

“There is somebody in heaven who takes care of you!”

Nursing care and religiosity on a hospital ward in Ghana

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Looking at care delivery in hospital settings worldwide, it is the work of nurses that appears most prominent. While this is true in a general sense, it is important to realize the impact of cultural norms and social perceptions on the variety and differences in care giving. This paper explores the notion of care and religion on a medical ward in a Ghanaian teaching hospital. Analyzing the daily routine on the ward, it shows how medical nurses deal with the challenges put before them and how religion must be considered as an important element of the working routine in understanding the notion of care in the hospital setting. Both nurses—and patients subscribe to a set of cultural norms; they base their expectations and decisions on a mixture of professional formation, traditional heritage and individual background. Since the beginning of nursing in Ghana, the Christian belief influenced and transported a certain image of the nurse and woman in general. Religion plays an important role; it shapes perspectives, offers possible reactions to disease and death and influences social behaviour. This paper shows that the hospital is not a culturally-neutral biomedical institution but embedded in the Ghanaian culture. It is a place of medical treatment, social encounter and defined rituals.

[care, religion, nurses, hospital, Ghana]

*“We are all Christians. God manifests in the patient.
I get my blessing when I come to the hospital and nurse my patients.”*

This personal confession of a nurse in the teaching hospital in Ghana's capital Accra is just one example of the deeply rooted Christian belief in this West African country. In an attempt to understand what nursing entails and which perceptions of health and health care exist and are shared, it is crucial to take into account the notion and the impact of religion. This paper shows the role of religious beliefs in the delivery of care in the hospital setting. It is based on research carried out on a women's ward in the teaching hospital in Accra. By analyzing the daily routine and collecting conversations about care motives and strategies to manage challenges, the working reality and under-

lying perceptions become visible (Böhmgig 2010b). Focusing on the ideas and work of nurses, the paper discloses relevant factors and the framework within which care is delivered. Following the introduction of the Ghanaian setting and locating biomedical treatment in the West-African context, the motives, working routine and understanding of care are described. The presence, use and impact of religion are presented as crucial in the understanding and perception of care. Nursing work is contextualized within a social and religious definition of care and healing that exceed a merely biomedical understanding of treatment-seeking behaviour. Separated from the day-to-day culture of the streets outside the hospital walls, the ward represents hope and healing, and emerges as a heterotopian space within the rough reality of Ghanaian society.

The setting

Following the celebration of 50 years of independence in 2007, Ghana's society faces change in several aspects. Traditional norms of showing respect, upholding the solidarity of the family and recognizing the authority of older members remain as crucial values. Children are socialized to respect older members of the family and to all members of the society as a whole. But the society is also influenced by expanding markets and globalisation, including massive economic migration, urbanization and monetarization as can be seen in the rising number of mobile phones and internet cafés.

Religion forms one stable factor. Old and young Ghanaians alike confirm that Ghana is a religious country. "If we talk about all things and don't add the religious part, it's like there's nothing inside" (57-year old nurse). Along with indigenous religious beliefs, Christian denominations are predominant in the South and Central part of the country, while in the North most people are Muslims. Attending an established church (like Roman Catholic, Anglican, Methodist or Presbyterian congregations) or participating in one of the countless charismatic and pentecostal churches is not of particular importance in assessing a person's religious belief. Conflicts between different Christian denominations and disputes about beliefs and dogmas are subordinate to being a practising believer (Nukunya 2003; Senah 2004; De Witte 2008). To be 'a good Christian' is displayed by going to church regularly and leading a life according to the Bible's principles. Following the state's liberalization of the media in 1992, television and radio stations continuously report on religious developments, and telecast or broadcast Bible studies and church services. Churches play an important role in organizing and regulating the daily lives of Christian Ghanaians. Church welfare committees assist their members in times of hardship, helping to finance health expenditures and funerals. Prayer groups support sick church members.

In this context, ethnographic fieldwork was carried out from 2004 and 2007 in the teaching hospital of Accra.¹ It is the largest in the country and serves as a referral tertiary institution and an acute-care hospital. Built in the 1920s under British governance, it expanded to a 1,600 bed-capacity with total staff of 3,000. The average time of in-patient care is 11 days. Most cases are referred for specialized treatment from regional hospitals or clinics, and most admissions are for surgery, birth and delivery

complications, and treatment for internal diseases related to the heart, kidneys, liver failure, CVA, diabetes and cancer. The main causes for out-patient attendance are malaria, diarrhoea-related diseases and hypertension.

