. He prays: "Jesus, come with your healing power and touch these patients. The doctors here are only human beings, but you are God Almighty and can heal. Come with Your powerful hand and give healing. We soak our lives in Your blood." He comforts a patient who had to undergo a lower leg amputation due to diabetic gangrene: "Don't cry, you cry for the devil. Rejoice in God, for you will be healed and alive!" Then he makes the sign of the cross with oil on the patient's forehead and goes on to the next row of beds. The nurses do not participate in the prayers but continue feeding an unconscious girl at a nearby bed.

Faith in eternal and heavenly life without pain is prominent among severely ill patients. A medical student suggests that "religion is a form of palliative care; it helps to accept death" (Joseph). Indeed, Christian promises and dogmatic sayings are often heard when a patient dies. Patients themselves refer to God's power when talking about their fear of dying. After the woman next to her has passed away in the night, an older woman says:

> God knows best. We cannot talk too much about everything, but in all we have to give him thanks. I talked to my neighbour last night; she said her life is in God's hands. Then I fell asleep and when I woke up, I saw you shifting the bed. We have to give thanks to God. But I am afraid when you start shifting the beds.

Mandy, a 20-year-old student, died on the ward after having suffered for several years from leukaemia. She had been a regular patient on the ward; all the nurses and doctors knew her well. In her last days when she began suffering severely from bone pains and became restless, nurses encouraged her to pray. A matron said:

> Mandy, look at me! Why are you so down? It will be well. Do you know there is somebody in Heaven who takes care of you? He always hears you. Do you know Him? Just keep calling Him. He is mighty and powerful. You have to address Him and He will come and glorify His name in you. He will come in the right moment and help you. We will also continue to pray for you.

It seems that the more severe and complex the health condition of a patient becomes, the more religiosity is displayed and called upon.

All situations and explanations of faith form a specific picture of God. He is perceived as a miracle-working God with endless power. The patients express it in the ever-same reply, "By God's grace I am doing better, I am feeling fine

today" and "I am doing much better"; "By the grace of God I am doing fine. Praise be to God". Their faith in God's healing seems endless as "Only God knows, it is not difficult for Him to let me go home." One older woman rationalises her situation thus: "It is the first time I am in the hospital. God wants me to rest. And God wanted the doctors to see me. This is why He brought me here. They made an X-ray of my chest, and yesterday, they made an X-ray of my whole body. It seems God wants the doctors to see me completely, from hair to toe. Every day you have to praise God and thank Him. I am doing fine. God brought me here on a Sunday, so I have my Bible with me." A woman who survived a severe allergic reaction (Steven Johnson Syndrome) praises God: "I learned a lot, especially to love God more. I am not better than those (who died). I could also be lying in the fridge now, but God is saving me. And He can do it. He can tell the doctor to go to me and give me the right medication."

The nurses on the ward share the trust in God's healing power. They recall occasions of miraculous healing on the ward. Sister Martha is happy as one woman is discharged: "This is very amazing. She came in unconscious and in such a bad condition due to hypertension and CVA. And look at her today, 11 days later. She goes home on her own feet. She is fine, only her speech needs to improve. I remember a similar case of a patient who almost died but recovered and went home by herself. She said God decided to send her back to earth and not to die yet. Amen." Stella, a young woman, was hospitalised for several weeks due to hypocalymia as a direct result of an unsuccessful thyroidectomy. Her condition was unstable and for days all the nurses feared she would die. A week before Christmas, she was discharged. The nurses say, "She is our little Christmas wonder. It is proof that our God is a miracle-doing God." But they are also aware that some conditions are severe and God cannot be forced. Nursing assistant Joy assesses the situation of a patient by weighing the influence of medicine and belief: "She knows the doctor cannot heal her. The doctor can treat her, he can manage her, but the doctor cannot heal her. So she looks up to God every morning. But you know that sometimes when you give the Devil a chance, he takes over your life. So you must pray. You have to pray."

Conclusion

The above-illustrated examples of lived Christian religious faith on the ward have several meanings and fulfil several functions. Considering the four major aspects and roles of religion, it will become clear which position the belief has for the nurses.

Firstly, rituals help the nurses form a group every day. They help the nurses encourage each other and confirm their basic convictions. Religious symbols and rituals strengthen their style of living and give them authority. They are "pre-

sented as the ultimate expression of hope against the reality of death" (Van der Geest 2005: 143). For the individual nurse, belonging to the group and praying and singing aloud is a way to show and channel her emotions and experience solidarity. This togetherness enables all nurses to share the burden of the work ahead of them. While routine actions like making beds, washing and feeding patients are regularly corrupted by external shortcomings, fixed moments of religious expression and praying provide sense and shelter. This includes the aspect of socialisation nursing students undergo in their training. In following the more experienced nurses and fulfilling their tasks obediently, they grow into the position of mature, believing, caring nurses. Non-believing nurses, like the European trainees described, who represent a purely secular definition of the reality, experience misunderstanding and displacement.

Secondly, religious expression also has the function of reinforcing the image and status of a good nurse (also referring back to the colonial norms) and decent woman in the broader society (Holden 1991). Towards patients, doctors and visitors, religious expression shows that nurses' work is grounded not only in professional theories but also in heavenly foundations. The nurses 'do good' and 'serve God in the patient'; criticism of their work is therefore out of place. Nursing in an understaffed and poorly equipped environment means improvisation and balancing between the ideals and reality of nursing care. Religion is a means to deal with that stress and the uncertainties on the ward, and is also a supportive factor for nurses and patients to deal with illness.

Thirdly, religion addresses the complete person in need and not merely the physical problems. Being admitted to the hospital, patients experience fear and threats on their bodies and souls, a "quite severe time of testing" (Hallstein 1992: 249). In order to understand the hospital routine, to pull through and be discharged again, the patients are in need of certainties and referral points. All is new to the patients – the medical language, the organisation of the day and uncertainty about their individual well-being and healing. Religious belief functions in this critical and threatening situation as a referral point and framework to place one's fears and find hope. Prayers refer to the complete being of a person, bringing together the sick body, insecure mind and searching soul. To nurses and patients alike, religion is binding, meaning that "a fragmented world is united to form one ordered whole. Things are brought in agreement with one another." (Van der Geest 2002: 139) The nurses are able to provide this recognisable feeling of belonging and fulfil the role of a religious leader, who "is not in control … (but) can facilitate the right conditions" to go through the liminal phase successfully (Hallstein 1992: 249). As Comelles (2002: 285) argues in a similar way, "miracles become a functional tool, in the sense that they help resolve uncertainty".

Finally, what is striking in the hospital is the absence of medical doctors in the religious rituals. They neither participate nor comment on it. It seems the nurses feel the need of sociability and care while the medical profession remains outside, representing the realm of diagnosis and therapy. Defining their part in the medical setting as decision takers without being influenced by sentiments (Comelles 2002: 267), they relish to occupy the leading role guiding the patients through the difficult time of hospital admission. At the same time, doctors do not work against the lived religiosity on the ward, but remain in their public appearance gatekeepers of the orthodox scientific realm. It is important to notice that there seems no conflict in control between the medical doctors and the belief in a powerful God. The marginalised position of religion that Norwood detects in Western hospitals is a visible and real one in the Ghanaian context. Doctors and nurses alike confirm this with the statement that 'by God's grace' that they are able to do their work.

Summing up, we can see that religious expression on the ward reflects the lived religiosity of the Ghanaian cosmology. According to Clifford Geertz, religion is a system of symbols, beliefs, and patterns of behaviors by which human beings control that which is beyond their control. By using and integrating their religiosity in their work, nurses on the medical ward seem better able to face uncontrollable situations on the ward. Religion provides them with the framework to place and endure shortcomings in care and medicine and compensate by giving a sense of saftey and belonging. This shows that the hospital cannot be understood simply as the deceptive familiar place and clone of Western biomedicine. In order to achieve and perceive healing, medical practices and religious symbolism have to be combined in the routine on the ward.

14

Pride and prejudice: Doctors, orderlies and patients

In this chapter, I portray and discuss three groups in the hospital that are in direct contact and interaction with the nurses. The medical staff are less frequently on the ward but demand high levels of attention and service when present. They make rounds to visit and diagnose their patients, carry out small examinations and tests that need to be done and fill the necessary papers. The orderlies on the ward are responsible for cleaning, sweeping and distributing food to the patients. While they have their own routine, they share the nurses' physical space and their work schemes mingle continuously. Finally, the patients will be introduced during their communication and interaction with the nurses. I will show which views the nurses and these groups have of each other, how their activities influence each other and in what way responsibilities and power constellations are constructed.

Medical doctors: Ward rounds and paper work

> Around 11 am the ward gets very busy as the medical specialists from Unit 3 arrive for their weekly rounds. The medical officers and about 20 medical students accompany them. A student has to present a patient's anamnesis and current condition and explain the proposed therapy plan. The professor asks critical questions about the patient and the disease in general. While being examined, the patient is absolutely silent as if in a sleeping state. She is not asked anything. Nurse Joyce stands silent nearby and hands papers to the doctors when needed. She explains: "They scare the patients. They are intimidating when they come in a crowd. Later the patient will ask us and tell us her worries."

This section describes the doctors' work and discusses the interaction between the nurses and doctors in order to understand their existing perceptions and

underlying images. Every day, medical doctors come to the ward to see their patients, examine them and process paper work. The medical officers and house officers arrive before 8 am, often during the morning prayer of the nurses. They check for necessary information or changing health conditions during the night, see some patients, write overdue documentation and prepare for the round before they continue on to their other activities in the outpatient departments (OPD).

During the renovation of the 5-storey medical block, the various medical disciplines shared three temporary wards (two for males and one for females). The female ward with its rows is divided into four units: dermatology and thoracic (Unit 1); endocrinology, neurology and general medicine (2); nephrology, thoracic and general medicine (3) and nephrology and endocrinology (4). Even so, such strict division is not enforced; empty beds are given to new admissions that need hospital treatment most. Next in hierarchy to the medical director of the department, a specialist and/ or a consultant heads each specialisation and has several residents (doctors with a medical specialisation) and medical officers working for him or her. They are joined by house officers and medical students in their final year. The hierarchy of doctors is as follows:

- Consultant and medical director, head of a department
- Specialist: Working in a teaching hospital or own practise, head of a ward
- Resident: Specialised doctor
- Medical officer: Licensed doctor, starting specialisation, five to seven years
- House officer: One year of medical work in two departments (not yet licenced)
- Senior clerkship (internship in last year of medical study)

In this department, all but two of the doctors in the rank of resident or higher are male. Among the house officers and final year students, about one third is female. The dress code for all doctors is a white coat over their normal clothing; there is no shoe code, as there is for the nurses. Some female doctors can be heard arriving on the ward by the sound of their stiletto heels. Mobile phones are an important means of communication with colleagues, family and friends; they ring regularly during rounds and medical procedures and seem to be turned off only during the round with the medical director.

Each unit has daily medical rounds and once a week a round with the specialist/ consultant. As a result, every morning, a particular part of the ward is crowded with doctors and their students. The situation described at the beginning of the section illustrates this. They look for their patients, discuss cases and possible treatments, write documentation in the medical file and move on. In most cases, the report reads as follows: “patient is doing better / condition unchanged / CT (continue treatment).” Sometimes more detailed information is given or it is decided to start a new medication. During the rounds, English is spoken throughout and the patient is hardly addressed. The doctors look through

the medical file that is placed on the table at the foot of the bed, check newly received laboratory results and may request new tests. The students listen and make notes. On one occasion, the resident doctor got frustrated with the students' slowness. He urged the students to hurry up: "You came in too late this morning. We should have started earlier. Today is our day at the OPD and we have to be there at 9. The other days we can stay longer, till 2 or 3, but today we have to leave for the OPD. And if we have a patient to be admitted, we do it directly if a bed is free on this ward. Otherwise we send them to the emergency ward and they are admitted here later." When a patient is discharged, her file is placed on the nurses' table with the attached note 'for assessment' in order to write the discharge report, have the bill calculated and thus inform the nurses. On most days, the nurse in charge or the matron joins the round. In advance, she has a plastic bag prepared containing the most needed documentation to have at hand.[1] Sometimes the nurse may be asked for nursing information or to describe the condition of a covered wound, or she may be criticised when a medication has not been given or the intake-outcome balance[2] is not accurate. In all cases, the nurses have to go over the files, read the medical notes and get to know the changes in the treatment. While medication is generally bought by relatives, there are two exceptions: For patients who require a medication that is absolutely necessary, or for patients who paid a big deposit on admission, medication can be requested in the medical file and then collected at the main pharmacy by health care assistants. In these cases, the file will be placed on the nurses' table with the note 'dear pharmacy' on it. Indeed, most exchanges of information go via the file. A medical officer says:

> We do not directly communicate with the nurses, but via the file. I write my notes and new decisions. They should come with us during our round, at least during the big major rounds once a week, to learn about the changes. I understand they are busy, we both could improve to make our work better. If something is important, I will tell it straight to a nurse or take the file to the nurses table. Or I attach a paper to the file with the change, so the nurse will see it in the doctors' notes or treatment file. When a patient is discharged, I tell it straight to her and the nurse, so both know it.

The matron knows about this custom but is not satisfied with it: "You know how it is, they come and they need everything at the same time. When we were in the medical block, you had just one unit and specialisation, so everything was easier and more organised. Now these four units are together, things get lost and we are not able to keep up with the information." A nurse confirms this: "Ideally we should go with the doctors on their rounds and get to know all important

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[1] It contains prescription forms, forms for medical notes, medication lists and general request papers.

[2] Some patients, especially those with kidney- or heart diseases are on fluid balance. This means that all fluid intakes (drinks, soup, drips) and the urine outcome must be documented and daily calculated to see whether there is fluid retention or a threat of dehydration in the body.

changes. But you see, we are few and cannot go with them as they deal with patients forever. If we do it, we cannot attend to the patients and do our nursing."

Next to the rounds, the medical and house officers spend time on the ward to do the other necessary work. This includes setting lines for newly-admitted patients or when a canula is blocked, giving certain types of medicine, like chemotherapies, or blood transfusions and doing smaller procedures such as a puncture of the sternum, a lumbar puncture or inserting pleural catheters. These medical procedures require a sterile environment and optimal equipment. In some cases, the patients are asked to buy the catheter or puncture set at the Central Sterilisation Department. In other cases, the doctor brings the equipment to the ward and supplements it with materials from the ward, setting a tray with disinfection spirit, plasters, sterile cotton wool and sterile gloves. Lack of equipment frustrates the doctors. One morning, a doctor comes asking for spirit and gloves to set a line: "You walk 100 miles here to get the things." In most cases, the doctor will look for a Spanish wall to create some privacy for the patient and to aid his concentration. When a procedure is expected to be complicated or long, a nurse is asked to assist. Most nurses on this medical ward are not eager to assist with these procedures; they feel uncomfortable and try to delegate it to nursing students. The following example illustrates this:

> A 52-year-old patient is admitted with severe pericarditis and ascites. During the ward round, it is decided that a puncture of the pericard should be done to aspirate some of the fluid. The doctor sets a tray with several puncture needles, a tube and urine bag attached to it, spirit, sterile gloves and gauze. He places a Spanish wall around the bed and asks the patient to lie on her back. A nursing student is asked to assist. Without local anaesthesia, he enters the pericardium with the longest needle, attached it to the tube and tries to aspirate the fluid, which is thick and whitish. After 10 minutes, when he has gathered ca. 200 ml, the tube seems to clog. He infuses saline, waits for two minutes and tries again. Some fluid comes out again. The whole procedure is repeated again and again for almost one hour. The patient shows no emotion and nobody speaks to her. In the process, the doctor's phone rings. He asks the student to pick it from the pocket of his shirt. She feels uncomfortable in this situation, but he just laughs at her. She needs to hold the phone onto his ear while he continues with the aspiration of pus. When he finishes the phone call, he says to her: "You will eventually learn to assist well." Finally, he fixes the tube on the patient's skin and links it to the urine bag for the pus to flow. The wound is covered with sterile gauze. The doctor leaves and the student cleans the place.

In another situation, a lumbar puncture had to be carried out on a young leukaemia patient. The doctor initially tried it alone, but later called in assistance from a nurse. As he did not manage to aspirate fluid, but had run out of needles, stopped the procedure and asked the nurse to look for more needles in the matron's office. He also realised he had forgotten to bring clean bottles for the sample, so the nurse was also asked to look for bottles. She succeeded, and five minutes later the procedure continued and went on to be successfully finished.

Some recurring tasks are the documentation of work in the medical files, the writing of prescriptions and the registration of death certificates. As described above, the nurses check for new medical orders and treatment plans after the ward rounds. When they read that a feeding tube should be removed or a urethral catheter inserted, they follow that order. Orders to the pharmacy are gathered and collected by early afternoon. Nurse Martha observes: "When the medication is finished we have to inform the doctors to review it. Maybe, they may change or stop it. Some medications are given by the pharmacy, some the relatives must buy. But the doctor has to write the 'dear pharmacy' or the prescriptions." In reality, doctors are sometimes behind on the reviews and new orders. The consequence of this is visible in the following example:

> One patient came to the hospital because of a deep vein thrombosis, but her heparin[3] ran out several days ago already. Nurse Martha makes a dash on the day and time on the treatment sheet and reminds the patient that this is an important medication and needs to be bought. It seems there is no prescription. As the doctors are not around, she writes the name of the medication on a prescription form, signs it and gives it to the patient for her relatives to buy it. "We have to remind the doctors that it is finished. If they don't write, we do it. It is a problem."

The completion of the death certificates seems to be the source of most irritation. As described in the chapter on dying, those certificates are crucial for the nurses to close the file and for relatives to see their deceased family members at the mortuary and start organising the funeral. When a post-mortem is requested, it is even more important to have the initial death certificate completed quickly. Nevertheless, this task is unpopular. Regularly, relatives need to return and wait several days before they receive the paper. It is difficult for the nurses to justify this waiting. They ask the relatives to remain patient and explain that it is not their fault if the certificate is still not written. "We tell the doctors to sit down and fill the forms, but this is all we can do. We are not in the position to force them." Nurse Rosemond says:

> We cannot write it; the doctors have to write it. They first attend the living before they write things for the dead. You see, we keep all these folders here on our table for them to see it. That is all we can do. When they come we tell them, but we have our own work. When we have done our work and look round, they are gone and have not written it. We cannot force them.

This unclear and unsatisfactory communication frustrates the nurses and influences the relations between the two professions. In general, the communication is friendly and cooperative. Doctors and nurses greet each other in the morning; occasionally, a doctor joins the morning devotion or unmarried doctors flirt with the younger nurses. But most of the time, both groups work next to each other.

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[3] Heparin is a medication for reducing blood clotting. It is given as an injection under the skin (subcutan).

The matrons have cordial and respectful relations with the specialists and support their work. Their wish to have a clean and tidy ward with white bed sheets is grounded in their aim to present a well-organised ward to those doctors. When it comes to medical orders, the hierarchy of the two professions is clear. Typically, the doctor arrives on the ward, examines the patient and returns to the nurses' table saying something like: "I have to place a tube in her right pleura. We expect free fluids there and want to aspirate some. Please prepare a tray for us." In the doctors' notes, nurses may read: "Start physiotherapy, teach relatives to feed through tube, prepare for discharge." In arranging for new admissions, the medical officers count on nurses' cooperation: One morning, a doctor comes and sees that most beds are occupied. "Please, keep this last bed here empty for me. I will bring a patient for it, so this bed is mine, ok? I can also place a sticker on it, but I think it is not necessary, you know now."

Not all nurses are willing to follow all orders immediately or do the doctors' groundwork without grumbling. One example is that it seems not clear whether the nurse or doctor is responsible for the functioning and running of a drip. Some nurses check it regularly and are handy in making a drip run or even setting a new line themselves. Others will call the doctor and not take any further action. There are various situations in which the nurses would only take direct orders and refuse to take own initiative. One woman was admitted with ascites and the doctor planned a paracentesis to retrieve some of the fluid. He ordered nurse Maggie to have three litres run before removing the cannula. Martha does this and then she removes the cannula and closes the spot on the swollen stomach with cotton and a plaster. The collection bag is emptied in a bucket and the bodily fluid disposed of in the toilet outside the ward. She notes in the file that three litres were taken out. After doing that she finds a request form from the doctor that a sample should be taken from the fluid. "He did not talk to us about it and did not mention it at all. So it is not taken. I cannot help it, it is too late now." In another situation, nurse Vivian gets angry with a doctor who left a patient who was receiving chemotherapy without finishing his work: "He just connected it and left. He has to write concrete steps down in his notes and inform us well. We do not take orders just from verbal instructions. What if this woman reacts? I will check it and call him back. Oh you have to teach them so often how to proceed." Indeed, almost all nurses can recall situations in which they felt treated unfairly and overwhelmed by the responsibility they had to take or by unclear instructions given by the doctors. They complain of not being respected and they experience neglect as the doctors do not fully accept nurses.

It seems doctors and nurses are not using each other's knowledge structurally in order to have the patient benefit optimally. The tension that originates from that disintegration of information has a negative influence on their job satisfac-

tion. Interestingly, medical students give another picture. One student who was to enter the housemanship expressed respect for the nurses:

> Normally, the contact between nurses and medical staff is not so good. When we students come to the wards for the first time, we do not know anything and have to learn a lot. And when we return as doctors we stand above them. So they do not like us normally. You have to humble yourself and be kind, then you learn a lot. You learn all from nurses. During my studies I also did some nursing, feeding and washing and all, and I see what nurses do. You as individual person can make a difference and you should do so when working in a team.

The matron of the ward has a clear vision on how the relationship between medical doctors and nurses should look. She sees the need to train young doctors to work in a team: "You teach them all well, and they'll be rubbing shoulders with the nurses. We teach them the basics in nursing. They do bed baths, they pass NG (nasogastric) tubes and catheters and do vulva toileting. So when they come and there are patients around, they know the nurses' duties." Her vision is clear and she tries in her work and talks to improve cooperation:

> If a patient needs a catheter, an NG tube or oxygen, we do it right away. It is insulting to me if a doctor has to tell me to do that with a patient and I did not see it. We nurses have assessed this patient. Be very proud to be a nurse. The patient will not suffer, but profit. So make sure you know what you're doing. If you do not know, the respect goes with the wind. You have to gain it. Do what you know and know what you do!

Based on the observed situations on the ward, a few points stand out: The two professions hold different perspectives and professional aims. Working with and for the same patients in the same suboptimal environment, the two professions need to cooperate. The daily reality on the ward and in the hospital in general shows that such cooperation and respect is there to some extent.

The medical doctors were trained in the standards of biomedicine; they radiate its aura of unquestioned knowledge, and appear to have the means to facilitate healing, power and unlimited possibilities. Through training and hospital practise, they develop a sense of hierarchy and intellectual arrogance (cf. Zaman 2005, Becker *et al.* 1983). Senah (2002: 62) analyses the Ghanaian situation sharply in that "(m)ost physicians appear cocooned in their clinics in the belief that through clinical practice they are contributing significantly to the improvement of this country." In a modern hospital like Korle Bu, the patient has been depersonalised and objectified. Following Foucault's analysis of the modern clinic, the focus of medical staff is on the malfunctioning of the body, observing objectified facts and reading laboratory results rather than individual fates (Foucault 2003, Gibson 2004). The discussion goes into the possibilities of applicable treatments, leaving the personal circumstances and needs aside. This is especially recognisable in the regular ward rounds. They follow a clear structure, reinforce the hierarchical system within the medical group and towards the nurses and expect the patient to be silent and obedient. This is comparable to Weiss (1993)

who analysed the ritualistic character of ward rounds in an Israeli teaching hospital. While being outnumbered by the nurses, the medical staff stands higher in hierarchy, are more broadly represented in the presentation and management of the hospital and demand respect in all aspects of the hospital organisation. The relationship between the director of nursing and of medicine is characterised by cautious reservation from the nurses and demanding decisiveness from the doctors' side.

Against the background of this hierarchical and ritualised appearance of the doctors, the nurses find themselves in the position of having to pay respect to the doctors and request similar respect from them. In the public perception, during training and in interactions with doctors, nursing is associated with the image of caring, following advice and standing lower in hierarchy than medicine. The old saying from the Middle Ages states. "It goes without saying that women, being so to speak born sick-bed attendants and nurses, have always carried out these functions" (in Garmanikow 19991). Nursing as the presumed female activity is described in relation to and hierarchically subordinated to medicine. Applying Foucault, Garmanikov (1991: 114) states: "The ward reflected exclusively the knowledge and organisation principle of medicine." Two aspects are important here: The existing gender gap between medicine and nursing and the constant (re)definition of power. The matrons of the ward try to strengthen their position and encourage their nurses to stand up for their profession and enforce respect by doing the nursing work accurately and convincingly. Matron Mary says: "Let no doctor step on my shoulders." This reflects a fully developed professional view and demands respect for her work and her responsibilities.

