A Narrative Inquiry into Ghanaian Midwives' Experiences of Caring for Women during Labour

by

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Abstract

In this research, I focused on inquiring into midwives' experiences of caring for women in Ghana during labour. Using narrative inquiry, four midwives, currently working in private maternity homes, were invited to share their experiences. I was constantly guided by the three dimensional narrative inquiry space: temporality, sociality and place (Clandinin & Connelly, 2000). My research puzzle was shaped by the following wonders: What are the experiences of Ghanaian midwives who care for women in labour? How do these experiences reflect the professional knowledge landscapes and the personal practical knowledge midwives hold? How do their personal experiences across time, place, and in diverse contexts impact their care for women in labour? What forms of knowledge do midwives who care for women during childbirth hold?

Being guided by the concept of relational ethics (Clandinin & Connelly, 2000), I developed a trusting relationship with participants over a period of five months. During this time I held several tape-recorded conversations with participants and engaged in multiple other interactions, which I recorded as field notes and in my journal. As part of moving from field texts to interim and final research texts, I listened to each tape-recorded conversation again and again and repeatedly read my field notes and journal entries. Participants and I co-composed narrative accounts that reflected their stories of experiences as lived and told, as well as reflected our relationships.

To identify resonant threads across all four narrative accounts, I read each account with intentionality and with the research puzzle in mind. A narrative thread of three distinct professional knowledge landscapes for midwives was identified. These were the professional knowledge landscape of working in rural communities, urban communities, and private

maternity homes. Two concepts of knowledge: knowledge for midwives, and midwives' knowledge were identified on each of these professional knowledge landscapes. I discussed the implications of the three professional knowledge landscapes to midwifery education, practice and research.

Preface

This thesis is an original work by Evelyn Asamoah Ampofo. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name: A Narrative Inquiry into the Experiences of Midwives in Ghana Caring for Women during Labour., Study ID. Pro 00066023. Date. July 7, 2016

This thesis is organized in six chapters. Chapter 1 is the introduction to the research and includes narrative beginnings of the researcher's experiences as a midwife and a mother. It also provides information on midwifery education in Ghana as well as an overview of the importance of childbirth, and the research puzzle that guided the study. Chapter 2 is a literature review on various conceptions of knowledge. Chapter 3 provides an overview of narrative inquiry as the methodology used for this study and provides details of how the study was conducted. In Chapter 4, I present four narrative accounts of participants: Happy, Anna, Martha and Adjoa. Chapter 5 follows and I discuss the narrative thread of professional knowledge landscape of midwives, and the professional, and personal practical knowledge of midwives. In Chapter 6, the final chapter, I reflect on the implications of the study on midwifery education, practice and research. It too includes the personal, practical and social significance of the study.

Dedication

I dedicate this thesis to my husband Kwasi, and children Michael and Rachael. I am forever grateful to them for their support, encouragement and love.

It is also to my late father Edward K. Haizel. Through his guidance and support I have become who I am. May his soul rest in peace.

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Chapter One: Introduction

Beginning this thesis with my stories as a midwife helps me situate my understanding of the experiences the midwives in this study shared with me. It enables me to listen to midwives not only as an outsider, but as someone who can identify with their unique yet familiar experiences. My interest in midwifery research has evolved over the past six years and my call to inquire into midwives' personal knowledge was awakened about four years ago. During a job interview, a panel member who had been a victim of an unfortunate childbirth experience, was of the strong opinion that midwives' attitudes are a direct result of how they are educated. While I could see the reason for this argument at the time, I also knew that midwives' knowledge is shaped only in part by their formal education. In retrospect I realized that I had been thinking about the professional knowledge landscapes midwives work within and the knowledge that they hold. Despite my growing interest to inquire into midwives' professional knowledge landscapes and how it influences their practice, I had difficulty conceptualizing how this could be studied. This changed when I was introduced to Clandinin and Connelly's (1996) work on teachers' professional knowledge landscape. Throughout this study I have been guided by the concept of professional knowledge landscapes; it has been the basis for the conceptualization of a narrative inquiry study of midwives' knowledge landscape and their personal practical knowledge (Clandinin & Connelly, 1996). This study into the experiences of midwives in Ghana, has been guided by Clandinin and Connelly (2000) methodological approach of narrative inquiry.

Narrative Beginnings

Growing up in a very quiet neighborhood in Burma Villas, a residential area for senior military officers of the Ghana Army in Accra, I did not interact much with my neighbors. I did not have the benefit of hearing stories about childbirth. On few occasions I overheard my mother

in conversation with some of her friends as they shared stories of their childbirth experiences. I would often listen to such conversations with rapt attention but could not ask questions. I could not ask questions because I was brought up to understand that it was culturally inappropriate for children to get involved in adult conversations. Thus, for most of my formative years, stories about childbirth and the work of midwives were gathered from my friends and other colleagues in school, as well as from what I had seen in movies. Interestingly the movies I saw of childbirth portrayed childbirth as filled with pain and anguish. As a result, my conceptualization of childbirth was that of a painful experience that could end in joy or sorrow. I also assumed that the ability to endure pain was a price and mark of motherhood. Most women would speak with pride about how they spontaneously delivered their babies, and because caesarean birth, especially during the 1970's and 1980's, was seen as an unfortunate occurrence. This perception still holds for some families and communities. My perception of a midwife was that of a stern coach assisting a woman during birth with the sole aim of ensuring that the woman pushed her baby out. I considered the primary work of the midwife as being there to 'catch' babies at the time of birth. The more I heard different accounts of childbirth experiences and learned about the role of midwives, the more curious I became. The many unanswered questions I had and my curiosity to know more, drove me to the labour ward in October 1987 as a first year general nursing student at the Nursing Training College in Kumasi, a city in Ghana. I wanted to see what childbirth was all about. It was there I encountered a woman in active labour for the first time and saw midwives at work.

My invitation to the labour ward by a final year midwifery student was in response to my expressed desire to witness childbirth. Dressed in my uniform, I headed towards the first floor of the six-storied maternity block where the labour ward was located. I had to be in my student

nurse uniform, a green straight dress with a white Peter Pan collar, to secure entry into the labour ward. I recall having mixed feelings when I entered the labour ward. My desire was to reconcile the knowledge I had received from friends about childbirth with what actually happens during labour. I wanted to see how women labour. I wanted to know what midwives do when assisting women in labour. I also wanted to see the setting where labour took place. I simply wanted to find answers to the many questions I had about childbirth. I somehow thought that by going to the labour ward to observe the process of childbirth I would make sense of the stories I had heard.

My perception about a labour ward setting shifted the moment I entered the ward. I was expecting to find a setting that ensured a high level of privacy with a midwife sitting by a woman, ready to assist her. Instead, I entered a room that had a desk at the entrance with a couple of chairs around it. The desk was the midwives' station and the room was the first stage room. The first stage room had more than six beds arranged in close proximity to each other with no partitions between them. The lack of privacy was so evident. I remember clearly a particular woman who caught my attention from the moment I entered the ward. I will call her 'Ama'; the Akan name for a female born on Saturday. Ama was the heart of my experience that afternoon and has remained in my memory ever since. This woman verbally and physically demonstrated her pain as she kept pacing up and down the room that housed not less than three more labouring women. She occasionally stopped by her bed but did not sit or lie on it. Rather she would stand and doze off for a few minutes and then burst out moaning in pain with both hands on her hips. She had no clothes on but did not seem to be bothered by who was seeing her nakedness. Although the other women in labour had different ways of expressing their pain it was obvious that they all were enduring their pain. As I watched them helplessly for hours I had

many thoughts running through my mind. I wondered if there were no answers to their anguish or if the midwives simply did not care. I recall seeing two midwives sitting by the desk. They seemed to be writing and having a conversation at the same time. The other midwives also seemed busy but none of them engaged the women in any form of conversation except when they had to examine them. The student midwives made themselves busy as well; some were cleaning used instruments while others prepared cotton wool swabs for sterilization. I realized I could not just sit and observe, so I decided to help out with the preparation of the swabs but my thoughts were occupied with Ama's suffering. Before long I had concluded that the midwives lacked empathy. Considering that all the midwives were women I wondered why they did not seem to care? I also wondered how their own birth experiences, influenced their practice as midwives? Or perhaps they had become used to childbirth? I formed an initial opinion about midwives as being generally uncaring. Even as a novice in issues related to childbirth I thought that if they cared, their actions should demonstrate some caring behaviours, such as encouragement and reassurance.

Ama continued to labour in pain. From time to time a midwife admonished her to stop shouting and save her energy to push when the time came. The same midwife also examined Ama to ascertain the progress of labour. After a while, Ama was taken to the second stage room for the baby to be born. In the second stage room the contractions became more frequent and expulsive. The second stage room was small and had three delivery beds. Ama was positioned on one and was encouraged to push. I could see by her actions that her pain had intensified. She kept complaining of thirst, her eyes wide open and neck veins distended she tried to push her baby out. Her efforts at pushing did not receive much commendation from the attending midwife. Ama was often scolded for her seemingly poor effort at pushing. She did her best to

push whenever there was a wave of contractions and dozed off when contraction ceased. At a point in time the midwife picked up a pair of scissors and asked Ama to push. I become alert, wondering what the scissors were going to be used for. To my surprise, the midwife gave Ama a cut at the opening of the birth canal. I can literally still hear the sound of the scissors cutting through her flesh and the scream and look on Ama's face as I write this account many years after. Neither Ama nor I knew there was going to be a cut. In all my birth stories that I carried with me to the labour ward that Saturday afternoon I had not heard of any such procedure. I realized Ama had not been informed about the procedure, as she screamed asking the midwife what she had done to her. Following the cut (which later in life I came to know as an episiotomy given to widen the outlet), the baby was finally born. There was such joy and relief for Ama when she saw her baby girl. Ama burst out with praises and thanksgiving to God. I naturally shared in her joy. I was excited and felt a part of her success. Ama, the midwives, and I were all happy. The shift in emotions was real and mutual. A few minutes before the baby was born I was anxious and very empathetic towards Ama. I wanted to help her, but did not know what to do. I was also afraid of the unknown. I had heard about women dying during birth or losing their babies and I did not want that to happen. My inability to assist Ama and my fear of the unknown had caused me a lot of anxiety. As Ama held and embraced her baby I began to reflect on all that had happened.

As I walked back to my hostel that night I had so many thoughts running through my mind. I began to reflect on what had gone on that day and the different emotions that characterized the entire experience. I reflected on what Ama had experienced, I reflected on the role the midwives had played and I tried to make sense of childbirth and midwifery. Overwhelmed by emotions I concluded on that day that I would not want to be a midwife. I had

no plans of returning to the labour ward except when I was in labour, but I did not have to worry because that was to be in a very distant future. The events of that day and its impact stayed with me. Perhaps it is the reason why I become a midwife.

Importance of childbirth

Pregnancy and childbirth in Ghana, a middle-income country in West Africa, is seen as a direct gift from God. Having children is so important that infertility is generally frowned upon by society. Women who are unable to conceive and bear children are stigmatized and, in some cases, maltreated by family members. Naab, Brown, and Heidrich (2013) in a study conducted in Ghana found that women reported high levels of infertility-related stress and some level of social isolation and perceived stigma. The strong desire to have children is not only a Ghanaian phenomenon; it dates back several centuries. Accounts in the Bible reflect the gravity of the stress of infertility on a woman. In Genesis 30:1 (KJV) there is an account where a woman named Rachel weeps at her husband's feet saying *give me children or I die*. In some segments of the Ghanaian society having many children is associated with a favourable social status and pride for many families. A woman's ability to give birth thus becomes a way of validating her womanhood, and the respect and honour of a man is traditionally related to his ability to father children. As Datta (2002) noted, women who are childless may also suffer from physical violence, verbal threats from their husband and family, and they often face rejection, abandonment, and divorce. On the other hand, male infertility is often not acknowledged. Childless couples in some parts of Ghana are often looked upon as immature, a disgrace, and an embarrassment. A large family is not only desired for social reasons, but also for economic ones. The economic importance of children is evident by the help children offer working on farmlands, trading, and working at home to support parents. Children are seen as a form of

investment and security for parents in their old age. More recently, however, some families desire fewer children.

Due to the multiplicity of ethnic groups and diverse cultures in Ghana, there are numerous customs, traditions, taboos, and superstitions associated with pregnancy and childbirth. Ultimately all of the different beliefs and practices are directed towards the same goal: to ensure the safe delivery of a healthy child. The importance of having healthy children cuts across different ethnic, cultural and religious backgrounds. Traditionally women in Ghana do not announce their pregnancies, except to close family members. Women keep their pregnancy a secret, until it can no longer be hidden, in order to protect the pregnancy. Aside from eating well and taking good care of herself, a pregnant woman is encouraged by traditional and religious caregivers to protect her pregnancy by praying. In some cases, an expectant mother is forbidden from certain practices such as eating snails, sweeping or bathing at night, and exposing her abdomen to strangers. These practices are believed to have negative outcomes for her pregnancy. Similarly, the onset of labour is kept a secret from everyone except close relations, such as the husband or the woman's mother, until the baby is born. During labour, prayers and religious pronouncements are often made by both mothers and sometimes caregivers for safe birth outcomes (Ampofo Asamoah & Caine, 2015). Religion and culture form an integral part of many aspects in Ghanaian society and are important in issues related to childbirth. It thus influences decisions related to childbirth such as the choice of place of birth and who attends to a woman during labour. Discussion of the importance of childbirth is incomplete without reference to the role of a traditional birth attendant or a midwife.

Before Western medicine was introduced to Ghana in the 19th century, care during childbirth was the preserve of Traditional Birth Attendants (TBAs). The work of birth attendants

can be traced to ancient Greek and Roman civilization with midwifery being considered one of the oldest professions. The practice of midwifery is evident in myths, texts and oral traditions (Doherty, 2010). Before midwifery practice was formalized in Ghana, older women in the communities instinctively assumed the role of assisting younger women to give birth. It is important to mention that, in as much as assisting in childbirth was the role of women, not every woman was accepted to practice this role. Some women in the communities were selected by community elders and family heads based on their reputation, character, and skill. Others became birth attendants by virtue of their relationship with the birthing woman. Midwifery care was a communal or family affair and thus can be described as having a social role. The women who attended to birth, usually elderly illiterate farmers, have been referred to as TBAs and attended to birth in either their own homes or in the home of the pregnant woman (Ampofo, Nicholas, Amonoo-Acquah, Ofosu-Amaah, & Neumann, 1977). A TBA was expected to be a woman advanced in age (past childbearing age), had gone through childbirth herself, and was preferably a family member to the woman in labour, or a well-respected woman in the community. Most TBAs, in addition, acquired their skill through personal experiences and apprenticeship by assisting other birth attendants. Women who had no children or who lost children during childbirth or soon after birth were not qualified to attend to births (Ampofo et al., 1977; Itina, 1997). Gradually over the years trained midwives have taken over the provision of prenatal and labour and delivery care in Ghana. More midwifery schools have been established to train different categories of midwives, and education on the importance of delivering under the supervision of skilled birth attendants have intensified and yielded positive results.

Beliefs about pregnancy and childbirth have changed over the years due to education and the explosion of accessible information on pregnancy and childbirth. The increase in information

and improved access to maternal health care has not only affected women's decisions about where to deliver but has also lead to a paradigm shift in the activities of both skilled and unskilled birth attendants. Maternal mortality has decreased and maternal health has improved significantly over the last two decades. Part of this success can be attributed to the increased number of skilled attendants and the improvement of their skills over time. Despite this progress maternal death rates still remain unacceptably high with an estimated 319 deaths per 100,000 live births (UNICEF 2015). Currently childbirth in Ghana is predominantly institutionalized with trained midwives being the main caregivers.

The choice of place of birth and mode of delivery is influenced by several factors including: education, religion, socioeconomic, and cultural factors, as well as the availability and accessibility of skilled birth attendants. Midwives like other health professionals work in constantly changing environments that require different forms of knowledge to maintain standards and improve care. Over the past century, the explosion of information and technological advancement has significantly impacted midwifery practices. As the sociopolitical and economic climate in Ghana has changed over time, the practice of midwifery has also seen a significant level of change.

The concept of culture has been described as shared ideas, systems of concepts, rules, and meanings that underlie, and are expressed in the way humans live. It is considered a 'fuzzy' concept in that group members are likely to share identical sets of attitudes, and beliefs but no absolute set of features definitively distinguishes one cultural group from another (Spencer-Oatey, 2012; Keesing, 1976). In other words, an individual is not born with a culture, but rather born into a culture. This understanding underscores the idea that culture is not static, but dynamic and changes over time. Culture is said to provide certain tacit knowledge that shapes the

way each of us live in the world (Peacock, 1986). The knowledge base for midwives is not final at any given time, but is dynamic and shaped by culture. Midwives work within the context of diverse cultures. These include client, institutional, and societal cultures, as well as their own culture. If indeed culture shapes the way we live, then midwife practice must find the balance between the different cultural demands. Each context of practice comes with its own peculiar demands, expectations and challenges depending on where midwifery is being practiced in Ghana.

The prevailing cultural and religious beliefs, and educational level of clients influence accounts of childbirth and midwives' experiences. For example, a midwife working in a rural community in Ghana, where traditional norms and cultural beliefs are strongly upheld, is likely to have an experience completely different from that of her colleague who works in the cosmopolitan city of Accra. Irrespective of the similarities in their training or educational background of midwives and the standards of practice set by the Nursing and Midwifery Council of Ghana, there is a possibility that their experiences of how they practice and come to know midwifery will differ.

Stories of childbirth and activities of birth attendants and midwives have been shrouded in myths and superstition. For example, there is the belief that difficult childbirth is a result of a curse, witchcraft, or a sin committed by the expectant mother (Itina, 1997). There is also the misconception that a midwife is only trained to deliver babies. From my own interactions with women from diverse cultures, I have come to know that expectant mothers also have their misconceptions and superstitions about midwives. Most of the perceptions are concerned with the character, attitudes and beliefs of midwives and not so much about their knowledge. It is generally believed by most Ghanaian women that a midwife with 'bad spirits,' and an 'evil eye'

can have negative spiritual influences on a newborn. Women are often urged by their religious leaders to pray for a good midwife. Once a woman perceives a midwife negatively she will not solicit her services and would rather seek help from an unskilled attendant (Asamoah Ampofo & Caine, 2015).

Literature on the history of childbirth and activities of midwives in Ghana before westernization of midwifery practice is missing or inadequate. As a society, Ghanaians do not generally talk about the activities that occur during childbirth and actual childbirth stories are not shared freely. In some cases, women do not talk about their difficult experiences of childbirth such as perinatal loss or unsatisfactory childbirth experiences for years (Ampofo Asamoah & Caine, 2015). Thus information on childbirth experiences of both midwives and mothers remain largely undocumented, sketchy and the facts are left to the imaginations and speculations of society. The lack of clear information, multiple stories and uncertainties about the experiences of midwives and childbirth has served as impetus for my inquiry into midwives' experience as they care for women in labour.

My life and practice as a midwife has been shaped by my different experiences of attending to birth and of giving birth, yet it remains my experience and is interpreted from my own perspective. Perhaps if I hear others share their experiences it will help me find meaning in my own experiences. It too may help others. Looking back on my experiences I can see the different landscapes from which I have come to know to practice midwifery. The focus of this inquiry is to inquire into the experiences of midwives to better understand the knowledge landscapes of midwifery.

Midwifery education in Ghana

To provide insight into who Ghanaian midwives are and what they do, I provide an overview of midwifery education in Ghana since its formal introduction. As far back as 1917 there were concerns about high infant mortality rates as a result of poor midwifery practices especially during the postnatal period (Ofosu-Amaah, 1981; Hussein, Phoyo, Ansong, Tornui & Okiwelu, 2007). To address this situation, the government opened maternity hospitals and trained midwives, signifying the beginning of formal training for midwives in Ghana. In 1927, domiciliary midwifery was started in two districts in the capital city of Accra. Two African midwives, trained in England, were hired to work in these settings with the responsibility to provide practical demonstration to traditional midwives who were the major care providers prior to and during the 1920's. Following this initial move to improve the skills of the traditional midwives, a more formal training program for midwives was implemented. In 1930, the first training school graduated its first group of locally trained midwives and by 1931 legislation for the training, examination, registration and practice of midwifery was passed.

To sustain the training of midwives after the first graduation, midwifery training schools were opened in other parts of the country to run certificate programs. The training started with Qualified Registered Nurses (QRN) and State Registered Nurses (SRN) who received 18 months and 12 months of midwifery education respectively to qualify as registered midwives. By 1970 the QRN program had been phased out and a two-year midwifery program was introduced as a post Enrolled/ Community health nursing program to run alongside the post SRN midwifery program. All of these efforts were made to increase the number of midwives and improve the skills of midwives to meet the growing maternal health needs.

With the introduction of the Millennium Development Goals 4 and 5 in 2000, the need to train more midwives became an urgent agenda for the government of Ghana. This was intended to meet the WHO target of having a skilled provider attend every birth by the year 2015 (WHO, 2017); a target that was not met. This led to the introduction of the direct three-year diploma midwifery program. Alongside all of these changes, the degree program in nursing started at the University of Ghana in Accra in 1999. In the absence of a baccalaureate midwifery program, midwives seeking higher education were forced under the circumstance to pursue undergraduate and post-graduate studies in general nursing and other academic fields. The need for skilled birth attendants continues to be important in achieving the new global agenda under the Sustainable Development Goals (SDGs).

Currently, only two universities in Ghana offer undergraduate midwifery programs. The country has seen many nursing and midwifery training institutions (public and private) develop in the last decade, with each of the institutions training different categories of midwives. After the phasing out of the certificate midwifery program and the introduction of diploma and degree programs, midwifery education has taken a step backward not because there is a shortage of qualified applicants in the diploma program, but because it is cheaper to train and employ certificate midwives with lower qualifications.

After formal midwifery training started in Ghana, TBAs continued to provide midwifery care alongside trained midwives. There is, however, a decrease in the number of TBAs, and their scope of practice currently is very different. Although the work of TBAs has been reduced drastically in contemporary times, their impact cannot be over looked. In Ghana, much like other locations in Africa, TBAs have been the main health care providers for women during childbirth in rural communities.

The scope of midwifery care under skilled midwives has evolved. Trained registered midwives are licensed to practice in public and private health institutions of all categories. The scope of care has also broadened from the initial direct focus on antepartum, intrapartum and postpartum care only, to embrace other roles. Since the late 1980s and early 1990s the scope of practice in Ghana has seen significant expansions compared to other countries (Reid, 2007). Antenatal care, for example, has shifted from the traditional antenatal practice characterized by several visits, to the Focused Antenatal Care (FANC) which emphasizes the quality of care received during a few visits (WHO, 2003).

Also in response to the global agenda to improve maternal health and reduce maternal mortality, the scope of midwifery care over the years has expanded to include lifesaving procedures, family planning, and abortion care. Through the Safe Motherhood Initiative introduced by the WHO in 1987, many midwives in Ghana have received training to provide emergency obstetric care (Okiwelu, Hussein, Adjei, Arhinful & Armar-Klemesu, 2007). As a result of midwives learning lifesaving skills to handle emergency obstetrical complication, childbirth has become safer and birth outcomes have improved. For example, the use of partographs as a managerial tool to monitor the progress of labour has enabled midwives to detect complications of labour, such as obstructed or prolonged labour, and to initiate prompt referral.

Over time, Ghanaian midwives have been given some level of autonomy to provide emergency care. They are also authorized to carry out emergency interventions such as the manual removal of placentas and assisted vaginal delivery. A few decades ago midwives did not have the mandate to carry out such interventions. Such new mandates were implemented to avoid delays leading to death or serious morbidities (Thaddeus & Maine, 1994; Barnes-Josiah,

Mynitti, & Augustin, 1998) and have contributed positively to the reduction of maternal mortality. Although midwifery training has always been comprehensive, it takes more than the formal education for one to be a competent midwife. Skills and knowledge evolve as the midwife interacts with clients, colleagues and the environment.

Attending to a birthing woman: A midwifery experience

In 1994, six years after my first encounter with childbirth I walked into the maternity ward of a hospital in the Brong Ahafo region of Ghana. This time I wore a blue-black belt on my green and white nursing uniform. Anybody in Ghana who is familiar with the nurse's uniform could easily identify me as a midwife. Somehow that belt, which I had grown to identify as a symbol of authority and pride, was a reminder of my responsibility. It reminded me of my personal determination to provide quality care and make patient satisfaction my focus. It also reminded me that I had a responsibility to preserve the life of the mother and baby whenever I attend to birth.

Working as a newly qualified nurse-midwife I realized within a couple of weeks that, I needed more than what I had learnt in school and from textbooks, to be a 'good' midwife – a midwife I imagined I would be. I soon began to appreciate the complexities of maternity care and to realize that the progress and outcome of labour cannot always be predicted. I had to contend with institutional complexities, as well as the politics of the workplace environment. More importantly I had to work with pregnant women and their families from different cultural, religious and social backgrounds to ensure safe and satisfying childbirth experiences. The decisions related to pregnancy and childbirth care were not always simple; I had to pay attention to the factors that influenced decision-making in childbirth such as cultural, religious, and socio-economic considerations. I soon began to appreciate dilemmas associated with midwifery

practice, and developed a stronger conviction about how much I needed to learn to 'be there' for my clients during birth. A few months into my midwifery practice I realized that each experience with childbirth added significantly to the knowledge I had already acquired.

There are several stories of my experience as a midwife that remain vivid in my memory. One such incident is a case of a pregnant teenager who presented in labour during one of my 8-hour afternoon shifts at the maternity unit. I have chosen to narrate this account out of my many stories of attending to birth for different reasons, but most importantly because of the time period when it happened. It occurred at the beginning stages of my career and triggered my awakening to the need to attend to my own emotions, in order to help my clients attend to theirs. On that fateful day, as I recall, I was on duty with one other midwife and one ward assistant. We were responsible for an entire unit comprised of the labour ward, the antenatal ward where both obstetric and gynecological cases were admitted, and a postnatal unit. At the time I reported on duty at about 1pm there were two women in labour, one was a teenager who I will call Akosua. Akosua was 17 years of age and in active labour. She was going to be a mother for the first time. The other woman was much older, also in labour for the first time, but her labour contractions were not well established. The other units were almost full to capacity, as was the case on most days. Based on my impression of the ward I anticipated a normal afternoon shift.

During the handing over (shift change), the morning staff did not hesitate to inform us that the young lady was uncooperative. Akosua had refused to be examined on several occasions and did not take any instructions given to her. It was not long before I understood what the morning staff described as being uncooperative. As her contractions intensified Akosua refused to be in bed for her baby's heart rate to be monitored or for vaginal examinations to be done. Her crying and refusal to stay in bed made it difficult to assess the progress of her labour and to

detect any deviation from normal. My colleague midwife, who was more experienced than I, decided to attend to her, but soon became frustrated. She tried to reason with her but it did not make any difference. She ordered her to get into bed and even threatened not to attend to her again, yet Akosua's attitude did not change. Out of frustration my colleague left me in the labour ward to take care of Akosua and decided to work on the antenatal ward. I also had begun to feel the frustration and wondered what difference I could make, given that I had less experience in midwifery practice. I also sensed that underneath my frustration was a deep fear because I was mindful of the implications of poor management. At that moment all sorts of thoughts raced through my mind. I thought of the possibility of the baby dying or the mother bleeding to death. The implications of any unfortunate event frightened me. I knew I had to do something. I then realized that I needed more than what my midwifery education had given me to handle the situation. For a moment I was confused and extremely worried, yet very determined to ensure a positive outcome of Akosua's labour. I felt I had lost control of my authority as a midwife. My thinking at that time was that as a midwife I had to be in charge. My clients had to obey and follow my instructions. Out of my fear and frustration, I remember saying a short prayer, asking for wisdom and also for a peaceful ending.

I instinctively approached Akosua and asked her to tell me what she would like me to do for her. To my surprise she responded positively and told me she wanted the pain to disappear. She also wanted her mother to be with her. I explained to her that until I examined her I could not recommend the appropriate pain relief for her. Although against hospital policy, I agreed to invite her mother, who had been anxiously waiting outside the unit, to come and speak with her. This simple act turned around her 'uncooperative attitude' and opened an opportunity to relate with her. Akosua and I began to enjoy a relationship. Initially it seemed a fragile relationship,

because I had to do a lot of talking and coaxing to get her consent for every little thing. Her mother sat by her side weeping constantly. I felt a sense of relief and accomplishment. My frustration and fears were gradually turning into confidence and a sense of accomplishment even though labour was not over. Akosua was calm and only cried out when her contractions became strong. I had taught her mother to give her sacral massages at the peak of contractions as Akosua held my hands tightly with each wave of contractions. In the midst of her pain I felt gladness and joy that I could help her. I eventually became the only person she would allow to attend to her. I spent almost my entire shift by her bedside. I did a lot of talking and negotiating to get her to cooperate with all the activities associated with her care. I was happy I could 'be there' for her, however I could not make sense of her mother's continuous weeping even when her contractions waned. I could only think that being a mother, she was identifying herself with the pain her daughter was enduring. I decided to reassure her that Akosua would get through labour just like she did and that I appreciated her support. Her response to my reassurance came as a surprise to me.

Akosua's mother was crying because her daughter did not choose to endure labour pain at the age of 17 years. She told me Akosua became pregnant as a result of rape. She had to continue the pregnancy because, for religious reasons, the family did not want an abortion. This information sent a surge of emotional waves through me. I immediately understood Akosua's attitude from a different perspective. I could literally feel her emotional pain. I also felt guilty for my poor judgment of her. Teenage pregnancy during that period was stigmatized and erroneously associated with promiscuity and waywardness. Teenagers who became pregnant were usually misjudged and I too had unconsciously misjudged Akosua by not asking what her story was. I could not tell what I did to gain the full cooperation of Akosua, but something

intangible took place. I realized that providing midwifery care required skills that cannot be taught and learned in class. There is a knowledge that is embodied (Johnson, 1989) and personal (Polanyi, 1958). In my opinion this embodied knowledge comes from the midwife's own experiences in life. It is knowledge that is gathered over time through various life experiences. The experiences that produce this tacit knowledge may not be midwifery related. Although there was a lot of drama and negotiation surrounding Akosua's childbirth process, she finally gave birth. One significant lesson I learnt that day was the importance of relationship in care. I had come to know through my midwifery education that good maternity care puts the woman at the center of care provision. The quality of care that characterizes 'good' maternity care is dependent not only on knowledge and skill, but also on a relationship between a woman and the midwife. I realized on that day that my formal education had not taught me how to build relationships.

A personal experience of childbirth

My personal experience of childbirth deepened my knowledge and understanding of pregnancy and childbirth. Soon after I got married I began to look forward to becoming a mother. I also realized that I had other people in my social circle who equally were waiting in anticipation for the news or signs of pregnancy. The show of concern and anticipation for reproduction made me appreciate the importance of pregnancy and childbirth even more. It made me wonder what stories women bring with them to the birthing room. I received my results of pregnancy with joy and great expectation of having a safe and satisfying birth experience. I had no doubt that my knowledge and experience as a midwife would be useful to enhance my ability to cope with the stress of labour. I had learned so much from the stress and the joy of pregnancy from my midwifery practice that my anticipation for delivery and becoming

a mother was high. I assumed that I would be able to interpret the progress of my own labour and advise appropriately as I have done for other women. To ensure that I received optimum care I decided to deliver at the new facility, where I had been working for a couple of months. In my opinion choosing that particular facility had numerous advantages. My familiarity with the place was one factor I considered. Additionally, I assumed that since I was a staff member of that hospital my colleague midwives would take good care of me. Many of them had expressed their wish to be on duty the day I arrived in labour. The facility was a moderately resourced hospital that could handle most emergency cases. Having all this in mind I looked in anticipation toward a satisfying birth experience.