The mutual influence and mixture of religion and health is often mentioned when discussing the religiosity of the hospital staff. Lighthouse Chapel International, a charismatic Christian ministry, began on hospital grounds about 20 years ago. Its founder and current bishop was a medical doctor at the hospital before becoming a full-time reverend. Many nurses remember the beginnings of the ministry held in the hospital's canteen. They still attend this church and recall miracle healings. It is within this context of prayer meetings, funeral announcements, broadcasting of divine services and individual counselling that nurses and patients organize and give meaning to their daily lives.

The introduction of biomedicine in Ghana

Along with colonialism, missionary activity and Western education, the introduction of Western medicine dates to the end of the 19th century. The British colonial administration built the first hospitals and health posts and soon opened them to the whole population. Successes in treatment and professional opportunities lead to a growing acceptance of the new medical system. In the 1920s, the first buildings of the hospital in Accra were erected; today, it is one of the two teaching hospitals in the country and one of the largest in West Africa.

In 1878 the first European nurses arrived in the Gold Coast to care for European officials with the objective of treating the sick and maintaining a healthy living environment for both Europeans and Africans (Holden 1991). The selection of these nurses gave priority to their moral and social convictions as they were expected to represent their home country and its moral norms. With the beginning of official (Western) medicine in 1878, it became apparent that local workers were needed to support the medical doctors, bathe and feed patients and dress their wounds. But nursing work had a low status and dealing with naked bodies, blood, faeces and odours was seen as a menial job, not proper for women. Patterson writes:

The colonial physician was often a puzzling figure for Africans. He was usually a white male stranger who had to use an interpreter. He often asked impolite questions, demanded, for reasons unknown to the patient, samples of blood, urine and faeces; and sometimes cut open the bodies of the dead. On the other hand, he frequently had great power over sickness and injury (1981: 15).

The recruitment of candidates for medical assistants constituted a formidable problem (Addae 1996; Kisseih 1968). Dr. Henderson, the former Chief Medical Officer, reports: "No native of intelligence would like to be a nurse because the pay is low and conditions of service are not good" (Owusu 1980: 1). It took time for this perception to change and for nursing to become an accepted and rewarded profession (Böhmgig

2010b; Sumani 2005). In 1944, plans were made to establish a school for nurses in the country, standardize their training and establish their certification by the British Nursing Society. In 1945, the first training college began its work with seven nursing students. In 1947, the Board of Nursing was set up and a Principal Matron was appointed to head the nursing service in the country. A retired nurse recalls the beginnings of her training in the late 1940s:

Mothers didn't let their daughters go and do nursing, because it was such a strange sort of job. You must understand our nursing at the time. Clean chronic wounds and carry blood-stained sheets, rinsing them before taking them to the laundry. It was difficult to get girls as the women were supposed to be in the houses. Gradually as years went by, the girls were brought into the system little at a time and they were also trained on the job for about six months or so and given a special certificate. We learned that being a nurse was a prestigious thing because the British women did it. We understood we were also allowed to wear the uniforms and have power. We could do the same work as the White; there was the possibility for promotion. This was attractive to our parents and us.

The development of formal nursing in Ghana presents an interesting case study. Nursing in health institutions was a new phenomenon. Cultural barriers forbade women to join the nursing profession and taking care of sick strangers was initially regarded as inappropriate. The European perception of the good woman caring for the sick and needy could not be translated immediately into the context of Ghana in the 1940s. Initially, secretarial work, teaching, and midwifery were the options for young women leaving school – professions imported from Europe and labelled as 'typical female activities'. Nursing was added to that list slightly later, became a respectable activity and perceptions about it changed because it was work developed by the colonial administrators. The white nursing uniform intensified this idea; Western thought and standards dominated nursing in the Gold Coast. Like in other African countries (see Martin 2009 for Uganda or Schuster 1980 for Zambia), the rationale of the practical work was copied from the British model without cultural adaptation. Schuster criticizes this as a "cultural process of imitation ... and the perpetuation of colonial dependency" (1980: 78).