Stein (1968) was one of the first to analyse the expectations and perceptions of the doctor-nurse-interaction, formulating rules that the two groups have to follow in order to guarantee functioning ward routines. While it is obvious that both professional and social changes have taken place since the late 1960s and changes to the rules are desirable, the old mechanisms of listening and obeying are still present. "The separation (of the work of doctors and nurses) thus lay not in tasks, but in social relations: doctors have the power to name the diagnosis and prescription and this is performed by a nurse as 'following doctor's orders'." (Garmanikov 1991: 120) The existing power constellation makes it difficult if not impossible for the nurses to bring in their view and develop mutual understanding. Ceci (2004) analysed a conflict in a Canadian hospital through which the power inequality between doctor and nurse could be understood as the decisive factor in the development and escalation of the conflict. Processes of power display lead to a construction of knowledge and truth. "Nurses it seems, before they even spoke, were confined within already existing relations of power and knowledge that determined them to be, that positioned them as, the sorts of

persons whose concerns need not to be taken seriously" (Ceci 2004: 1884). Larson (1995) asks for new rules of the game and pleads for interdisciplinary education of medical and nursing students to increase mutual understanding and improve collaboration on the wards. Opare, the head of the Nursing Department in the University of Ghana, picked that plan up and asked for improvements in the education of nurses and doctors in Ghana: "Old rules do not work anymore. Partnership and collaborative practice are the desired relationship between the doctors and the nurses" (Opare 2002: 4). Successful cooperation in small details gives hope for the development of teamwork and mutual respect.

Cleaners and orderlies: Support and disassociation

> In the early morning, around 4 am, David the male cleaner of the ward arrives. He is a middle aged man with a skinny build. He starts sweeping the ward. All lights are on; most patients are awake or dozing. The smell from the toilets is strong, and several immobile patients need fresh diapers. About an hour later, the night nurses, who have been in their resting room, arrive and start their medication round and the health care assistant empties the urine bags and checks the vital signs. During the night, an older, partly disoriented patient fell off her bed. She is semi-conscious and moans. The nurses did not put her back in bed. "She is heavy. Look at her, she does not cooperate. If I carry her, my back hurts and I get sick and nobody pays for that. We will call David to put her in bed, he is stronger." David busily continues to sweep the floor and does not care about the request. The patient remains on the floor. Finally at 6:30 am, shortly before the visiting hour starts, David manoeuvres her back in bed. Around that time, the two female orderlies Pauline and Leila arrive and take up their work.

On the medical ward, eight orderlies are employed, four male and four female. They work in the morning and afternoon shifts six days a week and cover the Sundays in turn. Their room is outside the ward and they share it with the orderlies from the neighbouring ward. The uniform of the female workers is a pink dress; the men wear brown trousers and shirts. The responsibilities of the orderlies differ. David describes his daily routine:

> I start my work every morning before five o'clock. My shift ends at two in the afternoon, then my colleague comes. In the early morning before visiting time, I sweep the floor and then again after the families are gone. I do it all day. Also the toilets and bathrooms are my responsibility. Every time I check and when it is dirty, I clean it. You know they (the patients) go to the toilet but do not flush. It is because these women are ill; they just leave it like that. So I come and clean it for the next patient. That is my daily work.

The women arrive a bit later, starting the morning shift by 7 am. Their first task is to wash and iron small towels that nurses and doctors use for hand washing and then organise breakfast from the central hospital kitchen and distribute it to the patients. Pauline is married with six children and is the only breadwinner in her family since her husband lost his job as a driver some years ago. She is in her 50s and heavily overweight, being almost unable to bend down. Like the

others, she did not follow any particular training to do this work but was hired straight away. She says:

> I start my work at 6:30, latest by 7:00, and we close around 4:00. We work every day and are one day off a week. We had no training but just do our work. We are four female cleaners for the ward. Our task is to clean the ward, the tables, lockers and windows. We do not do the sweeping, this is done by the men. And we also distribute the food, breakfast around 7:00 and lunch around 14:00. In the morning, the males get the breakfast from the main kitchen and it is our duty to distribute it. After that we clean the used bowls in our kitchen here before we send it back to the main kitchen. The same goes with lunch. Today I work here in the toilet. The toilets are cleaned twice a day by the men, we just do the bedpans. The nurses take the bedpan and when it is used, they clean it and put it in the sink, then I rinse and clean it well before putting it back on the shelf. I have to wear gloves, as the antiseptic is very strong. If I do not wear them, it will affect and hurt my hands.

The breakfast consists of ricewater or corn porridge and a piece of white bread. It is brought to the ward in big plastic containers. Pauline and her colleague Leila walk along the beds and distribute it to the patients who are supposed to have their own cup and spoon; only on rare occasions are hospital cups borrowed. The same goes with lunch when rice, kenkey and yams with light soup, fish soup or vegetables are served. There are no dietary guidelines offered; it is up to the orderlies to decide themselves on the amount of food given to a particular patient. When a particular food is finished, the patients get the leftovers. Considering the unconscious and tube-fed patients, they filter the porridge and soup and leave it on the lockers for nurses to feed.

The second task during the day is cleaning the ward. As Pauline said, they use disposable gloves, the same sort nurses and doctors use for (para-)medical procedures. This contributes to the fact that the glove supplies run out by mid morning. While the men sweep the floor, the women are responsible for dusting and sweeping the patient's lockers, the nurses' tables and boards and the windows. Given the structure of the ward and the open mechanism of the windows, they are covered with mosquito nets and can only be partly closed with glass, allowing a lot of dust, sand and dirt to enter the ward constantly. While the open surfaces are cleaned every day, the windows behind the patients' beds get their turn less often. One day, the orderlies decided to clean all windows in Unit 1, which took all morning. The men shifted the beds away from the windows and removed the lockers. A hosepipe was connected to the sink and David stood on a ladder sprinkling the glass while Pauline and Leila cleaned them. The floor was wet and the whole unit was disorganised. It was impossible for patients, nurses or doctors to pass or do their work there. Luckily, no emergency occurred among those patients that very morning.

As described above, it is the women's work to clean the raised bedpans and nursing utensils in the sluice room and the men's to clean the toilets. During the research period, the sluice room was cleaned by the close of the day and the

toilets were (especially when compared to public or shared toilets in town) in a clean, hygienic state and with water running most of the time. The orderlies are also responsible for the doctors' rooms outside the ward. Paulina explains: "First I clean the doctor offices every morning. I do this with a different towel as the ward is contaminated. After the offices, I continue here on the ward." These rooms are used by the specialist for occasional patient talks[4] and for medical students to gather before and after the visiting rounds to discuss cases and relax from their work. Paulina is often ordered to buy minerals like Cola or Sprite and kebabs for them after the rounds. During their work, they chat with some patients, mainly those who are about to be discharged or who they can connect to due to family connections or shared social activities. They comment on their health condition, encourage them to pray or read the Bible, and inform them about relatives waiting outside for the next occasion to come in. When they finish their work, the orderlies gather in their kitchen and chat with colleagues, or sit outside watching the activities in the hospital.

Thomas is part of the orderly group, but works independently. He does not clean but is responsible for the blood, bodily fluid and urine samples that are taken from patients and need to be brought to the laboratories. He collects used penicillin bottles from the ward, which he cleans and sells to patients' relatives. He has his table near the entrance. He also collects money to pay for laboratory results. The nurses often call him to collect samples or complain to him for forgetting his duties and spoiling samples.

Lilith is the watchwoman at the entrance to the medical wards. Sitting there Monday to Saturday, she guards the door and restricts family members from entering outside official visiting hours. She has good relations with the nurses and orderlies and chats with them when they take a break. She welcomes them to the shifts and often functions as the first informant for unexpected or special news like the death of a well-known patient or the admission of a returning chronically-ill woman. Most nurses greet her by asking "How is the ward?" Lilith knows all relatives, those sitting close to her waiting for news and those coming only at fixed times. As a gatekeeper, she knows a lot about the patients and is informed of deteriorating conditions and deaths on the ward. Occasionally, she will allow a concerned mother to enter the ward and bring food to her child or permit a brother to check with his sister whether she needs new medication. The rest of the day, she sits in front of the door, reads her Bible and talks to colleagues.

Nurses and orderlies do not spend their breaks together and do not share the moments of prayer. The hierarchical separation between the trained nurses and

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[4] All specialists have their consultation rooms in the original medical block and hold their regular office hours there.

hardly trained orderlies is clearly visible in their communication and interaction. Only the head of the orderlies has a cordial relationship with the matron, talking regularly with her. The others remain more aloof. When asked about the orderlies, most of the nurses speak in a friendly way about them, saying that they work here together and have to carry the burden of the temporary ward as a team. Nevertheless, nurses command orderlies to do certain work, clean more carefully or use fewer gloves for their work. One senior nurse says: "I need to supervise them as well. Otherwise, they won't do their work. And the men have to go and refill the oxygen cylinders. I tell them so often, but they don't mind me."

A few points crystallise when trying to understand the work of the orderlies and their relations with the nurses: There is a clear gender bias in the distribution of work. Men do the rough work, cleaning the floor and the toilets, while women clean the smaller objects and distribute the food. All of them report that they feel underpaid and undervalued, although they also say they are satisfied having a job in the well-known hospital. They define their job as an integral part of the ward routine and take the space they need, as shown in the example of the window cleaning exercise. Their appearance radiates confidence and pride and they are visible on the ward during the whole day.

Comparing the Ghanaian situation to statements of workers and literature on hospital cleaners, certain parallels stand out. Cleaners, members of the security and ward helpers function as gatekeepers. Just like in hospitals elsewhere in the world, they are often the first contact for new admissions and help relatives to stay in touch with their inpatients (Zaman 2005: 125). Looking at their work, they complain about not being valued. Like cleaners in British hospitals, they would like the nurses to understand their position and recognise the work they do. Messing offers an interesting point of analysis: Cleaning is often left out of the list of necessary health professions in a hospital, and this invisibility is characteristic of the position cleaners are given in the hierarchy of a hospital. According to Messing (1998: 178f),[5] cleaning is marginalised as it is "considered to be far from the central mission of an establishment … And within domestic tasks, cleaning is at the bottom of the list. A third way emphasises their social class position. Cleaners have a low pay and low prestige compared to doctors and nurses." This is parallel to movements and views in the broader society where garbage collectors and cleaners, both male and female, are seen as low in the social ranking. Nevertheless, the orderlies are indispensable for the functioning of the ward and the hygienic work of nurses. The nurses differentiate themselves from the cleaners. Their profession started as a menial and low-esteemed job (see Part II; Owusu 1981) but rose in prestige and status. It is in the nurses' interest to

[5] Messing refers here to D. Gaucher (1983), *Le maternage mal salarié: La division sexuelle du travail dans un milieu hospitalier*. Montréal: Presses de l'Université de Montréal.

contrast favourably with orderlies and position themselves higher in hierarchy and power. Nurses want to be linked to the medical profession rather than to the category of cleaners.

Patients: Obedience and support

> In the early morning, most patients are awake. They rest in their beds, read the Bible or check their mobile phones. Asking a patient how she is doing, she grabs my hand, her eyes are wide open. "My heart is paining me, I cannot breath. Help me. The night was horrible. I had such a bad dream; they were gone home to inform everybody I am gone. I am so afraid. They are calling me. I want to see my mother, oh she went away to say I am dead." The other patients remain silent, some nod with their heads understanding her fears. Shortly after, the visiting hour starts and all patients get visitors who talk to them, wash them, bring food and pray with them.

This part shows some aspects of the patients' reality. The nurses' perspective on patients will be discussed by combining it with the description of the patients' fears, their financial situation and their religion. To illustrate their reality, three types pf patients will be portrayed.

The 30 beds on the medical female ward are always occupied, the patients arriving either straight from the OPD during a consultation session or via the emergency ward (SME), where they stayed till a bed was free. Their duration of stay on the ward varies. While some stay just a few days to be cured of malaria or wait for results, the majority is admitted for any length of time between one and two weeks. A minority is admitted for longer than one month.[6] As described in Chapter 12, death is present, for every month 15 to 26 patients die here. This has an influence on the behaviour and expectations of the patients. In the following section, several general aspects of the patients and their relation to the nurses will be highlighted; after that, three types of patients will be portrayed and their interaction with the nurses analysed.

Nursing means helping ill persons and supporting them in their process of getting better, accepting the diagnosis of an acute or chronic disease or come to terms with staying in the hospital.[7] The nurses on the ward try to make the patients feel comfortable and at the same time integrate them in the ward routine without allowing too many exceptions.[8] The matron teaches her students: "When they come into a hospital bed, we recognise them as patients. It could be me or you, it could be somebody else. You expect your relatives and loved ones to be cared for well." She urges her nurses to take all patients seriously and to look after them. The nursing director confirms that perspective: "You have to think for the patient. You are his advocate. Yes, because he just lies flat, he doesn't even

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[6] See also Chapter 9 on Korle Bu.

[7] See, for example, the definition of nursing by the International Council of Nurses ICN (www.icn.ch).

[8] For most patients, it is their first hospital admission or at least their first time in this teaching hospital.

know where he or she is. She's not aware of her surroundings, so you need to think for her, turn her, feed her, bathe her, dress her wound, and so on and so forth." It starts with the admission, when the patient and her relatives are welcomed, the ward routine is explained to them and they are given their beds. Nurse Liz elaborates: "If you introduce the ward and yourself well, all will be well and the family will feel comfortable leaving the patients in your care." Stephen agrees and formulates it even more strongly saying: "The behaviour of health workers is very much influential. When somebody is sick, depending on the way you speak to this particular patient, she will either be well or sink and die."

The general approach towards new patients is to talk to the relatives, informing them of visiting hours and what they are supposed to do, and in so doing, possibly allay their uncertainties. But the nurses have the perception that many (if not most) patients come too late to the hospital. They blame the patients for being ignorant: "The problem with Korle Bu is that the patients come too late. They use all their money on traditional healers, the quack doctors and in private clinics. We need a law that if a situation does not improve in two weeks, you need to refer a patient to the next hospital. When they finally come here, it is often too late" (Matron Hilda). Her colleague Grace even blames the patients for being irresponsible:

> The rich ones go to private clinics and keep long there. When their money is finished or the doctors do not know (what to do) any longer, they come here. Others think when you're sick you have to go to the juju man, herbalist and other things, because every sickness, they think there's somebody behind it. You come here when it is too late and expect the doctor to do some miracle.

Most nurses share the conviction that many patients could be treated better and discharged in a stable condition were they to come earlier. The Teaching Hospital is a site of both attraction and rejection for patients, a fact which is reflected in the nurses' accusatory attitude towards patients/blame of patients, and the patients' state of fear.

Indeed many patients are afraid, mainly for two main reasons: The fact that they have been admitted to the teaching hospital, and the fear that something could happen during the night. The teaching hospital has a reputation throughout the country of being a place where the best medical help can be received. But hope mingles with fear of the unknown and many factors play together.

> Korle Bu makes people afraid. They do not want to go there. They know that when they are referred here, it is serious. So they will not voluntarily go there, but to traditional healers or a polyclinic in their surroundings. And when they are sick and the doctor says they have to come here, they get afraid and think they have to die. They also think it is expensive, and when they know you will die, they discharge you to die at home. The diseases brought here are deadly. That is what frightens patients. Because they know this is a teaching hospital,

> when the other hospitals try their best and it doesn't work and they bring them (patients) here and it still doesn't work, they lose hope and give up unto death. (Matron Mary)

The diffuse fear of the patients can partly be explained by ignorance that becomes prominent in their anxiety in the night. It is a common fear that death can come by night. This, in combination with pain, and unfamiliar sounds and smells, leads to the fact that many patients do not sleep during the night and are nervous in the morning. Nurse Grace elaborates: "The night is interesting. Some patients are restless and difficult, you need to reassure them. They do not sleep because they think death will come when they sleep. So they are awake all night and want to have all lights turned on. When day breaks you will see them fall asleep." Naa, a young Sickle Cell patient, confirms this view:

> I was scared in the night. The days were ok, but the nights were horrible, I could not sleep. They were calling me; the other patients called my name and I could not sleep. And this woman was dying and they (the nurses) pushed her out. It was horrible.

Later, she received a bed near the nurses' table. Her father expressed relief:

> She saw too much at the old place. The people were dying and she saw all. Here, she was closer to the nurses and could talk to them directly, and she could watch the television. She did not feel so alone and the nights were cooler.

This patient describes well how afraid she is of the night and of the fact that the ward is the place for many severely-ill patients. Death is constantly present and frightening. A retired nurse remembers her time in hospital: "First of all, we all fear death somehow. We try to console the patients, but so many die here in this hospital and everybody knows. They hear the name (of the hospital) and are already afraid" (Dora).

Another factor that makes patients insecure is the financial implication of a hospital admission. When admitted to the ward, the patient is supposed to pay a deposit of ¢ 300,000. From this, emergency medication can be ordered at the pharmacy (through the medical order, see above) and deducted against the final bill. Some patients are shocked by the cost as they think health care should be free as it was under Ghana's first president, Nkrumah. The fact that Korle Bu is a government hospital also makes some Ghanaians think that the treatment at Korle Bu will be free. According to Matron Mary, there are families who decide to bring their sick relatives and expect help: "They say Korle Bu is for the government, so if you have no money, the government should pay for you." Table 10 gives a rough overview of the costs of items patients pay. The figures were compiled during the research period in 2005 and 2006.[9]

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[9] he numbers are based on informal information, written documents, interviews with the hospital administration and statistics collected by the researcher.

Table 10 Costs and expenditures in hospital in 2005

Fixed costs:	
Accommodation	¢ 5,000 daily
Food	¢ 12,000 daily
Sanitation	¢ 8,000
Documentation	¢ 6,000
Over this:	
Development fund	10%
Spirit & disinfection:	¢ 25,000 (for pharmacy)
Consumables, used on demand:	
Gloves	¢ 1,000
Syringe & needle	¢ 1,000
Cotton balls	¢ 1,000
Sterile gloves	¢ 5,000
NG tube	¢ 4,500
Catheter	¢ 12,000
Urine bag	¢ 7,000
Examples of final costs for hospital admission excluding medication:	
- up to 1 week	¢ 160-538,000
- 1-2 weeks	¢ 411-819,000
- 2-4 weeks	¢ 767-1,680,000
Tests and medication (not included in final bill):	
Blood test	¢ 20,000-60,000
EEG	¢ 75,000
CT scan	¢ 370,000
CT with contrast	¢ 700,000
Physiotherapy	¢ 15,000
Blood transfusion	¢ 58,000
Dextrose saline 500 ml	¢ 12,500
Normal Saline 500ml	¢ 8,000
Standard antibiotics 1g	¢ 61,000 (given for at least 8 days)
Dialysis	$ 100
Chemotherapy	ca. $ 100 per injection
Sold by nurses directly:	
Water 500 ml	¢ 300
Diapers	¢ 15,000
Blood sugar strip	¢ 15,000

Source: Information by the ward accountant and data collection of the researcher

Many patients are afraid of these costs and are not able to pay. Due to the cash-and-carry system in the health sector at the time of my research, all patients had to mobilise money to pay the cost. Only few civil servants and employees of multinational companies had health insurance and could request a refund. The National Health Insurance Scheme (NHIS) that started in 2005 is slowly catching

on with Ghanaians.[10] The constant financial insecurity leads to frustration both among nurses and doctors on one side, and patients on the other. In many cases, tests cannot be run and a therapy cannot be started due to lack of funds. One patient was supposed to have a tube inserted in her lungs to drain free fluid but could not afford the cost, so nurse Lydia reacted thus:

> You are supposed to buy the tube and all needed material yourself. We write them a prescription and they go to the CSSD for the tube, sterile cotton and gauze and so on. She did not buy enough, so we will borrow some gauze from another patient. The ward should provide the patients with the drainage bottles. But look around you, we have only one bottle for the whole ward, and no sterile gauze.

In this case, a patient was willing to donate some of her materials; however, in other cases such solidarity is impossible. A patient who needed dialysis was not able to mobilise the money. Matron Mary says: "She needs dialysis, but it is too expensive. Her family cannot afford it. She is on Lasix[11] and on a diet. This is how we try to treat it; that is all we can do." In other cases, the family promised to pay the costs but did not return in time. Such delays often lead to spoiled samples. The following is a typical example of such situations:

> Several days ago, a sample of fluid was taken from the lung of a severely ill patient. This sample is still lying on her (the patient's) table. The nurses see it lying there everyday but nobody takes action. Nurse Martha explains: "She has to pay for the test. Once she gives the money, Thomas will take the sample to the lab. But she says she has no money. This is why nothing happens. It is old now, we have to discard it. The same happened to the scan-report. It was ready long ago. Her children have to go for it and pay the remaining sum before collecting it. They have not done so, This means we do not have a report. You see, this is our problem. She remains on the ward and nobody knows what is wrong with her."

As a consequence, the doctors are sometimes incapable of definng a diagnosis and deciding on a therapy. One doctor expresses his frustration thus: "The family asked me yesterday to get her home as she looks a bit better. We requested some tests be done, but you see, the request forms are still lying here. They are expensive. We will discharge her and she might die at home." In another case, the family returned to their village 'to mobilise money' but did not return. The doctor saw only one option: "We cannot make any big examinations. Unless we just order it and it is added to the final bill; if she cannot pay then, the Welfare Department might jump in or we discharge her untreated. This is our situation here in Ghana. We do not have enough money." This quote shows how crucial the financial situation of a patient is in order to make hospital admission worthwhile and create a possibility of regaining health. In other situations, old family problems come up and influence the decision whether a patient is supported or

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[10] See Chapter 4 for details.

[11] Lasix is a medication that is injected in the vein to avoid edema and fluid retention, and to motivate and improve the production of urine.

not. Matron Mary recalls the case of a patient whose family refused to buy expensive medicine with the following explanation:

> They told me straight in the face: 'this one, she doesn't contribute to the family fund so we can't take money from the coffers to buy her medicine'. Where are the children? They are not here. That is the end. They go and don't come back and the patient dies.

Nurses and doctors agree that this tension and stress has an influence on patients' health, but see limited ways to solve this problem. Patients who cannot pay the bill sometimes stay longer on the ward without treatment till family members succeed in coming up with some money.

In some cases, the church or religious community to which the patient belongs assists and pays part of the cost. When such a solution is also not possible, patients can receive support from the hospital Social Welfare and medical departments, which have funds for indigents. The Social Welfare Department, in which five social workers and two assistants work, is informed by the matron of the ward when a patient is not able to pay a bill and the relatives then have to go there to explain their situation.[12] According to the matron, "about 90% of our patients can pay their bills. The others have problems, and we refer them to the Social Welfare Department. The social workers will then go to the home of the patient and see whether the family can generate the money or not. They will search for family members to pay; they always find somebody (she laughs)." Some patients are satisfied with this solution, while other feel ashamed and fear opprobrium in their neighbourhood when this becomes known. Another aspect is that the Welfare Department need a guarantor who has a regular income and a bank account as security. When the deal is done, the patient can go home and pay the debit in instalments to the hospital. The medical department has its own fund, called *Mobrohunu (compassion)*, which was initiated by a private person about five years ago. Nurse Grace explains:

> It distributes ¢ 500,000 each month to each medical ward. It can be used for emergencies and to pay for important test for those patients who have trouble mobilising a bigger sum of money. Sometimes, if we see that a person is in difficulty but needs a test, then we help. But it cannot be used by one patient. This means the fund is not meant for the settlement of final bills. Last month, one patient was granted ¢ 25,000 for a blood test, another patient ¢ 88,000 for another test. The form for it must be filled out and signed by both a nurse and a doctor stating the medical need and financial situation of the patient. Then it is given to the administration to arrange the transfer of money.

In this way, the nurses have some influence on the well-being of their most needy patients. Truth and cooperation are required; otherwise the nurses are not willing to help, as Nurse Edith confirms: "These traders and farmers do say that

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[12] In 2006, 1,120 cases were handled by the social welfare service for the whole hospital. 120 patients were declared paupers and their bills, being worth more than 77 mio cedis, waived off. (Korle Bu 2006)

they do not have money, but they do. The problem is that they always first try to cure themselves, take any medication from the pharmacies. Then they go to private clinics. By the end of the day, they all come to Korle Bu. Another group of patients comes here because we are a government hospital and cheap. They come for cheaper treatment. If they come too late and are not cooperating, there is nothing we can do." This shows how fragile the confidence of the nurses in the financial strength and honesty of the patients is.

Just as it is for the nurses, religion is an important aspect of the patients' lives. All Christian patients have Bibles with them. They are placed next to their heads or under the pillow, forming together with their mobiles phones and some money their most valuable property. During the visiting hours, their families pray, sing and meditate with them. The same routine goes for Muslim patients. Every now and then, a Catholic priest visits the wards, offers to pray with patients and blesses them. He encourages severely ill patients to trust in God:

> Don't cry, you cry for the devil. Rejoice in God for you will be healed and live! Jesus, come with your healing power and touch these patients. The doctors are only human beings, but you are God Almighty and can heal. Come with your powerful hand and give healing. We soak our lives in your blood.

