Analysis of the Moral Habitability of Obstetric Settings in Ghana

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Priscilla Nailatu Boakye

A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
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Morally habitable workplaces are essential for enhancing the ability of nurses and midwives to meet their caring responsibilities and to limit the experience of moral distress and other work-related adversities. Morally habitable places are those that promote recognition, cooperation, and shared goods as compared to those that create suffering, distress, oppression, and violence. While there have been studies exploring moral habitability or moral climate and its impact on nurses in Western countries, little is known about the moral habitability of the workplaces of nurses and midwives in resource-constrained settings. The purpose of this research was to examine the moral habitability of the work environment of nurses and midwives and its influence on their moral agency. The philosophical works of Margaret Urban Walker and Kwame Gyekye were used as interpretive lenses. A critical moral ethnography was conducted with 30 nurses and midwives working in obstetric settings in Ghana. Data were collected through interview, observation, and documentary materials. Five themes were identified reflecting the moral habitability of the obstetrics settings and moral agency including: 1) holding onto the values, identities, and responsibilities of being a midwife/nurse; 2) scarcity of resources as

limiting capacity to meet caring responsibilities; 3) gender and socio-economic inequities shaping the moral social context of practice; 4) working with incoherent moral understandings and damaged identities in the context of inter- and intra-professional relationships; and 5) surviving through adversity with renewed commitment and courage. The nurses and midwives work in a context dominated by the scarcity of resources, overwhelming incoherent moral responsibilities, oppressive conditions, and workplace violence that constrained their moral agency, endangered patient lives, and provoked suffering and distress. Nurses and midwives negotiated their practice and adversity through the influence of their moral values. Creating morally habitable workplaces through a collaborative effort from institutional managers, nurse leaders, doctors, and policymakers may promote a culture of ethical and ideal nursing and midwifery care for childbearing women and professional wellbeing. Given the ethically laden nature of the work environment, there is a need for an enhanced ethics education and consultation to help the nurses and midwives confront the issues with confidence.

Dedication

To my husband Isaac Boakye and my children Grace, Emmanuel, Abigail, and Albert for the sacrifice and love

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Chapter One
Introduction

Background

Midwives and nurses have been recognized as pivotal in the strategies outlined for reducing maternal morbidity and mortality and newborn deaths in Lower- and Middle-Income Countries (LMIC) (United Nations Population Fund (UNFPA), 2014), thereby placing them in the same time and space with childbearing women. They are the first point of call for women during the maternal health trajectory mostly in rural and remote settings. They are exposed to difficult and precarious work environments that constrain their practice as they struggle to provide care for women and their families (Brodie, 2013; Filby, McConville, & Portela, 2016; Pettersson, 2008). The prevailing midwifery work environment in resource limited settings are characterized by very high workloads, excessive overtime, staffing shortages, an inconsistent and erratic supply of essential medicine and equipment, lack of value for their work, poor remuneration, poor job satisfaction, and frequent exposure to painful maternal deaths and complication (Brodie, 2013; Filby et al., 2016).

Nurses and midwives work in close and sustained proximity with patients in that they are present at the patient bedside twenty-four hours a day and seven days a week because of shift work (Hillman, 2016; Peter & Liaschenko, 2004). While proximity allows nurses to respond and act on their moral responsibilities to patients, it also creates moral problems when these responsibilities are constrained by institutional structures. In resource limited settings, proximity can be perilous (Peter & Liaschenko, 2004) because the frequent lack of medical resources and staffing required to respond to patients needs can result in issues of poor-quality care such as neglect and abandonment and possibly moral distress. The perils of proximity may be extended into institutional and public discourse whereby nurses and midwives are frequently implicated

and blamed for poor health care outcomes or when resources are not available to attend to patients' needs.

In the context of maternal health care practice, midwives are embedded in networks of relationships with women and their families, communities, multidisciplinary teams, the health care organization, and the broader health care system all of whom come into the relationship with different perspectives and values. These networks of relationships are influenced and shaped by power relations and institutional and social pressures that impacts on midwives' everyday moral choices. Depending on the context in which they practice, such moral decisions and choices become complex for midwives who are the frontline care providers in a resource limited setting like Ghana where the work environment is a constant source of ethical tension. Yet there is limited understanding of how these relationships with others shape midwives' moral encounters and what role individual midwives play in shaping their everyday moral practices and the enactment of moral agency in Ghana.

Emerging literature reports negative attitudes of nurses and midwives towards labouring women, with many women recounting receiving an unwelcome reception, giving birth without support, shouting, scolding, beatings and in many instance, being left alone to give birth (Bohren et al., 2015; Bowser & Hill, 2010; Chadwick, Cooper, & Harries, 2014; Jewkes, Abrahams, & Mvo, 1998). Although these behaviors contradict the values of midwives such as compassion, respect, and dignity, this may also be a reflection of the broader health system challenges resulting in less than ideal midwifery care. The interplay of workplace concerns, structural issues, poor organizational climate, professional insecurity, professional inequality, socio-cultural factors as well as intolerable stress and excessive workloads have contributed to the poor quality of care experienced by women during childbirth (Filby et al., 2016; Jewkes et al., 1998).

These factors may constrain ethical practice and consequently lead to moral distress and other work-related stress, thereby contributing to poor quality care.

Evidence from high income countries (HIC) has established the powerful and pervasive influence of the work environment on nurses' ability to practice ethically. Nurses' practice and decisions, thus their moral agency, does not exist in isolation, but are shaped and influenced by micro (interpersonal and intra-profession), meso (institutional) and macro (broader health system) level forces (Rodney, Doane, Storch, & Varcoe, 2006; Wall & Austin, 2008; Wall, Austin, & Garros, 2016). Others have argued that the work environment and the ethical issues confronting nurses are mutually shaped and defined by the individual nurses' personal and professional identity and the social-moral context of the institution in which they are situated (Austin, 2016; Chambliss,1996; Musto, Rodney, & Vanderheide, 2015; Newton, Storch, Makaroff, & Pauly, 2012; Peter, Macfarlane, & O'Brien-Pallas, 2004; Rodney et al., 2006; Simmonds, Peter, Hodnett, & McGillis Hall, 2013).

In Ghana and other limited resource settings, midwives are witnessing numerous maternal deaths, still births, and painful obstetric complications women experience on a regular basis (Petrites, Mullan, Spangenberg, & Gold, 2016; Pettersson, 2008). The psychological and emotional impact of the work environment most likely exerts a great toll on midwives, and it is unclear how they sustain their moral identities and responsibilities in such complex work environment. The midwifery work environment and its impact on the everyday moral choices and practices of midwives have received very little attention in Ghana. For example, how Ghanaian nurses and midwives work in the obstetric department perceive the moral dimension of their work environment; how the work environment (personal, relational, political) influences and shapes their everyday moral choices and practice, what happens when their practice is

constrained; and how they navigate and sustain their moral ideals have not been fully understood. To address this gap, this research will answer the following research questions:

- How do nurses and midwives perceive the moral habitability of the obstetric work environment?
- How do these environments influence the enactment of moral agency?
- What kinds of identities, values, and responsibilities shape and influence their practice?

Purpose and Significance of this study

The purpose of this study was to explore the moral habitability of the midwifery work environment and to highlight the moral dimensions of the everyday practices and encounters of midwives in a resource limited setting through narratives. Walker (2007) defines morally habitable environments as those that promote recognition, collaboration, and shared goods among people as opposed to those that perpetuate their suffering, oppression, deception, and violence. As noted, habitable work environments are those places "where internal and external constraints to moral agency are minimized, difference is embraced, and moral well-being is promoted through shared understanding of responsibility" (Musto et al., 2015, p.4).

Walker (2007) highlights the importance of context in understanding the everyday practices of people and describes context as a "particular environment or set of circumstances that determines whether something is acceptable or make sense" (p.xi). She argues that without a clear understanding of the context, it would be difficult to comprehend the situation of those involved in it. In this study, the term context encompassed the implicit and explicit socio-moral and political factors at the institutional (work environment) and the national level shaping the practices of nurses and midwives. Walker's (2003; 2006; 2007) theory was used in combination with the work of Gyekye (1996), an African philosopher as an interpretive lens for exploring and

understanding the moral habitability of obstetric settings and the ways in which nurses and midwives enacted moral agency and sustained their moral identities.

The significance of this study was threefold. First, the study uncovered the morally uninhabitable nature of the work environment in resource limited settings and the impact of those environments on the moral agency of nurses and midwives. The study also revealed the moral values and identities influencing the moral agency of nurses and midwives in resource limited setting and the ways they navigated to sustain their moral ideals. Secondly, the study highlighted the voices of nurses and midwives' that have been marginalized and rendered invisible. Finally, the study identified some of the factors contributing to the inability of nurses and midwives to uphold their professional standards contributing to widespread abuse, disrespect, and neglect of women in childbirth. It is expected that the findings and recommendations may help in addressing some of the challenges confronting nurses and midwives and to develop strategies that will promote a culture of ethical practice and support nurses and midwives practice safely and ethically.

The Context of Health Care Delivery in Ghana

The Ghanaian health care system has made substantial gains in terms of meeting global maternal health care goals despite the enormous health system challenges. The healthcare system is publicly funded through governmental budgetary allocation, national health insurance levy, internally generated hospital funds, and international donors (Akazili, Gyapong, & McIntyre, 2011; Akortsu & Abor, 2011; Schieber, Cashin, Saleh, & Lavado, 2012). However, the funds allocated to the health care sector are insufficient considering the increasing demand for expanding and upgrading infrastructure and basic logistics and consumables for the providing of health care.

Ghana is one of the sub-Saharan countries to implement the universal access to health care through the National Health Insurance Scheme (NHIS) amidst many problems (Bonfrer, Breebaart, & Van de Poel, 2016). The NHIS provides 95% coverage of all conditions including outpatient, general specialist care, surgical care, hospital accommodation cost and emergency services (Bonfrer et al., 2016; NHIS Annual Health Report, 2013). As one of its strategies for improving access to skilled birth attendance for childbearing and reducing maternal morbidity and mortality as well as newborn deaths, the government of Ghana, through the NHIS provides free access to maternal health services during pregnancy, the intrapartum period, and six weeks postnatally. These among other strategies have contributed to the increase in the number of women seeking maternal health care (Ansong-Tornui, Armar-Klemesu, Arhinful, Penfold, & Hussein, 2007; Blanchet, Fink, & Osei-Akoto, 2012; Bonfrer et al., 2016).

The health insurance has contributed significantly in improving universal access to health care, however challenges of reimbursement to health facilities coupled with the existing resource scarcity have hampered the quality of care delivered (Agyepong et al., 2016). The implementation of the universal access has also resulted in an increased number of patients seeking care thereby increasing the workload of nurses and midwives and other health care professionals, non-adherence to professional practice standards, pressure on existing and limited health infrastructure, longer waiting times, and reduced patient satisfaction (Agyepong et al., 2016; Bonfrer et al., 2016; Dalinjong & Laar, 2012; Dixon, Tenkorang, & Luginaah, 2013). While these studies reveal several challenges, there was still a gap in understanding of the ethical issues confronting nurses and midwives who interface with the NHIS policy and subscribers. Moreover, the kinds of dilemmas encountered by the nurses and midwives was unclear due to the interpretation of policy and the rhetoric of free maternal care.

According to the organizational structure of the Ghana Health Service (GHS), health care delivery is based on the primary health care model: teaching and regional hospitals as tertiary level facilities, district hospitals as secondary level facilities and health centers and Community-based Health Planning and Services (CHPS) as primary level facilities. The majority of the population have access to primary and secondary level facilities, which are mostly located in peri-urban areas, rural, and remote communities. Like other countries in sub-Saharan Africa the existing health physical structure in Ghana is poor with most of the equipment being obsolete and the physical buildings being dilapidated. In remote and rural areas, health facilities are in temporary structures which are barely conducive for the delivery of quality healthcare services. Some of these rural health facilities in remote communities are not connected to the national electricity grid and for those that are connected the erratic nature of the power supply makes the storage of essential drugs and delivery of care extremely difficult for frontline health care workers (Banchani & Tenkorang, 2014). The health system is also crippled with a lack of potable water supply, making basic infection control procedures a challenge.

Ghana has improved the road network, but this is mostly concentrated within urban cities with nearly more than half of the country's roads being in a deplorable state which make the transport of emergency cases in rural areas a dilemma for health care workers. In a recent web-based report by the GHS on improving maternal health care, the lack of basic medical resources, poor road network, and the absence of an effective ambulance system and referral as well as regular transportation system have significantly contributed to poor quality of care and preventable maternal death. Besides hindering the provision of quality care, these factors also serve as a disincentive for the acceptance of postings to rural areas often resulting in one health professional being at post (Lori et al., 2012).

The Role of Midwives in the Ghanaian Health System

Midwives form the backbone of the Ghana's maternal health care program. They have contributed significantly to reducing maternal deaths despite the daunting challenges that they encounter at the institutional and community level (UNFPA, 2012). The scope of practice varies across different geographic regions of the world. In countries like Ghana, where maternal morbidity and mortality are high and the numbers of obstetricians are few, midwives have a wide scope of practice. Their responsibilities range from antenatal services, delivery services, postpartum services, family planning and comprehensive abortion care (CAC), treatment of sexually transmitted infections including HIV/AIDS counseling, child health services, and health promotion activities (Sakeah et al., 2014; USAID, 2006). According to the Ghana Health Service (GHS) Annual Health Report for the year 2014, midwives provided 90% of all antenatal services and more than 60% of deliveries (GHS, 2014). In rural and remote settings midwives provide life-saving treatment and emergency obstetrical and newborn care during pregnancy and the perinatal period. At the secondary and tertiary level nurses and midwives work in partnership with obstetricians and interdisciplinary teams (Floyd, 2013).

Practicing in a predominantly patriarchal system, nurses and midwives, who are generally women, experience low gender status both in public and institutional domains (Filby et al., 2016; WHO, 2016). This institutional hierarchy is reinforced by the sociocultural and traditional norms of African societies in which women are accorded subordinate roles in families and public institutions (Sossou, 2006). At the institutional level midwives occupy very few managerial positions and are perceived to be the lowest in the institutional hierarchy as are their nursing counterparts who lack professional respect and authority (Filby et al., 2016; WHO, 2016). The low social status experienced at the institutional level could have a downward effect on

childbearing women as midwives attempt to assert and gain control over their situation. In the health care setting, the hierarchy and power structure also have implications for the distribution of responsibility, accountability, and decision making. Considering the hierarchical nature of the health care system and the social location of nurses and midwives, it was imperative to understand how these arrangements influenced the context of practice and moral agency.

The education of registered nurses and midwives is mostly at the diploma level and is based on a three-year program. Although the training of nurses differs with that of the midwives in relation to the content of the program, their knowledge and skills enable them to complement each other's work. There is also a two-year pathway to midwifery education for those with enrolled nursing and community health nursing certificate to upgrade to a registered midwife status. The diploma and certificate level training are a contributory factor to the lower status and devaluation of nursing and midwifery knowledge in many health care institutions. Currently only four public universities, the University for Development Studies, the Kwame Nkrumah University of Science and Technology in Ghana, the University of Allied Health Sciences, and the University of Ghana offer Bachelor of science degree in midwifery when compared with graduate nursing education which is offered in almost 20 of the private and public Universities in Ghana. Despite the expansion of graduate nursing education, they still struggle for professional recognition and status. The lack of opportunity for career advancement and development in midwifery has contributed to fewer young graduates entering midwifery programs. Furthermore, poor remuneration, delayed promotion, and the lack of incentives for midwives working in rural and remote settings have been a source of dissatisfaction, professional agitation, and barrier to accepting posting to these areas (Lori et al., 2012).

The numbers of practicing professional midwives have seen some increase over the last two decades, however, the number of midwives retiring has also steadily increased since most of the aging workforce belongs to the baby boomer cohorts. According to the past Director General of the GHS, nearly 500 midwives were due to retire by the year 2016, a situation he described as critical considering the current midwife-patient ratio of 1:7200 which is far below WHO recommended standard of 1:1000 for developing countries (Ghana web online, 2015). Clearly the unacceptable number of midwifery professionals may have far reaching consequences on moral practice and the work life of midwives in terms of increasing workload, moral distress, stress, burnout, effectively dealing with complications, and the overall quality of midwifery care (Filby et al., 2016). Due to the shortage of midwives in Ghana, nurses are used to augment the staffing situation in the obstetric department and, therefore, in this study, the term nurses or midwives is use interchangeably and with specific reference to those working in obstetric departments.

Chapter Two

Literature Review

Context shapes the everyday interactions and encounters of people but is often ignored and taken for granted in moral issues (Walker, 2003). The context according to Walker includes relationships that define us in our own terms and other's eyes as well as the cultural setting and forms of social organization. Context is critical for understanding moral life which includes the individual practices and those of others within a socio-moral world and the moral understanding associated with those practices. The paucity of literature from LMIC examining the moral context and practice of midwives, warrants the use of studies from higher income countries to provide an overview of the complex socio-political and moral context that defines and shapes the moral life of nurses. The following terms (moral climate or ethical climate or moral habitability or health care organization or hospital or health care institution or work environment) and (moral agency or ethical practice or moral practice or nursing practice) and (nurse or nurses or nursing) were used in combination to search the following data bases; Medline, CINHAL, Google Scholar, and PubMed. Articles written in English and published from 2000 to 2020 were extracted.

Health Care Organizations and their Influence on the Moral Agency of Nurses in High Income Countries (HIC)

Nurses are embedded in a complex socio-moral environment which is mutually constituted and sustained by nurses and the health care organizations in which they work. Studies over the past decades have discussed the influence of systemic and structural factors such as staffing shortages, institutional policies, inappropriate use or inadequate resources, workplace hierarchy, emphasis on cooperate and biomedical ethos, and a lack of value for nursing work on the ethical behavior and practice of nurses (Newton et al., 2012; Rodney et al., 2006; Storch,

Rodney, Pauly, Brown, & Starzomski, 2002; Varcoe et al., 2004). Nurses have described the impact of these factors on various facets of their professional life including compromising standards and values (Humphries & Woods, 2015; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012), increasing workload (Beagan & Ells, 2007; Humphries & Woods, 2015; Varcoe et al., 2004), witnessing unnecessary suffering (Varcoe et al., 2012), conflicting values (Beagan & Ells, 2007; Varcoe et al., 2004), and a decreasing emotional contact with patients (Beagan & Ells, 2007; Humphries & Woods, 2015).

Several studies have explored the impact of the work environment on the moral practice of nurses in HIC (Rodney et al., 2006; Storch et al., 2002; Varcoe et al., 2004). In their study exploring the enactment of ethical practice, Storch et al. (2002) found that the realities of the workplace created an atmosphere for ethical distress. Nurses in this study described time as a resource that was often lacking in the face of increasing workloads, high patient volume, and high patient acuity and expectation. Nurses discussed distancing from patients due to the limited time to listen and support patients at the bedside, as well as limited opportunity for reflection on their practice with colleagues which they perceived to be important for the maintenance of their integrity and well-being. The work environment in which nurses are situated is complex and exerts a powerful influence that prevented nurses from reaching the moral horizon (Rodney et al (2006). They described moral horizon as ‘the good’ that nurses are navigating towards that is mutually influenced by the nurses, patients, team members and the health care organization. The authors described the privileging of a corporate ethos that took precedence over patient and professional wellbeing, professional satisfaction, and interdisciplinary collaboration. Focus on efficiency resulted in limited contact with patient as most of them were being pushed through the system. While their inability to navigate towards the moral horizon resulted in overall

dissatisfaction, the nurses found supportive colleagues, professional guidelines and standards, and ethics education facilitated their ability to navigate through the complex system. The health care environment is laden with different values which opposes that of nurses as they struggle in a shifting moral context dominated by corporate and biomedical ideals (Varcoe et al., 2004). The authors observed that in a health care environment in which corporate values such as efficiency takes precedence over care and the ideology of scarcity becomes the guiding principle, nurses are compelled to ration time and the care they provide to patients.

Hillman (2016) explored the responsibility of caring for patients in an emergency department in the United Kingdom found that the practice of health care providers is shaped and influenced by institutional priorities of accountability, resource allocation, and management. These influences led to competing values and agendas and placed a burden on the staff to care and 'managed' patients through institutional logic of efficiency, rationality, and accountability. In negotiating their practice in a context shaped by institutional values, the staff resorted to the practice of 'effacement', a situation in which patient care is reduce to faceless and impersonal interaction with limited moral regard. The practice of effacement although enabled the staff to cope and avoid moral distress through distance and detachment, it led to diminished moral proximity and contributed to demoralized health care staff and social space of the emergency department and dehumanized patients.

Exploring nurses' perceptions of their workplace ethical climate in New Zealand, Humphries and Wood (2015) discovered that three metaphors were used to describe themes relating to ethical climate; 'being burdened', 'pushed the bed' and 'us and them'. Being burdened was associated with the physical and psychological aspect of the work environment. Physical burdens were attributed to patient acuity and the intense demand for care of seriously ill

patients that increased the workload of nurses. The unsafe nurse-patient ratios during shifts, lack of support and staff augmentation during peak workload compounded the precariousness of the patient safety issues. Psychological burdens were associated with frequent feelings of being unable to provide the desired care and being forced to compromise standards. Participants acknowledged the enormous responsibility of having to care for a greater number of patients yet lacked the power to improve on the situation in which they found themselves. 'Pushed the bed' as a metaphor was used by participants to describe the dissonance that they experienced between meeting organizational goals of efficiency while at the same time trying to meet their ethical responsibilities to patients. Movement of patients within hospital units or to other hospitals occurred quickly and multiples with little regard to how this movement impacted patients and staff who are burdened with completing documentation. While these transfers were done by management in the context of easing the 'burden', the nurses found this approach distressing for them as care was left undone and documentation incomplete. Despite frantic efforts to get management to address this situation, their concerns have often been neglected, and their voices silenced by those in position of power creating a situation of "us and them".

Exploring the moral habitability of the nursing work environment post health care restructuring in Canada, Peter et al. (2004) found that nurses perceive the work environment as oppressive and dominated by corporate and medical-oriented values. The nurses recalled situations in which they felt powerless, marginalized, and exploited in the workplace. A lack of power and voice to influence decisions despite their overwhelming responsibility as well as limited time to engage in wider health care decisions compounded the existing situation in which these nurses found themselves. Experiences of interpersonal violence characterized by bullying and verbal abuse created an environment that was portrayed by nurses as "toxic" and "lacking

sympathy" (p. 360). Nurses experienced incoherent understanding of their moral responsibilities which were often unmapped (Peter et al., 2004). They took on the work of other members of the health team and in many instances these responsibilities exceeded their capacity, knowledge, competence, time, and other health care resources. This contributed to a greater workload leading to feelings of frustration, anger, emotional exhaustion, and feelings of abandonment by their institution. Nurses found direct and indirect opportunities for resistance through personal and professional efforts such as assertiveness and collective action within and outside the organization to sustain their values. The authors concluded by acknowledging that while Canadian nurses may be encountering poor work environments, nurses in resource limited settings may be experiencing far more difficulty.

Other studies have examined the influence of institutional hierarchy and power structure on the ethical practice and the work life of nurses (Storch, 2002; Vacroe et al 2004; Wall & Austin, 2008; Wall et al., 2016). Nurses described the intra and inter-professional hierarchies as a constraint that led to being silenced and excluded from patient care decisions and their knowledge devalued by other members of the health team which some participants attributed to their lower status. Nurses were often caught in a system of hierarchies that they found to be unfavorable and difficult to navigate for them and their patients (Storch et al., 2002). Many nurses described having to struggle between institutional hierarchies and conflicting values which hindered their ability to provide quality care. These created feelings of uncertainty, ambiguity, and self-critique as they attempted to balance their nursing responsibilities or when become stuck in between. The relationship with nurse managers and supervisors was described as hostile, fearful, and punitive and this made it impossible to speak up and advocate for their concerns and those under their care (Wall & Austin, 2008, Wall et al., 2016). The lack of power

to address their concerns led to marginalized feelings, isolation, and a perception of an oppressive work environment when their concerns were ignored by others. Nurses contributed to reinforcing and reproducing the very structures that constrained them through the blaming of the junior colleagues, lack of collegial support, and assertiveness to speak out. Creating spaces, time, support, and listening to nurses are imperative for creating a positive workplace climate and increase nurses' engagement.

The struggles of Canadian nurses to enact their values were explored by Beagan and Ells (2007). Although nurses described values such as helping others, being compassionate, making a difference, being patient-centered and an advocate, and having integrity, they also described the barriers that constrained the enactment of these values. Nurses described professional hierarchies, staffing shortages, and lack of funding to provide quality patient care as some of the barriers that interfere with their ability to enact these values which they perceive to be a constant source of frustration. Failure to enact these values exerted an emotional toll with many resorting to emotional detachment as a way of preserving their integrity and well-being (Beagan & Ells, 2007). Although detachment was perceived as a protective factor, the nurses acknowledged that this could have a negative impact on patient care such as diminished compassion and compromise in standards of care. One interesting finding by these authors is that the everyday struggles and ethical challenges of nurses can reach a threshold where it might become normalized and difficult for nurses to recognize ethical issues. Clearly, when unethical practice becomes the norm, nurses become insensitive to their values thereby threatening patient safety and wellbeing. Creating favorable work environments for discussing ethical concerns and building strong moral communities where shared understanding prevail are imperative for curbing this potential problem.

In a qualitative study describing what actions promote positive ethical climate among Swedish nurses, Silen et al (2012) found that reciprocity through giving and receiving support from colleagues and nurse managers, attending to concerns, and assigning staff to augment workload, positively affected the morale of the nurses. Other mitigating factors included collaboration, setting standards for ethical behavior, and having clearly defined policies and guidelines contributed to creating a positive working atmosphere. Limited hierarchy among team members and the recognition of every health care team member's contribution in providing optimum care for patients enhanced inter-professional collaboration, thereby decreasing conflicts and promoting a positive ethical climate. This study highlights the importance of reciprocity and enhanced power relations among staff promoted a positive work environment. It is evident that morally habitable spaces are created when team members feel valued and the health care institution is supportive and attentive to staff concerns.

Summary and Critique

The discussion uncovers the reciprocal relationship between the nurses' and their work environment. Such mutual relation demonstrates the complexity of the socio-moral and political environment nurses must maneuver to practice. While these studies revealed the role health care institutions have in shaping the moral practices of nurses, they also illuminated the role of nurses in reinforcing the structures that constrain moral practices.

The nurses encounter morally uninhabitable workplaces which were oppressive and stressful. Such morally uninhabitable workplaces have also been found to be predictor of moral distress, the effect of which is associated with decreased organizational commitment, reduced job satisfaction, increased job turnover, and dysfunctional behaviour (Beagan & Ells, 2007; Humphries & Wood, 2015; Peter et al., 2004; Storch et al., 2002). Although the fundamental

values of nursing are the same globally, the practice is shaped and influenced by the context and so are the ethical problems and associated moral distress. For example, while the extreme use of resources to prolong life, the dominance of corporate ideals, and the privileging of biomedical agendas generated ethical problems for nurses in HIC (Rodney et al., 2009; Varcoe et al., 2004) their counterparts in resource limited settings encounter ethical problems that may be due to the absence of basic medical supplies to attend to the fundamental needs of patients. The differences between Western nursing culture and practice and midwifery cultures in resource limited settings limits meaningful comparisons as well the applicability of any intervention from HIC to address moral problems in resource limited setting.

In a sub-Saharan African health care context, fraught with chronic resource shortages, meeting the basic care needs of patient remains elusive for midwives. It is unclear how such an environment impacts on the moral practices of midwives in these resource limited settings. The inherent ethical nature of midwifery practice whereby midwives work in between their own values, the sociocultural values of childbearing women, and values of the institutions in which they are located, adds to the moral complexity of the situation of midwives working at the forefront of maternal health care. As roles and responsibilities of midwives expand and resources are inadequate, moral agency and enactment of values may be constrained frequently. Evidence suggest that when nurses are frequently exposed to unhealthy working environments, nurses may become less sensitive to their own values and ability to practice ethically (Beagan & Ells, 2007). This assertion is supported by literature from sub-Saharan African that indicates the abuse and disrespect of women in childbirth has become normalized and widespread (Abuya et al., 2015; Bowser & Hill, 2010; Jewkes et al., 1998), which may be signaling a lack of moral recognition among midwives about their values and patient needs underscoring the need for an investigation

into the moral habitability of the midwifery work environment and the moral practices of midwives.

Narrative Review of Midwifery Practice in Resource Limited Settings

A narrative review was undertaken to provide a comprehensive understanding of the contextual factors influencing midwifery practice in LMIC. A narrative review was chosen because it allows for discussion of the literature from a theoretical and contextual perspective (Green, Johnson, & Adams, 2006). Two broad searches were undertaken in 2017 and revised in April 2020. The following search terms (experience or perception or views or opinion or perspectives or voices) and (midwi*or nurse-midwi* or community midwi* or obstetric* or nurs*) and (working conditions or workplace or work environment or health care setting or hospitals or health facilities or clinics or health care organization or obstetric setting or maternal health care setting or perinatal care setting) and (resource limited setting or resource constrained setting). The use of the search term resource limited setting or resource constrained setting was use instead of the broader World Bank classification. It is important to note that, while the World Bank country classification might be useful for economic analysis and comparison, it has limitation in terms of its application to the domain of health care research. For example, in countries like China, Turkey, and Thailand among others where health care delivery is more advanced and health care resources are favourable, it becomes nearly impossible to compare experiences of health care professionals from countries like Iraq, South Africa, and Botswana that have all been classified as middle income economies. Based on the above critique, the final search was done using countries categorized as resource limited settings and defined as countries without adequate funding to cover the cost of health care both at the individual and national level, shortages of supplies, poor infrastructure development, shortage of qualified personnel,

and inadequate transportation (Vasco et al., 2019). An extensive search was conducted using the above keywords in combination with specific countries in the following databases; Medline, CINHAL, Scielo, Google Scholar, Pubmed, Plos One, and BioMed Central. Articles written in English and published from 2000 to 2020 were extracted. The year range was chosen to enable the capturing of current publications and contemporary issues influencing health care delivery. A total of 27 relevant articles were retrieved exploring the experiences of midwives about their work environment (sub-Saharan Africa=19; Middle East=2; South Asia=4, South America=2).

Contextual Barriers to Midwifery Practice in Resource Limited Settings

Midwifery practice is shaped and influenced by the broader systemic factors and policies. The work environment is precarious and unsafe with most midwives working alone. Several factors have been identified as barriers to midwifery practice. These factors are structural and systemic as well professional and include staffing shortages, a lack of basic medical resources, an inadequate referral system, lack of decision making power, and conflicting roles and undefined responsibilities. These factors are not mutually exclusive but influence one another may constrain the moral agency of nurses and midwives

Staffing Shortages

Nearly all studies reported that staffing shortages impacted severely on midwifery practice and quality of patient care. In a Rwandan study exploring the understanding of midwives applying knowledge gained from an Advanced Life Support program, the authors indicated that the shortage of midwives resulted in difficult working conditions, hindered quality of emergency care and the implementation of knowledge and skills they acquired (Uwajeneza, Babenko-Mould, Evans, & Mukamana, 2015). Furthermore, midwives stated that the implementation of the advanced life-saving skills was also constrained by the shortage of

obstetricians. They recounted instances when they identified women in need of emergency care but women unable to get access to these services because obstetricians were often not available. In highlighting factors influencing staff intention to leave among maternal health care providers, the shortage of staff emerged as a demotivating factor (Chimwaza et al., 2014). Midwives reported being burdened by having to work alone with laboring women with various degrees of complication without any assistance during night shift. In instances when the workload became overwhelming, midwives felt compelled to prioritize care to determine women in need of urgent care. While this contributed to easing their burden, they felt guilty and demoralized for not being able to provide the desired care to all women. Staffing shortages led to work overload, prolonged working hours, and decreased contact hours with many labouring women resulting in a poor quality care, lack of accomplishment, and emotional exhaustion (Bremnes, Wiig, Abeid, & Darj, 2018; Macdonald et al., 2019; Mothiba, Skaal, & Berggren, 2019; Mselle, Moland, Mvungi, Evjen-Olsen, & Kohi, 2013; Nunes, Reberte Gouveia, Reis-Queiroz, & Hoga, 2016; Rahmani & Brekke, 2013; Turan, Bukusi, Cohen, Sande, & Miller, 2008). Others described the inadequate staffing led to low staff morale, feelings of frustration, fatigue, burnout, and ethical dilemmas, and a heightened sense of loss as they struggled to provide care to women (Bream, Gennaro, Kafulafula, Mbweza, & Hehir, 2005; Matlala & Lumadi, 2019; Nunes et al., 2016; Pettersson, Johansson, Pelembe Mde, Dgedge, & Christensson, 2006). Although Matlala and Lumadi (2005) indicated in their study that midwives experienced ethical dilemma due to staffing shortages, the causes and nature of these ethical dilemmas were unclear.

In two Iraqi studies and one Pakistani study exploring the perception of midwives about their working environment, the authors reported severe shortages of midwifery staff which resulted in increased workload, stress, and a threat to patient safety (Ghiyasvandian, Piro, &

Salsali, 2016; Hassan-Bitar & Narrainen, 2011; Jamil Piro, Ghyasvandian, & Salsali, 2015). The Iraqi midwives reported a heavy workload when they had to attend to 20 or more deliveries per shift with very few obstetric staffs and felt being abandoned and forsaken in their daily struggles as they acknowledge their frustration and hopelessness for not being the kind of professional they had aspired to be (Ghiyasvandian et al., 2016). In the Palestinian study midwives described the situation as 'usual' to have one midwife on duty, although they acknowledged that this can compromise the standard of care (Hassan-Bitar & Narrainen, 2011). Although midwifery staffing shortages are widespread in resource limited settings, it is important to acknowledge that countries devastated by wars and civil unrest such as Iraq and Palestine, the staffing situation might be severe as most health care workers might have migrated to other countries or were displaced.

Lack of Essential Medicines, Equipment and Effective Referral System

The absence of medical supplies and equipment to attend to the basic needs of childbearing women dominated participants' narratives across many of the studies reviewed. Situations of a lack of basic supplies and equipment (Bradley et al., 2015; Bream et al., 2005; Chimwaza et al., 2014; Ghiyasvandian et al., 2016; Macdonald et al., 2019; Mothiba et al., 2019; Mselle et al., 2013; Nabirye, Beinempaka, Okene, & Groves, 2014; Turan et al., 2008; Ur Rehman et al., 2015), inadequate and insufficient medicines (Hassan-Bitar & Narrainen, 2011; Lester & McInerney, 2003; Munabi-Babigumira, Glenton, Willcox, & Nabudere, 2019; Pettersson, Svensson, & Christensson, 2001; Uwajeneza et al., 2015), and malfunctioning equipment (Adolphson, Axemo, & Hogberg, 2016; Pettersson et al., 2006) affected the provision of midwifery care. Midwives in these studies cited the lack of delivery kits, oxygen, intravenous fluid, oxytocic agents, blood products, resuscitation kits, intravenous fluids, beds, screens and

suctioning equipment as frequently occurring in their daily practice. This led to poor quality of care and outcomes of obstetric care, unsafe practice, delayed care, and compromised professional standards (Adolphson et al., 2016; Beltman et al., 2013; Chimwaza et al., 2014; Jamil Piro et al., 2015; Lester & McInerney, 2003; Macdonald et al., 2019; Nabirye et al., 2014; Ur Rehman et al., 2015). Others described inadequate spacing and poor infrastructure created precarious working conditions and overcrowding and hindered the provision of humanized care (Macdonald et al., 2019; Mselle, Kohi, & Dol, 2018; Munabi-Babigumira et al., 2019; Narchi, de Castro, Oliveira, & Tambellini, 2017; Nunes et al., 2016; Rahmani & Brekke, 2013). The struggle to maintain balance in an uncompromising work environment and meeting their professional responsibilities may frequently generate ethical dilemmas and distress for midwives.

The medical resource challenges are also related to the inadequate referral system. In their study of Pakistani midwives, Ur Rehman et al (2015) found that the inefficient ambulance system to refer obstetric emergency cases to nearby tertiary facilities was a hindrance to midwifery practice. Midwives cited cases where transportation was available that it took several hours to get to the nearest facility due to poor and inaccessible road networks. Similar studies in Mozambique and Angola reported that midwives working in remote settings who have limited capacity to attend to obstetric emergency cases, were constrained by non-functioning referral systems and unreliable ambulance services, resulting in the delay of cases requiring emergency care and the death of women (Adolphson et al., 2016; Pettersson et al., 2001). Angolan midwives also reported the absence and sometimes erratic supply of electricity, led to instances they had to attend to labour cases at night without lights and experienced power outages during caesarean sections (Petterssen et al., 2001). An Indian study found that the lack of resources and professional issues led to circumstance driven midwifery characterized by three dimensions of

midwifery practice described as compelled, restricted, and invisible practice (Sharma, Johansson, Prakasamma, Mavalankar, & Christensson, 2013). These practices resulted in stressful and risky practice, deskilling and diminishing potential, and a lack of professional satisfaction.

Hierarchy, Lack of Decision-making Opportunities, and Organizational Policies

Inter and intra professional power imbalances constrained the ability of midwives to make and influence health care decisions. Midwives described situations where physician authority and health facility policies such as assigning a midwife per night and shifting midwifery task to junior medical officers with limited experience and competence limited their scope of practice and ability to practice autonomously (Chimwaza, 2014; Uwajeneza et al., 2015; Ur Rehman et al., 2015). The midwives in these studies perceived that the power imbalance was disruptive to patient safety as they could not attend to cases that needed urgent attention in the absence of medical officers who were often not available. Misunderstanding and conflict between experienced midwives and novice medical officers were also cited by participants when they challenged their orders and decisions made, which were not in the best interest of the woman and the unborn baby.

Exploring the perception of midwives about their working relationship with their managers, it was found that the hierarchical relationship led to maltreatment of junior staff and new recruits (Chipeta, Bradley, Chimwaza, & McAuliffe, 2015). Feelings of demotivation, decreased morale, and an unwillingness to come to work were narrated by participants when managers treated them with contempt. Many recounted the working relations as oppressive and intimidating and contributing to some staff members leaving to join other hospitals. Disrespectful communication and lack of confidence in midwives were reported to affect the outcome of childbirth (Pettersson et al., 2006). A sense of inadequacy and inferiority dominated

midwives' discussion when obstetricians did not trust their work which resulted in midwives declining or delaying the provision of care to women. Nunes et al. (2019) found that the hegemonic attitude of obstetricians toward decisions about patient care hindered the ability of midwives to implement new birthing guidelines in a Brazilian facility. The midwives described being forced to comply with the values and preferences of the obstetricians, thereby hindering the development of collaborative practice.

McDonald et al. (2019) found that nurse-midwives recounted feeling trapped between the government and institutional rhetoric of free perinatal health and the expectation of women. The nurse-midwives described the policy as contradictory to the reality of their practice settings and that it created barriers to women seeking care, led to confusion and conflicts among them and the women and their families, and placed greater burden on them to negotiate care for women. Unrealistic expectations and the emphasis on financial goals by managers to the detriment of patient care outcomes were found to be inconsistent with their values (Shaban, Barclay, Lock, & Homer, 2012). It is imperative for health care institutions to generate income for the acquisition of resources, but in countries were resources and the standard of care are poor, prioritizing profit over patient care can generate ethical conflict for health care workers.

Conflicting Roles and Undefined Responsibilities

The scope of midwifery practice although defined within the International Confederation of Midwives (ICM) and World Health Organization guidelines, is challenged in terms of how these roles and responsibilities are enacted especially in resource limited settings. A Palestinian study found that midwives have an overwhelming number of duties and responsibilities when compared with nurses and doctors (Hassan-Bitar & Narrainen, 2011). The authors found that the absence of job descriptions resulted in midwives taking upon themselves several responsibilities

that exceeded their knowledge and abilities. Other studies reported that midwives recounted feeling frustrated when they were unable to practice as desired due to the lack of job descriptions and role clarity and limited right to practice which led to blurring of professional boundaries and marginalizing practices (Shaban et al., 2012; Sharma et al., 2013).

In Rwanda, midwives described the lack of job descriptions and role ambiguity led to being overburdened when they had to take up non-midwifery work to the neglect of their professional responsibilities (Nabirye et al., 2014). In addition to their already extensive responsibilities, midwives in this study reported undertaking the tasks of record keeping, calling doctors and laboratory technicians who are supposed to be on duty, and cleaning of floors taking them away from providing care. In two Iraqi studies, midwives recounted assuming a variety of roles and responsibilities in an environment where professional boundaries were blurred (Ghiyasvandian et al., 2016; Jamil Piro et al., 2015). In all these studies the midwives' narratives were characterized by confusion and uncertainty when multiple responsibilities made it difficult for them to determine who was accountable for what action.

