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

Böhmig, C.

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“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. Regularly, the main laundry encounters problems with the water and electricity supply, resulting in less linen 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 urinary 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 5. 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 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:

89 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.
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 assess 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).90

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 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

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90 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.
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 group91. 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 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

91 In previous chapters, the gap between nursing theory as taught in school and nursing reality on the ward was already discussed.
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 1980’s, 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 public 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
weeksends. 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 and 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’. Maintaining 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, 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” (20002: 202). 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.