My labour pains started late afternoon, on the 26th of October, my birthday. I identified the signs of labour from the onset. I decided to labour for a while at home until my contractions became more established. I spent the night at home and gradually the labour pains became more intense. At dawn the next day I decided to finally report to the labour ward. My journey to the hospital was about one hour and fifteen minutes. It was a journey I had made on countless occasions to work and back, but that dawn it had surprisingly become too long. I wanted to get to the hospital quickly. The bumpy road and potholes made my contractions more painful and unbearable. My husband had to drive very slowly whenever I felt contractions, thus further increasing the time it took us to get to the hospital. The labour pain was becoming unbearable and I really felt I needed some care. I finally arrived and managed to climb the narrow staircase that led to the labour ward. The labour ward had three sections; the first stage section had two rooms. One room had six beds and another cubicle had two beds. Being a staff of the hospital, I was admitted into the cubicle. The second stage room had two delivery beds positioned very

close to each other. The third section of the ward had only two beds where mothers are kept to rest for the first few hours after delivery.

Lying on the bed in the first stage room I realized I was learning many things for the first time. Firstly it occurred to me that I had never been admitted to the hospital until that time. It was a strange feeling, difficult to explain. I felt my freedom had been taken away. I was now experiencing the hospital environment differently, not as a midwife but as a client. Perhaps it was like being left in a boarding school for the first time under the supervision of a housemistress. My husband had accompanied me to the ward but could not go further than the entrance. I developed a feeling of abandonment. I started looking forward to my discharge the moment I was admitted. I immediately had a different understanding of how important it was to ensure that clients are received warmly on admission.

I was surprised at my sudden feeling of anxiety. It was a feeling I simply could not shake off even with my knowledge in midwifery. I had always anticipated a normal delivery but suddenly became extremely anxious. I needed someone to speak with me and reassure me that all was going to be well. None of the midwives explained anything to me and no reassurance was given. I can only assume that they thought being a midwife I knew everything that would happen. Indeed, I was constantly reminded that I already knew what labour was about and that I needed no further explanation. As the midwife attending to me carried out the physical examination to assess the progress of labour, I began to understand more practically what my clients might have endured and complained about. With each wave of uterine contractions, I understood what I have explained to my clients and encouraged them to endure over the years. Everything was new and understood differently. Labour pain was more painful than I had ever imagined. I started reflecting on how I had treated my clients and realized I could and would

have paid more attention to them if I had this knowledge. Each moment that passed was a learning period for me.

About four hours into my admission the morning staff reported for work and took over from the night staff that I met at dawn. Five midwives reported for the morning shift, I knew three out of the five. I was determined to go through labour without becoming dramatic and I kept to my word. I recall lying in bed in the first stage room experiencing strong uterine contractions accompanied with increased intensity and duration of pain. Although I did not verbally express my pain, I was in so much pain that at one point I felt I could not continue to bear it. I realized I had to put all diplomacy aside and ask for help. The pain was too much and I felt alone in that cubicle reserved for staff. The midwives did not pay much attention to me and this deepened my feeling of abandonment. I managed to call one midwife, asked her to do something about the pain but she stood at the door way and told me she could not give me any pain medication, because I had dilated more than six centimeters and any medication at that point could have an adverse effect on the baby. As a midwife I knew this but I still needed some help. I felt I had been left to suffer and her answer did not make sense to me. All I was concerned about was that I was in so much pain that I needed something to be done about it. Unfortunately, the attitude of that particular midwife was strange. I was meeting her for the first time. She seemed to carry the perception that midwives are difficult clients to have and had personally assigned herself as my midwife for that shift. Her aim, as I later came to understand, was to ensure that I behaved like a patient and not a midwife.

My ‘self-appointed’ midwife, as I would like to call her, prevented any other midwife on duty from entering my cubicle claiming she had everything under control. She constantly reminded me that she was in control and as far as she was concerned I was a patient. She would

not explain the progress of labour to me and would not allow me to ask questions. I immediately considered her a 'bad' midwife and could see wickedness in her eyes. I wondered what her motivation was and why she had been allowed to torture me. My emotions were on a roller coaster at that time. One minute I was angry and ready to fight for my rights, then the next minute I was sad and powerless and not prepared to confirm the impression that staff are the most difficult clients. Just when I thought I could not make it through, Cynthia, a midwife and friend of mine, who worked on another unit, came to visit at the end of her shift. I was so glad to see her. Her presence made such a difference and somehow shortened what initially appeared to be an endless time of suffering alone. She gave sacral massages at the height of my contractions, teasing me occasionally, which helped because it made me smile in the midst of my pain. We also talked in-between contractions, yet the subject of our conversation I cannot remember; neither am I sure if I made any meaningful contributions, but it helped me a great deal. I remember insisting that she stay with me until I delivered. I also told her about the strange behaviour of the attending midwife. She agreed to stay with me for a while and soon it was time for the baby to be born.

I was transferred to the second stage room and positioned. All was set and I was asked to push but I was weak, exhausted and emotionally drained. All my efforts at pushing the baby out were not helping. The pain was unbearable and the anxiety was high. I had been in the second stage of labour for more than forty-five minutes and all the midwife could do was to stand there and pray while I started tearing through the engorged vulval varicose veins I had developed. My instinct told me I needed someone else to come in to do something, or else I would lose my baby. I am not against praying in the face of difficult delivery and I have heard my clients on many occasions pray when in labour. I had personally prayed to support my

clients as they prayed. The difference was that as a midwife, I acted and prayed at the same time when I needed to do so. Lying down observing the 'self-appointed' midwife praying out loud without making any effort to assist me to get my baby out was devastating. I began to question the ability of the midwife to take care of me at this point. I asked my friend Cynthia who was looking on helplessly to go and get help. Cynthia had earlier suggested to the 'self-appointed' midwife that she make an episiotomy but she refused. I guess she was still in control and it did not bother her if I lost my baby.

After what seemed to be a long wait, Cynthia came back with one of the medical officers on duty and the nurse manager of the unit where I worked, who also happened to be a nurse/midwife. The moment they entered the labour ward they sent the praying, 'self-appointed' midwife out of the ward and took over. Within five minutes I had been given an episiotomy and my baby boy had been delivered. I had however sustained multiple vaginal tears that took about an hour to be sutured. I was overjoyed that my baby was alive and well and my ordeal that fateful Friday afternoon was over, but I needed answers to questions concerning the care I had received. My ward manager took the issue up and eventually it was revealed that the 'praying midwife' was trained as a psychiatric nurse and although she holds a midwifery certificate, her years of practice until she was transferred to that hospital, was in psychiatry. It came to light that she had suffered a mental breakdown as a result of marital issues and occasionally exhibited some traces of the illness.

Despite the numerous apologies from the nurse manager of the labour ward, the effects of the events of that fateful Friday still remain with me. The lessons and the knowledge I embodied from different experiences have influenced my midwifery practice and my passion as an educator. It has changed my personal philosophy about care during childbirth. The experiences

of my life as a mother, midwife and a woman, together form the stories I live by (Clandinin & Connelly1998). The stories I live by and the stories I have been told from the women I worked with during the research for my Masters thesis are what I bring into this new study.

Making sense of my stories

I came to this inquiry with my own stories and sets of beliefs and values that I have developed through my personal and professional experiences over time. I have come in contact with a wide range of women, midwives and people with different philosophies. I have also encountered different workplace cultures, politics and policies. Some values I encountered were explicit whiles others were implied, but in one-way or another have influenced my midwifery practice. These various sets of beliefs, values and experiences have shaped and continue to shape my conceptualization of pregnancy, childbirth and midwifery practice in general. It has also influenced who I am and my stories to live by and who I am becoming, as a midwife, whether with a woman in labour or with midwifery students in the classroom. The knowledge landscape in midwifery needs to be further explored and understood. Through this inquiry I have come to better understand the knowledge landscape in midwifery practice.

Research Puzzle

Over the years I have pondered how unique my experiences as a midwife have been. I have wondered what other midwives' experiences are, and what resonates across our experiences. I have also wondered how as midwives we come to know how to care for women. I have again wondered how our personal experiences in life shape the care we give to women during birth and also how our experiences as midwives impact our personal lives. The multiple stories, sketchy information and uncertainties about experiences of midwives and childbirth has influenced my interest to find meaning to my wonderings. My quest to make meaning of my

own experiences and that of other midwives was what deepened my interest to engage midwives in this study. My focus was to better understand the knowledge landscape of midwives as I inquired into their experiences. My research puzzle centers around these wonders: what are the experiences of Ghanaian midwives who care for women in labour? How do these experiences reflect the professional knowledge landscapes and the personal practical knowledge midwives hold? How do their personal experiences across time, place, and in diverse contexts impact their care for women in labour? What forms of knowledge do midwives caring for women during childbirth have? These were the puzzles I sought to explore.

Chapter 2: Conceptualizing Knowledge

The concept of knowledge has received the attention of philosophers since early Greek and Roman times and has been understood differently, depending on philosophical standpoints. Epistemology is the branch of philosophy concerned with the study of theory of knowledge, especially with regards to its methods, validity, and scope, and the distinction between justified belief and opinions (English Oxford dictionary). Most discourse about knowledge in the Western world before the last half of the 20th century focused on the matter of justification and around questions about the nature of knowledge and what can be qualified as knowledge that is true and justifiable being asked. Discussions have also included how knowledge is accumulated, accepted, and how it is classified (Basford & Slevin, 2003). During this period, for the most part, knowledge was conceptualized by analytic philosophers as objective, non-contextual, and accepted as true based on certain criteria such as its ability to be transferred and objectively observed. The idea that knowledge implies truth, belief and justification was strongly upheld. In other words for something to be considered as knowledge it had to be true and justifiable.

In the last half of the 20th century some philosophers raised questions about knowledge and truth, questioning the objective nature of knowledge that had dominated the first half of the 20th century. They argued that this conceptualization of knowledge was too narrow and excluded other forms of knowledge. Philosophers like Williamson (2000) argued that knowledge is the most fundamental state of life and argued that analyzing knowledge based on its objectiveness

was limiting. Within these tumultuous arguments about the nature of knowledge, that is, epistemology, many different conceptualizations of knowledge began to be offered. Different conceptualizations of knowledge have been described in the philosophical literature as well as in discussions of practice (Polanyi 1958; Ryle 1949; Carper 1978; Higgs, Jones & Titchen, 2000). However, two main distinctions within the nature of knowledge are still relevant in current discourses on knowledge that are relevant to nursing theory and practice. The two broad categorization of knowledge are a) propositional knowledge, which is concerned with 'knowing that' and b) non-propositional knowledge, 'knowing how' (Polanyi 1958; Ryle 1949; Higgs, Jones & Titchen, 2000).

The categorization of knowledge as propositional and non-propositional is relevant for nursing/ midwifery knowledge. Nursing, and midwifery for that matter, has been described as both an art and a science (Johnson, 1991; Chinn & Kramer, 2008). The science of nursing has been described as the empirical knowledge used by nurses, which is objective and verifiable. The art of nursing is seen as aesthetic knowledge (Carper, 1978; Chinn & Kramer, 2008; McEwen & Wills, 2014). The empirical knowledge, seen as the science of nursing, is from direct and indirect observation and is expressed through facts, models, scientific principles, laws and theories. The purpose of empirics in nursing is to describe, explain, and make predictions about a phenomenon. It can be likened to the propositional knowledge described by Polanyi (1966). The art of nursing, on the other hand, is seen to be abstract representation of the creation of knowledge gained through experience, perceptions, rhythms, and propositions. The art of nursing is expressed aesthetically through engaging, intuition and envisioning (Carper, 1978; Chinn & Kramer, 2008; McEwen & Wills, 2014).

For nursing and midwifery to be responsive to the needs of clients and relevant to society, both propositional and non-propositional knowledge is needed. Johnson (1991) cautioned against the complete separation of empirical and aesthetic knowledge, arguing that both the art and science of nursing work together to make nursing what it is supposed to be. Johnson (1991) noted, "artful nurses use scientific principles of asepsis, if they do not possess this knowledge as a habit, they would not be considered as artful…scientific knowledge must be complemented by knowledge of a particular situation" (p.14).

Within the multiple arguments about the nature of knowledge, particularly the nature of teachers' knowledge, I came across Clandinin and Connelly's (1996) understanding of professional knowledge landscapes and personal practical knowledge (Connelly & Clandinin, 1985; Clandinin, 1986; Connelly & Clandinin, 1988). Their conceptualization of knowledge, which has its roots in the Deweyan theory of experience, now forms the framework for my development of a conceptualization of midwives' knowledge. However, in the subsequent paragraphs I first examine other conceptions of knowledge.

Understanding Experiential Knowledge

The term experiential knowledge according to Borkman (1976) refers to truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation or reflection on information provided by others. In other words, by being part of, or participating in a situation, an individual gains insight and knowledge about a particular phenomenon or situation. Experiential knowledge, which is a posteriori in nature, involves perception and the use of the five senses to know and understand the world. Experiential knowledge can therefore be considered as knowledge that is gained by perception through

seeing, hearing, touching, smelling and tasting and can be described as being self-evident (Storkerson, 2009).

Another view of experiential knowledge draws on Dewey's (1938) theory of experience. While he conceptualized experiential education in reaction to two approaches of education, traditional education and progressive education, he argued that the two approaches of education built upon different conceptions of knowledge. Dewey asserts that, traditional education viewed knowledge as a body of information and skills that has been completely worked on in the past, and puts the role of education as passing this knowledge on to the learner. By this notion, the life experiences of students are considered irrelevant as far as knowledge acquisition is concerned. According to him traditional education lacks holistic understanding of students, and curriculum focuses only on content or learning knowledge that is objective and already categorized. On the other hand Dewey (1938) argues, that within progressive education, knowledge is not predetermined and controlled outside each learner's influence but is what learners come to know from their experience.

Working dialectically between the two kinds of education and thus the two conceptions of knowledge, Dewey (1938) proposed creating opportunities for each learner to interact with social environments, explaining that, people live in a world within which there are other people and things. The role of education must be to facilitate the interaction between the learner and his/her social environment. The interaction within the social environment results in experience. "The principle that development of experience comes about through interaction means that education is essentially a social process" (Dewey, 1938, p. 58). In his theory, Dewey (1938) introduces two concepts or criteria of experience: continuity and interaction. Continuity implies that each experience an individual has will influence future experiences. Interaction refers to the

situational influence on an individual's experience. An individual's present experience is therefore a product of the interaction between his/her past experiences and present situation. In this case, knowledge is experiential in that it is socially constructed. Dewey noted that no experience can be rated higher or more valuable than another. It can be argued that not all can be considered as educative. The importance of the experience depends on the effect it has on the individual's present and future life, and how it contributes to society.

Following the work of Dewey on experiential learning, other philosophers and writers like Schoen and Johnson further developed Deweyan conceptualizations of experiential knowledge. Schoen (1983) expanded on Dewey's theory to include the practice of reflective professional learning. Schoen (1983) introduced the concept of *reflection-in-action* by proposing an approach to professional education, which recognizes the importance of learning through problem solving in the day-to-day experiences. The type of knowledge that is derived when performing the actions of the day-to-day activities of the professional life is referred to as *knowledge-in-action*. It comes from the routines of everyday actions. "Knowing-in-action makes up the great bulk of what we know how to do in everyday and in professional life" (Schoen, 1995, p. 30). According to Schoen (1983) this type of knowledge is the spontaneous, intuitive performance of action in everyday life. He likened it to physical skills like walking, riding a bicycle, or managing our everyday interactions with people. *Knowing-in-action* is similar to what Polanyi (1958) calls tacit knowing. Schoen (1995) explained that if a skilled performer tries to teach their *knowing-in-action*, they must first discover what they do when confronted with a particular situation. This suggests that knowledge derived in action is personal and subjective. He proposed that professionals should develop the ability to think on their feet, or "*think in action*", reflecting while they carry out tasks and exercise their skills. Schoen (1995) further

noted, “if we want to teach about our doing, then we need to observe ourselves in the doing, reflect on what we observe, describe it and reflect on our description” (p. 30). Schoen (1995) posits that failure to reflect on what we do before we attempt to teach will result in teaching not what we *know-in-action*. Schoen (1992) believes that we can learn to observe, reflect on and describe our knowing-in-action “by for example, writing out instructions for performance and observing what happens when other people try to follow them” (p. 30).

Johnson (1989) further developed the idea of experiential knowledge as embodied knowledge. He points out the importance of human embodiment in understanding, reasoning and knowing, and argues that there exists an experiential dimension of knowing. According to Johnson (2015) “[e]mbodied understanding is not merely a conceptual/propositional activity of thought, but rather constitute our most basic way of being in, and engaging with, our surroundings in a deep visceral manner” (p. 1) Johnson (2015) is of the view that human beings are embodied creatures in that, before any other cognitive activities take place, the body must be in the requisite condition. He noted that understanding is not just an intellectual activity, but rather a series of full-bodied engagements with significant aspects of one’s environment. This is to say that for experience to be meaningful the mind cannot be detached from the body and the environment. Johnson (2015) explained that the environment is not only physical, but that it includes culture, and interpersonal interactions and making sense of the interaction. Johnson (2015) noted, “to say that we understand something is to say that we grasp it’s meaning in a way that allows us to at least be somewhat “at home” and not alienated from our world. Grasping meaning is not restricted to an intellectual act, but is rather a process of intelligent bodily organism-environment interaction” (p.3).

Narrative knowledge

Another conceptualization of knowledge which appeared as the arguments around the nature of knowledge developed in the 1980s was the conceptualization of narrative knowledge. Some philosophers such as Maclntyre, and psychologists like Polkinghorne and Bruner conceptualized knowledge as narratively constructed. Polkinghorne (1991) describes narrative knowing as the cognitive process that gives meaning to temporal events by identifying them as parts of a plot. He describes plot as the organizing theme that identifies the significance and role of the individual event. It highlights the contribution that certain events make to the development and outcome of the story thereby making the story meaningful. According to Polkinghorne (1988)

> [t]he products of our narrative schemes are ubiquitous in our lives: they fill our cultural and social environment. We create narrative descriptions for ourselves and for others about our own past actions, and we develop storied accounts that give sense to the behavior of others. We also use narrative scheme to inform our decisions by constructing imaginative "what if" scenarios. On the receiving end, we are constantly confronted with stories during our conversations and encounters with written and visual media. (p. 14)

Polkinghorne (1988) posits that, human experience takes place in different realms of reality, which include the mental, organic, or material realm. He further explains that narrative meaning is a cognitive process that organizes human experiences into temporally meaningful episodes. Narrative meaning is thus a product of the mental realm and therefore not directly observable. It is not observable because narrative knowledge is constructed in the human mind and is based on mental activity. However, the product of the narrative activity is observable in the form of stories, histories, and tales among others. As Polkinghorne (1988) noted, narrative meanings are

created by noting the contributions that actions, and events makes to determine a particular outcome.

Bruner (1986) wrote about two kinds of knowledge used to understand and interpret human experience; they are paradigmatic knowledge or logico-scientific mode and narrative knowledge. Bruner (1986) explained the paradigmatic mode "employs categorization or conceptualization and operations by which categories are established, instantiated, idealized and related one to the other" (p. 12). He noted the paradigmatic mode deals with general causes, and their establishment. In other words, the paradigmatic mode, being the logico-scientific mode, seeks to establish the relationship between a set of observable variables. It makes use of procedures to ensure verifiability. The second mode that Bruner (1986) describes is the narrative mode. This is concerned with the meaning given to experience through stories. According to Bruner (1986), it is concerned with "human or human-like intention and action and the vicissitudes and consequences that mark their course" (p. 13). The narrative mode brings meaning to human intentions and actions that are more subjective. Each mode of knowing is unique and has its role to play. No one mode is rated better than the other. Bruner (1986) makes it clear that, "each of the ways of knowing, moreover has operating principles of its own and its own criteria of well-formedness. They differ radically in their procedures for verification" (p. 11). The products of narrative activities are conveyed through the use of language. As stories are told verbally or by text, narrative knowledge is created and shared. Bruner (1987) argues that people anywhere can provide intelligent accounts of their experience, but what varies is the cultural and linguistic perspective. In Bruner's view, it is how that story is told that is more important rather than only the content. Bruner (2004) argues, "any story one tells about anything is better understood by considering other possible ways in which it can be told" (p. 709).

Personal knowledge

Polanyi (1958), known for his writings on personal knowledge, proposes a rejection of a positivist notion of science, which disregards the role of personal commitments in the practice of science. Polanyi claims that all knowledge relies on personal judgements and advocates for a post-critical approach to knowledge where personal knowledge is recognized as a driving force for discovery. According to Polanyi, human beings know more than we can prove, and know more than we can say. A knower actively participates personally within the environment.

Polanyi (1958) discussed knowledge as being propositional or non-propositional, whereby propositional knowledge is derived through research and scholarship and non-propositional knowledge from experience. Propositional knowledge, he further explained, is concerned with 'knowing that', while non-propositional knowledge is described as 'knowing how' (Polanyi 1958; Ryle1949; Higgs, Jones & Titchen, 2000). Polanyi also presents another perspective of non-propositional knowledge as being grounded in tacit knowledge, which forms part of what he calls personal knowledge and is mainly experience based. Both propositional and non-propositional forms of knowledge are critical in midwifery practice. I share in the argument put forth by Higgs, Jones, and Titchen (2000) that the medical model, and in this case the empirical form of knowledge, though very important, is inadequate for many health professionals. Experiential knowledge is critical and must receive attention, according to Polanyi. Personal knowledge is vital in the discussion of knowledge for midwifery practice.

Tacit knowledge

The concept of tacit knowledge is credited to Polanyi (1958; 1966) who argued that there exists a type of knowledge that cannot be adequately articulated by verbal means although its existence cannot be denied. According to Polanyi (1966) all knowledge is rooted in tacit

knowledge. Polanyi (1958), in discussing non-propositional knowledge, introduced the concept of tacit knowledge. Tacit knowledge is conceptualized as the kind of knowledge that is difficult to transfer to another person by means of writing, demonstrating or verbalizing. Chugh (2015) defined tacit knowledge as skills, ideas, and experiences that people have, but that are not codified and may not be easily expressed. The nature of tacit knowledge is such that people are not often conscious of the knowledge they possess and therefore cannot ascertain how valuable it can be for others. Tacit knowledge can be acquired through experience (Polanyi, 1966; Ryle, 1945). Lam (2000) posits, without some form of shared experience, it is extremely difficult for people to share the knowledge they unconsciously possess.

Based on the distinction of knowledge as *know-how* and *know-that*, tacit knowledge has been described as *know-how* (Ryle, 1945). Knowledge categorized as *know-that* is considered facts, explicit, can be written down, coded, and easily transferable. However, knowledge considered as *know- how*, which is tacit knowledge and is sometimes referred to as craft knowledge, involves learning and skill, but is difficult to be written down and transmitted. Thus whereas explicit knowledge, which is propositional knowledge and hence *know-that* can be generated and acquired through logical deduction and practical experience, tacit knowledge, being implicit, non-propositional and considered as *know-how* knowledge, is acquired through practical experience (Polanyi 1958). Tacit knowledge is considered intuitive, unarticulated knowledge. This type of knowledge cannot be communicated or transferred without close interaction with the person who embodies the knowledge; it often requires a relationship that is built on trust and understanding over time.

The debates around the nature of knowledge drew me toward the ways that Clandinin and Connelly (1996) developed a conception of teacher knowledge composed of personal practical

knowledge, teacher's professional knowledge landscapes, and teacher identity or stories to live by that live at the nexus of personal practical knowledge and knowledge landscapes. Their conceptualization brings together ideas of experiential knowledge, personal knowledge, narrative knowledge and embodied knowledge.

Understanding teacher knowledge as practical

Fenstermacher (1994) described practical knowledge of teachers by comparing it with the formal knowledge that teachers carry. Teacher knowledge, in his view, is either knowledge for teachers or teacher knowledge. Knowledge for teachers is the formal knowledge that is derived from textbooks, workshops, and guidelines. The knowledge for teachers is objective and transferable. On the other hand, teacher knowledge refers to the practical knowledge, which is subjective and informal. According to Fenstermacher (1994), practical knowledge is the knowledge teachers generate as a result of their teaching in educational contexts. Teachers' practical knowledge, therefore, comprises all of the experiences that teachers go through as they interact with their students as part of their responsibilities as teachers. Fenstermacher (1994) states,

> Practical knowledge is the type of knowledge that is bounded by situation or context in which it arises, and it may or may not be capable of immediate expression in speech or in writing. The teacher's practical knowledge is generally related to how to do things or the right place and time to do them, or how to see and interpret events related to one's actions. (p.11)

Elbaz (1993) conceptualized practical knowledge as being represented in three ways. Firstly, Elbaz (1993) considers practical knowledge as being related to practical issues and includes brief, clearly formulated statements of what to do and how it should be done. Secondly,

practical knowledge is seen as practical principles, which are less explicit, inclusive and make more evident a teacher's purposes. Thirdly, Elbaz (1993) conceptualized practical knowledge as images which are brief descriptive and sometimes metaphoric statements which seem to capture some essential aspects of teachers' perception of themselves, their teaching, or their situation in the classroom (Rahmany, Hassani & Fattahi, 2014).

Elbaz (1983) further explains practical knowledge as knowledge that includes first hand experiences of students' learning styles, interests, needs, strengths, and difficulties. It includes the teacher's knowledge of the social structure of the school, the community in which the school is situated, with its norms and values. Additionally part of a teacher's knowledge are their responsibilities as teachers and what roles students are expected to play. Elbaz (1983) emphasizes that practical knowledge is experiential knowledge and is informed by teacher's theoretical knowledge of subject matter, and other relevant concepts such as child development, learning theory, and social theory.

Schoen (1987) outlined four characteristics of practical knowledge. Firstly, practical knowledge is perceived as being "time bound", and secondly, "situation specific" and cannot be easily transferred into another situation no matter how similar they may be. Thirdly, practical knowledge is "personally compelling" meaning a teacher's willingness to change practice may not necessarily be based on formal information given at a workshop or seminar unless it is relevant a problem being faced by the teacher in the classroom. Fourthly, Schoen states that practical knowledge is "action oriented". In this sense personal practical knowledge is demonstrated in activity and leads to a change in practice. This reflects the pragmatic nature of practical knowledge.

Understanding teacher knowledge as personal and practical

Drawing on Clandinin and Connelly's (1996) work on teachers' professional knowledge landscape to explore the personal practical knowledge of teachers provides a sense of direction to study midwives' personal practical knowledge and professional knowledge landscapes. Their work is based on the assumption that the most important aspect of teacher knowledge is what teachers know and how their knowledge is expressed in their teaching. As part of their research on teacher knowledge, Connelly and Clandinin (1995) considered individual teacher knowledge, the working knowledge landscape and the ways in which this knowledge landscape relates to public policy, and theory.

Dewey (1938) put forth a conception of knowledge as personal and practical. According to Dewey, knowledge could be both personal and practical without ceasing to be public and examinable. He opposed the view that for knowledge to have theoretical importance it must be free from subjectivity, in other words, knowledge cannot be personal or practical. This notion of knowledge as objective has its roots in the positivist paradigm that considers anything practical as in contrast to the theoretical, while anything personal is considered as subjective and private, versus objective. Dewey's aim was to reject any attempt to ignore the personal and practical aspects of knowledge. While Dewey did not develop a concept of personal practical knowledge, other researchers did (Clandinin, 1985; Elbaz, 1981, 1983; Connelly and Clandinin 1988; Schoen, 1983; Fenstermacher 1994).

Connelly and Clandinin (1988) defined personal practical knowledge as "a moral, affective, and aesthetic way of knowing life's educational situations" (p. 59). Clandinin (1985) asserts "[t]eachers develop and use a special kind of knowledge. The knowledge is neither theoretical, in the sense of theories of learning, teaching and curriculum, nor merely practical in

the sense of knowing children" (p.67). Personal practical knowledge as used by Connelly and Clandinin (1984, 1985) denotes a type of knowledge involving all that makes up an individual. "It is knowledge which has arisen from circumstances, actions and undergoings which themselves had affective content for the person in question" (Clandinin, 1985, p. 68). This statement describes personal practical knowledge as being a product of experience. Johnson (1984) also describes personal practical knowledge as "a contextually relative exercise of capacities for imaginatively ordering our experience" (p. 467). Personal practical knowledge cannot be acquired in classrooms or in a library engaging the content of a textbook, or at a conference or workshop. The assertion of personal practical knowledge being born out of experience is in line with Polanyi's (1958) non-propositional knowledge described as *know how*. It is also a form of tacit knowledge, embodied, and not easily transferable. Clandinin (1985) points out that the study of teachers' personal practical knowledge begins with the study of practice. She argues that personal practical knowledge is found in practice.

> Personal practical knowledge is revealed through interpretations of observed practices over time and is given biographical, personal meaning through reconstructions of the teacher's narratives of experience… It is knowledge which is experiential, embodied, and based on narratives of experience. (p.69)

Johnson (1989) explains that this form of knowledge is embodied and becomes part of who the teacher is over time. He states that human beings have bodies that are the locus of their complex interactions with their environment. It is clear by this explanation that a successful teacher/ teaching experience is one that combines both personal practical and theoretical knowledge.

Clandinin and Connelly (1984) also considered teacher *image* as a component of personal practical knowledge and as based on narrative unities within an individual's life and a core

concept in understanding teachers' knowledge. They emphasized the need for image in this context to be seen as part of teachers' personal practical knowledge. Using image metaphorically helps to imagine meanings and patterns generated in practice. In this sense the image that a particular teacher has about the classroom and teaching in general influences the actions and activities of that particular teacher. To understand a teacher's personal practical knowledge that includes the idea of image would mean looking out for attributes that depict how the individual teacher conceptualizes his or her practice. This can be understood narratively by living along the teacher or as he/she narrates experiences. Johnson (1984) explains that "it is our images and deep metaphorical structures, as well as our concepts and propositions that constitute our practical knowledge" (p. 467). The idea of image as part of personal practical knowledge lends credence to the view that personal practical knowledge is composed by individuals in action and is an intersubjective type of knowledge.

The role of personal practical knowledge is significant because it influences teachers' actions either negatively or positively depending on what the teachers' experiences are. Personal practical knowledge is, therefore, an integral part of teachers' teaching and day-to-day practice, and comes from teachers' embodied experiences and personal histories. The teacher, whether a novice or an expert, comes to the classroom with embodied knowledge developed from past educational experiences in schools, their upbringing, and lived experiences in general. Individual teachers, experienced or novice, have their own personal narratives of experiences and this partly shapes how they are as teachers (Connelly & Clandinin, 1988).

Drawing on Dewey's (1938) conceptualization of experience as a result of situation and interaction, where the interaction is usually between an individual, objects and other persons, Clandinin and Connelly (1995) developed a metaphor of a landscape to study how teacher

knowledge is shaped by the different forms of interactions teachers have with different people including students and colleagues. They also recognized the different places and different times these interactions took place as important. Based on their perception of the professional knowledge landscape as being composed of relationships among people, places, and things, Connelly and Clandinin (1995) described it as both an intellectual and moral landscape.

Understanding the professional knowledge landscape

According to Clandinin and Connelly (1996), a landscape metaphor as a way to "speak of school contexts allows us to talk about space, place and time". Furthermore, "it has a sense of expansiveness and the possibility of being filled with diverse people, things and events in different relationships" (p. 25). Their narrative understanding of teachers' professional knowledge landscape was conceptualized as filled with secret stories, sacred stories, and cover stories. Connelly and Clandinin (1995) described secret stories as stories of the classroom. According to them a classroom is the place where teachers are free to live their stories of practice (Clandinin & Connelly, 1996). Secret stories are the in-classroom stories where teachers' lives and practices are not under scrutiny. The secret stories embody what teachers actually do, how they teach, and what classroom environments they create for children, themselves and the children's families. Although there are standard expectations of how teachers ought to practice, the in-classroom place where teachers are alone with learners allows teachers to live out their lives as teachers without the pressure of conforming to rules, policies and protocols. Secret stories are safe to be shared among some teachers. Based on the understanding of teachers' personal practical knowledge, one would not be far from wrong to suggest that secret stories are made up of a combination of "teacher knowledge" and "knowledge for teachers", that is to say

knowledge that is given to teachers and includes research, policy, and protocols, as well as personal practical knowledge.