Lack of Collaboration and Team Support

A collaborative work environment is an essential component for enhancing a positive work climate and positive patient health outcomes. In maternal health practice, collaborative practice is vital due to the complexity of the cases that are being presented. Several studies reported the absence of support, inadequate supervision, lack of team work, and a limited professional support system negatively affected the work climate and created a sense of distrust for the system in which they worked (Hassan-Bitar & Narrainen, 2011; Mselle et al., 2013; Nabirye et al., 2014; Pettersson et al., 2006; Pettersson et al., 2001; Ur Rehman et al., 2015). Rwandan midwives described inter-professional collaboration and team support contributed

positively to managing obstetric complications but acknowledged that the shortage of staff and physician authority and domination were a hindrance to building a positive collaborative working climate (Uwajeneza et al., 2015). In Pakistan, newly qualified midwives described the realities of the working environment which were overwhelming and exceeded their expectations, yet there was no adequate supervision and support from management and superiors (Ur Rehman et al., 2015). The absence of structured workplace support appears to be a common feature of health systems across resource limited settings.

Lack of Recognition, Appreciation, and Visibility of Midwifery Practice

While professional recognition and appreciation may promote positive work engagement this appears to be elusive for midwives practicing in precarious and resource limited settings. In several studies across sub-Saharan Africa and other resource limited settings, midwives reported the lack of professional recognition, appreciation, and support by management, supervisors, medical officers, patients and families, and the public at large (Bremnes et al., 2018; Chimwaza et al., 2014; Ghiyasvandian et al., 2016; Matlala & Lumadi, 2019; Mothiba et al., 2019; Shaban et al., 2012; Sharma et al., 2013). Instead, managers and supervisors were found to be fault-finding and blamed midwives for negative outcomes. Lack of professional recognition and policy regarding the status of midwives in health teams, subordination of midwifery under the nursing profession, and the privileging of the work of doctors by institutions affected their confidence, constrained their ability to make and influence decisions in the workplace and contributed to the invisibility of midwifery work (Shaban et al., 2012; Sharma et al., 2013; Matlala & Lumadi, 2019).

Midwives' inability to provide quality care due to the multiple constraints they encounter contributed to the lack of respect and their negative public perception and image. In sub-Saharan

Africa midwives narrated how patients and their families often blamed them for situations they had no control over such as the lack of medicines and other supplies (Bradley et al., 2015; Bremnes et al., 2018; Chimwaza et al., 2014; Mselle et al., 2013). This contributed to the negative public image of midwives with many midwives expressing feelings of frustration, humiliation, resentment, anger, and with many considering leaving the profession. In middle Eastern countries, researchers found the low social status accorded to females, and by extension midwives and nurses, contributed to the lack of respect and value for the nurses and midwives by health facility managers and the public (Jamil Piro et al., 2015).

Culture of Fear, Blame, and Organizational Injustice

Fear of being blamed for the death of a mother or a fetus and litigation for poor health outcomes generated feelings of anxiety, demotivation, and demoralization among midwives in sub-Saharan Africa (Bremnes et al., 2018; Chimwaza et al., 2014; Chipeta et al., 2016; Matlala & Lumadi, 2019; Mselle et al., 2013). In Malawi, midwives described how recording a maternal death or stillbirth during one's shift was greatly feared due to the severe sanctions from management including the possibility of withdrawal of their professional license and job loss (Bradley et al., 2015; Mselle et al., 2013). Although midwives perceived this to be an unfair practice due to the difficult working conditions they encounter, the fear and repercussions following a maternal death were described by some midwives as reasons why they sometimes use all possible means to get women to comply, including physical and verbal aggression.

Organizational injustice and victimization negatively affected the work environment of midwives. This was associated with a lack of proper communication structures and transparency, favoritism, unfair treatment, and a lack of equity in promotion, and victimization of those who challenge unfair management practices (Arnold, van Teijlingen, Ryan, & Holloway, 2015;

Chipeta et al., 2015; Hassan-Bitar & Narrainen, 2011; Pettersson et al., 2006). This contributed to unsafe working environments and general dissatisfaction among midwives.

Summary and Critique

The literature illuminates the work environment of midwives in resource limited settings and the constrains it exerts on their ability to practice and enact their moral responsibility. The significance of providing and sustaining quality midwifery care in the face of an overwhelming lack of human and material resources has been highlighted by midwives. Midwives who struggle to maintain a balance in such uncompromising work environment experience constant frustration and resentment, a heightened sense of loss, and hopelessness when they are unable to enact their moral responsibilities.

Midwives encountered hierarchical and oppressive workplace structures that constrained their scope of practice and the ability to enact moral agency. Such oppressive environments were perceived to threaten patient safety and well-being when midwives did not have control over patient care decisions. Midwives who attempted to challenge the prevailing situation and assert their voices were often victimized by management and isolated by their colleagues compounding their perceived sense of powerlessness. While midwives value collaboration and the positive impact it has on obstetric outcomes, the inability of midwives to collaborate in such oppressive work environments affected the quality of obstetric outcomes.

Midwives experienced confusion in their responsibilities in an environment where job descriptions were inadequate, and boundaries were blurred. Their sustained presence in the practice setting and their moral responsibilities may leave them vulnerable and susceptible to assume the duties of others in the interest of the wellbeing of childbearing women. The ability of midwives to sustain an ideal moral practice and determine the scope of their accountability was

difficult in such a context. Midwives' proximity to childbearing women often implicated them in poor quality of care issues without due consideration of the context in which they practice.

Although these studies provided a detailed discussion on the impact of the work environment on midwifery practice they are not without critique. Most of the studies were descriptive and exploratory with no explicit connection to the moral dimension of midwifery practice. While the methodologies used may be consistent with the goals of their research, a critical approach may have enabled the uncovering of the hidden and taken for granted aspect of the work environment, considering the socio-political and moral nature of the health care environment. In addition, the theoretical analysis and criteria for establishing the validity of the findings were inadequate.

While several studies discussed the lack of resources as a barrier to quality maternal care, they failed to adequately capture the role of national and institutional policies and values shaping the allocation and distribution of resources. It is imperative to uncover how these values and policies contribute to resource shortages and shape the institutional climate. Moreover, the socio-cultural factors shaping the moral context of practice have largely been omitted in most of these studies. The studies also only investigated the influence of the work environment and external barriers to midwifery practice without examining the role of the individual moral agent. The role of midwife as a moral agent along with how their moral values and identity shape and influence their practice has not been fully understood in a resource limited setting. Moreover, strategies for negotiating their practice in the context of limited resources have not been fully understood. This may be attributed to the specific goals of these studies and the methods used which were mostly focus group discussions. In all these studies, the participants perceived the work environment as a constraint without examining how their values and identity influence their actions and

decisions. As noted earlier, health care professionals and their work environment mutually define each other, underscoring the role of structure and agency (Musto et al., 2015).

Contemporary studies have discussed nurses' role in contributing to the poor institutional climate that constrains their practice and contributes to moral distress (Chambliss, 1996; Musto et al., 2015; Newton et al., 2012; Peter et al., 2004, Rodney et al., 2006). Therefore, focusing on the structure and ignoring the role the individuals play in reinforcing and reproducing the very structures that constrain them, warrants attention in a resource limited setting. Finally, the literature provided little understanding of how midwives navigate such a complex moral and sociopolitical work environment to sustain their moral ideals.

Theoretical and Philosophical Lens

Feminist ethical theory was used as an interpretive lens to guide this study. Feminist ethical theory evolved from the devaluation of women in personal and public life and views the personal as political. It begins with an explicit commitment to challenging women's subordination as well as their moral experience in realm of traditional ethics (Jaggar, 2000).

Feminist ethicists have identified three main assumptions that should guide inquiry: "to articulate moral critiques of actions and practices that perpetuate women's subordination; to prescribe morally justifiable ways of resisting such actions and practices; and to envision morally desirable alternatives that will promote women's emancipation" (Jaggar, 2000, p.528). Feminist ethics as a theory situates the analysis of individual actions within a context of broader social practices. It focuses on the unequal distribution of power and privilege in everyday interactions in which the thin line between politics and ethics is often concealed (Peter & Liaschenko, 2004), thus exposing patterns of domination and oppression. It highlights the moral dimension of issues in everyday life that may go unnoticed when viewed through the lens of traditional, principled-

based ethical theories. Hence feminist ethics moves beyond describing and interpreting women's moral experiences to raise consciousness and moving toward collective change.

Moral Context

The work of feminist ethicist Margaret Urban Walker provided an interpretive lens for this study. Walker (2003) underscores the importance of context in understanding a given situation. She described context as a "particular set of environment or circumstances that determines whether something is acceptable or make sense" (p.xi) and that without a clear understanding of the context, it would be difficult to comprehend the situation of those involved. According to Walker context embodies the history of a situation, how it was generated, the nature of relationships involved, and the shared expectations and understanding of every interaction. In every society, individuals are trained in a particular context or setting and are imbued with knowledge and skills to negotiate their social, working, and professional lives. Through the acquisition of specialized language and rules of a particular discipline or institution, individuals adopt a cultural worldview that frames their moral values, responsibilities and judgements.

Walker (2007) asserts that context shapes the understanding of morality in different ways. Firstly, the specific assumption acquired from a particular context becomes a frame of reference for guiding everyday moral thinking, actions, and judgment. The context whether institutional or professional prescribes particular ways of living by determining what values deserve our attention, which relationship demands our obligation, what principle should frame our judgment and what responsibilities we should take, and this can either facilitate or constrain moral life. Secondly, context shapes and influences the everyday practices and choices of people. It also includes the individual's roles and position within a social organization. Walker reminds

us that the values and people that shapes our moral lives and define practices of responsibilities in different ways are often unchosen and calls for critical examination of social context in determining the distribution of responsibilities and moral agency.

From Walker's (2007) perspective, morality is situated in the context of everyday practices, thus shaping ethical theory as well as everyday choices and interactions. Walker proposes the expressive collaborative model (ECM) as an alternative medium for theorizing moral issues. Unlike the theoretical juridical model which is based on the application of impersonal abstract principles or ethical formula to moral issues, the ECM views morality as interpersonal, collaborative, and arises between people. From the ECM, Walker makes three assumptions (Walker, 2007). The first assumption states that morality consists of everyday practices. Based on this she defines morality as "socially embodied medium of mutual understandings and negotiation between people over their responsibility for things open to human care and response" (Walker, 2007, p.9). Walker argues that moral life cannot be extricated from the social world in which our values, identities, and responsibilities are continuously being defined and reproduced. In the context of healthcare, the ethical practice of midwives is dependent on the health institutions in which they work, and these institutions tend to shape their values and the responsibilities they undertake. Midwives in resource limited settings are constantly faced with complex moral choices in their everyday practice that have the potential to threaten their fundamental values and identity, yet they are often blamed by the same institution that give rise to these moral problems. Walker calls for the critical examination of the social world to understand the situation of those living within it, something she calls 'transparency testing' by exposing the hegemonic power structures that produces and sustains moral understanding and ways of life.

The second assumption posits that morality is located in "practices of responsibility" that "implement a commonly shared understanding about who gets to do what to whom and who is supposed to do what for whom" (Walker, 2007. p.16). Practices of responsibility are distributed through divisions of labour and moral accountability and invoke ways of critically examining how these responsibilities are determined, what the scope and limits of our agency are, who we are and what we stand for and who has the power and authority to blame or judge our actions. In other words, moral accounting allows us to assign, accept, and deflect responsibilities. Walker views practices of responsibility to be multidimensional and embedded in tasks, roles, attitudes, behaviours, habits as well as the consequences of action that are beyond our control and the people with whom we have relationships. In the realm of nursing and midwifery these activities are directed to people in need of healthcare and are therefore vulnerable as a result of the action and inaction of nurses and midwives. She also acknowledges these activities can give rise to feelings of regret, indignation, grief, anxiety, and fear as well as feelings of satisfaction, pride, and hope all of which are dependent on whether we are able to meet our practices of responsibility.

Lastly, Walker (2007) assumes that morality is not socially modular but is enacted through social ones and the distribution of responsibility. Moral practices and understandings are inextricable from social practices and the social roles and institutions that shape particular ways of life and prescribe what we and others do and for what we are accountable. In social moral orders, such as the health care institutions, people occupy different positions and locations which becomes the ground from which they are accountable, judged and blamed. In social moral orders where hierarchical power relations are the norm, not everyone carries the same burden and

responsibility. Walker calls for feminists to critically analyze social moral orders to determine whether they are morally habitable.

Walker (2007) defines morally habitable environments as those that promote recognition, collaboration, and shared goods among people as opposed to those that perpetuate their suffering, oppression, deception, and violence. Walker calls for the critical examination of moral understandings and practices of responsibility in social-moral orders and the questioning of these practices to determine if they foster cooperation, mutual recognition or oppression, and suffering. According to Walker, this type of analysis will determine whether moral understandings are intelligible and coherent to those who enact practices of responsibility. This requires us to draw information on the everyday interaction of people and then compare and contrast practices of responsibility between social actors and within them to determine "who gets to do what for whom and who is supposed to do what for whom" (Walker, 2007, p.16) as well as who has the standing to give and demand accounts. Walker contends that the social world is laden with imperfect understandings, conflicts, diverse worldviews, and resource inequities that render other people's moral lives incoherent, their voices muted, and their moral agency compromised. Critically scrutinizing these diverse accounts of experiences and moral understanding opens up space for understanding the material conditions, power, and institutional values that shape the moral habitability of a community or an institution. This type of analysis also creates possibility for transformative change and actions.

Moral Practices

Critical analysis of the moral habitability of social orders also requires the examination of moral practices to determine what kinds of identities, relationships and responsibilities sustain these practices. According to Walker (2007) relationships are developed through an expectation

of trust, past and present histories, and a possibility for continuity of these relationships. People assume responsibility for others based on a previous or ongoing relationship they have with them, which makes it morally demanding (Walker, 2007). In other ways, Walker assumes that people do things for others because those needs are critical and there is no one to assume the responsibility or sometimes their closeness demands that they respond. Walker (2007) asserts that complex moral demands raise several conflicts and dilemmas that have the possibility of threatening the integrity of the individual whose moral life is defined by the need and demand of others and the institution in which they work.

In the realm of midwifery, relationships are central to the philosophy and ethics of midwifery which requires midwives to develop partnerships and relationships with women, families, communities, members of the health team, the health system, and policy makers to improve the health and wellbeing of women as well maintaining professional integrity (ICM, 2014). From Walker's perspective, these kinds of relationships are based on trust, mutual understanding and expectation on the part of all stakeholders. Walker (2007) also reminds us that in the social world where hierarchical relations are the norm and people are differently located, there is bound to be violations in the mutual understanding and expectation which may give rise to resentment and indignation. Reinterpreting moral distress experienced by nurses using Walker's perspective, Peter and Liaschenko (2010) concluded that the moral distress nurses encounter may be a violation of the trust of the shared understanding on the part of the parties with whom nurses have a relationship.

Feminist ethicists have argued that identity is central when analyzing moral practices. Moral identity, according to Walker (2007) is comprised of the historical inscriptions that determine what a person values and is constituted by what one cares for, assumes responsibility

for, and cares about. These values are prioritized and devoted to certain kinds of situations and people. According to Walker (2007), some of these identity inscribed values are dedicated to family relations, institutions, and some are distinctively devoted to mitigating the suffering of others. In the case of nurses and midwives, these values are directed towards alleviating pain and suffering of those they care for. For midwives, these values may include protecting and safeguarding the life of women and their unborn babies and preventing complications. People are confronted with everyday choices and demands that require them to express, apply, affirm or reaffirm, and negotiate certain values based on previously acknowledged values and what these values mean to them, thereby mapping out new ones as the situation demands (Walker (2007). Others also scrutinized these values to determine if they are consistent with their histories and identity. These identities shape the everyday life of people and how they respond to certain situations. Nurses' training and socialization imbues them with certain values such as caring, compassion, and alleviation of suffering, however, their ability to realize these values depends on the people they work with and the particular institutions in which they work. Peter and Liaschenko (2010) argue that moral distress arises when nurses cannot enact their values and conclude that moral distress is a constraint on the moral identity of nurses. Midwives in resource limited settings may be encountering morally uninhabitable work environments in which their identity as trusted caregivers are constantly being threatened. In an environment fraught with a lack of medical and human resources, it is imperative to understand how midwives enact their moral agency and sustain their identities and values.

Finally, moral practices and agency are connected to the kinds of things for which people take responsibility. According to Peter and Liaschenko (2010), in the domain of health care, these kinds of responsibilities are enshrined in a code of ethics and standards of practice that

create certain expectations. This kind of responsibility might entail caring for the sick, vulnerable, frail, and the dying whose wellbeing demands our attention. In the domain of midwifery, these responsibilities are geared toward caring and advocating for pregnant and laboring women and the prevention of complications. Although they are obligated to respond to these kinds of vulnerabilities, their ability to do so widely depends on how well others collaborate. Walker (2007) acknowledged that frequent contact and exposure to complex life circumstances and the unlimited demands it places on us might lead to a strain on our responsibility, exhaustion, and sometimes compromising values.

The embeddedness of midwives and nurses in the complex world of patient suffering and struggle may create an emotional burden and provoke feelings of moral distress especially when they are unable to alleviate the suffering of these patients (Peter & Liaschenko, 2013). Midwives in resource limited settings have morally demanding responsibilities that require them to ensure that women have save births, prevent complications, and reduce maternal deaths. These kinds of moral responsibilities in resource limited settings demand cooperation and support from other members of the health team and managers. Walker (2007) calls for mapping the geography of responsibilities to determine how social actors make themselves accountable to each other. Tracking responsibilities of differently situated people provides a landscape to critically examine who has responsibilities for what and who should be held accountable for certain failures. There is a need for an understanding of how well midwives are supported to meet these kinds of responsibilities placed on them and what happens if they are unable to fulfill these responsibilities.

African Philosophy

African philosophy reflects the social moral values and beliefs that guide moral life as well as the interpretation of those values and beliefs within the African cultural context (Gyekye, 1996). Within African philosophy, morality is inherently a social practice influenced by social rules, norms, and maxims that govern how people live (Gyekye, 1996). These social rules, norms, and maxims are embedded in ethical narratives, folklore, and proverbs that are taught during moral instruction and upbringing. These ethical narratives along with their interpretive statements emphasize the importance of interdependence and sense of humanism as the meaning and purpose of life and serve as the basis for guiding and assessing everyday lives, actions, choices, and decisions (Gyekye, 1996). Moral values that provoke interest and a sense of duty to others are considered worthwhile if they contribute to shared and individual goods. The internalization of these values is expected to lead to a morally good life that promotes human wellbeing and, therefore, the foundation for moral practice Gyekye (1996, 2010). Moral practices are oriented towards the ethics of responsibility in which one expresses a caring attitude or feels obligated to respond to the wellbeing of others (Gyekye, 1996). To the African people, the ethics of responsibility is indispensable to human flourishing and harmonious living.

Despite the social nature of morality, it is inseparable from the religious beliefs and practices of the African people. The presence of God is inherent in the everyday thinking of the Africans and this intends mediate their thoughts, actions, and decisions (Gyekye, 1996). Doing the right thing, such as promoting the wellbeing of others is considered a moral obligation as well as a religious one and when fulfilled will lead to eternal rewards (Gyekye, 1996). This consciousness about God makes the desire for non-material values such as kindness, compassion,

and empathy central to the life of the African people which they perceive to give meaning and purpose to their lives (Gyekye 1996; 2010).

Drawing on African philosophy provides an interpretive lens for understanding the socio-moral dimensions influencing the moral agency and identity of nurses and midwives in Ghana. Gyekye (1996) argues that African epistemology is rooted in natural ways of knowing hence, moral knowledge and systems are embedded in the social world. This understanding is consistent with feminist conception of epistemology and morality. Feminist ethics and African philosophy share similar fundamental assumptions regarding morality in that they both place emphasis on human relationships, responsibility, and the promotion of harmony and cooperation as well as the particularity of the moral situations. Combining feminist ethics and African philosophy as interpretive lenses provides a medium for analyzing the socio-moral and political dimensions of the obstetric settings and moral agency of nurses and midwives.

Chapter Three

Methodology and Methods

This chapter presents a detailed description of the epistemological underpinnings, methods, and analytic procedures guiding this study. Qualitative research explores human behaviour by "attempting to make sense of or interpret phenomenon in terms of the meanings people bring to them" (Denzin & Lincoln, 2005, p. 3). This approach to research allows for multiple and holistic perspectives of a phenomenon by taking into consideration the complexity of human experience and interrogating the interaction of factors in the social world that shapes the lives of people. According to Walker (2007), the social world becomes a site for investigating moral issues by allowing researchers to make transparent the "structure of the social worlds, people's actual places in them, the understanding that hold the places in place, and how people are parties to these understandings" (p.238). Considering Walker's (2007) and Gyekye's (1996) conception of morality as embedded in a social context and the purpose of this study, qualitative research was deemed suitable for answering the research questions:

- How do nurses and midwives perceive the moral habitability of the obstetric work environment?
- How do these environments influence the enactment of moral agency?
- What kinds of identities, values, and responsibilities shape and influence their practice?

Feminist Ethics, African Philosophy, and Critical Inquiry

Feminist ethics research draws on a naturalized moral epistemology that "takes actual processes and determinants of human cognition and inquiry as its subject" (Walker, 2007, p.65). This epistemology seeks to understand the human world through exploring the life of people, the everyday situations or circumstances, conditions, and values that shape and determine moral life. Walker's (2007) moral epistemology holds the assumption that morality is not a set of standards

and principles that is located within a person but rather is shaped and influenced by the social world and moral understandings. This understanding is also consistent with the African philosophical conception of morality as rooted in human experiences and interactions with the natural world rather than on a set of principles (Gyekye, 1996). Inquiry into morality from the feminist and African perspectives needs to be situated within the social experiences of people in relation to the ways of living. Walker (2007) appeals for a socially critical moral epistemology for understanding and interpreting the complex, interpersonal, and social dimensions of morality. She argues that feminist moral epistemology seeks to question "how social divisions of labor, opportunity, power, and recognition which reproduce gender and other hierarchies affect" (p.363) the moral understandings and habitability of moral social orders (Walker, 2000).

Critical inquiry is guided by the beliefs that there is no pure or value-neutral knowledge that is external to human cognition, that power and domination are inherently present in every social setting, and that language is the fundamental mode of communication and is thereby central to the creation of knowledge (Brown, 2000, Kincheloe & McLaren, 2005). This approach to inquiry assumes that social arrangements, language, power, and authority are important in understanding how people make meaning of their experiences. Walker (2007) argues that power and authority are central to understanding how moral issues are framed and interpreted and, therefore, require critical approaches to inquiry that will make transparent these arrangements constituted by diverse positions and roles, values, relationships, distribution of responsibilities, and institutional standards. Knowledge creation through a feminist lens is intersubjective and pays attention to the power and authoritative assumptions guiding the process of inquiry and interpretation as well as how the other may be rendered invisible (Walker, 2007). Moreover, this approach to inquiry is reflexively critical as it gives voice to participants' stories and serves as an

opening wedge for understanding the gender, political, and cultural systems shaping the moral life of people within and outside moral social orders that are often hidden from plain view (Jagger, 2000; Walker, 2007).

Ethnography and Critical Moral Ethnography

Walker (2007) suggests that inquiry into the social-moral world requires the use of empirical methods such as "documentary analysis, historical, ethnographic, and sociological" (p.11) approaches. These approaches provide methods and techniques for producing a rich and politically critical knowledge about moral-social orders and practices of people within them. Walker (2007) argues that it is common in "human societies (including our own) that moral standards, statuses, and distributions of responsibility work through social differences, rather than in spite of them" (p.246). Understanding moral knowledge will require information about how these diverse positions and social differences are sustained and reproduced within the social moral world. Given this intricate nature of morality, empirical observation, and information about the everyday interactions and practices of people are required to gain insight into how social moral orders like the health care institutions influence and shape the lives of those living and working within them. Walker (2007) proposes critical moral ethnography as a methodology for the empirical study of morality or ethics. This methodology provides analytic and critical devices for exploring the moral, political, historical, and cultural dimensions of moral life in relation to a broader social-moral context. Given the socially critical moral epistemology Walker envisions, principles and methods of ethnography and critical ethnography were used to frame this study.

Ethnography has its roots in anthropology dating back to the nineteenth century when researchers provided descriptive and comparative accounts of cultures (Hammersley &Atkinson,

2007). The fundamental goal of ethnographic research is to generate rich, in-depth, and holistic insights into people's behaviour, actions, settings, or culture using multiple methods of data collection. For the ethnographer, "the task is to document the culture, the perspectives, and practices of the people in these settings. The aim is to get inside the way each group of people see the world" (Hammersley, 1985, p. 152). The task of the ethnographer is to make the implicit aspects of a culture or institution explicit. Because moral life is intricately enmeshed with social life, there are parts of the social-moral orders that are not visible even to those who live within them unless those parts are subjected to critical analysis and interpretation (Walker, 2007).

Critical ethnography evolved from conventional ethnography as a distinct methodology for understanding human behaviour within a lived domain (Thomas, 1993). While a conventional ethnographer's goal is to describe and provide insight into participants' realities, a critical ethnographer begins their research "with a political purpose" (Thomas, 1993, p.4) and often has an ethical responsibility to improve human wellbeing and a sense of compassion for human suffering (Madison, 2005). The role of the critical ethnographer is to move beyond descriptive analysis to uncovering the taken for granted assumptions, forces of power, and control that constrain people's lives with the goal of changing them from "what it is to what it could be" (Madison, 2005, p.5). Because morality is shaped and influenced by norms and understandings that governs a social world, a critical methodology provides a medium of analysis that enables "participants in those institutions or observers of them, to track implicit commitments and assumptions and to reveal fault lines within and between commitments and assumptions" (Walker, 2007, p.ix). These assumptions often appear obscure and mundane in people's accounts of morality as well as their reflections of it when viewed through abstract principles. Using ethnography with feminist ethics and African philosophical lenses enabled me to make

transparent the implicit and explicit aspects of moral life of the nurses and midwives, the moral habitability of the obstetric settings, and the moral understandings that sustain practices of responsibility.

Ethnographers enter the cultural world of participants as they attempt to describe and understand the experiences of those living within it. The cultural world is made up of emic and etic perspectives (Naaeke, Grabowski, Linton, & Radford, 2012). The emic or the insider perspective is the reflection of the shared language, beliefs, and experiences of the group being studied (Naaeke et al., 2012). The ethnographer gains access to the insider perspective through observation and interviewing members of a social group. The etic perspective or the outsider perspective is the researcher's interpretation of the observed and unspoken behaviors and actions of the group being studied (Naaeke et al., 2012). The ethnographic researcher attempts to understand reality as he or she makes sense of the insider world. This mode of inquiry provides a researcher with the intimate knowledge of participants' social world and, therefore, serves as a powerful tool for reflexive analysis of moral life from within and outside moral-social orders (Walker, 2007).

Ethnography has been used in nursing to explore issues relating to clinical practice, hospitalization, nurse-patient relationships, and the ethical and social organization of nursing work (Chambliss, 1997; Coughlin, 2013). More specifically, Chambliss (1997) used ethnography to explore the social organization of hospitals and the ethical problems within them. He discovered that nurses were embedded in a complex world of the health care system that is mutually defined by them and the institutions in which they work. Critical moral ethnography was chosen as an appropriate methodology for understanding the complexity of obstetric work environments and its influence on the moral agency of nurses and midwives.

Research setting

This study was undertaken in the obstetric units of three tertiary level health facilities located in the Northern region of Ghana. These facilities are major referral points serving the Northern region and its neighboring regions of Upper West, Upper East, Volta, and Bono Ahafo region and for a significant proportion of patients from Togo and Burkina Faso.

The combined bed capacity of the three hospitals was difficult to approximate considering that most of the patients were admitted on floor mattresses while others slept on plastics sheets. For example, in one of the hospitals, the bed capacity is estimated at 800 even though the currently available beds are 668. As tertiary level facilities, these hospitals provide 24-hours and seven days a week obstetric services and receive referral cases from peripheral health facilities within the region and beyond. The obstetric unit is divided into subunits comprising of lying-in and labour, maternity (pre and postnatal), obstetric theatre, and recovery wards. The obstetric department provides services ranging from simple to highly complex obstetric care relating to medical conditions in pregnancy, deliveries, newborn care and resuscitation, postpartum care, and caesarean sections.

Each hospital is headed by a medical director and supported by administrative officers and a director of nursing service (DNS). Together these people form the core management of the hospitals who make decisions and have oversight responsibility for the procurement of medical supplies, logistics, and staff distribution. The obstetric department is headed by a senior medical officer and senior nurse-midwife in-charge who have oversight responsibility for managing the department. Each of the subunits is headed by a charge nurse or midwife who plays a supervisory role and oversees the everyday activities on the wards such as scheduling of staff for the different shift, making requisition for supplies, allocating supplies needed for each shift

work, reporting problems on the ward to management, and sometimes assuming responsibility for caring when there are staffing shortages.

Average daily admissions for the three obstetric departments in 24- hours range between 60-80 and total number of deliveries were between 25 to 40 per day. Besides the caesarean sections and clerking of patients, most of the caring activities within the obstetric department were undertaken by the nurses and midwives. Daily ward rounds and review of patients were done by doctors with minimal involvement of nurses and midwives. The nurses and midwives maintained a 24-hour presence through an eight-hour shift system comprising morning, afternoon, and night shifts. Although these shifts were supposed to last for eight hours, it was observed during the fieldwork that the nurses and midwives worked an average of two to three hours extra beyond their shift. Handovers between incoming and outgoing nurses were often neglected on busy days as incoming nurses and midwives found themselves starting to work right away upon entering the ward. Day time shifts had on average of four to five nurses and midwives while the night shift was assigned two staff despite the number of patients and activities being the same. This arrangement resulted in an excessive workload for the night staff as was seen in the five-nights I observed. Due to the high volume of patients and inadequate staffing, the workload per nurse/midwife, and their ratio to the patients was difficult to estimate. During each shift, the charge nurse or midwife assigned nurses and midwives to different care activities rather than to a specific group of patients. These included but were not limited to admitting and discharging, serving of medications, caring for newborns, conducting deliveries, dressing of wounds, swabbing vulvas, monitoring of vital signs, and preparing of patients for caesarean section. Although this was an attempt to ensure distribution of responsibility was even and to limit the burden of workload on others, these arrangements were mostly not sustained due

to the high influx of admissions and referrals of emergency cases compelling the nurses and midwives to abandon their original schedules. At each shift, one or two ward assistants were serving as support staff who ran errands for the nurses and midwives. On busy days these ward assistants were assigned some of the basic activities of bathing babies, receiving babies after delivery, and providing discharge teaching.

Gaining Access

Gaining access into the field can be considerably challenging depending on the phenomenon being investigated (Hammersley & Atkinson, 2007; Hoyland, Hollund, & Olsen, 2015). However, being a nurse educator who collaborated with these institutions before, I was able to negotiate access through each of the Directors of Nursing Service (DNS) at the hospitals who were nurse-midwives.

As an initial step, I presented the introduction letter and the IRB approvals to the DNSs to introduce myself and communicate the purpose of the research. I informed them about the nature of the study, duration, methods of data collection, and the type of information to be collected from the participants. All the DNSs expressed interest in the research project and looked forward to the outcome since according to them this was the first time to have a researcher exploring the nature of the work environment with an ethics lens. They indicated that the findings could help them to understand how best to support nurses and midwives to promote a culture of ethical practice. I was introduced to the medical director in charge of each hospital where I further communicated the purpose and nature of my research project. I made it clear that I was seeking information relating to the nature of nursing and midwifery practice and no information about patients will be collected. I was provided with letters of authorization by each medical director to commence the research which were subject to renewal after six months.

To observe all institutional protocols, I reported to the DDNSs in charge of the obstetric department where I submitted the letter of authorization and informed them about the purpose of the study and my intent to recruit nurses and midwives from the obstetric department into my study. I informed them in detail regarding the recruitment process, hours of observation to be made, the interview of eligible nurses and midwives, and a review of documentary materials. They gave their endorsement and introduced me to the senior nurse-midwife in-charge of each subunit within the obstetric department where I provided details of my research, eligibility criteria, and recruitment process. I was given orientation around the unit and the activities that take place on the wards after which I requested permission to place the research advertisement flyer on the unit notice board.

Although gaining access to the setting did not prove difficult, the process was continuously negotiated throughout the fieldwork. This was achieved through biweekly visits to the DNS to discuss my progress. Simmons (2007) argues that continuously negotiating access during fieldwork enables the researcher to maintain trust, minimize suspicion, and guarantee continuous access without hindrance.

Recruitment Process and Participants

Registered nurses and midwives were purposively recruited from different subunits of the obstetric department, comprising of lying in and labour, maternity (prenatal and postnatal), maternal ICU, and recovery wards to participate in this study. Recruiting participants from the different wards helped to obtain diverse and reflexive accounts of the everyday encounters of the nurses and midwives as it relates to the moral habitability of the obstetric settings and its influence on their moral agency. Due to the busy and fast-paced schedules in the ward, organizing a formal meeting to speak to all the nurses and midwives was impossible. Therefore,

during each shift, I briefly met with the nurses and midwives and introduced myself and the purpose of my research to every potential participant individually. These familiarization visits lasted for two weeks as I needed to ensure I reached out to all potential participants and to also understand the dynamics of the working relationships among the staff. In subsequent visits, I approached each nurse or midwife and invited them to participate in the study. Many expressed their willingness to participate. I was amazed when one nurse stated that *"telling these stories was long overdue"* (Field notes, 7). Given my familiarity with the punitive nature of the settings, it was expected that participants might not have felt safe to talk about the nature of their work environment. For those who offered to participate, I scheduled a date and time at their convenience for an interview. Prior to the interview, I reviewed the nature of the research to further clarify issues with the participants after which written informed consent was obtained. Only one participant declined to give written consent and therefore, verbal consent was obtained. According to her that '*there is nothing to hide. I am going to tell you the truth about the kind of environment we work in. Everybody here knows' (Field notes 25).* Walker (2007) argues that "the power of the truth that is told, and also the epistemic and emotional leverage of its telling" (p.264) confers credibility to the teller and those of others. A diverse range of participants were recruited to provide a rich and contextual account of the nature of the work environment. These included frontline staff and ward in-charges who were actively engaged in the everyday care activities and management of the wards. The inclusion of the ward in-charges was influenced by the preliminary interviews and therefore as a way of gaining a deeper understanding of the emerging issues, I decided to recruit four wards in-charges.

A total of 30 nurses and midwives who met the inclusion criteria of having worked for six months or more in the obstetric department were recruited and interviewed. Two participants

called for a follow-up interview after their initial interview to provide additional information after reflecting on their initial interview. Qualitative designs are not universal and there is no one method of ensuring data collection has reached saturation, however, researchers have agreed on commonly shared principles that is, when no new data, no new themes, or no new codes are emerging (Fusch & Ness, 2015; Guest, Bunce, & Johnson, 2006). Therefore, based on these common principles and with 30 interviews, two voluntary follow up interviews, and 80 hours of observation, 88 pages of nursing and 80 pages of midwifery curriculum, professional code of ethics, five media publications, and ward procedures and protocols, data collection was terminated. Appendix One provides detailed biographic data of the participants. Five participants did not indicate their age for privacy purposes. The mean age for participants who provided their age was 33.7 years with the youngest being 24 years and the oldest being 56 years. A total of 22 of the participants had training in midwifery and the remaining were generalist nurses. Sixteen had a Bachelor of Science degree midwifery or nursing and only one had a postgraduate degree. Years of practice were between six months to 35 years while years of practice in their current ward were between six months and six years.

Data Collection Procedures

The process of how data is collected and what type of data a researcher collects has the potential to shape and influence any critical inquiry (Thomas, 1993). Data were collected through observation, interviews, and documentary materials. Using these different methods provided an opportunity to make complete sense of the data from multiple perspectives, thereby enhancing the validity of the study (Denzin, 1989; Silverman, 2013; Morse, 2015).

Non-participant Observation

Due to the ethical requirements of respecting the privacy and confidentiality of others and the complexity of obtaining informed consent in a health care setting, the observation part of this study was limited to the spatial arrangement, everyday activity, and the organizational structure using an adapted version of Spradley's (1980) observation guide (Appendix Two). A total of 80 hours of observation was made with each observation lasting between two to three hours. The observations were structured in a way to minimize the distraction of nursing and midwifery care and activities in the ward. I stayed away from the patient bedside when the nurses were undertaking procedures or interacting with a patient. During the observation session, no personal or sensitive information and interactions were recorded. As a practicing nurse, there were times I assisted the nurses and midwives in cleaning and setting up instruments for sterilization, preparing cotton balls, and assisting midwives to get requisitions. Participating in some of these daily routines helped to facilitate good relationships and rapport with participants. While recognizing the methodological implications of taking part in any ward activity, I maintained a reflexive stance documenting my emotions, thoughts, and any other situations that I encountered as part of my field notes.

During these observations, I began reflecting on what questions to ask the nurses and midwives who were willing to participate. For example, during the fieldwork one of the wards was overflowing with patients to the extent that some were seen lying at the entrance of the ward while others were waiting to be admitted. I could not withstand the sight of what I was seeing, and I wrote in my field notes *what does it mean to work as a nurse or midwife under these conditions?* After each observation, I immediately moved to the staff lounge to document what I was seeing and observing in my field notes. I also used these times to extend an invitation to

those present to participate in the study later. Due to the busy nature of the wards, the nurses and midwives appear to be exhausted, and therefore scheduling an interview immediately after an observation was impossible.

Interviews

According to Walker (2007), people make sense of their moral life through stories. A semi-structured interview was conducted to generate narrative accounts of participants' everyday experiences and interactions. This approach to interview began as a conversation in which participants were invited to share their stories and the researcher probed purposively for details and clarification using a semi-structured interview guide (Appendix Three), however, there were instances when the interests and responses of participants directed the interview and other times the interviews were guided by certain observations made. For example, I observed in one of the wards that women were being examined in plain view without privacy and so I followed up with questions during the interview to understand why the practice was common and pervasive. Before the start of the interview, the informed consent sheet was given to each participant to read and questions were clarified after which the biographic information sheet (Appendix Four) was given to them to complete. After all questions regarding the consent were clarified, the nurse or midwife was invited to share his or her story in a non-coercive, respectful, and sensitive manner. Further probing questions were asked to yield additional data or clarify statements made by participants.

The use of metaphors and integration of the local dialect is an integral part of the everyday conversation of the Ghanaian people when narrating an event or sharing an experience. For example, in one of the interviews, a participant characterized the uncontrolled movement of family members into the ward as a 'farm'. Because metaphors are usually context-bound and

culturally specific, these metaphors were clarified during or after the interview to avoid misinterpretation.

At the end of each interview, I provided an opportunity for each participant to discuss issues concerning their practice which we might have not captured or what they perceived to be important about the work environment that they needed to share. These questions were treasure troves that provided very valuable insight into the data that I had not thought about. Each participant's interview was audiotaped, and notes were written about the interview process and reflected upon before the next interview. This process of listening to the previous interviews provided insight and generated further questions for subsequent interviews. Besides listening to what each participant said, I paid close attention to the tone of speech, facial expressions, silences, and emotional outbursts as well as any contradictions and documented them as field notes (Oltmann, 2016; Ryan, Coughlan, & Cronin, 2009). All the interviews were conducted in English and lasted between 45 minutes to three hours with nearly half of the interviews lasting two hours. Two participants upon reflecting on their first interview voluntarily called me for a second interview to provide further insight. All interviews were digitally taped, and transcription was solely done by me. The transcription was quite challenging due to the longer duration of most of the interviews coupled with the fact that some participants expressed some ideas in the local language which had to be translated.

Documentary material

Documents provide relevant information about a culture or an organization that forms part of the social activities within these settings (Coffey & Atkinson 2004). The nursing and midwifery curriculum, ward procedure and protocols, media publications, and professional code of ethics were obtained and used in the analysis and discussion sections. These documents

provided a broader understanding of some contextual factors framing the understanding of the midwives and nurses.

Data Analysis

A thematic narrative analysis was employed for data analysis and interpretation. Thematic narrative analysis focuses more on the content of what is said rather than the structure of the story (Reissman, 2008). People organize and make sense of their lives through narratives and narrative analysis gives the researcher access into the interpretive world of the tellers (Polkinghorn 1998; Cortazzi, 2001). Because the process of telling is interactive and co-created by the teller and the researcher, using a narrative approach to analysis provides a reflexive medium for understanding the meaning of ideas in relation to events, people, and context of constructing the narratives (Cortazzi, 2001).