Up to the present, there is little room for traditional healing practices in the Western hospitals, and nurses and medical doctors follow the imported Western models of healing and care. Four decades after the introduction of Western medicine and nursing in Ghana, the research of Akiwumi (1995) shows a nuanced picture and points out the vulnerable spots in the profession. Today, freshly-trained nurses state feelings of insecurity and report a lack of practical routine when beginning their employment in a ward. Insufficient supervision and outdated equipment are mentioned as additional factors that make the newly graduated nurses feel less prepared for their responsibilities. Qualities of the nurse are defined as observant, responsible, punctual, accurate and patient. These are attributes generally labelled as female and Christian, and while students may subscribe to these notions, they also feel restrained in a rigid corset leaving little space for new ideas.

Political unrest and economic hardship in the final decades of the 20th century led to a destabilization of society and, in particular, the health care system. Many nurses and medical doctors left the country to work abroad. According to the 2000 census, one third of the more than 1,100 doctors and 13,000 nurses worked within the Greater Accra Region. Presently, Ghana has two teaching hospitals (in Accra and Kumasi), nine regional, 92 district, and 210 private or missionary hospitals and about 1,200 health clinics and posts, providing more than 20,000 hospital beds for 22 million Ghanaians (GHS 2005).² In terms of access to care, an estimated 40% of the population live more than fifteen kilometres from a health facility, with rural areas being generally more deprived (Ghana MoH 2003; Arhinful 2003). In the teaching hospital, up to 1,400 in-patients and 1,500 out-patients are treated daily by 400 doctors and 1000 nurses. These figures can be translated as a deficient of 50% in the staffing of professional health care services.

Motives to become a nurse

When asked why they became a nurse, today's nurses bring up various motives. There is a clear difference between the generations: older nurses mention mainly guidance from the family and religious convictions. The decision of family members to enter the nursing training college was not accompanied by hard feelings; surely romanticizing about the nursing image and a professional ignorance played a role. They feel that they are like the pioneers of the profession, copying and fulfilling the role of the British sisters; as convinced Christians and well-educated women with a spotless reputation, represented in the neatly-ironed white dress, the symbol of 'the good woman'. Indeed, religious belief is one of the most frequently mentioned motives. As with many other professions, the longer nurses are employed, the more they seem to match reality with their expectations.

Oh, I'm happy that I've been able to work to save lives. It's only by the grace of God. I don't have any ill feeling at all, and I'm grateful to God for what he has done for me during more than 35 years in the job (retired nurse).

The younger generation of nurses is also exposed to and guided by family wishes and demands. In addition, existing role expectations to become a decent faithful woman influences their choice. Given the economic insecurities, financial pressure and an uncertain future, nursing seems to be a good job option. They see nursing mainly as a profession that should pay well, offer a job guarantee and incorporate the possibility to travel and work overseas.

When confronted with criticism from society, nurses from all generations join together and call for more respect and acknowledgement. Nurses in hospitals, clinics and health posts throughout the country find themselves working under pressing conditions such as an inadequate staff and sub-optimal equipment. Those who do not leave their job or the country want to be acknowledged for their daily presence and

contribution at work. Several times in 2005 nurses went on national strikes with the main objective of higher salaries. In their view, the long working hours and frequent weekend and night duties demanded better remuneration. They verbalized this claim by stating that they were “not being motivated enough.”

Along with the wish for social recognition, the term ‘motivation’ is also interpreted to mean ‘sufficient money’ to manage daily life and take part in the modern market and consumer society. This money should come in the form of enhanced salaries and additional incentives such as over-time pay, preferential treatment in gaining access to rental housing near the hospital, loans for buying a car or purchasing land. Nurses expect their supervisors to supply them with refreshments and cookies after a hard working day. Their claim is that raising the financial and material reward will guarantee more satisfied workers. Nurses try to cope with the pressures of an unfriendly working environment, growing demands from the society and the desire to (re)gain control and influence over the processes in the health service (Böhmig 2010a).

Nurses experience an extreme shortage of personnel and equipment in their working environments. Their declining status and the shortages at work are difficult to handle. The older generation tends to romanticize the pioneering period and stresses the religious implications of caring. The younger nurses find themselves caught between traditional values, the influence of their families and their own personal ambitions. For them, religious slogans do not hold much importance; they are struggling to find a balance. Career perspectives, higher and more stable financial compensation and more satisfying work conditions are pressing issues of today’s generation. These are the necessary motivations for the younger generation to enter the nursing profession and remain attracted to it. Nurses have to be creative and innovative on a daily basis to find answers to their demands, manage the challenges on the ward and care for the seriously ill patients.