In the patients' conception, two ideas are expressed: They surrender to God and they praise Him for His protection and mercy. Typical phrases to capture such situations are as follows: "only God knows; nothing is difficult for Him" and "God knows best. We humans cannot talk much, but in all, we have to give Him thanks." An old woman, who had never been sick before, was admitted after collapsing during a church service and diagnosed with high blood pressure. In her eyes, this is part of God's plan for her:

> God wants me to rest. And God wanted the doctors to see me, this is why He brought me here to collapse. Every day you have to praise God and thank him. I am doing fine now. God brought me here on a Sunday, so I have my Bible with me. They made an x-ray of my whole body. It seems God wants the doctors to see me completely, from hair to toe.

In line with that belief, patients are grateful to God for protecting them in these 'tempting times' of illness and death. The response to a morning greeting is: "by the grace of God, I am doing fine. Praise be to God" or "I am feeling much better, it is only God who knows." One woman who was admitted after a serious allergic skin reaction (Stephens-Johnson syndrome) expressed her praise and gratitude by comparing herself to her fellow patients: "I have learned a lot on this ward, especially, to love God more. I am not better than these, I could also lie in the fridge[13], but God is saving me. I pray, 'please God save me'. And He can do it. He can tell the doctor to go to me and give me the right medication."

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[13] Patients use the term 'the fridge' to refer to the mortuary where the deceased patients are brought. It is a common expression used in hospital and in the society in general.

The nurses pray as a group in the morning devotions but hardly ever with patients. They fully support the individual and family prayers, saying "It helps them a lot psychologically; It helps to solve or cope with their problems." After a patient has died, they try to console the nearby patients and their families: "This is a time of challenge. Today, a fine woman joined our Lord in heaven. So let her life be a memorial for us. These challenging times are to show our strength and belief. We know that our Redeemer liveth, God is in control. Do not look down, stand up and rise, the Lord is with you." Similar to what could be understood from the religious expressions and beliefs of the nurses, the faith in a supreme God and His healing power strengthens the patients to face reality on the ward. It helps them to cope with uncertainties, stand their pains and gain hope for a speedy recovery and successful discharge from the medical ward.

The nurses' view of patients is twofold: With some patients, nurses build up a relationship and know their backgrounds and families. This is mainly with returning, chronically-ill women like several young girls suffering from leukaemia or Sickle Cell disease. Even before they are re-admitted, their presence in the hospital is known and beds are arranged. Several of these patients died during the research period and these were moments when the nurses were emotionally touched and felt sad. But the majority of patients remains relatively unknown and the contact with the nurses is superficial. The following section portrays three different types of patients that represent the hundreds of women who pass yearly through the medical ward.

Lizzy

Lizzy, a 17-year-old girl, was admitted with Stephens Johnson Syndrome.[14] She claimed to have suffered from malaria and went to a local health post where she was given medication. She developed blisters and swelling on her body and was rushed to Korle Bu for further treatment. Her whole body is showing signs of burns, the skin is peeling off and she can hardly open her eyes. Her mucosa is also affected, which makes swallowing fluids almost impossible and painful. The file says: "She was apparently well till seven days ago when she was given amoxyclin. She was thought to have chicken pox as some people in her neighbourhood had it." Lizzy lies in bed partly naked, only covered with a sheet. Nurse Phyllis has specialised in caring for such patients and washes her every morning. In the meantime, two nursing students change her bed-sheet. These pa-

[14] Stevens-Johnson Syndrome (or Toxic Epidermal Necrolysis) is a potentially deadly skin disease that usually results from an infection or a drug reaction. It starts with rashes and blisters on all parts of the body. The mucous membranes can become inflamed. It is very painful and patients risk dehydration or hypothermia. Layers of skin, hair and nails can come away with ease and often the skin peels away in sheets.

tients use their own sheets as the mercurochrom[15] colours the sheets. On the old sheet there are particles of old skin soaked by the fluid that comes from the bursting blisters. Nurse Phyllis pushes her in a wheelchair to the shower and washes her with soapy water. Lizzy is in pain but cooperates by turning around and not itching. Phyllis wears a plastic apron and gloves. With cotton, she rubs Lizzy's body, and with a razor blade and a needle opens the blisters so the fluid can come out. Old, dead skin is removed carefully. Lizzy shivers. At the end, Phyllis covers the skin in mercurochrome, which is the most painful part. Back in bed, the care continues: Phyllis opens the blisters on the hands and feet. She does it with a needle as she cannot find a sterile blade. She explains: "It is important that they come early and stop taking the medication that causes the reaction. Here they are put on several antibiotics and painkillers. She will be fine, I have seen much worse cases going home. She will be ok." Student Susan explains further: "They say she took some medicine she bought on the market or from a herbalist. This girls take anything, she will not tell you the truth."

A few days later, her situation has worsened. Lizzy can hardly walk and only drinks small amounts of water or coke. It is time for the shower. Matron Mary goes to her office and gives the nurses the last supply of cotton wool. "She will replace it; her sister will come later today. We will collect money from the staff and buy it ourselves. Each nurse pays ¢ 10,000 and we can buy the needed materials." Phyllis chips in: "The problem now is the vomiting as she is losing too much fluid. They tried to set a line but it did not succeed. The whole skin is swollen or peeling off."

After the washing is finished, Lizzy is feeling hot and cold. The nurses push her in a wheelchair and place her under the fan in the middle of the ward. One hour later, she collapses. Nurse Grace calls everybody: "All hands on deck, we need assistance." Two nurses, two HCAs, and the orderly, David, put her back in bed. She passes urine and stool uncontrollably and is gasping for fresh air. Her head falls back. The matron comes and starts oxygen to be passed through the nose. A doctor is present and orders the nurses to check her blood sugar level, which turns out to be low. Two nurses stay, more or less shouting at her to open her eyes and look at them. After some time, Lizzy recovers, she breathes normally again, asks for water to drink and urinates in a bedpan. At noon, the nurses decide that she should get a wound dressing by applying a protective cream on the skin and covering it with gauze and bandages. It is called "wet dressing." Two nurses do the dressing, two others assist. Lizzy sits up and they start with the arms and legs. They apply the cream thick on the body, then cover it with the non-sterile gauze and fix it loosely with the bandages. Matron explains: "We

[15] Mercurocrom is a fluid iodium containing disinfectant (antispetic) used to clean wounds. Its colour is red and difficult to remove from clothes.

leave it for two days, then we renew it. Those on duty on Saturday have to change it. The cream is water soluble, so we will soak it in water and it will easily come off. Together with the gauze and bandages, this is a ¢ 100,000 cedis affair. All nurses will contribute and buy the next cream. I want this girl to go home." One hour later they are almost finished, when Lizzy's body gets heavy and her head falls back. They lay her on her back but she does not react. The matron shouts at her "Lizzy, come on, open your eyes. Do you hear me?" She squeezes her arms and legs to evoke a reaction, but no response. Then they try to re-connect the oxygen and realise it is finished. She calls for the sucking machine but it is not working. Mary gets angry and starts with the re-animation. The body, partly in white bandages, moves up and down uncontrollably. Grace stands there, motionless, Edith stops smiling. Mary calls for a stethoscope, checks for the heartbeat, looks up and shakes her head. Her face is without emotion. The other patients are quiet. Mary explains: "Her mother is also ill, it is a tragedy. She had just told me that she wanted to finish her school education, her English was very good. I wanted her to go home."

The doctor comes, looks at Lizzy and puts on gloves to examine her. He looks in her mouth and says: "She is not so pale after all. The Stephens Johnson is a problem here in Africa. I would like some nurses to attend a workshop on how to care for those patients best. Especially the wound dressing and pain therapy are important. I am not sure why mainly women get this reaction. One explanation is that men start drinking when they have problems. Women start taking drugs of all kind." He takes some gauze to open the swollen eyes and shine with his torchlight, the eyes do not react, he shakes his head. Lizzy is pushed out of the ward to the treatment room. At the table, the nurses are sitting silently then suddenly, Catherine says: "The work of a whole morning is gone."

Elisabeth

Elisabeth Kwasie is 59 years old, divorced and lives on the Kwahu plateau in the Eastern Region working as a cacao farmer. She is admitted to the ward with pleural effusion on the right side and pneumonia. She has never been hospitalised before. Her brother visits her every week and is informed about her treatment and new prescriptions. Her older children remain in the village, but her youngest daughter of 18 came with her to look after her. She brings her food every day and washes her clothes and sheets. Her bed is in the middle row at the end. The nurses call her auntie Elisabeth, greet her in the morning, check her vital signs and give her medication. For the rest of the day they leave her alone. Auntie Elisabeth has pains in her lung and difficulty with breathing. The doctors decided to insert a chest tube in her right lung and gave her brother the prescription to buy it. Now that they have the materials, they have placed a screen around her

and have started working, but as the site is a bit dark, they ask for a torchlight from the matron's office. Fixing the tube is a painful process; she is crying and coughing. After half an hour, the tube is inserted and fixed. There is blood on the floor and on the bed. It seems the tube and collecting system is a new method and neither the nurses nor the doctors know how to use it well. The matron comes to see it also and is asked for advice. They manage to set the equipment and finally bloody fluid is running into the container. After draining half a litre, the tube is closed. The doctor explains: "You have to do is small small, otherwise the lung reacts with an oedema and we do not want that to happen." Thirty minutes later, the matron says: "Let's look after that chest tube." She goes together with three nurses and looks at it. A paper lies on the locker, stating that it is a single use chest drain system. Matron Mary elaborates: "Yes, it is a single use system meant to be disposable, but we are here in Ghana, we cannot afford that, but have to empty it and use it again. We cannot use it and just throw this away."

In the course of the weeks, there is no improvement in Auntie Elisabeth's health. She lies in her bed and only gets up to go to the toilet and shower. A CT scan is done, but the resulting diagnosis reveals: 'massive pleural effusion; cause unclear'. Her family is angry, as the test was expensive without leading to any satisfactory new diagnosis. It is decided she should be treated for tuberculosis. The doctor says: "The treatment for TB is free. You know, some patients might not be TB cases after all. But if you as a doctor do not know it any longer, and the patient is short of money, you put her on TB treatment. From that moment on, they do not pay any longer. In many cases the real problem is the malignancy of the tumour. We would need a biopsy, but there is no money." Auntie Elsiabeth is getting weaker. The brother gets impatient and says: "They say maybe it is cancer. What can we do? Her life as a farmer was not always easy. But she was never sick; she never had to go to a clinic before. She is getting weaker, and the debts are piling up. I cannot take her to my home here. Who should look after her there? She has three sons, but they are busy. If she dies, fine. If she recovers, we thank God. Praying is all we can do." After three months on the ward, nurse Vivian states: "She is here too long. Some patients can become emotionally stressed and need a change of environment. The TB treatment also makes you weak. She was here most time of the year, imagine that. They need to talk to the doctor." A few weeks later she is discharged, weak and coughing. It remains unclear what causes her lung problems. Her bill totals 1.5 million cedis. Her brother needs several days to come up with it. Then they leave. Auntie Elisabeth says when leaving: "My family is fighting about the money. My daughter, too, left me today in anger. She should give me porridge but I was lying down. How can I eat lying down? At home, they have to give me medicine, Blackman medicine, you know? It will help me, so I will take small together with your

medicine. If only God wakes me up." Nurse Grace bids her farewell and then turns to her colleagues: "Money was the problem. She has been here too long and nothing has happened." Auntie Elisabeth had been on the ward for more than four months.

Akosua

Akosua is an ever-friendly young woman in her early 20s. Two years ago she was diagnosed with acute lymphatic leukaemia. She lives with her mother in Akosombo, about one hour drive from Accra. During the research, she was admitted four times for a check-up and chemotherapy. Her general condition is good and she is mobile. Normally her mother, a nurse herself, stays with her bringing her fresh fruit and juices. She is her only child. Returning regularly to the ward, Akosua knows all nurses and considers herself their friend. "I normally try to be in this bed next to the nurses. You see what is happening and I do not feel too alone. I use a mosquito net. There are too many mosquitoes, especially during the night. And they are big, they bite you well. The nurses are good, they are doing well. They give me my drugs and I take them on time. If you are nice, they are also nice. But some patients are rough and do not want to take their medication on time. In such cases the nurses are also rough, but you cannot blame them. It is not easy for them, so they become unfriendly. What can you do?" Knowing each other well, she has the privilege of being allowed to use the nurses' bathroom. When feeling well, she helps them with the selling of diapers and ice water from the fridge and at times keeps the collected money for them. During the day, she makes her own bed and reads a lot or chats with the health care assistants. Like many of them, she did not do too well in her final school examinations and they study together for the re-sit papers. Stella, another girl with leukaemia, is her best friend and they often meet on the ward. Stella dies one Sunday night in the bed next to her after being rushed in having suffered from bone pains a few days before. The nurses, sad themselves, comfort Akosua and bring her candies and vitamins to strengthen her. For her therapy she needs regular lumbar punctions and the medication is injected straight in the spinal chord. Akosua tries to bear the pain and the subsequent 24-hour bed rest, suffering most from being dependant on others for help. The nurses know that, so they are patient and understanding with her. The doctors know her also and sometimes take her out of the ward. "I hope to feel better soon. You see, I know all of the doctors. Sometimes one takes me out for a ride. This is how I know a bit of Accra. They know that me, I won't run. I am grateful to all the doctors and nurses. All nurses here are hardworking and friendly. I really like them." Over the months, her condition does not improve and financing her therapy becomes a problem. One chemotherapy treatment costs more than $100 and she would need

12 to 14 in a row. When her blood count is too low, she is discharged home to rest and regain strength.

Returning to the ward in 2006, I meet Akosua again and witness her ongoing struggle against leukaemia. In the latter part of 2006, she is weak and rushed to the ward. Even when the ward is officially full, the nurses manage to find her a bed and admit her straight to the ward. They want to spare her from having to stay at the overfilled emergency or a foreign ward. The nurses recall: "Akusua was here; oh she frightened us. She even was on oxygen. We were afraid. She is slowly deteriorating, oh she was sick and we were scared." Later they learn that Akosua died at home shortly after her last admission in 2007.

Conclusion

The three life stories above show the variety of patients and of possible nurses' reactions. Patients like Lizzy demand exhausting manual work and the nurses often blame them for their conditions. Auntie Elisabeth represents the large group of patients who remain invisible, and with whom relations remain impersonal. Akosua is an example of those patients who build up a close relationship with the nurses and develop friendships.

Asked in concrete terms about differentiating the patients in their nursing activities, the nurses feel uncomfortable. Martha states: "No, we don't label a patient as difficult. No, you don't label them; they are unique in their own way." Her superior admits problems in treating all patients the same: "We don't want to, but sometimes some patients are quite troublesome. You go and change the bed, you barely turn and then the bed is wet again. You barely empty your trolley and the bed is wet again. And the next time you see her in a pool of urine, you'll pass by, because you're tired. If you don't take care, you'll get fed up." (Matron Regina). Nurse Grace reflects on her work and is critical:

> Actually, we do not manage to treat all the same. Like a patient who's supposed to have her drugs served. If you don't have your drugs, how do I treat you? Do you understand? And no matter what, even if the person is poor or rich, you are supposed to bathe the patient. You're supposed to give the patient food. But when the patient doesn't have other things like a bed sheet to use to cover and there's no bed sheet in the hospital, and a rich man has his bed sheet, obviously, you'll use his bed sheet to tidy his bed and that's where the differences start.

She agrees that the personal wealth and appearance of patients make a difference in how they are treated on the ward. Another differentiation is made between 'the educated' and 'the illiterates', standing for those with a higher education and profession on the one hand, and the petty traders and people from the rural areas on the other hand. They blame 'the villagers' for being ignorant: "They are not educated and go to the herbalists. They give them drugs to take or apply. We have a lot of problems with them." (Nurse Catherine). Edith agrees:

"You know, most patients are illiterates, excuse me to say. We need to talk to them in their dialect so that they can understand us and do what they need to do. We try to educate them but it is difficult." The nurses' aim for all patients is to have them rest and relax while on the ward in order to regain strength and have all therapies work out well.

In order to understand the interaction between nurses and patients, it is interesting to start by analysing the patient's behaviour. During contact with doctors, all patients are silent, waiting to be asked questions, and not daring to pose questions themselves. Towards the nurses, they sometimes utter their feelings of insecurity, but there is no structured counselling or psycho-social encounter. The nurses expect them to be compliant with the ward routine. This is comparable to the sick role model as elaborated by Parsons in the 1950s. For him, "being sick is not simply a state of fact or condition, it is a specifically patterned social role" (Parsons 1951: 436). This role allows patients to be temporarily exempted from their usual social and professional duties and generally they are not blamed for their condition. However, the exemption obliges the patient to seek advice and treatment from qualified people and to develop the will to get better. Although this model is criticised and weaknesses are shown, it applies in many respects to the patients on the medical ward. They are expected to lie in bed, relax and obey orders from doctors and nurses. Contrary to Parson's claim, in the context of Korle Bu, blame is often placed on patients for their current situations, and it is hardly suppressed. Patients are accused of being negligent about their health, bringing severe illness to themselves. Their lack of education, the expression 'villager' and constant financial pressure belittle the patients and manifest the power of nurses over their patients. The three types of patients described above reveal how patients' status and their relation to the nurses are negotiated and determined. Anderson describes it as "negotiations of relative status (that) are important because they produce a particular allocation of power between individuals" (Anderson 2004: 2006). Patients respect nurses highly, even if they are much younger than the patients themselves, and they are asked for advice and explanations. The nurses' reaction is mainly to command them to be silent and passive. This fits also with the cultural norms that emotion and fear should not be vocalised, and that too much questioning is seen as a childish behaviour and a provocation (Geurts 2002). There is hardly elaborate communication between them. Sazs & Hollender, who analysed the interaction between doctors and patients, elaborated several models. The activity-passivity model that could for this purpose be expanded to the nurse-patient relation fits in the research situation: "There is a similarity here between the patient and a helpless infant, on the one hand, and between the physician (or nurse) and a parent, on the other hand" (Sazs & Hollender 1978: 101). In 1983 Armstrong described the fabrication of

the relationship between nurse and patient. Assuming that this is a relationship between two subjects rather than a subject and an object, he looks into the development of nursing. The main points were (and are, in this case) gaining the patient's trust and conveying a sense of good health. "It was clear the relationship was construed as something dynamic, that led to problems of communication and emotions. The nurse plays a part; the patient watches and is hopefully impressed" (Armstrong 1983: 457). As nursing developed further by theories initiated in Europe and the US, especially the emotional and spiritual care of patients gained more attention. The relationship between patients and nurses on the ward can be understood in those older terms. Displaying discipline and presenting knowledge on the one hand and requesting unquestioned obedience and respect on the other are the main features that characterise the nurse-patient interaction.

The analysis of the three major groups with whom the nurses interact during their work on the ward shows the power constellation and ongoing definition of the nurses' situation. They are dependant on the doctors and need to show respect while hoping for improved cooperation. They clearly separate themselves from the orderlies, give them orders and avoid being associated with cleaning work. The nurse-patient relationship is characterised by limited communication. The nurses' attitude is that of the knowledgeable and respected health worker. Presenting themselves as powerful and in control is the guiding principle towards all groups but can only be partially realised, depending on their counterparts.

15

"We are managing." Challenges in nursing

As in every profession, there is a mix of professional standards, individual expectations, cultural influences and structural aspects that shape the working reality for the nurses in the hospital. It provides resources that can lead to both stronger bonding with the profession and individual frustrations and general job dissatisfaction. Some factors can be traced back to individual experiences; others have their roots in the nature of the organizational structure of the hospital or in the nature of the work itself. In this chapter, a few of these factors will be highlighted. Starting with the challenges nurses face on the ward, the focus will then move to factors related to the organisation of the hospital and health sector and finally highlight several complicating aspects of the nurses' private lives.

Working on the ward: Dealing with expectations

> We try our best, but it is not enough, we are just improvising. If the doctors cough, all hear them coughing. If nurses cry, nobody hears their cry. (Evelyn)

The nurses regularly express their problems in coping with the workload on the ward due to poor working conditions. Three aspects can be isolated that challenge them: The provision and use of equipment, low motivation and limited job satisfaction, and the intergenerational gap between the nurses.

To measure vital signs, the ward has three digital thermometers, two working blood pressure gauges with stethoscopes and one machine to check blood-sugar levels. All wards are regularly supplied with general equipment like gloves, normal and sterile cotton wool and gauze, syringes and plasters. Every morning,

the laundry service is supposed to deliver clean bed sheets and collect the used and spoiled ones.[1] Regularly, the main laundry encounters problems with the water and electricity supply, resulting in less lnen or no delivery at all. During the rainy season, the drying process is slowed down, leading to additional shortages.

Once a week, the nurse in charge files a request to the hospital's pharmacy for disinfectant spirit, parasol and plasters. In addition, there is a basic supply of drips (normal saline and glucose), sterile urinal catheters with urine bags and stomach probes. The reality however is that the stocks of bed sheets and disposable gloves are especially limited, leading to delayed nursing actions. Matron Hilda elaborates:

> Supply is our problem. We make a yearly budget, estimate the number of patients, the gloves and everything that is needed. You know, at other wards, they are not so ill, so you do not need so many gloves there. But here, people are sick. Normally they should supply us twice a week with equipment. We write what we need and it is brought to us by the main supply. I think the shortage has to do with the general import. There are people who say the hospital owes the main supply money that is why nothing is given out. Like this, all work is affected. And you see, we also had the water shortage last week. There are still not enough bed sheets for us. Monday they brought only few sheets, yesterday none at all, and today five. And that must be enough for the whole ward. And we just have two boxes of gloves for the whole day. What happens in the night? The night nurse has not enough gloves to protect herself when something happens.

Every morning, the matron provides her team with some bed sheets, a box of gloves and some spirit for disinfection. She keeps the stock locked in her office. Depending on the supply, all or just some beds can be refreshed. There are sheets of different sizes, and the nurses have to try their best to have the whole bed covered with a sheet so no patient is lying on the plain plastic. As described in Chapter 10, the aim is to have a 'white and clean ward', so the nurses refuse the patients' colorful own cloths.

Nurses, doctors and the orderlies use disposable gloves for making beds, feeding, dressing wounds, examining a patient, cleaning the ward and so on. The matron keeps them in stock and hands out the boxes reluctantly. An opened box with gloves seems to attract all personnel to collect several pairs and keep them for later procedures. In the morning, a box (with 100 pairs) can be emptied within half an hour. When later that morning, doctors need gloves to set a line, nurses look for gloves to insert a urinal catheter and students request some to dress wounds or change a soiled bed sheet, the search for gloves is part of the preparatory procedure. Nurses and doctors alike complain about the shortage, students are frustrated and joke about it. One morning, a nursing student feeds a patient suffering from tuberculosis through a tube wearing no gloves. She says: "You know they are having a strict glove economy here." Similarly Sister Grace

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[1] The number of collected sheets is recorded in a booklet. Each ward marks its bed sheets and makes sure it receives all collected sheets back.

gets angry one morning: "I do not know what they (younger nurses and students) do with them. Do they hide them or what is happening?" Nurse Vivian explains:

> Here at medical, we need a lot of gloves. It is now ten o'clock and they are already finished. You see how serious it is here? Me alone, I used already four pairs by washing this patient, Joyce needed seven pairs to treat the patient with severe wounds. And the orderlies pick a lot of them to clean the ward.

The matron justifies her hesitant supply: "I give out full boxes. Where do they all go? We do not have enough. How can we work without equipment? I have to be prepared for a critical shortage and we need to have enough in store for the doctors' rounds and in case a medical exam takes place and we need to present our ward well" (Matron Mary).

The mode of general maintenance of the old hospital building is reflected in the unpredictability of the work. When the electricity supply is cut, it takes up to 30 minutes before the generators work at full speed and provide the ward with an adequate supply of electricity for the lights and ventilation to function again. In preparation for such eventuality, a few torches and fans are always available. For unclear reasons, however, the telephone line has been down for over a year without any attention paid to it. In emergencies, a nurse was sent to the neighbouring wards for a doctor, leading to delays and critical situations in the care for patients. The hope of the nurses lies in the fact that this situation is temporary. The original medical department is under renovation and about to be ready. Although planned to take only a short time, the renovation period has already lasted for several years and is frustrating the nurses. Several reasons were given for the long delay: Mismanagement, delayed payment of the workers and political reasons at the local and national level.

> It seems they have forgotten this ward while they are renovating the block. In the new block, we will have much more space and more equipment, everything will be better there.