Walker (2007) argues that people construct, describe, and make meaning of their moral lives, identities, relationships, and institutional context and those of others narratively. These narratives may portray or consist of multiple fragments of actions and events connecting individual stories to a shared or larger social organization. The researcher carefully and systematically organizes these multiple and fragmented stories into a meaningful and coherent interpretation highlighting both the content and context of what is said. Cortazzi (2001) argues that this kind of analysis serves as a powerful interpretive tool that enables a researcher to explicate these meanings, give voice to the tellers, highlight the human attributes of personal or professional lives, and tell a story about an inquiry.

A good narrative analysis views the data with faith and suspicion to be able to explicate these meanings. Josselson (2004) suggested that the need for an interpretation of faith arises when the researcher becomes genuinely engaged with the participants and seek to represent the

“subjective world of the participants and/or the social and historical world they feel themselves to be living in “ (p.5) through the process of empathic understanding. Interpretation of suspicion enables a researcher to uncover hidden meanings that may have been masked and overlooked during the interpretation of faith (Josselson, 2004). Approaching narrative analysis with faith and suspicion creates an opportunity for the researcher to reveal the realities of participants and provide an in-depth and broader understanding of both the individual and shared experiences of people.

Reissman (2008) emphasizes the role of theory in facilitating the analysis and interpretation of the data. She argues that the use of theory allows the researcher to think beyond the face value of what is told towards a broader understanding. This analysis was guided by the theoretical and philosophical work of Walker and Gyekye discussed above. A critical interpretive stance was maintained during the data analysis by paying close attention to power relations, oppressive structures, and shared meaning. Kim (2016) argues that although narrative analysis seeks to understand the meaning of people’s experience, it is imperative to take note of power and other oppressive forces shaping participants’ narratives when the research is framed with a critical perspective. This understanding is consistent with feminist ethics research in which attention is given to power, oppression, and voice (Jaggar, 2000). The notion of voice arises out of the need to share the experiences of others whose voices are marginalized especially in professional and institutional spaces by uncovering the “insider's view of what a particular job is ‘really’ like” (Cortazzi, 2001, p.6) and highlighting the “epiphanic moments, crises, or significant incidents in people's lives, relationships or careers” (Cortazzi, 2001, p.22).

An iterative process was incorporated throughout the analysis to allow for the discovery of common patterns and themes within and across the multiple sources of data whilst keeping in

mind the research questions and the context of the story, the events and complexities within the stories, and voices of the participants (Cortazzi, 2001; Reissman, 2008). Josselson (2006) argues that narrative analysis is "always interpretive at every stage" (p.4) thereby allowing the researcher's analytic logic to emerge as well as reveal the human and moral qualities embedded within the stories (Cortazzi, 2001; Sandeloski, 1991). The process of analysis was based on the synthesis of qualitative and thematic narrative analysis literature whilst keeping in mind the research questions and interpretive nature of the qualitative inquiry. Dedoose qualitative software was used to manage the data.

Data Analysis and Interpretation

Data analysis begins simultaneously during fieldwork and continues throughout the entire research project "as ideas emerging from data are reconfirmed in new data; this gives rise to new ideas that, in turn, must be verified in data already collected" (Morse, Barrett, Mayan, Oslon & Spier, 2002, p.13). The initial phase of this analysis began with a careful review of the audiotapes and field notes at the end of each interview. Careful listening to the audiotapes provided preliminary analytic thoughts and insights into the data and led to the refinement of the interview questions and subsequent interviews. Morse et al. (2002) describes this process as key in helping the researcher to gain deeper insight into the experiences or the situation of the participants. Once the transcription of the interviews was completed, I immersed myself in the data through reading and rereading of participants' stories in their entirety including the field notes to identify the kinds of narratives that permeated through the stories. The transcripts were read thematically and holistically as well as line by line while paying close attention to the content of what was said (Reissman, 2008). Key expressions and statements that depicted the narrative of value, identity, relationship, responsibilities, and institutional context, as well as

significant happenings, events, and actions within the story were highlighted. In a narrative analysis, the coding strategy is focused on the narratives and grouping them into patterns instead of the line by line coding done in other forms of qualitative analysis (Schutt, 2004). Documentary materials obtained during the field work were also read and key content relating to an observed phenomenon within the narrative of the participants was highlighted. This process allowed for the development of conceptual categories and thematic threads within and across individual narratives rather than assigning codes. Analytic memos and questions were written to capture analytic insights and to further interrogate the data.

The second phase of analysis was focused on an in-depth analysis taking into consideration the research questions and the theoretical and philosophical works of Walker and Gyekye. In this stage of the analysis, the interplay of inductive and deductive approaches to analysis were used to illuminate meaning between the experiences of the participants, and the broader theoretical interpretations. This process helps to ensure the researcher's preconceived ideas and thoughts are not imposed onto the analytic process as the moving back and forth allows for ideas to be compared, revised, and new explanations generated (Glynos & Howath, 2019; Emden, 1998). This type of analytic reasoning enabled me to pay attention to the relationship between individual stories and the institutional and broader social context that shaped the narratives and to elucidate a rich and contextual understanding of the data (Emden, 1998). Recurring actions and responses were grouped and assigned meaning based on the theoretical concepts underpinning this research.

The next phase of the analysis involved the synthesis of all the concepts and meanings from the second phase of the analysis to determine the emergence of patterns. Morse (1994) argues that synthesis allows the researcher to move away from the individual stories to

generating and extracting common patterns within the stories, distinguishing the significant from the insignificant, revising initial ideas and possibilities within the stories. Possible explanations were made based on the individual and shared accounts and the theoretical and philosophical works of Walker and Gyekye. To ensure the participants' stories and the context under which those stories were told were not lost (Reisssman, 2008), the first and second phases of the analysis were revised using the hermeneutic cycle of moving between the individual story, the data set, and the overarching research question (Thorne, 2016). Because qualitative analysis is not fixed and linear, moving between the analytic process enables the researcher to verify, revise, refine, and advance a deeper understanding of the analysis and interpretation (Thorne, 2016).

The final phase of the analytic process was the theme generation. Consideration was given to the theoretical concepts and relationship among emerging themes within the data and labeling of the themes. To gain insight between the emerging themes, the analytic process of phases one, two, and three were revisited to verify and confirm the emerging thematic ideas. Quotes and expressions that were noted and highlighted during the first and second phases of the analysis were used to support the themes and subthemes and to provide thick descriptions of the moral habitability of the work environment of obstetric settings and its influence on the moral agency of nurses and midwives (Thorne, 2016). The information that was highlighted in the documents was integrated in the analysis and discussion chapters.

Rigour

The strategies for evaluating the rigour of qualitative research have over the years depended on Lincoln and Guba's (1995) four criteria including credibility, transferability, dependability, and confirmability. While these have been the gold standard for assessing the rigour of qualitative research, they have also been subjected to critique by many qualitative

scholars. Sandeloski (1993) argues that focusing on a common, rigid, and implied criteria takes away the “artfulness, versatility, sensitivity to meaning and context” (p.1) that are distinctive of the different qualitative designs. Many have suggested that rather than having one ‘criteria fit all’ researchers should rather focus on epistemological and methodological congruence associated with each qualitative design as a means of establishing rigour (Morse, 2015; Thorne, 2016). Morse (2015) further suggested that researchers should avoid the indiscriminate application of strategies that may not contribute to the rigour of qualitative research. With this understanding, the following strategies synthesized from qualitative scholars were applied to enhance rigour: methodological coherence, prolonged engagement, triangulation, participant validation, investigator responsiveness, and audit trail (Morse, 2002; 2015; Thorne, 2016).

Methodological coherence requires the researcher to demonstrate congruence between the research questions and other components of the research process (Morse 2002). The conceptualization phase of this study was grounded in a comprehensive review of literature that led to the development of research questions which guided the choice of research design and methods. The theoretical and philosophical works guiding this study are rooted in the understanding that morality socially embedded in the everyday life of people and is therefore consistent with the interpretive assumptions underpinning qualitative inquiry. Congruence between the theory, design, and methods were demonstrated throughout the process and evident in the write up to ensure fitness and coherence. Data were collected through observation, interviews, and documentary material all of which led to generating data that were congruent with the analytic goals of the study (Morse, 2015).

Prolonged engagement is achieved through persistent observation which has been reported to increase the validity of qualitative research (Lincoln & Guba, 1989). The assumption

behind this strategy is that spending more time in the field enables the researcher to build intimacy and trust with the participants which allows for rich data to be generated to reflect the realities of participants (Morse, 2015). The process of data collection lasted for five months which provided ample time to 'get in' and engage with participants within the context of their practice. As noted by Krefting (1991), as rapport between the participants and the researcher increases, they are likely to provide more detailed and sensitive information than they do at the onset of the study. Morse (2015) further stated that generating rich and thick descriptions require variability and appropriateness of the sample size. This study was undertaken in three health care facilities and 30 participants were recruited from multiple units within the obstetric departments all of which contributed to variation. Further, as the interviews were analyzed, the sampling strategy was revised to include participants with particular interests to ensure in-depth understanding and completeness of the data generated. For example, at the outset of the research, charge nurses and midwives were excluded, but the analysis of the initial interviews led to their recruitment to gain insight into the emerging conceptual patterns within the data.

Triangulation of data sources enhances the completeness of the data and broadens the researcher's understanding of the phenomenon being investigated (Morse, 2015; Thorne, 2016). As indicated above, the data was collected in three health care facilities. Data was generated through observation, interviews, and documentary material to ensure comprehensiveness. The observation times were varied across different shifts to expand my understanding of the nature of the work environment during these different times as well helped in reshaping subsequent interviews.

Verifying information provided by participants is another strategy for enhancing rigour in qualitative research (Morse, 2002). In this study, verification of participants' stories was done

iteratively and concurrently during the data collection and analysis through repeating of questions, probing for more details, and clarifying statements made to minimize distortion or misrepresentation.

Morse (2002) also emphasizes the responsiveness of the researcher as an essential component of ensuring the process of analysis is kept in check. Responsiveness enhances the ability of the researcher to remain sensitive, creative, and open to other interpretations and possibilities and move beyond the initial ideas or assumptions (Morse, 2002). With this understanding and open-mindedness, the process of analysis was done iteratively with constant moving back and forth to compare the fitness of the emerging conceptual ideas and the data. Being responsive enables a researcher to seek alternative perspectives from the research team about the data and findings (Morse, 2015). Through frequent supervisory committee meetings, I was challenged to reflect on my deeply held assumptions and to think alternatively by revisiting the analytic conceptualization and interpretation.

Keeping an audit trail of all assumptions and decisions taken during the process of inquiry further enhances the validity of qualitative research. Thorne (2016) suggested keeping a reflexive account of the analytic reasoning and using the thick description from the data to support the interpretation. In this study, detailed field notes were generated during the fieldwork and used to support the analysis and interpretation of the data. Analytic memos were also written during analysis to capture the process of analytic reasoning. Reflective discussion of the data analytic strategies and interpretations with the supervisory committee as well as their thoughts were documented and used to refine the analysis. The interpretation and report were illustrated with a thick description of the participants' realities and context.

Reflexivity and Positionality

Reflexivity is an ongoing process that spans the entire research process (Doyle, 2013). This process allows researchers to question and to account for how their values influence the process of inquiry, thereby making the researcher methodologically self-conscious (Gough, 2003). Reflexivity is important for researchers who undertake research in a familiar setting, where their preconceived knowledge, personal, and professional identities may threaten the research process. Ethnographers need to be reflexive about their position in the field as insiders or outsiders depending on how they are perceived by participants in the field. The issue of the insider/outsider perspective is much more fluid and difficult terrain to navigate due to the tension arising especially when the researcher holds the dual role of researcher and practitioner (Allen, 2004; Corbin Dwyer & Buckle, 2009). For example, nurse researchers undertaking research within their professional circles are faced with greater methodological challenges because of their embodied insider knowledge whilst maintaining a critical outsider perspective.

Considering my previous working relationship with these institutions as a nurse and a nurse educator, I have been embedded with some of the participants and the institutional practices. Because the researcher comes into the research process with different identities and multiple sets of statuses, these tend to influence how they are situated in the research process (Merton, 1972). Given my previous role as a nurse educator, I was engaged in activism during my teaching sessions as a means of empowering nurses to speak out about unfair and unjust arrangements within the healthcare institutions. It was obvious that this previous role enabled trust to be fostered and created the space for the participants to share their experiences. However, I struggled within myself as I was perceived by participants as the one to ‘save’ the situation in which they found themselves. As one participant stated during an informal conversation “*I am*

happy you have come to ask us questions about this place we know as for you, you will speak for us". This question made me uncomfortable as I struggled to define my role as a researcher rather than being the problem solver. As I reflected on these tensions, I was confronted with another question of what if "I don't speak for those less privileged than myself, am I abandoning my political responsibility to speak out against oppression, a responsibility incurred by the very fact of my privilege?" (Alcoff, 1991, p.8). This question prompted me to be conscious in navigating the tension and finding ways to represent the voices and realities of the participants in the write-up. Further, I intend to present the findings to stakeholders to spur attention to the situation.

Feminist researchers are sensitive to the power dynamics in the researcher-participant relationship and how this shapes knowledge production (Merriam et al., 2001). I was inherently mindful of the power dynamic between myself and the participants considering how I was perceived by them. I made it clear to the participants at the outset of the study that my presence was not to evaluate their practice but to gain an understanding of what it means to practice in the obstetric setting from their perspective. Walker (2007) states that "all would-be knowers" (p.64) are found in different epistemic communities and knowledge production is achieved through community resources and practices. Given this understanding, the research was co-created with the participants' stories as the anchor. Recognizing this shared process of knowledge production "forces us to acknowledge our own power, privilege, and biases just as we are denouncing the power structures that surround our subjects' (Madison, 2005, p. 8).

Ethical Considerations

Ethics approval

Being an internationally based research project, ethical approval was obtained from the University of Toronto Health Sciences Research Ethics (RIS PROTOCOL NO. 35502) and the

Navrongo Health Research Center Ethics boards (NHRCIRB296).

Confidentiality

Researchers are obligated to protect the confidentiality of participants engaged in their research (Kaiser, 2009). There was no personal or identifiable information collected. Audiotapes and the transcripts were de-identified, encrypted, and protected with a password. Once transcription was completed, the audio files were destroyed. Upon return to Canada, the data was uploaded onto a secure server at the Faculty of Nursing, University of Toronto. Hard copies of all written notes, memos, consent forms, and other research related materials were de-identified and kept in a secured cabinet located at the Faculty of Nursing, University of Toronto. Since this is a doctoral dissertation, the transcripts and other research materials were accessible to my supervisory committee and clearly outlined in the consent and verbally communicated to each participant at the beginning of each interview.

In nursing and other health professional research, those who disclose information about the problems in their institution are often sanctioned by management (Gallagher, 2010). Pseudonyms were generated and assigned to each transcript and excerpt and will be used for reference in future publications and dissemination of all findings. The pseudonyms were generated from everyday conversational words to ensure anonymity of the participants. These pseudonyms are gender neutral and do not represent any specific gender. For example, Mbo means well done and Afani means benefit. The names of the health care institutions and their specific locations were not identified to avoid linking excerpts to participants. Interviews were conducted at locations chosen by participants to further enhance privacy and confidentiality.

Informed Consent Process.

Informed consent is a prerequisite for any research involving humans. It is a means by which participants voluntarily agree to participate in research without any coercion or undue influence (Byrne, 2001; Mertens & Ginsberg, 2009). In this study, informed consent was an ongoing process and renegotiated throughout the research process. Prior to the start of the interview, each participant was given 10 minutes to review the consent information sheet detailing the purpose of the study, duration of the study, confidentiality, expectations of participants, and risk and benefits. Questions were clarified and those who agreed to participate signed the consent sheet. Although it was stated on the consent sheet, I verbally informed the participants their participation was voluntary and that they could refuse or withdraw their consent at any time during the study or before the expected completion date of the fieldwork. After the completion of the fieldwork, all codes linking to the participants' personal information were de-identified and assigned pseudonyms.

Compensation

Nurses and midwives who participated in this study were given CAD 7 (Ghc 20) after each interview to compensate for their time spent. However, four participants declined to accept the gift and stated that I deserve to be appreciated for providing them the opportunity to speak about their work environment.

Conflict of Interest

No conflict of interest was encountered in the course of this study.

Risks and Benefits

Researchers must strive to maximize the good of their research findings to humanity and minimize any risk or harm to individuals involved in their research (Mertens & Ginsberg, 2009).

Because the researcher and participants' power relations may be a potential source of harm in a research project, I became very conscious of the power dynamics and constantly reminded myself regarding the ownership of the data, analysis, interpretation, and representation. During the interviews, I collaborated with the participants by clarifying what was said. To give participants a sense of ownership, their voices were projected through excerpts and quotes from their stories.

The potential benefit of this research was that the participants saw it as an opening wedge to draw attention to the challenges they encountered in the health care work environment which they perceived will create an opportunity for redress. In addition, as they shared their stories, spaces were created for healing, self-reflection, self-critique, and self-discovery as they connected their personal experiences to the larger institutional spaces.

Chapter Four

Findings

This chapter presents the findings of this study. Three research questions guided this study. The first research question was to understand how the nurses and midwives perceived the moral habitability of the obstetric work environment, the second question was to understand how these environments influence the enactment of moral agency, and the third question was to understand what kinds of identities, values, and responsibility shape and influence the practice of nurses and midwives. Careful and critical analysis of participants narratives revealed five themes and their content areas. The themes identified are: holding onto the values, identities, and responsibilities of being a midwife/nurse, scarcity of resources as limiting capacity to meet caring responsibilities, gender and socio-economic inequities shaping the moral social context of practice, working with incoherent moral understandings and damaged identities in the context of inter- and intra-professional relationships, and surviving through adversity with renewed commitment and courage (Table: One).

Table One: Themes and subthemes

Themes	Subthemes
Holding onto the values, identities and responsibilities of being a midwife/nurse	Preserving moral integrity Holding on to moral commitments of one's calling Having a sense of moral fulfillment
Scarcity of resources as limiting capacity to meet caring responsibilities	National and institutional policies and practices shaping the social moral world of nurses and midwives The lack of basic supplies, equipment, and space as limiting capacity Understaffing as limiting capacity and creating distress
Gender and socio-economic inequities shaping the moral social context of practice	Caring at the intersection of gender and poverty Negotiating conflict and practice with women and their families Gender-related workplace aggression and violence.

Working with incoherent moral understandings and damaged identities in the context of inter- and intra-professional relationships	Hierarchical and oppressive inter and intra-professional relationships as constraining moral agency Culture of blame Negotiating Practice and Responding to Conflicts
Surviving through adversity with renewed commitment and courage	Suffering and enduring the moral and emotional cost Fostering moral resilience Demonstrating moral resistance and influence

In the subsequent section of this chapter, a detailed description of the findings of each theme and subtheme will be discussed and illustrated with quotes from the participants. This approach allows for detail and coherent presentation of the findings while creating a nexus between the research questions that guided this study, theoretical and philosophical underpinnings, and institutional and cultural context that shaped participants' understandings and narratives.

Theme One: Holding onto the Values, Identities, and Responsibilities of Being a Midwife/Nurse

This theme represents the moral identity and values influencing the enactment of moral agency and is important in determining the moral habitability of the work environment. Moral identity is central in understanding how the nurses and midwives made sense of their moral responsibilities and embody values that define them and what they stand for (Walker, 2007). The following subthemes and their characteristics will be discussed: Preserving moral integrity, Holding on to moral commitments of one's calling, and Having a sense of moral fulfillment.

Preserving moral integrity

Integrity is central in matters of moral deliberations and is imperative for understanding who we are, our moral point of view, and what values are at stake (Walker, 2007). Integrity is a means through which people guide their everyday actions and choices, and the compass for

judging the consequences of those choices. Participants believed that being a nurse/midwife was about standing up for what they believed was right in the face of overwhelming institutional pressures. According to Walker (2007) "doing what you, particularly, believe is right, doing what's particularly and morally acceptably right for you, doing what is it takes to keep yourself or your life in all one piece" (p.115) is an essential component of a person's integrity. By standing up for what they believed was morally right, the participants affirmed who they were and what they valued. Tena, who worked in the prenatal ward, illustrated how she consistently strived to stick to her values despite the institutional pressure to do otherwise:

> Sometimes as nurses, you want to do the right thing because of the people you care for. You know if you don't do certain things right, they would be affected...so even if you are tired or you are not in the mood because of the patients when you look at the patient even if you are alone you would want to do things right so that the patient would get quality care. So, the professional aspect you will want to do the right thing. (Tena)

The desire to do the 'right thing' was a dominant narrative across all the interviews. Participants understood that there was a temptation to act contrary to their deeply held values and, therefore, they needed to stand for what they believed was right, in essence, affirming their moral reliability by demonstrating dependability and responsiveness in their actions and decisions under considerable social pressure in matters of their own good and those of others (Walker, 2007). People act with integrity based on a particular standpoint, expectation, and consequences in situations pertaining to their moral commitment (Walker, 2007). By acting and standing by these beliefs in the face of institutional constraints, participants felt they were honouring their commitment to women. Standing by one's moral commitments and finding ways to honour them is imperative for maintaining a high sense of integrity (Walker, 1993). Tena recognized acting contrary to her deeply held values had implications for women's well-being and her professional

well-being. In other words, endeavouring to do the right thing was crucial for maintaining professional integrity and accountability.

Moral accountability is fundamentally connected to a person's integrity and is based on the assumption that one is morally accountable for his or her actions. Moral accountability enables people to think ahead and backward when exploring the choices and consequences of their present actions (Walker, 2007). In professional nursing terms, moral accountability is about being answerable to one's actions to patients, professional regulatory bodies, legal institutions, and for many others accountability to a religious order. The awareness that their decisions and actions were accountable was reflected in Didi's excerpt:

> I know what is right, so I want the right thing to be done and then as we said ethics and now people know my right. Clients they know their right so if you play with the client and you don't do the right thing, she can sue you and you will be in trouble. So, all these things at the back of my mind I try to do to perfection… and if I put somebody's life into jeopardy the person can actually sue, and I will lose my license. (Didi)

Didi recognized patients are becoming enlightened about their rights as patients which instilled in her a sense of awareness to ensure her actions did not endanger the lives of patients. There was a recognition that failing to act ethically had both professional and legal implications. Professional accountability entails conditions for punishment when there are violations, and this serves as a driving force for acting and adhering to values defined by the profession. In keeping with the standard of accountability, people can sustain their values and preserve their integrity. Preservation of integrity is connected to how people try "to honor commitments or act creditably in a situation compromised by someone else's bad behavior, recklessness, or ineptitude" (Walker, 2007, p. 124). Napo said:

> For me, I have always not wanted to go with a record that is not good. So, I try to work hard every day. (Napo)

Walker (2007) argues that integrity might be fractured when people are confronted with institutional pressures making the preservation of integrity imperative for those whose moral life is defined by it. Actions or decisions that resulted in unfavourable outcomes were perceived to be a threat to participants' integrity and so they acted in ways that promoted positive outcomes as they attempted to preserve their sense of wholeness. This view of integrity is perceived to be a "self-directed and self-protective virtue" (p.122) that enables a person to aspire to actions that preserve their moral integrity (Walker, 2007). To fail to act in accordance with one's moral integrity would likely set their conscience into motion as reflected in Deli's excerpt:

> My own conscience would not set me free if something could have been done and may be out of ignorance or negligence, I wasn't able to perform that procedure and may be the patient happens to experience something. My own conscience wouldn't set me free. (Deli)

Walker (2007) argues that integrity equips people with the medium to judge the fitness of their actions and choices and the consequences those actions might incur. Because moral relationships are full of expectations and interpersonal acknowledgement, they do not only prompt us on how to live but signals us to recognize when we act inconsistently (Walker, 1998). Being able to recognize the consequences of their actions enabled them to preserve their integrity by holding onto their moral commitments and responsibilities.

Holding on to the moral commitments of one's calling

Values are important for "understanding those who bear them and what they are expected to do" (Lindemann, 2000, p.24). People express their values by showing a deep sense of moral commitment to things that are central, defining who they are as bearers of those values. The participants had a strong belief that being a midwife or nurse was a calling to care for women and, therefore, their actions and choices were in response to the fulfillment of this calling and how they responded to situations. This inner conviction inspired by religious and moral traits set

the foundation for understanding how they interpreted their moral responsibilities as expressed by one of the midwives when she said:

> My calling is to help the pregnant woman to go through labour and delivery successfully (Beni).

There was a strong conviction among participants that being a midwife or nurse was religiously and morally inspired. Within the African philosophy, all thoughts and actions including moral ones are religiously mediated (Gyekye, 1996). Religion provides the basis for guiding everyday thinking and moral action. Being a nurse or midwife was interpreted as a response to a moral and religious 'calling' to help and this was reflected in how many of them acted and made decisions. In the following excerpt, one participant highlighted how her religious teachings shaped her 'moral upbringing' which in turn influenced her actions as a nurse:

> We don't only concentrate on our work we have morals. Most of us are religious so sometimes the religion guides us to do certain things. The moral upbringing…because my religion tells me to help people and feel pity for people especially when they are in difficulty you need to help them, be kind to them so that guides me…because we are all humans there is this kind of human nature in us (Tena)

According to many of the participants, religion provides the basis for moral action. Religion plays an important role in the moral life of people by providing "sanctions for moral obligation and responsibility" (Gyekye, 1996, p.17) which provided a medium from which the participants judged their actions, thereby serving as a social-moral understanding for ethical action. As illustrated by Tena, being a nurse was more than about the physical aspects of care but was inspired by her religious values and upbringing to show compassion and respond to the needs of those suffering.

Compassion is a fundamental moral requirement associated with the concern for the suffering of others and having the desire and motivation to relieve their suffering. Expressing compassion through their actions and choices embodied the identity of who these participants

were as nurses and midwives. For many of the participants, staying true to this value meant they needed to go beyond the extraordinary to ensure women's needs were met. Such altruistic behaviours were pervasive across participants' narratives in instances when they were faced with the demand for care and patient poverty. This capacity to act compassionately is based on the ability to sense the needs of others. Human relations of interdependence are created by specific histories of relationships that generate varying degrees of obligation and responsibility (Walker, 2007). To be able to respond to the needs of others, one must be an object of moral concern to deserve attention. People respond to others when they become aware of the situations of others and are able to feel and understand what those experiences mean, determining the appropriateness of their response which is highlighted in Dami's excerpt:

> If it was my sister or my mother how would it be for you not to care for the fellow? Sometimes you feel it and assuming it was my sister or my mother who is in this situation why won't I also do feel that. So sometimes when you feel it that way it encourages when you have certain things you bring it to help the patients out. (Dami)

By envisioning the suffering of others, participants demonstrated empathy for women, which is reflective of the moral understandings inspired by the golden rule: "do unto others what you would deserve if you were what they are" (Walker, 2002, p.442). Throughout the training of nurses and midwives, values such as compassion and empathy are emphasized and there is an expectation that one's actions and decisions be guided by these values. Such professionally normative values, according to Walker (2007), shape the lives of people and how they act in varying situations. In an emotional state during one of the interviews, one nurse spoke of her personal experience and struggles of going through infertility, which influenced her decisions:

> I am a mother too. I mean you know my personal experience wanting a child and not getting and this is somebody who has carry her pregnancy for nine months and is expecting a baby and then this is happening I put myself in the person's shoe I mean how will I feel if I was in their shoes? I mean that is what I ask if I was the one. How will I handle this? (Mani)

Walker (2007) acknowledges that a "suffering shared [is] suffering respected" (p. 211). Being a nurse who experienced infertility significantly influenced how Mani interpreted and understood her values and moral responsibility to women. Our present selves are indebted to our past, our future selves are connected to our present decisions, and all of these, in one way or the other, are connected to a similar situation and inform what we owe others (Walker, 2007). Having such an understanding, according to Mani, enabled her to act in the best interest and protecting the lives of women and their unborn babies. Protecting the lives of others requires people to uphold the right of others to live, and by this, we invoke a shared norm of the moral conduct of what we and other parties do and deserve (Walker, 2007). This kind of moral understanding is situated and determines how we make sense of our practices of responsibility and relationship. Beni who works at the maternity ward described how her decisions were influenced by the acknowledgment of her dual moral responsibility of safeguarding the lives of women and their babies:

> I have decided to be a midwife and as a midwife I know my duty that I am holding two lives so I can't leave the work, but I have to work. (Beni)

In a situation where moral stakes are high, people tend to act in ways that reflect and embody what they care about. The statement 'I am holding two lives' was dominant in several of the narratives and had a great influence on the moral agency of participants. Walker (2007) noted that vulnerability is influenced by the history of relationships and connections we have with others that require us to assume the responsibility of "protecting those vulnerable to our actions and choices" (p.86). The value of safeguarding the lives of women and their unborn babies was central to the theme of being a midwife/nurse with the ultimate moral responsibility to promote safe birth and to prevent complications, morbidities, and mortalities. By acting to safeguard the

lives of women, one participant perceived it to be a pathway for guaranteeing an eternal reward. Napo said:

> I think that that is how you win favour because after life you want to buy your way into heaven in a way. So, you know this is what pleases your God, so you try to be Christian in how we handle our situations and that is what the Bible teaches us. So, most that is just because I am Christian and a Catholic at heart so mostly you just want to work. (Napo)

The desire for an eternal reward was commonly shared by more than half of the participants and significantly influenced their decisions and actions. The participants acted consistently according to their values based on the belief that "I am doing the good [thing] so that my way to the world of the spirits might not be blocked" Gyekye (1996, p.19). This deeper understanding and appreciation of moral and religious responsibility was further reflected in how they prioritized their values and actions. When people prioritize their values towards caring for special others and relieving suffering (Walker, 2007), they devote a significant part of their energy and passion toward accomplishing these values.

Passion exerts a powerful influence on the capacity of a person to enact moral agency. When the actions of participants were judged in the light of what is morally at stake, they were moved to make decisions and acted in ways that were consistent with their values. Mani illustrated this when she recounted that being physically present at work does not necessarily translate into caring practices without the passion to care:

> The first thing that should compel you to come to work is because you are supposed to and that is what will even move you from your house to the work environment, but then what makes you work to want to serve is the inner thing. As nurses some people are called nurses others were not called. So probably you are excited because you have been called into nursing….may be the others were given SMS [Short Text Messaging] [burst into laughter] or text messages but those that actually had the phone call come to work but some are not able to sustain the call [laughing]. (Mani)

Using the metaphor of a phone call and text message Mani provided an explanation of how the passion for care was connected to her calling. The passion to care or act depends on an agent's

ability and disposition to care or the awareness of a need (caring about), and then taking responsibility to care or attend to the need (taking care of) (Walker, 2007. Mani highlighted that although others may have received the calling, they were unable to follow through with their moral responsibilities because they did not have the 'inner thing' or the motivation to work. Passion for the work compelled the nurses and midwives to honour their standing moral commitment to women and have a sense of fulfillment.

Having a sense of moral fulfillment

Being a nurse/midwife was about doing the little things that transform women's lives in many ways and was about feeling fulfilled as a moral agent. A person's identity is shaped by a previous history of relationships and understandings that bind them to others (Walker, 2007). These kinds of relationship generate "special moral obligation" (Walker, 2007, p.86) that create certain expectations and impact a person's actions. In this way, moral lives make sense only when decisions, choices, and actions promote the good of others and foster mutual understanding. During one of the interviews, Afani provided insight into how her desire to make a difference shaped her everyday choices:

> I feel like it is something you have signed to do. It is a way of serving. It is something you have told yourself this is what I want to do…You know the most amazing feeling is to feel like you have saved a life, or someone is really content with what you have done**…** It makes it look like you are being appreciated for the little things you do for someone to get well or recover from whatever they are suffering…For somebody to feel like you are doing it well and show appreciation of what you do it makes it look beautiful and satisfying. (Afani)

Making a difference was also connected to narratives of patient recovery. The joy of knowing they had contributed to making a difference in the lives of women lies at the heart of the nursing and midwifery profession and contributed to a sense of fulfillment and satisfaction. People act toward "others as a way of honouring a history of a relationship" (Walker, 2007, p.118), which

shapes the understanding of their choices over time. Being able to care for the patient through to recovery was perceived to be integral to their professional fulfillment and mutual satisfaction.

Mutual responsiveness and recognition form the foundation for a moral life by determining the continuation of certain ways of life and how others perceive us in light of our accomplishments (Walker, 2007). Receiving appreciation from women was important to the overall satisfaction and eased participants' sense of responsibility. This was reflected in the Ziga excerpt:

> When you meet a patient, who appreciate things you see that you are gingered to even offer more. (Ziga)

Because moral agency is essentially relational and is connected to what we value and take responsibility for (Walker, 2007), it requires appropriate recognition and acknowledgment from the other. For many of the participants, women expressing appreciation was a reminder of who they were and the difference they were making in the lives of others. Walker (2007) reminds us that failure to recognize the pain, suffering, and struggles of others may diminish respect and compassion for the other. Feeling appreciated invoked a deep sense of their moral commitments and served as a form of motivation. People draw satisfaction and pride in meeting their responsibilities (Walker, 2007). In other words, sustaining a particular way of living is deeply rooted in the moral accomplishment of what a person care about. We make sense of our moral responsibilities through an "ongoing process of self-expression and mutual influence, through an appeal to mutually recognized values" (Walker, 2007, p.69). Such a moral understanding creates a reciprocal condition of mutual satisfaction between participants and women. Women's satisfaction was directly linked to participants' own sense of satisfaction and influenced how they responded to their needs.

Theme Two: Scarcity of Resources as Limiting Capacity to meet Caring Responsibilities

This theme represents the nature and influence of scarce resources on the capacity of nurses and midwives to meet their caring responsibilities. Walker underscores the importance of context in understanding how people make sense of their moral responsibilities (2003). Context, whether institutional or professional, influences the moral agency and moral lives of people. Working in the context of scarce resources shaped and influenced how participants made sense of their caring responsibilities. Although participants described values that were fundamental to their moral identity, they felt there were instances when these values were compromised. The moral identity of people may be "overridden or disconnected" (p.444) by forces that are beyond their control (Walker, 2002). One nurse highlighted how the institutional constraints altered the moral habitability of the work environment that hindered their ability to enact moral agency and stay true to their deeply held values:

> You need to work as a nurse alright. You are ready to render your service alright, but the things around are not there, the systems, the bureaucracies. They are actually putting so much barriers that you are not able to resolve them immediately and cross over. (Kahu)

The overwhelming majority of participants acknowledged that they were not being the kind of nurse or midwife they wanted to be due to the systemic constraints. Subthemes to be discussed includes the national and institutional policies and practices shaping the social moral world of nurses and midwives, the lack of basic supplies, equipment, and space as limiting capacity, and understaffing as limiting capacity and creating distress.

National and Institutional Policies and Practices as Shaping the Social Moral World of Nurses and Midwives

Practices of responsibilities are interconnected and reflected in the shared understanding of each other's responsibilities and expectations (Walker, 2007). Because practices of responsibility are interconnected, it is imperative to understand what national and institutional

policies shaped the participants' options and "how they have gotten to the situation that requires moral attention" (Walker, 2007, p.75). Such understanding, according to Walker, informs us about the situation and the practices of responsibility under moral consideration.

Participants described how inconsistent policy interpretations and implementation processes of the NHIS contributed to delayed reimbursement to the health care facilities that significantly impacted on the ability of the institutions to procure and supply basic resources needed for the delivery of care. As part of the strategies to improve access to skilled birth and reduce maternal morbidity and mortality, the government partnered with the National Health Insurance Scheme (NHIS) to roll out the free maternal health care program. Under the free maternal health scheme, women pay a subsidized premium to get registered to access services. The rhetoric of political campaigns of government officials has often misrepresented the maternal health care program as 'free' requiring no payment. In the following excerpt, Kasi recounted how politicians had contributed to creating false assumptions regarding access to health care services under the maternal health insurance scheme:

> The mentality is that everything is free...the politicians also have a role to play because it is they that disseminate those information to the people in their constituency that you are not supposed to pay for this or that. (Kasi)

Walker (2006) argues that the social landscape of normative expectations, the trust, and conditions that sustain them are uneven to the extent that those in high positions exploit the trust of others and deprive them of social goods. With the idea that care was free, most women came to health care facilities not knowing that they were uninsured, making it difficult for nurses and midwives to meet their caring responsibilities. The nurses and midwives felt constrained as most of the time, uninsured women were unable to pay for the cost of medicine and other services. The 'free' maternal health care program requires institutions to provide care for women seeking

care and then to obtain reimbursement later by the NHIS. However, participants recounted delayed reimbursements from the NHIS resulting in the inability of the hospitals to purchase needed supplies to care for women:

> The NHIS is owing the hospital so they have some financial crisis so buying of somethings are difficult for the hospital. They NHIS don't pay that is why the hospital is in financial crises. (Paya)

Nearly all participants spoke of how delayed reimbursements contributed to impoverishing many of the hospitals. With the abolition of the out-of-pocket payment system, hospitals depend on insurance reimbursement to fund operating costs. Therefore, when there are delays, the hospitals find it difficult to acquire and supply resources.

The inability of institutions to purchase the needed supplies coupled with the NHIS selective coverage of services hindered the capacity of participants to fulfill their moral responsibilities. For example, Zoya recounted that specific medicines for the management of obstetric conditions are not captured under the NHIS medicine list as they are deemed too expensive to be covered by the policy:

> Apart from the IV [intravenous] fluids and the oxytocin that they give. Even this MgSO [Magnesium Sulphate], Cytotec is not covered by the health insurance. So even at the hospital, they buy if you go to the hospital pharmacy you go and buy. (Zoya)

The failure of the health insurance to provide full coverage on essential life-saving treatment for obstetric conditions might be inconsistent with the national policy agenda of reducing maternal morbidity and mortality. Zoya revealed how essential lifesaving medications like MgSO and Cytotec required for the management of eclampsia and postpartum haemorrhage were not covered by NHIS and were also not provided by the hospital. The NHIS has developed an approved medicine list based on cost and affordability that institutions must comply with and will only reimburse for medicines dispensed on this list. Even medicines that are part of the

NHIS list were often not procured and supplied by the institutions, requiring patients to buy them. This kind of situation was perceived by participants to be unethical and a breach of a contractual agreement between clients who have their insurance premiums and service providers and often left them in a dilemma. Bama said:

> With the current operation of the health insurance, they wouldn't even buy it though it is for her own good but is unethical…is like she has already paid for. She will tell you I am on health insurance. Some are bold enough to tell you that I have health insurance and she is not willing to pay anything extra aside the health insurance. Once she has paid the patient is right because she knows that she has gone into mutual relationship with the insurance people. (Bama)

Walker (2006) argues that people navigate their responsibility and the world around them through establishing and acting on normative expectations of others and themselves. Bama's excerpt reveals how the inconsistent implementation of the NHIS has made it difficult to navigate their expectations of providing care and left them vulnerable to legal liability. When people have normative expectations of others, they expect them to perform as they should and therefore may hold them responsible for not doing what they are expected to do (Walker, 2006). Such situations often resulted in conflict between them and their clients who have paid their premiums, as many accused the nurses and midwives of extortion for services. While the reactions of the patients may be justified based on standards of normative expectations, they fail to consider the institutional and policy factors contributing to the inability of the nurses and midwives to perform as they expected of them. As a result of these systemic failures, the participants were compelled to respond by paying for medicines or the cost of service themselves or by completely neglecting and abandoning patients. The lack of transparency between the operations of the NHIS and the institutions has created conditions whereby the lack of basic supplies such as gloves, syringes, and dressings among other things were attributed to delayed

reimbursements. Such a lack of transparency made it difficult to determine who should be held accountable for the failures.

Practices of responsibility are shaped by the values, rules, and assumptions of the context or social world in which people live (Walker, 2007). The inability to procure enough resources resulted in the implementation of a quota system. Under the quota system, participants were required to submit requisitions for supplies on a specific day of the week, were expected to use the allocated resources within a certain period, and were not allowed to put in requests unless on a specific day of the week allocated to them even when all the resources were utilized. Participants recounted that such practices were pervasive and contributed to the erratic supply of basic supplies, thereby, hindering their capacity to meet their caring responsibilities. Lina described rationing in the following excerpt:

> They regulate our usage of glove...the hospital has a quota for every ward. When they give you the glove, they expect that you use that glove for a number of days before you come in for. But when they supply, and you use it you don't reach the number of days when you go back, they would not supply you. (Lina)

Lina described that the quota system used by administrators to allocate and distribute basic supplies did not take into consideration the nature of the work and patient turnover in the obstetric unit. Participants revealed how rationing resulted in staff having to work for several days without the necessary supplies. There were instances when the number of items requested were either not supplied or the quantity supplied was inadequate. During field work, one of the maternity ward nurses in-charge, Maya, showed me a copy of the requisition (gloves, detergents, dressings, stationary, gauze, cotton) she made for the week in which the quantity supplied was less than what she had requested for. For example, she made a requisition for 10 boxes of gloves (each box contains 100 gloves, making a total of 1000), but only six boxes were supplied. Based on her estimation, her ward uses an average of 150 to 180 gloves per day, and with the quantity

supplied, the gloves would last for three days. Such a situation resulted in frequent shortages, compelling the nurses to either buy, go to other wards and borrow, or to ask patients to buy their own supplies.