Hospital care in a medical ward

In a thirty-bed female ward, twenty nurses run three shifts. The beds are always occupied; women of all ages are hospitalized for diseases like hypertension and CVA, liver or kidney diseases, lung problems, diabetes and cancer. The nursing routine is characterized by basic care delivery (making up beds, assisting in washing and feeding), dispensing of medication, dressing wounds and completing large amounts of paper work. The hospital building and the equipment are outdated and of poor quality, which results in, among other things, insufficient bed sheets and dressing materials along with frequent water shortages. The open architecture impedes privacy for both nurses and patients. In this setting, nurses give functional and impersonal care; emotions are not shown, personal attachment is unwanted. The hierarchy among the nurses is strict and from the top-down. The senior nurses distribute the work and demand obedience from their younger colleagues.

Family members are not involved in care giving, distinctly different from the pattern in many other hospitals in Ghana and elsewhere in Africa and beyond (cf.

Andersen 2004; Zaman 2005; Martin 2009). Daily visiting hours are restricted to two thirty-minute sessions during which family members bring food, quickly wash their relatives and pray with them, along with checking new medical orders for examinations prescriptions for medicines. At the time of the research, patients had to pay for medical services. This was a problem for most patients, as they feared unmanageable costs. Lack of money led to a delay in medications and examinations and a premature termination of treatments. Nurses had to work within these limitations as initiatives to raise money were limited and donations were rare.

Many patients die on the ward. Nurses have to cope with and react to death on an almost daily basis. They discuss reasons for the high mortality, using arguments that patients arrive too late, bring in too little money or are just 'too ignorant'. Nevertheless, the death of patients forms a major challenge in their work in the ward, which they often perceive as particularly 'unrewarding' or even a punishment (Böhmig 2010b).

The combination of the material limitations and technical difficulties, the constant understaffing of the ward and the emotional burden impede nurses from carrying out 'good care'. Ideas about caring and individualized nursing characterized by concepts such as "dedication, attachment and caring as indirect self-fulfilment" (Kleinman & Van der Geest 2009) are known and shared by the nurses. In reality, contact often remains impersonal and emotionally detached. The workload is high and the routine unpredictable. The nurses are in the ward to keep order, maintain cleanliness and radiate serenity. Important factors supporting this work are idealized concepts of good care and the religiosity of the nurses.

Negotiating 'good care'

Western nursing theories and Ghanaian norms of respect and authority serve to form clear ideas of the 'good nurse'. The president of the nurses' association GRNA states:

The Ghanaian nurse has certain qualities: she is honest, punctual, qualified, and intelligent. Yes she must be intelligent. Nurses have to dress moderate and not overdress. A health worker has to be neat when talking about health, otherwise it is not good. We are a role model and people watch us (The Ghanaian Nurse 2000).

This profile of the ideal nurse is based on the history of nursing. As described above, the work of British nurses was first seen as inappropriate and dirty, but soon perceived as a 'service to God and mankind'. Nurses formed a well-organized group which faced sickness, dirt and death. Their order and discipline were symbolized in their self-sacrificing attitude and spotless white uniform. The 'right type of woman' was often compared to a soldier. As Tooley states, "No place is too remote, no climate too deadly for the nurse to ply her ministrations. Like the soldier she obeys the call of duty and if need be gives her life for the cause" (in Holden 1991: 68). Taking care of severely ill and dying patients and carrying out the Christian idea of servitude soon

became highly valued. The nursing profession turned into the perfect activity for God-fearing and humanitarian women dedicated to serving society.

Built on this understanding and in combination with the religious conviction, nurses today see their attitude as empathic. Even though working conditions are harsh and unpredictable, the reward comes by the wish to “touch somebody’s life and be useful for the community.” Nevertheless, nurses remain psychologically distanced from their patients and control their emotions: “Crying with them does not help.” The nurses on the ward organize their work within the possibilities of this given framework. Because the involvement of relatives in care is restricted to short visiting hours, the nurses’ workload is high. With their assistants, they carry out all basic care such as washing, feeding and bed making. They are authoritative towards patients and try to present their care-giving actions as complementary to that of the doctors. All nurses present themselves as convinced Christians and see this attitude as a requisite for a good nurse. Praying with patients to accept God’s ultimate plan is inherent to their definition of nursing care. In this way, they fulfil the role model of the well-educated woman who is morally pure and whose behaviour is beyond dispute.