Clandinin and Connelly (1996) described cover stories as stories that are lived and told in and out of classroom places. Cover stories are stories told by teachers to conform to what authorities and policy makers expect of them as teachers and are not necessarily what teachers actually do within the classroom. Teachers tell cover stories when they perceive that their actual stories of practice would raise issues of concern.

Clandinin and Connelly (1995) suggest that there is also a sacred story in which practice is understood as theory driven. In this view, practice is understood as applied theory. The theory-driven practice story has the quality of a sacred story in that it is not questioned by either practitioners or policy makers. The theories and policies that are delivered to teachers to be applied in practice are constructed outside the classroom and include the generally accepted expectations of what they have to do as teachers. The theories and policies are based on what is prescribed by the system and handed over to teachers, and therefore cannot be altered by individual teachers. Teachers tell cover stories to portray that they know what policies they are expected to implement even if they live different stories in their practice..

Furthermore, Connelly and Clandinin (1988) described teacher's personal practical knowledge as expressed on the professional landscape and noted that personal practical knowledge is a term designed to capture the idea of experience in ways that allowed them to talk about teachers as knowledgeable and knowing persons.

> Personal practical knowledge is in teacher's present mind and body and in the future plans and actions. Personal practical knowledge is found in the teacher's practice. It is for any

> one teacher, a particular way of reconstructing the past and the intentions of the future to deal with exigencies of a present situation. (Connelly & Clandinin, 1988, p. 25)

Personal practical knowledge thus is knowledge that reflects the individual's prior knowledge and acknowledges the contextual nature of the knowledge. Personal practical knowledge is a reflection of the knowledge that teachers generate through their experiences over time. It is carried by both novice and experienced teachers. It is shaped by, and shapes, their professional knowledge landscapes. What is funneled into the professional knowledge landscape is theoretical knowledge, policies, research and prescriptions. This knowledge is passed onto teachers through formal education, policies, and workshops. As Clandinin (1985) noted, a teacher's knowledge is composed of both kinds of knowledge, blended by the personal background and characteristics of the teacher and expressed by them in particular situations.

Personal knowledge of midwives through stories

Thinking about the professional knowledge landscape of midwives in light of Clandinin and Connelly's (1996) work with teachers helped me to understand my work with midwives in this study. Reading the articles on teachers' personal practical knowledge, and the concept of professional knowledge landscape, helped shape my research puzzle. Dewey's (1938) concept of experience also grounds my conceptualization of midwives' experiences. I wonder what secret, sacred and cover stories fill the professional knowledge landscape of midwives. What stories do midwives know and tell? How do these stories shape their practice as they interact with their clients and other midwives? Drawing from my experiences as a midwife, my interaction with clients, colleagues and other members of the health team I have developed secret and cover stories that have shaped my knowledge and practice. Through this study, I wanted to understand how the stories in the professional knowledge landscape of midwives who were

invited to take part in this study have been shaped by their knowledge, and how their knowledge has been shaped by their experiences. My search through the literature suggests that the idea of studying personal practical knowledge and professional knowledge landscape as proposed by Connelly and Clandinin (1996) is absent in nursing and midwifery research. However, I find the concepts useful for understanding what midwives know and how their knowing is expressed in their day-to-day interactions with clients, colleague midwives, and other members of the healthcare team. I hold the assumption that midwives' knowledge and knowing affects every aspect of their professional and personal lives.

My understanding of personal practical knowledge from the various philosophers and researchers I have referenced in the pages above serves as a guide to studying midwives' personal practical knowledge. I conceptualize the personal practical knowledge of midwives as non-propositional, embodied, tacit, implicit, and narratively expressed in the stories that midwives tell and live by (Dewey, 1938; Polanyi, 1958; Clandinin, 1985; Elbaz, 1981, 1983; Connelly & Clandinin, 1988; Schoen, 1983; Fenstermacher 1994). I draw a distinction between "knowledge for midwives" and "midwife knowledge." Knowledge for midwives is formal knowledge that is developed from formal midwifery education in classrooms, from textbooks, during workshops and use of protocol guidelines, which the midwives talk about in their conversations. Such knowledge is the type that the experienced midwife can easily transfer to a novice midwife.

The notion that knowledge is socially constructed has implications for understanding the experiences of midwives and their professional knowledge landscape. In Ghana, midwives are accountable for what they do. Over the years the scope of work for midwives has shifted from the traditional non-intervention oriented care to include a variety of life saving interventions.

The rapidly changing role of the midwife, as a result of changes in society and increasing health demands of women, warrants a deeper understanding of the dynamic social context within which midwives work and the knowledge they carry.

Professional practice especially in the health sector has been found to be multifaceted (Higgs & Jones, 2000; Higgs & Titchen, 2000). It is important to understand midwives' experiences in order to understand the professional knowledge landscape of midwives. Midwives come into their practice with their own experiential knowledge, values, and beliefs. Similarly, clients also carry with them a set of beliefs, values, and experiential knowledge about childbirth. The interaction between the different sets of experiential knowledge can generate ethical issues about care if not acknowledged as important. The midwife is constantly faced with the dilemma of decision-making that requires her to consider the diverse sets of values and beliefs as well as varied experiences. An understanding of what constitutes knowledge is therefore an essential component of midwifery practice.

The focus of this study is to understand the types of knowledge midwives embody in their professional knowledge landscape. Of particular interest is their personal practical knowledge, which I describe as midwife knowledge. I am also interested in how place, time and social interactions influence the generation and use of their personal practical knowledge. I also pay attention to midwives' secret and cover stories. Midwives share their experiences with each other during their informal meetings (Chase, 2005). Through the stories that midwives hear from other midwives as they recount experiences of their practice, narrative knowledge is shared that has the potential to influence the actions of hearers when they encounter similar incidents in future.

Chapter 3: Methodology

Narrative Inquiry

Why Narrative Inquiry?

To enable me to inquire into the experiences of midwives, I carefully and reflectively considered a methodology. Reflecting on my own stories as a midwife and stories of other midwives that I have heard through informal conversations at different occasions, I sought a methodology that would enable me to inquire into the experiences of midwives, an inquiry where I could also consider the emotional and ethical components of their narrations. Thinking about how midwives share their experiences of practice I agree with Chase (2005), who noted that midwives share stories of their practice whenever they come together. During these conversations enormous information and experiences are shared. With a focus on experience I turned towards narrative inquiry, a relational research methodology. As Connelly and Clandinin (2006) stated, narrative inquiry is "the study of experience as stories" (p. 374). It is first and foremost "a way of thinking about experience" (Connelly & Clandinin, 2006, p. 375). Linking this notion of experience to Dewey's (1938) view of experience helps me to ground my choice of methodology. Dewey (1938) asserts that experience arises from the interaction between continuity and interaction, where continuity implies that each experience takes place in the past and has an effect on the future experiences of the individual. On the other hand, the criteria of interaction according to Dewey (1938) refers to the situational and educator's influence on the experiences of students. Narrative inquiry as posited by Connelly and Clandinin (1990) draws on

Dewey's understanding of experience, and proposes a framework that enables me explore the experiences of midwives and understand their knowledge landscape in relation to time, place and social interactions. From this perspective using narrative inquiry to study experience, helped me to inquire into the nature of the experiences of midwives and their knowledge landscapes.

Being cognizant of the different approaches to narrative research, I have chosen Connelly and Clandinin's (1990) understanding of narrative inquiry to guide my research. According to them, the argument for the development and use of narrative inquiry comes from a view of human experience, in which "human beings are storytelling organisms who individually and collectively lead storied lives" (p. 5). Narrative inquiry is a process of gathering information for the purpose of research through storytelling as the researcher explores experience (Clandinin & Connelly, 2000). I am also reminded of the words of MacIntyre (1981), who states: "it is because we all live out narratives in our lives and because we understand our own lives in terms of the narratives that the form of narrative is appropriate for understanding the actions of others. Stories are lived before they are told" (p. 197). Based on the assertions by Clandinin and Connelly (2000), and the notion that midwives generally share their experience through storytelling, using narrative inquiry provided an appropriate framework to guide the telling, living, retelling and reliving of Ghanaian midwives' experiences as they care for women during childbirth.

In the Ghanaian culture, stories over centuries have served as a way of teaching culture, establishing morality, portraying right and wrong, and guiding how one ought to behave or conduct themselves in a socially appropriate manner. Thus engaging midwives in Ghana to tell stories of and about their experiences was not a new phenomenon. Storytelling is one of the fundamental ways by which we come to know, teach and learn as Ghanaians. Through the stories participants and I shared, new knowledge and insights were brought to light.

Another characteristic of narrative inquiry that makes it an excellent choice for this study is the relational nature of the methodology. Narrative inquiry has been described as a relational inquiry (Clandinin & Connelly, 2000; Clandinin, Murphy, Huber & Murray, 2010; Craig & Huber, 2007). Being a midwife, I sought to study alongside other midwives not only to understand their experiences, but also to make meaning of my own stories. Narrative inquiry is a methodology that supports a relationship where both the researcher and the participants become co-inquirers and feel cared for. This is possible as narrative inquiry "moves away from the assumption of studying a 'thing' or subject where there is no relationship between the researcher and the researched, to researching alongside participants" (p. 97). Throughout the inquiry, I negotiated close relationships with participants and developed a research relationship by which the midwives and I could work together. Greene (1995) states:

> To see things or people big, one must… view them in their integrity and particularity… one must see from the point of view of the participant in the midst of what is happening if one is to be privy to the plans people make, the initiatives they take, the uncertainties they face. (p. 10)

Narrative inquiry is a methodology that allows me 'to see things big' and gain a deeper understanding of the phenomenon being studied (Greene, 2013).

My interest in the experiences of midwives, as they care for women in labour, required that I inquire into how their personal, educational, cultural, social, as well as institutional experiences shaped their practices. Narrative inquirers explore human experience by engaging with participants in the field over time, as they tell or live their experiences. They create field texts, and write interim and final research texts. The researcher also "pays attention to ethical tensions throughout the process of inquiry" (Clandinin & Connelly 2000, p. 135; Clandinin &

Caine, 2007). Narrative inquiry is a way of thinking about experience; "it is both a view of the phenomena of people's experiences and a research methodology for inquiring into human experience" (Clandinin & Connelly, 2000, p. 2).

Experiences are understood as taking place across time, at a place or series of places, and involve social interactions (Clandinin & Connelly, 2000). Connelly and Clandinin's (2006) proposed framework for understanding stories is based on what they refer to metaphorically as the three-dimensional narrative inquiry space. This three-dimensional space serves as a guide that helps the inquirer navigate their way through the study. The three dimensions are: temporality (past, present and future), sociality (feelings, hopes, desires, aesthetic reactions and moral disposition of the inquirer and participant, as well as relationship between participant and inquirer), and place (Connelly & Clandinin, 2006). Place is described by Connelly and Clandinin (2006) as "the specific concrete physical and topological boundaries of place or sequence of places where the inquiry and event took place" (p. 480). These dimensions directed my attention during this research.

Historical evolution and philosophical assumptions of narrative inquiry

The living and telling of stories serves several purposes. It serves as a form of teaching and learning, imparting knowledge, shaping morals and providing a way of passing on traditions from one generation to another. Lived and told stories as posited by Clandinin and Rosiek (2007) are "ways by which we fill our world with meaning" (p. 35). Story telling is not a new phenomenon rather, what is relatively new, is the use of narrative, and narrative inquiry as a research methodology (Connelly & Clandinin, 1990). Narrative inquiry, as a research methodology, is relatively new in nursing and midwifery especially in Ghana. During my master's thesis I used narrative inquiry as a methodology to inquire into Ghanaian women's

experience of pain during labour (Ampofo Asamoah & Caine 2015). The emergence of narrative methodology is linked to what is referred to as a narrative revolution, which began after the decline of the dominance of a positivist paradigm (Lieblich, Tuval-Mashiach, & Zilber, 1998; Clandinin & Rosiek, 2007).

Although there are many philosophical bases for the study of experience such as Aristotle's idea of studying experience or Marx's concept of experience, narrative inquiry has its philosophical grounding in the Deweyan view of experience (Clandinin & Connelly, 2000; Clandinin & Rosiek, 2007; Dewey, 1938). Dewey (1938), a pragmatist, is noted for his writings on the theory of experience. According to Dewey, experience is the starting point for knowledge. He describes experience as something that goes beyond what words can express; the inexpressible that determines what is expressed. Midwives have often told their experiences in the form of stories and have thus invited their listeners to share in their experiences. As Clandinin and Connelly (2000) noted, stories are the closest we can get to the experiences of others. In other words, the closest one can get to the knowledge brought forth through experiences of others is to hear their stories. Dewey alludes to the fact that there is something beyond what we generally see.

Dewey's (1938; 1934) concept of experience indicates a continuous interaction of human thought with our personal, social and material environment (Clandinin, 2006; Clandinin & Rosiek, 2007). The idea of continuous interaction between 'subject' and 'object', between a 'self and its world' as expressed by Dewey, is key to making meaning of experience. The idea of experience being a continuous interaction between a self and the world provides the ontological and epistemological bases for studying experience. To make meaning of midwives' experiences, the dimension of time and of personal and social interaction must be considered. It must be

understood that individuals create meaning from experience through physical and social interactions over time (Schmidt, 2010).

Several features of the three-dimensional space in narrative inquiry, as proposed by Clandinin and Connelly (2000), can be traced to Dewey's ontological and epistemological assumptions about experience. The importance of temporality in narrative inquiry can be traced to Dewey's criteria of continuous interaction. The Deweyan view of experience emphasizes continuity and considers experience on a continuum; experience builds on experience (Clandinin & Connelly, 2000). This speaks to the recognition of the role of time or temporality in experience.

Furthermore, Dewey (1938) describes experience as an interaction between a human being and their environment. This also addresses the issue of place and social/ personal interaction. From a pragmatist viewpoint truth is seen as transactional and finding truth means examining the interaction between thought, personal, social and material environment. Commenting on the epistemological view of Dewey about the study of experience, Clandinin and Rosiek (2007) noted that "the implications were revolutionary" (p. 42). The aim for inquiry in this case is not just to generate knowledge but also to bring about a new relationship between human beings and their environment, their life, community, and world. This is intended to create new experiences and new ways of doing things or interacting in a more significant way than previously. The idea is that "experiences grow out of other experiences and leads to further experiences" (p. 2). Each past experience leads to another experience in the future (Clandinin & Connelly, 2000). Conducting a narrative inquiry requires me to "engage with participants in the field, create field texts, and write both interim and final research texts" (p. 8). In order to go through the process of narrative inquiry I am guided by the twelve qualitative touchstones for

narrative inquiry proposed by Clandinin and Caine (2013). Using touchstones metaphorically, Clandinin and Caine were paying attention to ways of ensuring quality in narrative inquiry. They identified twelve touchstones, which included relational responsibilities between researcher and participants, and a recognition by narrative inquirers that they always enter into research relationships in the midst of ongoing lives of both researcher and participants. Negotiation of relationships throughout inquiry is named as another important touchstone. Other touchstones such as writing and inquiring into researcher's own narrative beginnings, negotiating entry to the field, being in the field and writing of field texts as well as writing interim and final research text among others. The touchstones provide an outline of the key components of the process of narrative inquiry.

Engaging midwives for the study

Considering the relational nature of narrative inquiry, my first concern was to attend to the ethical issues associated with the inquiry (Clandinin & Connelly, 2000). Relational ethics is the most appropriate form of ethics in narrative inquiry (Clandinin, 2013). This is because relational ethics places the relationship that researchers and participants build at the center of their work. "Relational ethics is characterized by a responsiveness, as well as short and long term responsibilities researchers have towards their participants" (Huber, Clandinin & Huber, 2006, pp, 185). I was also guided by the argument of Coles (1989) regarding relational responsibilities between researchers and participants, and in particular the importance of respect. According to Coles (1989)

> We have to pay the closest attention to what we say. What patients say tells us what to think about what hurts them: what we say tell us- what we are thinking, and what may be

> wrong with us. … Their story, yours, mine- it's what we all carry with us on this trip we take, and we owe it to each other to respect our stories and learn from them. (p. 30)

During this study, I engaged with four midwives over a period of five months from October 2016 to February 2017. All four participants were midwives between the ages of 54 to 66 years old. All of them still actively worked as midwives during the time of the conversations. Three of the participants worked full time at private maternity homes, each of them having previously worked for more than twenty years in the government sector. The fourth participant, who was still in active service in the government sector, worked part-time at a private maternity home. I anticipated living alongside my participants in their practice and as such I paid close attention to ways that would foster an ethical relationship that is marked by trust, respect, and equity. As I invited midwives into the inquiry I was careful to explain to them in detail my responsibilities as a researcher, as well as their responsibilities as participants. I welcomed all participants to be involved in the co-composing of interim research texts. Being cognizant of their unique characteristics, each participant was invited differently to be part of the study**.** In chapter four I describe how each participant was recruited into the study. The telling and living of their experience was guided by the ethical responsibilities that were established at the beginning of our interactions, and which were continuously negotiated (Clandinin & Caine, 2013). The ethics of everyday life guided my interaction with participants. Based on this, I negotiated my relationship with each one of the participants. I negotiated when, where and how their stories would be told and lived, taking into consideration the importance of building relational spaces.

My second concern, as I reflect on the qualitative touchstones, was to be mindful that the inquiry commenced with both participants and myself being in the midst of our ongoing lives. I

too imagined the various lives that might be interrupted as the inquiry began. Having this in mind I consciously and constantly negotiated each phase of the inquiry. Clandinin and Caine (2013) caution that when designing narrative inquiries, inquirers need to imaginatively place themselves amidst possible lives of potential participants. Throughout the inquiry, I was attentive to and imagined the temporality, sociality, and places of participants' lives.

I engaged four midwives as participants for this study. According to Sandelowki (1995) sample size in qualitative research should be one "that permits by virtue of not being too large, the deep, case-orientated analysis that is a hallmark of all qualitative inquiry. This also results in, by virtue of not being too small, a new and richly textured understanding of experience" (p. 183). Engaging with four midwives facilitated the building of trusted relationships characteristic of narrative inquiry. The participating midwives were selected from private maternity homes in the western regions of Ghana. The western region was selected for two main reasons. Firstly, I had the opportunity to work as a midwifery tutor in the Western Region for five years and have lived in the region for close to nine years. During this period I had the opportunity to travel across the region. I am therefore familiar to a large extent with midwifery activities as well as the geography of the region and as such was able to relate to the experiences shared by participants, which shaped our conversations. Secondly, working with midwives in the Western Region where I live afforded me the opportunity to build both short and long term relationships with participants since distance was not a challenge. I intentionally worked with individual midwives in private maternity homes, because most midwives working in maternity homes have the advantage of building long-term relationships with their clients. Unlike most government hospitals, the same midwife usually sees the clients from the antenatal period through to labour and the post-natal period. I explored how the long-term relationships between midwives and

clients influenced their practices. Also, since most Ghanaian midwives working in private maternity homes in Ghana have previous experience of working in government facilities their stories would reflect the advantages and complexities of both sectors that influence midwifery practice in Ghana. Midwives who qualified to be participants were registered Ghanaian midwives and have worked either continuously or intermittently in the labour unit for not less than three years of their practice.

As part of my recruitment strategy I personally contacted the Ghana Registered Midwives Association (GRMA) secretariat after I received ethical clearance from the University of Alberta Research Ethics Board and from Noguchi Memorial Institute for Medical Research in Ghana. I obtained from the GRMA secretariat a list of private maternity homes in the Western Region. This list provided me with the contact phone numbers as well as location of the maternity homes. Due to my past work in the region, I could easily make sense of where the maternity homes where located.

The Western Region of Ghana can be located in the southwestern part of Ghana. It is boarded on the east by the Central Region, to the west by the Ivory Coast, to the north by the Ashanti and Brong-Ahafo regions, and to the south by the Gulf of Guinea. The region covers a total land area of 23,760 sq. km, making it the fourth largest among the ten regions of Ghana. It has an estimated population of over 2,376,021 with a population density of 99.3 people per square kilometer. The region is 42.4% urban with 75% of births assisted by a skilled provider.

My priority was to begin recruitment from maternity homes that were geographically easy to access for me. I also personally spoke to some midwives who worked in the government hospitals and explained what I intended to do in my proposed research and ask them assist me in contacting eligible midwives who may be interested in the study. To complete the recruitment

process, each midwife who agreed to be part of the study was invited to sign a consent form after details of the study had been explained. Considering the relational nature of narrative inquiry as posited by Clandinin (2013), I worked at building a relationship with each participant. Initially, I made several phone calls to participants and negotiated short visits just so that we could get to know each other. This was very important because at the beginning of our interactions some of the midwives were cautious because they were uncertain if my intention was purely to engage them in research, or if I had been sent by some authorities to investigate their work. With time trust was built and it greatly facilitated our interactions. Another important touchstone in narrative inquiry is the negotiations of relationships, which continued throughout the inquiry and included negotiation of entry and exit.

I negotiated four formal tape-recorded conversations with each participant. The place and time for conversations were always at the convenience of participants. Each appointment to hold conversations was preceded by a phone call the day before to confirm our appointment or reschedule when necessary.

Being in the field

"Field in narrative inquiry refers to the relational space created by both researcher and participants" (Clandinin & Connelly, 2000 p. 12). Negotiating entry to the field is one of the qualitative touchstones Clandinin & Caine, 2013). Connelly and Clandinin (2006) have described "two starting points for narrative inquiry, which include listening to individuals tell their stories and living alongside participants as they live and tell their stories" (p. 165). I negotiated with participants to tell their stories as my primary starting point of exploring their experiences. Clandinin (2013) explains that narrative inquiry offers multiple ways to gather, compose and create field text as experiences are studied. As part of telling and listening to the

experiences I engaged each participant in tape-recorded conversations. The conversations provided both participants and I the space to share our stories and to begin to co-compose narrative accounts. Conversations allowed for flexibility in dialogue and turned away from posing questions and waiting for responses. Being mindful of the busy schedule of midwives I carefully negotiated the place and time for conversations with each midwife. I made several phone calls during the period when I engaged participants to foster our research relationship and also to negotiate for date, place, and time for each meeting. Negotiations are significant and a constant feature of being in the field as a narrative inquirer. As Clandinin and Connelly (2000) stated, "when researchers enter the field they experience shifts and changes, constantly negotiating, constantly reevaluating, and maintaining flexibility and openness to an ever-changing landscape" (p. 71). The details of some of the negotiations I made with participants are recorded in the individual narrative accounts.

The conversations were primarily conducted in English however participants intermittently spoke Fante; one of the Ghanaian languages I speak fluently. In addition to tape-recorded conversations, I invited each midwife to bring photographs and/or artifacts that speak to their experiences. Participants brought pictures, certificates and in some cases citations that accompanied awards. As a follow up to the stories participants shared with me, I also had the opportunity to spend time with participants at the maternity homes where their experience with women in labour took place. My main aim of spending time with participants in the clinic was to observe first hand the places and the social interactions that are characteristic of their experiences. Although I did not get the opportunity to be present at a time when deliveries were conducted, being with each of them at the clinic gave me more insight into their lives as midwives and women with other responsibilities. I kept a journal in which I recorded my

feelings, reflections and activities throughout the inquiry. Field notes were also written alongside conversations and journal enteries.

From field to field text

Field texts are records that include transcripts of conversations, field notes, artifacts such as photographs, artwork and, documents that can trigger memories (Clandinin & Connelly, 2000; Clandinin, 2013). As part of the constant negotiations, I negotiated with participants the form of field texts to be taken. After each conversation I listened to each tape-recorded conversation several times and transcribed the conversations verbatim in English. In some cases this meant that I translated Fante into English. Listening to each conversation over and over provided me with a focus for my subsequent conversations with each midwife. As I listened to and transcribed the conversations I paid particular attention to statements that needed clarification or further explanation. I also documented alongside the transcripts, my own experiences as a researcher thus bringing forth my own emotional embodied responses to the stories that participants told. Throughout the period of inquiry I reflected upon and interpreted field notes and journal entries together with the transcribed data. Being fully aware of the possibility of deconstructing stories as cautioned by Gergen (2003), I constantly thought narratively about interim text and attended to temporality, place and sociality.

Writing interim and final research text

Interim research texts are the first step in making meaning of the conversations and the participants' experiences. It is the first co-composition of accounts of participant's stories. Interim research texts are also a link between the research puzzle and the final research text (Clandinin & Caine, 2013). During the period of writing interim and final research text, I continued to live in relational ways with my participants as we co-composed the stories of their

experiences. While co-composing the narrative accounts I paid attention to place, time and context as reflected in the field text. I also constantly reminded myself of my research puzzle as well as the personal, practical and social justifications of the research (Clandinin & Caine, 2013). Based on Clandinin and Connelly's (2000) assertion that both researcher and participants collaboratively compose field texts, in May and June 2017 I went back to share with each midwife, the co-composed interim accounts. Although, all my participants could read, they requested that I read the composed interim accounts to them. I negotiate with each of them a reasonable time and place for the interim text to be read to them. Participants responded to the text by reemphasizing some of their experiences but there were no variations between what had been recorded as interim accounts and their responds. The reason for inviting participants to respond to interim research text was to ensure that their stories have been told in a way that reflects who they are and are becoming.

Finding the balance between writing final research text to capture the voices of participants and the uniqueness of their stories, while at the same time having in mind the wider audience who will read the accounts, can be a source of tension (Clandinin & Connelly 2000). To overcome this tension, I wrote the final research text bearing in mind the uniqueness of each midwife's experience, the ethical considerations inherent in the study and the research puzzle. I identified a key narrative thread woven across the experiences of participants carefully. In some narrative inquiries multiple resonant threads are identified, that reverberate across participants experience (Clandinin, 2013). I have chosen in this dissertation to focus on one thread. This thread was significant in the narrative accounts, as well as it spoke clearly to the research puzzle – this thread become increasingly visible as I read, re-read, and contemplated the narrative

accounts. While writing the final research texts, I also negotiated my final transition with the participants as I gradually left the field.

Ethical considerations

The issue of ethics is very important in narrative inquiry; "relational ethics is at the heart of each inquiry" (Clandinin & Connelly, 2000, p. 54). This calls forth long-term responsibilities and relational commitments associated with the participant and researcher relationship. In as much as ethical protocols such as confidentiality, anonymity and non-maleficence are important aspects of every research project, ethics in narrative inquiry goes beyond these fundamental principles to embrace the day-to-day relationship between researcher and participants.

It becomes important that the issues of ethics are attended to at each stage of the inquiry, whether at the beginning where inquirers negotiate entry, or during the composition of field text and even after the research. Thus negotiations are expected to be on-going throughout the research. I was mindful of the fact that the research started when participants and myself were in the midst of our lives; I negotiated an appropriate way of engaging each participant noting the unique circumstances of each one of them.

As a matter of responsibility I endeavoured to consciously build a respectful and trustworthy relationships based on the ethics of everyday life. This I did through informal interactions with participants before commencement of our conversations. Details of how I met participants and how they consented to be part of this research are recorded in the individual narrative accounts in the following chapters.

Chapter 4: Narrative Accounts

Narrative Account 1

Happy's story

Beginning the Journey

I recall going on a bus with a group of students many years ago to attend a function to commemorate the celebration of the International Midwives' Day. It was my first time on that dusty road somewhere within the Western Region of Ghana, not too far from the regional capital. I was surprised to see a vibrant community and watched with keenness the numerous signboards along the road indicating the presence of several commercial and religious activities. I remember one such signboard that caught my attention. I could not ignore that particular signboard because it had a picture of a pregnant woman and a midwife. I concluded by the name on the board that it was a private maternity home. I thought it was an interesting discovery because some of my midwifery students could go there for their practical experience. However I had no immediate intention of visiting the place.

More than six years after discovering the maternity home in that part of the region, I found myself one afternoon in September 2016 on that same road. On this occasion I was not just passing through but on a mission to invite the midwife there to be a participant in my study. Not much had changed on the road since the last time I went by except for road works that were being carried out. I drove slowly looking for the signboard to the maternity home. Surprisingly I saw the signboard earlier than I expected. Apparently the location of the maternity home had changed but was still within the same community. After about a five minute drive from where I located the signboard, I finally pulled up in front of the maternity home not certain what kind of

reception awaited me. I had worked in a private maternity home during my days as a student midwife. From my experience at that maternity home and from similar experiences my colleagues had shared with me, I knew that the owners of private facilities were usually guarded in their relationship with people who had no business with then. I was anxious partly because this was my very first attempt to recruit a participant for my study. I was nervous and apprehensive but ready to give it a try. My anxiety and nervousness had nothing to do with my study, it was from the tension of being turned down. I was so much interested in hearing the experiences of midwives that I wished I could talk to each one of them. I was conscious of my feelings of apprehension and anxiety that day because, though a relatively quiet person, I am usually not anxious about interacting with people but this time it was different.

After sitting in the car for some few minutes recording how I felt, I mastered courage and stepped out. I gently knocked on the entrance door to the first block of buildings, which I later got to know was Happy's house, and requested to see the midwife. I was directed to the next block which was actually the clinic by an elderly man who happened to be Happy's husband. At the entrance of the next block of building I gently pulled the trap door in front of the wooden entrance door to make my way into a lobby. The wooden door was not painted, but had some carved designs on it that gave it a natural artistic impression. The door opened into a small entrance lobby that had three outlets; one that led to a stairway leading to the first floor which was still under construction and two corridors, one to the left and another to the right. The short corridor to the left led to an 'L' shaped open space which had a nurses' station and five wooden benches arranged opposite the nurses' desk. At the left hand side of the nurses' station was an area corded off with plywood. This is where pregnant women attending antenatal clinic were examined. There were four rooms within that space that were clearly labelled as office,

procedure room, female room and labour ward. This section was the maternity wing of the clinic. The short corridor to the right of the entrance lobby led to wards for general cases.

As soon as I entered the lobby, a young lady approached me and nicely asked what could be done for me. I took notice of her action because it was not the usual practice in most hospital especially government hospitals. Upon requesting to see the midwife in-charge I was ushered to the antenatal space to join the pregnant women waiting to be seen by her. I sat down and waited for over an hour. I made sure all the pregnant women and other patients who even came after my arrival were seen. I did not want to interrupt her work for the day. The one-hour plus waiting period seemed much longer than expected. So many things were going through my mind. I observed with keenness what the staff were doing. I wondered if they were midwives because most maternity homes employed lay people who were trained on the job to assist the professional midwife. To get my mind off the anxiety of waiting, I tried to read a book but I realized I had lost concentration for reading completely. I kept reading the few health educational posters on the walls over and over without making much sense of it.

Finally the last client came out of the office and it was my turn to enter. I took in a deep breath and entered with a smile. Somehow it appeared as if Happy suspected that I wasn't a client or someone seeking health care. She welcomed me to sit on a chair close to her desk with a curious look on her face as she looked at me through her reading glasses at an angle. She asked to be excused for some minutes and went out of the room. I knew then that she did not consider me as a client or patient. During those few moments alone my eyes scanned through the office. It was a typical consulting room. There were trays and trolley for examination and minor procedures, a couch dressed with white linen with an ultrasound machine by it and a folded screen standing in readiness to be drawn once a client got unto the couch to be examined. There

were boxes of medical supplies such as syringes, gloves and dressings in boxes arranged. The high windows draped with nice brightly coloured cotton curtains and the door that remained closed until someone entered provided a sense of privacy. The ceiling fan and the additional standing fan kept the room cool. The table in the room had stacks of hospital folders and other papers for documentation and for various medical requests. It was clearly an office in use.