Another participant recounted how the requisition of resources was saddled with bureaucratic processes further compounding the existing scarcity of resources.

> There is a channel, you report to your in-charge, your in-charge is supposed to report to procurement, procurement is supposed to take over to whoever is in charge then the bureaucracy is long. Everybody goes to the central one [stores] so you see the bureaucracies are long. Is a very long process to just even get pens you have to do requisition, it goes through your departmental sign, this person has to sign, it goes to stores, store will sign then they will check what you have requested the processes are just too long. (Napo)

The requisition process was characterized by multiple and endless documentary processes, in addition to the lack of decentralization of the resource allocation process that resulted in delays in the supply of resources that were urgently needed. For example, I assisted one of the participants (Lina) with a requisition that was prepared and signed by the charge nurse. It was then taken to the director of nursing to sign, followed by the administrator, the head of procurement, the supply officer, and finally the stores assistant. This process took five hours of valuable nursing time and yet not all the items were supplied. Having such a long and bureaucratic process for allocating resources coupled with rationing in a setting already constrained by the scarcity of resources was counterproductive and led to unnecessary suffering for both patients and nurses. One participant highlighted the consequences and implications of the rationing of resources on nursing practice and patient well-being:

> The cutting down of items when they are requested hampers a lot of work because it results in artificial shortage. So, if it is not there the nurse has nothing to do…the work is left undone and at the end of the day if it is a life-threatening situation the patient goes down. So, it affects work in a negative sense…it is a major barrier to quality nursing services. It means that the quality of work on a particular patient or what nurses are

> supposed to do at a particular point in time is not done because of the things have been cut off. (Kahu's second interview)

Rationing resulted in artificial shortages at the bedside, hindered the capacity of nurses and midwives to meet their caring responsibilities, left care undone, endangered patients' lives, and diminished the quality of nursing care. As a form of controlling the limited supplies, the charge nurses have also instituted their mechanism of rationing supplies for day-to-day use which Kahu believed led to artificial shortages within the ward. For example, in the unit that Kahu works, the items needed for the morning shift were supplied by the charge nurse and they were expected to utilize them judiciously until the end of their shift without consideration of the number of patients or emergency situations that may arise requiring the need for more resources to be used. In most instances, these items were often utilized within the first three hours, leaving the nurses struggling to meet their caring responsibilities. During an informal conversation with Mani, she recounted how the process of rationing within her facility resulted in the hoarding of essential supplies and medicines at the stores, pharmacy, and within the wards. She described instances when items that should have been used to save the lives of patients ended up expiring and being disposed of because of the rationing. For these participants, seeking to control and ration resources to the detriment of patients and staff was an act of irresponsibility on the part of institutional authorities.

Practices of responsibility are shaped by background understandings of mutually recognizable goods (Walker, 2007). These understandings determine the expectations of people in their commitment to achieving shared goods. The participants held strong beliefs that administrators lacked understanding of what caregiving activity entails at the bedside. This lack of understanding influenced how resources were allocated and the perception of how resources were utilized. For example, in their attempt to justify the rationing of resources, administrators

created a false narrative regarding nurses and midwives wasting resources at the bedside. Such false narratives were dominant within the institutions and reported by more than half of the participants:

> They [administrators] are saying that we are wasting the gloves but here when you came you have seen the work in maternity…there is no wastage not in maternity and labour ward…removing cannula the person wants to wear gloves to protect herself. People come with bleeding I can't say I am to use my bare hands. I have to wear gloves. Someone wears gloves to set up an IV line, someone has to wear glove to be passing catheter, removing catheter, people come in you shave, you are going to expel clots, you are going to do VE [vaginal examination] and I can't do VE and come and keep the glove till the next VE and use it or I can't do someone VE use that same glove to pass someone's cannula. I have to remove and change. (Velim)

Velim laid out the high-risk nature of their work most of which cannot be done without using gloves, but institutional management failed to take into consideration these circumstances. Such false narratives commonly associated with the use of gloves, plasters, syringes, and needles were dominant within the institutions. The goal of the false narrative was to get these nurses to accept responsibility for contributing to shortages and to limit the 'waste' at the bedside. Although participants resisted the discourse of wastage as they perceived it to be an attempt by management to cover for their inefficiencies, they may have also internalized it. For example, I observed that when the shortage of gloves was imminent, the nurses and midwives chose to wear only one glove on one hand, while others recycled gloves that were not soiled in an attempt to limit wastage and conserve the limited resource despite the risk to them and their patients. Other participants believed that the false assumption was influenced by the administrators' lack of understanding. Fako said:

> Because most of them [administrators] there are not clinicians, accountants and procurement officers, all these people need orientation. They need to be oriented. They need to have orientation as part of their training in whichever school they go. They should spend some months in the clinical setting to be able to understand what is happening…I think that if they have the hindsight of clinical experience they will not come and sit down and say there is wastage in the system. (Fako)

There was a strong belief among the participants that administrators had no clinical background, which made it difficult for them to appreciate what it meant to manage an obstetric emergency. As a result, Fako suggested that administrators should be exposed to the clinical setting during their training to enable them to appreciate and have a better understanding of what goes on at the bedside. Fako was optimistic that this approach might help to bridge the gap in knowledge of what it takes to provide care and how resources are allocated.

Practices of responsibility are sustained or maintained by the moral ecology of social moral orders (Walker, 2007). Weiss, Malone, Merighi, and Benner (2002) define moral ecology as "the institutional influences that shape the social and moral working environment" (p.243). In this study, the nurses and midwives described the material and institutional values shaping the moral ecologies of their institutions and the influence it had on their moral agency. The participants held the notion that the decisions guiding the supply and allocation of resources were influenced and shaped by corporate and business-oriented values. The implementation of the health insurance was accompanied by reforms and restructuring of hospitals in Ghana, to enhance efficiency and profit maximization. According to Kahu, these kinds of reforms altered the moral ecology of the health care institution:

> You know there is something like import of ideas from other institutions into the health system like the banks, the schools, and other institutions. They are trying to compare and import certain terminologies to actually mean the same thing here. Because attending to an emergency situation you can use a whole lot, especially obstetric cases…somebody sitting somewhere will see that one as ineffective use of resources or inefficiency in the use of the things at that point in time but that is the case. It is an emergency. (Kahu's second interview)

Participants believed that business-oriented ideas altered the care climate to which they were accustomed to a corporate climate in which values such as efficiency were prioritized over patients' well-being. The introduction of corporate 'terminologies' into the discourse of

caregiving was perceived to be incompatible with their goal of saving lives. In an obstetric emergency, where the focus is on lifesaving, efficiency may not be the priority for nurses and midwives. The demand for efficiency was further influenced by the desire to maximize profit at the expense of patient care. In the following excerpt, Fako said:

> Health care is now like a business and the impact would be very poor and we will be increasing the problem of clients. That is why referring to the patient as a client is to foster some kind of relationship. But I think we are now looking at the patient not just as a health client but as an economic client because you are looking at somebody who is sick and you trying to maximize profit…we cannot use the name of health insurance to continue to maximize profit and do all sort of things. (Fako)

The business-oriented climate altered the way institutions perceived and related to their patients. The patients were commodified and perceived to be 'economic' resources from whom institutions could make a profit. For the participants, commodifying patients in their most vulnerable state was an act of exploitation and inconsistent with the moral relationship they valued and cared about. Walker (2006) defines a moral relationship as a "certain disposition of people towards each other and the standards they trust, or at least hope, are shared" (p.23). Nurses and midwives understand their relationship with the patients as a moral one based on trust and reciprocity in which there is an expectation that certain moral values that bind the relationship will be honoured and prioritized. Walker (2006) argues that moral relationships can be severely distorted or diminished when conditions that support people to fulfil the terms of the relationship are no longer what they expect. For these participants, relating to the patient as a business partner in a profit-driven climate seeks to distort the moral relationship they have with patients. Kahu said:

> Actually, it confuses the whole system altogether. Health is health and when it comes to emergency situation you have to use all that you have in order to save a particular life. When you try to manage you lose a life. You are trying to manage, you are trying to undercut, you are trying to withhold something in the name of efficiency you are doing a disservice to patients or clients and it brings a whole of things. (Kahu second interview)

The drive towards efficiency and profit blurred the boundary between the health care needs of patients and institutional demands as well as posed a significant threat to patients' lives and safety. Kahu noted that such a drive for efficiency without due consideration for patient safety and well-being amounted to 'disservice'. Such an emerging profit-driven climate in an extremely resource-scarce setting had severe consequences for patient well-being and the moral and professional identity of the nurses and midwives.

As a result of their drive towards a corporate climate, the administrators had redirected their attention away from their core mandate of providing safe, competent, and ethical culture for caring to promote a culture of luxury for themselves. Walker (2007) argues that in differentiated moral-orders, "terrible social burdens and injustices are borne by many with courage, dignity, fidelity to what and whom they love, whereas the social privileges of others permit… irresponsible, craven, or dishonorable commitment and actions"(p.130). The overwhelming number of participants believed that administrators had placed primacy on their comfort over the care and well-being of patients and nurses. Napo said:

> You can hear that we don't have oxygen to save life. The predominant role of a hospital is to save life. Oxygen saves life but you can be in the hospital for two three months no oxygen, but we have never heard that the hospital car did not have fuel to pick the CEO [Chief Executive Officer] on his rounds. The hospital has wrong priorities. They prioritized things that make them comfortable over care of patients. Their allowances in meetings are always paid, their cars are always filled, the ACs [air conditioners] in their offices work but the fans in the wards are not working…yet still they don't have money to work on them, but yet still they have money to work on things that they benefit directly from. (Napo)

Napo revealed how institutional leaders neglected to provide oxygen and create a conducive environment for the delivery of care. According to Walker (2007), people in positions of privilege may enjoy the goods of "our premier achievement" (p. 253), while others suffer to

provide the conditions for their enjoyment of the goods that they are likely not to share with them. Administrators prioritized their comfort over patient well-being, while the nurses and midwives bore the burden of supplying the conditions for their enjoyment.

Institutions failed to demonstrate commitment to sustaining the caring practices that define and justify their existence. Observations made during the field work in the maternity and labour wards revealed that fans and AC were not working; delivery couches were old and rusty; lightening system were poor, compelling nurses to use their phones light to set up intravenous infusions; the water supply was inconsistent, requiring the nurses to leave the ward in search of water; and washrooms and toilets were not provided, leaving women with no option than having to use public latrines nearby even when they were in labour or had threatened abortion. While nurses and patients were living under such hazardous working conditions, administrators were living in luxury and fully air-conditioned offices including their hallways. The lack of accountability within the health system has allowed administrators to rig the system while nurses and patients continue to suffer.

According to Walker (2007), because moral arrangements and people are not perfect, it is imperative for systems to set up shared norms of performance. Such a system according to Walker functions by exerting pressure on performance and accountability. When such a system is in good working condition, it can "shape, correct, and enliven individuals' senses of responsibility and strengthen the common fabric of trust in people's senses of responsibility" (Walker, 2007, p.101). The common thread was that hospitals were neglecting their core mandate as places of care to be a self-serving business environment. This kind of self-serving practice contributed to the poorly resourced health care facilities that constrained the capacity of nurses to meet their caring responsibilities as will be discussed in the following subtheme.

The Lack of Basic Supplies, Equipment, and Space as Limiting Capacity

Participants described the scarcity of basic supplies and equipment as an everyday phenomenon as they struggled to fulfill their moral responsibilities to women. One participant during her interview said: *It is a common situation that resources are scarce (Kena).* Common among these were: the lack of gloves, catheters, syringes, infusion sets, urine test strips, and cord clamps. Others included oxygen tanks and masks, maternal and foetal monitoring devices, ventilators, medications, neonatal resuscitation kits, and vacuum extractors. As a result of the scarcity of these resources one participant highlighted that:

> You are constrained. You virtually have nothing to work with. You are really constrained you have nothing to work with. (Bama)

The scarcity of basic resources hindered the capacity of the nurses and midwives to meet their caring responsibilities and resulted in the violation of deeply held moral values. The frequent lack of basic supplies for effective and safe delivery of care left the nurses and midwives in compromising positions. According to Walker (2007), when people find themselves "under conditions of imperfect understanding…and dramatic inequities in material…resources" (p.78) their standing as moral agents might be compromised. In recounting her experience, Neira described instances in which the scarcity of sterile gloves resulted in compromised care:

> Certain things are there it leaves you no other alternative than to compromise to do certain things. I want to do vaginal examination and is a sterile procedure and a woman has come and is in pain…there is no surgical gloves. I used disposable and in that case I think I am compromising because that is not the right thing I am supposed to do, but surgical glove is not there and I cannot also leave the woman to push otherwise the baby would be in trouble and her cervix would also be in trouble. So that is why I said that I will weigh the two. (Neira)

Neira described how working under conditions of scarce resources led to instances in which care was compromised. When people are confronted with varied situations of moral importance, they weigh their choices and actions based on what moral values are at stake (Walker, 2007). In the

context of scarce resources, morally significant values such as safeguarding lives had a strong influence on how the nurses and midwives enacted moral agency. The frequent shortage of gloves was a common phenomenon in obstetric settings which made it difficult for participants to provide care exposing them and their patients to risk of infection and contributed to situations of care being left undone. For example, during one of the observations, there were instances in which women in need of intravenous fluids were left unattended, dressings were left undone, and vaginal examinations were postponed because the ward had run short of gloves. Such situations according to Ziga meant that:

> The right care the patient needs will be tampered with because the accurate thing was not done. (Ziga)

There was recognition among participants that compromising the standards to attend to the urgent care needs of women were unethical and interfered with the quality of care. Such unethical actions, according to one of the participants, contributed to the negative portrayal of nurses and midwives in the public and institutional domains:

> It affects our work as nurses and people see it as nursing going down. Standards of nursing falling most of the time that is the term, but the contributing factors that are leading to that are not being looked at. So, the major contribution of the bad name of the nurses out there is as a result of the bureaucracies and the things that are not there in the hospital. (Kahu)

According to Walker (2007), we are affected not only by the fulfillment of our responsibility but how we are perceived when we are unable to accomplish our desired goals. Kahu highlighted the inability to maintain the ethical standards as a result of a lack of basic resources negatively affected how they were portrayed. Walker (2007) argues that morality is constituted by a shared understanding of what we and others are supposed to do for each other, and mutual accountability for certain situations. By doing this, “we define the scope and limit of our agency,

affirm who in particular we are, show what we care about, and reveal who has the standing to judge or blame us" (Walker, 2007, p.16).

The nurses and midwives felt the lack of resources hindered their ability to relieve the suffering of patients. Moral agency is influenced and shaped by a moral environment that supports and fosters the fulfillment of moral values and responsibilities of its members (Walker, 2007). One nurse recounted how their inability to enact moral agency and relieve the suffering of patients as a result of a lack of equipment occurred despite their knowledge and skills:

> You actually want to put up your best as a nurse or midwife. You actually want to render your service best…you come you have the technical know-how but the machines or the implements are not there for you to actually render your service so you kind of idling around and then you see the patient wailing in pain, something that you could have intervened, but is beyond you. (Kahu)

While values and responsibilities were significant in determining the enactment of moral agency by participants, the lack of material resources rendered them incapable of fulfilling them. Afani expressed her feelings in the following excerpt when she felt constrained by the lack of basic resources to meet her caring responsibility:

> It makes you feel like your best is not enough professionally because this is the case you have left your home environment just to come and nurse a patient to help the patient get better then you get to work and there is nothing to work with. Professionally you close and you are not feeling satisfied…the satisfaction you are supposed to get as a professional you don't feel it not because you are not doing your best, but because what is there to aid you to do your best is not there then you keep blaming yourself because you feel you did not do enough. (Afani)

According to Walker (2007), responsibilities entail the standard for expectations and "blame and shame…if responsibilities that fall to one cannot be met" (p.96). The lack of resources meant the nurses and midwives were unable to meet their moral responsibilities leading to feelings of dissatisfaction, inadequacy, and self-blame.

In obstetric care, timely and efficient care delivery is essential in saving the lives of women, but participants recounted having to contend with the lack of these essential resources to meet these goals, thereby contributing to delay, unwanted outcomes, and feelings of worthlessness. Zoya recounted feeling worthless and helpless as a professional due to the non-availability of emergency medications to attend to a woman with eclampsia.

> Yesterday there was an emergency we needed Magnesium Sulphate. I went to the box and nothing is there. You just feel useless because you cannot do anything meanwhile is an emergency…you don't know what to do. You just be looking at somebody something that you can help. You wish you can help. (Zoya)

Zoya described feeling 'useless' when she could not access Magnesium Sulphate to manage a woman with eclampsia. The lack of resources made it impossible to manage certain conditions, thereby, provoking feelings of professional worthlessness. Didi described such situations as difficult and constraining:

> With all this, it makes the work difficult. You want to give more but your hands are tied, and you cannot do your best. So, you are kind of doing mediocre when you can actually give out the best. So it actually doesn't make you happy or fulfilled as a person because if at the end of the day I want to record zero maternal mortality and foetal mortality and yet because of all these things you come and somebody dies then I think I have failed as a midwife. (Didi)

Throughout the interviews, a narrative of 'your hands are tied' was used by several other participants to depict the material constraints they experienced in an attempt to fulfill their moral responsibilities. Such an expression reveals the constrained nature of the work environment in which the nurses' practice and how it promoted a culture of mediocrity. In Didi's excerpt, she characterized their practice as 'mediocre' when she could not provide the quality of care and interventions to avert maternal mortality due to the lack of basic supplies. The lack of resources undermined her moral agency and resulted in the violation of her deeply held moral value of safeguarding the lives of women. Safeguarding the lives of women and taking responsibility to

alleviate or minimize unwanted outcomes was fundamental to the moral identity of the participants. However, this deep sense of moral commitment was undermined by the lack of basic resources exposing them to suffering and distress. Kahu said:

> I see that affects us; it makes us ineffective; it make nursing work difficult; it makes frustrating at times, and then depressing or psychologically traumatizing because you see patient dying as a result of lack of basic consumables or items to actually work on the patient. (Kahu)

When people are made incapable of fulfilling their commitments or their best attempt to fulfill them is hindered, it "inflicts on people miserable cost and terrible losses, including psychic ones" (Walker, 2007, p.132). Such moral suffering was revealed in Kahu's excerpt which was described as 'depressing or psychologically traumatizing' for not being able to respond to the needs of women. Kahu's excerpt reflects the realities of practicing as a nurse or midwife in the context of scarce resources as they attempted to meet their caring responsibilities.

Feelings of failure ensued when participants felt they were unable to fulfill their moral responsibilities and commitments. The lack of resources to address the urgent needs of the women and that of their babies led to a growing sense of failure. Working under conditions of scarce resources undermined the professional competence of participants leading to a state of feeling unaccomplished. Pini illuminated how the lack of basic resources to respond to the needs of women made them feel professionally 'inferior', incompetent, and exposed them to ridicule by other members of the health team.

> Sometimes it makes you look like inferior. You don't know your work. Sometimes because of the lack of equipment, if we fail to do something on a patient, someone can take the folder and talk as if you don't know what you are about. It makes you feel like a failure...sometimes if I am not mistaken it makes you feel like you don't know what you are about. (Pini)

There was also a strong feeling among participants that the scarcity of resources posed a constant threat to their professional competence and integrity. For participants, the inability to act

consistently in accordance with their values, commitments, and expectations provoked a sense of 'failure' and incompetence which significantly impacted their moral integrity. Due to the lack of clinical monitoring devices, the nurses and midwives were unable to monitor the vital signs of patients, leaving them vulnerable to criticisms by doctors and other members of the health team. Other participants also recounted that the lack of basic resources resulted in frequent improvisation which many feared might lead to the loss of professional competence and skills. Improvisation was a common practice among participants and a means by which they negotiated their practice in the context of scarce resources. Although the goal of improvising was intended to temporarily address a need, it became part of their everyday moral discourse and institutional culture. While improvising in the absence of resources was seen as a way of life and fundamental for the enactment of moral agency, many acknowledged that the continuous practice of improvising items not fit for the intended purpose could endanger patients' lives, result in negligence, and lead to the loss of professional competence over time.

In most of the wards observed, there was only one electronic BP apparatus shared by two or more wards, while other wards that had BP apparatus were not supplied with batteries by the institution. These situations coupled with the frequent breakdowns of the BP apparatus made the monitoring of patients challenging, compelling some nurses to acquire their own personal monitoring devices. Kasi revealed this when she said:

> You are restricted and at a point in time you have to buy some of the things yourself…the fetoscope for the checking the FHR almost all of us we have our personal ones because you will not even get it. So to make your work easier you bring your personal things to help…because is the mother and a child for me that is what really pushes me because you are talking about two or more lives...no option than to buy unless you don't really care which I belief is not the case once you a human you always care. (Kasi)

Kasi acknowledged that the dual responsibility of caring for women and their unborn babies and their desire to relieve suffering made it morally demanding for them to acquire their items to

promote the well-being of women. Walker (2007) argues that our proximity to the vulnerability of others may obligate us to respond to those others especially when "the stakes are high, and solutions are limited" (p. 88). In an emotionally charged environment like the obstetric settings where participants have a dual responsibility to save the life of mother and baby, buying their personal items and supplies to provide care was not a matter of choice but one inspired by the desire to fulfill their moral responsibility. Although participants acted for the 'sake of the patient' and out of compassion, other participants, like Kahu, felt that such actions contributed to maintaining and reproducing the constraints they encountered. Such feelings of moral ambivalence were expressed by several other participants as they perceived that their actions rendered the situation invisible and perpetuated a certain false understanding about the resource scarcity. Although the participants were aware their actions contributed to sustaining a morally uninhabitable work environment, they also felt taking action such as improvising and buying supplies to care was necessary to preserve and sustain their moral and professional integrity. Fako said:

> As a professional if you know a patient is going through a certain challenge …but you are not able to and when the person passes on your professional integrity is challenge as a health worker. Your professional integrity is challenged because what you have been trained to do you have not been able to do it fully because of lack of basic resources. So, at the end of the day your professional integrity is compromise…your integrity as a professional is basically based on how effective you are able to discharge your duties as a professional. (Fako)

Moral integrity is connected to a person's moral agency and is demonstrated in the ability of moral agents to fulfill their moral obligations and responsibilities (Walker, 2007). For participants, moral and professional integrity was consistently challenged by the frequent moral demands that they were unable to fulfill. Walker (2007) argues that integrity can be "out of reach for people" (p.130) when they are compelled to live a life not defined by their own choices or

they are denied the conditions to live the life they desire. For the nurses and midwives, being forced to work under conditions of scarce resources imperiled their professional integrity as highlighted in Fako's excerpt. The deprivation of the opportunity to maintain or sustains one's moral integrity in a "matter involving important commitments and goods (p.113) might impose on some people miserable cost (Walker, 2007) which is reflected in Tali's excerpt.

> It affects when you see a patient may be you have this thing to help the patient and you don't have the resources, the resources to help the patient recover always your conscience will not just leave you so it affect your work, it affect your work…is just telling you that you are not sound. (Tali)

Conscience as a form of moral recognition is connected to a person's integrity which alerts a person when moral values are threatened or violated, provoking a feeling of resentment and indignation (Walker, 2006). Tali described her inability to act in accordance with her core values provoked feelings of resentment and indignation resulting in suffering, which she characterized as 'not sound'.

When moral demands remain persistently unresolved over time, the moral structure and beliefs of people also change and shift over time (Walker, 2007). The frequent unfulfilled moral demands resulted in situations in which some nurses and midwives no longer felt the need to be responsible for the things they valued and cared about. The moral consequences of resource scarcity had altered the moral landscape and the way nurses and midwives responded to their moral responsibilities and it made it impossible to demand accountability from colleagues:

> You cannot actually hold the staff responsible. You come with rules and then it is broken down because the right things are not there for them to actually monitor…lot of lapses…there is missing times or missing vitals and you cannot actually keep track whether a patient is getting better because a lot of vacuum and most of the times that there were a lot of pressure ..you become fed up with work and it brings your morale down. (Kahu)

Walker asserts that people are accountable for what they take responsibility for (2007). In an environment riddled with the scarcity of resources, it remained an elusive requirement to uphold mutual accountability. Kahu described how the consistent lack of monitoring devices resulted in 'lapses' and neglect which made it difficult to enforce accountability standards. Others also described the inadequate supply of equipment to support advanced care resulted in a resource allocation dilemma of scarce resources and preventable maternal deaths. Kahu illustrated how difficult it was to decide which patient to allocate the only ventilator when two women were in need:

> There are occasions whereby two patient needing mechanical ventilation at the same time. There is no way we can actually take the ventilator from one…hmm actually is a hard decision to actually take. Sometimes the other patient may even see you as you don't actually like her. We have to run around to see the main ICU to see if they have an idle ventilator that fine but if you don't get you only fold your arms and see the patient go [slow tone] (Kahu)

Kahu described it as a *hard decision* signaling the moral nature of such decisions and moral considerations therein. Kahu acknowledged that it would be immoral to disconnect a ventilator from one patient to give to another as this may have led to conflicts with the patient and their families and their values. Such situations left the nurses and midwives feeling resentful for choosing nursing or midwifery as a career.

> You regret being a midwife and ask yourself why did I chose this profession just because of the frustration at the work side. You want this you can't get, you want this you can't get...you want to do this you can't do so that is just the issue. You can't do you just regret, but you have chosen your profession so whatever it is you go on or [laughs] you have to move on. (Lasi)

Feelings of regret and resentment for being a midwife or nurse were shared by several participants when the realization of certain values became impossible. Walker (2007) argues that the practices of responsibility are not only the tasks and roles we undertake but also equip us to

reckon when we have been unable to fulfill them. These kinds of intense reactive responses resulted in many of them questioning the choice of their careers.

Participants recounted the limited space and beds to accommodate women and their babies was a major challenge that constrained their capacity to meet their caring responsibilities. With the implementation of the free maternal health care program, obstetric wards have consistently increased in admission rate and yet without any corresponding increase in the capacity of the wards to accommodate these growing demands. This high admission rate coupled with the fact that some wards are operating as a combined obstetric and gynaecological wards led to admissions exceeding the capacity of beds and space available. Neira shared her experience with this situation in the following excerpt:

> Generally, the working deiiii [infact] you can see for yourself is not good at all. There is overcrowding, no beds for our clients. The place is always full every day and by 12 midday, you will see people roaming for places to lie down but no beds. (Neira)

Neira expressed her displeasure for being unable to accommodate all women in need of care. The average bed capacity for the maternity wards of the three hospitals ranged between 21 and 41 beds. In one of the hospitals with a 21 maternity bed capacity, the daily minimum admissions were 12 and the maximum was 20 based on their monthly admissions data. These kinds of situations contributed to admissions to the wards that exceeded the capacity of the beds available resulting in patients having to wait or being turned away. The phenomenon of inadequate beds to admit patients, referred to as the ‘no bed syndrome’, is a common feature of the Ghanaian health care system. It is characterized by a lack of space and beds, resulting in the admission of patients on the floor and chairs, bed-sharing, and in some instances, patients being denied admissions.

The refusal to admit patients became a subject for public discussions at the time of fieldwork resulting in institutional directives barring health care professionals from turning

patients away and yet there were no attempts by government or institutions to improve the situation. Nurses and midwives as front-line staff were implicated in the crisis compelling them to shoulder the burden of a failed system. Bama described the distress she sometimes endured knowing she could not provide women with dignified accommodation:

> In fact, it is so sad sometimes you closed and you are going home with that kind of pain in you seeing a woman sitting who probably if care is not taken probably will spread rubber on the floor and think of lying down…there times you packed the mattress together like this [demonstrating with hands to show two mattresses being put together] so that they will be lying down like that. Not that one to a one mattress, two mattresses combine for three patients and their babies to share in that order. (Bama)

Bed-sharing was a common phenomenon of the 'no bed syndrome' and a means by which the participants attempted to manage the inadequate space and beds situation. Although they felt distressed for admitting women under inhumane conditions, they also felt it was necessary to safeguard the lives of women. Walker (2007) argues that we are obligated to respond to the needs of others when a particular situation renders them morally dependent on us or our proximity places us in a position to avert any harm. Recognizing their moral commitment to avert harm amid challenging working conditions compelled the nurses to look beyond the present circumstances. In this way, we express our sense of moral responsibility to "others for the moral sense our lives make" (Walker, 2007, p. 69). The value of wanting to save lives and the desire to fulfill their moral commitments compelled them to provide care for women and their newborn babies on the floor on a piece of plastic, signifying the lack of dignity for women seeking care. Mbo described this situation was not befitting a hospital:

> Sometimes you will even come and see patients on the floor, and it is not looking like this is a hospital. You see patients lying on the floor not even on mattresses. They are just lying on the floor with their babies [laughing]. It is not easy. (Mbo)

The hospital is meant to be a place for promoting the dignity of patients, however, under such degrading conditions, this remains a fantasy. In one of the observations made women were

seen lying on the floor in between beds, including the entrance of the ward, while others were waiting on the corridors yet to be admitted. To enter the ward people needed to jump over patients and as a researcher, I felt some discomfort having to walk in between these women. These kinds of situations created congestion within the ward commonly referred to by health professionals as a 'market day in Ghana'. This kind of 'market day' situation according to Ziga, resulted in overcrowding, hindered movement within the ward, and constrained her capacity to meet her caring responsibilities:

> It really affects my professional life in a way, especially with the client. The place is really congested makes the work difficult because even with those lying on the floor you can see there is little spaces in between and so when you want to move in between is very difficult. So is affecting me in a way that how I want to give care to my client. I am not really getting it that way because of that congestion. (Ziga)

Ziga clearly articulated the difficulties she encountered in meeting her caring responsibilities as a professional midwife. As patients occupy all available spaces between beds including hallways, navigating through the ward and standing to undertake a procedure were restricted and resulted in the possibility of neglect and care left undone. During the observation, nurses were seen administering treatments to women sitting on chairs and squatting to carry out physical and vaginal examinations for women on the floor, while others who were uncomfortable squatting avoided undertaking such procedures. Kasi who works in the postpartum ward recounted during an informal discussion how she could not assess uterine involution, provide other essential postpartum assessments, and expel clots for women after delivery because she experienced back pain anytime she bent or squatted to do so. When attempts were made by participants to move other women from the bed on the floor to enable them to undertake these assessments and to care for emergencies, it was often misconstrued as an act of discrimination and resulted in conflicts among the nurses and patients and their families. For the majority of the participants, although

such a decision was necessary, they also felt uncomfortable asking one patient to move to the floor to make way for others. This was reflected in Shia's excerpt:

> It's always bad. I feel bad always. Because if it was to be me that would be lying on the bed and you ask me to come and lie on the floor, I will not feel happy. I think we should treat people all equally. But sometimes too, I understand them because here is the case the person's situation needs a bed at the same time the emergency will also need a bed. Sometimes it's very difficult. I always feel bad for the person coming down to the floor. Sometimes it is not easy they always complain, but that is what is to be done at that instance. (Shia)

In attempting to manage the situation of inadequate space, and safeguard the lives of the women, the participants felt they were violating other fundamental values. Walker (2007) argues that as people become more selective in their values and responses, the fulfillment of certain values becomes impossible. For example, Shia acknowledged moving other patients onto the floor violated the principle of equality and dignity which gave rise to distress**.** Other participants also recounted the lack of space and beds and overcrowding coupled with the absence of screens, made it difficult to maintain privacy for women seeking care. Although some wards had mobile screens, the overcrowded nature of the ward made it impossible for the nurses and midwives to use them while others refused to use the screens because of safety concerns. This was revealed during an interview with Awe:

Even the screen you saw if you don't take care it will even prick your eye. (Awe)

Observation after the interview with Awe revealed the only screen on the ward was broken, unstable, and had its protruding rusty edges exposed. These prevailing circumstances compelled the nurses to undertake procedures or counsel clients without the necessary privacy, resulting in distress.

> I don't feel good at all. I don't feel good. Because I feel like we exposed them too much. The nursing confidentiality and the uniqueness we talked about like treating our people with confidentiality we are not doing that and like the privacy aspect now is not there…we are not supposed to expose for the other persons to see but that is what we do. Even look at the second stage like this you will be delivering somebody or even repairing

> somebody's tear the other person is lying there and is looking at you…so that is the privacy we always say we talked about privacy but we are not doing that one. We are not providing the privacy at all. When you complain that there are no screens. They don't have it in the stores (Zoya)

Privacy and confidentiality are core components of nursing practice and participants are obligated to maintain privacy during interaction with patients. Exposing women and their personal information to the full glare of other women was perceived to be a violation of their professional code of practice. Privacy violations were consistently an observation made during the fieldwork as a result of the open and overcrowded nature of wards. For example, vaginal examinations, abdominal examination, and abdominal wound dressing were done in the open to the full glare of other patients and visitors. There were instances in which nurses and midwives who were uncomfortable with these privacy violations, resorted to improvising by getting other nurses or students to hold the ends of a bedsheet, but there were times this was impossible when staffing was inadequate. Although there were several attempts to draw the authorities' attention to the fact that these violations needed to be stopped, these calls were often ignored. The failure of institutions to provide the resources needed to provide privacy for women seeking maternal health services highlights the role institutions play in contributing to the widespread disrespect and inhumane care experienced by women.

Other participants recounted a worrying trend of how the lack of space resulted in patients being discharged earlier than expected to pave the way for incoming patients. Afani who works in the obstetric recovery/post op ward shared her experience of how patients were discharged home quicker and sicker due to the lack of space and beds.

> When there are emergencies then we need space and they are compelled to discharge so that the emergencies can come in…there are instances patient don't recover, but we still trans them out because there emergencies to be done and the beds are occupied so we are compelled to send them out because we need space…Sometimes when they are going we are supposed to give patient education on how to care for the baby at home and all that

> but probably because of the pressure, space issue we even push them out without the education…I kind of carry some guilt on my shoulders because I am like as they are going what will happen next (Afani)

There was a ripple effect of the inadequate space and beds across all the units in the obstetric department. During the observation in one of the hospitals, the whole post op ward was full and there were six new patients referred from peripheral health facilities for emergency C-sections. The situation compelled the discharge of patients who were 24 hours post C-section to make room for emergencies. Although the nurses hurriedly discharged these women to make way for others, one could notice the discomfort in the nurses as most of these patients could barely get out of their beds by themselves. Because nurses and midwives drew satisfaction in their ability to care for clients through to recovery, being compelled to discharge patients still recovering could be perceived as a violation of their fundamental values. These discharges were often unplanned and done hurriedly, Afani recounted that they were unable to provide discharge teaching to the women which left her to feel guilty and uncertain about the outcome of patients who still required close attention and care. The experience of guilt and discomfort by participants was an indication that the moral choices were not satisfactory since our "choices will often be a selection of one among various imperfect responses" (Walker, 1998). Another participant also shared an experience regarding how the discharges were done:

> It affects because you are just pushing them like they are sardines (canned fish) or are they logs?...that individual interaction and care is not there….is like you are running a system like any other institution at all. You can compile all your files I mean like the schools and mark them at the same time or process somebody's loan at any time that you want but in health it is not done like that is affecting the work…to actually get satisfaction of care or the quality of care is not there. (Kahu)

Kahu felt how patients were being discharged objectified them and lacked dignity. There was no due consideration for their individual differences in the process of recovery. This kind of

situation was perceived to be inhumane and lacking in empathy and compassion. It also contributed to poor quality care outcomes and staff dissatisfaction.

Understaffing as Limiting Capacity and Creating Distress

This sub-theme reflects the influence of understaffing on the capacity of the nurses and midwives to meet their caring responsibilities. Staffing shortages coupled with high admission rates resulted in excessive workloads that significantly impacted on the capacity of the nurses and midwives to sustain their values and responsibilities and created distress. Yiko, who works at the maternity ward, recounted her experience in the following excerpt:

> If we come and the workload is heavy. At times some people would be on medication but because of the workload and some of the nurses are not there you can't do all the work. Shortage of nurses on duty. (Yiko)

Circumstances may shift or alter the moral life of people which may render them being unable to fulfill their moral commitments (Walker, 2007). As narrated by Yiko, they had to leave some of the care undone when they were overwhelmed by the workload. Excessive workloads resulted in multiple responsibilities exceeding their scope and resources. The nurses and midwives recounted several situations in which they in which they were confronted with patients' conditions that were beyond their scope of practice and yet they had no support and resources to attend to them. This was illustrated by Deli in the following excerpt:

> You have the task facing you. What are supposed to use and solve the problem is either not available at that time or not only material items you need more help somewhere a little push somewhere that one too zero. Like doctor coming around or even the staff maybe you come the number is less. (Deli)

Deli recounted feeling unsupported and not supervised to undertake certain procedures that were beyond the scope of practice to safeguard the lives of women. Staffing numbers including nurses and doctors were inadequate in all the three health facilities. For example, in one of the hospitals, the maternity ward had 30 midwives and nurses, but three were on annual leave, four were on

maternity leave, and one was on modified duty leaving 22 nurses and midwives. The average number of staff per shift was between three and five for the morning and afternoon shifts, while on night shift there were usually two. Within the same ward, the total number of women in each ward was between 30 and 40. These situations resulted in the nurses being burdened with the workload. Kena recounted having to contend with multiple and unending responsibilities.

> You come on duty and you have 24 clients plus neonates 6 or 7 because sometimes we get them up to 8 in a ward so that is 28 patients and you are only 3 midwives….you are to do swabbing, cord dressing, bathing of babies, and wound dressing, then doctor would come on rounds, changes, preparing for CS, taking of blood samples to lab, medications and you are only 3 midwives. So, what would you do as a midwife? Though you know is the right thing to do but you cannot do it because the skilled personnel are not much, because the ratio of a midwife to a client here is 1:10, which should have rather been 1:5. (Kena)

With only three midwives, Kena who works at the maternity ward highlighted the multiple responsibilities they confront including caring for newborns. Similar narratives of unending responsibilities were shared by more than half of the participants. In the face of manifold responsibilities coupled with inadequate staffing, Kena asked a moral question; 'what would you do as a midwife' to fulfill all these responsibilities? This kind of rhetorical question according to Walker is important in determining the habitability of places by asking "what good comes out of this way of life, what of value does it make available, and what does it foreclose?" (Walker, 2007, p. 248). In this way people are able to determine the scope and limits of their moral agency. Although Kena knew what her moral responsibilities entailed, she was unable to accomplish 50% of them due to the inadequate midwife-patient ratio.

> You have a goal at least 50% of the work done a day. A day you should be able to do 50 to 70% of your midwifery work or the real nursing work…we have left nursing and midwifery work and we are practicing different things…the normal routine for midwives and nurses we don't do it…sometimes there are certain things you can't do or you skip some or you skip so many things. Sometimes we do it but not the right procedure or you don't follow the right procedure because of no time, busy wards, busy schedules and resources too are not there. (Kena)

'Real nursing' work was described as the daily routines of talking with patients, being there at the bedside, providing support for newborn mothers, assisting women to breastfeed, and health teaching, however, under the present conditions they were compelled to 'skip' or leave these important aspects of care undone. Even though there were attempts to practice 'real nursing,' care fell below the expected standard as a result of the lack of time and complex nature of obstetric conditions they had to contend with. Bama who also works in the maternity noted any attempt to do 'real nursing' or devote much attention to one particular patient would result in the neglect of other women:

> Giving one patient that kind of special attention at a point if you are not strong enough you will give up. You will end up spending the whole day with that one patient at the expense of others or you neglect more less do little for a patient and give the rest of the attention to the others. So, the special care and attention she may not get it. (Bama)

Providing 'special attention' to women in the face of competing moral responsibilities was impossible. Conditions such as threatened abortion, foetal distress, maternal distress, postpartum haemorrhage, eclampsia, and obstructed labour are high-risk conditions all requiring close monitoring and attention and, therefore, require nurses and midwives to devote a significant part of their time on one patient experiencing any of these conditions. This attention might mean neglecting or doing little for other women and could endanger their lives. For Bama, providing 'special care and attention' for women was unattainable.