The respect towards higher-positioned nurses is another important factor that guides the nurses’ actions and understanding of care. Experienced nurses are seen as role models by younger colleagues and as knowledgeable authorities by their families and neighbours. They request that younger nurses be humble: “You should have a servant-hood attitude, you should always serve.” The younger generation perceives this demand as problematic. They learn new concepts of individualized care and specific nursing techniques and want to discuss and implement them. The intergenerational gap leads to frictions and frustrations between nurses and open discussion is hardly possible. A few matron-nurses understand the wishes of their junior colleagues and see the need to include them and their ideas in the nursing organization. But at the same time, traditional norms of respect and methods of disciplining younger members remain decisive. One nurse formulates what holds up to today: “As a nurse, you must be humble and outspoken, that is the trick.”

Religiosity on the ward

Hospitals are often perceived as secular places, identical clones following worldwide administrative and technological criteria. Norwood (2006: 8) speaks of the hospital as an “insulation from the outside world” where religion has been given a marginal position both structurally and ideologically. The opposite is true in Ghana. The medical ward is a space where the scientific diagnosis and the complex needs and personal beliefs of individuals meet – be they patients or health workers. Following Geertz’s (1973) comprehensive definition of religion as a cultural system, Christianity delivers coping perspectives to people who face the suffering, bafflement and injustice of a life-threatening disease. Research on the ward shows the role of religion and how religion can be observed as an unconscious, natural and self-evident part of the nurses’ and patients’ self-definition. It unveils the role of belief and religion in the daily rou-

tine of nurses and shows how the perception of God's almighty power influences the acceptance of and dealing with disease and death.

For the nurses, being religious and receiving strength from that belief is a way to form a group and experience moments of solidarity. This is visible in various situations during the ward routine. The following example from the ward illustrates this:

In the early morning, after the night nurses have finished their documentation and administered oral medication to the patients on the ward, the matron calls all nurses to the table. They form a circle. "All come for devotion. Hurry up, it is already late." She calls a student: "You will lead us today." They start by singing a short song, and then the student prays, asking for healing mercy and support for the work of the nurses, accident-free transportation for the night nurses back to their homes, cure for the patients, and strength for all. Some nurses confirm by calling out "Amen" and "Soak us all in the blood of Jesus!" Then the group says the Lord's Prayer, followed by the sharing of grace. They form a circle holding hands. "Let's close the circle, let the chain not break. The grace of our Lord Jesus, the love of God and the sweet fellowship of the Holy Spirit shall be with us now and forever more. Amen!" Only after this ritual the matron divides the work.

Such moments are crucial in the working routine of the nurses. On the one hand, forming a group serves to encourage each other. By praying together publicly in front of all patients, the nurses refer their work to religious convictions. The communal display of their personal beliefs and hopes draws them closer to the patients. This is the inclusive aspect of their religion. The nurses form a group and place their group in a larger one of religious and pious persons. Sharing prayer and receiving grace are important factors which form and bind a group within a context where work is divided and completed, challenges faced and solutions found. Student nurses are reminded of their task when entering the medical department. The head nurse teaches them: "Service done to mankind is service done to God."

Such behaviours illustrate how private belief is transformed into a shared activity in the public sphere. All nurses are expected to participate. Those who do not join in are perceived as less trustworthy, which also emphasizes the excluding effect of religion on the ward. Good nursing and caring can happen only within the given Christian framework, wherein all nurses form one group. This perception also holds for visiting nurses from outside of Ghana and for myself as a researcher. This raises several questions concerning the ethics and agenda of ethnography and the possibility of participatory research and ethnographic fieldwork.