Happy returned shortly afterwards and requested to know why I had come to see her. I took my time to introduce myself to her and to explain my purpose for visiting her. I provided her with detailed information about my study. She had many questions to ask. For example she made it clear to me that in as much as she was interested in participating in the study, she needed to be sure that I had not been sent by a political party to come and spy on her activities because she was perceived as supporting a particular political party just because of her tribe. Considering that we were few months away from our national presidential and parliamentary elections, this concern was not strange. People across the nation had become more politically conscious especially on social media. I provided her with more details and phone numbers of the Institutional Review Board in Ghana where I had obtained ethics locally and even offered to provide her with email address of my supervisor if she so desired. She decided to take a copy of the consent form to study, and promised to give me a call sometime soon. That is how my relationship with Happy began.

I left Happy's clinic with a sense of satisfaction more than worry. She had come to see me off to my car after introducing me to some of the staff at the clinic and asked that I be welcomed whenever I came there. Although Happy had not agreed to share her story with me I had a sense of relief and satisfaction. I also had many questions to wonder about. Did I convince her enough that I was there for the purpose of research and nothing else? Did she have more

questions and doubts? How long will it take her to contact me? What if she never calls back? The most troubling question I had was what if she tells other midwives to decline because she was not convinced with my explanation? I had no answers to these questions yet I wondered. The weeks that passed were full of expectation and uncertainties. I gave Happy a call at least once a week just to find out how she was doing. It was also my subtle way of reminding her that I was waiting to hear from her.

Negotiating for participation

I came into contact with the midwife in-charge of a maternity home, who wishes to be called Happy, when I visited her clinic to invite her to be part of my study. This marked the beginning of our research relationship. Initially, though very welcoming, Happy was guarded in her interactions with me and had several questions to ask. I was careful to provide her with all the answers to her questions. I equally provided her with detailed information about myself and about my study with all the necessary documentations. Though very busy, her reception and eagerness to share her story after building a research relationship for almost a month was encouraging and sustained our relationship until we were ready to hold conversations.

Happy, a private midwife in her early 60's is the owner of one of the maternity homes in the Western Region of Ghana. While working in the government sector, Happy had the opportunity to work in different parts of the region as well as in other parts of the country. She worked in both rural and urban areas, and in the process has amassed a great deal of experience and knowledge. The weeks before our first tape-recorded conversation were characterized by phone calls and few visits. During one such visits Happy consented to be part of the study by signing the consent form but asked me to give her a call so we could schedule a date and time for

our conversations. She had already indicated that we would hold our tape-recorded conversations in her office in the evenings or on Saturdays but needed some time to give me the date and time.

Happy would call me occasionally to reassure me that she was still interested in sharing her story but needed to find an appropriate day. Understanding that I would meet my participants in the midst of their lives and also bearing in mind the importance of negotiating every aspect of my interaction with my participants I patiently but anxiously waited for the appropriate time. I was rather glad about getting the opportunity to start our conversation.

The Conversations Begins

Our first conversation took place on a Thursday evening and was followed by three other long conversations and many visits and phone calls. That day was important to me. It happened to be a day after my birthday, and my son's birthday as well. It was exactly 21 years after my personal experience with childbirth; a story I wrote about in my narrative beginnings. When Happy called me to confirm our meeting the fol1owing day, I considered it as a birthday gift to me and hoped and prayed that nothing would cancel it. We had already rescheduled two appointments in the past. I was in good spirit, as I drove to meet Happy. When I arrived I was warmly welcomed by one of the ladies at the clinic who informed me that Happy had gone to her house to take a nap and asked to be called as soon as I arrived. Before long Happy walked in, welcomed me, and apologized for how long it had taken us to meet.

Sitting with Happy in her office that evening after a few hours rest following her day's work, on the 27th of October 2016, Happy began to tell her story of how she ended up as a midwife. According to Happy, her journey to become a midwife started in 1972 in a mission hospital in another part of the country where she worked as a ward assistant. Ward assistants are auxiliary nurses who receive basic training in first aid and nursing with the aim of assisting the

professional nurse or midwife to deliver quality care. As a ward assistant she worked during a period where there was serious shortage of nurses and midwives. Because of economic difficulty many nurses and midwives left the country to seek greener pastures elsewhere. The shortage of health workers was significant between the 1970s and early 1990's and put undue demand on everyone who worked within the health sector at that time. According to Happy she often had to provide care beyond what was expected of her per her job description. She recalls working as a ward assistant attending to general medical cases as well as maternity cases at the mission hospital where she first worked sometimes under little or no supervision. Happy indicated that, there was only one midwife overseeing the maternity unit so as a ward assistant she was called upon to work at the maternity unit often.

Although not a trained midwife or a nurse she was forced under the circumstances at that time to attend to pregnant women and conduct deliveries. Happy told me " ….*you know midwifery work at that time that there were no staff those days so we the ward assistants do everything, from medical side, maternity side and sometimes work alone at the Out Patient's Departments. Midwives were too scarce so we the ward assistants at that time we were the "big midwives", we do everything".* Happy traced the beginning of her experience with women in labour to her days as a ward assistant. However, she was quick to admit that she did not have adequate knowledge and skill to practice midwifery. I wondered what kind of knowledge she relied on to provide care for women in labour. I knew that even TBAs not being professional midwives have references for their embodied knowledge base. A person qualified to be a TBA usually because she at least has worked with another TBA or has experienced normal labour herself. There was some form of personal knowledge they could draw from. Happy said she had the only midwife at the facility teach her how to care for women in labour but on several occasions she had to rely on her

instinct and follow her intuition while drawing on her faith for strength and courage. According to Happy *"When you* (ward assistant) *come, you will be put in the labour ward to work…. when the women come in labour you* (ward assistant) *are monitoring them till they deliver. The* (midwife) *will teach you something but not everything. God also knows that you don't know something. When you don't know something He* (God) *helps you to bring things out. I think there are a lot of things we human beings can do, it is in us. When you meet a situation and you don't know what to do then God will help you to bring it out. There was nobody and the women needed help so I just deliver. I help deliver even breech in those days, I didn't know many things but I did all that by God's help. God willing I was able to do everything including twin delivery, breech and cephalic until eventually I went for midwifery after I had finished Enrolled Nursing".*

Happy's explanation of some form of inherent or embodied knowledge drew my mind back to how women gave birth in ancient civilization as described in literature. There were no trained midwives in some cultures, ordinary women with certain moral characteristics played the role of the midwife. There are even records of women giving birth all by themselves. Some of these I have made reference to in my first chapter. I do wonder how complications of childbirth were handled. It is also difficult to ascertain what the maternal and neonatal mortality rates were due to unavailable records. It is fascinating to know that in the not too distant past being attended to by a skilled birth attendant was a privilege. I believe that the initiative to train more midwives has improved the number of births attended to by midwives and has contributed to a reduction in mortality rate.

After working as a ward assistant for a couple of years, Happy gained admission into the Enrolled Nursing training programme to train as a nurse for two years. Being a very religious person, Happy believes that there are some people whose careers are ordained by God. She also

strongly believes that one's interest in a particular career will influence how well the person will perform on the job. She holds a strong belief that she was called to be a Nurse/Midwife, that belief has helped her to remain focused and to give her best care to her clients at all times being mindful that her ultimate accountability is to God. I was curious to know how someone could determine what he/she was born to do. Happy's response was intriguing *"What I know is that once you are interested, that strong interest sometimes I think its God. God will give you your work. He will put the interest in your heart and when you follow your heart you will find it. He will say this is your work."* I wondered if that divine knowing was for everyone or selected few to know what career to pursue. But it did not really matter to me at that point because that was what Happy believed. She had followed her heart and had become what she had always wanted to be.

Happy explained that unlike other people who may have been forced into nursing by circumstances or by relatives, she had a personal interest to become a nurse/midwife. She attributed the poor attitude of some nurses and midwives towards clients partly to lack of interest in the profession, a point she made on many occasions. Happy' s choice of nursing/ midwifery as a career was made as far back as her primary school days. When I asked Happy why, and at what stage in life she decided to become a midwife her response was,

"I was just interested in the nursing and I could have gone for medical assistance course then I said no, let me do my midwifery. I don't want any post. I want to help my clients. I was just interested, so that's why I started from the beginning as a ward assistant. Giving birth, giving birth (attending to birth) *and all that. So I was just doing it, nothing pushed me to. I was interested in the nursing from my school time. That was my answer to the question posed by my*

teacher "what is your future career?" I would always answer by saying "I want to be a nurse and then to be assisting mothers to give birth."

Between the 1970s and early 2000s, a certificate in general nursing, either as a State Registered Nurse (SRN) or an Enrolled Nurse (EN), was a prerequisite for midwifery training. Attending midwifery training was compulsory for career progression as a nurse. From my personal observation and experience, because midwifery was perceived as a stepping stone to career progression at that time, nurses who were not interested in midwifery were forced to undergo training as midwives just so they could be promoted. Some people after the midwifery training never went back to practice midwifery while others gradually developed interest and made it a lifelong career. I went to midwifery school not with the mind to practice but along the line got inspired by one of my tutors who taught with passion and projected midwifery as profession worth pursuing. Perhaps for people like me who did not receive the divine call to be midwives this was a way to introduce us into our field of interest. Happy had made similar observation about the transition from nursing to midwifery.

According to her, at that time, *"it was compulsory that you entered midwifery. You have to… Nobody will force you; you see it was compulsory for me as a female nurse. It was compulsory that when you finish the nursing you will add the midwifery to it to help in those days unless you don't want to rise. If you do, you have to add the midwifery to it. Those of us who had the interest, it mattered. If you were interested and you don't get the chance you fought until you entered midwifery school. But today it is optional, if you like you go, if you don't like nobody will force you because there are many branches of nursing today. Those days they were training straight midwives. I didn't like the straight midwifery training; I wanted to do nursing first. I wanted to do the delivery and know how to care for the baby and be able to nurse them. Those*

days it was compulsory, when you finish nursing you have to add the midwifery to it." Happy's narration underscores how midwifery education in Ghana has evolved. I write about this evolution in my first chapter. It also highlights the erroneous perception that some others and I had about midwifery back then when we thought midwifery was a specialty of nursing. Even presently there are people who still hold that perception. I have on several occasions in recent times taken pains to explain to people that midwifery is a profession on its own.

The Call: Following Your Heart

Another phenomenon that Happy spoke about was the perception that midwifery is a call. According to her, people are destined to be in specific professions and it is evidenced by their dedication, commitment and attitude to that profession. She believes that she was called to be a midwife; called to care for women and save lives and not to just have a profession to make a living. Her perception of who she is as a midwife has been the core of her entire professional life. She has always been intrinsically motivated to acquire the necessary knowledge and skill to facilitate this call while depending on God for greater wisdom. Happy also emphasized the importance of a personal interest in the profession as another motivating factor for good midwifery practice.

Discussing what has kept her in the profession for years while providing care under different circumstances, Happy had this to say; "*God will give you your work once you are interested. He will say this is your work, but those who misbehave towards the clients I can say that it is not their work. Most of them when they finished the school* (high school) *they don't know where to go. Especially if they have relatives in the field* (nursing/midwifery) *they just push them in to nursing and midwifery by force."* Happy goes on to further explain her point by saying; "*Errrm, so I think these people who God has not given them that job (call) when they go*

into that work they do not have the heart to care for the client. You know if you cannot care for your own sick person in your house how much more are you going to be able to handle someone else's sick person. Things like that you do it when it's from your heart. So I think for some people it's not their call …… Even those days there was no money in nursing. (She used nursing to encompass both nursing and midwifery). No money at all, we the poor ones, we used do that work but now, today is it not the big people's children (people holding influential positions)…" I do think that Happy was describing caring as an intrinsic nature. Does it mean that without having that intrinsic nature to care there is no way that nature could be developed through experience? Happy's response was "*if only that individual is ready to learn but even that it will take some time if caring is not your nature."*

In the last decade admission into nursing and midwifery schools has become more competitive with increasing number of applicants and comparatively fewer opportunities for admission and training. This has resulted in most of the schools admitting beyond their capacity. Although positively this supports the global agenda to reduce maternal and infant mortality it raises a question of whether quality will not be compromised. I do believe that this also has implications for the professional knowledge landscape of midwives.

As I listened to Happy's story of how she came to embrace midwifery as her lifelong career, it was clear that many factors had contributed to the shaping of her life as a midwife. It was a blend of her unique personal characteristics and attributes, her unique life circumstances and the opportunities she was exposed to. Though the details were unique to her story, I could identify with the broader perspectives of what collectively shaped who she is as a midwife. It awakened me to my own unique circumstances, characteristics, attributes and opportunities that have

influenced who I am now and who I am becoming as a midwife, midwifery educator and researcher.

Apart from believing in midwifery as a call and the importance of personal interest as a vital key to becoming a good midwife, Happy's notion of a good midwife is based on some qualities she believes will make a particular midwife stand out. I invited her to tell me more about the good midwife. Quickly she responded, "*Not every midwife is a good midwife. When you meet a good one nobody will tell you. The person I will call a good midwife must be smart, respectful, humble and hardworking. She must be knowledgeable, her skills must be good,"* I questioned if these qualities must all be present to make a person a good midwife. Are these the only qualities to determine a good midwife? Happy also touched on humility as an important virtue necessary for developing passion and knowledge for midwifery practice. She is also of the view that midwifery requires smartness and ability to make decisions and take action promptly to save lives. According to her, a midwife must be courageous and caring, ready to empathize with her clients. Most of these attributes, she agrees, cannot be taught but can be acquired depending on the opportunities and experiences presented. These experiences and opportunities are not limited to midwifery education and practice but can be derived from different areas of life.

Reflecting on my own experience from the level of a novice midwife soon after school to who I have become, I do think that some attitudes though difficult or impossible to teach can be consciously modelled for others to emulate. There are qualities I acquired that I can trace to some senior colleagues I had the privilege to work with although it is impossible to tell when and how I acquired them. Happy nodded strongly in agreement as I made this statement. It is important that we as midwives consciously model the right attitudes I added. Few seconds

passed as we both went silent. As I write this account I can only imagine that perhaps for those few seconds Happy, and I, were reflecting on what attitudes we had modelled for others to learn.

I invited Happy to tell me more about how humility can facilitate learning. To respond to this Happy told me about her childhood. "*Actually me I humble myself, I don't make myself big. Whether I am older than the person or not, I humble myself because the experience that that person is having is what I came for. If I see I don't have that experience, why don't I learn? I will learn. I always want to move with the seniors so that I learn as they teach me. I am a village girl. I don't have anything to make me proud. When you are proud you look down on people: you can't learn from anyone. Midwifery is not like that. If you want to be good you have to serve, then you learn … you can learn from everyone even from your clients"*

Upholding Virtues

Happy described her childhood as a humble one. Growing up in a village in one of the deprived regions of Ghana, she was nurtured to be respectful and humble. She said, "*I didn't come from a rich home: we had to work hard for everything so hard work is my nature. I brought it into nursing. It wasn't nursing that made me to work hard. When I was growing up in the village anybody, I mean any grown up, could call me and send me. It wasn't only my parents or relative. By that you learn to serve not only your family people. It was the normal thing to be respectful, humble and always ready to serve. That is where I built my character. These days it is not the same, not even in the villages. People don't care anymore.*" I pondered over her statement, wondering why people do not care anymore. From the village, her next opportunity to experience the world more broadly was at a mission hospital as a ward assistant. It is common knowledge that most mission hospitals are founded on principles that include humility, caring, self-sacrificing, dedication, respect for human life and dignity. Happy noted that starting her

career, as a ward assistant was also humbling and prepared her to have a good attitude and readiness to learn from those above her. As a ward assistant who was expected to do more than she had been trained to do, Happy had no option than to learn from more experienced people. Happy says, "*I am a hard working woman by nature. You know nursing and midwifery you have to be smart to save life. You move up and down to save life. So when you are proud, you will end up killing someone because you will not humble yourself to learn from others or listen to your client. You see, like I said, people no longer care and the young people these days don't value humility and respect.*" Mmmm I see, I said as I nodded. *Ahaa*,! Continued Happy as she sat up and leaned forward. "*They care about money and post, mmmm! For most of them it is about money*."

Happy went on to underscore the relevance of humility in her life as she spoke about her work as a ward assistant. Happy indicated that as a ward assistant attending to women in labour with no midwifery knowledge and skill, she had to learn from an experienced person. I began to think about the virtues differently. I thought that not everyone would come from the humble background Happy had alluded to and not everyone would start his/her career at a lower level of the hierarchy. I thought of how else the virtue of respect, humility and hard work could be promoted. The respectful midwifery concept has gained much attention recently. I still continue to think of this. As I continued to reflect on my own life and upbringing; born and bred in the city to educated parents who fell within the middle income bracket, had a life that most families at that time could only dream about, never lived in the village, but yet humility, respect for human dignity and hard work are virtues that we lived by at home. Could it be that my parents, being influenced by their upbringing in the village under much difficult circumstances, modelled these qualities for me to emulate? Perhaps it is not only the place or opportunities that one is

exposed to that shapes who we become. I also reflected on Happy's statement that people no longer care and the young people these days don't value humility and respect. Why don't people care? Is it a social problem? Could it be a generational issue? What was the missing piece and what can be done? These are questions that are still on my mind as I write.

As we continued our conversation, Happy spoke about how the shortage of midwives at that time coupled with her placement at the labour ward made her appreciate the need to help the women who came to deliver. From her account, it was quite clear that Happy had no choice but to submit herself to be trained on the job informally so she could assist women in labour. With time she could conduct deliveries unassisted either because the only midwife there was attending to someone else or had taken a rest. The obvious need to help a woman go through labour safely, her interest and passion to help women have safe satisfying deliveries made it imperative for her to seek formal midwifery education and certification. Happy's recognition of her lack of competent midwifery professional knowledge (knowledge for midwives) challenged her to go to school. "*When the women come in labour I was always ready to help but I wasn't a midwife. I couldn't do everything. I knew that if something went wrong while I am taking care of a woman I will be in trouble so I had to go to midwifery school"*

Becoming a midwife

To become a midwife, Happy had to be trained first as a nurse. Gaining admission into the Enrolled Nursing Programme and moving on to become a midwife was not as easy and straightforward as one would have thought. After training as an enrolled nurse, it took Happy over a decade to get the opportunity to be trained as a midwife. She told me, "*Those days you keep long before you will be sent for midwifery training so I went there 1998.*" In between the transition from an enrolled nurse to become an enrolled nurse-midwife, Happy worked at

different places both in the rural and urban areas between 1976 and 1998. As a general nurse in the urban areas in the regional hospital, her work was restricted to medical/surgical nursing units, however, as a nurse at the districts and rural centres Happy had to work in the maternity unit and conduct deliveries in the absence of a midwife. Most of the time during that period she relied on her experiences from the labour ward at the mission hospital as the ward assistant "midwife". There she had the midwife in-charge to teach and guide her. Although Happy picked up a few midwifery skills she still had much to learn. She lacked confidence, and adequate knowledge and skills to manage complications. She was not a midwife yet but in the meantime she had to attend to the pregnant women who came to her at the health centre. She narrated by saying, "…. *I was not a midwife but when a woman comes you have pity on the woman, your own fellow woman,* (shaking her head)*, a woman like you? You can't just send her away. You will try to do everything successfully to help her. I did that for a long time until I went for midwifery training. It was then that I got to know that this is what they* (midwifery council) *want* (referring to standard practice). *Because those days I don't know, so I was just doing the delivery. But they are all alive. They are healthy children. I help deliver even breech in those days, I don't know how I did it but I did all that by God's help. I did it till I went for training, midwifery training. Nothing bad happened to any woman."*

I wondered then if the women Happy attended to at that time knew she was not a professional midwife. I again wondered if knowing that would have made any difference in their decision to deliver at that particular facility. As a midwife I know that the scope of midwifery is broad and is far more than "catching babies" though that was my perception of midwifery before I became a midwife. I asked Happy what her perception of midwifery was at that time and what

was the difference during and after her training. Happy shared her story of moving from an amateur midwife to a professional midwife in another conversation we had.

From Amateur to Professional and Beyond

Although in our conversations Happy traced the beginning of her midwifery practice back to her days as a ward assistant at the mission hospital, she made a clear distinction between being able to successfully conduct a delivery and being a midwife. Happy totally agreed with me when I said the scope of midwifery practice is far broader than just "catching babies" and that midwifery is a world on its own. "*Oo yes! It is very broad, we midwives are trained to do a lot of things.*" She nodded her head. According to Happy her first station after her midwifery education was in a small town in the Jomoro District in the Western Region of Ghana. The health facility where she worked was situated in a poor community of predominantly farmers and fishermen. Though not too different from the village where Happy grew up which was also a farming and fishing community, her new community in general, and particularly the hospital, was completely different from the regional hospital where Happy had her clinical rotation as a newly qualified midwife. At the regional hospital, there were different categories and ranks of midwives; Registered Midwives, senior staff nurse/midwives and enrolled nurse/ midwives among others. The regional hospital also had several doctors, medical specialists and other paramedical staff. There were also different units of maternity care that included the antenatal unit, labour ward, postnatal and family planning unit among others.

The workload on Happy at the regional hospital as a newly qualified midwife was not too enormous. Due to the departmentalization of maternity services at the regional hospital, she was assigned to one unit at a particular time. Happy noted how some midwives end up working in a particular department of midwifery for years either by choice or due to circumstances, without

the benefit of having an all-round experience in maternity care. I knew it was not uncommon to find a midwife at the regional hospital working at the antenatal unit for years and thus becoming an expert in pregnancy care while losing the sharpness of her delivery room skills. On the contrary, at the district hospital where Happy worked, there was only one doctor who was responsible for all cases including medical/ surgical and, obstetrics and gynaecology. Two midwives (Happy and another) had the responsibility to run 24-hour maternity services comprising of antenatal, labour, postnatal and family planning services. She was presented with the opportunity to work in an environment that demanded the utilization of a variety of midwifery skills, some of which Happy admitted she did not have at that time.

In order to build competency, Happy had to learn from more experienced people. She had to unlearn some of the things she had learned in her past experiences as a 'lay-midwife'. She had to reconcile what she knew about childbirth prior to midwifery education with what she had come to know through her training and practice as a qualified midwife. I listened with great interest, as Happy told me some of her experiences; "*When I finished school my first practical work experience was at the district hospital. Although I was conducting delivery long time before I went to school to do the theory, I still didn't know anything. I didn't know anything like membranes or bulging membranes, I didn't know how to do vaginal examination. Before going to school I didn't know any intervention. The only thing I could do during labour was to wait for the baby to come. I will be there the membranes will just break and the water will pour. Sometimes we* (with her other colleagues) *don't even protect ourselves. Those days we use our bare hands for delivery, no gloves, we don't even think about protection and infection prevention, so when I came back from school my experiences from training really actually helped me. But I still had to learn to practice what I learnt in school …… I remember on the*

labour ward whenever I do vaginal examination (VE) I will feel something bulging then I will say aaai!, there is something there oo, forgetting that that was the membranes. So I will complain to the doctor, he will come and check and say ooo mama it's the membranes, it's bulging so do artificial rupture of membranes then I will do it and do the delivery. So actually I had more to learn after school and I gradually picked up."

As Happy spoke I could not imagine the risk to herself and to her clients during those days, conducting deliveries without any professional knowledge regarding infection prevention practices. At the same time I tried to think about what alternatives the innocent mothers who went there to deliver had. I couldn't think of options. In any case even if I do consider some alternatives, it is already in the past. I can only hope that nothing like that is happening anywhere in the country today. I was also reminded that the reason why formal midwifery training was introduced in Ghana in 1917 was that there were concerns about high infant mortality rates as a result of poor midwifery practices especially during the postnatal period with poor infection prevention practice being key. It is interesting how midwifery practice and health care in general has slowly changed over time.

I remember in 1993, soon after my midwifery education, I was working in the Brong-Ahafo region in Ghana; it was difficult to have basic items such as surgical gloves to work with. I was working in the labour ward; one of my duties as a junior midwife was to help the ward assistants to powder washed surgical gloves when I had some spare time. After using gloves for delivery or any procedure, the ward assistants had the responsibility to hand wash the used surgical gloves. In the process of washing they had to fill each glove with water to make sure it had no holes in them. The good ones were dried and during the afternoon shift we would powder them and neatly fold them in papers so they could be autoclaved. The recycled gloves were

reused a couple of times. Sharing this with Happy, she felt that my experience in the early 1990's was an improvement on what she experienced in the 70s because she did not have gloves to wear at all. Though a serious issue, we found some humour in it during our conversation as we reminisced our past experiences. We were also thankful to be alive in spite of the risks we were exposed to in the line of duty. Over the past two decades, infection prevention has become a major issue in health care. Many workshops have been organized to increase knowledge on infection prevention practices and protocols have been developed to that effect. Happy and I have both benefited from such workshops.

Happy continued to share with me some of the challenges she faced during her early days of post midwifery training. Aspects of her narration accentuate the phenomenon of the difficulty in translating theory into practice. This is a real challenge that newly qualified midwives face despite the attention given to it in literature. Happy continued with her story,

"*While I was working at my first district I had a woman who came with twin pregnancy but she didn't know she was having twins. I have done twin delivery in the past when I wasn't a midwife. That time I don't do anything, I just wait when the first baby comes then I pull that one out and wait for the second one. If it is breach or by the head I will ask the woman to push then I pull the baby out. It was when I went for training that I heard about "hands off breech. This time I had to practice like a proper midwife. I didn't know the woman was expecting twins. If you know there is a second twin, after delivery of the first, you do vaginal examination to check dilation of the cervix. But if you don't know from the beginning that there are twins, then you can be in trouble. Even if you know the protocol at that time says that you give the oxytocin at the delivery of the anterior shoulder so I gave before I realized that there was other baby to come*

and the cervix was not dilated for the second twin to come. I knew that day that I had met something I had not met before."

The woman was pushing with real strong contractions. I did not know what to do, hmmm I was confused so I had to call the doctor and told him what I have done (we both laughed). So when it happened like that I didn't want the relatives to know that I didn't know what to do. I did not want her to have a cervical tear and I did not want the woman to pour (bleed). We had to rush her to the theatre to remove the second twin. And I told the relatives that the second twin was not well positioned so that is why she is going to theatre. I met many challenges but sometimes I got worried when I am alone; "green horn" newly from school with no senior around and I am alone that was the big problem. You know the shortage of nurses/midwives at that time. Sometimes I am alone on duty at the labour ward with a ward assistant. It was a district hospital so sometimes I have to go to the hospital matron to ask for her help." After that experience Happy decided to always make sure there was no baby in the uterus before administering oxytocin. She did not strictly follow the protocol. She said, "*You know that that protocol has changed now? As for me after that incident I decided that I will always ensure that there is no other baby before I give oxytocin."*

Although Happy's midwifery education was a combination of classroom learning and clinical practice, her immediate experiences after school provided her the real opportunity to link theoretical knowledge to practice. My assumption is that perhaps in school the main focus of students is to pass exams and graduate rather than to give care. It could also be that there is a deficiency in teaching or in curriculum that fails to adequately link theory with practice. These are assumptions that require further investigation for the appropriate interventions to be put in place.

Happy shared some stories of moments where she found herself alone and unsure of what to do. As she spoke about how she developed her personal practical knowledge it reminded me of my own experience as a fresh midwife from school. Unlike Happy's time I was always on duty with at least one senior midwife except for one night when I happened to be on duty with another midwife who qualified the same year I did. We were still on rotation, less than a year after midwifery school. It is amazing how most of the strange and complicated cases happen in the night. That night my colleague and I also had an encounter with an undiagnosed twin delivery. That was my first twin delivery. After the delivery of the baby, which I assumed was the only one, I was expecting the placenta to follow but it delayed for a while. The woman's abdomen was not extraordinarily big for me to suspect twins. I do not think I had heard the phenomenon of undiagnosed twins then. I had rather heard too of many strange and weird occurrences that I think for a moment my mind ceased to work as a midwife.

Since the placenta had delayed in coming I decided to do a vaginal examination expecting to touch something that felt like a placenta. To my surprise I felt a pulsating cord and something that turned out to be the foot of the second baby. Fear gripped me and I withdrew my hand instantly not recognizing what I was touching. For no reason I can explain now, nothing in my mind suggested to me another baby, rather my mind went to some of the strange stories about creatures being born. Griped with fear I asked my colleague to do the vaginal examination again but she refused and insisted that we call the doctor who was home outside the hospital compound. It was the client who drew my attention to the possibility of her delivering twins. I had reassured her that the placenta had delayed and that the doctor will be seeing her soon.

As we stood by the woman awaiting the arrival of the doctor, she (woman) asked if there was another baby because she could feel foetal movements adding that her mother is a twin. It

was then that everything began to make sense to me. The cervix had closed but the doctor came in time to assist us. The contractions that had ceased started again, the cervix dilated much faster and the doctors assisted me to conduct my first breech delivery. It was a long night I was very nervous throughout the delivery but it ended well. Both Happy and I laughed as we relived and shared our stories alongside each other's.

Using different forms of knowledge

As Happy told her story, I began to recognize how she had developed personal practical knowledge over the years from various sources and at different periods and places over time. Prior to her enrolment into the midwifery school, Happy had developed her practical knowledge in assisting women in labour through some form of apprenticeship, that is; on the job training. Happy recalls being directed as to how to conduct delivery by a professional midwife who she worked with as a ward assistant. Most of the actions she took to care for women in labour were based on concepts and theories in nursing and midwifery that had clear rationales yet she was uninformed about the bases for her actions.

Happy through the mentorship of the midwife over time developed some form of aesthetic (personal practical knowledge) midwifery knowledge. She however lacked empirical and ethical knowledge needed to make critical clinical judgments and for clinical decisions as a professional because she was not trained. Her "midwife knowledge" was not comprehensive enough, making it difficult for her to provide comprehensive care. "*At first I was ok but then any time something changed during delivery from what I expected then I become afraid, somehow I will be able to overcome it and help the woman but after that I will say to myself that I have to do midwifery oo before I get into trouble one day."*

As Happy continued to assist women in labour her personal practical knowledge increased. She recalls that the more practical experience she gained, the more she realized how limited her professional knowledge in midwifery was. She needed the midwife each time she was confronted with a new situation. Her personal practical knowledge gained through apprenticeship gave her confidence to assist women who were experiencing normal labour only, but did not make her a midwife. She soon realized being a midwife goes far beyond just being able to successfully conduct delivery. Happy did not understand the key concepts and principles guiding midwifery practice. In her words she said, "*The thing is if you are not a midwife, you are not! My sister, you will be deceiving yourself. There are many things you will know and you can learn from a midwife but until you go for the training all you can do is practicals and you will have no paper to show."* Because she did not have the requisite professional knowledge and certification she could not see herself as competent. Happy's desire to acquire professional midwifery knowledge became instinctive and grew with each delivery she conducted. Her perception of truth about labour was grounded in what the midwife told her and what she had experienced which was usually normal labour. Happy was yet to acquire professional knowledge about childbirth. She was yet to develop her own philosophy about childbirth and the role of the midwife. "*You should be able to defend what you do."* She could not question or add up to anything she was told to do by the midwife. It was clear from our conversation that personal knowledge and discovery is essential for development into maturity and to move from a state of total dependence to autonomy, from a novice to an expert.

Happy's training as an enrolled nurse gave her some understanding in physiological processes of life and basic principles of caring but that did not make up for formal midwifery education. As time went on Happy had the opportunity to develop further her professional

knowledge for midwifery practice and to be certified as a professional midwife following her completion of a two-year midwifery programme. During her training she began to reconcile the practical skills with empirical principles and also develop professional knowledge. The theoretical exposure Happy received as a midwifery student was however not the end of both the professional and personal practical knowledge she needed to practice.