Walker (2007) argues that "different demands of different persons or the different demand of the same person" (p.118) might result in conflicting responses and cause a person to weigh their choices by determining what they can tolerate and what sacrifices can be made. For example, in the following excerpt, one midwife recounted her experience of being unable to fulfill her moral responsibilities to other women as a result of other competing demands:

> Some came with their ready blood forms that they have blood that is those for transfusion we couldn't go for the blood meanwhile their Hbs [Haemoglobin] were low. We were still taking care of others you wish you could go for the blood for the client but you can't go because turning away for 5 minutes someone can pass on within that time you would be going for the blood so you have to wait. (Kena)

The nurses and midwives recognized that they were morally responsible for all patients in their care; however, due to the competing nature of their responsibilities, it became difficult to respond to the needs of others. Kena acknowledged in her excerpt that, even though there were women requiring blood transfusions, she was unable to respond because she could not turn away from other patients.

The burden of workload coupled with such multiple and competing moral demands resulted in incoherent moral responsibilities which were oftentimes difficult to prioritize because people's moral positions and responsibilities may be rendered incoherent when they are pressured by the frequent needs and demands of others and unpredictable circumstances (Walker, 2007). Deli described her responsibilities as 'jammed up' making it difficult to fulfill them:

> Sometimes you are confused you don't know how to tackle the issue because…they are jam up so sometimes is just a hell…You become confused as to which one to tackle first and which one to tackle last you would start it and half way you jump into a different thing and that one is left out so is like you are on a time bomb…So at the end you see that you started this one and half way someone is calling then before you realized you have forgotten of something important that you were doing somewhere …You are not able to finish one thing before the other…I know some of us are already trained as jack of all trades master of none, so you only continue jumping and tapping where the danger signs are blinking. (Deli)

In Deli's excerpt, she described her responsibilities as jammed up, implying a lack of intelligibility, thereby, making it difficult to determine which ones to fulfill. This kind of unintelligibility was interpreted as a hell signifying the suffering associated with being unable to meet her expectations. Being unable to fully accomplish the urgent care needs of women coupled

with the unpredictability of obstetric conditions made Deli feel she was sitting on a ‘time bomb’. Deli recounted hopping from one task to another with many of the tasks left incomplete or left undone as she attempted to manage the situation. Once Deli knew she was sitting on a ‘time bomb’ she had to find tactical ways of diffusing the situation. Morality does not only provide standards for the fulfillment of moral responsibilities, it also makes available remedies for addressing the situation of moral concerns (Walker, 2007). In this way, Walker notes that such remedies prevent unwanted outcomes and enhance a person’s sense of moral responsibility. For example, Deli acknowledged that their training imbued them with remedies to manage such situations.

In addition to their overburdened responsibilities, participants recounted several occasions in which they had to assume the responsibilities of other members of the health team many of which were beyond their scope of practice and outside hospital policy. While the participants acknowledged it exceeded their scope of practice, they also felt it was necessary considering the lives that were at stake. In the following excerpt, one midwife recounted how they were often compelled to refer women to other facilities which were out of their scope of practice and not consistent with policy:

> We work in this hospital not only as midwives but sometimes also as doctor. We know we are not supposed to refer cases, but sister if you want to follow that policy in this hospital many women would lose their lives, many women would lose their lives. So, what we do here is that when there is a case and we don’t get the anaesthetist, we don’t get the driver, or doctor is not reachable we quickly just refer. (Niya)

Considering the unpredictability of obstetric conditions coupled with the difficulty in accessing doctors and other essential staff to attend to emergencies, the participants felt compelled to refer women in need of emergent care to other institutions. For these participants, considering what they valued and cared about, they were prepared to violate institutional policies

to avoid putting women's lives in peril. When moral actions were weighed against institutional regulations and standards, participants were inclined to act in accordance with their values. Morality exerts a certain thrust on us that makes it possible for us to recognize what values are stake and how to act in ways that sustain who we are and what we stand for (Walker, 2007). For example, Niya indicated it was inconsistent with her values to allow patients to endure suffering because of institutional policies. Although participants acted in the best interests of the patient by assuming the responsibilities of others, they also had the awareness their actions were beyond their scope of practice. Despite knowing the consequences of their actions, their moral values and proximity to women influenced them to assume the work of others:

> Sometimes is the betrayal of the patient or you cannot look at a fellow human being suffering just because there is no somebody to take care of the person and then you have to also sit down and wait and looking at the person suffer. Sometimes we are forced to take our own decisions especially when clients are in pain. You are forced to give your own prescriptions. You are forced to manage the clients base on your training making sure that you don't cause injury or harm to the patient. (Fako)

Walker acknowledges people assume responsibility for others because those needs are crucial or there is no one to respond to those needs and our closeness demands that we respond (2007). For most of these participants, their moral proximity to women made them vulnerable to taking on the work of others and compelled them not to ignore the suffering of women even when others failed to pay attention. This kind of understanding also shaped how the participants understood their responsibilities beyond their shift hours and after leaving the hospital. Bama said:

> Psychologically you will even be at home you may not be on duty, but you feel like always be coming around. The time you are supposed to rest you feel like you won't take that rest because you still feel within you like you have a responsibility you left somebody unattended you still have to come around. (Bama)

While the inability to fulfill their moral responsibilities resulted in suffering and distress feelings, it also provoked a deep sense of moral commitment in the nurses and midwives. Bama described how the thought of knowing that she was unable to honour her commitment made her feel obliged to return although she was off duty. The nurses and midwives became preoccupied with honouring their commitments even when they were away from the hospital. These kinds of narratives demonstrate a deep sense of moral responsibility leaving them vulnerable to suffering and distress that impacted their well-being and ability to be morally attentive.

Persistent experiences of suffering and distress had a significant influence on the moral attentiveness of the nurses and midwives. Being morally attentive enables people to acknowledge "that a person's pain is real and worthy of attention" (Walker, 2007, p. 213). This is expressed through acts of compassion and empathic engagement with the other which tends to enable a person to provide an appropriate response to pain. Walker (2007) further argues that the capacity of a person to remain attentive and respond to the needs of others diminishes over time when they are exposed to complex episodes of demands and unlimited responsiveness leading to situations of misrecognition. Mani recounted how nurses have become less responsive to their values due to frequent exposure to workplace pressure and adversities:

> I think it get to a point people conscience just becomes so seared. They are so use to the situation and they are not move by it…so a woman is in pain she is wailing and then you go…don't shout I don't like the noise because the person has had it up the point that I can't stand the pressure. The stress and then at any moment can just explode on the patient. Any little the client does is annoying…then the fact that you are at that end of providing service then you get frustrated and you vent it on that person. (Mani)

Diminished moral attentiveness leads to misrecognition and this tend affects people's ability to notice situations requiring moral action, impairs their thought and judgment, and makes them less sensitive to their decisions and actions and, in many instances, they may become cruel and callous towards others (Walker, 2007). Mani used the term 'seared conscience' to denote a state

of diminished moral attentiveness and misrecognition that is characterized by a lack of compassion and empathy, along with irritability, and the displacement of feelings and concerns onto women. As a result, women became the subject of verbal and physical abuse from the nurses and midwives. Another participant recounted how the interplay of poor working conditions and their desire to save women resulted in the harsh treatment of women:

> You have line 15 patients down you are just the second person to deliver and then you are wasting time refusing to push meanwhile other women are also getting into active phase they need that same bed to give birth. At a point you begin to lose yourself in the work and then you become easily irritated and become harsh. While you are working on those others are on the way coming in with more critical cases so you cannot afford to let one person waste your time. So that takes away that love you have for patient where to want to pamper patients and then cuddle patients you have to be fast and then edge them on and sometimes you can be harsh doing that because you want to get it done with and help another person. (Napo)

Participants held a strong belief that it was impossible to compromise the value of safeguarding lives over compassion. Although participants acknowledged that all patients deserved to be treated with respect, dignity, and compassion, Awe like others, perceived the value of safeguarding lives as taking precedence over other values:

> I have to protect the life of somebody. You are working the woman is not even cooperating push push and the person is not pushing …When the baby also keeps long over there the baby can die. So sometimes the situation that you are finding yourself you can't also allow the baby there to die have you seen it. So even if it is shouting, we will shout the woman to deliver at the end of the day you save both lives. Because you save the child and the family as well, they are also part and the woman is also part. (Awe)

Safeguarding the lives of women were perceived to be more important and central to the moral identity of the nurses and midwives. For Awe, she would do whatever she could including abusing women. This sentiment was echoed by several other participants as the reason they would continue to coerce women to comply. While the nurses perceived the abuse and disrespect of women was in not in harmony with their values, they also felt it was in was a natural reaction to the stressors they encounter.

> As I said most people do not come as nurses because they have the mind to be wicked and then no nurse get up in the morning with the mind of I am going to be wicked towards people or I am going to disenfranchise people or I am going to the hospital to make people suffer. Nurses, midwives, doctors we are not super humans. We also have emotions. Even though we are trained on how to suppress these emotions when we deal with the sick and people…You cannot be absolute. The training is not an absolution that you can contain it is not possible…so people expect a lot from us that good but we will always err it will not change today it will not change tomorrow that a nurse has been rude to somebody it will not in the near future. (Napo)

Walker (2002) argues a person's moral identity may be "overridden or disconnected" (p.444) by profound pressure making the acknowledgment and responding to certain values such as compassion, empathy, and respect for others fragile. Napo like others noted that while it was unacceptable and inconsistent to be 'wicked toward people' or 'make people suffer', she acknowledged it was unavoidable due to the ongoing circumstances despite their training.

When morality is viewed as a set of "codifiable, impersonally action-guiding within an agent or as a compact set of law-like propositions that explains the behaviour of a well-formed moral agent " (Walker, 2007, p.8), it fails to acknowledge the social environment in which the agent is situated. Such code-like assumptions [respect for autonomy, beneficence, nonmaleficence, and justice] are the main concepts found in the nursing and midwifery curriculum and Code of Ethics of the Nursing and Midwifery Council of Ghana (Nursing and Midwifery Council of Ghana, 2015) without consideration of the context of practice. It was, therefore, not surprising when Napo indicated that they were not 'superhumans' living in a perfect working environment in which they have to apply these codes. Although they were trained to do so, it was impossible to apply these codes to practice uniformly since "morality is not socially modular" (Walker, 2007, p.17). Napo further acknowledged while they were expected to do 'good', violations were bound to occur since everyday moral practices cannot "transcend culture, history, and material conditions" (Walker 2007, p.9).

Theme Three: Gender and Socio-Economic Inequities Shaping the Moral Social Context of Practice

This theme provides insight into the gender and economic inequities that influence and shape the socio-moral context of nursing and midwifery practice. Walker (2007) argues that a moral environment is "culturally and historically" (p.45) shaped by the characteristics of its social setting, relationships, practices, and roles. This theme will highlight the nature and the characteristics of the moral-social context in which the participants practice. Subthemes to be discussed include: Caring at the intersection of gender and poverty, Negotiating conflict and practice with women and their families, and Gender-related workplace aggression and violence.

Caring at the Intersection of Gender and Poverty

This subtheme represents the intersection of gender and poverty and how it influenced and shaped the moral practice of the nurses and midwives. Practicing in a context dominated by gender and economic disparities had a strong influence on how the participants understood their moral responsibilities and capacity to enact moral agency. Nurses and midwives described the role and influence of poverty on the delivery of care to patients at their most vulnerable times.

The participants revealed the interconnection between poverty and the ability of women to receive care. For most of these participants, their moral agency was constrained by the inability of women to pay for the cost of health services due to poverty. Narratives of poverty and its consequences were dominant in several of the interviews and contributed to unfavourable outcomes as expressed in the following excerpt:

> I want to raise the level of poverty and we call it no money syndrome…They cannot actually buy the extra medications that are not covered by the health insurance or run the extra lab requested. So, you see that patient going down and you know that this patient could have survived with the appropriate antibiotics and the appropriate treatment to her, but you see that the patient will just go and then it would add to our mortality rate. This is a clear case of preventable maternal mortality. (Kahu's second interview)

Walker (2007) argues that illnesses, unpredictable vulnerability, and dependency may be influenced by "poverty and its lack of insulation from catastrophic effects" (p.143). Given that many women were uninsured, coupled with the existing social inequity and poverty, participants recounted that many women were unable to access care. The nurses and midwives described countless situations in which care was either delayed or women were left unattended for several days due to their inability to buy medicine and pay for other essential services. According to Kahu, such situations contributed to several maternal deaths which could have been prevented. Another participant highlighted that poverty was critical in how women made health care decisions, which posed a significant challenge in providing care:

> Poverty is playing a critical, critical role especially in the north here or this part of the country where a lot of people are vulnerable. I mean they are not financially empowered. So sometimes you just look at this woman who is standing there not employed…and confronted with this financial challenges and financial responsibilities…sometimes you get moved by it. Sometimes you just enter the ward and you just feel that just because somebody wants to deliver the person is ending up this way. There are certain times you can be moved by somebody's story and then staff will have to contribute, doctors and nurses all together would have to contribute for them. (Fako)

According to Walker, "any dependency and vulnerability is arguably created, shaped, or sustained, at least in part, by existing social arrangements" (2007, p.96). Such an unjust social arrangement stems from the oppressive conditions and patriarchal norms of Northern Ghana, which have consistently restricted women from gaining economic empowerment, thereby, creating conditions of dependency and vulnerability. According to Walker (2007) the "cruelty and burden imposed by oppressive conditions" inflicted on people miserable cost and terrible losses, including psychic ones" (p.132). Fako said:

> Sometimes this is the kind of trauma that we sometimes have to go through. Yes, in the training sometimes you are told that if you come into the field these are some of the things you would be seeing but in my own view I would have wish that looking at the kind of clients we take care of there are some people will come you can't feel than to get emotional. Sometimes you share in their pain and sometimes they eventually pass on and

> then you will have to suffer that torture for some time you don't have anybody to talk to. (Fako)

Caring for disempowered women provoked intense suffering, which negatively impacted the emotional well-being of the nurses and midwives. Although, Fako acknowledged that while they were aware of the impact of socioeconomic inequities on the access to and use of health services, the impact of caring under these conditions on their emotional well-being was underestimated during their training. As participants became witnesses to the "daily miseries, indignities, the intergenerational effect of poverty and social marginality" (Walker, 2007, p. 217) of women, they were left feeling emotionally traumatized. Bearing witness to injustice or gross violations and being unable to prevent them led to "storm of difficulty and exhaustive feelings" (Walker, 2007, p.222). Fako characterized these 'storms of difficulties and exhaustive feelings' as 'suffering, torture, and trauma'. These storms of difficulties often exceeded their internal coping abilities, and there was no form of emotional support provided.

In the face of overwhelming poverty and limited insurance coverage, the nurses and midwives recounted several instances when spouses and families either abandoned or neglected women at admission. In the following excerpt, Kahu revealed how spouses chose to abandon their wives due to financial challenges:

> Some of the relatives and husband will abandon their wives and go home because there is no money to care of them a situation where a particular service is not covered by the national health insurance, we are operating in Ghana…They just dump the patient not within an hour but running into days and the patient is being dump on the nurses like that. (Kahu second interview)

Similar narratives of neglect or abandonment of women by their families were dominant through the interviews. Conditions of dependency and "diminished statuses, economically and socially" (p.231) may render some people vulnerable to neglect and harm (Walker 2007). These

conditions resulted in the need for the participants to assume responsibility of caring for neglected and abandoned women:

> So, we have to go through the whole process of caring for such a person…You see them they are long overstay they are not getting food to eat nothing you have to support. You deep your hand inside your pocket and bring something out you give money. You are caring for a patient as a nurse and you turn to be a relative as well. (Bama)

For these participants, with the increased levels of family neglect and abandonment, their responsibilities have expanded to include the roles and responsibilities otherwise taken by families. Nearly all participants bought food, delivery items, baby sheets, baby clothing, diapers, medications, laboratory services, and transportation to bring women to the nearest facility and back home after discharge, out of their already overstretched monthly income.

> There is no day we would not buy food for patients and drugs…We have to use the little that we have at the close of the month, you go and take your token to care for your children you use that to buy food. (Velim)

The nurse and midwives were compelled to deal with the failures of a dysfunctional health care system and socio-economic inequities and policies with their monthly income, yet these invisible aspects of nursing care were left untold. In some instances, the nurses and midwives were projected in a bad light by the women and their families when they were unable to support them or attend to their needs. Kahu said:

> The public would see nurses as being insensitive because the patient lying down in pain is looking at you the nurse the immediate person he sees and she thinks that you are all in all and you have all that it takes to actually help her…so it actually dent our image as nurses. The public would say that we neglect their patients and the patients will also see that nurses are neglecting them but that is not the case. (Kahu)

For these participants, in the public domain, the word nurse was synonymous to a hospital; hence, when patients' needs were neglected or abandoned by relatives, it was assumed that the nurses had neglected their responsibility.

The demand for discharge against medical advice was reported by participants to be a common practice by families who are unable to bear the cost of health care services despite the seriousness of a woman's condition. Participants recounted several instances when the families of women with pregnancy induced hypertension and other high-risk pregnancy related conditions requiring prolonged care demanded that they be discharged due to financial constraints. Fako said:

> There are certain times some relatives too have no money to pay for the expenses and they will come asking for discharge against medical advice even though sometimes the condition is very critical…that they don't have any financial muscle to be able to tolerate the kind of treatment there are going through and three sometimes they will tell you that they want to go for treatment somewhere…but mostly, mostly, mostly is the financial muscle and then lost of trust in the system. (Fako)

Fako highlighted major reasons families demanded discharge against medical advice with financial constraints and 'loss of trust in the health system' being the most dominant. The loss of trust was associated with the challenges of the NHIS, coupled with the limited coverage provided by institutions for those insured. For example, the majority of the participants recounted that laboratory services, emergency obstetric medications, blood processing fees, and medical imaging procedures were not covered by the NHIS or provided by the institution, therefore, clients were expected to pay, which resulted in them demanding discharge. Although the nurses negotiated with families to rescind their decision, they also described that mounting hospital debts with no support compelled many families to abscond with their patients even though they still needed care. The nurses, meanwhile, experienced an ethical dilemma in their attempt to respect families' wishes for discharge against medical advice versus their responsibility to safeguard the lives of women. Such actions by families provoked a feeling of distress and expressed by one of the participants:

> Is the psychological. Definitely psychologically you will be hurt because you want to save the life and the person is not agreeing. You know the consequences behind the condition that she is in, but they don't know. (Paya)

Paya expressed feeling distressed knowing the consequences of such a decision by family members had on the patient's safety and well-being. The consequences of early discharge, such as an increased risk of poor treatment, increased morbidity and mortality, and readmission intensified feelings of distress.

Economic disempowerment, coupled with patriarchal norms, limited the ability of women to make decisions regarding treatment interventions. Feminists have argued that the intersecting nature of oppressive forces diminishes the capacity of oppressed people to exercise autonomy (McLeod & Sherwin, 2000; Walker, 2007). These forces are rooted in patriarchal and gendered social arrangements that subjugate women, perpetuate abuse, and violence against them, and hinder their capacity to develop the skills necessary for making autonomous decisions (McLeod & Sherwin, 2000). The nurses worked in a context where these oppressive forces were endemic and women were not allowed to make decisions, including those concerning their reproductive health. Lasi revealed in the following excerpt how these oppressive forces inhibited the ability of women to make decisions about their treatment. She said:

> Dealing with Northern women you know is very difficult. The men have a lot of bias ideas about women in Northern region like a woman cannot send a man to do this…They have the decision and a woman will be suffering kroaaa [continuously] wait till my husband comes I can't take a decision and that one is worry to us. It is very, very worrying you have to wait sometimes when you see waiting that the waiting period is too much then you take a decision and the man will come and be talking why did we take that decision. (Lasi)

According to Mcleod and Sherwin (2000), when an oppressed person lives in a context that does not foster the ability to develop skills and the self-trust necessary to make autonomous decisions, he or she will not be able to exercise autonomy, even when an opportunity is

presented. The women being cared for by the nurses and midwives had not been able to develop the skills necessary for making autonomous decisions because these oppressive forces had often limited a woman's "opportunity to make meaningful choices and to have her experience of having her choices respected" (Mcleod & Sherwin, 2000, p. 262). Lasi recounted instances of women suffering and in need of urgent obstetric intervention who would often refuse treatment because they had not learned to make their own decisions when the opportunity was presented to them. There were also instances when participants described women who were abandoned by their spouses still insisting on getting permission from their spouses before they would allow any intervention. Another participant shared her frustration in the following excerpt:

> Let me call my husband, my father-in-law to consult them first or they have to see a fetish priest before they agree. You feel so frustrated because the woman would not agree until the husband says yes. Wait for my husband to come. (Paya).

While many nurses and midwives perceived the women had the right to make decisions, the women insisted that their spouse must sanction their decisions:

> Some of them would just tell you that religiously that if the husband doesn't give her the go ahead to do any procedure you can't do it. You would think that you would use force and do it, but the woman would go home and have problem may be go and face divorce for not listening to them. So, in order not to separate them you just wait. (Maya)

Mcleod and Sherwin (2000) argue that oppressive forces constrain the choices of women by "placing them in a double bind" whereby whatever decision she makes has consequences. Maya revealed in her excerpt that any woman who attempted to exercise autonomy or override the decision-making process without spousal approval would likely face sanctions such as divorce. Another participant also revealed how the oppressive conditions have interacted to render women powerless and dependent:

> I feel like some of the women up North are not really empowered themselves so it like they are always depending on the husband if he is not able to buy the drugs for her she is incapable to get the drug…the husband doesn't even care and they are even nowhere to

> be found…I always feel for the women is like they have not been empowered enough to really speak for themselves or stand up for themselves is like what the man decides is what they really go by and sometimes it hurt, it really hurts. (Kasi)

Oppressive practices create conditions of powerlessness and dependency that render the oppressed incapable of living a meaningful life and the oppressor the power to dominate continually (Walker, 2007). The participants revealed how women were rendered incapable and depended on their spouses, who often did not show concern or regard for their health care needs. Since most of the nurses and midwives were women, they expressed resentment and condemnation of the oppressive conditions that disempowered women and hindered their capacity to access basic health care needs. Women's disempowerment was echoed by several participants as a major influence on their decision making. This included a lack of formal education and economic disempowerment, coupled with culturally prejudiced marital norms that turn women into men's property. These kinds of conditions render women subservient and create restrictive conditions for women to develop their autonomous selves. The relational influence on women's decision-making ability was a major source of conflict between participants and women and their families and contributed to delays in interventions and threatened patient safety. McLeod & Sherwin (2000) described these relational influences as the social and political structures within which an agent is located that tends to shape and control his or her ability to exercise autonomy.

The cultural myths surrounding medical intervention in childbirth constituted one of the difficulties encountered by nurses and midwives in meeting their caring responsibilities. According to the participants, these cultural myths are deeply rooted and shape how women made decisions regarding intervention when vaginal delivery became impossible. Culturally, vaginal birth is most desired and valued by women in Northern Ghana, thus, any attempt of

assisted delivery or intervention to prevent unwanted outcomes was often resisted by women and their families. While this belief about vaginal birth is consistent with the midwives' philosophy of natural birth, in conditions such as obstructed labour that make vaginal delivery impossible, they tend to encourage assisted interventions. Lasi shared her encounter working in the labour:

> Sometimes abruptio so you tell the woman that with this condition she can't deliver per vagina. She would say no I have been delivering normally why do they want to cut me I won't agree. Such situations are very common. You know they feel that a weakling goes in for CS [Caesarean section]. Those who go in for CS they cannot bear labour pains that is why sometimes they refuse. (Lasi)

Such actions in the face of impending complications were perceived by participants to be contrary to their values. Having a vaginal birth in some cultures in Northern Ghana is considered an act of pride and bravery. These kinds of beliefs are standard features of oppressive cultures in that they often "shape the agents' values and desires in ways that undermine their capacity for autonomous choice in certain matters" (p. 261) and to weigh the consequences of their actions (McLeod & Sherwin, 2000). For example, in the following except, Lina revealed that the value and desire of women to have a vaginal birth resulted in many of them concealing information about their previous history of Caesarean section:

> A woman came with three previous CS [Caesarean section] fully dilated from the house and they didn't write on the antenatal card. When I positioned the woman then I saw a scar then I asked bi na min nin a operation [have you had a caesarean operation] and then she said yes. So after the baby came out then she now said in Arabic [alhamdulila pun ponɔ n gba tooi duɣi m maŋ maŋa [thank God I have also delivered by myself] and I said why did you say that and she said I have gone through all deliveries by CS [Caesarean section]. Madam all the three deliveries were caesarean section, and this is the only delivery I have had on my own. You can imagine if the woman had ruptured. (Lina)

Women's cultural beliefs and values surrounding medical interventions had an impact on how participants understood their moral responsibilities. Given how deeply ingrained some of these values and beliefs were, the nurses and midwives would have to find ways of working between their value of safeguarding lives and those of childbearing women.

Negotiating Conflict and Practice with Women and their Families

For nurses and midwives to address the conflicts with women and their families and still meet their moral responsibilities, they had to find ways of negotiating their practice. Considering the complex nature of the conflicts they encountered with women and their families, participants adopted different strategies to deal with these conflicts. In caring for disempowered and uninsured women, participants negotiated practice through advocacy as they attempted to fulfill their moral responsibilities. Although the nurses often paid for some of the services and bought medicines, they also advocated for alternative, low cost prescriptions that were either not covered by insurance or deemed to be expensive. Kasi said:

> Sometimes what I also do in my own way is if the drug could be changed to another one which is within the hospital or cheaper then I draw the doctor's attention to change it. (Kasi)

While alternate and low-cost treatment ensured that women received the needed treatment, such cheaper alternatives may have compromised safety, increased risk of inadequate treatment, and prolonged the hospitalization period. Moral dilemmas associated with caring for poor and vulnerable women raised profound moral questions about social injustice and the deprivation of access to quality care caused by poorly implemented social intervention policies.

Participants also engaged in collaborative practice with the social welfare unit to negotiate care for women who were unable to pay for the cost of services as expressed in the following statement:

> Sometimes we even involve the social welfare, but they can also help to some extent. (Fako)

The social welfare unit was an administrative unit of the hospital set up to provide support for families who were incapable of bearing the cost of medical services during hospitalization.

However, poor and inconsistent funding from government agencies limited their capacity to support families in need.

> There is no system to actually absorb such things. Social welfare sometimes says that if the things are in the hospital they can write to waiver. (Kahu)

The failure of institutions and social policies to ensure equal access to health care further raised the question of whether health care was a right. A social welfare system is mediated by a background of understanding of human well-being, vulnerability, and principles of equity (Walker, 2007). But the participants acknowledged that the social welfare system operating within their institutions have failed to operate based on these understandings, leaving many women in more vulnerable positions. For example, Kahu indicated how inadequate funding to support social welfare programs continues to disadvantage vulnerable people in need of access to health services.

The nurses and midwives provided counseling sessions to women who were unable to make autonomous decisions regarding treatment in the face of imminent dangers to their health. Counseling was a way of getting women to reconsider their decisions. For example, women who refused to undergo birth by Caesarean section due to obstructed labour were often counseled about the dangers such as obstetric fistula formation. Although women had limited power to make decisions, participants felt counseling them about the consequences of their actions might help them to take responsibility for their own lives. Paya shared this in her statement:

> You are a counselor and so you need to counsel well for the woman to understand. Try to convince. (Paya)

Participants provided women with information on the risks and benefits of their actions to allow them to make informed decisions. While counseling of women was an alternative to addressing the oppressive forces that restrict women's ability to express autonomy, it did not produce any

effect since the sanctions for disobeying are great for women. Because the problem of women's autonomy is rooted in oppressive conditions, counselling without dealing with the oppressive conditions would not enhance the ability of women to exercise autonomy. As a result, the participants were left with no option other than to respect the rights and choices of women when attempt at counseling them to reconsider their decisions to refuse treatment or to seek discharge against medical advice failed. Respecting patients' right to accept or refuse care was in keeping with their nursing code of ethics as well as conventions. The importance of respecting patients' rights to refuse or accept treatment was expressed by Neira in the excerpt below:

> Is patient right you can't force the person to go and do it. So, whatever that you will do and the person is also claiming that no I won't do is patient right. So, once you are doing and you know your responsibility you should know your right as well because dealing with patient sometimes the kind of dicey situation if you are not careful you can put yourself in trouble. So, whenever I take decision, I look at both sides before I take decision. (Neira)

She acknowledged that while it was their moral responsibility to ensure the safety and well-being of women, it was also within the rights of women to refuse or accept any form of treatment. The desire to do what is right and respect women's choices left them struggling to define the limit of their responsibilities. In negotiating practice, Neira revealed that she looked at 'both sides' of the situation to determine what her limits were.

According to Walker because human relationships and situations are not always similar and moral negotiation is an ongoing process, "new situations must be mapped onto past understandings and projected into future possibilities" (Walker, 2007, p.72). The decision to respect women's choices was based on the understanding of similar situations and the consequences of future violations, as reflected in Didi's excerpt:

> We have had client who want to sue us, but the management always calls the various parties involve and they drop the issue. Now they know their rights, they know their right from the wrong. They know that they have right to refuse certain things…I know I have

> the right to say I want this, or I don't want this and some of them are also enlightened ….that is how come there are lot of people threatening to sue and all that. So if you maltreat or mistreat a client you will not go free because she knows her left from her right so if you go and beat a client because you want her to push after delivery she can take you to court. (Didi)

Recognizing the limits of their responsibility and the liability of their actions toward women influenced how participants negotiated practice. As women were increasingly becoming aware of their rights, the nurses and midwives had to balance women's needs for care and respecting their rights. While there were instances when the interplay of workplace pressures compelled the nurses and midwives to coerce and verbally abuse women during childbirth, Didi mentioned that such actions constituted a violation of women's rights.

Collaborating with families and community members was one of the strategies participants adopted in dealing with the conflicts associated with women's inability to make their own decisions. Walker (2007) argues that morality is essentially collaborative and expressed through a shared medium of understanding and negotiation between people over situations related to human care. This view of morality is culturally situated and allows for the resolution of moral problems through interpersonal understandings. For example, because decision making was gendered, hierarchical, and multiple, the nurses would have to negotiate with all important stakeholders before they were allowed to provide women with care. Maya said:

> Sometimes we involve the senior most person in the family and is difficult getting them to the hospital, very difficult. So sometimes we go to liaise with the community volunteers, the influential people and you know every community has a health volunteer so we get such a person and they would now tell us who to go and meet for the person to talk to the one with the problem to listen…so that is how we normally do. (Maya)

These kinds of negotiations were prolonged and involved multiple family members and clan heads and could take up to several days before decisions were finally reached. In emergency situations, this process was challenging for the nurses and midwives, compelling them to

override decision making authorities to save the lives women and their unborn babies as expressed in Lasi's excerpt:

> Sometimes we look at the condition too if the distress is much, we would not mind you we would go and do the CS for her and we let the woman thumb print [consent] then we will get other witness to do it. You know what is happening to the woman so sometimes you are looking at her health and her condition that she is presenting, and you know that if I should leave this woman, she would lose her life. (Lasi)

For the participants, knowing the nature and consequences of obstetric conditions, it was imperative on their part to prioritize the health and safety of the women over all other things. The inability of women to exercise autonomy in the face of impending complications resulted in instances of paternalism.

Mcleod and Sherwin (2000) have argued that oppressive conditions that render women powerless to exercise autonomy may leave them subjected to medical paternalism from health care providers. This was revealed in Lasi's excerpt when she recounted an instance in which she had to coerce a woman to consent to a Caesarean section based on the reason of safeguarding the woman's life. While this finding may contradict an earlier finding of respecting the rights of women, it also reveals the complex nature of making decisions when moral values conflict. For example, because participants perceived obstetric complications and death as a threat to their moral values and identity, they tended to justify the use of coercion as a means of demanding compliance from women and prevent unwanted outcomes. For these participants, failing to intervene was perceived not only as an act of irresponsibility but also a moral failure when their refusal to intervene resulted in maternal morbidity and mortality. Curricular documents, reviewed as part of this study, showed that the ethics training of the nurses and midwives did not provide knowledge and skills for addressing conflicts relating to treatment decisions and how to

respond when moral values conflict. In addition, the institutions themselves had no guidelines to support participants to address these kinds of conflicts.

Gender-related Workplace Aggression, Violence and Insecurity

Workplace violence and aggression associated with visitor intrusion was reported by more than half of the participants and contributed to creating a morally uninhabitable workplace that negatively threatened the safety of participants and that of their patients. Visitor intrusion was described by participants as a common source of conflict between nurses and patients' families, with the majority of intruding visitors being male. The institutions had designated times when families could visit their patients, however, nearly all participants reported there was non-compliance with these rules. Visiting hours were boldly written on directional signs of the hospital and the entrance of each ward to inform and remind families. According to the written information, visiting was from 5:30-7:00 am for the morning hours, while evening hours were between 4:30pm -6pm. However, a lack of enforcement of these visiting times resulted in non-compliance by the public in the wards, which Deli metaphorically described as a 'farm':

> It is a farm when you feel like entering. You enter when you feel like going out. You go because we don't have even though we have visiting hours, but our visiting hours doors are open. What time you are coming in you can come and visit that is the way I would say it. Because we have written the visiting hours and pasted on the door just the entrance to the ward, yet we don't have visiting hours. (Deli)

Despite the written policy stipulating the recommended hours of visiting, in real practice it was non-existent as visitors moved in and out at will with impunity. Such uncontrolled entry and exit times interfered with the participants' capacity to provide care for the women.

> You realize patients' relatives are all over the ward and you want to carry out a procedure or something and they are all over. You can be shouting they should excuse, you want privacy for the client and looking at thing we don't have a proper screen. Is just recently we had a screen that kroaa [even] it wasn't proper so sometimes you want them to go out and at least you just screen some portion and work for somebody some of them would even stand by and be insulting you and shouting at you. (Neira)

An attempt to get visitors to comply resulted in verbal aggression and slanderous comments toward nurses. Visitor intrusion has been described by Afani as the most frequent source of conflict between staff and patients and their families, especially when they were refused entry into the ward:

> Most of the time that is just where conflicts with patients, relatives and the medical team the nurses, Drs, and everyone. Because if you are coming on, we will prevent you from coming…they wouldn't understand. There are times it even becomes arguments like very loud ones. (Afani)

Nurses and midwives encountered resistance from visitors in their attempt to enforce compliance of the visiting hours. Besides the verbal abuse, other participants described encountering threats of physical abuse:

> There are instances you tell somebody to go and it will turn into a fight and the person wants to even beat you because you have prevented the person from seeing his relative. (Zoya)

Similarly, several other participants also recounted instances in which they were pushed, slapped, and threatened with acid and gang attacks when they attempted to prevent intrusion. These kinds of situations threatened the safety of participants and those of their patients.

Nursing and midwifery, as predominantly female professions, have endured low social status both from within and outside the workplace. This low status stems from the "complex history of long-standing systemic oppression and subordination that spans generations but remain partly hidden" (Walker, 2007, p. 214) and contributed to the violence perpetrated against nurses and midwives. Participants recounted that cultural prejudice towards women in a predominantly patriarchal society contributed to the violence they experienced as nurses. In Northern Ghana, women are not expected to exert authority over men, hence, any attempt by the

nurses to ‘sack’ male visitors out of the ward was met with fierce resistance. Neira shared her experience below:

> Mostly the male relatives they don’t respect the profession that we are into. They don’t respect you the nurse working here at all like they talk to you anyhow…sometimes they come and see you maybe they think that you are some small girl so…I think culturally it is because gender issues, they feel they are men, and man is man so a woman you can’t do anything or order him out. (Neira)

Gender-related factors were highlighted as the predictor of violent acts toward nurses. According to Walker (2007), oppression does not occur without “uncountable acts of violence and abuse committed” (p.214) against the oppressed. Oppressive forces diminished the value of others and make them vulnerable to abuse and violence.

A violence-free environment is a key component for effective and safe care delivery. However, participants described the lack of workplace violence prevention policies and inadequate security at the entrance of the wards both contributed to exposing them to violent behaviour from male visitors. An attempt was made by me to retrieve violence prevention policies and to ascertain whether there was a formal reporting system of the violent acts, however, there was none available in all three institutions. This was further confirmed during an interview with Maya:

> You don’t see any security person at any ward entrance. So, when we complain to management the way patient relatives are harassing us and attacking us. I wrote memos to the effect, but they told me that be your own security, be your own security and the simplest was that lock the door when you are inside …so whatever you would do to survive you do. (Maya)

Maya revealed how management has shown blatant disregard to protect them and provide a safe working environment. In a further demonstration of management irresponsibility, the participants were told to be their own security.

Walker argues that societies or institutions that preside over abuses often do not show interest in knowing what is happening and even if these abuses are reported they tend to doubt or downplay them (Walker, 2007). She further argues that such action prevents these institutions from taking on additional responsibilities. For example, instituting a violence reporting system may have revealed the extent of the situation and would have required the provision of security on the wards. Although they were told to be their 'own security', being predominantly female professionals working with female patients increased the risk of being exposed to violence and harm. Such a situation coupled with the lack of policies to address workplace violence resulted in a heightened sense of fear and insecurity among nurses and midwives, diminished work engagement, and threatened patient safety and well-being as expressed in the following excerpt:

> We have seen nurses threatened and nothing has happened…so that one has actually created some kind of insecurity…the patients are also under insecurity because we don't know who is coming in at any point in time and the nurse too you are alone in the ward with so many eyes on you and you are alone so you don't actually know what would happen to you next. (Kahu second interview)

Living in constant fear of the unknown in a work environment that was dominated by violent behaviour was in itself, a form of psychological violence. Deli also expressed her fears in the following excerpt:

> The insecurity of the ward is terrible. We should not wait for the harm to be done before we say aah we should have been prompt. So, me that is my fear, that is my fear…is not the best…is not a safe place. (Deli)

Unsafe conditions led to a decrease in work output as many staff focused their energy towards thinking about what could happen to them rather than focusing on giving care. The nurses and midwives have emphasized the danger of workplace violence. An environment that promotes violence and suffering is deemed to be morally uninhabitable and a threat to patient and staff well-being.

Theme Four: Working with Incoherent Moral Understandings and Damaged Identities in the Context of Inter- and Intra-Professional Relationships

This theme highlights the nature and influence of working relationship on the capacity of the nurses and midwives to enact moral agency. Walker (2007) argues that when analyzing the habitability of social moral orders, it is important to ask what kinds of "understandings sustain practices of responsibility, and how do those understandings work" (p.11). The aim of this kind of analysis is to determine what moral understandings shape the interaction among people. This theme represents the kinds of understandings that shape the relationships among the participants and other members of the health care team. Subthemes to be discussed are: Hierarchical and oppressive inter and intra-professional relationships as constraining moral agency, Culture of blame, and Negotiating Practice and Responding to Conflicts.