From my position as researcher on the ward, I was virtually unable to withdraw from the regular prayer meetings. It soon became normal that I joined the morning prayers and shared in reciting the grace before beginning the morning shift. The nurses knew about my connections with one of the churches in Accra and shared their religious experiences with me. One day, the matron announced that it would now be my turn to lead the prayer. I understood that this was their way of expressing their acceptance of me. My European reluctance and my discomfort with their request would have been out of place. Apparently my prayers on that morning were in tune

with the nurses' expectations; they expressed their satisfaction and said I was now 'one of them'.³

Another event several weeks later, when two European student nurses arrived for an internship on the ward, explained in contrasting terms the role of religion. Declaring themselves 'atheists' they did not join in the morning prayers, refused to lead the prayers and felt awkward about the ever-present religiosity. Soon, they were labelled 'unfriendly and disobedient', and the nurses on the ward stopped talking to them and felt uncomfortable in their presence. I was even asked to mediate for them. Their absence during the prayer meetings was a deviation from the expected behaviour and the prototype of the decent and modest woman, and good nurse, independent of any professional nursing abilities these trainees had.

Interestingly, the inclusive/exclusive character of the ritual holds only for the nurses. Medical doctors never join the prayer meetings; they notice them and go about their own work. While they are also members of churches, their belief remains private and covert; their authority is based on medical knowledge and decision taking.

Given the seriousness of the diseases, mortality in the hospital is high. Between 15 and 26 patients die every month in the female ward, some shortly after admission, others after several days or weeks of deteriorating health. The ever-present death constitutes a dilemma to nurses and patients. Culturally, illness and dying belong to the private sphere and should happen inside the house, within the family setting (Van der Geest 2004). In sharp contrast to this, patients on the ward die in public. Palliative care is hardly known and privacy cannot be arranged. For a patient in the large ward, no personal support is rendered, neither by nurses nor relatives. Family members are denied access, as nurses fear they might be "unable to control themselves, cry and disturb the whole ward."

Faith in eternal life without pain is prominent among severely ill patients. Patients read their bibles and trust God. As one patient explained: "It is only God who heals. He can make me healthy or also lay me in the fridge like the others who died. It is only His mercy that makes us live." A young nursing student said that "religion is a form of palliative care; it helps to accept disease and eventually also death." Religion also helps the nurses to cope with this situation. By trusting in God's healing power and 'His heavenly plan', nurses understand their work as supportive and a Christian duty on earth. At the same time, this belief makes the nurses less approachable for criticism and complaints from unsatisfied patients and their families. Statements such as "There is somebody in heaven who takes care of you" express a belief in a higher power which is in control of life and death as well as allow for the acceptance of (and excuse for) the limitations of their work of care.

Nurses encourage and support patients by referring to God as the ultimate healer. Praying in front of and with patients is one aspect of nursing care. "If you are a Christian like the patient, you pray with her and assure her that God will take care of everything. It helps the patient to calm down and find rest." Nurses encourage patients to pray and promise to pray for them. On her regular rounds over the wards, the department director of nursing speaks to the patients: "We are doing our best. We keep on praying for you." She encourages another patient to pray: "If you want to say some-

thing to God, you say it in the air, and He will hear for sure.” Patients are grateful for those encouragements and agree on the importance of religion. Indeed, most patients have a bible with them and during the day as well as into the night, read it and pray.

During visiting hours, family members regularly pray with the sick, ask for blessings and sing aloud. On Sundays, the songs and prayers from the nearby chapel can be heard on the ward and patients follow religious programs broadcasted all day on the ward TV. Being religious is one important aspect of rendering good care. One patient concludes what most women think: “If you ask me about nurses, they must be called by God. If He does not call you, you cannot be a good nurse. You deal with human beings, so you have to have this calling.”

Considering religion on this ward, four ‘functions’ can be distinguished. First, through sharing moments of prayer before beginning work, religion encourages the colleagues in their unpredictable work routine. It serves as coping mechanism on a ward where severely ill patients are admitted and death is a daily companion. Secondly, religion binds the nurses together, all are expected to be practicing Christians and perceive their work as religious duty. Non-believers are labelled as less reliable, both as persons and as caregivers. As such religiosity is part of the surrounding culture; its exposition is acknowledged if not expected by patients and their relatives.

Thirdly, sharing the conviction and accepting God as the almighty decision maker, suppresses criticism of the nurses’ work. Religion thus provides an escape from such criticism. Working under the premises of and in reference to God helps to fulfil expectations. Finally, religion serves as a disciplinary mechanism. Older nurses train their younger colleagues as role models and expect them to behave and work according to Christian morals of a decent obedient woman. Respect for the older generation is part of this.

Discussion

From the analysis of the data collected during extended fieldwork, three aspects about the role of religion in Ghanaian nursing become apparent: first, nursing care must be understood as performed ritual; second, nursing has undergone sacralization; and, third, the hospital represents a heterotopian place.