Towards the end of the research period, the matrons were invited to discuss and asess the new wards' equipment and plan for the transition period. All nurses hoped to move in within the coming year but "the rate at which they are working, I doubt it. I'm not convinced until I go in" (Matron Mary).[2]

While facing the shortage and shortcomings, the nurses invented their own means to manage the situation. The official measure is to fill in cost sheets per patient. S/he will be billed for the use of equipment like cotton wool, syringes and gloves and generate income for the hospital. In addition to that, nurses sell diapers to incontinent patients and blood sugar strips to diabetic and newly admitted patients. They buy the diapers and blood-sugar strips in the pharmacy and sell them for ¢ 15,000 a piece. That is a bit more expensive than the original

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[2] After the fieldwork in 2005, I returned to the ward several times. As of 2008, the transition to the renovated and well-equipped department still had yet to take place.

price, and with the profit margin, the nurses buy additional cotton wool or soap for the ward. Patients and their relatives appreciate that service and willingly pay the amounts. On admission, patients are as well asked to pay a (voluntary) amount into the ward fund to buy needed equipment. When a patient is discharged and does not take surplus medications and infusions with her, the nurses keep those in a special part of their storeroom for 'patients in need' and 'emergency situations'. In extreme emergency situations, all nurses are asked to donate money (for example ¢ 10,000) to buy soap or dressing materials for the patients. Sometimes, donations are presented, for example 200 bed sheets from the Catholic Archdiocese or four beds via an NGO from overseas. About halfway the research period, the situation of the sheet supply worsened and the nurses decided to appeal to visitors and families of their patients. A poster was placed at the entrance asking for help. It read:

> Special appeal: Dear valued visitor, it is our earnest desire to care for our patients in a healthy and conducive environment for their speedy recovery. We are compelled to make a special appeal to your for (1) one or two bed sheets for one bed or (2) more bed sheets for more beds or (3) material for bed sheets or (4) a token amount of money for the purchase of material for bed sheet. Measurement: 180 cm by 270 cm.
> We would cherish your contribution as a special gift to our ward K and our patients.
> God loves a cheerful giver. May God richly bless you! The Entire Nursing Staff.

After several weeks, sufficient donations had arrived and the pressure ceased.

The irregularity of service and low standard of the working conditions reflects in the motivation of the nurses. Even so, most nurses share firm religious convictions and motivate themselves by 'doing a good thing.' They all know moments when the job satisfaction is low and conflicts arise. A general statement is that: "We try our best, but our best is not good enough." It seems difficult "to enjoy nursing because we're just improvising." Feelings of frustration are intensified by long working hours and, in the nurses' perception, too-low salaries. This leads to financial struggle and tension in the nurses' personal lives and low working morale. Their dissatisfaction is vented on several levels: nurses are absent during their shifts to accompany relatives to the polyclinics, carry out bank transactions or follow their own business. Others report late to duty after a vacation. Depending on their position in the hierarchy, they are reprimanded for their behaviour, or it is just accepted with a sigh. In the case of a younger nurse who reported two days late after her annual leave, the nursing direction was considering what to do with her: "We have not yet decided on the punishment. We need her, but she is young and has to learn. Maybe we will take her two days off later this month. You cannot just stay away. In addition, she will get a remark in her file." Negligence or even refusal to care is treated more seriously, and it is the task of the matrons and nurses in charge to ensure that basic care is carried out well. The following example shows this: After a weekend, the departmental nurse in charge

recognised on her regular round a gap in the documentation of a patient's vital signs. That patient had developed a high fever on the previous Friday, but neither the chart nor the nurses' notes mentioned its development or any action taken. Calling the responsible nursing team, her position was clear: "Supposing this patient dies and the family calls us, the parents can sue the nurses. When they call for the papers, we all – the department of nursing, senior sister, matron, director – we are all in trouble." The responsible nurses had to apologise.

There is also pressure from outside, increasing the unhappiness of the nurses. Media reports every now and then about the poor quality of delivered service in the country's health posts and the effort to pursue patients' rights make the nurses feel they are under additional pressure and observation. A retired nurse recognised the falling standard in the hospitals but also demanded: "We (Ghanaians) should stop demoralising our nurses; the newspapers report so many negative things. Give us our praises when we deserve them and encourage the nurses when possible. This ongoing condemning demoralises all of us."

There is a split within the nurses' group between the older and younger generation. While it is common sense that all professions experience a gap between the taught theories and experienced practice, another aspect is prominent here, namely dealing with and preserving the generational hierarchy within the nursing group.[3] The exchange of knowledge, the will to introduce and experiment with new ideas and the intention to work as a team while respecting existing hierarchies, are a permanent challenge. Students express their frustrations that they are not sufficiently tutored and guided. Their complaint is in general that "we learn something, but on the ward, it is a different thing altogether, and we have to accept it." A male student in his second year sees the hierarchical organisation as the main problem: "We are not supposed to know anything. That's the idea!" His colleague recalls a situation when a senior nurse demanded her to administer insulin to a diabetic patient without following the correct medical procedure. "The senior nursing officer said: 'we were going to give medication' and said I should bring insulin. There was a doctor's chart with a sliding scale and I knew, we are to check the random blood sugar first. But the nurse said I had to give it straight." The student felt torn between the medical procedure and obedience to her superior and escaped the situation, leading to an angry superior and a lower evaluation on her side. A final year student tries to find a solution. "How can we bring the different views together, synchronise them and get the best out of it?" (Cecile). Their teacher expresses hope: "That's why I'm saying that if they don't join them and they put into practice what they've been taught, then we are going to have a change. But if they go back and they just join

[3] In previous chapters, the gap between nursing theory as taught in school and nursing reality on the ward was already discussed.

them and do the same thing, then we will have a problem. I hope there should be a breakthrough" (Ernestina).

The clash of generations is very visible in the implementation of the care plan for individual nursing. Having been taught and having practised recently in training colleges, it remains a mainly theoretical exercise for the students without regular follow-up on the wards. There, functional care is realised and the nurses give several explanations for that routine. For them, the time factor is decisive. Filling in the forms and conceptualising individual needs and resources takes too much time. Sister Grace says: "You see, the care plan is a good thing. We all learn it and know how to do it. But we do not have the time. We are just two nurses for 30 patients; how are we supposed to write all? Her colleague is more critical about her routine: "Actually you should be able to give patient centred care or teamwork care, when you have enough nurses. Currently, the students wash, and nurses check the vitals and the matron does the BP. The work has to be done, but it is not in the right way. What can we do?" While students are encouraged to practise on the ward, they miss support and supervision. "This is just theory. We do not see it practised on any ward. We just do it for the exam. I think the nurses tell each other the most important care issues during taking up." Her friend thinks along the same line:

> The care plan is just a routine for the exams, after that it is not used any longer but disappears in the cupboards, it does not live. We would like to implement it really, but there is resistance on the wards. Most matrons also never learnt about the plan, so nothing is happening. It is difficult for us students to bring something new into the system.

The above conversation shows that nursing students would like to implement new nursing theories and try out new ideas. Their position on the ward as lowest in the hierarchy seems to prohibit active involvement in the ward's organisation. As the older nursing generation defines the standards and demands respect, the younger colleagues have to fit in. Both sides feel uncomfortable in their position. Nurse Phyllis tries to justify their actions: "We are sometimes accused of not doing the right thing. But with some patients, you know that they will die. What could we do? They are many and we are few. When the situation gets worse, we send somebody for the doctors but they often come too late. We do our best." Demanding respect from the younger generation, realising one's own shortcomings and dealing with structural difficulties make working on the ward challenging both personally and within the group.

Working in the health sector: Forming alliances

> You see, by the end of the day you need a place to lay your head. The salary is not sufficient to buy some land and build a house. We see it that some old nurses do not have a place to go after they retire. This de-motivates the young nurses and they leave. If you are lucky, you

> have a good husband and he will care for you and buy some land for you and the children. Then it is ok, otherwise you are lost. (Nurse Phyllis)

The nurses on the medical ward see themselves as part of the bigger group of nurses within the hospital. Working in such a renowned national hospital brings status, but they also feel under constant pressure to perform well. Two aspects exemplify the way nurses vent this: The ongoing struggle for better salary and their view of the hospital's administration. Leaving Ghana to work abroad seems to be one solution to escape the shortcomings and frustrations of the country.

Most nurses complain that their salary is insufficient and should be raised. In 2005, the average monthly salary for a nurse varied between one and two and a half million cedis (about $100-250). This is comparable to the salary paid to civil servants like teachers in public schools. It is supplemented with the Additional Duty Hour Allowance (ADHA), bringing in the net salary to a sum between two and three and a half million cedis. While the salary is paid on a monthly basis, the ADHA is often delayed or detained. Negotiated by the nurses' association (GRNA), the ADHA started in the 90s as a financial compensation for the growing workload and irregular working times. Being meant to support additional work, it soon turned into a standard payment, but on varying scales. The association's president explains: "If you ask me for the biggest achievement so far, it is the increase in allowances. Nurses are given a general salary. In addition, there are the allowances, but they differ between hospitals depending on how much money they can generate. Those with much money are paid more; those with less money receive less. As the psychiatric hospitals and the TB and AIDS treatments are free of charge, those wards cannot generate much money there and nurses are paid less in allowances. This is a problem as the nurses are less motivated there."

Many nurses experience problems organising their lives with this salary. Paying the rent, their daily travel and food, caring for children and their schooling, it seems impossible to buy land or save money for later needs. It is an open secret that several nurses try to generate additional money by either working in private hospitals in their free time or engaging in trading or catering activities in their neighbourhoods. Some nurses think about traveling abroad to earn more. One nurse says:

> If I knew here in Ghana I can be paid some amount of money and I'll be able to build, it would be alright. If I only knew that when I go on retirement, I'll get a place to sleep, I wouldn't need to travel.

The irregularity of payment leads to irritation and frustration for all health workers. During the research period, doctors and nurses went on strike several times. These strikes took place across the country. The media reported it and both the workers' demands and the strike's consequences for the population were

discussed in the streets. In September 2005, the countrywide strike was caused by an ADHA payment delay of more than six months. Only the private and military hospitals continued their services and tried to cover the need. During this strike, the hospital was covered with posters reading: "REMEMBER THE 7TH … and keep it holy! No ADHA, no …" Nurse Martha explains: "It is about our allowances. You know several years back they started paying us those. They do come, but not regularly. We nurses cannot pressure them to pay, so the doctors do it with us. These posters remind them that they have to pay us. Doctors are heard better than nurses." During the strike, most wards were empty, and only a few patients were admitted. Officially, the emergencies were closed and the outpatient department ran on minimal workforce. As it turned out, those admitted patients were either chronic patients known to the staff or in one way related to one of the health workers. It mattered whom you knew. Nurses did come to work and used the time to clean the ward thoroughly with the orderlies, sort the files, and discuss their position. They were aware of public opinion. "In the former times when we did not complain even so we worked a lot and the payment was low, we were seen as gentle and called 'the noble profession'. Now that we claim good payment and want to enjoy life on earth, people criticise us. We going on strike is seen as crude, but we fight for our rights on earth, not only in heaven." (Nurse Edith) After two weeks of negotiations between the associations and the government, with pressure building through media reports of overfilled wards and people suffering from inadequate treatment, an agreement was signed to increase payment and a committee was established to rethink the salary structure in the health sector. Looking back, this strike was a moment where doctors, nurses and other professional groups in the hospital stood together to improve their working conditions and that strengthened the solidarity among them.

Within the organisation of the hospital, the Director of Nursing Services (DNS) represents and guards the interests of the nurses. She is part of the management board, decides on employment, postings and promotions and supervises with her departmental deputies the group of about 1,050 nurses. Running almost 50% short of staff, her main goal is to attract new nurses and keep the working staff motivated.

> My vision for the hospital was to have a fully staffed hospital, a staff very motivated and giving quality service to the patients. I wanted the nurses to be really happy and work for our patients also to be satisfied. That was my vision for the hospital. But I guess it was ambitious. (DNS)

Being aware of the structural problems, she mentions in the Annual Report 2005 "low staff moral, lack of best practice (due to non-availability and inadequate equipment) and lack of opportunities for upgrading skills and competences" as major challenges (2005: 14). As the department's means are limited,

she has few alternatives at hand. The in-service department runs workshops and training courses in which every year about one third of the nurses get the chance to update and upgrade their knowledge on nursing procedures and discuss current issues in nursing. The attrition of nurses is also visible in this part of nursing service, the staff reduced from five to two teachers, and new nursing instructors are needed to offer adequate workshops and discussion groups. The nurses express that the nurses' view is insufficiently represented in the hospital due to gender and professional hierarchy. A young nurse formulates the dilemma: "Look at the two major teaching hospitals in this country. Both are headed by men who are medical doctors by profession. Many of us have seen that at the end of the day, there are bound to be conflict of interest; because you are dealing with colleague doctors. So when issues about nurses, pharmacists and other paramedics come up, where is your loyalty? It's most likely to be towards the doctors" (Nurse Cecile). The relation between the male dominated medical and female dominated nursing groups is described as 'not very cordial', and nurses discuss whether the quiet and cautious approach of this moment is sufficient to represent the nurses' needs.

A new development is the recently established Department of Public and Occupational Health. Working directly under the administrative directorate, its goal is to ascertain the current working conditions and propose improvements that also lead to higher motivation and job satisfaction. The main employee names the major challenge as follows: "There is no health and safety awareness here. They take care of others but not of themselves. Most people have no sense for keeping the property well. The general attitude towards property is low. Ghanaians have to learn to keep maintenance." According to him, human resource management is new to most Ghanaians and he has to start with caution. "How can I reach them so they trust me? The director (of the hospital) wants immediate results, but my wish is to create awareness and have a bottom-up approach. If I mix a doctor and a nurse together, the nurse will not speak up. I plan for each profession separate meetings. They have to formulate the priorities concerning their health. Direct recommendations would work like imposed ideas and not work. I will develop it with them." Over weeks, wards were inspected, equipment catalogued and nurses (like other groups) asked to report on the working routines and major difficulties. The nurses alternated between feeling controlled and relieved that they could finally express their problems. Gaining trust and organising follow-up meetings took a long time for this section that had to mediate between the professional groups and meet their varying expectations.

A big money transfer company advertises its service with the picture of a nurse working in a well equipped hospital abroad, smiling at her family back home in Ghana. It reads: "Our sister is sending us her support." The message is

clear: The nursing profession is attractive and working abroad promises financial well-being and a comfortable living standard back home. All nurses know colleagues who left Ghana to work abroad. The braindrain of health workers is discussed and reflected upon in many correlations and has taken various perspectives. The exodus, as it is called, started under Rawlings in the late 1980s, when the country's economic crises worsened and political unrest created anxieties in the society. This situation forced many Ghanaians to look for financial means outside Ghana. Today, after several years of social and economic stabilisation under new government, the urgent need to work abroad and send money home to support the families seems reduced. But still, a shortage in manpower is present in many aspects of social and professional life and health workers still leave the country. In this hospital, it is a reality visibly manifested in the shortage of staff, and dreams, plans and hopes to migrate also are brought up during lunch meetings, small talks and gossip.

The nurses and nursing students on the ward have little or no experience of working abroad. Most state firmly that it is not their intention to leave. Some nurses combine their work in the hospital with national pride: "I want to stay in Ghana. I think I can get everything I want here. I do not need to leave. I never had that, I stay in Ghana to work and build this country. We do our best and God willing, we all do our work well" (Edith). Others know about problems migrating nurses may experience. Stephen, a male nurse, highlights the personal problems:

> After all, why should I leave my country to go and suffer somewhere? Walking in the snow and stuff like that, if I had a little thing to cushion me over here? Because if you go there, you cannot help our people in our own country.

Younger nurses were eager to explore travelling options but hardly realised that they needed a valid passport, visa and a mastery of the language of their destination country. Others have heard about complications in having the Ghanaian diploma recognised and managing language barriers. Matron Hilda, who worked for a short period in Europe, knows that: "Over there it is not easy to find work. They think you know nothing, but you are a full nurse. My certificate was not accepted there. Finally, I worked in an elderly home for several months and returned." Gloria emphasises similar trouble as nurses from abroad need to sit an examination and follow orientation courses before being accepted and registered. Additionally, nurses are aware of the fact that re-entering the Ghanaian health service after a working period abroad is complicated in itself. Even as the health service experiences a shortage of manpower, returning nurses are downgraded in their nursing position and salary. The official explanation is that the women might not have worked in nursing and forgotten essential procedures and routines. The nurses themselves experience it as punishment. Nurse Grace says: "When you come back the frustration you go through trying to come back

to the ministry (of Health) is very horrible. That's why people go and don't come. They'll be tossing you. As I'm a senior nursing officer now and I go and I come back for re-employment, they'll take me back to maybe nursing officer, they reduce my rank. They will punish me for going abroad. So people will not come *koraa* (at all). If they come, they'll stay at the private clinics."

Probing further, the secret wish to experience the world and working condition outside Ghana becomes unveiled. Almost everybody seems eager to travel, be it for only several weeks or few months. Edith and Esther are convinced that "nurses do travel, but they will not tell you. You will just realise they are no longer there. If they earn money there, OK. Why should they return? They will stay there and send money to their families here. They won't tell but just disappear and not come back. Why stay here when the country cannot support you well?" It is clear that financial reasons form the major motivation to leave Ghana. The salary in Ghana is perceived as too low to guarantee both a stable living standard and organise savings for retirement. Stephen explains it: "The salary here is not enough to survive. But when I go on retirement, I'll need a place to sleep. I understand everybody who leaves to make money. Oh, I would go, get some money to finish my house, get a beautiful car and return." The nursing students and freshly examined nurses are even accused by the older ones of choosing the profession mainly because of the travelling aspect.

"Young nurses are often only after the money. They enter the job for the salary or to travel, and the moment they don't like it here with us, they decide to travel and leave for greener pastures. This also means we cannot be critical on them. In one year outside, you make so much money that you can come home and just set up a house. They all go" (Regina).

The attached training college confirms that in the past years, up to 60% of a class left for the US and the UK before or shortly after the final examinations. When asked about their view, the students mention family obligations and the wish to reciprocate the help received. "My family supports me, they all invest in my education, so I have to give it back to them. You need to help your younger siblings, don't you? The money is not good here; when the opportunity comes, I leave. I have an aunt in London" (Vicky). Her friend adds: "The money is more abroad, whatever job you have there. So you melt it here in Ghana. This means it becomes more here, like water from an ice cube."

The remaining nurses experience mixed feelings. They are hanging between pride for their work and conviction of doing good on one hand and the sense of being left behind with all the work on the other. Matron Esther captures the point better: "Where are the fresh ones? The young ones are all running away. Almost every week, somebody leaves. And the frustrated women remain. And we'll continue to be frustrated until we also decide to leave."

The professional associations – GRNA and NMC – decided on several actions to improve the situation of the nurses and the health care delivery in general. One aspect is the strike (described above), which in a large part is supported by the union. In forming a group and negotiating both with other medical professions and the government, the union has tried to improve the financial and working conditions of the nursing group. Another response to the migration of nurses is bonding. As the training of a nurse costs about euro 5,000 (¢ 47 million in 2005), the Ministry of Health, supported by the NMC, has instituted that each nurse must work five years in the pubic health service before the verification of her nursing degree is issued. By this, the Ministry is trying to avoid attrition of nurses. However, working abroad, be it as a nurse or in some auxiliary job, many women are able to mobilise such amount easily and pay it back to receive their verification. Another idea is to block immediate entrance to the universities of registered nurses; they are only taken in after three years of practice, so that obtaining a university degree in nursing or another filed is not an immediate option for nurses who wish to upgrade their knowledge. This means that nurses who feel financial pressure or wish to study further join the group of visa seekers at the American and European embassies in the capital.

Being a person: Combining the professional and private life

> Being a nurse, mother and wife is not always easy. I have three children and need to bring them to school every morning before coming here. And in the weekends I need to do the washing and shopping and attend social gatherings. I am tired. (Maggie)

Almost all nurses are married with children; they have family and household duties to fulfil and try to combine professional and personal expectations. The following section highlights three aspects: Family duties and related problems, dealing with own sickness and the display of emotions.

Before coming to the ward to start their shift, all nurses have already completed daily chores. These include, in many cases, washing clothes and preparing both breakfast and packed lunch for the children as they leave for school, and care for older family members before coming to the ward. Those living in town beat the traffic every day and fill the trotros eager to be in time for the morning shift. Others are given accommodation in the nurses' quarters on the hospital compound. The nurses' quarters nearby are highly sought after as they provide two or three room apartments at an affordable price. Also, there is a primary school within a walking distance. In addition, they are closer to the working place meaning less time and money is spent on transport.

According to public opinion and informal talks, nurses are popular marriage partners. Matron Mary is explicit: "Many men want to marry nurses because of their salary and they know they can work hard. It gives them status. A lot of

Ghanaian women are still poorly educated so men want to marry nurses. But if there is no real love, it will end in a divorce." Her colleague also sees the other side of this perspective and predicts problems: "Nurses are wanted marriage partners as they are supposed to be rich. But then also, they are sent abroad, so the men are free again here in Ghana. Or they join the nurses in the north and worsen their problem there. You must be careful whom you marry."

Indeed the divorce rate seems high among the nurses, partly due to their exhaustive working scheme that clashes with the expectations the extended family and their partners. A nurse, who raises her child alone, says: "If there's a funeral you cannot go because you work your shift; if there's a wedding you cannot go, you can't go to any social gathering. And on Sundays I go to church and then I am tired." Another nurse unveiled serious marital problems caused by a conflict with her mother-in-law:

> I have four children. I only wanted two. But my mother-in-law is not educated and requested more children. She was quarrelling me and threatened to give her son to another woman if I did not give her more children. My in-law threatened me: 'If the pregnancy does not come, I will take you to the herbalist to check you'. I could not tell her I did family planning, and also as a nurse, I do not want to go to the herbalist. I had no chance, but gave her a third child. After that she bothered me again, so I got my fourth child. After that she did not stop, but I could not hide my feelings. So I told her: Fine with me, give your son to another woman, I cannot give you more children. But my husband was with me; he is not interested in more children or getting married to a young uneducated woman. My in-law stopped her quarrelling finally.

This scenario displays the complexity of the living situation of many nurses that want to work in their profession, but feel the cultural and social pressure from the family. While this nurse was supported by her husband, others have problems in their marriage and complain about their husbands who ask too much from them and complain about the night shift and working at the weekends. Divorces due to marital unfaithfulness are not uncommon. One nurse fell sick during the research period, and soon it was an open secret that she was troubled by her home situation. A colleague guessed: "I am sure there is a marital problem with her. It is the husband who worries her. If we could, we would do without all these men, and all would be better. You cannot divorce just like that. There needs to be a cause, mostly it is adultery." The nurse returned several weeks later to the ward and mentioned severe tiredness and stress. "I am so happy to be back. I was almost dead. I don't know what happened to me. I was confused and slept for almost one month. I just ate and slept at home. It is very good to be back at work."

Summarising, all nurses experience the tension between the professional duties and social obligations. Similar to the findings of Avotri & Walters' (1999) in their study on rural Ghanain women, many nurses complained about psycho-social health problems: 'thinking too much', and 'being worried a lot'. Main-

taining the core responsibilities at home, fulfilling family expectations (both of the husband and of the extended family) and managing the increasing workload in the hospital are a burden for them.

The second challenge is to see how nurses are dealing with their own sickness and illness. Most nurses experience physical exhaustion due to the workload and surrounding personal circumstances. They all feel the responsibility towards patients because "If we are sick, they are still there, the hospital is not like a shop you can close down when you do not feel well." Nurse Grace worked on night duty while being sick. She was coughing and having pains in her ribs and being feverish. Her small daughter suffered from the same condition and was even admitted at the emergency unit. Her school-age son also coughed but was at home with the husband. The nurse complained that she could not be ill, but had to work. During the rainy season, many nurses complain of headaches and fever.

Nurse Linda feels ill and exhausted after family obligations (involving cooking, washing and serving guests) at the weekend. "I have a funny feeling in my head. But I took a malaria treatment not too long ago, so I do not want to take another." During the morning shift, she rests in the room on the couch sleeping and leaves early. Sick nurses are never replaced and increase the personnel shortage. The remaining nurses fill the gap by working extra, staying longer or skipping the least urgent nursing activities. In another situation, the nurses also linked sickness of a colleague to personal problems. A young nursing assistant fell repeatedly ill without being diagnosed of a disease. The doctors considered a diagnosis of kidney failure, generalised abdominal pains and chronic malaria. While she smiles whenever asked about her condition, the nurses have made up their minds. Agnes, a resolute supervising nurse, states: "I am sure she is having a problem in her family. There must be something because she is not listening. She does not co-operate but just stays in bed. She does not talk, but I assume there is something in the family." A health assistant agrees: "She needs more attention, that is all." As the situation does not improve after some weeks and the young woman is on and off admission, the general opinion is formed: "She is too weak, I do not think she can do the nursing work. She should do something else. She has become too thin and weak." Months later, she was back to work but was posted to a part of the outpatients department, where the workload was less intense.

Nurse Kate summarises the view many nurses share:

> I do everything to avoid being sick as this only causes more troubles. When we nurses fall ill, we tend to die faster. It is because we know too much. We jump immediately to the final conclusions and get worried. Being worried makes you die faster. Anxiety and fear make the immune system break down. Happiness supports the making of fresh cells.

This statement may explain nurses' resignation to the given situation and stoicism in public.

