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

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“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 programme 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 examinations 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. Miss Isobel Hutton was the first Principal and functioned together with Miss Gladys Burton and Miss Kay Storrer 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:

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,

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)
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, supporting 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 (Otto 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 midwives 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 programmes (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 pre-requisite 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 5:30PM 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.” 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 licentialem 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. 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 attended 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

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

27 In 2005, ¢ 50 mio was the equivalent to $5000.
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 programmes 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 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 programme 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 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 (2005: 81).

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 researched the nurses’ ideas on their role and competencies (1995). 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.