Happy clearly underscores the importance of formal midwifery training and how well it prepares her to work as a professional. However she was also quick to point out the inadequacy of formal midwifery education alone to produce a competent, confident and all round midwife. The inadequacy was not due to weakness in midwifery curriculum but rather an indication that midwifery knowledge (both professional and personal practical knowledge) cannot be fully acquired during training. "*I learnt a lot when I went to do the midwifery. Some of the things I was doing them already. Like I told you I was practicing midwifery before I went for midwifery training. In school sometimes I will say aaa! So this is what and why I have been doing this or that. But you cannot be taught everything in the classroom. Not all or only all that we are taught in the classroom that we do for the client. Sometime comes when you use your own discretion to help the client. So there is something nobody will teach you but something will tell you to try this or that. You are not taught in the classroom like this is what you have to do… We shouldn't only depend on what the teacher taught in the classroom or what is there in the textbook.*"

Midwife's knowledge is developed through experience, continuous training and from midwife interactions as Happy disclosed. Sharing her work experience over the years, Happy told me that she gained the bulk of her midwifery experience while working in the rural areas especially at the one-nurse station in the different places where she had to work as the only midwife. She worked in such places for the greater part of her working life as a midwife. She

recounted several stories about how she had to work under challenging circumstances with few options for prompt referral. At the one-nurse station she worked 24 hours and on every day of the week. Being alone, she did not have the luxury of taking a vacation. Even her, annual leave could not be enjoyed. Whenever she was confronted with a situation that was different from what she already knew, she was presented with the opportunity to learn something new. Sometimes, she just had to rely on her tacit personal knowledge.

Happy narrated one incident, when on a rainy night at a one-nurse station in one of the villages in the Western Region she had an experience that continued to live with her. Happy had been transferred to this new clinic in the village. She was the first person to run the clinic. Prior to her posting, a midwife had been sent there but refused to stay so she (Happy) who was quite experienced in working in rural communities and at one-nurse stations was sent there. The Western Region is described as a rain forest with the highest amount of rainfall in the country. The village where Happy was sent was a cocoa growing area but economic activities were seasonal. Economic activities were at their peak during the harvest season when farmers had money to spend. Almost everything that required money came to a halt during the planting season. This included spending money on health. Sometimes Happy had to provide services on credit against the next harvest period. Due to this socio-economic fluctuation it was difficult to get clients to accept referrals outside the village when it was not harvest period.

Happy continued her narration about the incident telling me how during one planting season she was called upon in the middle of a rainy night to attend to a woman who was in labour. Happy lived within the premises of the clinic so that she could be called upon at any time. According to Happy, the first time the woman reported to the clinic was a few days prior to that night. The multiparous woman with a pendulous abdomen reported in her third trimester of

pregnancy for the first time in her pregnancy. Upon abdominal examination, Happy diagnosed her as carrying a multiple pregnancy. She anticipated twins and referred her to the nearest hospital. The nearest hospital was several kilometres away; the road network at that time was very bad and getting transportation required some money. Happy gave reasons for sending the woman to another facility by telling me "*I wasn't supposed to deliver triplets. It was only twins that I was allowed to deliver but God just helped me. The husband of the client was not ready to accept transfer but God too helped us. It was raining heavily"*.

All attempts by Happy to get the woman to go to the referral centre to take a scan failed due to financial constraints. On that night the woman was brought to Happy in labour. Fortunately for Happy, she had received three student nurses for the first time to work with her as part of their clinical experience. She quickly called them in to help. Unknown to Happy, the woman was carrying triplets. This was the first time Happy was assisting in the delivery of triplets and was totally unprepared because it was not anticipated. She, however, managed to successfully deliver all three babies alive but soon after the mother began to bleed. Multiple pregnancy predisposes women to postpartum haemorrhage (PPH) which obviously is one of the complications no midwife would wish for, especially on a cold rainy night in a remote village. Happy managed to bring the situation under control. She sums up her experience by saying, "*It was just God that I was counting on and thanking Him a lot. Even that place if you want to refer, there is no car. Sometimes in the morning all the cars will leave the town. Hmmm only God oo. In the night I called all the students. I said you should all come out oo something is about to happen.*"

During one of my visits to Happy, she showed me a picture she took with the triplet mother and her three children; two girls and a boy. Incidentally the student nurses who had been

brought to work with Happy were two females and one male. Happy, jokingly said, they (students) brought her the triplets that almost spoilt her record of no maternal or infant mortality. We both laughed. Through that experience Happy gained unique knowledge and became confident about twin delivery and management of postpartum haemorrhage (PPH).

Our conversations also highlighted how midwives share and gain personal practical knowledge through their interaction with each other. Happy told me about how midwife interactions have been a great source of knowledge for her. According to her, when midwives meet at seminars, conferences, workshops or even informally anywhere, one common feature is that they share stories about their work experiences; their challenges and achievements. Through such meetings lot of tacit knowledge is narratively exchanged. It is also during such fora that midwives share some of their "rituals". I use the term "rituals" because it is a translation of the word "kusum" commonly used by midwives/nurses in Ghana. The word "kusum" is from one of the local dialects. It is a word that I have heard midwives from different parts of the country use. It mainly represents unconventional and unorthodox actions taken by midwives/nurses to provide care. These rituals are usually a figment of their intuition, part of their personal practical knowledge that is experienced during difficult times when they (midwives) run out of ideas and interventions from the body of scientific and experiential knowledge they are exposed to. They follow their instincts and act in unorthodox ways to meet the needs of their clients and to save lives.

These "rituals" are mainly undocumented and are usually shared among only midwives,; they are guarded. Over the year some scientific basis have been provided for some of these practices. Happy narrated, "*you know when we* (midwives) *meet, we gain a lot of knowledge. We are always discussing among ourselves, sometimes we go for meetings and workshops, when you*

go for the meeting you hear someone say that 'some difficult labour that I had the other day! It was difficult and something told me I should do this or that and when I did it everything was all right it was very fine. Then another will also say that I got a client who kept complaining of lower abdominal pains and I gave this or that and the problem was solved. So when I go for meetings I learn a lot. You see, so when you also pick that, when you are experiencing something you will remember that last time when I went for the meeting my friend was saying that she was in difficulty and this is what she used or did. So during our meeting times too we learn."

Happy noted strongly that it is important that midwives are not selfish when it comes to sharing their experience and the experiential knowledge they gain through that. *"…we learn from each other so when you have more experience than me you shouldn't say I am a midwife therefore I should know…. When we go for meetings we discuss. We discuss about our work. It is not only just a meeting. We discuss how things are going on with us; the experience that we hear from other people helps. It's very important. As a midwife you shouldn't be selfish"*

Midwives are one group of health professionals in Ghana who often have the opportunity to attend workshops though not every individual midwife may have the opportunity. In addition to the training workshops are the numerous protocols available to guide midwives to implement lifesaving interventions. Happy shared some of her experiences attending workshops and using protocols. She showed me different certificates from the several training workshops she had attended.

The Ministry of Health organized some of the workshops; others were organized by the midwives association, and others at institutional level. Happy praised the efforts of the Ministry of Health, the registered midwives association and some non-governmental organizations to upgrade the professional knowledge and skills of midwives in Ghana. "*They have workshops on*

new things that are coming so we get to know. The workshops are very good but it is difficult to find time to attend these workshops. Even those in the government they don't even have time. When you are under somebody you have to ask permission. But when I was far away working in the villages I asked permission to attended workshops and meetings but because it was at a one-man station I have to get someone to be there. If I don't get then I can't attend. It was difficult but sometimes I just had to force and go."

She indicated how through these various workshops she always remained up-to-date with current trends in midwifery skills. "*When they say we should stop this and do this, the do's and don'ts. We only get to know when we go for meetings and workshops. Sometimes they are intentionally organized workshops.*" Happy noted that most of her life-saving skills were obtained through workshops. According to her it is that knowledge from attending workshops together with years of work experience especially in the one-nurse station that gave her the foundation to set up her own maternity home after retirement from active service. "*That is why some of us decided to come and do something for our own self (private maternity home) so we can practice what we have learnt from the many training workshops. I can practice in the village to help. All of us cannot go to the big hospitals so the people that are here we can help them. It is that experience that has helped me to run my own clinic. I take it that this is what the village work gave me. I don't need anything else."*

Happy believes that she has energy, experience and the basic resources to help her give back to society. Hence she decided to set up a private maternity home in a community where there is no other clinic. She was however of the opinion that some of the health policies and protocols do not take into consideration some of the cultural beliefs of the people who will be beneficiaries of these policies. According to her, the responsibility rests with the midwife to

understand her client and the community she serves in order to provide culturally sensitive care. Happy and I both agreed that understanding of client and community is greatly dependent on relationship. The concept of relationship in midwifery was one of the interesting aspects of our conversation.

Building relationship for practice

Building relationship with clients is a necessary foundation for midwifery practice. However it is a complex concept that goes beyond just meeting an individual a couple of times. Relationship for midwifery practices bother on interdependence, it is not a one-sided relationship. Both midwife and client must benefit from this mutual relationship. My conversation with Happy revealed the different factors that influence the midwife-mother relationship, which include the policies at a particular health facility, and the geographical location, that is, whether in the urban or rural area.

Cultural practices and beliefs of clients and midwife, including language and religion, influence relationships. In explaining the determinants of a good midwife-mother relationship, Happy began to compare her work experience at the one-nurse stations in smaller, usually rural communities, with her work experience at the bigger health facilities in the urban centres, as well as with her experience in the private clinics. According to Happy it is much easier to work with women when you have gained their trust. Gaining trust sometimes takes time and flows from a relationship built over time. This, she noted is easy to attain in facilities that provide continuity of care from pregnancy to delivery. She explained by saying "*in facilities like a clinic or maternity home like this one (her maternity home) you will know all about your client because you see them from day one, you get to know her status. If there are any problems you will have to solve all those problems and explain all conditions to her and solve her problems. What you*

can't solve you know where to send her. So they put their trust in you. If anything is not going well you explain to them. Sometimes when I am not there, my people here (referring to her assistants)*, there are about two of them who care for them when I am not here. Sometimes if clients insist on seeing me they may tell the clients to wait for me or they come another day if it is not an emergency. So they come and I solve their problems for them. They have confidence in me so they don't have any fear."*

Whereas in some facilities where Happy worked mothers could negotiate who to attend to them it is not the same in many facilities in Ghana especially in the urban government hospitals. Most women go into labour and see the midwife for the first time when they report at the labour ward. Happy believes this is not only a challenge for the woman but it is equally challenging for the midwife to know and understand the client within that short period of interaction.

Considering the nature of work in the large hospitals where maternity units are divided into units, that is; antenatal unit, labour and delivery, and post- natal with different sets of midwives working in each unit, continuity of care by a single midwife appears difficult to achieve. A woman in a district or regional hospital is likely to be attended to by one particular midwife during the antenatal period but will meet a completely new midwife the moment she goes into labour. Sometimes two or three different midwives may attend to the woman within the period of labour and delivery. This is because midwives in such facilities run three different shifts. It is possible for a woman in labour to be admitted to the labour ward by a midwife on the night shift, be handed over to a midwife on the morning shift, and deliver in the care of another midwife during the afternoon shift.

The interruptions with care can be attributed to the large number of clients that access such facilities. The numbers demand the presence of more midwifes. Happy noted that the small clinics and health centres usually have one or two midwives, who serve a more defined community or geographical area. The community members usually know the midwife and she (midwife) gets to know her clients and sometimes their families. Continuity of care in such facilities is assured throughout pregnancy to labour and beyond. Maintaining one midwife to attend to clients throughout has implications for the midwife who is an individual with needs and responsibilities. Some of these challenges will be discussed in subsequent paragraphs. Happy comments on the importance of relationship in midwifery "*my relationship with my clients have always been good… No matter where I work I am free with all my clients, I don't feel proud."* I asked Happy about the kind of relationship she has had with her clients besides just having a cordial relationship with them and her response was " ……*your client has to know you and trust you. You, the, midwife, must also know your client well. That relationship occurs when you are the only midwife attending to her. From day one up to the end of antenatal. Then they go through labour and delivery and postnatal with you. It helps them because she (client) knows you; she had the antenatal classes with you during the counselling from antenatal then to delivery and after delivery. Even with family planning. She (client) knows you alone so she has that courage to tell you everything. So that is the difference between the private and government. The woman will know you well in the private and one-man station."*

Happy further explained the benefit of building good trusting relationships with her clients but was careful to add that it was not ideal for bigger facilities. "*Because you know the woman well, in case she has any problem she will come to me first and if I also see that the problem is beyond me I know how to handle it, I know who to handover to because I know my*

client and understand her well. The government side I don't think it will be possible because both clients and midwives are many…."

Given the different circumstances under which midwifes in Ghana work, Happy emphasized that the type of relationship she builds with her clients depends on the setting where care is provided. Happy indicated that she enjoyed working at a place where she will have the opportunity to build relationships with her clients acknowledging that good relationship facilitates good care. Places such as the health centres in the village communities and at her private maternity homes where the number of midwives did not exceed three are ideal. Happy shared her experiences at the village settings including how she engaged her clients. According to Happy, her relationship with clients starts with a cordial relationship with the community she serves.

For each new community in which she was posted, Happy worked to gain the trust and acceptance of the community. Without that community acceptance, the pregnant women will not even access the clinic. Happy's aim with regards to her clients was to know them as individuals and understand their peculiar circumstances. To achieve this she was always welcoming and ready to listen to all their (clients') complaints, counsel them and allay their fears. She had to be transparent, empathetic, and identify with the people she served.

Although Happy hails from a different part of Ghana, spending all her career life in the Western Region meant she had to adapt. She tried as much as possible to identify culturally and socially with the communities in which she worked without losing her identity. Finding such a balance between who you are as an individual and who you become as a midwife to your clients did not come automatically to Happy. As Happy showed me pictures of some of the communities she worked, she noted that she needed to dwell with people so she could positively affect their lives.

" .. you have to take time to know them, to study their culture, know the -do's and don'ts and win them so you can educate them about the harmful ones."

Another type of relationship that Happy spoke about is the relationship midwives build among themselves and with other members of the health team. Midwifery work can be very challenging and emotionally draining. More often attention is on the childbearing mother with the midwife doing everything possible to ensure the woman has an emotionally satisfying childbirth experience. Managing the day-to-day activities of midwifery work coupled with organizational demands can be stressful.

In Ghana, health services are organized on five levels; community, sub-district, district, regional, and national levels. Policies and organizational structure reflects the level where an individual works. Happy, who worked mostly within the sub-district and district level, had to refer all cases beyond her scope to a higher level. She lamented about how challenging it was to get the support of fellow midwives who worked at tertiary health institutions (district and regional) when referrals were made. Happy always wished for a more cordial and welcoming relationship with midwives at the referral centres. She described the reception often received from fellow midwives as a demotivation especially when she accompanied her referral cases. She told me, "*It is something that we the midwives have been doing when you refer cases they will be talking and talking as if you intentionally sent the client. When I hear (that) I feel something within me. The way they will talk to you and what they will say to you. Sometimes I tell them that we have all worked in big hospitals before so they should not behave like that. It is not good.. They don't understand the way people behave in the communities."*

Happy continued to express her displeasure about how midwives working in different facilities sometimes fail to appreciate each other's role in ensuring safe delivery. She said, "*We*

are all helping to take care of women and save lives. Some women go to the big hospital and wait for hours. At the end of the day it is the same thing that they are given. Even here (her maternity home) we care more than them because we get to know our clients so the relationship is good. When the women go there they don't have the best of care because the people are many. The midwives also leave their community (and go) into another community where they are not known, and the clients are too plenty so they can get away with any behaviour. Things are not the same everywhere so we all have our peculiar challenge."

Still talking about relationship, Happy also lamented about how religion and culture can sometimes interfere with the work of the midwife with negative consequences on mother and baby. "*Culture is still working and is important in midwifery. The women go to different places in some communities. Here they go to "Nackabah" (a religious sect dominant in the Western Region); they are given all sorts of concoctions to take when in labour before they come to you. They will go for special prayers from the Nackabah priest before they come in labour; it's part of their culture. When they are pregnant they go round to prayer camps and all that. But when they come and there is a problem with the delivery then it is on you, the midwife, and they feel it is the midwife's fault then you are the one in trouble. The effect of culture is strong in the villages.*"

Happy told me an unfortunate story of a baby that died a few days after delivery. This was to emphasize the role of culture. According to Happy, a woman came to deliver at her clinic and was discharged 24 hours after. The woman was educated on how to care for the baby's cord and was asked to report back on the third day or when she notices any unusual changes in the baby. The woman reported on the 5th day with the baby completely jaundiced, lethargic and the cord infected. The mother and grandmother did not notice that the baby was jaundiced because it

was their custom not to bring newborn babies out before the 7th day. Despite the education that was given about how to care for the cord, the woman applied some substances to the cord to facilitate a quick fall off but the cord got infected. Without delay Happy provided some first aid care and referred the baby to the regional hospital where the baby was admitted but died by the 7th day.

Changing Hats: Midwife, wife, mother and so much more

Like most midwives, Happy wears many hats as an individual. For the greater part of her career up until our conversations, Happy has been a midwife, a mother, a wife, daughter, a member of an extended family and a devoted member of her church. Combining these many roles can sometimes be challenging but Happy has maintained a balance in all these roles. She said her work as a midwife had taken a greater part of her life. "*My life is midwifery that is all I have done and now that I have retired from the government side that is what I am still doing. I could not carry my family with me everywhere I went. If you keep moving too it will affect your marriage so I had that problem too……The thing is a sacrifice ahaa! Sometimes I think it is only God who can reward….. "* Happy describes the many sacrifices she had to make in order to find the balance and play her many roles well. Showing me pictures of the various places where she had worked, Happy shared with me the stories behind the pictures. For the greater part of her life as a midwife she was separated from her family because she had to work in rural communities with poor social amenities. Her husband had to be in the city with the children where they could have proper education. She sometimes had to get other relatives from her extended family to help out with the children. Happy told me "*Before I left for my first transfer I went and brought my mother from my village to come and stay with them (husband and children) at Takoradi. I never sent them with me to any of my transfers. I thought the up and down will not be good for them,*

especially the children's education." Her absence from her husband came with some marital problems as well.

I could relate with the extent of separation between Happy and her family. I could only imagine the extent of sacrifices she has made. Unlike recent times, having access to telecommunication was very rare. There were no mobile phones or any other form of social media to stay in touch with family and with the rest of the world. The most reliable means of communication then was by post and that could take days. I was reminded of my first postings after nursing school in the early 1990s to Sunyani, the regional capital of the Brong Ahafo Region. I was several kilometres away from home. I was fortunate; we had a phone at home, a landline. At the hospital there was a telephone exchange but it was always difficult for the operator to put me through to what she called a distance call. I remember the profound joy I felt when I was able to speak with someone at home. Just knowing they were doing well was enough.

Happy showed me more pictures as she continued her narration. There were some places where she felt isolated, working in a community with no source of electricity or any form of recreation and far away from her family. She worked under difficult conditions; sometimes she had to conduct deliveries at night using lanterns. "*I took this picture at the village, my one-man station. I was the first person to open that station. I was told somebody came initially but did not stay because she said it was remote. There were other surrounding villages inside (using gestures that indicated a far distance) where people came from. They walked from there to come to the clinic. That was the only clinic and somebody had to be there so I was there. It was a cocoa farming area so people came from far. Those days there was no health insurance so we credit them and when they harvest their cocoa they come and pay. Some actually come back to*

settle their bills. Others too do not bother and we leave them. It is a sacrifice to work in those places oo. Me I told you that midwifery is my call so I was okay."

Although she identified herself with the community members and even registered her name in a local church, her work schedule did not allow her to be as committed as she would have liked. She did not have the luxury of taking a vacation or visiting her family at will. Time to attend work-related workshops was even a struggle at times. Happy continued going through the box of pictures on her lap, she picked another picture and said, "*This other picture was taken at another village also in the Western Region. While I was there my sister visited me, my daughter was also on holiday so she visited with her. This picture was taken on a weekend so I am not in uniform but I was working... I work even on Sundays. They come every day. Sometimes I will be in church and they will come and drag me that someone is in labour. I went to church because I can't sit down and say I am waiting for a case to come. When case comes they should come and call me but I also have to find time to call on my God."* I asked Happy what happens when she travelled or went on leave. Her response was not what I expected. She said, "*No leave oo throughout till I came on retirement. When I was working at the district I took leave but when I moved to the one-man stations no leave. Even when I ask my director he would say no because there will be no one to go and replace me."*

Shocked at her response, I asked Happy if she received any compensation for her forfeited leave. Her response was, "*no compensation at all. So you just have to find a good time and go away. Sometimes I go and hide. Sometimes my district director (doctor) will say that you are tired, let me give you some few days to go and rest; then I run to Takoradi before I can rest. Even when I am sick and want to rest I can't rest. Someone will come and knock on my door. I don't rest. So in fact working in a one-man station is a problem."*

Towards the end of her work in the government sector, Happy had to request postings to a more remote village. She told me her husband had taken ill and she needed to take care of him. He had suffered a stroke. She had become the breadwinner for the family and so she could not afford to stop working to take care of him. Since she had the responsibility of taking care of her sick husband, her only option was to request a transfer to a very remote village. According to her it was the worse place she had ever worked. Her reason for requesting a transfer was that the workload at that facility was low and could give her time to attend to her sick husband, who she had brought to come and live with her. She recounted, "*it was getting to my retirement time and my husband was seriously sick. I sent my husband with me there ... The workload there wasn't heavy so I could have time to be going to see him at home because I lived on the compound. The place was not good at all. It was very rejected. It is just near the seashore. The staff quarters had been well built but nobody wanted to go there. Somebody had to go and make the place fine. I went there so I could take care of my husband before going to work. Now when you go there it's a very nice place and even the queen mother says I have made the place fine. She wanted me to continue working there after retirement but I told her I am tired of serving the government. I want to retire and do my own thing."*

Interestingly, Happy recounted her experiences at these different places with nostalgia. She indicated that each sacrifice was worth making. Through her many journeys to different places to work as a midwife she gained great experience and has been able to set up her own maternity home which she is operating after her retirement. Happy's life experiences as a midwife include hard work, sacrifice and hope. Although Happy received no awards, plaques or citations she felt very rewarded. The personal practical knowledge she gained through her experiences is her reward. She now owns a private maternity home and is able to still practice

midwifery. I wondered how life would have been for Happy if she didn't have the opportunity to continue to practice midwifery after her retirement from the government sector. She was full of energy, experience and zeal for midwifery each time we met.

Narrative account 2

Anna's Story

It was in the month of September 2016, my fieldwork had just begun slowly, I had invited the first participant to my study and was still awaiting her response and consent to share her stories. I was in constant touch with her mainly through phone calls and our relationship was progressing steadily. As I waited to fully engage her in conversations I decided to talk to another midwife about my study and invite her to share her experiences. That is when I met Anna. Going through the list of maternity homes I obtained from the Midwives Association I traced my way to a maternity home in the heart of a very vibrant community, more vibrant than the one I had visited previously. Although I had heard the name of the maternity home a couple of times I had not been there before.

Finding my way into the community was not a difficult task at all, however, getting to the maternity home was like going through a maze. The streets were very narrow; the houses were just a gutter away from the road. People were practically walking on the road because there was no space or walkway for pedestrians. I had to carefully weave my way through the cars that had parked along the road and the people walking along the way. Following the winding road, I occasionally stopped to confirm from a passerby that I was on the right path. I finally arrived at the clinic at about 3pm. Visiting this maternity home was not my plan when I woke up that Wednesday morning. I had tried the phone number of the maternity home several times the previous week to book an appointment with the midwife but never got through. I tried again that Wednesday morning. After another failure to get through I decided to go there to make an appointment, take the midwife's phone number or speak with her if possible. As I left home I was not sure how things would turn out. I could not tell if I would be able to speak with the

midwife. I actually did not know how many midwives worked in that maternity home. My plan was to engage the owner or midwife in-charge or any other midwife who met the criteria to be a participant in the study. I was not apprehensive or anxious this time. I think it was because I had not planned specifically to speak with a participant that very day. My desire was to know how I could contact a participant and the most appropriate time to do so. I think my major concern about recruiting participants into the study was how to be careful not to interrupt their lives. I chose to visit in the afternoon because usually the workload in many clinics would have reduced by then. I recall having a good feeling about this visit. I was not afraid of being turned down neither did I worry about the midwife thinking that I have an ulterior motive rather than research. The calmness I had was different form how I felt when I went to recruit the first participant. I think I was just ready for anything.

My walk from the car park to the entrance was very short. The entrance gate opened into a courtyard that spanned about 36 to 40 square meters. On one side of the courtyard were the wards and consulting rooms for the maternity cases while the rooms at the other side were a residential accommodation for the resident "midwife" who was not a professional midwife. The courtyard had canopies and benches and that was where the women who came for antenatal, postnatal or family planning visits sat for all documentation to be done, and had their vital signs checked before they went to the consulting room. At the courtyard there were less than 10 women sitting there waiting to be seen. There was a woman in white uniform and two student midwives sitting by the nurses' table (I identified them by their uniform). I greeted them and asked if I could see the midwife in-charge. I further explained to them that I wanted to see her about something personal and therefore would wait till she had finished seeing all her clients. I was offered a seat in the courtyard and waited for less than 45 minutes. When the last client

came out of the consulting room one of the student midwives went in to inform Anna. Because I was much more relaxed the waiting period did not seem so long. I sat down deleting my junk emails. It seemed like the easiest thing to do at that time. I had not done that in a while so it kept me occupied for that period of time.

When the consulting room door opened I was expecting the student to come and inform me that I could go and see the midwife. To my surprise an average height woman in her late middle age followed the student nurse. Her white uniform was a clear indication that she was the midwife. I got up to meet her as she looked in my direction and tried to descend the short stair from her office to the courtyard. She smiled and extended her hand as she said Madam "akwaba" meaning welcome madam. That welcome was enough to drive away every anxiety if I had any. I was warmly welcomed into her office where I told her about my study and asked her if she would like to be a participant.

Anna willingly agreed to participant telling me of her interest in research, noting she has supported students who come to collect data from clients at different times and in different places but has never been a participant. This being her first time she was glad to share her experience. She was also interested in my study because she has worked for several years but no one had come to ask her to tell her experience. She sounded really excited about the opportunity, her smiles, gestures and phrases, the conveyed expressions like "*don't worry I will do it*", "*I am ready to retire finally this year*", "*this will help me to remember my work,*" "*Just give me a copy when you finish*". These were her words when she saw me off to the gate. Anna requested that I come again so that she could introduce me to the administrator of the clinic because she would wanted us to hold our conversations in her office after work and therefore would need his approval.

I went back to my car feeling very happy. With Anna's words still ringing in my ears, I pondered over them with many questions in mind. What stories did she carry? Are they stories of joy or regret? What does this opportunity to tell her story mean to her? I wanted to hear and write her story. I was glad I went to her, not only because I got another participant but because it meant so much to Anna to share her experiences. At that time I did not know what name she would choose. I decided to go back on the Friday to speak with the administrator. I was amazed at the connection I made with Anna at our first meeting and was ready to nurture it; I had her cell phone number. The next day I gave Anna a call to thank her for her warm reception and to tell her I would pass by to speak with the administrator. Her soft voice and the prolonged hello were heartwarming. I imagined how her clients felt, if that was how she received them. I so much wanted to hear about how she had nurtured relationships with her clients. She told me she was ready to see me whenever I was ready for us to talk. Within three weeks after meeting Anna, we were ready for our first conversation.

My relationship with Anna, a veteran midwife as I have come to know her, had started very cordially. Our meeting for the first time was very warm and welcoming thereby making it easy for us to engage in conversations over a long period of time. The fast connection between us gave me hope to anticipate a great relationship. Our first tape-recorded conversation was preceded by a few interactive visits and several phone calls all aimed at strengthening the new relationship we had started. Most of the phone calls were courtesy calls to check how Anna was doing or to tell her about how I am looking forward to our subsequent interactions. It was during one such interaction that I negotiated a date for our first tape -recorded conversation. Finally the day came for us to meet and record our conversations.

The short drive from my home to the maternity clinic where Anna worked was a time for reflection for me. Though alone in my car, I wondered aloud how our conversation would go. Although we had succeeded in building a very cordial relationship I still had uncertainties about our conversation. My uncertainties were centered on openness to invite me into her world as a midwife was essential for Anna and me to co-compose stories of her experiences as a midwife. I too live in a world of midwifery but perhaps in a different midwifery world. By engaging other midwives I was on a journey to explore other worlds and to make meaning of it. Counting on the relationship I had established with Anna I was hopeful that our conversation would help me and others who would read her story understand what midwives experiences were.

I arrived at the clinic after about 30 minutes of driving through moderate afternoon traffic. We agreed on an afternoon meeting time hoping that if she had a heavy clinic day, the workload would have eased by noon. Anna, who was anxiously expecting me, met my arrival with a nice welcome. I knew she was expecting me because she mentioned that she thought of calling me that morning to tell me she would be expecting me. Her excitement could also be seen from her smiles. She had two more antenatal clients to attend to. I was offered a seat under the canopy where the pregnant women sat to wait. I waited a few minutes as she attended to her remaining clients. Upon seeing her last client Anna ushered me into her office, which was the room where she attends to her antenatal clients. The room was average sized, had a desk and a chair at one end and a couch on the other end. The ventilation in the room was not adequate, making the room quite warm especially on a hot afternoon. Anna was concerned about my comfort. She quickly pushed the standing fan closer to where I sat as she apologized for the warmth in the room. After some pleasantries we got into our real conversation.

Anna is a 66-year-old midwife who had passionately and actively practiced midwifery for many years in different parts of the country but largely in the Western region. Her vast experience of being a midwife was evident in the stories she shared in each of our conversations. According to Anna her decision to be a midwife was not deliberate. She started off as a general nurse. Her great desire to help people had increased her admiration for nursing while in school so when she had the opportunity to be trained as a nurse she took advantage of that. Anna traced her very first attempt at midwifery to the late 1960's when she was a student nurse. She was living with her grandmother in a small community in the regional capital.

Because of her green student nurse uniform, the people in the community assumed that she was a nurse or midwife. She told me that in her experience, "*some people came to knock on our door one morning, that their relative was giving birth at home and they want me to help. I went with all the courage I could command. When I got there, the head of the baby was almost out, then I told her to sit on her buttocks and push hard. Then the shoulder came and I helped to deliver the baby. Then I asked them what they had and they said they had nothing around because they didn't know she was going to give birth at that time. Then I asked if they had alcohol, they said no, but they went to get some locally prepared gin. I told them I needed a blade and thread. Then I put the thread and the blade in the alcohol. I gently tied the knot and cut the cord and the baby started crying. I had not done anything like that before. I only passed through the labour ward once. I left as soon as the baby came out so I did not know about the placenta. Now, it was left with the placenta. After cutting the cord, there was something still hanging there, so I tapped on her abdomen and the placenta just came out. I only thought of midwifery as a simple thing."* Based on that experience Anna had perceived midwifery as just being with a woman and waiting for labour to take place involuntarily. It was only a matter of

time for her to come to appreciate and understand the scope of midwifery and the skills that were needed.

When she qualified as an enrolled nurse in 1970 she had in mind that she was going to work as a nurse to the best of her ability to save lives and alleviate suffering. That plan changed as soon as she was exposed to midwifery practice. She identified another area of health care where help was so desperately needed. In 1974 Anna was transferred to a village in the Western region of Ghana known as Ekabeku. At that time in 1974 Ekabeku was one of the remotest and poorest villages in the region. The health facility there was poorly resourced. Anna worked there as a general nurse for several years. She recalls that during that time there was only one midwife who attended to all the maternity cases that came from far and near. Both Anna and the midwife had come on transfer from the regional capital, leaving their families back in the city. Their integration into the new community was initially challenging because of the difference in social amenities available. Being her first work in a rural area she had to adjust to her new environment with all its limitations.