Finally, we can see how nurses deal with their own emotions. When asked about their feelings and how to overcome all the suffering and dying around them, all nurses confirm that, "all that we do is that we cry inwardly. You will not see us weeping, we weep inside." Some nurses say that they cry at home, while others pretend that they keep their emotions to themselves. One of the nursing teachers states: "You are not supposed to cry, it does not help. You come alone into this world and you go alone, that's all. You have to take the good times and also accept the bad times. The nurses here have seen so many dying, they know. After some time, you get used to it; there is nothing you can do. You learn to deal with it." Nurse Grace is critical about this attitude:

> I also keep it to myself. Unless I get myself into problems, I also do not talk to my husband about things on the ward. It might actually be a good idea to talk as a group about it, discuss issues like an unexpected death, whether a treatment or nursing care was appropriate or wrong, to learn from each other. I think we should do that but I am not sure it will work.

Regarding their emotions two aspects seem to come together: Firstly, the professional attitude of nursing that is emphasised again and again is that "as a nurse you're supposed to empathise and not sympathise." Nurses explain the difference:

> Imagine that when you are with the patient you should get too emotional. If you have this patient on a ward, and let's say she's dead or something. And then the parents come weeping, crying and all that and then you also join them to cry. That's not professional. Though we should be with them and help them, we shouldn't get emotionally involved. We shouldn't express too much emotion on the ward. We should tune ourselves to situations. Anything could happen at all and that's what we have been doing. We should stay cool, yeah. (Cecile)

Secondly, the nurses act according to existing cultural norms and expectations. Nurse Martha summarises:

> Here in Ghana, when you are an adult you do not really show emotions. You do not talk. You are brought up not to ask too many questions. Since the olden days we have been asked to be silent. So it is not always easy to open up and talk about your problems. But after some time, they will talk to you and then you can help. As a woman and a nurse you should not show emotions; you have to be strong and support the relatives. You show empathy, but you do not cry openly.

Conclusion

The scenario above shows the type of challenges the nurses face during their work on the medical ward. Infrastructural shortcomings, the nature of the organisational system and personal circumstances influence the nurses both in their individual expectations of and attitudes towards life and in the perception of the chosen profession. To find solutions to the daily and structural challenges as a nurse, several aspects appear prominent:

The nurses need to find strategies to solve daily problems on the ward. Working in a poorly equipped ward and with reduced staff strength, the nurses have to adapt their professional expectations. One possibility is to justify their professional shortcomings by pointing to the working conditions. Nurses blame the irregular and insufficient supply and equipment for problems, low motivation and probably mistakes in their work. Another option is to find creative solutions by for example, bridging financial gaps (like selling nappies and blood sugar strips) or giving more responsibility to young nursing students. Martin writes about a similar nursing routine in Uganda, where "improvised practices therefore actually constitute the routine to enable a facility … to function despite the working conditions" (Martin 2006: 162). A lack of access to sufficient resources and a tacit knowledge of the correct routine leads to professionalised improvisation aimed at continuation of the routine and professional survival (Martin 2009: 167).

The nursing students learn that they have to adjust their ideas on nursing from the 'correct way of nursing' taught in college to the real world to suit the situations on the ward. While all nurses know that the theory learned during the training differs from the reality on the ward (Melia 1987), the challenge to transport innovative nursing aspects in current nursing is sharpened by the existing hierarchy within the nursing organisation. Not only nursing students but young nurses in general experience problems with integrating new aspects of nursing on the ward or questioning existing routines. This intergenerational conflict can be explained through cultural norms that demand obedience and unquestioned respect for older people and people of higher status (Müller 2005).

For some nurses, the level of frustrations they encounter in the ward seems too high to continue with their work. Being a well-trained nurse but being unable to perform the expected procedures well constitutes a contradiction. The gap between the learned nursing work and the theoretical framework of the biomedical concept on the one hand and the confronting reality on the other hand, creates tension (Böhmig 2010). In addition, the financial situation of many Ghanaian families is problematic and a nursing salary possibly earned abroad is tempting. Leaving the country and joining the group of nurses abroad seems an attractive solution for those nurses. The trend to learn a medical profession and then leave the country soon after the final examination is not new and has been well documented. Ghana, like many African countries, experiences this braindrain of well-trained medical and paramedical staff (Nyanator 2004, Hagopian 2005, Gaidzanwa 1999).

The overarching aim with many individual nurses appears to be a well-tempered person, being in balance. Keeping up the composure both as a professional nurse and as a person is the image and perception to uphold. Managing

emotions by not showing them openly and containing a professional attitude, are important aspects of this goal. Following Geurts (2002: 202), being balanced is an essential part of its definition of being human and "to maintain stability and not become ill, was important for children to learn a kind of maintenance or regulation of the feeling in the body … that involves an 'aesthetic of the cool' or keeping balanced and calm in an effort to prevent sickness". The problems and uncontrollable situations given by the personal lives, social expectations and working conditions, challenge this goal and make it difficult to realise it. Health problems occur due to the increased burden of work and family demands; the nurses experience, like other Ghanaian women, distress due to social and material circumstances (Avotri & Walters 1999). Multiple responsibilities have to be mastered everyday, and there are few release mechanisms for the nurses on the medical ward.

16

"We have to protect our dignity." Perceptions of a good nurse

> The Ghanaian nurse has certain qualities: She is honest, punctual, qualified, and intelligent, yes she must be intelligent. Nurses have to dress moderate and not overdress; they must move easily and the dress should end under the knees. No jewellery and no perfume, as it can trigger asthma; and the shoes must be low, closed and should make no noise so they do not disturb patients who are resting. A health worker has to be neat when talking about health, otherwise it is not good. We are a role model and people watch us. We should be recognised in our speech, dress and behaviour as a nurse. The ethics of the profession are to do no harm and be empathic, be loving as you also want to be loved. Our attitude reflects the profession at work and during our social life. We have to protect dignity in our profession.

This statement of the president of the Ghana Registered Nurse Association (GRNA) illustrates the various aspects the profession of nursing can include and how the nurses present themselves and are seen by others. This chapter focuses on the perceptions about nurses and nursing. In three steps this is approached from different directions. Firstly, the nurses themselves are given space to present their motivations and definition of a good nurse. Secondly views of nurses from the outside are presented. Finally, light is shed on the profession itself. It will be shown how these three views form a mosaic of the unstable state of Ghanaian nursing, as it is influenced by history, shaped by reality and supplemented by expectations and wishes.

Nurses working on the hospital ward or other sectors of the health care have their own perceptions on their profession and the realization of their ideals and wishes. Throughout the generations, they state that nursing is a built-in thing,

giving an inner satisfaction. A student nurse says: "I like to see people happy, coming out of their problems; as a nurse I have so many ways to help patients." An older colleague seconds that view:

> You do your job well and get a lot of satisfaction out of it when you care for a patient and see him improving and leaving the hospital smiling. Often, former patients recognised me in the street and thank me for the care they received.

Indeed, many of them aim to make a difference by "touching somebody's life and be useful in their community" because "when you care for a patient, that is rewarding and satisfying. I can make a difference here in Accra or elsewhere in Ghana." Older nurses see the impact of their work on their families and neighbourhood. Nurse Edith adds:

> Nursing is a good job. I always liked it. It is nice and feels good to make patients happy. Am I telling lies? I like to be a nurse. Once you learn it, you always stay one. You are 24 hours on duty. Also the family and neighbours see the nurse in you.

Ernestina reiterated the same experience because "people come with all kind of problems. Where I live, it is the nurse and drug stores where people come first. They ask and listen to my opinion. So I deal with minor health issues and nurse them. Only when this first aid is not working, they will go to the hospital or traditional herbalists." Also, all nurses share the need to be empathic towards patients. A retired community nurse remembers: "It is a difficult job, you must be patient and tolerant. Sick people are naughty, so you must be strong"; and a young nurse on the medical ward supported this view when she said: "Nurses must be empathic and patients must be able to trust them in order to get healthy; that is good nursing."

All nurses struggle with sub-optimal work conditions, irregular equipment, water and electricity supply and unclear work distribution. While agreeing also on the general rationale behind nursing, differences in the daily work are visible, especially when it comes to the intergenerational conflict. Retired nurses remember their own working attitude: "It all boils to training. The Girls' Guide says you should smile at all your difficulties. You smile at all of them and they'll go. But today, any difficult thing that you have, you squeeze your face. And most of our patients they like smiling, so you should smile to them so that they get well. That's what I always said: We nurses are our own enemies." Students today are expected to be humble, older nurses expect it by teaching them that "you should be in a servant-hood attitude, you should always serve." Good behaviour is probably rewarded as "the nurses will see when you are interested and helping, so they will teach you." The director of nursing combines all expectations towards young nurses by stating:

> Be submissive like a doormat. Let others step on you, you are silent and observant. Later, when you have your diploma, nobody can take that from you. Your knowledge will be in your head.

Such statement unveils the underlying friction between the generations meeting on the work floor. The president of the GRNA sees similar problems but also sees changed social behavior as reason for this: "We are losing our dignity. You know the new generation of children coming up in this country are different. In Africa, the child is controlled, should be respectful and obey the elders. Nowadays, children have their say, they claim their rights. And they bring it into nursing. They are not responsible, want to dressed sophisticated and stand on their rights. This is troublesome and brings along conflict." There are only few experienced nurses who see all parties involved in this debate. Nurse Ernestina thinks this way:

> We overwork ourselves. The older ones are also not playing their role because there should be role models within the system for the young ones to emulate their examples. So when you're a senior nurse, the junior nurse should learn from your work. When we came into nursing, your senior nurse was on the ward doing everything with you. So how do you go and sit down? But it is different today. If they are saying that the younger ones are not doing well, then they should blame themselves, because they are with them 24 hrs and whatever they are doing, they will also follow. Because all of us were encouraged by our seniors.

Students see little ways to change that perception of their role as submissive helpers but young persons in training having both questions and ideas on innovation. "When we see the nurses, we're supposed to get up and stand. There is no rationale behind that. It's archaic. Those days that we used to do that are over; these days we don't do that any longer. Their argument is that we don't respect them, because we don't get up when they're coming. But we don't see that as nursing." It seems difficult to bridge that gap in expectations mixing cultural and historically grounded reasons in the attitude of young nurses. Changes in society and education are felt and fought against by persisting on unwritten rules of normative behaviour by one side, while the other side mixes uncertainties about the professional future and with new ways of expressing themselves. A nurse with experience on the work floor and about to finish her degree study in nursing sees only one way out of this dilemma:

> If you are the lone ranger, you're the only one who's always screaming at the top of your voice. Because you think you want to improve the lot for nurses you scream but people don't look at it that way. So what you do is that you ask yourself 'do I have to go through all this alone? And for what?' Because, after all, this is sacrificing. Until we as nurses begin to identify our own problems and know that it will take us as a group and not anybody else to solve our problem for us, we will continue to be the way we are. Of course, it will take one person to start making the difference. But you need the support of all to succeed in improving nursing.

This statement shows clearly how this nurse, coming from the routine in the hospital and now returning as a student, recognises the intergenerational problem

of the group of nurses. Clearly, it is not only this one specific ward that has both its roots and solutions in the broader community of nurses in Ghana.

Looking from the outside, a slightly different picture emerges. Nurses are valued for their service to the ill and needy members of the society, but at the same time they are questioned on the role they take in society. Also here, historical, moral and modern views are mixed, leading to official and hidden statements. Everybody agrees that the profession of nursing is needed and is fulfilling an important and necessary role. From its very beginnings in the early twentieth century, nurses were respected and praised for their work. Up to today, nurses share memories of grateful patients, recognition on the streets and marketplaces, free rides to the hospitals from grateful drivers and being a role model for the area. "You are respected, it is seen as a good job. In my time, you chose it because it is respected. You help everywhere, at the family, church, friends." Indeed most nurses can share situations of counselling, helping and nursing friends and family members and being appreciated for it. This is connected to their cultural understanding of care and support. Matron Mary observes: "You are a role model to them. You know, here in Africa, we live in the extended family system, so actually we are all relatives. I don't mind being asked, it is my duty." Many nurses report that patients and their families are grateful, as they witnessed and experienced the efforts and dedication of nurses. A teacher of nursing confirms this adding a sociological view:

> In our society, we do not believe in talking but acting. You do not say you love somebody but show it by giving food or money or the like. If you like me, you will do something for me. This then means also, that care is doing something. It can be to let patient lie and die in dignity, relieve pain, give food, make urine and faeces invisible or to have a neat appearance. And when all physical needs are met, we will be praying and talking to them.

With the changes in society, rising economic burdens and demands from families and groups, the status of nurses has changed. Not unlike their colleagues in other parts of the world, nurses in Ghana started to complain about irregular and inadequate payments, fought successfully to establish a degree at the university level and demanded new lines of communication with the medical profession. Their outspokenness and readiness to go on strike led to improvements in their working conditions and to a critical perception in the society. People complained about too many strikes and treatment that had been refused in the hospitals in the country and started questioning the moral dignity of the nurses. In addition, many nurses left the country to work abroad sending money home but leaving empty spots in the Ghanaian health sector. This can be exemplified in their position as women: In the beginning of nursing, these women were seen as doing a dubious job associated with dirt and death. Being seen as a filthy occupation dealing with faeces and blood, its status rose together with medical developments and successful treatments. This also had influence on the perception of

nurses as women, they became models of good health and morality and attractive and wanted marriage partners. Given the level of job security and possibilities to travel, they were supposed to be rich, and, given the kind of work they did, seen as hard-working women and future caring mothers. Newspapers today regularly publish positive reports about the nurses' work for the well-being of the country and show donations being made both by nurses abroad and by grateful patients to improve working conditions.

Parallel to this positive public image of nurses, a more hidden negative image remains. Nurses were labelled as too knowledgeable and too dominant, threatening the male position in the family. In addition, their irregular working hours and night duties made them absent in family, church and social gatherings. A nurse who went abroad for future studies experienced this: "Nowadays men are aware that we nurses have work and can travel. Initially, we were not so attractive, because they think we are fat and we knew too much what to do. They still think we are fast, we like life, we move along with the doctors, who finally do not like marrying us. So men do want to marry us for our money but also fear our position." Attached to the prejudice of sexual freedom, nurses have little means to fight this image. Indeed, many nurses are divorced, raising children as single parents or face serious relationship problems. This is one reason, why the senior nurses care about the appearance of the nurses: "We are a decent profession. You are married, you do not need such dressing and painting. We do not want to be too attractive to the patients, but we care for them. So make sure your dresses are long enough, not showing anything." Nurses are aware of the society's perception of them, moving between gratitude and doubts. Also nurses who did not voluntarily choose this path but followed their families' reasoning and those who chose it out of Christian conviction are faced with it. Their knowledge and influence in the health care sector labels them as emancipated women no longer fitting into the cultural position of women. Wanting to improve the profession, participating in the global economy, achieving more autonomy within the rigid hierarchical structure of the Ghanaian health care system and being faced with such double images in their home society, the nurses seem to face an unsolvable dilemma.

Looking at the profession itself, nurses have different ideas about which path to follow. Several students desire a strengthened link to science and medicine, wishing for more co-operation and teamwork with the medical sciences in the hope of lifting their status. They are backed by lecturers at the university, who also predict an improvement in the public perception of nursing when more interdisciplinary co-operation, including academic research and discussion, is promoted. Nurses on the ward stress in this respect that "nurses and doctors need to sit up and define what is best for health care delivery in Ghana" (nurse Evelyn)

and nurses "need to know what they are doing and do what they know" (Matron Mary). Other nurses prioritise their impact on the patients and their families. Helping, counselling and caring for patients in the hospitals and home situations lead to gratitude and understanding. Many nurses agree that only those people who never were hospitalised "are ignorant but those who experienced illness and saw us working for them, are grateful and respect us highly." The professional unions strive at protecting the status of nursing by clearly separating nursing from auxiliary work. The president of the GRNA wants "to protect the title of the nurse well; only trained nurses should use it. All the auxiliaries and HCAs are no nurses. It must be clear who and what nurses are. We must deliver first class nursing and give effective care." The Ghana Health Service supports them:

> Nursing tended to be a female profession and it is till today not dynamic enough, so we missed the opportunity to make our points strong. Still many people wonder why we would need to have a university education just to stand finally at the bedside. Changes come there very slowly.

Nursing in Ghana looks back on a history of 100 years. Introduced by British nurses, it was seen as a foreign and strange concept of working with ill people, associated with the colonial rulers and authorities and attached with signs of power and European images of female appearance and behaviour. By 1945, the first school opened and with it the image of the humble serving healthy nurse got attached to the Ghanaian apprentice. Nurses were perceived as perfect women, reigning over dirt and death, following the orders by the male doctors and representing health, morale and religious convictions. Successes in treatment and improvements in health care delivery helped to lift its status and present nursing as an independent work and nurses as well educated knowledgeable workers. With the taking over of crucial positions in the health service by Ghanaians in the 1960s and the implementation of the university programme in the 1980s, nursing was implemented as an emancipated profession with its own responsibilities and duties. Its membership with the international worldwide council of nurses and its affiliation with the medical word and its modern technologies and achievements make it an attractive and popular occupation and it evokes hopes and dreams of participation in the globalised medical world. The sharp contrast between the above given self-presentation and the experiences in the daily work, the self-image and the perception by the surrounding public, form a reality in which the Ghanaian nurses oscillate. They feel unable to meet all expectations set by the profession, their families, the community and themselves. The matron in charge of the medical wards expresses this balancing act thus: "As a nurse, you must be humble and outspoken, that is the trick."

PART IV

SUMMARY AND CONCLUSION

17

Nurses in Ghana: Between tradition and change

> If you know what you are doing, you do what you know. Make sure what you're doing is the right thing. Be very proud to be a nurse. (Matron Mary)

This research has described the working routine of nurses on a medical ward in the largest hospital in Ghana and unveiled perceptions and expectations both from the involved nurses and the surrounding society. It is in people's coping with disease and in care, that core values of a culture are found. The findings show at first hand the daily routine and continuous actions of nurses on the medical ward. Looking closer, they reveal their strategies to manage the situation and perceptions justifying their work.

Like recent hospital ethnographies (Zaman 2005, Martin 2009, Mulemi 2010), this study followed the methods of participant observation and personal involvement in the world of Ghanaian nurses. While numerous researches have been carried out in hospitals, most of them focus on medical doctors, experiences of patients or the interaction of the involved groups. Literature on the work and position of nurses in general and in Ghana in particular is still limited but is needed to understand what is going on in a hospital. The hospital ward formed the stage to observe and analyze particular actions of that one profession. Applying an ethnographic approach to produce a state of the art of contemporary nursing in Ghana, it has shown what nursing means on a ward. Furthermore, the specific context of a teaching hospital in the capital of Ghana shaped the experiences on three levels: On the macro level, nurses perceive themselves as part of the biomedical family, being in contact with globalized procedures and techniques, carrying expectations and searching for similarities with hospitals in the West that serve as leading concept. On the meso level, the teaching hospital turns out to be an important place of health care and a searched for place of healing.

Being situated in a country where health care facilities and their access are limited, the medical setting operates next to traditional, religious and private health institutions. On the micro level, dreams and fears of the individual nurses in the organization become visible as they clash with, follow and question the training and work demands.

The research started with ethical and methodological considerations (Chapter 2) leading to the choice of the hospital. Procedures of formal and informal consent were passed through prior to the research and I reflected on my role as participating nurse researcher during the months of data gathering on the medical ward. Working towards the formal approval and getting acquainted with the nurses made me sensitive to the research setting as part of the overarching culture. Adjustments had to be made, limitations and restrictions were experienced through the hierarchical organization and prolonged requests which positioned me as dependant on the health care providers. At the same time, my mere presence as nurse, anthropologist and European woman turned out to be an unintentional demonstration of power. Some nurses experienced it as threatening; the research situation created and maintained a perpetual situation of retrieving and exchanging signals and information. My professional background enabled me to assist and help in times of personnel shortage, but also positioned me as one 'who knows how nursing has to be'. The nurses were proud to be part of an internationally published research but feared their stories would be taken away.

I started the research with three main questions, and can now summarize the following: As a result of extensive colonization of West Africa, nursing was introduced in Ghana alongside biomedical procedures and the rise of hospitals. British nurses started their work in the Gold Coast by the turn to the 20th century and soon trained locals to assist them in their work. As the concept and work of hospital nursing was new to the population and challenged cultural norms, they began with male apprentices. By the mid 1940s, the training program was standardized and nursing turned into a typically female profession. The presentation of nurses as disciplined, obeying and patient caregivers for the sick and dying and their appearance in the clean white uniform displayed and conveyed the image of a good woman, morally integrated Christian and possibly a perfect wife. By this, nursing became an attractive profession and gained status. Looking back on fifty years of professional nursing training, various motives can be unveiled. As shown in Chapters 6 and 7, cultural norms, family expectations and current socio-economic factors play a role in the professional choice; older generations mention reasons partly different from current students. The above mentioned image is till today one reason why families support young women to enter into nursing. The current reality on the hospital work is to a great extent unknown to the future nurses and they experience a theory-practice gap when

they enter the wards. A century after its introduction, nursing in Ghana is today a profession that attracts many students but faces problems to keep certified nurses working on the wards and health posts.

Secondly, the research indicated and described how nurses do manage their work under the given circumstances. The daily work is marked by routines of basic nursing care, tidying and cleaning to present a white serene ward and doing extensive administrative writing (Chapter 10). Being posted to the medical female ward rather by chance than by choice, nurses feel overwhelmed and unprepared. They need to care for severely ill patients and experience death on an almost daily basis (Chapter 12). The Christian religion forms a stable frame to manage emotions, regain strength and experience togetherness (Chapter 13). Their cooperation with doctors on the one side and orderlies on the other, positions the nurses as both dependent order receivers and superior instructors. Nurses perceive patients often as uneducated and accuse them of coming too late for successful treatment. Patients respect nurses as knowledgeable and their orders are followed (Chapter 14). Due to their limited equipment and resources and the unpredictability of their daily work, nurses need to improvise and be creative (Chapter 15).

The nurses see themselves as dedicated and subscribing to the principles of nursing. They are the most visible and represent medical workers on the wards and represent not only their profession but also the concepts of biomedical health care delivery to patients and their relatives. While appearing as one group to the outside, they have internal forms of hierarchy and differentiation. Chapters 8, 11, and 16 focus on different aspects of their perception as students, registered nurses and matrons, each having their clearly demarcated position. Cultural values like respecting the older generation and appearing as balanced mature person reinforce the top-down structure of the professional hierarchy and complicate innovation and the introduction of new ideas. Their working schedule and quota, their appearance and working rationale make nurses a crucial element in health care delivery. Initially they were rewarded with a high status in society. Dissatisfaction due to sub-optimal working conditions and frustrations due to insufficient payment have led to strikes, countrywide understaffing and emigration. This challenges the status and perception of nursing both within the nurses' group and in society.

What conclusions can be drawn from this research? Two themes have turned out to be crucial: The existence and application of power that leads to specific forms of knowledge, and the interplay between Ghanaian nurses in their cultural setting and the international profession of nursing.

Power and hierarchy in nursing

> The failure of nurses to recognise power as an issue in their interactions with colleagues and clients is closely related to their failure to confront the relationship between knowledge and power. (Mulhall 1996: 633)

Referring to the concept of power as existing element in human interactions, it is possible to detect places of its existence and the exercise of power. The display and application of power leads to a specific distribution and application of knowledge. Elements of power display and power distribution can be found in structural and flexible aspects of their work. The organization of this ward in the hospital and the set-up of the routine enable, shape, regiment or discourage relationships and interactions. It is most visible in various types of relations on the ward. In the following, five of them will be highlighted.

Forms of relations

The relation between nurses and doctors is extremely hierarchical. On the management level, the hospital structure places the nurses through their nursing director and the various deputy directors as one pillar next to the medical professions. But as the management board is headed by a medical doctor, nurses experience their position as inferior and their interests are at times neglected. The doctors are only briefly on the ward, they appear as visitors but their firmness and self-assurance in acting interrupt and dictate the nurses' routine. They define all actions during their brief presence. Arriving mostly in groups, their status is unquestioned. Established nurses like the matrons can influence their work partly by bringing patients to their attention or pointing at shortcomings; they even try to encourage their nurses to stand firm and defend their own profession against medical orders. But also high positioned nurses have to accept delay in their work if doctors do not finish required paper work or fail to update medical prescriptions. In decisive moments, nurses are positioned in an inferior position to doctors and do not succeed in integrating and applying their nursing knowledge.

Nurses are organised in a clear top-down structure. This is apparent in their attitude towards the deputy director of nursing, whom they respect and with whose directives they comply. Possible conflicts or queries are avoided through respectful greetings, appearing busy and responsive when the ward is inspected. In the distribution of work within the group, the youngest and lowest in the hierarchy cleans and makes the beds, control vital signs, bathe bedridden patients and go for supply in the pharmacies. Higher ranked nurses do the wound dressing and documentation while nurses in charge supervise and work in the background. As the group composition fluctuates, such tasks distribution is consistent in its orientation but fluctuating in its realization. The night shift forms a special group as nurses are alone throughout the night, forced and privileged to decide by

themselves how to handle in upcoming nursing situations. They escape the power of the matrons and are out of the gaze of the doctors, fulfilling an invisible routine and following their own working rationale. While some nurses feel uncomfortable during these hours, others prefer this shift that enables them to work outside the limiting hierarchy of the day.