Hierarchical and Oppressive Inter and Intra-professional Relationships as Constraining Moral Agency

Nurses and midwives described working in a context that was generally dominated by hierarchical and oppressive relationships. These oppressive relations led to a morally uninhabitable work environment and constrained their capacity to enact moral agency. Power is central in determining how people exert control and influence in moral social orders like health care institutions. Participants described how interprofessional power struggles among members of the health care team were pervasive in the obstetrics departments. The culture of the obstetrics departments was one in which power remained unshared and guarded by each professional group. This desire to concentrate power was characterized by Napo as 'power drunkenness' in the following excerpt:

> There is internal power struggle among the people here as to who is to lead. Nurses, doctors, orderlies, everybody. Is just power drunkenness. Everybody wants to show that he is powerful where he is. You know is power. People want to assume I am in charge of this, is my place. I control this sector. (Napo)

Walker (2007) argues that when a society or institution is "pervasively segmented and stratified" (p. 56) along the lines of gender, educational status, professional status, and hierarchies of power, there are bound to be "competing styles of moral understandings" (p. 56). Healthcare professions are dominated by power and hierarchy and the distribution of responsibilities follows these kinds of patterns in determining who has control over treatment decisions and spatial boundaries. Nurses and midwives recounted instances of power struggles among doctors in the obstetric departments as they all attempted to assert control over treatment plans. This excessive show of power left the nurses and midwives entangled within power struggles. Trying to thrive in such a work environment had an impact on the enactment of moral agency of nurses. Kahu said:

> We are drawn into these struggles because whose orders are you following at a particular point in time? Because doctor A has ordered a, b, c within 24 hrs or just after 24 hrs doctor B has come to order a, b, c. You cancel one, then one will ask you that yesterday I ordered this and it is not given why. Oh, doctor there is a new review so he will say ok then it means that you are following him than me. So, they have kept us in a very bad light. Some of them think we don't want to take their orders or something. So, they have drawn us into the power struggle. (Kahu)

Amid struggles for control and dominance, nurses and midwives found themselves entangled in hierarchies of power that often made it difficult to determine whose treatment orders should be implemented. Walker (2007) argues that where there are "competing styles of moral understandings" (p.56), there were bound to be challenges and problems. In an attempt to assert authority, maintain control, and in a show of big personalities, treatments were often changed intermittently without due consideration for patient safety and well-being, thereby instigating the power struggle. The attempt by nurses and midwives to change or reverse orders was perceived by doctors as taking sides. These kinds of incoherent moral understandings had implications for patients' safety and well-being. Kahu highlighted how the power struggle has resulted in the lack

of continuity of care as treatment orders were changed in less than 48 hours, thereby making it difficult to determine the progress and efficacy of treatment on patients. Given the frequent changes in treatment plans and indeterminate orders, the nurses and midwives struggled to meet their caring responsibilities. Other participants also recounted how the power struggle and demand to respect the medical hierarchy created conditions whereby care was delayed. Mani said:

> Delayed care because I cannot go straight to a consultant despite how serious the case is and even despite how your personal relationship with the person is…once it comes to this you are seen as disrespectful to their professional hierarchy. You tell them I need your attention, oh you know I am a house officer I cannot do this I have to call my MO [medical officer]. MO is called ok you see we need to call a senior person and the person is probably not around or this one is specialist case I cannot touch…I think this our hospital people are so much post conscious. (Mani)

The hierarchical nature of the medical profession resulted in consistent delays in initiating nursing interventions and sometimes the neglect of patients. Mani revealed several hierarchies she had to navigate to get doctors to attend to patients. She recounted that despite her personal relationship with senior doctors, she was not allowed to communicate directly with them about matters related to patients as doing so amounted to disrespect of the medical hierarchy. The medical profession was pervasively hierarchical with a strict chain of command that ranged from the consultants and specialists to house officers. Within this hierarchy, senior doctors were directly responsible for making decisions regarding the treatment and discharge of patients. As a result of the junior doctors' desire to respect the medical hierarchy, coupled with fear and intimidation, made it difficult for them to effectively communicate with senior doctors even when the patient condition demanded urgent attention.

According to Walker (2007), when social moral orders are pervasively segmented and hierarchical relations are the norm, there are likely to be "different moral identities in

differentiated moral-social worlds" (p.18). These kinds of differentiation are based on the social location of people that for some prescribe privilege and for others subordinate or marginalize status. As a predominantly female profession within a patriarchal environment, the nurses and midwives described being ascribed a subordinate status. Pini shared her experience in the following excerpt:

> You know our setting one [doctor] wants to show that I am a doctor and you are a nurse. So, because I am a doctor, I am superior, and you are inferior. (Pini)

Nearly all participants used terms like 'superior,' 'superiority complex,' 'bossy,' 'boss-ship,' and 'boss' interchangeably to characterize the domination they experienced. These kinds of conditions created an unpleasant situation for the participants and constrained their ability to practice autonomously in several domains of their practice. One participant described the circumstances that contributed to the domination they encountered in the workplace:

> In Ghanaian society when you go for program with a doctor and there is one chair. They will give it to a doctor whether he is younger than you or whether he is older than you. So society places them above you…There are a lot of factors that makes them to have that superiority complex which is wrong anyway. So that superiority complex is in the doctors and they lord it over the nurses and some nurses also begin to feel inferior. (Napo)

According to participants, the societal privileging of doctors in public spheres and their placement above nurses had already created an unequal playing field. Walker (2007) argues that a society that embodies and legitimizes coercive forms of power allows some people to manipulate the arrangement that binds them with others. For example, Napo recounted how newly qualified doctors with no experience, enjoyed all the societal privileges that the senior nurses may not have enjoyed. According to the participants, these kinds of discriminatory practices already set the boundaries between nurses and doctors. Another participant also described how the training and socialization of nurses and midwives contributed to reinforcing their inferior status. She said:

> When we were students you were made to belief or see a doctor as a god or something. Because when we used to go to the ward, a doctor comes and the in-charge will be like get up and let doctor sit down, go and bring this for doctor to wash the hands and all that. So, if you don't take time you will be trained to see the doctor to some extent as your god. (Kasi)

From Kasi's excerpt, it was evident that the nurses and midwives have contributed to the subservient role accorded to them. According to Walker (2007), our conception of who we are is shaped in part by a "particular set of historical, cultural, and material circumstances, which already includes some legacy of moral understandings and practices of responsibility" (2007, p.13). The historical legacies of nursing have continually shaped the training and socialization of students into the nursing fraternity. Students were socialized during training to see themselves as servants of doctors. According to Kasi, such self-constituting master narratives (Nelson, 2001) propagated by senior nurses and midwives during training and in practice, contributed to how they were perceived and treated by the doctors.

When status and social position within social moral orders are constituted by unequal and hierarchical power relations, it tends to result in the subjugation of others (Walker, 2007). Participants characterized their relationship with doctors as one that required them to be obedient servants who need not question the authority of doctors. Ziga compared the relationship with doctors as that of a father and child:

> Some of them [doctors] when they come, they want you to be following them like you are a kid and they will be ordering you around, but we are also professionals, so we need to stand on our own in certain things. When they order you like that they demean your profession which is like they make you feel bad as if you don't know what you are about or something like that. But me I don't think midwifery is so. We are professionals with or without the doctor. You should be able to work without somebody ordering you or something like that. (Ziga)

There was an expectation that the nurses and midwives were to obey the doctors' orders without questioning them however, the nurses perceived that these kinds of expectations

undermined their professional identity that many have resisted. It was important to state that narratives of resistance were commonly shared by the younger generation of nurses and midwives who either had a diploma (30%) or a Bachelor of Science degree (53%). For the younger generation of nurses and midwives, resisting the subservient identity which had been accepted and uncontested by the older generation, was the only way to assert their professional status and demand for recognition. Mani said:

> The boss servant relationship is still there. They [senior nurses and midwives] don't question whatever the doctor says and so we the young generation when they see us questioning their authority then even the in-charges are wondering where that boldness is coming from. They think whatever they [doctor] say is final which we the young generation think it shouldn't be so. Then makes it look like nursing is still a vocation which is not so. Nursing is a profession now and as a professional I don't need to be given little instructions that belittles me, that makes me feel like I don't know what I am about. These are some of the things some of us the young ones quarrel with them [doctor] over but the older ones don't see anything wrong. (Mani)

While older generation of nurses still accepted the notion that they should remain obedient to doctors, the younger generation of nurses felt otherwise. According to Walker (2007), "when members of groups historically or systematically disqualified from epistemic and moral authority" (p. 79) begins to gain access to institutional spaces and assume positions of authority, moral understandings begin to shift. Given the changes in nursing education from certificate to diploma and degree, nurses have gained increased professional status and 'epistemic authority' but nonetheless, participants still struggled to gain such status and recognition. When the younger generation of nurses and midwives began to question the doctors' authority, they were perceived by the older generation of nurses as transgressors of established norms. The younger generation believed that failing to resist the subservient identity amounted to reinforcing the long-held assumption that nursing was still a vocation. For these participants, the relationship

between nurses and doctors must be one of mutual respect in which they both should work towards a common goal. Kasi provided an insight into the kind of relationship she envisioned:

> We are working together but we are working within our lane. They have their hierarchy they are following. They have like the house officer or medical officer is supposed to report to a higher person and then I as midwife or nurse I also have my hierarchy that I am supposed to follow. So ideally is just that respect should be between us. It should be reciprocal, but it does not mean that I should worship you. It doesn't mean that you should look down upon me or talk to me anyhow. I will not really give you that chance. (Kasi)

Walker (2007) argues that moral understandings on shared terms create mutual intelligibility and equilibrium among people as they try to harmonize and acknowledge each other's expectations, standpoints, actions, and responses. But these kinds of moral understandings may not be recognized in common because not everyone will abide by these shared terms. Participants expected that doctors would acknowledge these shared terms that bind the relationship between them, however, the doctors failed to honour the terms of the relationship. For example, Kasi expected a relationship based on reciprocity and mutual respect but rather found herself in a place where these understandings are dominated and sustained by hierarchical power arrangements. For many of the participants, as long as this mutual intelligibility and understandings were not recognized in common, they would continue to resist any relationship that was sustained by these unjust arrangements.

In a moral social order constituted by hierarchical and oppressive relations, not everyone has the moral and epistemic authority to speak (Walker, 2007). The matter of "who knows and who gets to say" (p. 56) in specialized institutions like health care was often the perceived preserve of doctors who are "most entitled to speak because they are in the best position to know" (p. 61). Afani described instances when she felt her knowledge was devalued because she

was deemed to be less competent and perceived to be lacking in the expertise and epistemic authority to contribute meaningfully to patient care:

> Sometimes they come to review without just asking anything. Its kind of make you feel like it is their work they know it and you have no idea about what they are doing. They are superior to you. Even if he asks you what at all are you going to tell him. He feels like he is knowledgeable in that aspect more than you are and there is no point in even asking you of your opinion. (Afani)

Despite the experience gained through their sustained proximity and presence at the bedside, the participants felt they were deprived of the opportunity to influence patient care decisions even when they knew the right course of action. For those who made attempts to assert their epistemic authority, they were described in derogatory terms. Kahu said:

> There are a number of occasions they will tell you, you are a mere nurse you cannot determine to me what to do. It is actually unpalatable situation. It doesn't at the long run helps because what happens is that the subsequent times I may not give you information that will help you and at the end of the day is the patient that suffers…so you are not recognized, your views are not taking into consideration. As times goes on that zeal and compassion for patients begin to also die gradually. Disuse and decay sets in. You get new ideas you want to discuss with people, but they are not actually trying to take it because you are tag in certain way [laughing]. (Kahu)

Being called a 'mere nurse' was the way participants who attempted to assert their authority on patient care decisions were characterized. These kinds of comments evoked unpleasant feelings within the participants and created a toxic culture whereby nurses and midwives withheld information that otherwise would have been useful in the planning of patient care, while others who perceived doctors to be unapproachable, failed to seek their support and advice, thereby endangering patients' lives. According to Walker (2007), when individuals experience disregard from those with whom they share a common moral understanding and trust, it can lead to confusion, hurt, outrage, and withdrawal. In the above excerpt, Kahu described feeling withdrawn from making any contributions since their suggestions were not recognized. These kinds of misrecognition and disregard contributed to diminished work engagement and

compassion towards patients and hindered their sense of initiative. Mani also shared a similar experience:

> Nobody thinks the nurse is a smart person. The nurse does something novel nobody recognizes it, but you do anything wrong then the whole world gets to hear about the nurse. We are looking for the good of the client and so if somebody who has been doing this for some number years suggest to you this should be done in this way irrespective of your certificate you should be able to understand that this suggestion is good for the benefit of the clients. (Mani)

In societies where the relationship among members of a community is asymmetrical, people in subordinated positions may find their moral and epistemic standing disqualified, silenced, discredited, or marginalized by others in privileged positions (Walker, 2007). Because most nursing activities largely consist of ministering to the physical and emotional needs of the sick, dependent, and vulnerable people, they are often disregarded and trivialized. According to Mani, this kind of trivialization of nursing practice, discredited and disqualified them as competent knowers, there by marginalizing and depriving them of social recognition and eliminated them from participating in decisions (Walker, 2007).

Mani further indicated that doctors should consider what is at stake since the continuation of their relationship and "particular lifeways rest on the goods to be found in living it" (Walker, 2007, p.7). Refusing to take the right course of action at the appropriate time was described by participants as contributing to negative outcomes. Patients invariably suffered in a health care environment where oppressive and hierarchical relations are the rule. For participants, excluding and marginalizing them from patient care decisions hindered their ability to exercise autonomy and resulted in a delay in initiating the right intervention required to save the lives of patients.

Participants also described how power struggles among nurses and midwives significantly impacted the nature of their relationships. Intra-professional issues relating to differences in educational levels, opportunities for promotion, and territorial control contributed

to power struggles among nurses and midwives. Didi shared her experience working in labour ward:

> I don't know whether is women thing? You know when two women are there post sharing. I want the post. I want the post…power struggle is there because the one who is in charge thinks I am taking her post from her and meanwhile is not so. I am the principal, you are all principals at a particular place. One has to be an in charge and already this one thinks she should have been the in charge and this one also thinks she should be. So already there is tension at the particular ward. So, with this whoever goes to this side you are attacked ok. You are for this person, so you are attack. (Didi)

In Ghana, the midwifery profession has different levels of education and qualification. Currently, there are four different categories of midwives practicing across hospitals in Ghana namely: enrolled-nurse midwife, diploma midwife, general-nurse midwife, and degree midwife as well as generalist nurses. As a result of the inconsistency in the licensing process, lack of clarity in the scope of practice for each level of midwife coupled with inconsistent and delayed promotions resulted in the struggle for control and power over ward management. Didi noted that this kind of intra-professional power struggle affected the relational dynamics in the ward.

Despite some of the power struggles among nurses and midwives, participants also described some of their relationships with their intra-professional colleagues as cordial, collegial, and respectful. For participants, the cordial nature of the relationship created an atmosphere for effective collaboration and fostered professional growth. During an interview with Ziga, a newly qualified midwife, she described how accommodating her colleagues were despite her inadequacies as a new graduate. She said:

> In terms of relationship with senior and junior colleagues is ok. They don't shout at you. If you do something and is wrong, they will call you and tell you. You should have done it this way and that way. That way is good, and I appreciate that. Because they wouldn't talk to me in front of patients. (Ziga)

Unlike most of the encounters with doctors, Ziga felt her colleagues created a more supportive environment that fostered her professional confidence. Ziga described how both her

strengths and weaknesses were embraced as well as her professional contributions acknowledged by her colleagues. Participants perceived their relationships with colleagues were less threatening and often collaborative. People make sense of their moral responsibilities and understandings through interpersonal acknowledgement (Walker, 2007). In this way, moral responsibilities and decision making were often shared among nurses and midwives. This kind of collaborative understanding is constructed and sustained by how people relate to each other (Walker, 2007).

Culture of Blame

Participants described working in an environment where blame was widespread and institutionalized. The blame was often associated with maternal death audit review processes. Maternal death audit reviews are conducted to determine the actual and potential factors leading to maternal deaths and to identify possible ways of preventing future occurrences. This process involves an in-depth review of obstetric interventions and care and a non-judgmental interview of health care workers involved in the caring process and some family or community members to improve care processes at an institutional level. However, participants described the failure of authorities to comply with these normative guidelines that resulted in the apportioning of blame to individuals. Maya shared her perception about maternal audit reviews:

> Me the one that I attended is like a blame game. I was saying like we are not trying to find solution to deaths but to apportion blame…when something happens and there is fault you don't blame anyone. You try to find a way of solving it but don't blame people. The whole hospital is dreading maternal death and even the doctors they all fear it because it discredits everyone. Anyone who is involve in that your image is brought down because is like you are not so smart at your work. When you allow a mother to die in your hands or a baby to die in your hands there are lot of question marks on you. (Maya)

Nearly all participants described the maternal audit process as blame apportioning. Maya recounted that the audit committee focused on who rather than what and why when maternal deaths were being reviewed. For these participants, the focus on individuals and the desire to

name and shame took away the attention from the broader institutional and socio-cultural factors that contributed to these deaths. Maya described how the blame culture resulted in widespread fear among the staff involved as their competency and integrity were often questioned during the review process.

A pervasive culture of blame and fear exerted a significant toll on how the nurses and midwives made meaning of their moral responsibilities as well as the distress it provoked. Lina also shared a similar perception of the maternal audit review:

> The hospital they blame you seriously, torture you more [high pitch voice] this one I will stress it…So at that moment they would put the guilty mask on you and sometimes they would even push the blame on you…They would push blames a lot of blames on you. They don't try to analyze what went wrong. They don't try to analyze anything…Even at that moment when they are talking you are not supposed to talk because you are a junior. (Lina)

Being made to wear the 'guilty mask' was how Lina characterized the outcome of a maternal death audit process. Participants perceived blame as a form of torture and associated with guilt and shame of being accused of 'killing' a woman. Walker (2007) argues that because social-moral orders are asymmetrical, those in positions of power are allowed to demand accounts from subordinate others, who are not able to demand the same from them. Lina described how institutional authorities did not allow her the equal standing to also demand accountability from them when a maternal death was being audited.

Blaming the nurses and midwives shifted the focus on addressing the underlying systemic challenges and reinforced and kept the blame culture circulating. Fear of being blamed even when they acted within their scope of practice bolstered the culture of blame and hindered their ability to pursue actions that were within their scope of practice. This was revealed by Bama when she said

> That kind of fear will be in you. I don't want blame. Doctor has not written. They didn't say I should give that kind of thing. At least there are other things you can do too but once that thing registers in the mind like even if I do the question will be who ask you to give it or who ask you to do it? (Bama)

These kinds of situations diminished the ability of nurses and midwives to provide compassionate care as well as led to the neglect of patients. The culture of blame and fear contributed to a defensive practice of covering up and denials and blame shifting. Because institutions substituted accountability for blame, staff failed to accept responsibility for errors or wrongdoing. In recounting an incident of a maternal death, Didi revealed how staff engaged in defensive practice:

> They [doctors] were trying to defend themselves that it was not them that they did the right thing…nobody was ready to accept the blame. For them they didn't do anything wrong. It was just meant to happen, and it happened. So, if I come and even if something happens on the ward and because we don't want them to mention name everybody is like is not me oh. I am not supposed to be telling lies at work ok but sometimes because of somebody's mistake and you want to save the people in a particular shift or prevent the hospital from going through a law sue I have to lie so that everybody goes safe. (Didi)

Defensive practice was pervasive because the accountability structure focused on people rather than problems. Dysfunctional relationships among team members also ensued as staff spent a valuable amount of time trading in blame games and cover ups rather than seeking to address the underlying problems. Defensive practice compromised patients' safety as participants engaged in cover ups. Didi described how she had to 'lie' to cover up for others wrongdoing to avoid exposing herself, other staff, and the institution to legal liability, thereby violating her professional value of truth telling.

Blame shifting was described by participants as a way of shifting the burden of blame to other wards or hospitals. Patients whose condition became unstable or were perceived to likely result in unfavourable outcomes were often pushed to another ward or transferred to other

hospitals. This resulted in conflict and animosity among participants and their colleagues. Lasi shared her experience in the following excerpt:

> We and labour ward sometimes as if we are rivals. If a client is there and the condition is changing, they would say go to maternity, go to maternity is maternity case. They are trying to push to you meanwhile the patient is collapsing, and you are carrying the patient to a different place definitely I would talk [laughs]. It is happening because of blame games. No one wants to be blamed…they would be pushing the client out to a different ward. (Lasi)

In an attempt to avoid blame, decisions were often taken not in the best of patients but rather as a self-protecting measure. There were also instances when blame shifting resulted in the neglect of patients as nurses spent valuable part of their time arguing about where the patient should be. During one of the observations, a patient in distress was being transferred from the labour ward to the maternity ward, but the maternity ward staff rejected the patient because they felt the labour ward nurses were pushing a terminally ill patient to them as a way of avoiding blame in the event of the patient's death. The patient was seen lying in the hallway between the labour and maternity ward for close to an hour while the nurses were playing blame games. As a result of the culture of blame, a valuable amount of time needed to resuscitate and provide urgent care for critically ill patients was spent on trading blames. Such a situation further endangered patients' lives and contributed to a poor working climate. Although maternal death audits have been instituted as a form of institutional accountability, the failure to abide by the standards guiding maternal death audits contributed to the overall culture of blame.

Walker (2007) argues that adopting a reciprocal and symmetrical approach to accountability would provide an equal standing for all parties to demand and give account. In this way, the focus is shifted away from 'who' to a collective form of accountability of how we have all contributed to the problem.

Negotiating Practice and Responding to Conflicts

In relationships laden with conflicts, participants adopted different strategies for managing these conflicts and negotiating practice with doctors. According to Walker (2007), the socialization of people in a social moral order provides them the opportunity to understand the nature of the interactions within it and "how best to navigate one's way through it" (p, 247). In situations when the nurses and midwives found it difficult to confront doctors over treatment decisions, they resorted to taking covert actions. This approach was frequently used by participants when they encountered prescriptions from doctors that they perceived would expose patients to significant risks, but did not have the power to confront them:

> Sometimes they [doctor] write it, but you swap it and do it your own way and we have never failed in that. We just ignore his dose and we give the right dose and disregard what he has written. You will not let them know. You just give the right thing. (Kena)

Because the participants were consistently denied the opportunity to influence decisions, they adopted a more subversive approach of getting the right actions done through concealed means. Other participants also described circumventing the medical hierarchy to avoid delays in treatment and the neglect of patients:

> There are certain cases I don't really need to see a house officer. I will ask house officer please is there a medical officer or a specialist on duty? He says yes and ask any problem, I will say no, is my personal something I want to discuss. Then I will then bypass them and go and talk to the MO or the specialist. You just have to use your discretion or be smart and just bypass. (Bama)

The nurses and midwives found themselves in an environment in which they relied on shrewd strategies to address some of the difficult situations they encountered with doctors. Words such as 'smart', 'wiser', 'tactical', and 'discretion' were used by participants to demonstrate how they negotiated conflicts with doctors and other situations of ethical concern. For example, Bama

stated that she had to use her discretion by evaluating the situation at hand and circumventing the medical hierarchy to get the needed attention for her patients.

The approach to managing conflict with colleagues was influenced by the nature of their relationships. Participants used a more collaborative approach in dealing with conflicts with intra-professional colleagues. Through open discussion, ethical issues, and alternatives were explored, differences were embraced and a mutually agreed upon resolutions were fostered. This approach also reinforced the mutual trust and respect that existed among many participants:

> When there are problems, we do encourage each other. As we are all there if there are problems at ward we sit together and solve it among ourselves. (Dami)

In a similar approach, Lasi described how they sit to deliberate on issues and address underlying conflicts that arise on the ward:

> When we see that a lot of things are happening, we call for meetings and we deliberate on some of the things. (Lasi)

Approaching conflict through a collaborative means created a platform for addressing future conflicts and fostered a shared responsibility of creating morally habitable workplaces. However, other participants had contradictory experiences as they recounted situations in which the lack of trust affected the conflict negotiation. Neira shared her experience below:

> Sometimes you feel that if you share your difficult experience at the workplace with a colleague, she can betray…sometimes I will just keep it to myself…so me when I have difficult situation in this ward, I keep it. (Neira)

Violations of trust undermined the process of negotiating conflicts that led to some nurses withdrawing from the entire process. Gossiping and backbiting hindered conflict resolution among some participants as they became withdrawn, uncooperative, and failed to provide information that was necessary for addressing the problems. In some instances, unresolved conflicts led to a toxic culture that resulted in poor team cohesion. Participants described

instances in which they chose to channel their conflicts through ward managers when speaking out with colleagues or when doctors failed to meet their practice expectations. Zoya shared her experience in the following excerpt:

> What I do is that I go to the in charge and tell her this is what is happening, and she will go and make sure the right things are done. (Zoya)

There was an expectation that ward managers were in a better position to mediate conflicts that participants encountered. This approach to negotiating conflicts enabled the participants to avoid direct confrontation with doctors and intra professional colleagues over difficult encounters.

Theme Five: Surviving through Adversity with Renewed Commitment and Courage

This theme reflects the emotional and moral cost of caring in the context of morally uninhabitable work environment. When people share stories about their moral life and practice, it creates an opportunity for them to assess the moral costs and consequences of their decisions and actions (Walker, 2007). However, the nature and impact of these moral costs and consequences may vary based on the morally provoking situation, individual personality and disposition, and supportive resources (Walker, 2007). This theme will highlight the moral and emotional toll on the participants as well the strategies for fostering resilience and demonstrating resistance. Subthemes to be discussed are: Suffering and enduring the moral and emotional cost, Fostering moral resilience, and Demonstrating moral resistance and influence.

Suffering and Enduring the Moral and Emotional Cost

Values such as compassion and empathy were expressed and perceived by participants as significant to their moral identity of being a nurse or midwife. Walker (2007) argues that people experience grief, trauma, resentment, and indignation when their deeply held values have been violated or compromised. As participants were confronted with multiple and overlapping

constraints, their ability to sustain their values were hindered. These kinds of situations left the nurses feeling morally distressed and emotionally traumatized. Shia recounted her experience in the following except:

> Sometimes some cases personally traumatize me, or I think about it a lot. So, I think we need a counseling session… The trauma is there like psychological trauma. Sometimes things happen in the ward and it sticks to your mind. Whenever you enter the ward that thing always comes to your mind. Others whatever happens in ward they don't take it or they don't even think about…I think it is because of frequent exposure to these kinds of things that is why they don't really think about it but then the frequent exposure can even make you more traumatized. (Shia)

Post-traumatic stress is one of the consequences associated with involvement in caring due to exposure to traumatic experience or encounter. Many of these participants were consistently having flashbacks of traumatic situations they had encountered, and yet they had no support to deal with these kinds of emotional trauma. Shia described how others have developed numbness and indifference due to their frequent exposure to traumatic situations by deliberately avoiding thinking about the traumatic episodes. She further acknowledged that such a passive approach may provide only temporary relief and leave the person even more vulnerable. Another participant described normalizing the experience of suffering as a way of coping with the situation. Dami said:

> Sometimes you just have to imagine and feel normal. At least encourage yourself and feel normal…you cannot do anything about it. (Dami)

Although normalizing enabled them to ignore and overcome their suffering, it also reveals how suffering had become routinized. Such practice may conceal suffering and hinder the development of interventions all of which may impact their emotional wellbeing. Fako said:

> If you endure such situations to a certain level, if you don't take time, it will affect your way of thinking and your way of behaving. You see people dying…and you have to contend with it till when you decide to leave the work or when you decide to go on retirement without having anybody to work on your psyche. You have to deal with it the

> hard way by allowing nature to stabilize you in midst of all the storm…If you are not lucky as the days go by and you encounter another then it means your threshold of anxiety or threshold of trauma increases…Sometimes if you go through the hard way of things over a times….it doesn't help your emotional self and even the clients you deal with every day. (Fako)

Fako recounted that using such self-mediated coping mechanisms was not healthy for their emotional well-being. In a similar encounter, Bama made a passionate appeal for authorities to address the emotional cost of caring on the nurses and midwives:

> I think is about time they handle the emotional aspect of caring for the patient. The emotional aspect I think we have somebody who will come in probably take us through how to deal with stresses. You have been post traumatic hurt by a patient you have nurse so hard and you lost the patient…a little kind of counselling just to bring your mind back to the job that these things are in line with the job. You should expect them and when they come this is how you should try to take it off your mind but there is nothing like that. (Bama)

Bama highlighted that their frequent exposure to difficult situations left them traumatized which when left unchecked, might lead to diminished compassion, empathy, and desensitization.

Walker argues (2007) that "a suffering that is misunderstood or dishonoured can turn on the self in an unendurable pain" (p. 211). The participants perceived that the lack of management attention or initiatives to support them only demonstrated the lack of understanding and misrecognition of the emotional and moral cost of caring on their lives. Mani expressed her sentiment in the following excerpt:

> Nobody speaks for the welfare or the well-being of the persons working here. Yes, is our responsibility that we have been trained to do but I think we are also human beings and then we need to be taken care of. (Mani)

The nurses and midwives felt their well-being was not a primary concern for their institutions. Participants highlighted the devastating impact of the emotional price they have to pay as they navigated to sustain their moral ideals. The lack of care and support from management further

impacted on the ability of nurses and midwives to provide compassionate care as they became depersonalized and disengaged from the system.

Several participants expressed fears about the long-term impact of frequent episodes of trauma as they continue to work in obstetric settings. The nurses and midwives were calling for a comprehensive approach to help them develop strategies to confront the everyday stressors they encountered. Kahu said:

> I think is a very stressful situation and then one cannot continue to work in this environment five years, 10 years or 20 years' time. Before retirement no one can actually predict the outcome…If there is a way that nurses and midwives can be group or workshops or other counselling sessions to actually teach them ways of releasing or relieving stress, diverse ways of handling such situations, how to react to issues those things, how to absorb pressure and all those things. If there is pressure, how do you organize yourself in a particular situation? (Kahu)

Participants described their practice as laden with physical, emotional, and morally stressful situations, and yet there were no opportunities to help them navigate through these situations. Although the symptoms of moral distress, compassion fatigue, and post-traumatic stress were pervasive across participants' narratives, there were no programs or initiatives to address them within the institutions. Despite the ethically laden nature of the work environment, participants appeared to be inadequately prepared to deal with the ethical challenges they encountered in their everyday practice. This was expressed by Didi in the following excerpt:

> I think at every level if you are pursuing your BSc or your master or at the PhD level, there should be ethics as part of the curriculum throughout. The NMC (Nursing and Midwifery Council) can organized training and the association as well. They can organize workshops and get facilitators who know ethics to organized and educate staff on the various ethical issues and how to address them. Because every time things are coming on, things are changing, new information is coming in, laws are being passed and all that so if they organized workshops more then it will help those of us who are already working. (Didi)

Didi noted that nursing and midwifery practice is evolving quickly and there is a need for nurses and midwives to be adequately prepared to meet emerging trends. The NMC and the

professional unions were identified by Didi as institutions that should take the responsibility of ensuring that nurses and midwives were abreast of current regulations and laws. When reviewing the NMC curriculum documents, I observed that more than half of the content of the course syllabus for ethics was devoted to the history of nursing. Further, when Didi was asked if there was an ethics committee or consultation service within the institution to help mediate some of the conflicts associated with patient care decisions, she said:

> I know there is a disciplinary committee in the hospital, but I don't know of any ethics committee. (Didi)

In addressing ethical problems, institutions chose to focus on disciplinary and punitive approaches rather than creating moral spaces that provide equal opportunity for moral deliberations (Walker, 1993). This punitive approach to resolving ethical conflicts endangers the moral habitability of a workplace, encourages the cover up of ethical violations, and discourages the resolution of moral problems or dilemmas.

Fostering Moral Resilience

In an attempt to mitigate the influence of workplace adversity, participants fostered resilient identities which enabled them to respond and navigate the difficulties they encountered. Moral resilience is the inward capacity of an individual to sustain and re-establish moral integrity when faced with complex moral demands (Walker, 2007). Through flexible resilience, a person is able to maintain his or her sense of wholeness when confronted with ethically laden situations that generate significant moral costs by drawing from their inner strength and spiritual or religious beliefs.

Religion played a significant role in how participants fostered resilient identities in the face of multiple adversities. According to Gyekye (1996), religion plays an important role in how

people make meaning about life events and experiences. People tend to find solace and help in times of adversity through spiritual uplifting. In narrating how she coped, Nako said:

> I know my strength, and everything comes from the word of God. So, I focus on the word of God. Psalm 113:106 says His word is a lamp onto my feet and light unto my path. So far as the word is a lamp on to my feet and light on to my path why should I worry. Because when you look at Luke 1:37 it says, "there is nothing impossible for God". So, when you look at or have all these scriptures in mind you use it to talk to your or encourage yourself. (Nako)

Nearly all participants held the notion that their survival and ability to cope with workplace stressors were through their spiritual beliefs. In quoting several Bible verses, Nako highlighted how her religious values provided meaning to her everyday experience. Similarly, Ziga described how she inwardly mitigated her adversity through prayer:

> You leave it to God and say God should take control. You have done your best and what you couldn't do you wish but you could not. So, you just leave it to God to take control and you learn to forget about it because you can't keep on reflecting, reflecting it will haunt you. So, I just forget and pray over it and just have to tell God to strengthen me. (Ziga)

There was a widespread belief among participants that seeking God's strength and control was necessary for maintaining a resilient identity. In times of adversity, many participants depended on their spiritual strength to cope. While religiosity may have helped to foster resilience, it is important to note that over reliance on religion may be disempowering since the nurses and midwives tended to accept the situation as it is without making an effort to demand accountability. Moreover, religiosity may be used to conceal failures that may be due to their own actions.

Building a strong moral community is important in fostering resilience. Moral community is described as people "motivated by the aim of going on together, preserving or building self and mutual understanding in moral terms…harmonized our individual practices of moral judgement with standing moral beliefs" (Walker, 2007, p.71). A strong moral community

is one in which members share a common understanding of their problems and support one another in moral terms. In professional nursing practice, peer engagement and social support networks are strong foundations for building moral communities that act as buffers and protective nets for people facing various workplace adversities. Speaking with and consoling each other dominated several narratives as participants attempted to support themselves in moral terms. Kahu shared how the act of consolation was used to support a nurse who encountered a difficult situation on the ward:

> We actually console him, and he calmed down. I talked to them as usual to leave everything other and that you end up internalizing it you will die, and the work will still continue. So that is our small way of supporting each other. (Kahu)

By talking to one another, allowing others the opportunity to discuss ethically laden problems, and providing strong support to others, participants fostered resilience. Those who were not able to identify their moral community within the health care institutions reached out for support from family members. Didi shared her experience:

> At times you go home, and you are so moody the whole day. You go home and you are sad. Luckily, I have a husband so when I go and those things happen, he is the person I talk to and he will listen to me. So, my husband is my support when I am so down or when I am challenged with certain things, I talk to him and then he encourages me. (Didi)

Family connections and support played a vital role in how Didi coped with her adversity and fostered resilience. For many of these participants, sharing work related problems with spouses and family members in their low moments was how they coped with the everyday emotional and moral distress they encountered.

Moral reflection is a fundamental process by which humans attempt to mirror their actions in light of a given problem. Moral reflection is a normative way by which a person critically reflects on his or her actions, decisions, and practices (Walker, 2007). This kind of reflection is informed by a person's values, relationships, and moral responsibilities. According

to Walker (2007), moral reflection enables a person to reshape and renegotiate his or her practices of responsibility.

In nursing, moral reflection is the basis for developing moral practice, fostering resilience, and finding and building one's moral community. For the majority of nurses and midwives, self-reflection was a common practice they often engaged in by examining their moral values, responsibilities, and relationships and what it means for their moral identity. In expressing how she coped with the everyday ethical demands, Velim said:

> If you are a normal human being or the one who is dedicated to the work or have a heart for it, when you go home and lie down you will be thinking that today what have I done wrong in the ward? What I have done am I happy? How many cases have I gone through? How many cases have I seen? Have I done someone wrong? Have I hurt my colleague? If you really love the work, you have to think of these things. When you set off to work the next day what I did yesterday I have to improve upon it today. So that is how nursing should be. (Velim)

Self-reflecting about one's moral values leads to a deeper sense of awareness about what moral values mean to people. Flexible resiliency enables a person to re-examine, re-establish, and reaffirm his or her values when confronted with situations that threaten his or her moral identity. Through moral reflections, people are able "to check if things are as we think, if they are good in ways that we think, and if there are ways, they could be better" (Walker, 2007, p. 251). By asking questions about her everyday practice, Velim was able to identify and embrace her strengths and limitations and determine strategies for improvement and change. Another participant also described how self-reflection helped her to identify her weaknesses and shortcomings. She said:

> Whenever I come on duty, whatever happens when I go home, I reflect on it. Did I really do my best? Did my action do something, or did I act wrongly or gave a bad effect to a client and was it really my best I did today? (Shia)

Self-reflection and awareness promoted and strengthened resilience among the nurses and midwives. By being aware of their thoughts, feelings, and actions the participants were able to exchange their difficulties for flexible resilience and sustain their moral values. Amid drowning in constraints, participants felt the need to sustain their values as they navigated through the system. Rather than being drowned by the tidal storms of adversities, they managed to keep their values from being submerged. Napo said:

> Because the whole system is not good you are drowning. We try to keep above water and then survive and make everything look that way. You are just trying not to drown but keeping above water. We are doing what we can to survive and not drown...we are just keeping above water just trying to survive. (Napo)

In keeping their values above the constraints, Kena said they had to look beyond the constraints and strive to make a difference:

> We don't have logistics. We don't have skills and we are not much, but we have to at least be doing what we are supposed to do. No matter the cases, no matter the schedules, no matter the number of clients we have, we should try and do the right thing. I expect that we should do the right thing no matter the logistics at hand, no matter the situation we should be able to give the best quality care to clients. (Kena)

Walker (2007) argues that resilience enables people to restore their moral reliability in matters relating to their commitments. Despite their challenges, the participants expected not to relent on their core values. Walker (2007) acknowledges how resilience enables people to re-establish their commitments and navigate towards the good. As the participants faced actual and potential threats to their moral integrity, they were able to maintain their sense of wholeness through recognition of their moral commitment, enabling them to foster their resilience. Didi said:

> Whether you are sad, or you are not sad, you have to come on duty the following day so you have to put yourself together because the other clients too are waiting for you to attend to them. So you have to put yourself together and work other and that if you allow that moodiness to also influence you so much it will affect the next client whom you are supposed to attend to…so you move on because we don't want to also kill the rest who are there. (Didi)

There was an understanding among participants that their ability to safeguard the lives of other women were dependent on their ability to re-establish their commitment. Walker (2007) states that adapting and readjusting to one's moral commitment is based on "preservation of integrity, sustainable responsibilities, valued relationships, and certain moral values themselves" (p.72).

Being able to prepare themselves mentally and emotionally helped participants to embrace flexible resilience in ways that promoted their professional and personal well-being. By readjusting to the difficulties, they encountered, participants regained and re-established their commitment to caring for other patients. Such an approach enabled them to also see difficult encounters as opportunities for learning. Zoya said:

> Those things when you see them at least you sit and ponder small then life must go on. The rest of the clients must be saved. If we have lost one you shouldn't let that one affect you so much or weigh you down that you are not able to help the others too. You have to at least psych yourself and learn from that mistake. So at least you will sit down and say ok next time when you get such a situation you should be able to do something that you did not do for the first person to save this one. (Zoya)

Participants perceived difficult situations as leverage for them to learn and press toward making responsible choices in future encounters. By recognizing challenges as opportunities for growth, participants were able to foster change, to morally commit to patients, and to look forward to the future with renewed hope and optimism. Having a high sense of hope is strongly connected to an individual's ability to navigate through adversities and serve as a form of internal resistance for survival, protection, and preservation of moral integrity. By accepting their present situation, participants were able to maintain a positive outlook into the future and were able to renew their strength to deal with their everyday encounters. Masi reflected this in her excerpt:

> We are just hoping that one day one day all that a client would need would be in the pharmacy and the logistics, everything would be there. We would get a more ventilated ward and spacious ward where clients can all have beds and not be on the floor. (Masi)

Despite the overwhelming challenges, participants had a hopeful attitude. In fostering resilience, being hopeful can be empowering in mediating the negative aspects of a difficult situation. Through hope, participants envisioned an ideal work environment, one in which systemic constraints would be eliminated. According to Walker (2007), moral deliberation is an ongoing process that enable people to analyze current situations in relation to their past understandings and provides the opportunity for a renewed future. Embracing hope enabled the participants to find new possibilities of navigating through their challenges.

However, while narratives of hope were threaded across the interviews, other participants expressed their hopefulness with caution as seen in the following quote:

> I cannot be hopeless, but I am hopeful with caution. I don't want to be overly hopeful but let's hope that things would improve but it will take a long time. (Fako)

Being hopeful, yet cautious, enabled some participants to recognize their limitations and those of others as they envisioned a better working environment. Hopefulness with caution enabled participants to have an open mind about the outcome of future possibilities. This kind of inner balance served as a protective shield, thereby fostering resilience.

Demonstrating Moral Resistance and Influence

Demonstrating moral resistance is a process by which a person engages in assertive behaviour against situations of unequal power relations (Peter et al., 2004). Individuals that demonstrate moral resistance are motivated by the things they value and care about. In navigating through morally uninhabitable places, some participants engaged in assertive behaviours, while others found it difficult to speak out effectively. Operating in an environment of powerlessness can exert an influence on a person's ability to articulate their moral stance in a way that makes them feel empowered. Moral resistance gives a person the standing to articulate their position and follow through with actions and the conviction in their own terms and voice.