Awakening to the call to become a midwife

According to Anna an incident that occurred in Ekabeku made her consider midwifery training as an option to pursue. On that day she had gone to the clinic to perform her duties as a general nurse. The only midwife with her had traveled to the city to attend to her sick child. Anna recalled that because the midwife had to travel often out of the village to attend to family issues she had developed an interest in learning a few midwifery skills so she could help when the midwife was absent. She was confident that she could conduct deliveries as long as they were normal. She recollected,;

"*For a period the midwife's child was taken ill. The midwife therefore used to travel often so I developed the interest to learn how to do deliveries so that in her absence I could help. As for the delivery I was sure I could have done that but the possible complications that could arise was the problem. As for the delivery I was doing it but on a low key.*"

It was during one such day working alone in the clinic, that she had an encounter that deepened her desire to be trained as a midwife. Anna shared,

"*I was there one day when some people came calling out that someone was in labour so I made them bring her into the labour ward and I positioned her. One thing about that particular community at that time was that they liked home delivery. Apparently they had attempted home delivery and the woman had become exhausted from prolonged pushing (bearing down). She said she couldn't push any more. That time it was even difficult to get infusion. All we (nurses) knew and had at that time was normal saline, 5% dextrose and dextrose saline; there was no ringers lactate. But the midwife made me understand that for labour we needed something that contained sodium. I had that at the back of my mind so I set up normal saline and I monitored her for a while. Later she said she wanted to push so I conducted the delivery. But after the delivery hmmmm! She started pouring! I had not encountered postpartum haemorrhage* (PPH) *before.*"

Anna went on to describe her ordeal and how she attended to the woman drawing from the pieces of knowledge she had gleaned over time. Anna told me "*I could see the blood draining into the basin at the foot of the bed. She was just pouring! I wasn't used to seeing such amount of blood. I became afraid, I wondered what I could do, I was confused then I remembered that the oxytocin is said to dilate the cervix by inducing contractions so based on*

that knowledge I injected her with oxytocin intramuscularly and then I started to rub the uterus because I had seen that being done."

At this point in our conversation I could feel Anna's emotions resurfacing although the incident happened many years ago. She raised her voice and spoke faster than usual. She sat up as if she was about to actually do something. I could easily identify with what she might have experienced that day. I understood how stressful those moments could be, especially when you are not equipped with the requisite skill and knowledge. Anna resolved to appear in control in order to give hope to the woman and her many relations that had followed her to the center. Anna recounted,

"*Because that place is a village all her people followed her even into the room but I didn't want them to know that I was afraid. Any sign of fear on my path would scare them. I kept reassuring them that they should take heart but all will be well. I kept reassuring them and the woman as I kept rubbing the uterus then eventually I noticed that the bleeding had reduced… I continued to give her infusion … When I realized she was much better I asked someone to assist me put her in bed… I realized then that if you worked in a one-man station and you are not "all round" you will get into trouble. That is when I started developing [an] interest in midwifery.*"

It was after that experience that Anna decided to pursue midwifery as a profession. However it took her several years to have that dream fulfilled. The passion that was kindled in her to become a midwife was never lost and is still strong. She expresses this by stating; "*My interest to do midwifery grew. I wanted to now go for the training. But I was married at that time and my husband did not allow me to leave the home and go for the training but after a while I forced, it took me some time (years) to go for the training.*"

Anna shared similar stories when she had to perform midwifery roles although she did not have formal midwifery training. The combination of all such experiences further deepened her desire to become a midwife.

Gathering Knowledge: Learning out of Necessity

The foundations of Anna's knowledge for midwifery practice were laid outside the classroom. Before enrolling into a 2-year midwifery training programme at Atibia in the Eastern Region of Ghana, Anna had some knowledge in midwifery from the many encounters at Ekabeku. "*It is interesting that when I went for the training. I already knew how to do most of the practical midwifery procedures. I managed to pass the training exams at one sitting. I really excelled in the programme. I scored 100% and 99% in some of the courses. That further deepened my interest.*" In spite of her previous experience and formal training, Anna soon realized that developing comprehensive knowledge for midwifery practice was more complex and undefined. As Anna told her story I perceived that gaining competency in midwifery practice was multifaceted. Personal practical knowledge was influenced by many factors: the level of formal training: the level of exposure in the field of practice: the place and circumstances under which midwifery care is rendered: one's interest in developing knowledge: the midwife's own personal experiences: and social interactions with other midwives and members of the health care team. These are some of the aspects of personal practical knowledge that I identified as I listened and transcribed our conversations.

Anna's journey to develop knowledge for midwifery practice, the evidence of which was clearly demonstrated each time I interacted with her, started from her first post midwifery postings. It is important to note that I am not in any way discounting the pre midwifery training experience she had which undoubtedly is a part of her story of becoming a midwife. I am

wondering how she developed personal practical knowledge in the context of her work as a professional midwife. Her first placement was at a one-nurse clinic in the Western region of Ghana. Most of such clinics at that time, and even in some places presently, were in rural communities where access to well-resourced health care facilities was absent. A midwife working in a one-nurse station is expected to be competent, experienced and resourceful. She (the midwife) usually was responsible for all the health care needs of the people in that community. In Anna's words "*she must be all round*." She traced the basis of her experience back to her days at Ekabeku.

The foundation for personal practical knowledge has its roots in her experience of working without formal training. Although a general nurse, the need to help laboring women in the absence of the professional midwife drove her to an apprentice position to learn midwifery personal practical knowledge from the midwife assigned to the facility and also to learn through her day-to-day encounters with the pregnant and laboring women. Anna recounted her "training" period at Ekabeku with joy and a sense of gratitude.

"*It was at Ekabeku that I had most of my experience. When the midwife travelled and I had that experience of postpartum haemorrhage, it changed everything for me. That was the beginning of my experience.*" She went on to explain to me how she worked with the midwife to acquire some basic skills in midwifery "*So when she [midwife] came back I would go to her when she is working. Sometimes I would close my shift but I will stay on and go to her unit. There she will be directing me to do things. She will say, do it this way or that way. Sometimes she will leave me to work on a case as she stands by to watch. She will allow me to be with a woman and conduct the delivery while she looks on. She will ask me to do it while she directs me. I decided then that this midwifery work is what I will like to do. That woman* [midwife in

Ekabeku] *is the primary person who made me develop interest and gain knowledge in midwifery.*"

Anna indicated her gratitude to that midwife saying, "*When she died not too long ago I even wrote a tribute for her. She really taught me a lot of things that if a patient come and cannot push because contractions are not strong enough for the second stage I have to set an IV line with oxytocin in the drip. That time there were no protocol guidelines. She told me to set up a drip with syntocinon in and regulate it and in no time the baby will come. I really got a lot of experience from her.*" Although there were no formal protocol guidelines I could see that the midwife had given Anna some guidelines about how to manage particular conditions. As I pondered over the actions of the midwife I am inclined to think that in their own ways, midwives had some form of protocol guidelines. Perhaps the difference was that they were not documented and could not be traced to any form of documented evidence.

Anna, on several occasions during our conversation, emphasized the fact that knowledge comes through experience. She was of the view that the broader her experiences are, the deeper her knowledge would be. "*The midwifery work is not all about classroom work, it is the experience you get from different places.*" While acknowledging the importance of formal midwifery training, especially classroom learning experience, Anna was quick to point out that book knowledge and classroom experience were not enough to generate the knowledge for midwifery practice. "*Some of the things we read in books we don't see on the field. But if you also read there are things you will see in practice and you will be able to identify them."* She underscored the need for practical exposure before, during and after formal training.

According to Anna, the greater part of knowledge for midwifery practice is not received during training. Knowledge is gained outside the classroom. Empirical knowledge is there to

provide understanding and explanation for what midwives do. It provides the basis to clarify some of the things we may see in the field of practice. Anna said: "*I had read about a condition known as hydrops fetalis but did not see one while in school but I saw one while working. I saw one and even saw anencephaly. At another hospital the midwives I worked with could not identify anencephaly although they had read about it but could not identify it. I told them because I learnt it well. I can link what I read in books to what I see in the field. When we go to the field and we encounter things they help."* Anna shared several stories of how she had to draw on her past experience to provide care and save lives.

Gathering Knowledge: Tacit knowledge and personal birth experiences

Another interesting point that came up in our conversation was related to the type of knowledge which Anna says just comes to you when in need. She referred to it as "kusum." She alluded to the fact that midwives have certain practices that are passed on to the next generation of midwives during practice. The source of these rituals cannot be traced in literature but have produced positive results over the years. Some of these rituals were products of tacit knowledge that midwives had responded to in their moments of desperation to save lives. These were moments when empirical knowledge had been exhausted. I too in my practice have come to know some of these rituals. Over the years I have realized that science has been unsuccessful in explaining some of these rituals. Unfortunately, midwives at least in Ghana cannot be credited with research findings related to those rituals that have been given empirical explanations. I believe that a look at some of these 'rituals' would be an important area of research for midwives. Most midwives usually guard such knowledge and would not want to share with other members of the health team. Interestingly, sometimes the use of this knowledge is even not recorded in client's folders for fear of being quarried for its appropriateness, especially in an era

of evidenced based practice. Anna made reference to one such occasion where she used her "kusum":

"*While I was working in the hospital I had a woman who came in labour. On auscultation the fetal heart (FH) sound was very weak; it was actually falling. The woman was an elderly primip. The doctor could not be reached. I had devised a way of dealing with low FH while working in the village. No one taught me but I had good results all the times I used it. It was my own 'kusum'. I had also read that when a baby is getting into distress you give the mother oxygen. So in this case we gave oxygen as well in addition to my 'kusum'. Within a short time, the FH started to pick up and eventually was stabilized.*"

Anna had already made attempts to reach the doctor who eventually came and decided to do a caesarean section to save the baby's life. Anna said after the surgery, the doctor wondered why the fetal heart was recorded as low because the baby at the time of birth did not show any sign of distress. Anna told me,;

"*As soon as the uterus was cut open the baby was brought out crying. The doctor said didn't we say the fetus was in distress? Then someone said not to the hearing of the doctor though that Anna had performed her magic again. Even the morning staff said I had done magic. The baby did so well till discharge. I still know where that particular client lives. That pregnancy was the woman's first after so many years of marriage and after she did not have another one ever. Can you imagine if she had lost that baby at birth? That would have been it. The doctor was indeed surprised at the sudden change in condition. Even here I still use that knowledge when a baby is in distress so we don't usually get SBs [still births]. I always want to save lives. My wish is that whenever we prepare our end of year report we will not have any deaths on record.*"

Anna spoke about some situations that defy all the concepts and principles in midwifery. According to her such cases require God's divine intervention. "*God plays an active role in our work. Sometime you become very worried with a case. You can try everything it doesn't seem to come. I had a case in my first midwifery station. The woman came in labour; I monitored her; everything was normal until I position the woman on the delivery bed. The contractions just stopped. I set up oxytocin drip, did everything I had to do as a midwife but nothing changed. Even the oxytocin did not make a difference. I started praying and reassuring the woman. She was also praying, then something told me to tell her to push gently although she felt no contractions. As soon as she attempted without the expulsive contractions characteristic of the second stage, the baby's head came. The woman even didn't have to push much. Sometimes God just works it out for you and you marvel. So, as for me, fear God and worship God because I need him in my work.*"

Anna perceived her reward for her work as a midwife as coming as blessings from God. Because of that she is very conscious of how she treats her clients because she believes God is constantly watching her. She said, "*Sometimes what the clients will say to you is even a blessing." She told me how her clients in that village will wish her well by telling her that "When you meet a difficult situation God will deliver you from all of them because you are a good person.*" Anna believes that in the same way when she maltreats a client she can pronounce curses. I pondered over how religion is intertwined in her stories and how that has influenced how she cares for her clients.

Anna narrated how she has learned to listen to her clients because of her personal experience of childbirth. She told me she has had been in labour for hours with strong contractions but the labour was not progressing. The doctor came to see her and asked that she

should be prepared for C/S. "*As I was lying down I started praying. At a point I felt the pains were unbearable but when I called that they (midwives) should come and attend to me because I felt the baby was coming. I was told that the baby was not coming and that if I would deliver I would have delivered by now. Nobody minded me. After a while I started screaming. That is when they came to see me. My baby was actually coming. Because of that if I have a client who is 1cm dilated and she calls I will go close and attend to her because of my experience I wouldn't want the woman to experience the same. For me because of my experience, when a client calls I will go and check up on her. It can be that she has dilated fast and wants to push. I learnt this from my personal experience.*"

Gathering Knowledge: Influence of Social Environment

Another phenomenon that Anna described as having contributed to the development of her knowledge was the effect of working in many different places. Anna has had the opportunity to work in different facilities with varying resources, different cultural perceptions, as well as different geographical locations within the region. She worked in both urban and rural settings. She had worked in bigger hospitals and smaller hospitals, as well as at one-nurse stations. Anna also had the advantage of working during different eras that were characteristic of the evolution of midwifery practice in Ghana. Each place and period where she worked shaped her practical knowledge. She worked from the mid-1970s to 2016 when I met her. She described some of the differences in working in smaller facilities as against bigger hospitals. She noted,

"*You know at the smaller place you build a cordial relationship with clients because you may be the only one so you (midwife) interact with the client quite often. You cannot behave anyhow towards them. It makes the woman develop trust in the midwife because they know that the same midwife who attends to them at antenatal will care for them during labour so they*

become confident in you. Such knowledge no one will teach you. You will have to personally know how to relate to people." Anna continued by commenting on the attitude of midwives and the importance of knowing how to build relationships:

"*The truth is that we have all worked in the government hospital before, [where] the attitude and behavior of some midwives is very bad. In the village and maternity homes the relationship with the client and community is already there*". This statement by Anna reminded me about the importance of positive midwife attitudes in relation to reducing maternal and infant mortality. I also understood differently the importance of social interaction in shaping behavior. Could this also shape the professional knowledge landscape of midwifes? I wondered.

Anna went on to explain further how she found out that the social environment within which the midwife works will compel her to develop interpersonal skills to facilitate the use of her practical midwifery skills. She said, "*In the villages the people will not attend the clinic on time. Sometimes you would have even closed work. They will go to their farms before coming for antenatal clinic. They consider the clinic to be theirs and that they should have access whenever they want. You just have to learn to be nice and tolerant and ask her* (client) *to go wait for you at the clinic. I had to learn that so I could work with them. You can't be rude or disrespectful; you can't say you will not attend to her because she came late. Such things don't happen in the village or smaller communities. If you do that you will lose your clients. Even the men will discourage their wives from coming. But because of the cordial relationship I built, I could get them to gradually change. You have to have time and patience for every client."* As Anna spoke, I began to think silently as I listened intensely, how that in order for a midwife to get the opportunity to utilize her personal practical knowledge and develop more personal practical knowledge through experience, she would have to consciously consider the social environment

in which she works and learn to make the necessary adjustments. Could it be that this statement speaks to the relationship between social environment and experience? Does it also mean that social interaction/environment influences a person's personal practical knowledge? If it does, how important is it and do all social environments contribute to developing personal practical knowledge? I ask these questions because Anna was specific about the effect of the village or small communities when she said, "*If you go and work in a village or a small community with a bad attitude they will write a letter about you and demand that you be removed. As for the village they know how to write such letters. When you go there with a bad attitude and behavior you will have to change or you will not have experience because they will not attend the clinic. Sometimes I will refer a case to another facility but the client will refuse to go because of the attitude of the people there unless I am ready to go with them. As for the village when you go there to work your attitude must change. If it doesn't when you need help in the community you will not get it."* These are the questions that I continue to ponder as I write.

Gathering Knowledge: Overcoming challenging situations

When Anna finished midwifery training her first assignment took her to a predominantly fishing village in the Nzema East district in the Western Region of Ghana. Although it is not more than 70 kilometers away from the regional capital, the poor road network at the time Anna was sent there made it difficult for her to travel to the capital easily. There was no doctor at the clinic where she worked. She was the main health person in-charge of the maternity section and had to refer all her cases to the regional hospital. She recalls that there was a particular TBA who the women in town had accepted so much that they would prefer to deliver with the TBA than to come to the clinic.

Armed with her experience from Ekabeku regarding building relationship and collaborating with community members and opinion leaders as a fundamental key to successful work in the rural community, Anna decided to win over the TBA. One day the opportunity came for Anna to relate with the TBA. According to Anna, "*There was this TBA in the village, the women preferred to deliver with her. They would only come when there are complications. She would usually bring them in a very bad state. She waits till it becomes life threatening."* Anna mentioned that one of the reasons why the women did not want to come to the clinic was that they had the notion that when you come the clinic you are likely to be referred to the regional hospital and end up having your baby through caesarean section (CS). They considered an operation during childbirth as an indictment on womanhood. On that particular day the TBA had to bring one of her clients to the clinic when she feared the worse could happen. Anna said, "*When the woman was brought to my facility she had already delivered the first twin, it was left with the second twin that couldn't be delivered so she was brought. She thought I would scold her but I didn't. I told her I was the only person on duty so she should stay because I would need help. I set an IV line and reassured them. The cervix gradually became fully dilated but still the baby wouldn't come. The TBA was there with me. I eventually got the baby out, but I noticed that there was no liquor (amniotic fluid). All the liquor had drained. I had to resuscitate the baby for a while. I involved her as my assistant in all that I was doing."*

I wondered why the women would not come to the clinic but go to the TBA and why the TBA would wait until the women were in a life threatening condition before she brought them. She explained that the pregnant women would come to her for antenatal care but would want to deliver at home mainly for fear of referral and surgical intervention. "*The TBAs would delay in referring the women because that would spoil their records. Their fear was with time the women*

would stop coming to them because they will end up at the clinic. Because of that fear the TBAs will always keep the women there and try everything possible when all fails before they bring the women. They know they (TBAs) are not supposed to handle some cases such as twin delivery but they will do it. When they bring the bad cases that is when the midwife will scold them, then next time they will bring a worse case." The dynamics didn't seem simple and straightforward I realized. Solving this problem required collaboration between the midwife, women and TBAs.

Anna continued the events of that day; after the baby had been born and resuscitated the placenta had been retained and the woman was bleeding. Anna goes on to say "*It is always my desire to try my best for the client and when it is necessary I will refer the client. I usually accompanied the women to the regional hospital especially when I think her condition is too critical such that she may not make it if I don't refer. Even when I work with doctors, unless it is beyond me, I don't go calling them every now and then about just anything. The doctors don't stay there all the time so I work hard to prevent complications. I detect them early so that I refer as soon as possible. If you are a midwife and for every little thing you go running to call a doctor, they (doctors) will not even respect you as a midwife. Your in-charge can trust you when you are on duty even if you are a senior.*"

Anna was not going send the woman on this 70km road to the hospital without trying to remove the placenta first. The only problem she had was that she had not been trained to manually remove a retained placenta. Anna continues "*I remember I didn't know how to deal with retained placenta I had not had an opportunity to attend a workshop on that. But the first place I work in 1974, there was one case of retained placenta that I encountered. I wasn't a midwife I hadn't attended any workshop on that yet but I learnt how to manage retained placenta at that village from the midwife. I said to myself I could manage retained placenta. I learnt it on*

the job from the midwife. I could do a lot of things. It was the same with episiotomy. I had difficulty in cutting. I had not attended a workshop on it although we were taught in midwifery school. I was always afraid to cut because I had not been trained on that well. One day I had to cut or stand the risk of the woman sustaining a tear. I was scared but managed to cut and the baby came out. I realized that it wasn't even a deep cut. I just put in about 3 stiches and that was it. Then I said that all this episiotomy that most midwives are afraid of is not anything difficult to do after all."

We both burst out laughing as Anna had this rubbishing look on her face to indicate that it was nothing to worry about and she continued talking. "*After encouraging myself with that I decided to remove the placenta for the woman"* Anna said without showing any sign that she did not actually know how to do that, she carefully removed the placenta and stabilized the woman. Both the woman and her husband were so grateful to her for her help and competency. Most of all they were grateful that the woman did not end up at the regional hospital. The TBA was equally grateful and through that became her friend. She worked for 14 years in that community. Anna concluded her story by making this statement "*Everything I know I have been forced to learn how to do it and to do it well so that when I am alone I will not be found wanting. I tell my junior colleagues the same thing. Even the health care assistants I tell them if they have plans of doing midwifery they should learn now so that when they get the opportunity for training in future that knowledge will help them to do well. I teach them how to do a few things because you may never know when I will need them when I am overwhelmed with work. I see every challenge as an opportunity to learn.*"

Anna had a couple of such stories that challenged her to do things she had not done before and in the process added something new to the list of things she could do. She told me about another

time in a different community. She was at home, this time she was working as a nurse in a bigger hospital and living far from the hospital. She had people calling out for her one early morning, as she was getting ready for work. Apparently one woman who had been in the process of delivery at home had a prolapse uterus and they needed her help. Anna recalled the incident, "*When I got there the baby had come out but was still connected to the mother by the cord. I quickly found something to tie the cord and I cut it to separate the baby from the mother. I noticed that the uterus had prolapse so the cervix was out of the vagina. Apparently she had been pushing and pushing for a long time and had pushed the uterus out. I rushed back home to get some gauze from the house and managed to push the uterus back after the delivery of the placenta. I had seen it being done only once. I wasn't a midwife but I observed well how it was done. You know once you are in this uniform (held her white uniform) the public don't consider whether you are a nurse or midwife, they think you can do everything. People will look up to you. The responsibility lies on you to learn but these days it is not like that. When you are teaching the young ones they see it as a bother.*"

Anna told me that a couple of months before our conversation another similar case was brought to the maternity home where we were and she took care of the woman to the admiration of her colleagues and the student. Each story she shared with me increased my respect and admiration for her. She did not have a high level of education. Her nursing and midwifery education was at the certificate level. She did not even have a state registered nursing certificate but her level of knowledge and intelligence in her field was deep. Most of the statements she made were profound. She ended our conversation on this prolapsed uterus with one of those statements. "*Midwifery is a practical thing, you can't get the experience by only reading books or learning in the classroom. The books and the classroom experience is to help you think on your toes and*

take the right decisions but the implementation comes through practical experience." That was a profound statement about how the combination of experience and formal training leads to competency.

After each conversation with Anna I felt practically full but not satisfied. She would graphically describe each procedure she carried out as she told her story. She provided detailed information on the education she gave to them after each procedure. It felt as in I was in a classroom or at a workshop. She did all these from memory as if from a textbook. Though physically she looked tired and weak, her memory of midwifery skills was sharp.
Though out all our conversations my admiration for her left me with many unanswered questions. Why did she not pursue higher education? Is her knowledge mainly from practice, considering that her last formal education was many years ago? I also imagined who she could have become with that level of intelligence. I was very happy I had the opportunity to know her and hear her story. Anna mentioned to me that she was finally retiring from midwifery practice on 31st December 2016 because of ill health as a result of an injury she had at the labour ward many years ago. She shared this tragic incident with me during our last conversation. I have captured it in her account.

Gathering Knowledge: classroom experience, protocols and workshops

Anna's demonstration of professional knowledge could not only be attributed to her. I mention to her how I admired her knowledge on issues. From human anatomy and physiology to management of complications. She would provide me with rational for every action she took and possible complications that could occur. Anna had an incredible way of explaining issues that could not be over looked. I invited her during our third conversation to share more on that ability. Anna started by telling me that she has always had an interest in reading. Any

opportunity she got she wanted to read and she always wanted to write down things she learns from people so that she can go back and read over or refer to them when there is the need. She said, "*I've always been someone who reads a lot I have always loved reading. Instead of watching just anything on TV I will rather read something. I remember when I was a student midwife, we had objectives test one time and there was a questions like "one distortion of the pelvis is ... we were supposed to give answers. I wrote, "Asymmetric" and the entire rest of the class wrote "Assimilation". I was marked down, so I opened my textbook and I took it to my teacher and she was surprised. And she asked me not to tell anybody".* We both laughed out loud. Anna said that she has never stopped learning and reading. Up to date whenever she is in doubt she will go back to her books. I found that as encouraging because midwives are perceived as very busy people it was interesting to hear that she made time to read.

Although Anna did not talk much about her desire to go school a statement she made, "*I got married in 1974 after enrolled nursing training with time my interest to do midwifery grew. I wanted to now go for the training but I was married at that time and my husband did not allow me to leave the home and go for the training but after a while forced. It took me years to for the training."* This indicates that she did not have the freedom to make that choice.

Anna did not go back to school for formal education but her interest in learning made her take advantage of training workshops to develop her knowledge and skills. She told me this about the training workshops, "*The workshops are very important for we midwives but not everyone wants to attend. They say there is too much learning. You know some people don't like learning but at the workshop you will be forced to learn because they will examine you after the session. Some also say they are busy. Midwifery things keep changing so if you don't take*

advantage you will be practicing with old knowledge. As for me I attending it has helped me a lot."

She went on to tell me about the many workshops she has attended telling me the content of some of the things she was taught. She added, "Even now there is one on syphilis coming up, I was not invited to attend so I have gone to see the doctor in-charge. He says I should come for the invitation letter next week. I usually teach the students when they come here so I need to know the current protocols." As a midwifery educator I appreciated how Anna had taken interest in teaching student midwives who came to her facility and would deliberately continue to learn because she had to teach students. This attitude from my personal experience is uncommon. Some practicing midwives do not see the training and mentoring of midwifery students as part of their work as midwives. They would usually not voluntarily offer to teach students. Some have also argued that the students are not ready to learn. This is an issue that needs to be investigated and address. I had become hopeful from Anna's statement that there are still some midwives who are ready to teach students.

Living through Tragedy

This was supposed to be our last conversation but Anna was happy to meet with me to record another one if there was the need. All our conversations had been exciting, educative and revealing. During our second conversation Anna had mentioned an accident that she had at the labour and promised to tell me some other time. I had also noticed that Anna had a limp, which coupled with her weight made it significant when she walked. I noticed it the very first day I met her when she descended the short stairs in front of her office to meet in the courtyard. I had no intention of asking her about it because I assumed that it was something she has lived with all her life. I also didn't ask her because I wasn't sure how she would take it.

We met on a Wednesday afternoon as usual in Anna's office. The same warm reception was given to me when I arrived. The student nurses and her other colleagues had all come to know so and me received me warmly as soon as I entered the courtyard. Our conversation that day started with Anna telling me about her work at the maternity home and her plans to retire completely in December. She told me that after her retirement from the government sector at age of the 60 she had no plan of working. But she had become used to working and she felt she still had more to offer. Anna said ,"*I was working here part-time but I retired and stopped practicing midwifery but they (owners of the maternity home) came to call me to come back and to work. I worked in this clinic but stopped. I was home when the owners came to see me again that I should come back because their clinic attendance has reduced. They said the way I smile and attend to clients they keep asking of me.*"

Anna told me that she stopped because the administrators were not treating the staff with respect so most of them left. She agreed and came back in 2015. According to Anna, "*When I came back I saw that numbers had reduced drastically. Since I came back we can work for hours. We work from morning to 4pm and then attend to clients as and when they come after 4pm. Anybody who has delivered here before would always want to come back. They would say that if aunty Anna is here then we will come and deliver here. It is also because I have time for my clients. I will always take a chair and sit by the client. One thing is that we hardly get several women in labour at the same time so I am able to have time for them. I will encourage and reassure my clients till the baby is born."* Anna noted that one secret to running a good private maternity home is having a good attitude and building cordial relationship with the community you serve. According to her that is what will keep the clients coming "*When you are in private practice your attitude is very important to retain your clients. When you are nice to then and*

smile at them, then you will do well. If you work in the community your attitude and how you relate with the people is important. If you are good, the community will love you and they will not have anything bad to say about you. The community members talk among themselves. They know where the good midwives or clinics are. They would either recommend you or discourage people from coming to you."

Anna's interpersonal skills were developed during her work in the village and small communities where she worked in for years. She spoke about the importance of building relationship in midwifery. "*You know at the smaller place you build a cordial relationship with clients because you may be the only one so you (midwife) interact with the client quite often. It makes the women develop trust in the midwife because they know that the same midwife who attends to them during antenatal will care for them during labour so they become confident in you. For you the midwife it helps you to know your client well and prepare her for labour. It helps you to take decisions about the care.*" She went on to express her disappointment in how some midwives behave towards clients and sometimes even fellow midwives just because they work at referral centers. "*The truth is that we have all worked in the government hospital before, the attitude and behavior of some midwives is very bad. They show that bad attitude to their own colleagues but there is something we can all learn from each other.*" Anna who had become emotional at this point continued to talk about some personal experience "*Sometimes I send referred cases to the regional hospital. I have to stand there for a long time and no one will mind you. I just have to reassure the client that the midwife is busy and will attend to us. But even when you are busy once someone comes and says I am coming with a referral patient, you should have time to attend to them. They will not mind you until they have finished with everything.*"

Anna told me about how she relates with her clients irrespective of their social or economic backgrounds. She strongly believes that every woman deserves to be loved and cared for. Anna spoke about how much she enjoyed bringing hope to women not only during labour but in all her interactions. She explained, "*For example my HIV positive mothers are always happy to see me. I interact with them just like with any other client. I counsel them and work with them. They share all their worries with me. It is just because of how I relate to them. I have time for my clients because I see that it makes them happy. I also learn from them and get to know what they want. It's all about attitude. It makes both the client and you the midwife happy. The clients have to be drawn close and not pushed away. Midwifery work is about relationship. When the clients are happy they will keep coming to you."*

This attitude is one that I personally find it difficult to understand and to explain. The same nurses who work in the government facilities with bad attitudes toward clients work part-time in private hospitals and clinics with near excellent attitudes. It reminded me of the assertion of the panel member I write about in chapter one who alluded to the fact that midwives' bad attitudes are due to their training until I reminded him that the nice ones at the private hospitals undergo the same training. I still question this attitude and what can be done.

Anna suddenly became quiet for some time. I noticed that her countenance had changed. I was also quiet, not sure what had happened. Then she said, "*let me tell you of my own sad experience with nurses at the hospital when my husband was sick.*" My heart sunk even before she could tell me what had happened. She started narrating her story with a trembling voice, "*My personal experience recently when my husband had to be admitted before he eventually died was bad. Even to serve his medication on time was a problem. I had to prompt the nurses. They will sit at the table. Even when I prompted them they came with frowned faces. It was so bad! I have vowed*

that if I get the appropriate platform I will talk about it. It was only one or two out of the lot on that ward who had devoted their time to do the right thing and interact with care and respect."

Anna spoke with mixed emotions of sadness, anger, and disappointment. I wish I had something to say to help her but I could not think of anything. I was silent and so was she for about a minute then she continued "*Some people have spoilt the work so even when you say you are a nurse some people brand you as wicked or uncaring. It is bad. Especially when you are at the receiving end that is when you can understand the clients. I think the discipline in the schools has reduced. It shows in the behavior of students when they come for clinicals.*" I pondered over the comment about discipline in school. As I write I am wondering what form of discipline did Anna and my other participants receive when they were in training. I wondered what has changed and what could be done because that was not the first time I heard such a comment.

Anna went on to tell me about the accident she had at the labour ward and how she did not want to work after retirement but to get her mind off her husband's death and also support her only son to finish university she had to keep working. Her son had graduated and got a job some few months from the time of our conversation. It was time for her to rest. Anna's countenance was still down. I could feel the sadness in her voice. I wanted to stop the recorder and reschedule another appointment. I was also wondering if she just would prefer to talk about it since she had mentioned that she was looking for a platform to voice her feelings. I did not think that this was 'the' platform but I felt it was 'a' type of platform. She was already talking; I did not know how to interrupt to find out if she wanted us to discontinue our conversation. I managed to ask her but she insisted that she was okay to continue.

Anna narrated the incident "*I went to work one day at the regional hospital in 2006. There was a woman who came in labour. I was told she had been pregnant six times and had lost*

all the six children at birth. I was there when she shouted for me to come and see her because the baby was coming." Anna recalls that at the labour ward they used to wear boats and slippers. She responded to this woman and positioned her because her baby was almost out. The baby came out with a gush of liquor (amniotic fluid).