That hierarchy is very visible in the distribution of the limited space. Nurses do not have a conference room; a simple table serves as documenting and reflecting place. All written work is carried out there and the table is sometimes made available to doctors when they demand it. The nurses' room outside the ward is very small and serves as cloak and resting room only. The matron's office is used for stock keeping and discussing confidential matters with nurses and patients. The matrons retreat here for organizational purposes and to have their rest period separated from the other nurses. The key to this room is closely guarded and nurses are given access to this room for special reasons only. The higher in the hierarchy they are, the more space is available to nurses. Given the changing working schedule, nurses meet in different combinations in each shift. This leads to continuous redistribution of work and responsibilities within the group. Being in charge on one day and subordinated to a nurse in a superior position the next day, demands flexibility and creates shifting categories. The group manoeuvres to find and remain in balance displaying and exercising power and sharing nursing knowledge.

Different ranks demand different appearances. This is visible in the dress code. Different colours, belts and shoes announce without words the power of their bearer and her position in the hospital (Chapter 11). Older nurses checking the neatness of the clothes of younger nurses is one overt aspect of establishing and confirming their power and non-negotiable authority. The whiteness of their dresses strengthens their appearance as a group, the colour places them near the more powerful medical profession and is an expression against transitory situation of the ward and the dirt in the streets.

Nursing students and young nurses learn the tricks of the trade of how to negotiate and handle responsibilities through observation, imitation and staying in their role as subordinated and obedient helpers. Nursing students as a group are perceived as being at the receiving end of the disciplinary measures (Chapter 8). Being emotionally challenged by the reality of the ward, some question their professional choice, but they have little means to discuss their perspective with nurses and teachers or initiate change. This group consists of two 'parties', the diploma students from the nursing training college (NTC) and the degree students from university. While the first wear green dresses and are by this easily recognizable, they are trained for practical work. The latter students wear white imitating the registered nurses but lack practical skills due to their rather theo-

retical study. Between those groups exists little communication and both try to position themselves so as to be respected by the nurses. Some students feel unequal to the challenge. They have limited means to display their power as necessary helpers and participate in the transfer of knowledge by introducing new nursing concepts. But they understand that they are indispensable workers on the ward. Their status as students allows them to come late to work or leave early, explaining this with lectures or indisposition. As the nurses depend on them, they on their side have little means to reprimand them. Some teach and encourage the students, trying to keep them motivated and invite them to ask questions; others expect respect and obedience. Everybody knows that the students represent the new generation that will either take over one day or quit the work in the hospital 'for greener pastures' abroad, leaving the older nurses behind.

In relation to patients, nurses act authoritatively. Multiple moments of supervision are executed during a shift. Nurses exercise power in giving orders to patients and dividing their days by means of bed making, serving food and carrying out nursing procedures. Nurses label patients as educated and uneducated and rich or poor and these labels have implications for their attitude towards counselling and bringing patients needs to the attention of doctors (Chapter 14).

The old architecture of the ward has one room, only divided by semi walls, leaving limited privacy for the patients. Screens are few and used for some procedures only. In general, patients are watched and watch each other. Nurses control the space of patients, which is restricted to their bed, assist them when going to the toilet or bathroom and they prevent or allow visits. This is a power to label and socially control patients. Most patients are silent and seem unable to discuss treatments or consider alternative options because they are in an unfamiliar ward, confronted with an often unclear diagnosis, personal fears and the covert accusation from doctors and nurses of arriving late in the hospital. The absence of a cost covering insurance system contributes to the insecurity of the patients in their social and family position and to the frustration of the nurses of being unable to carry out nursing procedures adequately. Most patients recognise the power and hierarchy of nurses. Nurses know that patients and their relatives have influence on the nurses' perception in society through public appraisal and criticism. They are aware of the growing importance of patients' rights and discuss possible consequences of their actions.

The use and application of language help to understand the hierarchy within the nurses' group and with other groups. Language transports meaning and by this influences the direction and understanding of interaction (Holden & Littlewood 1991). While English is the official language of Ghana and the working language in the hospital, patients mainly speak local languages. Language func-

tions both as inclusive and exclusive phenomenon. Medical staff and nurses here form one group and exchange information orally and in written English, using in addition biomedical terminology. Most patients accept their exclusion from communication through their limited knowledge of English and of medical jargons. They respect doctors and nurses as authoritative actors and expect them to decide on diagnosis and therapy and direct their behaviour during their stay in the hospital. Exclusion and inclusion as exemplified in language happens both as unplanned barrier in the constant exchange of knowledge and functions as a mean of power display.

Throughout this study, the concept of power was disclosed as a phenomenon that exists in all interpersonal relations and influences persons in their actions and reactions. According to Foucault (1977: 194), "power produces: It produces reality; it produces domains of objects and rituals of truth." Power oscillates and the actors try to gather power and apply it according to their wishes and goals. This means that, "power is everywhere not because it embraces everything, but because it comes from everywhere" (Foucault 1978: 93). Working with nurses on the medical ward, aspects of power were revealed in the research setting by looking closely at the daily routines exemplified in the relations within the nurses' group and in their interactions with other groups. All those recapitulated aspects form the mosaic that outlines the work of nurses on the ward. They provide structures and are powerful in forming the frame for their actions. This power is not centralised but circulating, stimulating exchange of information and teamwork, enabling actions and also limiting possibilities and spheres of influence. As unravelled in various forms of interaction, actors with power have the ability to produce and apply knowledge that influences nursing actions (Ceci 2004, Riley & Manias 2002). There is no neutral space, as such power exists and needs to be recognised. Nursing students enter a stage where relations and interdependence are already formulated; nurses work with other professions and have to obtain and defend their status while nurses in charge need to shape and reshape their position in the organization of the ward and hospital.

Nurses and their cultural environment

Looking back in time and taking cultural norms and values into consideration is crucial to understanding nursing in modern Ghana. As Part II illustrates, culture and social structures prepare, set and largely define the setting in which nurses work. Traditions, gender roles and the interplay of generations in the organization of daily life position women and leave them with limited options.

Religion and the expression of religious feelings are important elements in the life of most nurses as it is for most members of the society. The hospital, mirrors society while religion 'colours' the interaction between nurses and patients. In

Ghana healing sessions are offered by Pentecostal congregations; advice and guidance is sought not only at birth, wedding and funerals but also on a daily basis (Chapter 3). Similarly, praying, referring to God as almighty power and encouraging patients in regular Bible reading are important features of nursing. Religion enables nurses to process their working reality and manage their lack of power. This is reflected in morning devotions where nurses share their faith and show it to the patients. It both consoles the nurses faced with the unpredictability of the day and sets the frame within which they act and patients can expect to be approached. The power of their faith radiates in their attempt to come to terms with serious disease and death. Belief in an Almighty God and eternal life helps nurses and patients alike to deal with medical impotence and untimely death.

A second theme that shapes the nurses' situation is respect. Accepting hierarchy and obeying senior colleagues are closely interwoven with cultural patterns and norms touching on the role of women and on the relation between generations. The society is based on the idea of respect and intergenerational exchange of knowledge (Müller 2005). Respect towards older persons is an important element in interpersonal relations and taught from childhood; opposition to the advice or decision of senior family members is reprimanded (Van der Geest 1989). An adult person and accepted member of the society is known by her balance, visible in her appearance and handling of emotions. Saving face and avoiding a social faux pas are important to reach and remain an honoured position (Geurts 2002). To the nurses, this means accepting given limitations and withstanding the pressures that challenge them in their work on the ward and constitute a threat their status in society. It is unquestionable that younger nurses respect their senior colleagues. Even though society is changing and elements of the ongoing globalization have introduced new forms of communication, today's nurses are raised and socialised with the norms of respect and obedience towards older generations.

The future of Ghanaian nursing as a profession

> Tomorrow's nurse is expected to be multipurpose in function. Qualities considered to be most important to the nurse include being observant, punctual, responsible, truthful, patient, accurate, educated and respectful. (Akiwumi 1994: 57)

Akiwumi, one of the first Ghanaian nurse researchers and head of the Nursing Department in the University of Ghana for several decades, formulated this postulate in the early 1990s, looking back on forty years of nursing education in the country. Fifteen years later, Ghanaian nurses find themselves in this 'tomorrow', facing multiple demands and managing various situations in their health posts. Some young women are not free in their professional/occupational choice but are directed through family desires and socio-economic pressure. As 'objects'

in the family decision, they try to cope and regain some control over their life in the process of becoming and being a nurse. They face an unexpected reality on the wards and have limited choices to react and improve their situation.

The ward is the domain of nursing knowledge that is transmitted either through training or experience; older nurses dictate to younger colleagues what to do and when. The nursing routine consists of planned treatments and reactions to unforeseen situations; an appropriate action following official nursing standards is at times difficult to carry out. The main maxim is: 'do what you learned that proved right'; innovations like a care plan are difficult to carry out. Students and newly graduated nurses have to adjust their plans and actions by looking at and following orders from older nurses. Professional unions like the GRNA and NMC, acting from the outside of hospitals, have influence on the nurses' situation; they function as mouthpieces, connect nurses all over the country and set procedures to guarantee or raise the position of nursing. They operate as official spokespersons and negotiate the status of Ghanaian nursing nationally and internationally. Nurses want to be recognised as having an independent profession; the university degree is one example to link up to international standards.

Akiwumi's quotation at the beginning of this section puts the emphasis on the nurse in her Ghanaian context. The expected attitudes have a slightly different connotation than the definition of nursing given by the ICN as quoted in the introduction, where the nurse is called to work as an independent partner in the health system. So, where does the Ghanaian nurse stand in the twenty-first century? Through the worldwide shortage of nurses and a declining image, the discipline of nursing in Ghana is also at a crucial point in its development and needs to choose a direction. Under the given training system and working circumstances, the trained nurse has limited tools to bridge the gap between cultural expectations and professional demands. Medical systems are complex and are more than just scientific institutions. As demonstrated in other ethnographies on hospitals, the health service is situated and operates within the society. Biomedical rational explanations and evidence-based approaches clash with cultural and traditional beliefs that combine social, religious and physical elements to understand and oppose disease.

The Ghanaian situation is not corresponding well with the image of the globalised technological biomedical hospital. Biomedicine with its high technology, exchange of information and flow of knowledge, objects and images represents globalization. It is intensified by the urban hybrid culture (Kapuscinski 2008: 32) of Ghana's capital. Nurses and doctors alike know this and imagine themselves as part of it, but experience their reality differently. Horton describes the ongoing exodus of doctors, nurses and technicians, the lack of financial incentives and the inappropriate medical infrastructure as major challenges to keep and motivate

doctors and nurses in the health sector (2001). For those who have difficulties with the actual work in the Ghanaian health service, the only options to escape are: Working in a private clinic, leaving the profession or migration. Others want to change the position of nurses and nursing in the country and empower nurses to present and defend nursing as an independent profession that is needed to improve the delivery of health service in Ghana. Some nurses decide to enter university for a degree and equip themselves with more knowledge before re-tuning to the health service on a higher level and interfere constructively in the current definition and distribution of responsibilities and power. Schuster (1980: 78-79) emphasises the importance of nurses for a sustainable development process in her research in Zambia:

> Despite differences in philosophies of development, and despite the wide range of theoretical orientations in the literature on the roles of women in … the development of health care facilities, there is a virtual consensus that the work of professional nursing is vital no matter what the orientations of the health care system.

Berger & Luckmann (1966: 25) argued some decades ago that social reality is constructed by the actions, concepts, representations and reciprocal roles of the involved individuals: "Compared to the reality of everyday life, other realities appear as finite provinces of meaning, enclaves within the paramount reality marked by circumscribed meanings and modes of experiences." In Ghana, the experience of the reality is marked by challenges and demands, and this shapes the reaction of the nurses (Emerson 1970). The distribution and display of power, the dissemination of knowledge, reactions to planned and unforeseen situations, the delegation and acceptance of responsibilities and the individual management of goals and dreams form and define the relationships within the nurses´ group and in their interactions with patients, doctors and visitors on the ward. Nurses working on the ward define and constantly redefine their situations; they are the representative of the biomedical setting and members of their Ghanaian cultures. All come together in their described behaviour, their use of language, their definition and treatment of patients' bodies and personalities. A constant creation of a biomedical environment and professional nursing gaze is not always possible. It is corrupted and threatens to collapse due to shortcomings from various sides. This leads to several realities existing next to each other. Foucault (1984: 61) emphasises the positive nature of power:

> What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression.

Recognising power as a productive tool can help the nurses to organise their work and stabilise their position in the hospital. The display and negotiation of

power and knowledge by all actors on the hospital ward weave a net that makes the management of the situation possible and leads nurses through their daily work.

Epilogue

While writing these last pages in summer 2009, US President Obama visited Ghana saying, "We will fight neglected tropical disease. And we won't confront illnesses in isolation – we will invest in public health systems that promote wellness, and focus on the health of mothers and children."[1] He also stressed, that there need to be ways to keep African nurses and doctors in their country. The future of Africa, Obama claims, depends on Africans in the first place and their development and well-being does matter for the whole world. Is this an empty phrase or a call for recognition of the complex reality in a globalised world? While Ghana's economic situation is stable and the recent presidential elections took place without much social unrest, the country is still highly dependent on the industrial countries. The shortage of nurses continues and the acceptance of the health insurance scheme is slowly catching on, leaving health workers and patients in critical situations as before.

My last visit to Ghana dates back to 2007. Revisiting the ward, the nurses welcomed me in a friendly way. "By the grace of God, we are all doing fine. How is your research going? When will you bring the book?" Initial reserve made place for pride to appear in my writing. They briefed me on the latest news. This patient had finally died; that nurse had been transferred to another department; another colleague left the hospital for further studies. The retirement of some senior nurses had led to a shift in the hierarchy, but only few new nurses had been added to the medical department; the shortage still existed. Most health care assistants are still assigned to the ward, doing their work, smiling and chatting. After five years, the ward was still on its temporary site. Construction work was going on, but nobody could explain the delay. Maybe the upcoming presidential elections next year would speed up the process. Everybody hoped the medical department could soon move back to its original site in a four-storey building, with sufficient space and modernised equipment.

I left the hospital and joined the nurses whose shift has just ended. We picked a trotro and rode back to town crossing the Korle Lagoon. For the last five years, I have listened to their stories, heard their cries, worked and prayed with them. Which direction will Ghanaian nurses take in the years to come?

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[1] http://edition.cnn.com/2009/WORLD/africa/07/11/obama.ghana/index.html on 11.07.2009

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Appendices

Appendix A: Abbreviations and terminologies

¢ Ghanaian Cedi	During the research, the currency rate was €1 = ¢ 10,000. In summer 2007, the exchange rate was changed to €1= ¢1.
CSSD	Central Sterilisation Service Department
Daily Graphic	Daily Newspaper in Ghana
(D)DNS	(Deputy) Director of Nursing Services
EN	Enrolled Nurse
GHS	Ghana Health Service
GSS	Ghana Statistical Service
GRNA	Ghana Registered Nursing Association
HCA	Health Care Assistant
ICN	International Council of Nurses
Last offices	A nursing procedure carried out after a patient died. The dead body is undressed, eyes closed, the yawn tied up, arms and legs tied together. Finally, the body is labelled and wrapped up in a cloth. Upon notice, workers of the mortuary arrive to collect the body.
MoH	Ghana Ministry of Health
NMC	Nursing and Midwifery Council
NMIMR	Noguchi Memorial Institute for Medical Research
NO	Nursing Officer
NTC	Nursing Training College
PM	Post Mortem examination, also called autopsy. A medical procedure that consists of a thorough examination of a corpse to determine the cause and manner of death
PNO	Principal Nursing Officer (matron)
QRN	Qualified Registered Nurse
RGN	Registered General Nurse (since 2007)
SIL	Seriously ill patient
SME	Surgical and medical emergency unit
SN	Staff Nurse
SNO	Senior Nursing Officer
SRN	State Registered Nurse (till 2007)
SSN	Senior Staff Nurse
Trotro	Small van to transport people, cheapest means of transport
Vital signs	Parameters of a patient's condition checked regularly by health workers, they include blood pressure, pulse, respiration rate and temperature.

Appendix B: Statistics

Statistics on Ghana

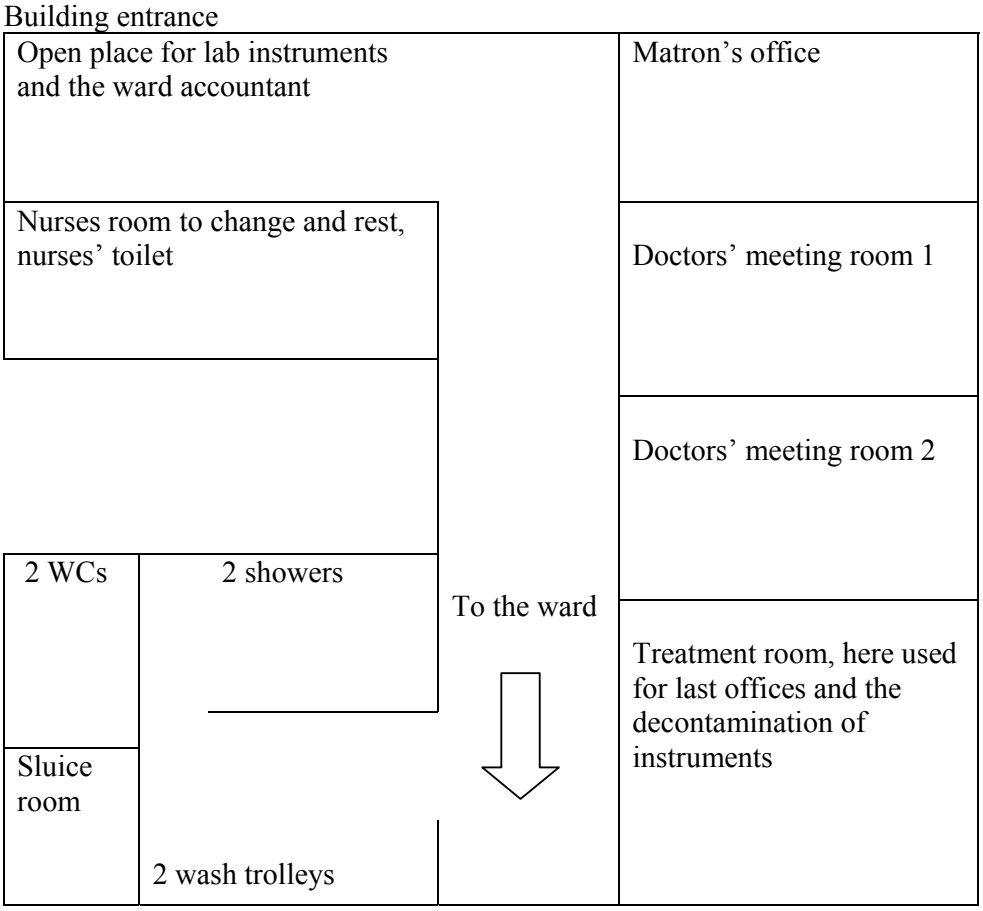
	2006	Past
Population	22,113 million	1960: > 6.7 million
Population in urban areas	46%	1970: 30%
Adult literacy rate	54%	1989: 32%
Primary school enrolment	63%	1992: 73%
Gross national income per capita	$ 380	1981: 400
Government expenditure on health as % of budget	5%	1976: 10% 1980: 8%
Per capita expenditure on health	$ 17	
- Private	68%	
- governmental	32%	
Life expectancy	Male 58 Female 59	1957: 45 1970: 48
Infant mortality	68/1,000	1967: 250/1,000 1988: 77/1,000
Maternal mortality	540/100,000	Ca 1990: 500-1,500/ 100,000
Measles Immunization coverage	83%	1994: 49.2 %
AIDS prevalence	3.6 %	First cases in 1998
Access to safe water	Rural: 52% Urban: 88%	
Access to adequate disposal facilities	Rural: 62% Urban: 44%	
Access to pipe borne (safe) water	Rural: 19% Urban 80%	
Improved sanitation facilities	Rural: 10% Urban: 25%	1988: Rural: 22 Urban: 63

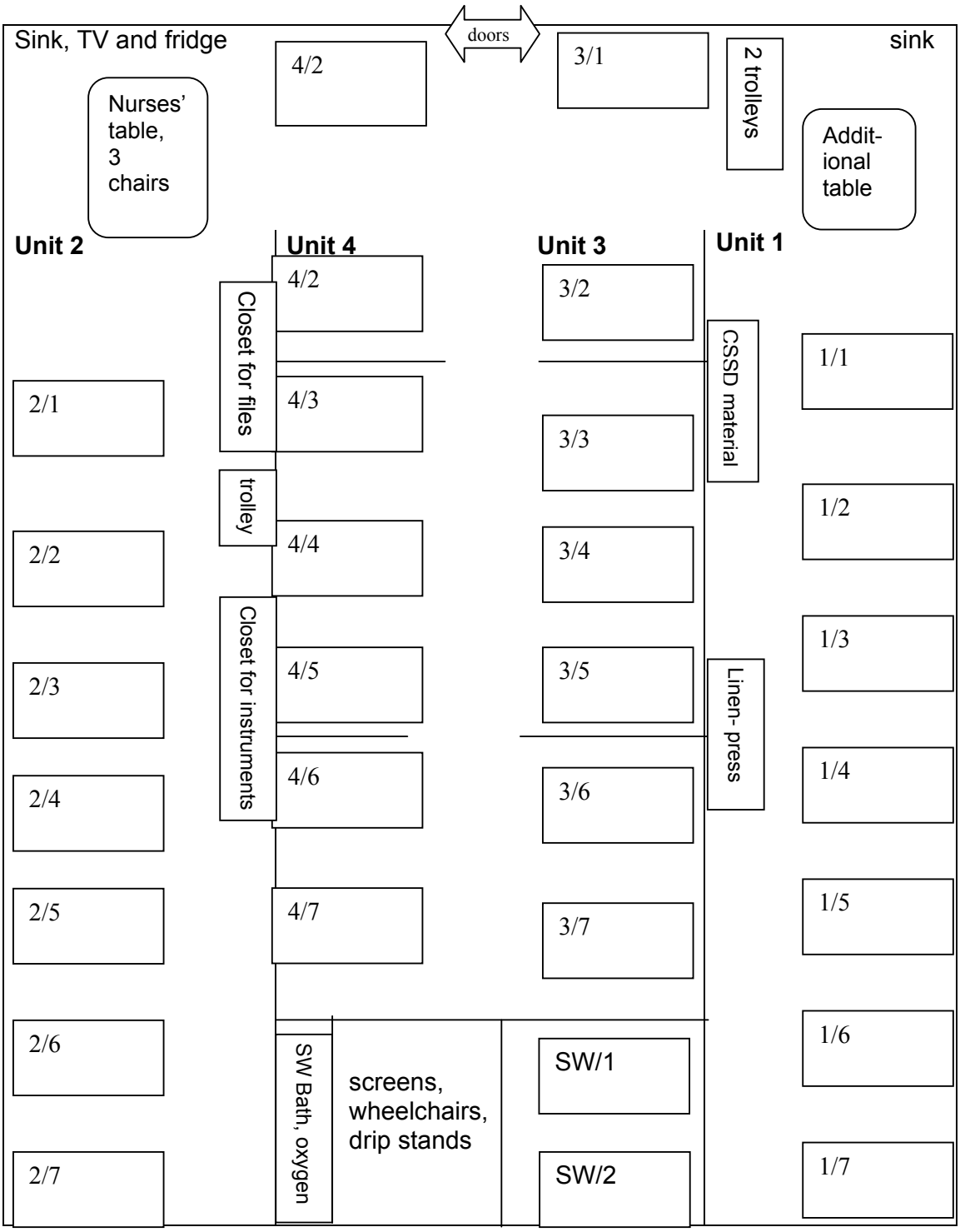
Facts on the health care system in Ghana

Physicians	3,240	1957: 330 1960: 372
Nurses	19,707	1957: 800 1960: 1,684
Physician vacancy rate	47.3%	1998: 42.6%
Nurse vacancy rate	57%	1998: 25.5%
Hospital beds	>20,000	1960: 2,354
Physician: Population ratio	1:6,790	1960: 1:18,000
Nurse: Population ratio	1:1,116	1960: 1:4,000
Bed: Population ratio	1:1,100	1:2,800
Access to health service within 30 minutes	Rural: 15-50% Urban: 50-93%	
OPD visits/capita	0.50	
Hospital admissions	36/1,000	1996: 25/1,000

Sources: WHO statistics 2004, WHO 2006, Addae 1996, Twumasi 1979, Senah 1997, Nyonator 2004, Dugbatey 1999, Ghana 2003.