By doing this, Walker (2007) argues that people become empowered, which can trigger a form of collective action and change within and outside social moral orders. Napo said:

> You see when I just feel like this is what is supposed to be done, I will stick by it. You might say I am difficult. I don't have understanding, but once I have a personal conviction that this is the right thing and is back by the law, even if you bring CEO (chief executive officer) it won't change my view. It will not until there is proof that where I am going is wrong and you have it but not that I condone the wrong. (Napo)

Moral resistance can serve as a coping mechanism for liberating oneself from coercive institutional power and oppressive conditions. Moral resistance enabled participants to think and act in ways that prevented them from compromising. This kind of moral resistance can serve as a powerful way of enhancing and supporting ethical practice. In moral social orders where unequal power relations exist, moral resistance can become leverage by which people demand for change. Although moral resistance appeared to be based on each participants' belief, nevertheless it served as a foundation for collective action. For example, Niya described how she was able to mobilize her colleagues against an institutional injustice:

> I came on duty and realized that they were [nurses/midwives] responding to a query for referring a case. So, I said this cannot happen. You referred a case to save a life, but we see people dying here because of negligence of doctors and none of them has ever written a query and you are going to respond to a query for referring a case it would not happen in this hospital. So, we summoned the ward and everybody came out and we rushed to the matron's office and complain to him. I was able to organize the ten midwives to move to matron's office just for this issue… if we had not taken this up that lady was going to respond to the query for referring a patient. (Niya)

Taking collective action empowered other participants and created an opportunity to liberate themselves from oppressive forces. According to Walker (2007) when institutions do not suppress the voices of the oppressed and are inclined to listen to their concerns, an equal moral playing field is provided for the oppressed to be heard. She further argues that when the oppressed find their voice in places of "strategically and systematically imposed silence," (p.

264) moral social orders begin to change. Through collective action, participants were also able to find their voices which enabled them to resist unjust arrangements by voicing their concerns.

Voice is a powerful tool by which oppressed people can break through from positions of marginality and be heard as bearers of a particular truth (Walker, 2007). However, Walker also reminds us that having a voice requires people to speak and be heard in places and by people who need to hear what is being said. In unjust social moral orders like the health institutions, many nurses' and midwives' voices often go unheard and are, on many occasions, discredited by their institutional leaders. In voicing their concerns to authorities, Napo said:

> You raise your voice but the person who is supposed to act do not see the need to act. So, we are aware of the circumstance; we have sent in the complained; we have even done some sit down strikes and mind you in the hospital anytime we go on strike is the patient that suffers. If you have love for your patients and to take care of your patients, you will not even have the strength to go on strike. So, you talk then it gets up someone's duty is also to act he is not acting. (Napo)

Napo recounted how the nurses had taken the initiative to address their situation by voicing their concerns and embarking on sit down strikes, but institutional authorities failed to recognize or notice their resistance. Failing to notice the voices of these participants in many instances was perceived as a strategy to coerce them into silence. To have a voice to speak and not be intimidated is imperative for counteracting and overcoming unjust social arrangements. However, the majority of participants described instances when they felt intimidated to voice their concerns:

> Sometimes we are not able to voice it we all fear, fear of the unknown. We don't know what will happen if you talk. You are under people so you don't know what will happen if you talk. They can place you where you don't want to be [laughing]. (Kena)

In these social moral orders with unequal power arrangements, institutional authorities used fear and intimidation to silence the voices of participants. According to Walker (2007), coercing people into silence is a hallmark of "oppressive power arrangement" (p. 228). For many of these

participants, in order not to be victimized, they chose to remain silent. In oppressive institutions like these health care environments, the authorities use intimidation to manipulate and coerced participants into silence, hindering them from demanding accountability. Maya recounted her experience in the following excerpt:

> One time we even threaten to say that we would lay down our tools for them to understand us…management told us we shouldn't do that, and they would be sack from work. That when we do, they would leave us intact and sack them and that is the norm now. If management allow your institution to go on a strike against the ruling government, you would be victimized. So, they would do all what they can to stop you not to say anything publicly so that it would come back to them. So, everybody is now afraid of losing his or her position. (Maya)

In an oppressive culture, silence is rooted in a complex system of " law, custom, language, force, and circumstance" (p.228) that is woven together and sets the boundaries for people to speak and be heard by the people who matter (Walker, 2007). In Ghana, the majority of the institutional heads including those in the health sector are politically appointed to serve the political agenda of the ruling governments. For many of these leaders, their responsibility is to ensure that the inadequacies within the institutions they govern are not brought to the fore by the employees. Failure to do so would amount to exposing the government to ridicule and likely result in their dismissal. Fako recounted:

> Because once your leadership is aligned to a certain political ideology [relating to national political party] you would not have the courage because anybody can just say anything, and you would be removed. The health system has been invaded by politics and so people cannot take decision. Even today medical directors are getting their positions because of politics so at the end of the day even the medium of ascending to that particular position is compromise…the medical director will now be the center or reservoir of compromise because you can't do anything or take action. So, I think that at the end of the day leadership must be strengthened devoid of political ties. (Fako)

According to most participants, these complex arrangements of institutionalized silence were used by government and institutional authorities to manipulate them and prevented them from speaking out. When silence becomes institutionalized, it denies people the opportunity to

question the existing unjust social arrangements, thereby reinforcing and reproducing such unjust social moral orders. Such political interference in the management of these health care institutions impacted on the ability of institutional authorities to criticize the system and contributed to their poor state.

The lack of courageous leaders was perceived by participants to have hindered moral resistance. Nurses and midwives as an oppressed group often lacked an "interpersonally effective voice" (Walker, 2007, p. 228). Walker describes an "interpersonally effective voice" as one in which a person has the will to speak boldly without being intimidated. To be able to speak in such an effective voice requires renewed ways of thinking and the use of different language to confront unjust social arrangements courageously (Walker, 2007). However, Mani described nursing leaders as ineffective in articulating their concerns:

> We ourselves we are not speaking loudly, and the interesting thing is that people that we put at the top there to speak for us are not actually speaking. (Mani)

The power to speak effectively requires the will, means, opportunity, and moral standing to speak and be heard (Walker, 2007). According to Walker 'being heard' is what represents a person's voice. The majority of the participants perceived that nursing leaders lacked the power to speak and be heard. One of the participants provided an understanding as to why nurses lacked the power to speak effectively and be heard:

> I think they [nurse leaders] don't have the courage. They have been disarmed by the system…they are disarmed by the fact that their opinions are not taken into consideration, their suggestion seems not to be important to anybody. They cannot initiate and move their own agenda…They haven't made themselves worthy of recognition in terms of serious policy drawing. Even when some are courageous to be able to say certain things others will distance themselves. (Fako)

Like many other participants, Fako believed that nurse leaders had been deliberately and systematically disempowered by the health system. Deliberately, the nurse leaders' opinions

were rendered uncredible and unworthy of consideration; further, they were made incapable of setting their own agenda. As described in an earlier section, the lack of power to speak out is an unjust arrangement in social moral orders and is created by institutional authorities to maintain control over nurses and midwives.

The power of voice lies in the ability of having the discursive resources that enable people to voice their concerns intelligibly and coherently in discursive space (Walker, 2007). Discursive resources include the skills, vocabularies, and reasoning that allow people to express their view coherently and impactfully while discursive spaces include the opportunity, standing, and access to people and institutional spaces where they these views can be heard (Walker, 2007). Fako believed that nurse leaders needed to harness these 'discursive resources' to enable them to speak and be heard:

> Nursing leadership are the most powerful people in this hospital because they can cause a standstill in the hospital and they can cause vibrancy in the hospital. I don't know if they know that they have that power and I don't know if they are aware of that power that they have and if they are aware whether they know how to use it or the courage to use it. I think the nursing front have the power to confront the system because they have the largest following, but I think they don't have courage. (Fako)

The participants perceived nurse leaders to possess power that could be used to initiate collective action and liberate them from this unjust system of power arrangements. As institutions deliberately and systematically disarmed nurses, many of them succumbed to the system and have been rendered incapable of speaking. By enforcing silence through a wide range of oppressive structures and discursive boundaries institutions set up restrictions that disqualified participants from speaking and rendered their voices ineffective. Discursive boundaries are "set of barriers that "contain or disqualify the speech of some individuals in hierarchical social and political arrangements or restrict the effect of their speech to limited domains of social

interaction" (Walker, 2007, 229). To be disqualified from speaking limited their capacity to articulate their position with confidence and moral authority (Walker, 2007). Fako said:

> If it keeps on going for some time you just forget about it and then you also do what you can do and that is what is happening because a lot of people are tired of complaining. When I first came here, I was very meticulous and radical, but later on I joined the bandwagon. When I came, they told me very soon I will relax. Because your complaints are not going anywhere, nobody would listen, nothing would change and at the end you will even be seen as a bad person. So, what do you do than to keep quiet and join the bandwagon. (Fako)

Fako described the paralyzing nature of the system that even those with the courage to confront the unjust arrangement ended up succumbing. By discrediting, disregarding, and rendering their complaints unworthy of attention, institutional authorities created conditions that disincentivized participants from speaking out. Failing to speak out against the system, the nurses became complicit in maintaining a system that perpetuates their oppression and suffering. Another participant shared a similar experience:

> I was persisting trying to push my way through because I understand what I am supposed to do as in charge, but some colleagues were telling me this hospital when you keep on pushing them too far like that, they won't like it. That when you keep pressurizing them on some of these items, they would victimize you in way that is how come I am relax and I am also not putting pressure. (Maya)

In attempting to coerce the nurses from speaking out in the public arena, institutional authorities have set up conditions in which people who speak out or demand change are punished or victimized. As a result of this punitive culture, the majority of the participants felt discouraged from speaking out, thereby succumbing to a dysfunctional system.

Despite the deliberate and systematic attempts to render them voiceless and unheard, the participants found the opportunity to participate in this research as a means of getting their voices heard. The decision to participate and speak out was important in supporting the significance of this research project, which is to give voice to participants' stories and

experiences. According to Walker (2007), researchers working from a critical perspective have the moral and political responsibility to have participants' voices to be heard. Denying the participants the opportunity to be heard, amounts to a failure to give due recognition to their suffering. Nearly all participants felt speaking out to the researcher was restorative, as well an opportunity to have their stories heard in strategic places:

> Sometimes we feel relieved when we are able to air some of our issues like this. Maybe one day you those taking our information will forward things up there for people who are ready to really help to come to our aid. So, when I see people coming to grant us interviews of this nature, I always feel comfortable giving out what I have hoping that one day what we are saying would make a change. So, I thank you for coming to take our information. (Maya)

Having the opportunity to speak in places and be heard, especially for those who have been silenced and discredited, can be both restorative and invoke political action as these stories become readable and heard from different social locations and moral positions (Walker, 2007). Walker (2007) defines restorative power as the "moral power of public acknowledgement" (p. 213). Through the listening and reading of participants' realities, policymakers may come to acknowledge that the suffering and unjust conditions are real and worthy of consideration. When people who are historically and systemically rendered voiceless begin to locate their voices and be heard in public spheres, moral social orders will begin to transform (Walker, 2007).

By speaking to the researcher, the nurses and midwives believed an important platform was being provided with credibility being given to their experiences, opening up spaces for transformative changes. This belief is consistent with the understanding that a loud and clear voice is perceived better in public places than one that is spoken privately, providing concrete, enduring, and evidential material (Walker, 2007). This understanding was reflected in Mani excerpt:

> I am sure at the end of the day the report will come…who ever read this and has authority or is at the position of enforcing certain things should ensure that the work environment is very safe, people who care about the welfare of nurses and midwives. I am happy talking. Sometimes I just want to talk about some of these things. I hope somebody read this and listen to whatever we are saying and then they will do something about it. We those who care about the profession including you. I hope you will not run away you still talk for nurses. (Mani)

Participants recognized the power of research as an alternative voice that allows them to speak the unspeakable. They believed that having their experiences documented in a research report would give them access to critical institutional spaces and provide the basis to initiate public discussion.

CHAPTER FIVE: DISCUSSION OF FINDINGS

In this chapter, I discuss the major findings of this study. Four areas that featured prominently in the reflections and the everyday encounters of the nurses and midwives about the moral habitability of their work environment will be considered. These include sustaining moral identity and commitment, enacting moral agency in the context of misguided policies, scarce resources, and incoherent moral responsibilities, enacting moral agency within the domains of oppressive conditions, and experiencing moral suffering. I will infer from the philosophical and theoretical works of Walker (2006; 2007) and Gyekye (1996; 2010) and previous literature to deepen my understanding and provide insight into the moral habitability of obstetric settings and its influence on the moral agency of nurses and midwives.

Sustaining moral identity and commitment

Nursing and midwifery are value-oriented professions. These values were described by the nurses and midwives to be an integral part of who they were and, most importantly, how they understood their moral responsibilities, enacted moral agency, and navigated through morally uninhabitable places. These values were reflected in the subthemes of ‘preserving moral integrity’, ‘holding onto the moral commitment of their calling,’ ‘having a sense of moral fulfillment’, ‘fostering resilience,’ and ‘demonstrating resistance’. The manifestation of these values was influenced and shaped by their interaction with women and their everyday situations and encounters. Doane (2002) found in her study that nurses construct their identity through a complex interaction of relational, contextual, and situational factors. This socially mediated process was an integral part of how the nurses and midwives constructed and sustained their moral identities and commitment. Despite the importance of this finding, the narrative review of

literature on the experiences of nurses and midwives in resource limited settings completed for this dissertation failed to capture this important dimension of their moral identity.

Acting with integrity was an essential part of sustaining their moral identity and commitment. Narratives of integrity were centered around doing the right things in the interest of patients and upholding the code of their nursing profession. This expression by the nurses and midwives reflected the deeply relational nature of integrity. This finding is consistent with studies that found that upholding integrity in nursing is mediated by the nurses' responsibility to patients and their profession (Davis, 2017; Iacono, 2013; Krautscheid, 2014; LaSala, 2009; Milton, 2008). Doing the right thing was described as a means of acknowledging and affirming their commitment to patients and their identity of being a good nurse or midwife. Statements such as 'as a nurse you want to do the right thing" are consistent with Walker's (2007) understanding that upholding integrity is an evaluative measure of one's "unconditional commitments, or uncorrupted fidelity to a true self" (p.112). This sense of 'uncorrupted fidelity to self' expressed in their desire to maintain a 'good record' was a way of preserving the ethical midwife or nurse identity. However, because human lives are constantly ordered by complex interactions and circumstances, there are bound to be shortcomings and limitations in attempting to maintain a 'good record' and preserve the ethical nurse identity (Walker, 2007). Their encounter with morally uninhabitable workplaces impacted on their ability to do the right things, thereby threatening their ethical midwife/nurse identity. Walker (1998) argues that sustaining moral relationships requires people to recognize the shared understanding of "each other's humanity and taking responsibility for certain shared expectations of proper treatment" (p.63). Walker characterizes this understanding as moral recognition that alerts a person about registered violations and prompts them to amend the undesirable behaviour. This kind of moral recognition

described by participants as their conscience, enabled them to readjust their course when their desire to maintain an ethical nurse or midwife identity was threatened.

This finding is consistent with the conception that conscience acts as a restrictive force that creates a sense of awareness in nurses, increases their sensitivity to patient vulnerability, and limits their capacity to provide inadequate care (Jensen & Lidell, 2009). This resonates with expressions of the nurses and midwives who saw their sense of moral recognition increased their awareness about their moral responsibility and consequences thereof and prompted them of the need for moral address. Walker (1998) described moral address as a form of reactive communication that tells the person who experiences it that something is wrong and there is the need for a response. 'My conscience will not set me free', a form of reactive communication, caused them to recognize the existence of a moral relationship and compelled them to adjust their present and future actions as well as reminding them of their moral accountability.

The International Council of Nurses (ICN) code of ethics states that "the nurse carries personal responsibility and accountability for nursing practice" (ICN, 2012, p.3). This statement reflects the moral and legal responsibility of nurses to patients, the public, and the nursing profession. Others (Iacono, 2013; Krautscheid, 2014; LaSala, 2009) have also argued that professional accountability forms the foundation for ethical and safe practice which resonates well with the experiences of the nurses and midwives who saw doing the right thing as being accountable to patients, institutions, and the professional nursing body. The nurses and midwives described that the fear of losing their license and being sued by patients deepened their awareness about the consequences of their actions and decisions, increased their sensitivity to unethical practice, and reinforced the moral commitment of some nurses and midwives to adhere to their calling.

The concept of a calling is one that runs through the history of nursing and continues to influence the contemporary life and moral identity of nurses and midwives. Emerson (2017) describes a calling as "having a passionate intrinsic motivation or desire (perhaps with a religious component); an aspiration to engage in nursing practice, as a means of fulfilling one's purpose in life; and the desire to help others as one's purpose in life" (p. 387). This definition resonates well with how the nurses and midwives envisioned their calling to 'help women'. This perception of being called to 'help women' had a deep spiritual meaning that connected them to their sense of being and purpose of serving the needs of women and promoting their wellbeing. This finding reflects those of earlier studies that found that altruistic motives were reasons nurses gave for their career choice (Eley, Eley, Bertello, & Rogers-Clark, 2012; Eley, Eley, & Rogers-Clark, 2010; Peter, Simmonds, & Liaschenko, 2018; Prater & McEwen, 2006; Price, McGillis Hall, Angus, & Peter, 2013).

The social-moral socialization of these Ghanaian nurses and midwives, both personally and professionally, shaped their calling, commitment, and sense of altruism. According to Gyekye, (1996) values such as kindness, compassion, empathy, concern for others, respect, and human dignity are the basis for moral teaching. These values are considered vital for human flourishing, a sense of personhood, and a means of establishing a spiritual connection with the creator. The internalization of these values becomes the foundation of a person's moral life. It was, therefore, not surprising when the nurses and midwives stated that responding to the call to make a difference in the lives of women was a moral as well as a religious obligation. This desire to make a difference was mediated in part by patients' vulnerability, respect for the sanctity of life, and their own personal experience of and reflection on suffering. These conditions prompted them of their obligation "to think and to reflect upon the interrelatedness of self and other, sacred

and secular" (Scott, 2007, p. 273). Nurses described this reflection increased their awareness and sensitivity to patient suffering and provoked empathic understanding and the desire to respond to the needs of women. Responding to the needs of women was perceived to be engaging in a dialogue with God who rewards people for doing 'good'. This 'good' expressed as protecting the sanctity of life was perceived as a sacred duty when properly executed, guaranteeing them eternal rewards. The anticipation of a spiritual reward created a reciprocal expectation that motivated them to honour their calling to women and heighten their sense of engagement. This finding mirrors those of Shrubsole (2010) who found that nurses who perceived their calling as sacred with anticipation of a blessing showed consistent commitment to patients and work.

The anticipation of an eternal reward energized them to hold onto their moral commitment and work engagement despite the daunting nature of their work environment. This finding resonates with studies that found that the ability of people to commit to their work and persevere was motivated by the motives related to their sense of having a calling (Peter et al., 2018; Prater & McEwen, 2006). However, the findings of this study revealed that this energizing power of the call can be impacted by the practice environment of nurses. One nurse gave insight into how some nurses and midwives, although they perceived themselves to have a calling, became unresponsive to the purpose of their calling due to the constraints they encountered in the work environment. Duffy and Dik (2009) have stated that macro-economic systems and workplace culture may hinder the individual's aspiration and purpose which could impact their ability to sustain their calling or career choice.

Moreover, the findings of this present study also reveal that recognition from patients is vital in sustaining a calling. The centrality of nursing care lies in the ''human connection that is largely intangible, unmeasurable, unquantifiable aspect of nursing practice that caregivers value

most'' (Scott, 2004, p. 348). This sentiment was echoed by nurses and midwives who acknowledged that being appreciated by patients was important to sustaining their commitment and work engagement. Such recognition of their effort, although intangible, 'gingered' them to work, gave meaning to their sense of being, and enhanced their overall sense of fulfillment. The expression of gratitude also provided them with the affirmation that nursing was truly a rewarding and satisfying career. This finding resonates with Peter et al. (2018) who reported that nurses maintained their identity through a process of reciprocal recognition in which recipients of care are expected to express gratitude and appreciation to nurses as a means of affirming their identity as good nurses. Although this was based on mutual recognition, the unequal nature of the power between nurses and patients in situations of misrecognition or ingratitude could affect the caring process (Peter et al., 2008). In this study, these nurses and midwives worked under extremely difficult conditions and sometimes used their money and personal resources to negotiate care for women. Under these circumstances, misrecognition or ingratitude could severely impact the caring process and diminish the ability of nurses and midwives to commit their resources, hold onto the commitment of their calling, and keep their values afloat.

Holding onto the moral commitment of their calling to make a difference in the lives of women was pivotal in navigating morally uninhabitable places, affirmed the purpose, and the motivation behind their calling. According to Gyekye (1996) because "Africans live in a religious universe" (p.1), they tend to depend on God for support and strength in all aspects of their work life including during times of adversity. The dependence on God was a recognition of their inadequacies as nurses and midwives and the need for a continuous dependence on God for strength, support, and guidance. Such acknowledgement gave meaning to their situation, provided emotional upliftment, and enabled them to overcome their difficulties which all

contributed to renewing their commitment and re-establishing moral equilibrium in times of adversities. While the appraisal of their adversities through a religious lens enabled them to cope, there is a possibility that this may likely have led to failure to take responsibility to act and confront the constraints impacting on their moral agency. Other studies reported in literature outside nursing similarly reported that while religious interpretation of personal problems and oppressive conditions enabled people to cope and defer their problems to a supreme being, it may have likely concealed their ability to take responsibility to address the situations they encountered (Fox, Blanton, & Morris, 1998; Nakonz & Shik, 2009).

Fostering a sense of community in times of adversity provided them with social support to flourish. Gyekye (1996) believes that having a sense of community promotes human flourishing by appealing to values of social solidarity, harmony, cooperation, and interdependence. Speaking with one another through consolatory words provided them with a sense of solidarity, reassurance, strength, encouragement, and emotional upliftment and also symbolized conveyance of empathy and a recognition that they were not alone. These understandings created opportunities and space to have an internal dialogue about their own shortcomings and those of their health care institution. Through a series of self-directed questions of 'why, what, and how', the nurses and midwives gained insight into their situation and critiqued their own actions and practice. By so doing, they were able to recover from their shortfalls and rekindle their sense of hope.

Hope enables a person to imagine and desire a "future good even amid dim and dwindling possibilities" (Walker, 2006, p. 41). Hoping for a better and ideal working environment enabled them to triumph over their present circumstances and regain strength and zeal to continue to work and hold on to their values and commitments. It is stated that without

this energizing and moral power of hope, it is impossible to sustain our moral world and find solace in times of adversity and courage to respond to future demands of similar kinds (Walker, 2006; Bevon, 1999).

Being able to demonstrate moral courage in nursing is considered integral in promoting a culture of ethical practice, increasing ethical awareness and sensitivity, minimizing the experience of moral distress, empowering other nurses as well as an instrument for collective resistance and transformation (Gallagher, 2011; Hamric, Arras, & Mohrmann, 2015; LaSala & Bjarnason, 2010; Peter et al., 2004). While my findings agree in part with the above, it also reveals that a repressive institution can limit the potential of nurses to demonstrate moral courage.

Walker (2007) states that when an act of injustice to others is committed by people with power, they set up a corresponding system, or political arrangement, to silence victims with the expectation that these injustices will not be uncovered. These conditions were achieved through politically motivated appointments of medical directors and other institutional heads and discursive boundaries. The intersection of these conditions creates what Walker (2007) refers to as political repression within the health care institutions to restrict nurses from speaking about the poor working conditions. This repressive system led to staff suppression, asymmetrical accountability, defensive, and unresponsive system. These findings are consistent with studies on barriers to moral courage (Barchard, Sixsmith, Neill, & Meurier, 2017; Dinndorf-Hogenson, 2015; Gallagher, 2011; LaSala & Bjarnason, 2010). Demonstrating courage and speaking out were perceived to come with a greater risk of being reassigned out of the institution to a remote clinic, denial of promotion, and stigma for being recalcitrant. This fear of retribution coupled with the unresponsiveness of their institutions regarding their concerns discouraged and deterred

them from taking individual and collective resistance against the poor health care system. This finding is consistent with literature from the United Kingdom that found being ignored by authorities for raising concerns, fear and blame, and retribution were recounted by the nurses as reasons for not speaking out about their poor working conditions at the Mid Staffordshire NHS Foundation Trust and other hospitals in the United Kingdom (Attree, 2007; Kalisch, 2006; Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). Similarly, the nurses and midwives described yielding to a dysfunctional system after their concerns were downplayed and ignored by their institutional leaders.

This punitive culture disempowered and deterred nurse leaders from demonstrating courage and resistance against the health system as well as supporting other nurses and midwives. Storch et al. (2002) reported that the failure of nurse leaders to speak out against unethical systems discouraged students and nurses from undertaking similar actions. Storch et al.'s (2002) work resonate with the experiences of the nurses and midwives who felt their attempt to assert their moral authority was perceived by nurse leaders as signs of disobedience that led to the isolation and stigmatization of nurses and midwives who demonstrated courage. This lack of support and appreciation for the nurses who demonstrated courage disincentivized the nurses and hindered their ability to nurture courage. Okuyama (2014) found the lack of assertiveness among the older generation of nurses was associated with their hierarchical mode of training and education in which the emphasis was on obedience and submissiveness, hence, assertiveness was perceived to be inconsistent with the 'nice' nurse identity. Nurses and midwives alluded to this desire of nurse leaders to conform to the 'nice' nurse identity as a barrier to initiating resistance and nurturing moral courage. However, the nurses and midwives also had a conviction that nurse leaders have the greatest power of numbers that when utilized

could transform the health care institutions into morally habitable workplaces. But exercising this power requires an 'interpersonally effective voice' and 'discursive resources' that will allow them to speak and not feel intimidated (Walker, 2007). Strategies for developing interpersonally effective voices will require a strong ethics education and training and a system of shared governance and collaborative decision making. These will increase their moral awareness and confidence and will empower them to develop and nurture moral courage (Gallagher, 2011; Hamric & Wocial, 2016; Hudek, 2012).

Enacting Moral Agency in the Context of Misguided Policies, Scarce Resources, and Incoherent Moral Responsibilities

The introduction of the NHIS and subsequently the integration of the maternal health care coverage was a commitment by the government to promote universal health care coverage. While the implementation of the NHIS is vital in meeting the SDG target 3.1 (to reduce the global maternal mortality ratio), the nurses and midwives described the challenges arising after the implementation which created ethical quandaries, altered the moral ecology, and compounded the existing conditions of scarcity, leaving them struggling to sustain their moral commitment and identity.

First, like any other social intervention policy in Ghana, the NHIS was born out a political party manifesto. Rhetoric of 'free' health coverage for maternal health care propagated by politicians was described by the nurses and midwives to have led to women coming to the health facility uninsured. Second, the lack of transparency on the coverage of medicines and treatments limited access to health care services for insured clients. Third, delayed reimbursement to institutions due to the multiple claim validation system and delayed release of funds by trustees of the NHIS led to the inability of the health care institutions to procure

supplies limiting access to health care for those insured. These findings are consistent with other Ghanaian studies (Agyepong et al., 2016; Dalinjong & Laar, 2012). However, my study examines these issues with a different lens as highlighted in the following paragraph.

These findings reveal violations in the normative expectations of the NHIS by patients who had the trust and confidence that their health care needs would be met (Walker, 2006). These violations had implications for the moral agency of nurses and impacted their relationship with women and their families. These challenges limited the ability of nurses to fulfill their moral responsibilities to patients that led to feelings of disappointment and anguish in patients and families and their blame of the nurses and midwives for refusing to provide them with care despite being insured or being promised free coverage. The desire of the nurses and midwives to fulfill their moral responsibilities led them to demand patients and families to pay out-of-pocket to enable them to provide the needed care. This demand was met with fierce resistance from patients and their families accusing the nurses and midwives of extortion and manipulation and in some instances, they threatened to sue them if they failed to meet their care needs. Nurses and midwives found these situations exposed them to ethical conflicts with women and their families and threatened their security. This finding is consistent with a Tanzanian study that found midwives felt trapped between the discourse of free access to perinatal care and the reality of scarcity of resources which often led to misunderstandings between them and women seeking care (McDonald et al., 2019). While these expressions of outrage by the patients were consistent with violations in normative expectations (Walker, 2006), they were wrongly directed at the nurses and midwives instead of the NHIS and the health care institutions who failed to meet their expectations. This attribution of blame to nurses and midwives may be due to the limited understanding of patients about their right to question institutions when their health care needs

are not met. Given the conditions imposed by the NHIS and their moral responsibilities, the nurses and midwives had to contend with two ethical questions: what should they do under the circumstances and what is their liability for being unable to provide care? These questions reveal the ethical burden experienced by nurses and midwives following the implementation of the NHIS and yet have largely been ignored in many discussions. Policies around universal access to health care must be transparent, and devoid of politics and deceptions. This will ensure frontline providers who interface between patients and the policy are not left with the burden of addressing issues arising out of policy failures.

Nurses and midwives further described that the implementation of NHIS led to an emerging business climate within health care institutions which impacted their ability to fulfill their moral responsibilities. They attributed these changes to the restructuring of the health system and health care institutions following the implementation of the NHIS. One of the pillars of Ghana's medium to long term health sector strategy is the restructuring of governance and financial system of health care institutions to improve efficiency, scale up cost containment, and enhance the sustainability of the universal health coverage under NHIS (Ministry of Health, 2017). These structural reforms are deeply rooted in neoliberal ideology in which health care is considered a "private good for sale rather than a public good" (McGregor, 2001, p. 83). The restructuring led to the recruitment of staff with backgrounds in administration, accounting, and management who have no understanding of what caring and caregiving at the bedside entails. This finding is consistent with an earlier study in which nurses described the administrators as grey suited guys who have no insight into "the little things that mean so much to both nurse and patient" (Sumner, 2010, p. E22). These administrators place primacy on institutional values rather than patient care needs. Decisions about health care were viewed through the lens of

efficiency, cost saving, waste reduction, and profit maximization. Nurses and midwives described how these corporate oriented values have altered the moral ecology of health care institutions and how they were expected to relate with patients.

Nurses interact and understand their responsibilities to patients in moral terms anchored in values, beliefs, and notions of vulnerability. This conception of nurse-patient relationships is fundamental to the construction of their moral identity. The emerging profit driven health care environment in Ghana is altering this relational dynamic between nurses and patients. In this ecology, nurses are expected to substitute their moral relationship with an economic relationship in support of an institutional agenda of enhancing efficiency and maximizing profit. These values were perceived to be inconsistent with their values since they only seek to exploit patients in their most vulnerable state. When values such as efficiency become the driving force in health care organizations, patients and health care become constituted as commodities to be traded for profit (Weiss, et al., 2002). In a context where poverty is endemic, health care resources are extremely scarce and there is a high obstetric risk, nurses and midwives envisioned that treating patients and care as mere commodities may have dire consequences for patient safety, blurred the boundaries of their moral responsibilities to their patients, and led to a fragile nurse-patient relationship. These findings reflect those of Weiss et al., (2002) who found that when organizational values take precedence over important components of professional practice, such as relational work and patient safety, it clouds the fiduciary responsibility of the nurses and threatens their moral identity.

Discussions relating to the NHIS and delayed reimbursement focused mostly on institutional reimbursement practices, revenue generation, and purchasing power (Ashigbie, Azameti, & Wirtz, 2016; Atinga, Mensah, Asenso-Boadi, & Adjei, 2012), without exploring how

these impacted on the distribution and allocation of basic supplies. The findings of this study have revealed that delayed reimbursement by the NHIS coupled with the institutions' desire to enhance efficiency and maximize profit prompted widespread rationing of basic supplies and equipment. The allocation of supplies was subjected to economic and quantifiable measures rather than the outcomes of the care and needs of the obstetric unit. In justifying rationing, a false ideology of wastage was created, which is the belief that resources were being wasted at the bedside and hence the need to control the waste. Rationing created widespread shortages of basic supplies and equipment leading to the inability of nurses to meet the basic health care needs of women. The strict system imposed by administrators made it difficult to request supplies coupled with the unconscious absorption of the ideology of wastage compelled the nurses and midwives to engage in the unsafe practice of recycling gloves and other disposable supplies, limiting the amount of supplies needed to care for patients, withholding care to conserve resources, as well as hoarding of essential supplies.

Rationing was considered a barrier to moral agency and the quality of care. Accounts of the frequent shortage of supplies were a daily occurrence leaving the nurses and midwives struggling to do more with less and left care undone. This finding is consistent with other studies that found that missed care was one of the major consequences of rationing of health care resources on nursing practice (Jones, Hamilton, & Murry, 2015; Papastavrou, Andreou, & Vryonides, 2014; Recio-Saucedo et al., 2018; Rooddehghan, Yekta, & Nasrabadi, 2018; Scott et al., 2019). The nurses and midwives indicated that rationing supplies left them with no option than to leave critical aspects of nursing care undone and the burden of having to prioritize the use of supplies and equipment. Walker (2007) states that people with special obligations are often faced with challenges of "disproportionate dispensation of resources to the few at what may be,

in the aggregate, very great expense to the many" (p. 97). Prioritizing and allocating supplies became an ethical burden for the nurses and midwives and exposed them to an ethical dilemma. For example, deciding to allocate the only ventilator between two critically ill patients was considered a 'hard decision' signifying the ethical burden that it entails. This finding is consistent with the understanding that rationing has an ethical dimension in terms of what aspect of care needs to be prioritized (Vryonides, Papastavrou, Charalambous, Andreou, & Merkouris, 2015).

The lack of explicit guidelines places a significant burden on nurses to decide how to allocate the resources and in some instances may trigger discriminatory practices (Scott et al., 2019). The complete absence of decision-making guidelines for allocating resources left nurses and midwives to depend on their own intuition which resulted in violations of certain moral values and conflicts with patients and their families who accused them of discrimination.

The extreme scarcity of resources led to a sense of powerlessness and promoted the neglect of patients. Nurses described that despite knowing what to do and the imminent danger facing patients, they were compelled to neglect them when resources became scarce. For example, the nurses and midwives recounted looking on helplessly while women and their unborn babies struggled for their lives due to the lack of medicines, oxygen, ventilators, and resuscitation kits. This finding is consistent with other studies that found that the lack of resources was a major contributor to patient neglect by health care providers (Reader & Gillespie, 2013). Nurses and midwives described feeling emotionally traumatized when they were compelled by circumstances beyond their control to neglect and abandon women. To sustain their moral identity and mitigate the experience of trauma, the nurses resorted to purchasing their own supplies and equipment to attend to the needs of patients. Although these

actions enabled them to enact moral agency, it may have provoked feelings of moral ambivalence when they perceived that their actions may have rendered the situation invisible and contributed to reinforcing the conditions that constrained their practice.

Working under conditions of extreme resource scarcity promoted a culture of compromise and wrongdoing. The nurses recounted undertaking vaginal examinations and other procedures without the appropriate resources, despite knowing the consequences. Compromising under conditions of scarcity led to violations of moral values and professional standards. This myriad of violations threatened and undermined their moral integrity and 'seared' the conscience of some nurses and midwives resulting in diminished attentiveness and abandonment of moral values. Kelly (1998) found that when nurses are exposed to circumstances that shock their moral integrity, they either distance themselves away from such events or become deadened by its outcome in order not to perceive it. Under conditions of 'seared conscience' a form of misrecognition, values such as compassion and empathy were replaced with anger and resentment which were mostly directed to recipients of care. This finding provides another dimension of why the abuse of women by nurses and midwives is widespread. These circumstances have led to the negative portrayal and blame of nurses and midwives for failing to uphold the standards and values of their profession.

Evidence from media publications captioned under the following headings "Minister Blame Nurses for Falling Standards in Healthcare Delivery" (Abuguri, 2018), "Nursing and Midwifery Boss Bemoans Fallen Standards" (Koomson, 2019), and "Nurses Asked to Work Hard to Improve the Falling Standards" (Ghana News Agency, 2012) are three examples of the negative portrayal of nurses by the health care officials. Ironically, these pronouncements are made by people and institutions mandated to provide the needed resources and support to enable

the nurses and midwives to adhere to the standards. These statements create the assumption that moral agency occurs in a vacuum and that nurses and midwives have the sole responsibility of maintaining good nursing practice, but Walker (2007) states that morality is a "socially embodied medium of mutual understanding and negotiation between people over their responsibility for things open to human care and response" (p.9). Although nurses have the moral responsibility to care for patients, their ability to do so depends on the collective responsibility of leaders who also have the moral responsibility to provide the needed resources. The falling standard of nursing practice is a result of an irresponsible and dysfunctional micro and macro health system governance which has left the nurses and midwives in situations of compromise.

Nurses and midwives are required to demonstrate competency at all levels of their practice. The ability of nurses to actualize these competencies is dependent, however, on multiple factors such as work experience, educational level, critical thinking, professional motivation, caring attitude, and type of nursing practice environment (Rizany, Hariyati, & Handayani, 2018; Smith, 2012). While these factors are deemed to be important, the nurses and midwives have described that the lack of resources limited their capacity to demonstrate competency in several domains of their practice. For example, despite having the knowledge, skills, judgment, and motivation, the lack of blood pressure monitoring devices and thermometers to take vital signs and medicines to relieve the suffering of patients led to a perceived sense of failure and worthlessness. Moreover, their inability to assess and document patient vitals made it difficult to determine the plan of care and sometimes led to other team members undermining their competency, creating a sense of inferiority. They struggled to maintain competency by frequently improvising items not meant for their intended purpose,

promoting mediocrity. Some nurses and midwives expressed fear of losing their competency if the scarcity of resources remained unaddressed.

This undermined competency also has implications for the competency development of new graduate nurses and students. According to Benner (1982), the process of developing competence spans over a period of time as the nurse progresses from novice to expert. For example, newly qualified nurses and students successfully progress through these stages with support and guidance from senior nurses. However, the persistent lack of resources may hinder senior nurses' and midwives' ability to gain the expertise to coach and guide new graduates and students. This creates a vicious cycle of inadequate competency development leading to a theory-practice gap. However, the increasing complexity and acuity of obstetric conditions along with the extensive scope of practice of nurses and midwives will require a competent nurse who has "feelings of mastery and the ability to cope with and manage the many contingencies of clinical nursing" (Benner 1984, p.27).

Inadequate space and beds limited the capacity of nurses and midwives to provide dignified and humane care to women seeking maternal health care. The second statement of the ICN code of ethics states that "inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect' (ICN, 2012, p. 1). This declarative statement reflects the importance of dignity as a right and the responsibility of nurses to always uphold the dignity of patients, but the failure of institutions to prioritize patient dignity affected the ability of nurses and midwives to promote it. Conditions of overcrowding, with women sharing beds and sleeping on bare floors, were viewed by the nurses and midwives as barriers to promoting and maintaining the dignity of women. This finding is consistent with previous literature which found the physical environment, i.e., spacing and

privacy, scarcity of resources, including beds, and the culture of the health care organizations hindered the ability of health care providers to maintain and preserve the dignity of patients (Gallagher, 2004). Nurses and midwives expressed difficulty in maintaining privacy during vaginal examinations and delivery due to the absence of screens and overcrowding. Because nurses perceive dignity as a 'human right' and a core value' (Gallagher, 2004), their inability to maintain dignity led to a perceived violation of their ethical obligation of maintaining the privacy and confidentiality of patients. Moreover, inadequate beds and overcrowding prompted the early discharge of patients while others were turned away. The discharge process took a reductionist approach and led to fragmented and dehumanized care, depriving nurses and midwives of the time to engage compassionately and provide discharge teaching to patients. These situations led to a feeling of uncertainty, guilt, self-blame, and loss of identity when they were unable to fulfill their moral responsibilities. This finding is consistent with the understanding that when nursing care is shifted from a humanistic to a reductionist approach, nurses may lose their sense of being as nurses due to diminished capacity to connect and engage with patients compassionately (Austin, Goble, Leier, & Byrne, 2009, Austin, 2011). Besides the suffering they encountered as a result of their inability to provide care, they were blamed for turning patients away for lack of beds or space otherwise known as the 'no bed syndrome'. There have been several investigations by the GHS in which nurses and midwives have been indicted for denying patients admission. Moreover, the Ghanaian speaker of parliament has called for the 'no bed syndrome' to be criminalized to enable the prosecution of health care professionals who have denied patients admission (Ayamga, 2018). Such an irresponsible approach to addressing the no bed syndrome seeks to deflect responsibility for failure of the health system and government to fulfill their responsibility. These actions led to fear among nurses and midwives and resulted in patients

being admitted under degrading and dehumanizing conditions. This finding has revealed both the ethical and political dimensions of the no bed syndrome. It is expected that the findings of this study will prompt discussion within the bioethics community to recognize the problem of inadequate beds as an ethical issue affecting frontline workers and patients.

Walker (2007) states that the obligation to respond to the needs of others is based on a combination of factors such as the absence of other crucial or equally competing demands of other persons, the number of people in a position to help, the limited chances of undesired outcomes, and the moral or practical cost to others dependent on the help. These understandings concurred with the experiences of the nurses and midwives in this study. The nurses and midwives had an extensive scope of practice including the provision of deliveries, postpartum care, care and resuscitation of newborns, and management of pregnancy related conditions, in addition to their basic nursing responsibilities of administering medications, taking of vital signs, discharge planning, and teaching, and engaging therapeutically. Responding to these responsibilities under conditions of inadequate staffing, unpredictability, and exigency of obstetric cases left the nurses and midwives to ask whether there was "any end to the number and types of demands that on this view morally claim my attention? (Walker, 2007, p.144).