Anna continued, "*The liquor just gushed out on me and on the floor. I had slippers on and I had the baby in my hand because the cord was still connected. Suddenly I slipped. My legs slipped apart, I was sliding down. I held the baby with one hand and held the bed with the other hand. I realized I was going down so I shouted for help. I was the only person there, God being so good there was a doctor passing on the corridor who heard me and rushed into the labour ward. He immediately took the baby and clumped and cut the cord. I was still slipping down with my legs apart. I called on the doctor to help me. I was just screaming. By then other people had come. They took hold of me but I couldn't put my legs together" At this point Anna was in tears. Tear flowing down her cheeks; I had tears in my eyes too. I tried to hold back my tears but I couldn't. I reached out for tissue in my bag and wiped my tears. I handed a tissue to Anna. She continued her story "They had to carry me to a nearby bed and help to put my legs together. It was serious and it's the reason why I can't walk well up to date. I was deformed for life. Up to date I limp.*"

My tears flowed more as she stood up to show me her leg. She had to seek medical help for her leg on several occasions. Several medications were written for her. The medications were expensive but she had to buy with her own money. She added, "*That is how now I have a leg to stand on, but even that it is not the same. It keeps worrying me. I am always in pain; it is difficult for me to work. When it happened I couldn't walk. Even when my legs were put together I couldn't walk. But I had to continue working for a few days after. I struggled to get to work. I*

found it difficult to walk without support. After some time walking became better but the pain never went. I had to take painkillers always. Eventually I had to take a scan. I was told recently that I had a slipped disk. I just know that it is the result of the fall."

After that chilling narration we both sat down in silence as I pondered many things. Anna had brought some pictures to show me about the places she had worked and to talk about the stories behind the pictures but we both agreed to meet another time to talk about it. I asked Anna if she has any regrets about becoming a midwife after what happened to her. She responded with a smile.

"*As for working as a midwife I have no regrets. Up to date I have offers. There is someone who wants to start her clinic and wants me to come and help her. Have told her I am not coming to work but will help her set up. She said she needs my help because I have had experience in both the rural and city settings. I am always grateful to God.*" Anna expressed her gratitude to me for having time to listen to her stories.

I am very glad I had the opportunity to speak with Anna and to come to know her beyond her identity as a midwife based on her white uniform and black belt. Each time I related with Anna I was amazed at the knowledge she had. I realized that I too had lived under the wrong impression that it is the formal classroom education with its equivalent degrees and certificates that determined the knowledge a midwife carried. I had always agreed that because of long service such a midwife would have rich experience; more tacit knowledge but may not be able to adequately explain the rational for most of her actions. Through my interaction with Anna that perception has changed. Anna's love for reading and learning was evident in the way she spoke about issues in midwifery. From knowledge in anatomy, physiology and management of conditions with clear scientific explanation, Anna spoke of how she had assisted women.

Sometimes in our conversations and even when the recording was off she would demonstrate some of the procedures she spoke about. Anna also demonstrated through her conversation that she had acquired rich experience and emphasized how important it is for midwives to have exposure to gather experience.

Narrative Account 3

Martha's story

Getting Connected to where it all begun

I got to know Martha through one of the midwives with whom I discussed my research. Martha's phone number was given to me and so my first contact with her was on the phone. Although Martha was the third participant to be engaged in my research, I realized I had not gotten over the anxiety of recruitment and the fear of possibly being turned down in ways that may discourage me. I had enjoyed my relationship with my first two participants though but still was anxious. The midwife who gave me Martha's number told me that she was a very welcoming person but I was still nervous. Prior to calling her I had many questions run through my mind that stirred up more anxiety. I wondered when would be a good time to call her, recognizing that midwives are very busy. I asked myself what if she was busy or having a bad day at the time I called. How would I know she was at a good place to take a call? I wished I could make sure everything was perfect before I called. Somehow I knew I just had to make that call anyway. It was past 5pm on a Friday evening and I was getting ready to leave the office for home. I needed to make that call before I set off for the house and for the weekend, I wanted to know if I had my third participant.

I remember waiting as the phone rang a couple of times then she finally answered the call. I heard her say a few words; I guess she was talking to someone. Seconds after a hoarse voice came across with a strong "hello." I quickly cleared my throat and introduced myself. Before I could finish she took over heartily, letting me know that she was expecting me to call and that she was told I would like her to share her experience with me in a study I was conducting. It sounded as if she was telling me "you don't need to introduce yourself before I agree to be part of your study. I want to tell you my story." I did not have to do a lot of talking; Martha's expression of willingness to share her story was reassuring.

Our short phone conversation was very cordial and stimulating. She started telling me about places she had worked and how it would be nice for us to talk. This increased my desire to meet with Martha so I could explain the details of my study and invite her to be a participant. On the phone she sounded enthusiastic and passionate; although I could not see her face, hearing the strength in her voice as she spoke, her laughter and how she even started to tell me about some work experiences even on phone was an indication of her enthusiasm and passion. When I got off the phone with Martha I felt a new surge of energy going through my brain. The tiredness of the day seemed to have suddenly disappeared; I already felt a sense of accomplishment. I was ready to know Martha. I got into my car to begin my one and half hour drive back home; my thoughts were frequently interrupted with the outcome of the conversation with Martha. Martha and I had agreed to meet in person on the Wednesday following our phone conversation and I had already begun to imagine who I was going to meet and how our conversation would go. Who would she be? What pseudonym would she choose? As I headed towards her place on that Wednesday I was less anxious compared to moments before my first phone call to her.

My impression upon meeting Martha in person for the first time was no different from the impression I got from our phone conversation. It felt as though we had known each other for a long time. Her infectious smiles, her passion about midwifery, and her enthusiasm could not go unnoticed after just a few minutes of interacting with Martha. Her tall well-built physique, hoarse voice and eloquence are still fresh in my memory and will be for a long time to come. I arrived at the hospital at around 4 pm; my aim was to discuss details of my study with Martha and to confirm if she still wanted to take part. When I arrived at her unit she was not there but had asked that I be directed to where she was a few blocks away. Apparently that place was a new theatre being set up for the maternity unit. When I entered the reception area there were two

women sitting there. I instinctively knew which one of them was Martha; seconds later her smile and voice confirmed it as she mentioned my name. I had been to that hospital a few times in the past and knew some of the midwives there. I wondered why I did not know or hear of her. She welcomed me into one of the rooms explaining as we went that she had closed her shift for the day but was helping out with the setup of the maternity theatre. As we sat down to talk I explained in detail what the study was about and our responsibilities as researcher and participant. I was careful to let Martha understand the relational nature of the methodology I was using and how important it was for us to remain in relational ways throughout the study. I also provided her a copy of the consent form to read so she could sign on a later date when we next met for a tape-recorded conversation. Our 20-minute interaction ended with us agreeing on a date, place, and time for our first tape-recorded conversation.

Martha is a nurse/midwife who works fulltime in a government hospital and on a part-time basis at a private maternity home. She readily agreed to be part of the study during our first face-to-face meeting and even began to talk about some of her experiences before we scheduled our first tape-recorded conversation. I perceived that her love for her work made her talk about it spontaneously and that greatly facilitated our conversations. All our conversations took place in her office at the hospital where she worked. Martha informed me that being the nurse manager for the maternity unit she was given accommodation on the hospital compound but she spends a greater part of her time at the office even after working hours. Her reason for staying on after her shift, as I came to find out later, was not because she did not enjoy her home but because she carries the burden of taking full responsibility of/for what happens to every woman and baby in that unit. She also has a passion to mentor other young midwives who work with her and would stay on at work when she felt a particular staff on duty needed assistance to build experience.

With time this has become her pattern of life. Being accommodated on the compound made her easily accessible. It was as if she was on call 24 hours a day. In all Martha and I held four interesting tape- recorded conversations.

Our first tape-recorded conversation took place on a late Friday afternoon in December and was followed by three more. I had been in a mood of expectancy the whole of that morning. As I drove to work that Friday morning it wasn't the dry, dusty, heavy fog and the poor visibility of the usual December Harmattan season that occupied my mind. My mind was preoccupied with my planned meeting with Martha later in the day. I was eager to hear another story, I looked forward to living alongside Martha to hear and understand her story.

After attending to a few things at the office I headed back home. My meeting with Martha had been confirmed the previous day. I waited in anticipation for the hour to come. Unlike my first tape- recorded conversation with the first two participants, my drive from home to see Martha was shorter. I felt less tension regarding how our conversation would go. I was more relaxed. I am not fully certain whether I was relaxed because I had held several conversations with other participants and was perhaps getting used to it or it was because of how well Martha and I had connected. Ultimately our connection right from the beginning of our research relationship played a part in all our interactions.

We met in Martha's office: It was a small office space at one end of the delivery unit of the maternity block. Walking down the hallway to her office brought back memories of working in the hospital particularly in the maternity wing. The first section on one side clearly was the antenatal section, it was an open space with chairs and benches and an area with tables and chairs which I believed was the midwives' station. There were some wards on the left and right of the hallway and I later found out that these were the antenatal and post -natal wards. The place was

very clean and the walls were neatly and freshly painted. The sight of new beds and other equipment in boxes arranged at different sections was a clear indication that the facility was still under construction. The sound of crying babies, the moaning sounds from labouring women and the smell of Dettol, that was typical of most delivery units, was present. Without reading the label on the door I could tell that I was at the labour and delivery section.

I walked almost to the end of the hallway and turned into a niche that had two doors opposite to each other. The door on my left hand side was opened. I could see beds and that was where the moaning of women and crying of babies was coming from. The door on the right had a label that read office. That must be the office, I said to myself. As I knocked and entered Martha's average sized office I noticed it was unusually crowded with various items including bags of rice and gallons of oil. This was completely different from what I expected in a typical office of a nurse manager. Her table was covered with well-arranged papers, files, books, and a container with keys among other things though well arranged. On one side of the wall was a notice board that had several papers and some posters stuck on and a metal cabinet at one corner. There was a small inner room where ward supplies were stored. From her office a door opened into the first and fourth stage rooms that remained opened on all the occasions that I visited her. I understood partly why Martha spent most of her time in her office; the close proximity of her office to the labour ward positions her to be able to monitor all activities. Yet this has also given room for the other midwives to work autonomously once her shift was over while at the same time making it easy for her to intervene when needed. She told me later in our conversation that, "*I came to work in the morning. I have closed but I had to stay on not only to speak with you but also to help. I recognized that the midwives on duty today are not experienced and we have some women in labour so I am around to help and teach. I live on the compound so that I can be*

called upon at anytime. Sometimes 1:00 am or 12 midnight but I always come to help. I always tell them (midwives) that what they need to learn is commitment; if they are not committed to learn you will not learn."

Everything in the room gave me an impression that it was an actively used office. Perhaps the curious look on my face as my eyes scanned the room could not be hidden because Martha welcomed me into her office and quickly added that the items in the office were to be given to her midwives the next day as an end of year package from their welfare association. She beckoned me to sit on the other seat across her table. After talking a little bit about how our national elections have been peaceful, we got down to the real business of the day. Our conversations about her experiences as a midwife started that day with a narration about her childhood. Martha was born in 1962 to parents who were committed to educating their children. Unfortunately for Martha, her father died when she was just ten months old. The death of her father did not deny her of the opportunity to be educated. By the age of 16 years Martha had completed middle school and gained admission into secondary school. However, her dream of going to the secondary school was shattered because her mother, a single parent after the death of her father, could not afford secondary education. Priority was given to her two brothers. This is not surprising because until relatively recent girl-child education in Ghana was not treated with great priority. Martha recalls "*I got admission to secondary school after primary six but my mother was a single parent so she could not afford because my two brothers had also gained admission to secondary school, it was difficult for her, so I couldn't go to secondary school at that time. When I eventually finished middle school in 1978 I again got admission to secondary school but there was still no money. I decided to apply to either teacher training or nursing training school."*

Martha, not being sure of what she wanted to do for a career, applied to a teacher training institution first but, unknown to her, her older brother was making arrangements for her to gain admission into a nursing training programme at one of the mines where he worked. The advantage of this nursing training programme over the teacher training was that, at the nursing school a student was not required to pay fees but was rather paid an amount of money equivalent to the salary of an employed laborer at the mines. Considering the financial hardship at home at the time, Martha was encouraged by her family to opt to be trained as a nurse. Martha, on several occasions, came back to the lost opportunity to pursue secondary school and eventually she got a secondary school certificate after working and attending school part time. Each time she spoke about it, her voice would drop and her smile would fade away. I sensed regret. During one of our conversations she said, "*My career is nursing/midwifery but my real passion is teaching. I wanted to be a teacher. Because of that as a midwife I am always ready to learn and teach."*

She explained further by saying, "*There is a degree midwife working here, very hard working midwife, always ready to learn. Because of that I always keep teaching her and encouraging her. In my absence she can take charge of the ward easily. She is always asking me why I didn't pursue higher education so one day I showed her my O' level certificate. She was surprised and asked why I didn't go back to school. I told her I had no one to take care of my children. My big sister who is a nurse went back to do SRN. I couldn't leave my children at home to go to school in Takoradi or elsewhere for three years. I couldn't. As for that thing it is unfortunate for me. I could have come for a year or two. I am sure I could have managed but three years was too much."*

I felt regret in her voice and I also strongly wished she had achieved her dreams. I have no doubt she would have been a great example and inspiration to many midwives although I

know she already is. The unfulfilled dream is something she has lived with for a long time and probably found difficult to accept. Though grateful to God for what she had become, she strongly believes it would have changed the course of her life. She could have been more than she is now. I could understand her because I too had dreams that unfolded differently than I expected. I recall how as a young woman in high school I had dreams of becoming a military officer in the Ghana Armed Forces. I took inspiration from one of the few female officers at that time who happened to be a public health nurse serving in the army. Being a daughter of an army officer myself, I had come to admire the discipline, respect, and opportunities associated with the army, although I knew about the risks. My future plans at that time were shaped by the dreams I had. I also wanted to lecture in the University of Ghana, the only university I knew of then. I had mapped out what I thought was a definite plan that could be achieved through hard work and dedication. I planned to serve the Ghana Army for a short service period of five years and then move into academia. I wanted to be young when I obtained my PhD. This dream was one of the reasons why I chose to become a nurse. My father's strong disapproval of my intention to join the army strongly influenced my change of plans. Though my dreams unfolded differently, I have found fulfillment in the path I am on now; yet up to this day I am reminded of that unfulfilled dream anytime I see a female army officer. Martha continued her story about how she started her nursing training. According to her after a successful interview, Martha began her training as an enrolled nurse. Having no initial desire or interest to become a nurse, Martha was compelled under the circumstance to pursue nursing, hoping to develop interest with time. Martha explained "*In fact when I decided to take the nursing option it wasn't easy for me at all because naturally I am afraid of many things but when I entered nursing I became very brave. A senior of mine put me on isolation ward within the first few weeks of training. The client there*

was dead and I had to help with the last offices. Initially when I heard the client was dead I was very much afraid but I decided to gather courage. When I was able to perform that task I knew I could be a nurse." We both laughed as Martha continued to tell me about how some of her mates ran away from nursing school resolving never to become nurses.

Martha mentioned that midwifery was not an option for her at that time because she feared the sight of blood. If circumstances had not forced her into nursing she would have never ended up as a midwife; a profession she now cherishes dearly and is unwilling to trade for anything else. I momentarily perceived that nursing was not for everyone; some people may enter into the profession with strong convictions about becoming nurses or midwives prior to training. Others through training and socialization into the profession fall in love with it and develop a passion for nursing and midwifery. However, there are some people who may never become nurses or midwives. I, too, had mates who abandoned nursing school due to similar reasons Martha gave. There were some who remained but never really enjoyed the work. Reflecting on our conversation about choice of career helped appreciate how circumstances also brought me into midwifery; a profession I almost turned down in the past but has, over the years, become my passion. Though unique, we still found similarities about how we both got into midwifery as we continued our conversation. Perhaps there are other midwives who through Martha's story and the stories of the other midwives in the study will see the uniqueness yet similarities in how they, too, came into this noble profession.

Martha completed her two-year enrolled nursing programme in 1984. Determined to climb higher the academic ladder in nursing, Martha took courses on a part-time bases, sat for and passed the General Certificate Examination (GCE) Ordinary Level examination with the aim of going back to nursing school to become a State Registered Nurse (SRN); the highest level of

nursing at that time in training schools. Her desire was to become an SRN/Midwife soon afterwards. Unfortunately these plans did not materialize because along the line she got married and had two children. Her husband, not being in favour of her leaving their home to go to school for three years, did not allow her to go back to school. I wondered about the many women who probably did not realize their dreams of becoming nurses and midwives because of marriage and childbirth. I thought of the story my mother told about how she too could not go to nursing school because she had no one to take care of her two young children at that time. It made me appreciate the opportunity I have to advance in my career and the great support I have enjoyed from my family. Yet I had to defer returning to school for years till my children were much older, not because of my husband's disapproval, but my own perception of the role of a mother in the family.

Though highly disappointed about not being able to go back to school, Martha remained resolute about becoming more than just an enrolled nurse. After working for some years she enrolled into a two-year midwifery programme for Enrolled Nurses in 1992. Martha was very successful in her midwifery training and passed with credits. She told me, "*while training as an enrolled nurse I became interested in midwifery but I had to finish the enrolled nursing that was the starting point. After that I saw the need to upgrade myself. I couldn't go to do the SRN because I had two kids and so my husband did not allow me to go. But even after the midwifery I wanted to go and do the SRN but when I considered my children, my work and the community in which I worked, it would have been difficult."* That statement profoundly indicates the selfless nature of Martha. I perceived her as someone who is committed to whatever she accepts to do. That priceless attribute was not limited to her work as a midwife but also significant in her role as a wife and a mother. Following the missed opportunity to go back to school, Martha never

pursued her dream. She mentioned that if she had acquired the SRN certificate she would have continued further to obtain a degree and even higher. She wanted to teach in a midwifery school. Just like any other time that Martha spoke about this topic, she became very emotional at this point and she paused for a while. I could feel the change in her emotions; her voice had gone low, the force with which she spoke had reduced, she stared at something on the table as she rolled the pencil in her hand. During the moments of silence I strongly empathized with her but yet felt uneasy. It is difficult to explain the reason for my uneasiness but I believe it came from a position of hopelessness. I wish I had a way to help her achieve that dream seeing how much it meant to her. My uneasiness was also because I could relate to her story because I also carried a dream of pursuing higher education for years. However, while I seemed to be living my dream while she has not been able to pursue hers. I wondered if it was appropriate to share it with Martha because our stories were unfolding differently at that time. I knew that aspect of her life meant so much to her, I wondered how she feels working with young midwives who qualify with diploma and degree certificates considering how she could have been like them. The more I listened to her and saw how midwives related with her, the more I could not ignore her level of confidence and the respect she commanded. I perceived that her experience made a great difference to the other midwives.

I broke the silence and asked Martha how she felt about working with younger midwives who had higher qualifications than her. Her response was simple but very insightful. She responded by saying, "*as for this place I have three midwives with degrees. They have not shown any negative attitude towards me. In fact all of them came here with diploma, I taught them the practical aspect on the job when they came. One came from somewhere she couldn't handle any case. I taught them; then later they went to do the degree and I am still teaching them so they do*

not have the tendency to feel proud because they know there is so much they have to learn. There is one person who is supposed to be a senior to the others but she cannot handle a simple delivery case; I can't confidently leave the ward for her. Her juniors can provide better care. This is also because when she comes to work she comes with several excuses so she can avoid work just because she lacks experience so she will rather avoid doing anything to expose her deficiency. Her juniors have become better than her because they are always ready to learn. Even some of the community health midwives can take charge of the labour ward and do a good job but this midwife with her diploma cannot do so."

Martha's response underscores the importance of experience in midwifery. Midwifery is largely a practice discipline therefore possessing practical skills in midwifery carries weight, however practical skills are not always recognised as such. Martha's response also confirmed an observation I made during my meetings with her. I observed from each of our conversations that the midwives on duty would on some occasions come and knock on the door to seek her opinion about something or call her to assist them in one thing or the other. Though the midwives had a friendly relationship with her, their interactions with her were more of a mentor- mentee relationship characterized by mutual respect and professionalism. Although the age difference between Martha and the other midwives could account for the respect, I am inclined to think that their attitude towards her was based on the respect they had for her rich experience. To repeat Martha's words "*....I am still teaching them so they do not have the tendency to feel proud because they know there is so much they have to learn."*

In our third conversation we talked again about the importance of experience and how the younger generation of midwives appear to be more concerned about receiving academic credentials than in developing skills and gaining experience.

Introduction to Midwifery Practice

Following Martha's graduation from midwifery school she was posted to a health center in the Wassa West District of the Western Region where she had to work alone for 6 years. Narrating her 6-year experience in the village Martha told me that one day she was informed by the district director that a clinic that was closed down some years back needed to be revived and charged her to go and revive it and work there for 2 years. Reviving the clinic was not as simple as Martha thought. She anticipated a community that would be spontaneously happy to have health care brought to their doorstep. Upon her arrival at the village she met a completely different situation. Apparently the first nurse who was sent there, a male nurse, got involved in chieftaincy issues and as a result was chased out of town. The community became reluctant about receiving another nurse for some time. When they finally agreed to open the health center, they requested a female nurse who could attend to pregnant women and conduct deliveries. A response to their request was what brought Martha to the village. Martha had to relocate to the village leaving her husband and children in the regional capital. Her husband who was previously a worker at one of the mines in the region had lost his job due to a re-structuring exercise.

According to Martha, adjusting to the conditions of village life was one of her greatest challenges initially. Having lived all her life in towns and cities, she found the village life difficult to adjust to for a number of reasons. The village was far from town with a poor road network to the city, there was no electricity supply and no potable drinking water, no shops, supermarkets or place of entertainment comparable to that of the city. Being alone with her family several kilometers away, she could only hope that her work at the clinic would keep her busy and occupied till the end of her 2-year posting. It was only a matter of time for her to realize that the two years would become six years. The fear of being left or forgotten often deters

most nurses/ midwives from accepting postings to rural areas as it happened to Martha. The other challenge Martha faced was that the community members were not willing to attend the clinic. The clinic was built to serve that particular community and several surrounding villages but the women would rather go to the "*Nackabah priest" or to the TBA than come to the Health Centre. At the Nackabah worship compounds, the Nackabah priests who are not midwives work as TBAs, attending to pregnant women and conducting deliveries amidst prayers and rituals. Martha recalls that for one month nobody had reported at the clinic, she had no client. She thought to herself that rather than sitting at the clinic and waiting for clients to come, she would reach out to the community, educate them and where possible attend to their health needs at home and invite them to the clinic for follow up. Martha said " *…… I went with the watchman I had employed, I started visiting the communities with him because he was one of them. I did community sensitization. It wasn't easy, hmm! I had to go into the community to talk with them over and over to convince them to attend the clinic. It was when they started coming to the clinic that the clinic came alive."*

To gain the trust of the community Martha had to do domiciliary midwifery although professional midwifery services in Ghana are predominantly facility based. She noted "*Some still wanted home delivery so I did domiciliary midwifery. Even some will deliver at home before they call me but when they call, I go to attend to them. I went wherever I was called to render service. Sometimes the person may need infusion but will still refuse to come to the clinic so I had to go to the home to set up an intravenous line and monitor the person at home and move to the clinic to see my clients there too. I would put together my monthly report and send to the district director for him to know what was going on."*

Martha told me how sometimes she was called to go to the Nackabah compound to attend to women in labour when there were difficulties. Martha recounts, "*so when I am called to attend to the women at the worship place, I would take the opportunity to teach them (the priests) the right things to be done and get them to refer cases to me and where possible I move the women to the clinic to correct anything that was not done well. Sometimes if it is beyond me I will refer the client to Tarkwa government hospital (the district hospital that served as a referral center for Martha's clinic) and ask the priest to go with me. Usually they don't want to refer cases or go because they are afraid the midwives will reprimand them. But I will go with them and make sure the right thing is done*." Martha worked hard in that community, serving all the neighbouring villages. For six years she displayed dedication, commitment, and hard work. The community did not want her to leave after her original two-year posting period was up. She was awarded the best community midwife in the Western Region while she worked there. The citation in her honour and the pictures she showed me during one of our conversations said it all. I could not agree more to the words on the citation. What I have come to know about Martha through my personal observation during our interactions and periods of living alongside her mirrors the attributes of commitment, dedication, passion and humility. I have always wondered since I came to know her how such attributes can be inculcated into up and coming midwives. I returned home after each interaction with Martha full of respect and admiration not only for her, but also for the profession we had chosen. How can many more midwives be a source of inspiration and hope for the women? How could they reflect that midwifery means "being with woman"?

Building Bridges for Care

Martha had endeared the hearts of the people she served in that community by her hard work and readiness to collaborate with the TBAs and Nackabah priests. The community

members so much wanted her to stay, making all her attempts to leave there after six years a struggle "*Even when I was leaving there for another transfer, it wasn't easy. The community did not want me to leave; I had to run away (we both laughed). I struggled before I was able to leave."*

One characteristic that Martha had that according to her, facilitated her work in the villages, was her ability to socialize and collaborate with members of the community. She stressed the importance of humility and relationship building in midwifery. To her, it is key to a successful midwifery practice aside from having the practical knowledge and skills. "*I needed the community to collaborate with me so I had to think of how best to do that. Personally I am a very sociable person. I easily get along with people. And I am always ready to help anybody who comes to me for help. And the work too I was very interested in doing it well. I also needed to get clients to attend the clinic. I could be there for over one month with no deliveries. I wanted that to change so I had to do that to win them.*" Martha concluded with a sense of accomplishment showing on her face as she nodded in agreement to her own statement. From my personal experience as a midwife and an educator I cannot confirm that the importance of relationship building has been emphasized in the training of student midwives. However it has been emphasized in most training workshops for midwives in practice. I began to wonder how this can be incorporated into the curriculum and training of midwifery students. I also began to reflect on how important this is to me as I work with midwives and students. I also thought of ways by which relationship building can be enhanced.

Martha's passion, commitment and readiness to know her clients and serve them were almost palpable as she spoke. I was beginning to appreciate midwifery and midwives differently. I appreciated even more deeply the difference the presence of a competent and passionate

midwife would make during a childbirth experience. I wondered how such attitudes could be modelled for others to learn. I only worked as a midwife in a rural setting for one-month district practice during my training in a rural community in the Ashante Region of Ghana. One midwife and the security man she had employed staffed the clinic. There was no electricity supply to that community at that time; we had to use lanterns to conduct deliveries at night. The place of convenience was not what I was used to. Everything was actually different from what I was used to. But the midwife who had been working there for years seemed to be happy living her life and serving the community while I counted the days for the one month to be up. Now after several years I am looking back, wishing that my mentality had been different.

Working after school as a professional midwife, I was part of a team that went on monthly outreach to some rural communities in the Brong-Ahafo Region in Ghana many years ago in the early 1990s. As sightseeing was one of my hobbies, I really enjoyed those trips. The travelling into the rural districts, seeing the greens and the different settlements and getting to know other parts of the country was fun. I also enjoyed the work in those communities. Women would walk for several kilometers to attend the vibrant outreach antenatal and postnatal clinics we held. The communities always welcomed our outreach vans with enthusiasm. I sometimes had the opportunity to make the announcement from the van as we drove around announcing our presence. It was fun; it was also fulfilling to attend to so many women and children who otherwise would have no access to professional care. I always looked forward to those trips. I thought that was all that serving in a rural community was about. Now, looking back, I think I was happy working because I didn't have to live in those communities. At that time I felt that being sent to live and work in the villages was a punishment. I thought one would lose her skills and would not have much experience in such small facilities. Now my perception is shifting

after so many years. I now see it as an opportunity to serve the people who need healthcare the most, especially women and children. I now see it as an opportunity to gain a different kind of experience that cannot be taught through formal education. As my conversation with Martha kept unfolding the importance of context in midwifery practice became clearer. There is no doubt that working in the hospitals in the towns and cities also come with advantages and different sets of experiences. I now "envy" the rich experience that working in the villages and smaller communities provide.

Nuances of Acquiring Knowledge

Exploring ways by which Martha has developed knowledge for practice over the years, I invited her to share with me another story about her work and the composition of personal practical knowledge. In Martha's view the knowledge needed to practice midwifery cannot always be predetermined. She believes that midwifery personal practical knowledge can be traced to many sources such as one's own personal life experiences, experiences from practice and from interacting with other midwives and other health professionals. "*As for the knowledge it is not from one source. Midwives get knowledge through many ways. Different situations in life will teach you things. It is not only from school…… Errrm, sometimes the source may not even be related to midwifery at all. When you are smart you will learn from every situation,"* In Martha's opinion midwifery knowledge can be derived in many ways intentional, unintentional and in subtle ways. However, she also believes some knowledge is incommunicable. I believe she was describing tacit knowledge; a kind of knowledge that is difficult to transfer when she said, "*Sometimes you know you know something but you just don't know how or when you knew and it is difficult to teach someone."*

Martha started to explain to me that her keen interest to learn and to excel started from school. She narrated how after lectures she would go back and read more on the topics that were treated in class. She would come back the next day to teach some of her colleagues who had difficulty in understanding the concepts. The more she taught, the more deeply she understood the topics. She told me how she mastered some topics so well that eventually her friends gave her a nickname based on one of such topics. "*In school my mates gave me a nickname of 'fetal skull'. I learnt everything about the fetal skull so my mates used to call me by that name. I was also good with the partograph. As for midwifery school I put in all my effort. I even had credits in some of my papers and also in practical exams.*" Wow that is great! Congratulations! I responded. We both laughed as we shared the joy. Martha went on to tell me how her desire to always learn continued even after school. She recalls how while on rotation as a newly qualified midwife, she engaged other rotation nurses and midwives who had higher qualifications in discussions about some of the things they had learned in school. She would always back her assertions with references from the textbooks because she had learned the theory very well. Martha then perceived midwifery knowledge as being embodied in textbooks. At that time she thought the best way to acquire knowledge was to read and learn what is in books because that was evidence based. "*I didn't joke with my textbook. I actually learnt from my textbooks so I could open the page when there is controversy. I knew then that with that I couldn't go wrong."* Martha concluded.

After school Martha had some more practical exposure while working in a small town in the Eastern Region of Ghana. That facility was different from the places she had worked at in the past. She was sent there as part of her post training rotation practicum. The clinic served several rural communities. In the community she encountered one midwife who taught her most of the

skills that helped her to work independently at her first posting to the one-nurse station. Initially Martha thought the midwife was too overbearing because she pushed her so hard, and even made her to handle difficult cases. Narrating her experience with the midwife she said. "*You see, at that place midwives were scarce. I was there with that midwife alone and so she involved me in everything. I learnt a lot from her: suturing, episiotomy, vacuum extraction. I learnt a lot because I was always on duty. Initially I felt that she was being too hard on me, worrying me and restricting me unduly but at the end of the day I found it very, very necessary. I have come to realize that what she took me through was very good because after school I went to a one-nurse station"*. The impression I got from Martha was that her encounter with the midwife continues to be a landmark in her experience as a midwife. Martha noted that some form of apprenticeship or understudy is ultimately necessary for developing knowledge and skills for midwifery practice.

Martha's experience of understudying with a more experienced midwife is one of the ways by which she developed her knowledge and skills for midwifery practice. That exposure prepared her to be able to work well at her first post. Not only did Martha learn midwifery skills, she also indirectly developed knowledge on how to work in a one-nurse station, how to relate with clients and with community members. She developed knowledge in ethics, professional practice, interpersonal relationship and so much more. Her focus as she went on rotation was to improve her practical midwifery skills but she unknowingly acquired unintended knowledge and skills. Martha appraised the concept of mentorship and wished it could be effectively integrated into the training of midwives. "*I wish every newly qualified midwife will be assigned to a more experienced person to mentor her. It is very important... I do that to the new ones I work with but because it is not official some of them will put up certain attitudes that will discourage you."*

Martha went on to talk about how her interaction with TBAs was a source of knowledge that helped her in her practice too. She took advantage of their interactions to correct the TBAs on things that were not done well based on standards for practice. To effectively do this, Martha needed to understand them and gain their cooperation. She gained their trust by always teaching them new things and corrected their mistakes without condemning them. As she gained their trust the TBAs opened up to share with her some of their work, work that was often done secretly. "*Sometimes we midwives get some knowledge from the people we interact with. Like the TBAs, when we interact with them we learn from each other. They* (TBAs) *have the perception that when they come we* (midwives) *will shout at them but I didn't do that so all the TBAs in the communities that I worked trusted me. When they come they will tell me all that they have done then I continue from there.*" The TBAs told Martha about their own way of managing postpartum haemorrhage and how they take care of newborn babies to keep them warm. Despite the complications that were associated with some of the cases brought from the TBAs, there was one important thing Martha admired and emulated; that was how TBAs relate with, and support, a woman during labour. "*I admired the way they talk and support a woman in labour…*" Martha said.

