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

Böhmig, C.

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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 situation. 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

\(^{1}\) Trotros are small vans transporting up to 15 persons. They form the cheapest means of transport in the country.

\(^{2}\) See appendix F for the full text of the poem Abooyo by A. A. Amartey.
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

\(^3\) 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).
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 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 cooperation 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 can be seen as the most prominent representative of anthropology in nursing (1977, 1985, 1995, 1999). 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. Evanseshko 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 and 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. 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 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 re-petition and re-cognition (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-individuated and clustered in groups and series. Nursing processes can be recognised as those through which social processes come into existence and discourses start. Holden and Littlewood mention language, symbolic systems and identity-features as possible areas for such analysis (1991). 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 be 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.