Appendix C: The ward setting




Sink, TV and fridge
doors
sink
4/2
3/1
2 trolleys
Nurses' table, 3 chairs
Addit-ional table
Unit 2
Unit 4
Unit 3
Unit 1
4/2
3/2
Closet for files
CSSD material
1/1
2/1
4/3
3/3
trolley
1/2
2/2
4/4
3/4
Closet for instruments
1/3
2/3
4/5
3/5
Linen- press
1/4
2/4
4/6
3/6
1/5
2/5
4/7
3/7
1/6
2/6
SW Bath, oxygen
screens, wheelchairs, drip stands
SW/1
SW/2
1/7
2/7

Appendix D: List of nurses and patients

List of nurses and patients (pseudonyms)

Nurses	*Rank*
Alice	Retired Nurse and Chief Nursing Officer
Ama	HCA
Araba	DNS
Bridget	Degree Student final year
Catherine	PNO
Cecile	Degree Student final year
Comfort	Mature degree student
Dora	Retired Community Health Nurse
Edith	PNO
Ernestina	Senior Lecturer
Esther	PNO
Evelyn	Junior Lecturer at NTC
Faustina	Degree Student final year
Gladys	Diploma Student final year
Gloria	Degree Student final year
Grace	SNO
Hilda	PNO
Josephine	Rotation Nurse
Rosemond	SN
Joy	SN
Joyce	SSN
Kate	Degree Student final year
Kofi	Degree Student second year
Liz	Retired nurse
Lydia	SN
Maggy	SNO
Martha	EN
Mary	PNO
Naa	Nurse working for the MoH
Phyllis	EN
Rachel	Mature Degree Student
Regina	DDNS
Stephen	Degree Student second year
Susan	Rotation Nurse
Tyra	Diploma Student final year
Vivian	SNO
Vicky	Diploma Student final year

Patients	*Age, diagnosis*
Akosua	19, leukaemia, died at home
Angela	37, diabetes and gangrene
Elisabeth Kwasie	59, Tbc, discharged after more than four months on the ward
Lizzy	18, Stephen Johnson Syndrome, died on the ward
Mandy	20, leukaemia, died on the ward
Naa	18, Sickle Cell Anemia, died in another hospital
Stella	21, hypothyroid disease

Appendix E: *Aboyoo*

ABOYOO
By A.A. Amartey, 1979

1. Come, whoever is passing,
Come and listen to me.
Listen to my complaint
My small story.
If you have read it before
Judge for me:
If yes, say yes, if no, say no.
I, Aboyoo, Dede[1] Aboyoo,
This is my song, come and sing with me.

2. It is the character of man to forget
But if we sit down
And let forgetfulness become part of us
It is not proper.
Is that not an evil intention?
Judge for me:
If yes, say yes, if no, say no.
I, Aboyoo, Dede Aboyoo,
This is my song,
come and sing with me.

3. From time immemorial
Because of this Accra
I had to stand like a man
Not a very small man.
The men of today do not know
What I have done before.
All this is the fault of their fathers
Haven't they been ungrateful?
If yes, say yes, if no, say no.
I, Aboyoo, Dede Aboyoo,
This is my song, come and sing with me.

4. Do people need fish?
Three times in every year
I pour it down for them
I gave them vast land
For the construction of Korle Bu hospital
If I did this for them
Have I done my children evil2?
If yes, say yes, if no, say no.
I, Aboyoo, Dede Aboyoo,
This is my song, come and sing with me.

1. Ba, bo mɔ ni hoɔ
Baabo toi oham
Kɛji onu tsɔ
Mimaniɛ kpɔoo nɛɛ;
Kɛ okane da
Loo onu agba,
Buamɔ he oha mi:
Kɛ Hɛɛ lɛ, kɛɛmɔ;
Kɛ Dabi, kaashe!
Mi Abooyo, Dede Aboyoo,
Milala nɛ; nyɛlaa koo!

2. Adesa he nɔ
Ji henɔkpamɔ
Shi kɛ ata shi
Ni henɔkpamɔ
Batsɔ subaŋ lɛ
Kwɛ jeee yiŋsha nɛ?
Buamɔ he oha mi:
Kɛ Hɛɛ lɛ, kɛɛmɔ;
Kɛ Dabi, kaashe!
Mi Abooyo, Dede Aboyoo,
Milala nɛ; nyɛlaa koo!

3. Blema tsutsu ko
Ga nɛɛ hewɔ lɛ
Midamɔ shi nuu;
Ni jeee nuu shwɛbi
ŋmɛnɛŋmɛnɛbii
leee; fɛɛ jɛ tsɛmɛi.
Afeko minɔ trumu?
Kɛ Hɛɛ lɛ, kɛɛmɔ;
Kɛ Dabi, kaashe!
Mi Abooyo, Dede Aboyoo,
Milala nɛ; nyɛlaa koo!

4. Yeliloo n'ehia?
Shii etɛ daa 'fi
Mifrɔkeɔ shwieɔ shi;
Shipɔŋ shwaŋŋ miduro
Kɛɛma tsamohe.
Aso nɛkɛ lɛ
Mifee bii efɔŋ?
Kɛ Hɛɛ lɛ, kɛɛmɔ; Kɛ Dabi, kaashe!
Mi Abooyo, Dede Aboyoo,
Milala nɛ; nyɛlaa koo!

[1] Dede is the name given to the first born girl in the family
[2] Have I not done my best?

5. I was there for a long time But people forgot about me. Nobody cries for my youth to come again People can do it But they cry about themselves. Is that right? If yes, say yes, if no, say no. I, Aboyoo, Dede Aboyoo, This is my song, come and sing with me. 6. What is paining me does not pain the people If I had only known That today I would break down And become what I am today And the crowd passing over me at my old age I would have done something. If yes, say yes, if no, say no. I, Aboyoo, Dede Aboyoo, This is my song, come and sing with me. 7. Yes, a time came Where I brought forth a newborn It heard my cry She is giving me back my youthful days And this person is Ghana Am I telling lies? If yes, say yes, if no, say no. I, Aboyoo, Dede Aboyoo, This is my song, come and sing with me. 8. This is my poem And my short song If you are challenged by this And you are convinced To serve your country Ghana Give yourself up. Is this advice so difficult? If yes, say yes, if no, say no. I, Aboyoo, Dede Aboyoo, This is my song, come and sing with me. 9. Why are you neglecting This old woman Full of wisdom and advice Who is depicting the wisdom of black man? Judge for me Yours should be Yes No should not be part of you. I, Aboyoo, Dede Aboyoo, This is my song, come and sing with me.	5. Hiɛ je minɔ, be Kplaŋŋ ni mibua shi. Mɔ ko fooo koni Miblayeiaŋ aha. Gbɔmɔ baanyɛ, shi Eefo enɔ mli.Aso enɛ ja? Kɛ Hɛɛ lɛ, kɛɛmɔ;Kɛ Dabi, kaashe! Mi Abooyo, Dede Aboyoo, Milala nɛ; nyɛlaa koo! 6. Mɔ nɔ edɔɔɔ mɔ! Kɛ mihe miye Akɛ makumɔ Kɛ afui ekoŋŋ Mile atatu Nɛɛ baakplaŋ kɛho. Migbalɛ lɛ be mli? Kɛ Hɛɛ lɛ, kɛɛmɔ; Kɛ Dabi, kaashe! Mi Abooyo, Dede Aboyoo, Milala nɛ; nyɛlaa koo! 7. Lɛɛlɛŋ, be lɛ ba. Bi hee jɛ mimli Nu miyaafo he. Lɛ ebakpale Miblayeiaŋ eha mi. Ghaana ji bi nɛɛ. Aso mimale? Kɛ Hɛɛ lɛ, kɛɛmɔ;Kɛ Dabi, kaashe! Mi Abooyo, Dede Aboyoo, Milala nɛ; nyɛlaa koo! 8. Mibɛ mibuɔ kɛ Lala kuku nɛɛ. Kɛ oyinɔ shi Ogbo, maŋ hewɔ Kɛbi bosɔɔmɔ Kpoomɔ ohe oha. Aso ŋaa nɛɛ joɔ? Kɛ Hɛɛ lɛ, kɛɛmɔ;Kɛ Dabi, kaashe! Mi Abooyo, Dede Aboyoo, Milala nɛ; nyɛlaa koo! 9. Mɛɛba oyaŋeɔ Teteete blema N'efɛo kɛ nilee Mata tɔtɔtɔ Ni tɛɔ mɔdiŋ Jebɔ kɛ nyam? Buamɔ he oha mi! Nyɛnɔ afee Hɛɛ! Dabi lɛ, kosɛ! Mi Abooyo, Dede Abooyo, Milala nɛ, nyɛlaa koo!

Summary

"I am a nurse!" This sentence can be heard all over the world. Being one of the oldest tasks of women, working as a nurse is associated with manifold images, expectations, dreams and clichés. The profession of nursing evolved over centuries, professionalized and specialized further, had to adapt to new situations, developed theories and up to today shapes its definition, appearance and goals. Originating in Europe from a religious duty carried out by nuns and benevolent women to old, poor, sick and dying members of the society, it is today a universal independent profession taught in training colleges and at universities. Nurses work on high technology wards, in hospitals, health centres and public health posts, working in co-operation with medical doctors promoting health, preventing disease and providing care to the sick and dying.

Working with nurses in the 1990s in Ghana, I soon realised a tension between the universal image of the nurse and the working reality in this country. Nurses needed to bridge the gap between professional goals, individual dreams and expectations from society. This experience shaped my research questions: How did nursing develop in Ghana? How do nurses in Ghana today manage their work and what expectations do they meet? Cultural ideas on health and appropriate treatment, the working environment in the public hospitals and clinics, and the role in the society challenge nurses in their daily routine and force them to define and redefine their role and to display their nursing authority and knowledge. This study, *Ghanaian nurses at a crossroads: Managing expectations on a medical ward,* describes the rationale and working routine of nurses on a medical ward in a teaching hospital in Accra, Ghana's capital. Ghana serves as a case study of conditions that are likely to occur in other African countries as well. It provides answers to these questions. Giving voice to the nurses on the work floor, this ethnographic description adds to the growing literature in medical anthropology and the anthropology of nursing, shedding light on the position and perception of nurses on a ward within an academic hospital.

Part I places the study in the field of hospital ethnography and the theoretical framework of assigning power and transferring knowledge (*Chapter 1*). Defining the hospital as a place where the core values of society are displayed, discussed and reinforced, the ward is here seen as a crucial space, and the nurses have the role of actors, mediators and reactors of the social and medical culture when providing care to seriously ill patients. Assigning, exercising and rejecting power places nurses on a crucial position within the functioning of the ward. *Chapter 2* focuses on methodological aspects of doing fieldwork in the hospital. It describes

formal and informal steps that were necessary to carry out the fieldwork and to be accepted as a researcher and person. Both the hospital and the ward were conscious choices to allow me to gain an insight in the nursing work. Being in the role of a participating observer and helping in the daily routine, I involved myself in nursing activities. This enabled me to connect with the nurses and experience their work, but challenged me also in the objectification of my work and lead to ethical considerations of my role and the consequences and implications of my study for the nurses.

Part II introduces Ghana and some relevant cultural features. *Chapter 3* describes its traditions and prominent social values. The importance of religion and respect are also highlighted as aspects of women's lives. Ghana is portrayed as a society in change, oscillating between tradition and modernity. Building on this, *Chapter 4* describes the main concepts of health that are found in Ghana. The introduction of scientific medicine has led to changes in the perception of health and disease and expectations in treatment and healing. Recent developments include the establishment of a national health insurance scheme aiming at better access to and treatment in the health centres and hospitals in the country. The following two chapters (*Chapters 5 and 6*) illustrate and analyse the emergence of nursing. Introduced by British nurses, nursing started as an unknown profession in the newly built hospitals. It started with male apprentices in the first half of the twentieth century and developed into to a mainly female profession by the turn to the twenty-first century. The opening of the first training college in 1945 was a sign of the growing needs for nurses and acceptance in the society. Today, all ten regions in the country have public training colleges along with the various private and confessional training schools. The Department of Nursing at the University of Ghana in Accra indicates the goal to further professionalise nursing and connect to international developments. *Chapter 7* looks at the motives of women from various generations for becoming a nurse. It is shown which motives are prominent in those groups and how their change can be explained by the broader social and economic conditions of the country. Religious convictions, the influence of the extended family, the function of role models and the importance of economic needs form a network of hopes, wishes, expectations and demands that young women try to untangle when entering the profession. *Chapter 8* then gives space to current nursing students. Their experiences on the ward contrast with their theoretical studies and individual expectations. This gap, and the limited guidance in the practical work, worries them and often leads to frustration and disillusion. Many nurses consider leaving the profession or working abroad, where the conditions and financial rewards seem more attractive and promising.

Part III presents the results of the fieldwork study on the medical ward. *Chapter 9* introduces the hospital and the medical ward, its place in society, the perception of the hospital by the health workers and the patients, and the working conditions that the nurses meet on the ward. The next two chapters describe and analyse the working routine of nurses (*Chapter 10*) and the differentiation within the group (*Chapter 11*). Nurses form the most visible group of health workers on the ward and are present all day and night. Their work on the 30-beds ward is characterised by recurring tasks in providing care to the patients. Making the beds and tidying the ward are also understood as forms of control over the patients, aiming at conformity in the appearance of the ward and calmness to enable recovery. Extensive paper work and documentation form a large part of their daily routine. A personnel shortage, irregular supply of materials and the gravity of the patients' diseases challenge their work schedule and force the nurses to improvise and continuously adjust their aims. Nurses can be differentiated in various subgroups. A strict dress code shows the status and rank of a nurse. A top-down structure, the radiation of authority and unquestioned forms of respect form the base of this differentiation. Given the changing work schedules and subsequent need to co-operate and act appropriately in unforeseen situations, no one is without power. Everyone is aware that every nurse, student and assistant is needed to manage the daily challenges on the ward. The following chapters pay attention to specific aspects of nursing on the ward. *Chapter 12* highlights the impact of dying patients on the nurses and their understanding of their work. Every month more than 15 patients die on this ward. Culture places dying in the private and personal sphere, but on the ward, death is public and observable. Nurses struggle with their own cultural values, medical and nursing knowledge and the given circumstances. Emotions are not shown publicly. The nurses sympathise with the dying and their families but at the same time remain distant to keep the ward calm and under control. The role of religion on the ward is the theme of *Chapter 13*. Religion's omnipresence is shown in the nurses' gathering for moments of devotion and encouraging patients to read the Bible and pray. Religion acts as an inclusive and exclusive factor in the work of the nurses: All nurses, and to a certain extent also patients, are expected to be member of a religious group, mainly Christian, providing moral values and being reflected in an exemplary life style. Non-religious or atheistic nurses are critically evaluated. My presence too was evaluated by my participation in their devotion. Religion helps the nurses to cope with the pressure and shortcomings in their work and has a binding effect in the group. *Chapter 14* gives space to other groups on the ward. Medical doctors come for their ward rounds and patients' examinations. They are the most powerful actors on the ward. They have their own rules and expect nurses to follow their commands. Nurses have little influence on the

doctors' work but try to draw their attention to needy patients and necessary paperwork. The orderlies support the nurses in the daily work. They have their own tasks and receive instructions from the nurses. Their work is important to maintain order and neatness on the ward. The patients are expected to be obedient and silent. Patients who are too knowledgeable or too poor are labelled as difficult. Patients can be in and out of the gaze of the nurses, which has consequences for the care they receive. *Chapter 15* shows the nurses as part of larger groups. They are one group within the hospital and this hospital is just one place in the health care sector. Alliances are formed, responsibilities distributed and expectations adjusted. In addition, nurses have to combine their professional life with their private one as wives, mothers, family members and members of social groups. *Chapter 16* is devoted to the nurses' own understanding of 'good nursing'. Nurses on the ward, at other places in the health sector and in associations know about the challenges. The profession is threatened by a loss of status and growing personnel shortage due to de-motivating work conditions and emigration. The aim is to keep the nurses motivated and appreciate their work while also introducing new nursing concepts and developing new standards for nursing.

Part IV summarizes and concludes the study. *Chapter 17* shows the display and exercise of power within and between groups. Many relations are defined by a rigid hierarchy as is reflected in the organisation of ward space, in the physical appearance and social behaviour of nurses and the in use of English language. Doctors and nurses communicate via fixed patterns of command and obedience. The nurses' group is organised top down and the older nurses demand respect from their younger colleagues. Criticism is not possible and it is difficult to introduce new ideas. Nurses, for their part, are authoritarian towards patients. Social norms and cultural roles predict, offer and at times limit possible actions. These factors can challenge the effective management of critical nursing situations and the further implementation and introduction of nursing standards. The Ghanaian situation does not stand by itself but is connected to and influenced by global developments. It does not correspond to with the Western image of a modern technological biomedical hospital. This tension leads to frictions in the perception, motivation and working reality of nurses. Recognising and acknowledging existing power and knowledge as a productive tool will help the nurses on the ward to manage their work and enhance the status of their profession in the health care system of Ghana. In conclusion, this study presents the work of nurses from their own perspective. It portrays their present situation and points to ways to further their professional development.

Samenvatting (Summary in Dutch)

"Ik ben een verpleegkundige!" Deze uitspraak kan men overal ter wereld horen. Het werk van verpleegkundigen is een van de oudste bezigheden van vrouwen en wordt omgeven met beelden, verwachtingen, dromen en clichés. Verpleegkunde ontwikkelde zich door de eeuwen heen, doorliep perioden van professionalisering en leidde tot specialisaties op veel gebieden. Het beroep moest zich continu aan nieuwe situaties aanpassen, theorieën ontwikkelen en tot op de dag van vandaag geeft de verpleegkunde zijn eigen definitie, verschijningsvorm en doelen vorm.

De oorsprong van het beroep verpleging ligt in het middeleeuwse Europa, waar nonnen en toegewijde vrouwen oude, arme, zieke en stervende mensen onderdak gaven en vanuit hun religieuze overtuiging verpleging en zorg boden. Vandaag de dag is het een universeel, onafhankelijk beroep, dat onderwezen wordt in scholen en op universiteiten. Verpleegkundigen werken op hoog gespecialiseerde afdelingen, in ziekenhuizen, klinieken en gezondheidsposten samen met medisch specialisten aan de bevordering van de gezondheid, het voorkomen van ziekten en het geven van zorg aan zieken en stervenden.

Toen ik in de jaren 1990 met verpleegkundigen in Cape Coast werkte, merkte ik al snel de discrepantie tussen het universele beeld van verpleging en de realiteit in de *public health* en ziekenhuizen van Ghana. Verpleegkundigen moeten de kloof tussen professionele doelen, individuele wensen en verwachtingen vanuit de maatschappij overbruggen. Deze ervaring heeft mijn onderzoeksvragen beïnvloed: Hoe heeft de verpleegkunde in Ghana zich ontwikkeld? Hoe organiseren verpleegkundigen in Ghana vandaag hun werk en welke verwachtingen bestaan er rondom hun beroep? Culturele concepten over gezondheid en te verwachten behandelingen, de werkomgeving in de *public hospitals* en gezondheidsposten en de rol van verpleegkundigen in de maatschappij dagen hen in hun dagelijkse routine uit en dwingen de verpleegkundigen hun rol continue te definiëren, herdefiniëren en hun verpleegkundige autoriteit en kennis te tonen. Deze studie, *Ghanaian nurses at a crossroads: Managing expectations on a medical ward,* beschrijft de beweegredenen en de werkroutine van verpleegkundigen op een interne afdeling in een universiteitsziekenhuis in Ghana's hoofdstad Accra. Ghana is hier een casus van een situatie die ook in andere Afrikaanse landen kan worden gevonden. Het geeft antwoorden op de bovengenoemde vragen. Door verpleegkundigen aan het woord te laten, draagt deze etnografie bij aan de groeiende literatuur in medische antropologie en de antropologie van de verpleeg-

kunde en werpt licht op de positie en ervaringen van verpleegkundigen in een universitair ziekenhuis.

Deel I plaatst de studie binnen het specialisme *hospital ethnography* en geeft inzicht in het theoretisch kader vanuit een Foucauldiaanse perspectief. De aanwezigheid en toewijzing van macht (*power*) en het overdragen van kennis (*knowledge*) zijn hierbij cruciaal (*Hoofdstuk 1*). Door het ziekenhuis als ruimte te definiëren waarin de sociale normen en waarden van een cultuur uitgedragen, bediscussieerd en bevestigd worden, krijgt de afdeling een cruciale maatschappelijke betekenis. De verpleegkundigen hebben hierbij de rol van acteur, mediator en tegenspeler binnen de sociale en medische cultuur tijdens het uitoefenen van hun werk. Het toewijzen en uitoefenen van macht maar ook het verzet tegen macht plaatst de verpleegkundigen in een belangrijke positie binnen het functioneren van een afdeling. *Hoofdstuk 2* legt de nadruk op methodologische aspecten van veldwerk in een ziekenhuis. Het beschrijft de formele en informele stappen die noodzakelijk waren om dit onderzoek te kunnen doen en om als onderzoeker en als persoon geaccepteerd te worden. Het ziekenhuis en de interne vrouwenafdeling waren bewuste keuzes om inzicht in het werk van verpleegkundigen en de leefwereld van vrouwen te verkrijgen. Door als verpleegkundige de rol van *participating observer* aan te nemen en bij de dagelijkse routine te helpen, werd ik rechtstreeks bij het werk betrokken. Hierdoor kon ik met de verpleegkundigen een direct contact opbouwen en verpleging op de afdeling ook zelf ervaren. Tegelijkertijd riep deze betrokkenheid ook vragen bij mij op. Hoe kon ik mijn data objectiveren en welke consequenties zou mijn studie voor de verpleegkundigen hebben?

Deel II introduceert Ghana en een aantal relevante culturele kenmerken. *Hoofdstuk 3* beschrijft tradities en prominente sociale normen. Het belang van religie en respect en ook de rol van vrouwen in de Ghanese maatschappij worden belicht. Het wordt zo duidelijk dat Ghana een land in ontwikkeling is, een maatschappij tussen tradities en moderniteit. Hierop verdergaand richt *Hoofdstuk 4* zich op de belangrijkste concepten van gezondheid. De invoering van de Westerse geneeskunde leidde tot veranderingen van zowel de waarneming van gezondheid en ziekte als de verwachting rond succesvolle behandeling en genezing. Een recente ontwikkeling is de invoering van een nationale ziektekostenverzekering. Hierdoor wordt getracht de toegang tot ziekenhuizen en de mogelijkheden van behandeling voor alle bevolkingsgroepen in het land te verhogen. De aansluitende twee hoofdstukken (*Hoofdstukken 5 en 6*) illustreren en analyseren de opkomst en ontwikkeling van verpleegkunde in Ghana. Tot de invoering ervan door Britse verpleegkundigen aan het begin van de 20ste eeuw was verpleging in de Gold Coast (het huidige Ghana) een onbekend beroep. De eerste leerlingen waren jonge mannen, maar in de loop van de eeuw veranderde het in

een door vrouwen gedomineerd beroep. De opening van de eerste school in 1945 markeert de groeiende behoefte aan verpleegkundigen en de acceptatie van het beroep in de maatschappij. Tegenwoordig hebben alle tien provincies in het land openbare opleidingen en bestaan er daarnaast talloze confessionele en private scholen. De oprichting van het *Department of Nursing* aan de Universiteit van Ghana (Accra) in 1963 (sinds 2003 *School of Nursing*) laat de wens zien verpleging verder te professionaliseren en aansluiting te vinden bij internationale onderzoeken. *Hoofdstuk 7* bekijkt de motieven van verschillende generaties vrouwen om de opleiding tot verpleegkundige te volgen. Het beschrijft opvallende motieven en hun verandering door de generaties heen en plaatst deze ontwikkeling in het kader van sociale en economische veranderingen. Religieuze overtuigingen, de invloed van de familie, rolmodellen en financiële aspecten vormen een web van hoop, wensen, dromen, verwachtingen en verlangens. Dit web proberen jonge vrouwen te ontrafelen als ze aan hun opleiding beginnen. *Hoofdstuk 8* geeft ruimte aan studenten die aan het begin van de 21ste eeuw de opleiding volgen. Hun ervaringen op de afdelingen staan in scherp contrast met zowel de meer theoretische lessen als de individuele verwachtingen. Deze kloof en het gebrek aan begeleiding tijdens het praktische werk belast de studenten en leidt tot frustraties en desillusies. Vele verpleegkundigen overwegen te stoppen of in het buitenland te gaan werken, waar de arbeidsvoorwaarden beter en de financiële beloning aantrekkelijker lijken te zijn.