Following Turner’s theory about rituals (1969), putting on the uniform and stepping on the hospital ground symbolize a separation from ordinary life. Nurses enter a specific arena and stage where they perform nursing care. Creating a clean environment, wearing white uniforms, commanding patients and creating a serene atmosphere function to dispel chaos and anxiety on the ward. All nurses participate in these activities; older nurses do this by habit and personal conviction, younger ones are introduced and educated to follow and carry on – voluntarily and through discipline. By praying together, the nurses form an ideological ‘communitas’ passing through liminal experiences as a group and aiming to stabilize the unpredictable. Nurses are expected to take part, conform to the role and act as expected; thus, non-conformers are reprimanded and excluded. As Rappaport states ”to perform a liturgical order,

which is by definition a more or less invariant sequence of formal acts and utterances encoded by someone other than the performer himself, is necessarily to conform to it.” (1999: 118). Grouping together and including nursing students strengthens the social bond between nurses. The ritualistic character of nursing care is repeated, passed on and perceived as never-changing.

Secondly, nursing work has undergone sacralization. The hospital ward serves both medical and social functions. The implementation of medical treatment has introduced Western concepts of diagnosis and therapy. At the same time, the hospital makes disease, pain and death visible and creates social and religious perceptions about these phenomena. For patients and nurses alike, the hospital thus becomes also a ‘holy place’. Within the religious reality of Ghanaian society, the hospital stands out as a place where personal hopes and fears and beliefs are publicly shown. While sacred and secular needs melt together, it is the religious convictions that form the organizing principle. Finally, the hospital can be seen as a heterotopy. Following Foucault (1984), the ward becomes a place of enacted utopia representing *and* contesting reality. Patients look for healing, doctors run examinations and make diagnoses, nurses provide care. Access to the hospital is regulated access yet it represents the setting for biomedical care. All parties display hope, an escape from insecurity and illness and hereby follow their own time, behaviour and logic (cf. Van der Geest 2005). The heterogeneity lies in the fact that the hospital is both a privileged and restricted space and a part of society, reflecting and mirroring society and its values (Zaman 2005; Böhmig 2010b). Nurses position themselves as health care providers and individuals, responding to needs and realizing their nursing goals. Praying in front of and with patients, they combine private and public lives, render hands-on care and refer to Godly power for ultimate healing. Upon admission, patients enter the hospital full of fears about therapies and ideas about healing. They are excited, anxious and uneasy about what to expect. By talking to them and praying with them, nurses form the link between their known life and the unknown biomedical world and guide them through the admission until released from the hospital or death occurs. Mythic and realistic at the same time, the ward is a ‘market’ of expectations and fears, encounters and farewells.

What is good care and what does religion have to do with it? Exploring nursing care in the setting of a Ghanaian hospital, the notion of religion is crucial. The presence of religion in this context shows the cultural bedding of the concept of care. This influences the definition and realization of care. In the present case, Christian belief is seen as an important aspect in the organization and perception of care. Historically this has influenced the role and position of women and the attraction of the nursing profession. To the present, it forms the framework within which expectations on nursing are founded.

If we want to address the notion of care in health care, we must consider the surrounding culture, which adds its own dimension to the supposed universal practice of nursing in hospitals. Unlike Norwood’s claim that the hospital is an insulated place, it must be seen as a cultural melting pot and centre where cultural norms and values are prominent. The hospital as space and stage plays an important role in understanding

and positing the idea of care and the role of religion. In Ghana, religion helps to understand suffering, cope with challenges of diminishing health and perform good care.

Notes

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Discussions and remarks during the symposium on 'Care and Health Care' provided useful thoughts on an earlier version of this paper and helped developing it further. The author also thanks the reviewers and editors for their critical and constructive feedback.

- 1 For details on the field setting, a description of the methodological aspects and an analysis of the main research, see Böhmig 2010b.
- 2 Other sources report 3,240 physicians and 19,707 nurses for Ghana in 2004.
- 3 Many articles have been written about the role of anthropological researchers and their involvement in daily activities to build rapport and exchange ideas. On the medical ward, an ethical dilemma was prominent as it touched on the researcher's personal beliefs and convictions. These were valued positively while personal convictions of non-believing trainees turned into disadvantages and reprimands.

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