The nurses and midwives expressed feeling burdened by the endless, multiple, and complex obstetric demands of women and their newborns, which sometimes exceeded their capacity and resources. The exigency of these demands led to conflicting and incoherent demands which were often difficult to map, prioritize, and be given attention. Under these circumstances, the nurses and midwives were compelled to leave 'real nursing' care undone, incomplete or delayed as they tried to fulfill other urgent demands. This finding is consistent with other studies that found that, in the face of multiple and conflicting demands, nurses

experience conflict between their professional expectations and what they practice (Papastavrou et al., 2014; Vryonides et al., 2015). ‘Real nursing’ care was depicted in the narratives of the nurses and midwives as those fundamental components of nursing and midwifery care that contributed to patient recovery and experience. Because these activities provided distinctive meaning, fulfillment, and a sense of identity to them, the inability to remain responsive to their commitment to ‘real nursing’ led to a sense of loss of identity, suffering, and distress.

Walker (2007) argues that when moral responsibilities are laden with contradictions and incoherencies, the costs are borne by those who bear the greatest burden of responsibility. Keeping their moral identity coherent under endless and multiple responsibilities and demands were difficult. The experience of incoherent moral responsibilities was described as a ‘time bomb’, creating an impending sense of doom when different demands were becoming difficult to fulfill. The pressure to fulfill their responsibilities and avert the poor outcomes led to emotional and physical burdens as they hopped between multiple demands in the midst of chaotic situations. This finding is consistent with other studies that found that the experience of conflicting demands led to increased pressure to fulfill one’s professional role and identity (Papastavrou et al., 2014). In coping with the chaotic situation, the nurses and midwives created coherent narratives to rationalize the incongruity in their moral ideals and the present situation by describing themselves as ‘jacks of all trades’. Walker (2007) states that acts of moral justification are essential in reshaping the understanding of people about themselves and the reasons they give for doing or acting in certain ways in matters that are morally important to who they are. Being a ‘jack of all trades and master of none’ was powerful in reshaping not only the understanding of their responsibilities but also served as a motivation for responding to the different demands. This finding, however, contradicts those of Vryonides et al. (2015) who attributed this sort of

justification as a disclaimer used by nurses to justify their inability to fulfill their moral responsibility. While the context may account for this difference, the finding reveals a 'jack of all trades' mentality may be a positive attribute that enabled them to cope and manage chaotic situations and respond to different and complex situations arising out of the work environment.

Walker (2007) contends that we are compelled to respond to the needs of others "when circumstance or ongoing relationship renders them especially, conspicuously, or peculiarly dependent on us" (p.113). The proximity of nurses and midwives along with their "history of mutual involvement" (Walker, 2007, p.88) with patients, rendered them vulnerable to take on the responsibilities of others who were unavailable. In obstetric settings where patient needs are crucial, it was not surprising to hear the nurses and midwives violating institutional policies to assume the role of doctors who were often unavailable to respond to the needs of patients. This finding mirrors those of Peter and Liaschenko (2004) who found that the spatiotemporal proximity of nurses deepened their sense of engagement with patients which allowed them to attend to the needs of patients when others failed to do so. Nurses and midwives described fidelity and concern for patient suffering motivated them to assume the responsibility of caring for the patients despite their overburdened responsibilities. Sumner (2010) characterizes the relationships nurses have with patients as a "collaborative, covenantal, social contract, related to providing solace for the human condition" (p.19). The nurses and midwives understood their responsibilities and interactions with patients in these terms in which failing to act might mean a betrayal of this covenantal relationship. This deep sense of commitment to patients enabled the nurses and midwives to "recognize that a moral concern to 'be for' exists and are solicited to act on a patient's behalf" (Malone, 2003, p. 2318). Moreover, this understanding further enabled the

nurses and midwives to remain connected to their patients and return to care for them even when they were off duty.

Peter and Liaschenko (2004) have pointed out that moral proximity can be perilous for nurses when they are unable to appropriately respond to the needs of patients due to institutional pressures which may lessen or diminish their attentiveness to conspicuous patient concerns. My findings support those of these authors. Competing demands from patients and excessive workload coupled with their desire and institutional demands to prevent unwanted obstetric outcomes, jeopardized moral proximity and led to diminished attentiveness to the concerns of patients and instigated the abuse of women. Although the nurses had the moral insight that they were expected to sustain the good, they also acknowledged that under imperfect conditions, they were bound to be fallible. Walker (2007) states that sustaining the good is not about a person's beliefs, values, disposition, or motives but depends, instead, on a "set of social arrangements and the ability of a community of people to make a certain kind of stable and shareable sense of themselves within it as they live together" (p.82).

Enacting Moral Agency within the Domains of Oppressive Conditions

In Ghana, patients' autonomy is mostly viewed through the lens of traditional ethics; however, the findings of this study have revealed the relational dimensions of women's autonomy that have largely been ignored. Women's socialization in northern Ghana is rooted in systems of kyriarchy which sets up patterns of "interlocking structures of domination" (p.8) in all spheres of their lives (Schüssler Fiorenza, 1992). These structures are sustained in place by social norms, traditions, customs, institutions, beliefs, and socialization processes leading to their internalization (Aggarwal, 2016; Sultana, 2012). These interlocking structures influence and shape the lives of women by depriving them of access to formal education, economic

advancement, and decision making at the family and societal level. The outcome of these deprivations gives rise to poverty and structural inequalities and limits the capacity of women to exercise autonomy and have a meaningful life, thereby constraining the ability of nurses to enact moral agency.

Mackenzie and Stoljar (2000) have stated that an oppressive orientation and socialization undermine an agent's ability to develop competencies and the self trust necessary for exercising autonomy by shaping her desires, beliefs, and values about her own self through cultural norms, practices, and social relationships. McLeod & Sherwin (2000) believe that the capacity to exercise autonomy depends on "trust in one's capacity to choose and decide effectively, trust in one's ability to act on the decisions one makes, and trust in one's own judgment" (p.26). With limited opportunities, cultural restrictions, and exclusions of women in some parts of Northern Ghana they are unable to develop these competencies to enable them to exercise autonomy. It was, therefore, not surprising when the nurses and midwives recounted women refusing to consent to procedures even when they had the opportunity. The institution of marriage as a means of sustaining the systems of domination, further undermines the ability of women to exercise autonomy. Marriage bestows onto men and their kinsmen the sexual, reproductive, economic, and decision-making rights of women and social norms are set up to enforce these rights by prescribing forms of punishments for women who violate them (Bawah et al., 1999; Horne, Dodoo, & Dodoo, 2013; Nukunya, 2003).

According to the nurses and midwives, because women have internalized these oppressive conditions, their ability to recognize these unjust arrangements had been concealed, thereby interfering with their ability to exercise autonomy even in life and death situations. The social sanctions they were likely to encounter for consenting to treatment without spousal

approval deterred most of them from exercising autonomy even when their lives were at stake. These circumstances constrained the ability of nurses and midwives to enact moral agency and fulfill their moral commitments. The failure of women to exercise autonomy and their moral responsibility for safeguarding the lives of women led to ethical dilemmas and feelings of helplessness. The corresponding consequences of refusing to receive care was perceived as a threat to their moral identity. To preserve their identity, the nurses and midwives resorted to acts of paternalism. While their actions may seem justified under the circumstances, McLeod and Sherwin (2000) have argued that the power difference between patients and healthcare providers may lead to the coercion of patients further limiting their ability to make autonomous choices.

Poverty and vulnerability are not mutually exclusive. According to the proponents of human development, poverty arises out of limited conditions of freedom and opportunity to develop the capabilities that enable a person to lead a functioning and healthy life (Nussbaum, 2011). Because women experience systems of domination, they are deprived of opportunities and resources that are necessary to enhance their capabilities for sustainable livelihood and access to health care. For example, the nurses described that women's lack of education and opportunities limited their chances of having better employment opportunities which then impacted their income status and ability to access health care. This finding is consistent with the literature on the social determinants of health (Baheiraei, Bakouei, Mohammadi, Montazeri, & Hosseni, 2015; Buor & Bream, 2004). These studies have argued that a person's health is linked to various socio-economic, cultural, and environmental factors. For example, income is perceived to influence a person's ability to seek health care and serve as a pre-requisite for meeting nutritional and other health care needs and expenses.

The nurses and midwives explained that these conditions hindered their moral agency and, in some instances, led to the demand for discharge against medical advice and the abandonment of women when families were unable to meet the high cost of hospitalization. Out of their proximity of contact and obligation (Walker, 2007), the nurses and midwives assumed responsibility for mitigating the suffering of women using their personal funds. Working at the intersection of poverty and vulnerability had implications for their emotional and moral wellbeing given what they were exposed to in caring for women. Yet the nurses and midwives described being inadequately prepared to confront the structural and social inequalities impacting on their practice as well as the emotional cost that came with it. This finding is further supported by gaps identified in the NMC (2015) curriculums. The review identified gaps relating to gender and relational influences on patient autonomy, social determinants of health, and cultural competency despite the context in which the nurses and midwives' practice.

The family system plays a critical role in how people show love, solidarity, interdependence, and concern for the wellbeing of the other, especially in times of adversity (Gyekye, 1996). For example, when a family member is hospitalized, it is expected that other family members will visit the sick as a show of concern for their wellbeing. Moreover, because women are valued for their ability to bear children and spouses are the sole decision makers (Horne, Dodoo, & Dodoo, 2013; Nukunya, 2003), they tend to play an active role during hospitalization which is often translated into frequent visits. While it is expected that this kind of support would have provided some financial leverage for women to receive the needed medications and interventions, instead it became a source of burden and suffering for nurses and midwives. The frequency and endless nature of these visits coupled with the lack of enforcement of the visiting times and compounded by the overcrowded conditions interfered with the ability

of nurses and midwives to meet their caring responsibilities. Enforcing compliance and controlling the number of visitors exposed them to acts of verbal assault and threats of physical harm by male visitors who perceived the actions of the nurses and midwives as undermining their authority. This is consistent with the understanding that violence is often used by men as a legitimate means of sustaining or exercising domination over women (Aggarwal, 2016; Sultana, 2012). Because women's domination is culturally ingrained within norms of society, the educational attainment and change in the status of these nurses and midwives did little to prevent violence against them. Moreover, the nursing and midwifery profession have enjoyed very low status within the Ghanaian society due to the predominant gendered nature of their work and the historical conception of them as handmaidens of doctors.

Threats of violence, or the experience of it, coupled with the absence of security created fear and insecurity which left the nurses and midwives feeling emotionally and psychologically traumatized. This finding contradicts an earlier study from Ghana which found workplace violence did not significantly affect the emotional and psychological wellbeing of nurses (Boafo & Hancock, 2017). My study reveals that workplace violence impacted the safety of nurses and how they responded to their moral responsibilities. These findings are supported by other studies which found that workplace violence led to staff demoralization and dissatisfaction, absenteeism, decreased workplace productivity, adverse patient outcomes linked to medication errors, diminished compassion, neglect and abandonment, and acts of retribution (ICN, 2009; Kamchuchat, Chongsuvivatwong, Oncheunjit, Yip, & Sangthong, 2008; Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). There was no workplace violence prevention policy even though the nurses and midwives reported several instances of workplace violence. Rather than initiating interventions to address the violence, the institution chose to blame the nurses for instigating the

violence. This lack of concern about their safety discouraged them from reporting and contributed to uncountable acts of violence with impunity.

The health care institution is dominated by systems of hierarchy, specialized knowledge, and expertise (Liaschenko, 2002). These systems give rise to different moral positions and authorities, which intersect at some point. This point of intersection became the site of power contestation among doctors when treatment decisions were to be made. Working in these contested environments led to the nurses and midwives feeling trapped between different moral and power positions. This finding concurs with Walker's (2007) assertion that when hierarchical power relations and epistemic lines collide, "people may literally not know who is who and what is what unless or until some moral understandings are shared" (p. 236). Because diverse knowledge and interventions are created by different epistemic positions and authority, the nurses and midwives experienced incoherent moral understandings as treatment decisions and interventions were frequently changed, which left them struggling to enact moral agency. Their attempt to navigate through these diverse epistemic positions, led to crises of conflicting loyalties as they struggled to determine whose treatment intervention to implement. The nurses and midwives saw that the incoherent moral understandings and the conflicting loyalties they experienced were detrimental to patient safety and obstetric care outcomes due to the lack of continuity of care and inconsistent treatment and interventions. Frequent changes in treatment by different doctors led to unnecessary financial burdens for the poor and vulnerable patients, who were already struggling to meet their health care needs. In obstetric settings where patient needs are critical, diverse forms of knowledge can help to avert maternal morbidity and mortality, however, the prevailing contested epistemic positions constitute a threat to achieving this goal unless a shared moral understanding prevails.

Moral understanding is sustained by the basic trust among parties that these understandings will not only embody how to live but also be worthy of their continual effort, loyalty, commitment, and sacrifice (Walker, 2007). In social moral orders where hierarchical power relations dominate, moral understandings may not be sustained. The medical profession is an embodiment of power and hierarchy, maintaining a strict chain of command as a way of sustaining these arrangements. However, in a shared and nested community, like the health care setting, these sorts of arrangements are bound to alter the moral understandings, responsiveness, and expectations of other team members. For example, the uncompromising nature of the hierarchy made it difficult for nurses and midwives to engage and consult with doctors and led to frequent delays in initiating appropriate and timely interventions and neglect of patients in need of critical and urgent obstetric care. Because nurses and midwives understood their responsibilities in "different scope, content, kind, or stringency" (Walker, 2007, p.56), they were compelled to refer some patients in need of urgent care to other health care facilities while others took covert approaches to circumvent the hierarchical structure to negotiate care for patients.

Working with damaged identities in the context of oppressive relationships further undermined the ability of nurses and midwives to enact moral agency. Walker (2007) states that how people relate to each other in a social-moral order is constrained and made visible by a background of understandings. She argues that because these understandings are influenced and shaped by gendered arrangements and structures, they can easily fall into relations of domination, marginalization, and misrecognition. When the moral understandings between nurses and doctors were made transparent, it revealed that these understandings were driven by oppression, deception, manipulation, coercion, and interpersonal violence. Walker (2007) states that "we do things for others as a way of creating a relationship that will become committed in

that way, or as a way of honoring a history of relationship that has been so" (p.118). Nurses and midwives perceived their relationship as being based on a long history of mutual dependence and shared benefits, but when this understanding was replaced with coercion and domination, it was no longer worthy of their continuation and sacrifice since it undermined their moral agency and their professional and moral standing.

Nurses and midwives have endured a long history of marginalization and diminished status through what Walker (2007) describes as representational practices, created and circulated by nurses and others. These representational practices are socially constructed identities of people that are made to fit them by virtue of their existing social location and role, which shape how they see themselves and how others perceive them (Walker, 2007). These identities are made to look necessary as a way of making them uncontested. Nelson (2001) argues that the effect of these social processes and representational practices on those who bear these identities is that it deprives them of important social goods and self-respect. These understandings resonate well with the experiences of the nurses and midwives. The nurses and midwives found the stereotypical conception of them as less 'smart' devalued and disqualified them as competent knowers. Because moral agency is relational, the ability of nurses and midwives to enact agency required the "reception and appropriate recognition" (Walker, 2007, p.205) by doctors, however, because doctors perceived them as "less than standardly human" (Walker, 2007, p.205) it hindered their ability to enact moral agency. For example, being addressed as a 'mere' or less 'smart' nurses marginalized, excluded, and diminished their moral recognition which restricted their ability to undertake meaningful engagement and interaction in matters pertaining to patient treatment. This type of misrecognition was perceived by nurses to be damaging to their sense of being and eroded their sense of responsibility. Under these circumstances interprofessional

collaboration became impossible as nurses withheld information required by doctors to initiate appropriate treatment or intervention while others chose to distance themselves.

When normative expectations that embody relationships of earned trust are no longer what others expect and value, they may be prompted to demand appropriate recognition of the shared norms that others are refusing to acknowledge or extend to them (Walker, 2006). Their attempt to demand appropriate recognition of these normative expectations was ridiculed and despised by doctors who saw them as unworthy of those entitlements. The nurses and midwives stated that the basis for the continuation of their relationship with doctors must be driven by mutual intelligibility and recognition, but when these moral understandings and ways of life could not be maintained by doctors they were compelled to shift course and question the power that sustained these gendered arrangements.

In shared life, people trust each other to be morally responsible, comply with the moral standards they all set together, and share the burdens of accountability by considering these normative standards (Walker, 2006). But in a system where oppressive relations are the rule, the distribution of responsibility and structures of accountability are uneven, hence the burden of accountability is placed on those in subordinate positions. One example of this uneven structure was identified as the maternal death audit review. Although the original intent of the audit review process was grounded in normative expectations and reciprocity, the uneven nature of the healthcare system has led to the blaming and shaming of nurses and midwives. The social location of nurses and midwives within the health system, the nature of their responsibility, and their sustained proximity rendered them vulnerable to blame and shame for poor health outcomes. Nurses and midwives were fitted with the ‘guilty mask’ by those who denied them the conditions for the fulfillment of their moral responsibility. This finding reflects the

understanding that the social position of people, be it subordinated or oppressed, and their distinctive set of responsibilities set the grounds by which others judge them or assign blame to them (Walker, 2007).

Blaming and shaming the nurses and midwives for maternal deaths and near misses enabled the institutional leaders to deflect responsibility by virtue of their position of power and their portrayal of themselves as above accountability. According to Walker (2007), asymmetrical accountability is an exclusive arrangement of abusive power relations in which those in underprivileged positions are "forbidden to speak and are punished for talking back" (p.182) about their entitlement to demand accountability from those who have the power to assign blame. The nurses and midwives were forbidden to speak to demand reciprocal accountability during the maternal audit process. Being blamed and denied the opportunity by unworthy judges was described as traumatizing and damaging to their inner sense of being. For example, having the 'guilty mask' placed on a nurse or group of midwives led to stigma and mockery by colleagues and team members, which they described as a form of torture. The fear of being blamed undermined their moral agency and resulted in many nurses and midwives refusing to act or make decisions including those that were within their scope of practice. Blaming promoted a toxic culture of self-protection and exoneration in which the nurses and other team members traded in accusations and counter accusations, engaged in coverups, failed to report wrongdoing or errors, avoided blame by transferring patients, and refused to accept critically ill patients. These conditions promoted mistrust and conflict among interprofessional team members and undermined patient safety. The lack of symmetrical and reciprocal accountability led to failure of institutions to explore and address the broader health system challenges that had led to the poor

health care outcomes. This finding is corroborated by other studies that found a culture of blame limits opportunity for corrective measures (Catino, 2009; Fast & Tiedens, 2010).

Experiencing Moral Suffering

Suffering is an unavoidable part of nursing practice due to the concern and desire of nurses to mitigate the suffering of those in their care (Rushton, 2018). Moral suffering is described as the unendurable pain a person experiences as a reaction to multiple adversities that arise out of participating in a wrongdoing or bearing witness to a wrongdoing resulting in a moral cost (Rushton, 2018). Encountering a morally uninhabitable work environment exposed the nurses and midwives to unendurable suffering due to persistent violations of their moral values and commitments leading to compassion fatigue, moral distress, and moral injury.

The prolonged exposure to the suffering of patients exposed the nurses and midwives to compassion fatigue. Peters (2018) described compassion fatigue in her concept analysis as an experience that "occurs when nurses develop declining empathetic ability from repeated exposure to others' suffering" (p.446). Because compassion and empathy are foundational to the moral identity of nurses and midwives, the continuous inability to respond to the suffering of patients and an overwhelming sense of duty to absorb these sufferings left them vulnerable to feeling the pain of patients. For example, their desire to bear the cost of patients' health care and their commitment to return even when they were not supposed to be on duty have been consistently reported in previous literature to be associated with the experience of compassion fatigue (Austin et al., 2009; Harris & Griffin, 2015; Lombardo & Eyre, 2011). These kinds of caring behaviours demanded emotional, physical, and personal time and commitment of the nurses and midwives, but they were sometimes unable to fulfill them, leaving them exposed to compassion fatigue. Some nurses and midwives described feeling drained emotionally and

dreaded going back for subsequent shifts while others expressed a loss of interest, emotional disturbance, and diminished empathy. These findings are consistent with related work describing the signs of nurses who experienced compassion fatigue (Austin, et al. 2009; Austin et al., 2013; Harris & Griffin, 2015; Lombardo & Eyre, 2011; Peters, 2018). There is also evidence in the narratives to suggest that compassion fatigue and other work-related stressors may have a lasting and devastating impact on the health and wellbeing of nurses and midwives if it remains unaddressed.

Walker (2006) states that when the normative expectations in shared life are betrayed by others, it provokes reactive feelings of resentment and indignation commonly described as moral distress in the nursing literature. Moral distress is the suffering experienced when a person feels he or she has "violated a core value commitment, failed to fulfill a fundamental moral obligation, or some other significant way fallen morally short under conditions of constraint or duress" (Carse & Rushton, 2017, p. 16). This definition resonates well with the experiences of the nurses and midwives in this study. The extreme and profound lack of material resources, inadequate staffing, incoherent moral understandings and responsibilities, unfavourable national and institutional policies, unjust power arrangements, and gender and socio-economic challenges faced by women and their families constrained their capacity to fulfill their moral responsibilities and caused them to violate their moral values and commitments. Feelings of anger, frustration, guilt, shame, anguish, inadequacy, failure, powerlessness, dissatisfaction, and demoralization were expressed by the nurses and midwives. These reported feelings are consistent with those found in the moral distress literature (Austin, 2008; Burston & Tuckett, 2013; Haggstrom et al., 2008; Harrowing & Mill, 2010; Huffman & Rittenmeyer, 2012; Maluwa et al., 2012; Shorideh et al., 2012).

The persistent unrelieved nature of these violations and threats and the conditions that gave rise to them inflicted moral and psychic wounds on the nurses and midwives referred to in the trauma literature as moral injury and describe as the experience of "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). Bearing witnesses to patient suffering and the vulnerabilities imposed by poverty and oppression and being unable to relieve their suffering due to a myriad of constraints caused the nurses and midwives to transgress their deeply held moral values and beliefs. The combination of these experiences inflicted on the nurses and midwives "a deep soul wound that pierces a person's identity" (Silver, 2011, para, 6). This left them feeling haunted by unendurable intrusive memories of their transgressions threatening their sense of being as nurses and midwives. Walker (2006) states that bearing witness to violations or the experience of it shatters a person's identity leading to a sense of loss, confusion, alienation, despair, and cynicism as well as an erosion of a person's sense of moral responsibility. This concurs with the experiences of the nurses and midwives.

People who experience moral wounds require and deserve support to heal, restore their identity, self-respect, and re-establish moral equilibrium (Walker, 2006). However, the nurses and midwives described an overwhelming lack of support and resources to help them heal and cope. Walker (2006) characterizes this lack of concern for the suffering of nurses and midwives as normative abandonment by people to whom nurses and midwives look for acknowledgement of their suffering and support. Normative abandonment leads to a second injury leaving the person with unbearable feelings of rage, anguish, humiliation, and bitterness, all of which resonate with the experiences of the nurses and midwives. There is an urgent need for moral repair to help the nurses and midwives restore their moral identity and sense of commitment.

Moral repair is described as “the process of moving from the situation of loss and damage to a situation where some degree of stability in moral relations is regained” (Walker, 2006, p.6). The process of repair requires individual and collective responsibility of the victims, perpetrators, and community members to whom one looks for acknowledgement and support along with the nature and origin of the injury (Walker, 2007). Walker states that the process begins by recognizing and taking responsibility for wrong, acknowledging and supporting victims, and recognizing and enforcing the shared moral terms and standards that guide normative practice. Walker (2006) also reminds us that there are instances when moral repair may require providing platforms for victims to voice their experience and suffering and to have others validate their experiences and opportunities for vindication and restitution. This approach to moral repair fits well with the purpose of this research and concurs with the narratives of the nurses and midwives, who felt that participating in this research provided them the voice and opportunity for validation, vindication, and redress.

CHAPTER SIX: STRENGTHS, LIMITATIONS, AND IMPLICATIONS

In this chapter, I will state the strengths and limitations of this study and highlight the implications for nursing and midwifery practice, policy, education, and research. I will conclude this section by stating the unique contributions of this research in deepening the understanding of the moral habitability of nursing and midwifery work environment and its influence on their practice in resource-constrained settings.

Strengths and Limitations

The task of representing moral life can be challenging due to the nested nature of human life and interaction. The exclusion of the voices of doctors, administrators, and childbearing women in this research hindered the ability to examine, compare, and contrast those aspects of social moral life influencing and shaping the moral habitability of obstetric settings. While recognizing that the inclusion of this group of people would have added more insight, involving such a large and diverse sample was beyond the scope of this research project. Nonetheless, this study highlights the marginalized voices of nurses and midwives and makes transparent the moral habitability of obstetric settings and how practices of responsibility are sustained within them.

Undertaking research in a familiar terrain provides the moral medium for interpreting, evaluating, and explaining moral life by virtue of our "history of interactions in some personal and political environment, and by our places in that" (Walker, 2007, p.69). Having a history of interaction fostered trust during the data collection phase and enabled contextual interpretation of the data that can be used to develop appropriate interventions and strategies to address the myriad of issues highlighted in the findings. However, this familiarity also requires a researcher to remain reflexive about his or her own assumptions and understandings incurred out of the

experience. Simmons (2007) argues that because most native researchers assume to know the cultural setting from which they work, they may be blinded by their own misconceptions and recommends the need for reflexivity during the research process. By acknowledging my dual role as a nurse and a researcher, my nurse educator position, and my embedded knowledge of the setting, made me conscious about my own assumptions about the data and power relations that existed between myself and the participants.

The value of moral inquiry rests on the "epistemic and emotional leverage" (p.264) that it brings to the fore (Walker, 2003). This research provides new insight into how nurses and midwives in resource-constrained settings constructed and sustained their moral identity through cultural and religious influences. The research further uncovers the moral understandings that govern the relationships among nurses and midwives, doctors, administrators, colleagues, and women and their families from the perspective of nurses and midwives. Given the space to share their narratives created opportunities for healing as well as have their experiences documented, the "voice of subjected people is itself already a change in the configuration of epistemic community…it may not by itself confer credibility, but it is an opening wedge (Walker, 2007, p.176). The willingness to participate and have their experiences documented was perceived to have instrumental value since the findings of this research will help to initiate dialogue, discussion, and debate within and outside the health care institutions as well as create opportunities for transformation of the health care institutions into morally habitable places.

Implications for Nursing and Midwifery Practice

This research highlights the importance of moral identity and values in enabling the nurses and midwives to make sense of their moral responsibilities and commitments to patients and navigate uninhabitable work environment. Supporting new and older nurses and midwives to

reflect on their values can be transformative in enabling them to reconnect and re-establish their commitment to patients, strengthen the moral bonds amongst them that are required for building strong moral communities and promoting a culture of ethical practice as well as enhancing their work engagement. Having an unwavering sense of commitment will also allow patients to "feel safe in the knowledge that nurses are doing this work because they have the right values, attitude, character, and motivation" (Carter, 2014, p. 696).

However, the ability to sustain moral identity was severely impacted by the extreme lack of resources and incoherent moral understandings and responsibilities. While nurses and midwives are expected to uphold the values and professional standards and demonstrate continuing competence, it is also expected that institutions must provide the adequate resources necessary to sustain their practice. Discussions about falling standards of nursing practice need to move beyond pointing fingers at the nurses and midwives and their educators to focusing on ways of addressing the profound scarcity of resources that have impacted their moral agency leading to compromised practice and a gap in competency. Walker (2007) states that the "task of maintaining practices of responsibility and individuals' senses of responsibility is the basic shared task of any community or society that is viewed as the authoritative reference point for the norms and normative expectations on which shared human lives must run" (p.225). This also includes establishing a symmetrical and reciprocal accountability that will allow the health care institutions and nurses to hold each other accountable and create opportunities for corrective measures collaboratively.

Incoherent moral understandings and damaged identities emerged as barriers to interprofessional practice and collaboration. Building interprofessional collaboration will require orienting doctors, nurses, and midwives to appreciate each other's role, contribution, and

position in sustaining the common good. Recognizing that interprofessional collaboration and practice are complex, there is the need to start with interprofessional education and training. The WHO (2010) framework for action on interprofessional education and collaborative practice provides nurses, midwives, doctors, other team members, and institutional leaders with knowledge and strategies for enhancing collaborative practice. The framework further provides guidelines on how institutions can support interprofessional practice. Institutions need to set norms and structures to foster interprofessional practice among doctors and nurses and other team members by creating daily clinical rounds to harmonize practices of responsibility, judgements, and expectations. An opportunity of this nature will address the power struggles, create mutual intelligibility, and foster a sense of moral community. Sustaining moral responsibilities as nurses and midwives requires "mutual recognition, cooperation, and shared enjoyment of many goods" (Walker, 2007, p.82).

Addressing damaged identities will require the moral space to create counter stories to challenge the dominant and distorted representation of them. Nelson (1995) described counter stories as those that contribute "to the moral self-definition of its teller by undermining a dominant story, undoing it and retelling it in such a way as to invite new interpretations" (p.23). The Ghana Registered Nurses and Midwives Association (GRNMA) and healthcare institutions must create spaces for nurses and midwives to share their experiences about those aspects of their practice that mean so much to patients, and yet are devalued and disqualified, as well as the ethical dimensions of their practice. These stories may be able to counteract and resist the effects of dominant stories held by doctors and others about them by replacing them with powerful and authoritative stories of moral integrity and accomplishment under morally uninhabitable

workplaces. Nelson (1995) argues that these stories have the potential to initiate collective action, resistance, and transformation of the health care institution.

Creating opportunities for ethics consultation within the health care institutions and providing decision making guidelines is urgently needed to help the nurses and midwives approach ethical issues arising within the workplace with confidence and less uncertainty. Ethics consultation will create the space for nurses and midwives to critically reflect on the values and beliefs guiding their actions, responses, and judgments. This kind of moral space creates an opportunity for deliberating on ethical problems and clarifying individual values, beliefs, roles, and responsibilities as well as serves as a future resource for confronting other ethical issues (Walker, 1993). In addition to ethics consultation, ethical decision-making guidelines or frameworks need to be developed to help guide nurses and midwives in allocating nursing and health care resources. Initiating these programs may help to minimize moral dilemmas and moral distress. Nurse leaders in collaboration with the institution need to develop interventions and provide counseling resources to help nurses and midwives who experience workplace adversity to cope and restore moral equilibrium.

Finally, developing and strengthening moral courage of nursing and midwifery leaders is essential in mitigating unjust arrangements in the health care institution and supporting other nurses to summon courage. Storch et al. (2002) have argued that nurse leaders need to recognize that they are the moral compasses for supporting the enactment of moral agency, promoting critical awareness and transformation, and creating the moral climate essential for ideal nursing practice. Training is required to help leaders recognize their power and provide them with the discursive resources to speak truth to power without fear or intimidation.

Implications for Policy

The scarcity of resources and inadequate infrastructure had implications for ethical and safe nursing and midwifery practice as well as quality patient care outcomes. The Ghanaian government needs to demonstrate strong political will and commitment to increasing capital investment in the health sector to build a sustainable health care system. The Ministry of Health and the Ghana Health Service as oversight institutions must prioritize the development of new infrastructure and expand and maintain the existing health infrastructure to meet the growing demands and reduce the burden of an overwhelmed system. Developing guidelines to streamline resource procurement, allocation, and distribution at the institutional level is required to ensure a consistent flow of basic supplies and equipment. Administrators need to have mandatory orientation at the frontlines of health care delivery to enable them to understand the nature of nursing and midwifery practice and how resources are utilized. Addressing staffing shortages through aggressive recruitment drives of nurses and midwives may ensure quality health care for patients. Digitizing the NHIS claim validation process is needed to increase the timeliness of the reimbursement to improve the flow of funds to the health institution to enable them to procure the basic supplies and resources. Educating NHIS subscribers of their benefits and coverage will promote transparency and prevent the ethical issues arising out of caring for the insured and uninsured. Finally, the universal health care policy like the NHIS must be devoid of political influences to ensure people are not lured into deception.

Workplace violence prevention is urgently required to promote the safety of nurses and midwives as well as patients. An integrative and collaborative approach between health care organizations and the national nursing association has been recommended for addressing workplace violence and includes instituting a zero-tolerance for violence policy, setting up

violence incident reporting system, raising awareness among the public and nursing fraternity, providing adequate and effective security measures, reporting any incidence of violence to legal authorities, providing legal and emotional support, and providing education and training of healthcare professionals on de-escalation techniques (ICN, 2009). The GRNMA needs to collaborate with the Gender and Social Protection Ministry to integrate workplace violence into the domestic violence bill. Criminalizing workplace violence may serve as a deterrent as well as compel institutions to take proactive measures to prevent it.

Implications for Nursing Education

Strengthening ethics education is required to help nurses confront their ethically laden work environment. Developing robust ethics education in partnership with the NMC Ghana and providing training for nursing and midwifery educators on narrative approaches to teaching ethics will ensure nurses acquire moral awareness, vocabulary, and deliberative resources and strategies to identify and confront ethical issues with confidence. This narrative approach to ethics education is consistent with Walker's (2007) concept of morality as arising out of social context and takes into consideration values, relationships, responsibility, and institutional practices when thinking about moral problems rather than appealing to codified principles. At the clinical level, providing professional ethics training for practicing nurses and midwives will provide them with resources to address ethical issues and to support each other. In addition, the NMC needs to revise and expand the current code of ethics into a comprehensive document with interpretive statements and practice narratives to serve as supporting resources for the nurses and midwives. Developing a global health course will also help increase students' awareness of the social determinants of health, expose them to the realities and challenges of caring for the vulnerable and poor patients, and motivate them to take advocacy roles to address these issues.

Implications for Research

Although a feminist conception of moral agency tends to highlight identity, relationships, and responsibility as central components to a person's moral agency, this study has demonstrated the availability of resources needs to be given due consideration as a fourth component. Future research should consider the influence of resources, especially the lack thereof, on the moral agency of nurses, midwives, and other health care professionals.

Moral habitability appears to provide a broader lens for exploring healthcare work environments in a way that captures the nuances and taken for granted aspects that are usually ignored when investigating ethical dimensions of the work environment. Questions about the moral habitability allow for the everyday social-moral environment and practice of nurses and midwives to be made transparent rather than ethics-oriented questions about dilemmas that tend to produce specific ethical problems. Future research should consider moral habitability as a useful theoretical concept for analyzing both the socio-political and ethical dimensions of nursing work environment.

While there has been an instrument for measuring ethical climate, developing a moral habitability instrument could provide a better approach for assessing what factors contribute to habitable or uninhabitable workplaces. Oslon (1995) defines ethical climate as the perception of nurses about the influence of the hospital organization on their behaviour and attitude. Drawing on business and organizational literature, Oslon (1998) developed the Hospital Ethical Climate tool (HECS). The tool focuses on five concepts including peers, patients, managers, physicians, and hospitals without considering the historical, political, policy, and other external influences shaping the broader health care system and the work environment. Moreover, understanding the nature of the climate of a place without determining its habitability limits the opportunity for

developing interventions to improve or address unfavourable conditions within it. Therefore, developing a moral habitability instrument will enable researchers to capture a broader range of questions such as "what we are doing in a specific form of moral life; another is about what we get from it; the last is about its price and the currencies in which we pay for it" (Walker, 2007, p.248). Since habitability of moral-social life depends on the goods that comes out of it, this instrument will provide better insight into developing strategies for habitable workplaces to enhance the enactment of moral agency of nurses, midwives, and other health care professionals.

Finally, there is a need for an institutional wide investigation to assess the prevalence of workplace violence within health care facilities at the regional and national levels in Ghana. This will help institutions to understand the contributory factors and consequences of workplace violence beyond the affected individuals to include the patients and the organizations as well as develop a collaborative approach to addressing workplace violence.

Final statement

This study is the first to explore the social-moral dimensions of the work environment of nurses and midwives in Ghana and how it impacts on their moral agency. This study provides a grim picture of the health care environment in which nurses and midwives provide care to childbearing women in Ghana. Enacting moral agency and sustaining moral commitment to childbearing women in resource-limited settings is complicated by the extreme scarcity of resources, staffing shortages, altered moral ecology, oppressive and hierarchical relations, and socio-economic inequities. Nurses and midwives attempt to confront this myriad of constraints with remarkable resilience and heroism. However, there were instances in which navigating through these morally uninhabitable places and conditions inflicted on them unendurable pain and emotional costs exposing them to compassion fatigue, moral distress, and moral injury.

These conditions led to the abandonment of moral values and threatened their sense of being and responsibilities as nurses and midwives. Given the impact of morally uninhabitable work environments, addressing these challenges will go a long way to improve maternal health care outcomes and move resource-constrained countries closer to meeting the SDG3.

Finally, as a way of honouring the nurses and midwives who participated in this study, I have taken a moral and political commitment to disseminate the findings of this study at strategic places to raise awareness and attention about the working conditions and to advocate for changes.

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Appendix One: Participants biographic data

Pseudonym	Age	Educational level	Years of practicing as a midwife/nurse	Years worked in current ward
Tena	32	Diploma	2years	2
Paya	56	Diploma/degree	27 years	4
Zoya	33	Diploma /degree	6 months	6 months
Didi	32	Diploma /degree	9 years	4years
Mbo	36	Certificate	1 year	1year
Tali	44	Diploma/degree	11 years	4years
Napo	30	Diploma/degree	6 years	4years
Ziga	25	Diploma	2 and half years	7 months
Bama	Not indicated	Diploma /degree	11 years	3 years
Shia	25	Diploma	2 years	6months
Mani	32	Diploma/degree	8 years	2 years
Afani	34	Diploma/degree	8 years	2 years
Pini	34	Diploma	I year	I year
Kasi	Not indicated	Degree	8 years	I year
Dami	32	Degree	8 years	3 years
Fako	33	Degree/Masters	8 years	3 years
Awe	27	Diploma	3 years	I year
Kahu	Not indicated	Diploma/degree	11 years	2 and half years
Nako	30	Diploma	1 year	1 year
Deli	38	Diploma	6 years	4 years
Lina	34	Degree	6 years	6 years
Niya	40	Degree	10years	4 years
Beni	29	Diploma	2 years	9 months
Yiko	Not indicated	Degree	9 years	5 years
Velim	59	Diploma	35	5 years
Maya	42	Degree	10 years	I year
Kena	31	Diploma	1 year	I year
Lasi	44	Diploma	11 years	4 years
Neira	26	Diploma	7 months	7 months
Masi	24	Diploma	3 years	6 months

Appendix Two: Observation Guide

Space:

- What is the spatial arrangement of the ward?
- What activities take place in the ward?
- What is the daily admission flow in the ward?
- What type of equipment is available and is it functional?
- How consistent and available are medical supplies and other daily consumables?

Adopted and modified from (Spradley, 1980; Mulhall, 2002).

Appendix Three: Interview guide

Please tell me a story about your everyday experience as a midwife in the maternity or labour ward.

I would like you to help me understand the work environment in which you practice, your relationship with other midwives/nurses, women and their families, and doctors including women. This story could be:

(Story prompts)

- A story that you have been reflecting about or a story you might have told someone or felt compel to tell
- A story that is related to the good or bad aspects of your work environment or your practice as a midwife
- A story in which you had to make a difficult decision about your practice and how you felt about it.
- A story that you feel compelled to share about caring for a woman in childbirth

Possible probes

1. What does this part of the story tell you about who you are and what you stand for?
2. What factors do you think influenced how you acted or the decisions you made in this story?
3. Did you experience any conflict if so, what was your response?
4. Who were those involved in your story?
5. How would you describe the nature and quality of the relationships of those involved in your story and how did they influence the decisions or actions you took?
6. What were your expectations about the people involved in your story and what do you think were their expectations of you?
7. Tell me about the support you received to carry out your responsibilities.
8. What does this whole story mean to you and other midwives and nurses and do you think the situation in your story is common?
9. How did it affect your professional life and those that you are caring for?
10. How were you able to navigate through the most difficult part of your story and what are the positive aspects of your experience?
11. What support you did need and who do you think is responsible for this support?
12. Before we end the interview, do have anything else to tell me?

Appendix Four: Participant Information sheet:

Please provide the following information about yourself. Fill in the appropriate responses or tick as appropriate.

Participant ID ……

What is your age? ……..

What is your educational level?

Certificate……

Diploma ……

Degree …….

Masters……

How long have you been practicing as a midwife? ……

How long have you worked in your current ward?.....

Thank you for making time to answer the questions.