Deel III presenteert de resultaten van het veldwerk op de interne afdeling. *Hoofdstuk 9* introduceert het ziekenhuis met zijn afdelingen, zijn plaats in de samenleving, de waarnemingen van medewerkers en patiënten en de arbeidsomstandigheden op de afdelingen. De volgende twee hoofdstukken beschrijven en analyseren de werkroutine van verpleegkundigen (*Hoofdstuk 10*) en de onderlinge verhoudingen *(Hoofdstuk 11*). Verpleegkundigen zijn de meest zichtbare groep van medewerkers op een afdeling. Ze zijn zowel overdag als ’s nachts aanwezig. Hun werk op de 30-bedden afdeling wordt gekenmerkt door zich herhalende verrichtingen. Het opmaken van bedden en het zorgen voor netheid in de ziekenzaal kunnen hierbij als vormen van machtscontrole over patiënten gezien worden met als doel conformiteit en een rustige en serene sfeer te creëren. Extensieve documentatie en het invullen van papierwerk maken ook deel uit van de dagelijkse routine. Het tekort aan personeel, de onvoorspelbare levering van benodigdheden en de ernst van de ziektebeelden maken een planning van het werk onmogelijk en eisen van de verpleegkundigen improvisatie en continue aanpassing van hun doelstellingen. De groep verpleegkundigen valt, van dichterbij bekeken, in verschillende subgroepen uit elkaar. Een strikte kledingcode laat rang en status van de verpleegkundige zien. De *top-down* structuur, het uitstralen van autoriteit en de verwachte vormen van respect vormen de basis van onder-

linge differentiatie. Door het steeds veranderende werkschema bestaat tegelijkertijd de noodzaak samen te werken. Op die manier kan men adequaat op onverwachte en kritische situaties reageren. Dit heeft tot gevolg dat geen enkele groep machteloos is. Iedereen is zich ervan bewust dat elke verpleegkundige, iedere studente en elke assistente nodig is om het dagelijkse werk te voltooien en de uitdagingen te boven te komen. De hierop volgende hoofdstukken belichten speciale aspecten van verpleging op de afdeling. *Hoofdstuk 12* beschrijft de impact van stervende patiënten op de verpleegkundigen en hun begrip van hun werk. Iedere maand overlijden er meer dan 15 patiënten op deze afdeling. Cultureel gezien hoort overlijden en dood in de huiselijke en privé-sfeer, maar op de afdeling is de dood openbaar en zichtbaar. De verpleegkundigen worstelen hierdoor met hun eigen culturele overtuigingen, hun medische en verpleegkundige kennis en de gegeven omstandigheden. Emoties horen niet in het openbaar getoond te worden. De verpleegkundigen sympathiseren met de lijdende patiënten en hun families, maar tegelijkertijd houden ze afstand en trachten ze de afdeling rustig en onder controle te houden. De rol van religie is het thema van *Hoofdstuk 13*. De aanwezigheid van religie is te zien in het dagelijks bijeenkomen van de verpleegkundigen voor het ochtendgebed en hun bemoediging naar de patiënten door in de bijbel te lezen en te bidden. Religie fungeert als inclusieve en exclusieve factor. Alle verpleegkundigen en ook patiënten worden geacht lid van een religieuze groep te zijn. Vooral christelijke groeperingen zijn vertegenwoordigd. Normen en waarden worden door een voorbeeldige levenstijl gereflecteerd. Niet-gelovende verpleegkundigen worden kritisch bejegend. Ook mijn aanwezigheid op de afdeling werd mede getoetst aan mijn deelname aan de gebeden. Religie helpt de verpleegkundigen met de werkdruk en tekortkomingen om te gaan en heeft een verbindend effect. In *Hoofdstuk 14* ligt de focus op andere groepen op de afdeling. Artsen komen voor hun visites en onderzoeken de patiënten. Zij zijn de machtigste groep, volgen eigen regels en verwachten van de verpleging gehoorzaamheid. De verpleegkundigen hebben een geringe invloed op het werk van de artsen, maar zij proberen hun aandacht te leiden naar hulpbehoevende patiënten en het noodzakelijke papierwerk. Het schoonmaakpersoneel ondersteunt de verpleegkundigen in hun dagelijks werk. Zij hebben hun eigen taken en ontvangen opdrachten van de verpleegkundigen. Hun werk is belangrijk voor het functioneren van de afdeling. De patiënten worden geacht rust te houden, volgzaam te zijn en geen vragen te stellen. Onbemiddelde en veel-eisende vrouwen worden als 'moeilijke patiënten' bestempeld. Patiënten kunnen binnen of buiten het blikveld van de verpleegkundigen belanden en dat heeft consequenties voor de te ontvangen zorg. In *Hoofdstuk 15* presenteer ik de verpleegkundigen als deel van een groter geheel. Zij vormen binnen het ziekenhuis een groep, maar deze plaats is slechts een deel van de Ghanese gezondheidzorg. Allianties worden

gevormd, verantwoordelijkheden toegedeeld en ontnomen, verwachtingen bijgesteld. Daarnaast moeten zij hun werk combineren met hun rollen als echtgenote, moeder, familielid en deel van hun sociale netwerk. *Hoofdstuk 16* gaat over het begrip *good nursing* en de invulling hiervan door de verpleegkundigen zelf. Op de afdeling, op andere plaatsen binnen de gezondheidszorg en in de beroepsverenigingen weet iedereen van de problemen en uitdagingen. Het bestaande tekort aan goed opgeleide verpleegkundigen en de latente demotivatie van de werkenden vormt een continue bedreiging. Het beroep wordt met statusverlies bedreigd. Het algemene doel is alle werkenden gemotiveerd te houden en de arbeid te waarderen en tegelijkertijd nieuwe concepten te ontwikkelen en nieuwe standaarden voor de moderne verpleging in te voeren.

Deel IV vat de belangrijkste bevindingen samen en tracht daaruit enkele conclusies te trekken. *Hoofdstuk 17* analyseert de aanwezigheid en uitoefening van macht binnen en tussen de groepen. Vele relaties worden gekenmerkt door een rigide hiërarchie, die zichtbaar wordt in onder andere de ruimtelijke organisatie van de afdeling, de kleding van de verpleegkundigen, hun verwachte sociale gedrag en het gebruik van de Engelse taal. Artsen en verpleegkundigen communiceren via vastgelegde vormen van bevel en gehoorzaamheid. De groep van verpleegkundigen is *top-down* georganiseerd en de ouderen verwachten respect van hun jongere collega's. Het uiten van kritiek is niet mogelijk en nieuwe ideeën kunnen maar moeilijk worden geïntroduceerd. Tegenover patiënten zijn de verpleegkundigen autoritair. Sociale normen en cultureel vastgelegde rollen voorspellen en limiteren mogelijke handelingen. Deze factoren vormen een uitdaging voor een effectief management in kritische situaties op de afdeling en voor de invoering van nieuwe standaarden. De Ghanese situatie staat niet los van de globale ontwikkelingen, maar is hiermee hecht verbonden en wordt erdoor beïnvloed. Zij komt niet met het Westerse beeld van een modern technologisch ontwikkeld ziekenhuis en geavanceerde ziekenverzorging overeen. Deze spanning leidt tot wrijving in de waarneming, de motivatie en de alledaagse werkelijkheid van de verpleegkundigen. Het herkennen en uitspreken van bestaande machtsverhoudingen en kennisoverdracht als productief en constructief instrument zal de verpleegkundigen helpen de dagelijkse arbeid op de afdelingen te organiseren en de status van hun beroep in de gezondheidszorg van Ghana te sterken. Deze studie presenteert de werkzaamheden van verpleegkundigen vanuit hun perspectief. Het portretteert de actuele situatie en toont mogelijke wegen naar een voortzetting van de professionalisering.

Zusammenfassung (Summary in German)

"Ich bin Krankenschwester!" Dieser Satz ist überall auf der Welt zu hören. Als eine der ältesten Tätigkeiten für Frauen weltweit ist dieser Beruf mit Klischees, Träumen und Erwartungen besetzt. Krankenpflege entwickelte sich durch die Jahrhunderte hindurch, durchlief Perioden der Professionalisierung und Spezialisierung und musste sich kontinuierlich an neue Situationen anpassen, Herausforderungen stellen und so ihr Selbstverständnis, Erscheinungsbild und ihre Ziele ausgestalten. War es ursprünglich eine Tätigkeit der Berufung frommer Frauen und Nonnen in Europa, die alte, kranke und sterbende Menschen versorgten und begleiteten, so ist es heute ein weltweit verbreiteter unabhängiger Beruf, der in Ausbildungszentren und an Universitäten gelehrt wird. Krankenschwestern arbeiten auf hoch technisierten Abteilungen, in Krankenhäusern, Gesundheitszentren und Einrichtungen, sie kooperieren mit Ärzten, fördern die Gesundheit, verhindern Krankheit und pflegen Kranke und Sterbende.

Während meiner Arbeit mit Krankenschwestern in den frühen 1990er Jahren in Ghana nahm ich schnell die Spannungen zwischen dem imaginären universellen Bild der Krankenschwester und der Arbeitsrealität im Land wahr. Krankenschwestern müssen dort die Diskrepanz zwischen professionellen Zielen, individuellen Träumen und gesellschaftlichen Erwartungen aushalten und überbrücken. Diese Erfahrung beeinflusste mich und präzisierte meine Forschungsfragen: Wie entwickelte sich Krankenpflege in Ghana? Anhand welcher Richtleinen und Realitäten organisieren Krankenschwestern heutzutage ihre Arbeit und welche Erwartungen werden an sie gestellt? Kulturelle Ideen über Gesundheit, Krankheit und angemessene Behandlungsmethoden, die Arbeitsumgebung in den staatlichen Krankenhäusern und Kliniken und die Rolle in der Gesellschaft fordern sie täglich heraus und zwingen sie zu einer konstanten Neudefinition ihrer Rolle und einer überzeugenden Darstellung ihrer krankenpflegerischen Autorität und ihres Wissens. Die vorliegende Studie, *Ghanaian nurses at a crossroads: Managing expectations on a medical ward*, beschreibt das Verständnis und die Arbeitsroutine von Krankenschwestern auf einer inneren Abteilung im akademischen Krankenhaus von Ghanas Hauptstadt Accra. Ghana dient hierbei als Fallstudie mit dem Ziel einer Zustandsbeschreibung, wie sie auch in anderen afrikanischen Ländern angetroffen werden kann. Die Studie gibt Antworten zu oben gestellten Fragen. Indem sie Krankenschwestern zu Wort kommen lässt, liefert diese ethnographische Beschreibung einen Beitrag zur wachsenden Literatur innerhalb der Medizinanthropologie und anthropology of nursing. Darüber hinaus beleuchtet

sie die Position und Wahrnehmung von Krankenschwestern innerhalb eines akademischen Krankenhauses.

Teil I ordnet die Studie innerhalb des Fachgebiets der Krankenhausethnologie ein und gibt Einblick in den theoretischen Rahmen der Arbeit. Aus einer Foucaultschen Perspektive heraus wird nach Formen und Zeichen von Macht (*power*) und Wissensübermittlung (*transfer of knowledge*) gefragt (*Kapitel 1*). Das Krankenhaus wird hierbei als Ort erkannt, an dem moralische und soziale Grundwerte der Gesellschaft dargestellt, diskutiert und bestärkt werden. Die Krankenschwestern haben die Rolle von Akteuren, Mediatoren und Reagierenden inmitten einer medizinischen und sozialen Realität während der Ausübung pflegerischer Tätigkeiten. Das Zuweisen, Ausüben und Zurückweisen von Macht stellt sie in eine herausragende Position. *Kapitel 2* geht auf methodologische Aspekte der Forschung im Krakenhaus ein. Es beschreibt formale und informelle Schritte, die notwendig waren, um die Feldforschung zu machen und sowohl als Forscherin als auch als Mensch akzeptiert zu werden. Sowohl die Wahl des Krankenhauses als auch der Abteilung geschah bewusst, um so Einblick in die Arbeitswelt der Krankenschwestern zu erhalten. Die Rolle des *participating observer* und die aktive Mitarbeit als Pflegehelferin ermöglichten es mir, die Erfahrungen und Realitäten der Krankenschwestern mitzuerleben und so Beziehungen herzustellen. Gleichzeitig zeigte mir diese Mitarbeit auch ethische Grenzen auf: Meine Anwesendheit auf der Abteilung beeinflusste die Arbeit und das Verhalten der Krankenschwestern, wie auch das Schreiben meiner Ergebnisse möglicherweise Folgen für ihre Arbeit und Position hatte.

Teil II gibt einen Einblick in relevante Aspekte von Ghanas Kultur und Geschichte. *Kapitel 3* beschreibt Traditionen und soziale Werte. Die Rolle von Religion und Respekt wird ebenso beleuchtet wie Faktoren, die das öffentliche und private Leben von Frauen bestimmen. Hieraus wird deutlich, dass Ghana ein Land im Wandel ist und seine Gesellschaft zwischen Tradition und Moderne pendelt. *Kapitel 4* stellt dominante Konzepte von Krankheit und Gesundheit dar, die in Ghana existieren. Die Einführung der westlichen Schulmedizin führte zu weitreichenden Veränderungen in der Wahrnehmung von Krankheit und den Erwartungen an Therapie und Heilung. Der Aufbau einer landesweiten Krankenversicherung ist eine der letzten Entwicklungen im Gesundheitswesen und versucht, den Zugang zu und die Akzeptanz von Krankenhäusern zu verbessern. Die folgenden zwei Kapitel (*Kapitel 5* und *6*) illustrieren und analysieren die Entwicklung von Krankenpflege in Ghana. Krankenpflege begann in der Gold Coast als bislang unbekannter Beruf, der durch die Kolonialmacht Großbritannien eingeführt und in den neu errichteten Krankenhäusern ausgeübt wurde. Waren es zu Beginn des 20. Jahrhunderts junge Männer, die rekrutiert wurden, so wandelten sich das Ansehen und der Status und ist es heute, 100 Jahre später, ein

weiblich dominierter Beruf. Die Eröffnung der ersten Krankenpflegeschule des Landes im Jahr 1945 markiert den wachsenden Bedarf an und die zunehmende Akzeptanz von Krankenschwestern. Heute haben alle 10 Provinzen des Landes staatliche Ausbildungsstätten, daneben gibt es zahlreiche private und kirchliche Schulen. Das *Department of Nursing* an der Universität von Ghana in Accra unterstreicht darüber hinaus die Bestrebungen, den Beruf weiter zu professionalisieren und Anschluss an internationale Entwicklungen zu halten. *Kapitel 7* zeigt Gründe auf, die Frauen verschiedener Generationen dazu motivieren, Krankenschwester zu werden. Es wird deutlich, welche Motive für welche Gruppe am wichtigsten sind und welcher Wandel darin zu erkennen ist. Soziale und wirtschaftliche Veränderungen beeinflussen den Berufswunsch. Religiöse Überzeugungen, der Einfluss der Großfamilie, die Wirkung von Rollenmodellen und die Existenz wirtschaftlicher Zwänge formen ein Konglomerat an Wünschen, Hoffnungen, Träumen und Erwartungen, welchem Krankenpflegeschülerinnen sich schutzlos ausgesetzt fühlen. *Kapitel 8* gibt Schülerinnen der letzten Jahre das Wort. Ihre Erfahrungen in der Berufspraxis stehen in scharfem Kontrast zu den theoretischen Schulstunden und individuellen Erwartungen. Diese Diskrepanz und die oft mangelhafte Betreuung während der praktischen Arbeit belastet sie und führt zu Frustrationen. Viele Krankenschwestern erwägen, den Beruf auf zu geben oder im Ausland zu arbeiten, wo die Arbeitsbedingungen angenehmer und die Bezahlung attraktiver erscheinen.

Teil III präsentiert die Resultate der Feldforschung auf der inneren Abteilung. *Kapitel 9* stellt das Krankenhaus und die Abteilung vor, seinen Platz in der Gesellschaft und die Wahrnehmung durch Mitarbeiterinnen und Patienten. Die nächsten zwei Kapitel beschreiben und analysieren die Arbeit der Krankenschwestern auf der 30-Betten Abteilung (*Kapitel 10*) und Formen der Differenzierung innerhalb der Gruppe (*Kapitel 11*). Krankenschwestern sind die am meisten sichtbaren Mitarbeiter im Krankenhaus und sowohl tagsüber als auch nachts anwesend. Ihre Arbeit lässt sich durch zahlreiche wiederkehrende Arbeitsvorgänge in der Pflege kranker Menschen charakterisieren. Betten machen, die Abteilung übersichtlich halten und Patienten zu Ruhe auffordern können aber auch als Möglichkeiten verstanden werden, Patienten zu kontrollieren und Konformität zu erreichen. Ausgebreitete Dokumentation in Papierdossiers und Büchern sind daneben wichtige Aufgaben in der täglichen Routine. Personalmangel, unregelmäßige Belieferung mit notwendigen Pflegeutensilien und die oftmals weit fortgeschrittenen Krankheiten der aufgenommenen Patientinnen machen eine vorhersagbare Arbeitseinteilung oftmals unmöglich und zwingen die Krankenschwestern regelmäßig zu improvisieren und ihre Pflegeziele anzupassen. Die Gruppe der Krankenschwestern lässt sich in mehrere Untergruppen teilen. Strikte Kleidungsvorschriften zeigen auf den ersten Blick den Rang und die Position

innerhalb der Gruppe an. Eine Top-Down-Struktur, das Ausstrahlen von Autorität und die kulturell fest verankerten Formen der Respektsbezeugung formen die Basis der Differenzierung. Durch die unregelmäßigen Arbeitszeiten und die daraus entstehende Notwendigkeit, konstruktiv zusammen zu arbeiten und gemeinsam auf unvorhergesehene Situationen adäquat zu reagieren, ist kein Mitglied machtlos. Alle wissen, dass jede Krankenschwester, Schülerin und Pflegehelferin gebraucht wird, um die täglichen Herausforderungen auf der Abteilung zu meistern. Die folgenden Kapitel beleuchten einzelne Aspekte der Arbeit. *Kapitel 12* zeigt die Auswirkung von Sterbefällen auf die Krankenschwestern und ihr Arbeitsverständnis. Jeden Monat versterben mehr als 15 Patientinnen auf der inneren Abteilung. Kulturell gesehen gehören Sterben und Tod in die häusliche und private Umgebung, aber auf der Abteilung ist der Tod sichtbar und öffentlich. Die Krankenschwestern haben Mühe, ihre eigenen kulturellen Vorstellungen, ihr medizinisches und pflegerisches Wissen und die gegebenen Möglichkeiten miteinander zu verbinden. Emotionen werden nicht öffentlich gezeigt. Sie sympathisieren mit den Sterbenden und ihren Angehörigen, bleiben aber zugleich distanziert und bemüht, Ruhe und Ordnung auf der Abteilung aufrechtzuerhalten. Die Rolle von Religion ist das Thema von *Kapitel 13*. Die Allgegenwart von Religion zeigt sich unter anderem in den täglichen Gebeten zu Beginn der Arbeit. Auch ermutigen die Krankenschwestern Patientinnen, zu beten und in der Bibel zu lesen. Religion kann dabei sowohl einschließen als auch ausgrenzen. Im Prinzip sind alle Krankenschwestern und beinahe auch alle Patientinnen Mitglieder einer religiösen Gruppierung; die meisten gehören einer christlichen Kirche an und unterstützen deren moralische Werte, die sich auch in einem vorbildlichen Lebensstil ausdrücken. Nichtreligiöse und atheistische Mitarbeiterinnen werden kritisch beäugt. Auch meine Akzeptanz hing zum Teil von meiner Beteiligung an den Gebeten und Gottesdienstbesuchen ab. Religion verbindet die Krankenschwestern und hilft ihnen, ihre Arbeit zu bewältigen und dem Druck und den Unzulänglichkeiten Stand zu halten. *Kapitel 14* legt das Augenmerk auf andere Gruppen auf der Abteilung. Ärzte kommen auf die Abteilung zur regelmäßigen Visite und für individuelle Untersuchungen. Sie sind die mächtigsten Akteure, sie haben eigene Regeln und erwarten von den Krankenschwestern, dass sie ihren Anweisungen Folge leisten. Krankenschwestern haben wenig Einfluss, aber probieren, die Aufmerksamkeit der Ärzte auf bedürftige Patientinnen und ausstehende Verschreibungen und Dokumentationen zu lenken. Das unterstützende Personal (weibliches und männliches Putzpersonal und Wachfrauen) hat seine eigenen Aufgaben und erhalt zusätzliche Arbeit von den Krankenschwestern. Diese Arbeit ist unersetzlich, um die Ordnung und Sauberkeit auf der Abteilung zu erhalten. Von den Patientinnen wird Gehorsamkeit und Ruhe erwartet. Frauen, die nachfragen, unruhig oder arm sind, werden

als schwierig gekennzeichnet. So können Patientinnen innerhalb oder außerhalb des pflegerischen Blickfelds geraten, was Auswirkungen auf Pflege hat, die sie erhalten. *Kapitel 15* zeigt die Krankenschwestern als Teil eines größeren Systems. Sie stellen nur eine Gruppe innerhalb des Krankenhauses dar, und das Krankenhaus ist seinerseits nur ein Teil des vielschichtigen ghanesischen Gesundheitswesens. Allianzen werden gebildet, Verantwortlichkeiten verteilt und Erwartungen angepasst. Darüber hinaus müssen die Krankenschwestern ihren Berufsalltag mit ihren Rollen und Aufgaben als Ehefrauen, Mütter, Töchter und Mitglieder in sozialen und kirchlichen Gruppen vereinbaren. *Kapitel 16* ist dem gewidmet, was Krankenschwestern unter 'guter Pflege' verstehen. Alle Krankenschwestern auf der Abteilung und auch an anderen Plätzen im Gesundheitswesen und Berufsgenossenschaften wissen von den bestehenden Problemen und Herausforderungen. Der Beruf wird von Statusverlust bedroht und der wachsende Pflegemangel führt zu Engpässen, erhöht die Frustration der Arbeitenden und nährt Plane, zu emigrieren. Alle verfolgen das Ziel, die im System arbeitenden Krankenschwestern zu motivieren, die getane Arbeit wertzuschätzen und darüber hinaus moderne Pflegestandards zu entwickeln und neue Pflegekonzepte einzuführen

Teil IV fasst die Studie zusammen und zieht Konsequenzen. *Kapitel 17* zeigt die Existenz und Ausübung von Macht innerhalb der Gruppe und zwischen den Gruppen. Viele Beziehungen sind durch rigide Hierarchie gekennzeichnet. Dies ist an der räumlichen Organisation der Abteilung, dem Auftreten und Verhalten der Krankenschwestern und de Einsatz der englischen Sprache erkennbar. Ärzte und Krankenschwestern kommunizieren anhand klar festgelegter Muster, Anweisung und Gehorsam sind hierbei auffallend. Die Krankenschwestern sind hierarchisch organisiert und ältere Krankenschwestern erwarten Respekt von ihren jüngeren Kolleginnen. Offene Kritik ist nicht möglich, neue Ideen können nur schwer besprochen und eingeführt werden. Die Krankenschwestern sind ihrerseits autoritär gegenüber Patientinnen. Soziale Normen und kulturelle Rollen schreiben das angemessene Verhalten vor, ermöglichen und limitieren Handlungen. Diese Faktoren erschweren eine effektive Reaktion in kritischen Pflegesituationen und behindern die Einführung neuer Pflegestandards. Die ghanesische Situation ist hierbei kein Einzelfall, sondern ist verbunden mit und beeinflusst durch globale Entwicklungen. Die Arbeitsrealität kann nur schwer mit dem Bild der hochtechnisierten schulmedizinisch ausgestatteten Krankenhäuser im Westen mithalten. Diese Spannung führt zu Brüchen in der Wahrnehmung, Motivation und Arbeit der Krankenschwestern. Das Erkennen und Wertschätzen bestehender Machtverhältnisse und Formen des Wissens kann den Krankenschwestern dabei helfen, die Arbeit auf der Abteilung zu bewältigen und den Status des Berufs innerhalb des Gesundheitswesens zu stärken. Diese Studie präsentiert die Arbeit

der Krankenschwestern aus ihrer Perspektive. Es beleuchtet die momentane Situation und zeigt Wege zu einer weiterführenden Professionalisierung auf.

About the author

Christine Böhmig (Würzburg, 1969) was trained as a general nurse at the Schwesternschule des Universtitätsklinikum Heidelberg, Germany, from 1989 to 1992. She worked as a nurse at the Maternal and Child Care Unit in Cape Coast, Ghana, and at the haematology unit at the academic hospital in Heidelberg, Germany. From 1992 onwards, she studied cultural anthropology (major), sociology and political sciences (minor) at the University of Heidelberg. In 1997 she obtained her Master of Arts degree.

In 1999, she started working as tutor at University College Utrecht, the Netherlands. Next to academic and individual advising of students, she also teaches courses in cultural anthropology, medical anthropology and qualitative research methods. In September 2004, she took the position of PhD researcher at the Amsterdam Institute for Metropolitan and International Development Studies (AMIDSt), University of Amsterdam, under the supervision of Prof. S. van der Geest. Her research interests are in hospital ethnography, religion and health, African belief systems and qualitative methodologies.

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