The Motorola

Martha emphasized the importance of building relationship with colleague midwives and other members of the healthcare team when it comes to midwifery practice. According to Martha in one of the districts where she worked there was a Motorola that connected all the health facilities in the district in order to provide support for each other. That system helped her to learn

and acquire more skills. As soon as she arrived in that district she tried to connect with the other midwives who were already working in other facilities within the district. Martha, being young in the profession and new in the district, thought it wise to take advantage of the Motorola system to seek assistance whenever necessary. There were instances where she had to call for directions concerning what to do while in the midst of attending to a client. "*I went to my station six months after school so I needed support. I didn't have much experience so what I did was - there were some midwives in the district, so I took advantage of the Motorola to connect with them and it helped me a lot. I sometimes called the two midwives or a doctor for them to direct me. Even when I am in gloves I got the watchman to put the handset to my ear while I listen to instructions to do a maneuver and I just follow."* One such occasion was when she conducted her first delivery at her first station. The client had postpartum haemorrhage and Martha had to seek help. Incidentally Martha had always been interested in the management of PPH. She told me how during her midwifery training she mastered everything theoretical on the management of PPH and taught her colleagues who didn't understand. She said, "*I have always had interest in PPH and I got what I said."* We both laughed. I found it intriguing that someone who could not stand the sight of blood prior to midwifery training had developed a keen interest in the management of postpartum haemorrhage. Martha told me how the events of the day she had the case of PPH unfolded.

I listened with keenness as Martha went on to explain that she had not yet had a client come to deliver at the clinic. On that night it was raining heavily, "*Sometimes it can rain heavily so much that for about three days no car will move out of the town so one of such days I had a case."* At around midnight, the watchman called Martha that a woman had been brought in labour. She rushed to the clinic to find that the woman who was pregnant with twins had

laboured at home for a long time and delivered the first twin but retained the second one. Martha continues by telling me "i*t was an oblique lie. I wasn't sure what to do so I picked up the Motorola and made a call to get help and directions from one of the doctors as to what to do."* Martha followed the directions of the doctor and managed to turn the baby into a longitudinal lie and monitored the woman until the baby was born. She said the baby was big, weighed 5.8kg. "That is big for a twin", I said. Martha had to give the mother a generous episiotomy to enable the baby to come out. Unfortunately the baby was born stillbirth. Martha had already secured an intravenous line to rehydrate the woman as soon as she reported. The woman was dehydrated and weak. After the baby had been delivered, the woman started bleeding. "*The client had started bleeding. So I managed everything based on the direction I received.*" Martha went on narrating the incident as though it was just happening. I listened as we both took a journey into the past to revisit that day.

Martha said she remembered that during her rotation she encountered a similar case. She remembered that the midwife she was working with set up IV infusion and added oxytocin. Martha also remembered some of the experiences the TBAs had shared with her concerning using the root of a particular tree to stop bleeding. That particular plant is believed to have some oxytocic properties. Martha tried that. "*It was a practice among most of the women to chew a particular root believed to stop bleeding. Others also insert the leaves into the vagina. I have seen it being used by the TBAs and it works. But because I was particular about infection prevention I preferred to wash it and wrap it in sterile gauze before inserting. They (women and TBAs) also liked it when you implement some of their methods."* It was obvious from our conversation that Martha relied on a variety of sources to deepen her knowledge for midwifery practice. Through all these combined efforts the woman's condition gradually improved, the

uterus became firm, the bleeding gradually ceased. Martha sutured the episiotomy. She completed her account by saying "*it wasn't easy for me that day but I was very happy I managed to save her life. You know PPH is a serious complication and a leading cause of death…."*

Martha also spoke about how sometimes she had to refer to her midwifery textbooks and procedure manuals when she was uncertain about what to do. "*Sometimes too I could leave the client for some few minutes to pick my book and glance through for the management of the condition.*" She goes on to explain how important it is for midwives to have a life-long learning attitude. She added with regret that some students and newly qualified midwives do not have interest in learning. "*The thing is you have to learn so you can work well. You just have to be prepared to learn and become better. There are some people, the way they talk to even their parents is bad and their behaviour is the same towards their clients too. Hmm. Once you have decided to be a midwife if you want to learn or acquire knowledge, you need to be committed to the work. It starts with commitment. The education is all right. I don't have any problem with the training of midwifes. When I was in school I will always come and take my textbooks, my dictionary and read after I have been taught. Teachers cannot teach everything. I always had a notebook to write new things in. I always carried my jotter and dictionary with me. I was keen about learning and after so many years I am still keen. Sometimes people teach me things and I turn to understand it and do it better than them. It comes from the interest and commitment*".

Attending workshops and using protocols: another source of knowledge

During one of our conversations Martha talked about workshops and protocols. According to her, the various workshops she attended helped her to connect with different people and to develop knowledge and skill, especially lifesaving skills. She noted that it is not every midwife who gets to attend the workshops and shared some of her experience. She explained that

"*In 2007 a new district hospital was being built and the ministry also decided to train more midwives to work at the neonatal and intensive care unit (NICU) so there was this new programme on integrated management of childhood illnesses (IMCI). They selected different midwives based on their work records, relationship with clients and their babies and other things. My community was also selected so I had the opportunity to be part of those who went to be trained. They made us sign a bond to work with the hospital for some number of years. I didn't have to sign the bond because I was coming from the community."* Martha went on to emphasize that a midwife needs a wide range of knowledge to work well in a community. Attending training workshops is a major way to achieve this. Martha continued by saying, "*The work of the midwife is very broad but it also depends on where you work. If you are working at a one-man station you take care of general cases just like a general nurse. You do suturing, take care of all general cases then we care for pregnant women, gynaecological cases we counsel them and refer to gynaecologist or obstetrician. When a woman is pregnant the midwife cares for the woman until she gives birth. You will be with the woman during labour and care for her and the baby for six months after delivery. You provide family planning services. A lot goes into midwifery".*

Martha continued to show me more certificates as she explained how each one has facilitated her work. Some of the workshops were organized to train people who will train others in various areas of practice. She showed me her trainer of trainers' certificate. She expressed her worry about midwives who are not keen on attending workshops "*It is unfortunate when some people turn down the opportunity to attend workshops saying they are busy with work. Such a person will be missing a lot. As for what you learn in school it is not enough at all especially the practical aspect of the work. The workshops give you a deeper understanding and also it affords*

you the opportunity to practice. Sometime new things come up. There are new models and dummies that were not available at the time when some of us were in school. The workshops help us to get to know the new innovations. It is a major opportunity for midwives to continue to learn. For example during the workshops you get to use dummies to practice what you are being taught and then you are given the opportunity to actually practice on a human being. In school we do more with dummies. For example you can learn how to do counselling and testing for HIV in class but when the client is sitting right in front of you it is different. The way the workshops are organized really helps with skill acquisition." Martha concluded by saying, "*the workshops have helped me a lot. These trainings I would say is what has given me the opportunity to be the block in-charge at the maternity unit. I have learnt so much. To be the maternity block in-charge you need to have wide knowledge because everybody working under you will look up to you to teach them and help take decisions. I teach my midwives at the hospital and also the attendants at the maternity home. I even teach the doctors. Without this I don't think I could have managed this place and do all that I do."*

The use of protocols, that is, the step-by-step instructions on actions to take to manage certain emergency conditions, was also a good learning resource for Martha especially for procedures that she was not be very familiar with. Additionally Martha was always ready to learn from her clients because she believed that each opportunity with a woman in labour is an opportunity to learn something new. According to Martha, "T*here are also various protocols that have been generated. When I am not sure what to do I refer to the protocol and manage my client. The protocol spells out what you have to do but you need to know how to do what the protocol is prescribing. That is the most important part. You improve the "how" by practice, which is how you gain the confidence and experience.*"

Martha went on to tell me that having the protocols is not enough to make a midwife competent. She is of the view that the protocols serve as a guide but the knowledge needed for practice goes beyond having protocols. "*As for the workshops and protocols they are a rich source of knowledge for practice. Not all of us may know what to do at a particular time so when it is written down it will really help. The protocols are good and really helpful but it is not enough to get the work done. You have to learn how to do it. Your knowledge must be comprehensive. It is a combination of a whole lot: experience, practice, intuition and others. You will have to apply all that you have learnt comprehensively.*" If you work alone at a place where you have to take decisions about management of labour complications, nobody will have to tell you about the importance of the workshops and protocols. As for me it has helped me a lot"

Developing Personal Practical Knowledge through Experience

As we continued our conversation, I asked Martha to share with me how her personal experiences have shaped her as a person and the qualities she possesses. "*I believe various things have had impact."* Martha stated, "*I am a Christian, I am the church nurse on the committee for health…."* Martha explained that the role she plays in her church, home and community influences the way she carries herself as a midwife. According to her, a lot of people look up to her: her children, community members, church family and many others. Her clients form part of these groups of people. She noted that her upbringing was such that she was committed to everything she had to do and did it well to get good results. She recalls that the hardship at home because her mother was a single parent made her and her siblings develop an attitude of hard work and commitment. She saw that nature in her mother who worked so hard to educate all of them.

Because Martha's husband lost his job in 2000, she has become the breadwinner for the family since then. It is her work as a midwife that has sustained the family all this while and so she is committed to doing it with passion. "*As for this work I do it with passion."* Martha said, "*This is because along the line in the year 2000, my husband lost his job. Since then he has not found a job so it is the midwifery that has helped me. So wherever I find myself, I work as if nursing and midwifery is my everything. I put all my efforts in my work and I am proud to be a midwife for life.*" She continued to tell me how her children have been influenced by her career. Out of her four children, her third and forth daughters are pursuing nursing and midwifery respectively. She said her children see the work she does in the community to help people and they are inspired. Because of that she becomes encouraged to do more to help her clients. Martha, who had become quite emotional at this point, and expressed herself by saying, "*My children have seen people come to my house, I counsel them, some come with their pregnant teenage daughters, I take time to counsel them. Parents, pregnant women, students, a lot of people come to me I counsel them, those who need treatment I give if I can or refer them. So my children when they see all that I do they have become interested in the profession and I am encouraged."*

The relationship Martha enjoys as she works with pregnant women through childbirth has been phenomenal. Martha said she has enjoyed so many favours from many people she had attended to. Sometimes she meets people she cannot remember but they remember her and will thank her for being there for them during labour. Some will intentionally come and look for her with their babies and inform her that the baby has been named after her. Others will recommend her to other woman who will come looking for her especially now that she works in a hospital and at the maternity home. They want to deliver at her facility because of her. In her narration

Martha said "*Some women will come to my hospital and say that 'your name was given to me by someone. I want a safe place to deliver and I was asked to come and see you. I am told you have time for your clients."* Martha continued by saying, "*When you attend to women you become part of their lives. They take you, they take your name with them wherever they go. Whether you do good or bad".* Being mindful of this, Martha tries her best to relate well with her clients. I agree with Martha, I am reminded of my own story of childbirth experience. I also carry with me the unfortunate behavior of the midwife who attended to me during my first experience with childbirth. It is an unpleasant experience I will never forget. I wrote about it in my narrative beginnings. That experience will be part of my story for life.

Another thing that shaped Martha's experience and practice as a midwife is her involvement in training other midwives as a preceptor. She shared with me how that role has also influenced her conduct. Whenever student midwives are sent to her facility for their practical experience, she will take her time to teach students and mentor them irrespective of their attitudes. Martha is passionate about her teaching. She said, "*The students also go with my name and tell others. Because when they come I take time to teach them. Some of them are naughty; it is common with this generation but how we, the experienced ones, handle them is also important."*

Martha said, "*The way you will talk to them is important. It will also encourage them to learn. So the students and clients always go away with my name and tell others. I have to do the right thing for them to learn if I am assisting a woman in labour, the students will learn how I communicate with the woman and do the same*." In order to model the right midwifery attitude for the next generation of midwives, Martha is conscious how she practices her midwifery. She is mindful how she relates with her clients and their family. She is also eager to update her

professional knowledge so that she can impart the right skills to the students. She is at all times conscious of doing the right things and considers what is best for her clients because she wants to model a good attitude.

Martha during our first conversation and subsequently, described midwifery as a profession that required selflessness. Being someone who is selfless, always putting others first, has been one of her strengths throughout her career. She wanted to get a degree and teach but now she has given up on that dream. I pointed out to her how I think her dream of teaching midwifery is still being realized although not in the classroom. Martha teaches students and newly qualified midwives at the clinical setting and is one of the examiners for student's clinical examinations in the region. Pointing out to her how she is contributing to midwifery education through clinical teaching was encouraging to her because she had not thought of it that way. "*You see I have not thought of it that way. As for the students I teach them and examine them. Some of my classmates are teachers. Whenever they see me they say to me I should have been a midwifery tutor.*" Although Martha did not get to see her dream materialized, she feels rewarded.

The Recognition and Reward

A few years ago Martha received another award as the overall best midwife in the Western Region. The inscription on the plaque, which read "National Association of Registered Midwives Best Midwife Award 2012, Western Region. In recognition for your outstanding contribution to midwifery in Ghana" indicated clearly that her hard work in the region and the nation in general had been recognised. When I read the citation for the award out loud during our conversation it evoked strong emotions. The citation provided a profile of her life and a paragraph of the qualities she had demonstrated. The key words used included words such as dedication, commitment, leadership, and hard work among others. I could see tears in her eyes. I

had a sense of relief from the lingering uneasiness I had felt during our previous conversation. My uneasiness started in a subtle way from our first conversation when Martha first spoke about her unfulfilled dream of going back to school. In our two subsequent conversations she revisited that subject always in an emotional way. As our conversations unfolded I appreciated Martha's passion for midwifery, her intelligence and commitment to teach other practicing midwives as well as young doctors she came into contact with. I knew that further education opportunity would have brought her fulfillment. The fact that she was not living the dream she had so much wished to live was the source of my uneasiness. During our fourth conversation when Martha brought the citation, plaque and pictures of her award ceremonies, I felt that it was a form of compensation for her hard work although it does not make up for her unfulfilled dreams. Martha told me that the awards were unexpected especially the second one. She never imagined that she would receive another regional award. Prior to that she had been awarded the best community midwife based on her work within the first community. As she narrated the events of the award ceremonies and showed me pictures, she started tearing up. It was very emotional for both of us. She said, "*The chief nursing officer called my DDNS to tell her that my hospital won the slot for best midwife for the Western Region so I was invited and was congratulated. I was told that the team went back to trace my work in the various communities that I have worked. I was told that in most of the places the community members even said they wanted me back. Then they came to my hospital too. All my life as a nurse\midwife I have worked in the Wassa West District in the Western Region. After midwifery in the Eastern Region I come to work in that district and in total I have worked for 25 years in that district. The community and the district health teams gave good recommendations. Even the chiefs were contacted. I was told the award ceremony was going to be held in Accra so I had to go there. In fact I didn't know what to do. I was*

overwhelmed. If you look at the pictures from the first award, you can see that I was smiling and laughing throughout. I didn't know what to do. I was over joyed. (We both laughed). *I was not expecting it,*" Martha continued, "*I didn't work with an award in mind. I was just serving and doing my best.*" This statement shows how selflessly she had worked and continues to work. She worked not for the reward but to serve a cause. In my opinion her work is significant in the training of the next generation of midwives. That part of her story was very touching to me and it made me want to tell her story to others.

It brought joy and a sense of accomplishment to Martha but again it placed a demand on her to do more. "*It really motivated me so much to do my best. I wanted to do more. Even later at a regional meeting my former district director singled me out and praised me.*" I had goose bumps and I felt a deep sense of happiness for her. I know she deserved it. For a moment I counted myself privileged to have the opportunity to hear the story of this great midwife. I thought, perhaps it is a way to understand experience, but also a way to inspire others to be passionate about what they do. Martha continues to enjoy recognition in the region because of her experience. She has earned the respect of the regional management committee and is invited to strategic meetings despite her level of education "*The other time my matron asked someone else to go in my place for a strategic planning meeting but they sent for me. My matron was called and asked that I come for the conference; she was told that she shouldn't think that because I am an enrolled nurse midwife I can't be there and that someone with higher educational qualification should go. They said they needed people with experience to help make decisions about how to reduce mortality so they sent for me.*" These experiences are valuable to Martha and I felt privileged to hear her recount them.

The Strange Encounter

To further understand how Martha developed personal practical knowledge for midwifery through experience, I invited her to share with me some of her rural as well as urban experiences. I was interested in her work in the urban setting, as well as in the villages, because the facilities provided different opportunities for practice. The setup in most rural health centers usually required just one midwife who will manage the facility and take care of all cases. The one-nurse station requires that the midwife be able to attend to all cases and refer promptly where necessary. Martha had earlier indicated that it was from these stations that she built her confidence and experience. The foundation of her midwifery experience was laid during her six month rotation period right after school when she worked with a midwife in a village setting. Martha emphasized the importance of gathering experience from different settings. According to her, finding the balance to know what knowledge (knowledge for midwives or midwife's knowledge) to draw on is the most important thing to do. Sometimes intuitions may be strongly depended upon. At other times actions may be evidence based or ethical knowledge where you do what is right based on the client's unique circumstances. Martha explained that there are times when the midwife does not know what to do, "*when you don't know what to do, that is when your experience becomes your only tool".* Experience is key to personal practical knowledge development, job satisfaction and excellent care delivery, but it depends on the individual midwife's interest to learn. Working in the rural area provides the opportunity for very rich experience. There are some cases that remain as book knowledge to the midwife until she encounters similar cases in her practice. Martha noted, "*there are some cases you read about it or learn it in school but the understanding is different when you have attended to one.*" Some of these cases are difficult to explain but must be handled by the midwife. Martha shared an experience of such a case.

"*Midwives face a lot of challenges, some of them are strange and unimaginable especially in the villages because the cultural and religious beliefs are really dominant there. Sometimes there are some cases that are really difficult to explain*" Martha made this comment as a preamble to an experience she was about to tell. I quickly wondered what strange challenges she had experienced and I wanted to hear the profound encounter that challenged her as a midwife. Martha was quick to recount an incident that occurred at one of her one-nurse stations in a village in the Western Region. Martha told me about a young woman who was brought to the clinic in the second stage of labour. Apparently the young woman had been labouring for hours at home and was fully dilated; yet the baby could not be born. The woman was admitted into the second stage room and Martha quickly positioned herself to get the baby out. Martha noted that strangely all attempts to deliver the baby did not yield the expected results. Physiologically everything was normal to get the baby out. The contractions were strong and expulsive, and the woman had strength to push, since the baby was big an episiotomy was given but still the baby would not come out.

According to Martha she started getting anxious, as she could not explain what was happening and did not know what else she had to do. She noticed that the lady seemed to be in some form of trance and appeared to be communicating with someone and asking whomever she was communicating with to allow the baby to come out. Fear started to grip Martha; she felt a strange presence in the room at that point she started to call on God. She asked the woman to tell her who she was communicating with but she would not answer. Martha went outside to talk to the woman's husband who was anxiously waiting at the door just to find out if she had displayed any such behaviour at home. The answer she received from the husband sent fear down Martha's spine. According to Martha, "*her husband told me that the woman was the daughter of a goddess*

and that he had not performed the necessary marriage rites before she became pregnant, hence the difficult labour." That revelation illuminated the strange situation that was taking place in the labour ward. Martha realized that all her midwifery knowledge could not help her get the baby out. Martha's description was so vivid, that I could relate to the emotions Martha was trying to describe. It literally felt like I was in that labour room with Martha.

Both Martha and I had goose bumps as she told the story. "*My sister! It takes courage!*" Martha said emphatically and continued her story "*I started to pray. I told her that please tell whoever you are communicating with that I don't come from this town. So if you do anything bad against me I will not be the one to suffer because when I go no midwife will be willing to come to this town so let the baby come. My watchman was outside calling me that 'madam there is a very heavy presence here'. So I intensified my prayers. I called on God not to let anything bad happen. I just kept calling, kept calling on God and the baby suddenly came out. I tried to resuscitate the baby but we lost the baby. Then the mother started to bleed. She bled and bled. I set up IV infusion. I tried to stop the bleeding but she was just pouring. I kept praying while doing all I could. Then finally, her condition stabilized*". Martha concluded by telling me how the chief priest of the village came to the clinic the next day to tell her that the woman did not die because she, Martha, had a pure heart and so they (spiritual forces) did not have a problem with her and did not want her to get a problem of maternal mortality. In as much as some of these strange accounts are subjective, it cannot be discounted based on lack of scientific explanation. I have heard of unique but similar accounts. I too have had moments in my career that I needed more than scientific knowledge to take care of my clients. The role of religion and spirituality will be further explored as I write my final research text.

Workplace dynamics

Unlike the other midwives in the study, Martha, continues to work in both the government sector and a private maternity home. During one of our conversations, Martha explained how the workplace affects the experiences of midwives by narrating how she came to work at the private maternity home. She began to examine the influence of workplace dynamics on the work of a midwife from her personal experience. I do believe that the place of work determines the type of knowledge one may require for practice. Talking about her work experience was significant for me as I continue to explore the professional knowledge landscape of midwives The workplace dynamics as I understand include policies, staff training and development, management and leadership issues, team-related functions as well as workplace culture, just to mention a few. These elements of the work environment influence how effectively and efficiently a midwife operates. They also shape the kind of experience that the midwife will have over time. Because Martha had worked in different health facilities, including health centers, district and regional hospitals and a private maternity home, she carries with her different perspectives of how workplace dynamics shapes experience. We started by reflecting on how a midwife chooses where to work. From our conversations Martha noted that as far as the government sector is concerned midwives had little or no say regarding where they are posted to work. As in Martha's case she was usually posted to a facility after little or no consultation. Her work at the maternity home was by choice.

Getting into private practice

I listened as Martha began to reveal how a retired midwife who wanted to set up a maternity home consulted her and needed her expertise. Martha explained that the owner of the maternity home, though a midwife, had spent all her work life in a big hospital in the city. The opportunity to take major decisions regarding care and management of a facility was limited for

midwives who work solely in big hospitals. Martha had the benefit of working in a couple of one-nurse stations where she made decisions on the day-to-day running of the clinic. At her first station she had the responsibility to employ a watchman from the community and negotiate with the community leader to remunerate the watchman. She learnt on her own how to budget, plan and resource the clinic. She developed negotiation skills to get the opinion leaders and other stakeholders to support her efforts to increase patronage of the clinic. Martha made almost all the major management decisions with the approval of her district director.

Additionally the retired midwife had worked mainly in the antenatal unit for several years and therefore acknowledged her weakness in labour management. The departmentalization of the scope of midwifery practice despite its advantages limits the all-round potential of the midwife. Currently Martha is working in a bigger hospital and is the nurse manager of the maternity unit. She spends her time at the labour ward actively attending to women in labour and teaching her junior colleagues. By virtue of her experience she can confidently work in any of the sections in the unit. Many midwives who have worked in some of the district and regional hospitals only cannot boast of this advantage. Perhaps the placement of midwives who work in such hospitals must be strategically done to help them maintain a broader scope of practice. The nature of such big hospitals, as Martha further explained, does not adequately equip the midwife to operate autonomously in all areas of midwifery practice.

Continuing her story about her part-time work Martha told me how she was introduced to the owner of the maternity home to help set up the clinic. Martha accepted to help with the set up but did not intend to work there afterwards. After setting up the home it became difficult to get a professional midwife to run the place. Additionally being a new set up it was difficult to get clients. Martha's association with the clinic was strategic because by reason of her experience

she could get clients to patronize the home. She agreed to help for a few years by working there as the only professional midwife and build staff capacity.

Despite the increase in the number of staff at the maternity home now, Martha remains the only professional there and is concerned about the constraints in providing professional care to women. One phenomenon Martha noted was the difficulty in recruiting professional midwives to work at private maternity homes. The difficulty in hiring professional midwives on full-time bases is not about shortage or unavailability of midwives but rather the ability to properly remunerate them. It is generally known that most professional midwives who work full-time in private maternity homes are retired from active service and are above 60 years. The younger ones work on a part-time basis. According to Martha most maternity homes end up hiring untrained people and train them on the job. The activities of the birth attendants who are trained on the job to practice midwifery sometimes undermine the ethics of the profession. Martha's primary reason for holding on to the work at the maternity home is to ensure that the right things are done. "*The attendants there lack skills and knowledge in a lot of things. Everyone working there is considered a midwife and even dresses as such but they are not. It is time that the private homes employ professionals. There are some skills that are difficult to get if you are not a professional."* Martha cited the use of the partograph; a managerial tool for the management of labour as one skill that is lacking at places where the attendants are not professional midwives. She said, *"For example the use of the partograph. It is the midwife who understands and can use it. Most of the maternity homes do not use it. At my private maternity home for example I have started using the partograph. It is high time that every maternity home gets a midwife who will run 24 hours. The ethics of the profession needs to be guarded."*

Martha further emphasized the importance of providing quality care for women during labour irrespective of where the woman choses to deliver. She noted that the proper management of a woman in labour is what makes the entire childbirth experience special. Martha believes that to achieve that, the midwife must be concerned about building a cordial relationship with her clients and the childbearing family. Martha noted that relationship building is a priority in the private maternity home. Women who attend antenatal clinic and eventually deliver at the same maternity home tend to enjoy better psychological support. I asked Martha to explain how relationship building is affected by place of work from her experience. Her response was, "*most workers including midwives are compelled to be nice at the private clinic if not they will not be paid. It is the client attendance that determines the income you generate. Interestingly it is the same people who work in the government sector who work at the private. The key thing is to respect your client. The private clinics charge directly for the services so if you are not nice you will lose your clients. As for my attitude towards my clients it is the same everywhere I work. Even my clients testify. Some people get carried away with pride. I think it is high time we as nurses and midwives change our attitude. We midwives work hard both in private practice and government. We work better than TBAs because of our knowledge and skills but our attitude especially in the government facilities sometimes negate all the good things we do."* Martha's story depicts consistency in character. A good midwifery character is one that is consistently positive irrespective of where you attend to birth. Time, place and other factors may influence a midwife's actions but ultimately it should not take away the core essence of caring for a woman in labour in ways that brings satisfaction not only to the woman but to the midwife as well.

As we continued to explore the significance of the concept of relationship based on Martha's experiences she expressed the need to consider not only the relationship between the

midwife and the client. According to Martha, the relationship between a midwife and her colleague midwife and other members of the health team also influences care outcomes of clients "*So sometimes the negative attitude is not only to our clients but also to other midwives.*"

Another element of the workplace is about staff development. In Martha's opinion midwives who work in the districts and rural facilities usually have opportunity to attend workshops and training programmes, but many are not able to take advantage of all the opportunities, because sometimes attending a workshop means closing down the facility and making arrangements for a replacement which is usually not easy. Despite this Martha's rural experience also provided her with the opportunity to attend several training workshops. She also indicated that she had the opportunity to implement most of the policies and protocols that she was trained for because there were no bureaucratic procedures to follow to make a change when she was alone. During our last tape-recorded conversations Martha brought out a big brown envelope and showed me several certificates and pictures of the various workshops she had attended. She told me how her passion for teaching drives her to impart the knowledge she has gained from these workshops to others. Martha believes that the knowledge and experience she has gained over the years should be fully utilized at any given opportunity. Based on this belief she is always open to help and share her experience wherever it is needed. It is that readiness to help that drove her to work at the maternity home.

The best arrangement

Looking back on some of her experiences in the one-nurse stations, Martha has come to the conclusion that working there has been her greatest experience as a midwife. It has greatly shaped who she is and who she is becoming as a midwife. Through that she has learnt how to support women as individuals in labour, she has developed interpersonal skills to relate to

clients, their families and community. She has come to appreciate the importance of collaborating with other healthcare providers including midwives to provide care for women in labour. Martha has also developed skills through training and personal experiences and she has received awards and recognition and she continues to teach others as she models best practices in caring for women in labour. She however would recommend a blend of opportunities in relation to place and length of stay in a one-nurse station and in a bigger facility.

"*Working in the one-nurse station has been my greatest foundation. When you are sent to a place where you are alone you get to learn. You also get the opportunity to attend for workshops. The rural life is not easy I must say. The best arrangement is to send the midwife there for a short term and bring the person back to the city. If you know that you will be brought back after 2 years you will be willing to go and do your best for the 2 years and gain the experience. But if the 2 years turns to 6 years it can discourage others. When you stay at the village one-nurse station for a long time there are also some things you will miss. You may not be able to use some of the modern equipment because you will not have the opportunity to see or use them. When you come back to the district or region you have so much to pick up again. There must be a balance where you are sent to the rural certain for a while and you come back after sometime."* During our last tape-recorded conversation I asked Martha for her concluding statement and she said, "*I am proud to be a midwife for life,*" I agree with Martha. After listening to her story I can also say I am proud to be a midwife for life and I am happy to hear and reflect upon her experiences.

Narrative Account 4

Adjoa's Story

Meeting Adjoa

I got to know Adjoa through Happy my first participant. I made a call to Happy sometime in December 2016 just to find out how she was doing. Writing her narrative

account had been slower than I expected because our subsequent conversations after the first one had taken some time. I needed to stay in relation with her so we could share her interim narrative account. She was excited about my phone call and also wanted to know how my study was progressing. I told her of my intention of inviting one more midwife to the study but would have to consider going further away into the region. Happy informed me that a midwife she worked with many years ago had moved closer to the regional capital. She had been informed that the midwife had started a private maternity home in a particular community. She indicated that it had been a long time since she heard from her but I could go to that community to find out where the maternity home was located. Happy was very hopeful that the midwife would be willing to share her experiences with me. That is how my search for Adjoa began. I took note of the information and decided to look for the maternity home sometime in January 2016 as I finished up my conversations with Martha the third participant.

Though I did not forget about going to look for Adjoa, I also did not occupy my thoughts with how to engage her at that time. One Tuesday evening early January, I had a call from Happy, she sounded excited on the phone. She said she unexpectedly ran into Adjoa in town that day. She told her about my study and took her telephone number for me. I was excited too and expressed my gratitude to her and took down Adjoa's telephone number. The decision to call her over the weekend was characterized by my usual apprehension about when would be the most appropriate time to call. I eventually sent her a text message introducing myself and requesting an appointment to meet her or call her. The response to my message was a call from Adjoa. She told me she would be happy to be part of the study and told me where and when we could meet to talk more about what it involved.

Following up on our planned meeting, I set off to meet Adjoa at her maternity home. We had agreed to meet at 10 am Wednesday 18th January 1017. The purpose of my visit was to explain to Adjoa what the study was about and to invite her to be a participant. She had already expressed her interest to share her stories but I needed her to understand the commitments that characterized the study. I needed her to know that it wasn't going to be a one meeting commitment.

My concern as I took a short journey to Adjoa was whether she would be willing to be engaged over a long period. I had become mindful of the busy schedule most midwives run and was careful not to interrupt her life in anyway. I needed to negotiate her participation in the study despite her interest. Surprisingly the issue of being guarded about her relationship with me for fear of my intrusion did not bother me at that time. I had in some way overcome that fear. I also think that because Adjoa had already expressed her interest in the study, my anxiety had reduced. The questions I had centered on what her experiences would be and how it will be storied.

My meeting with Adjoa was very successful. Immediately as I drove into her compound she came out to welcome me with warmth and affection into her office. The clinic was not a big one. It had four rooms; a consulting room which was Adjoa's office, a delivery room, a treatment room and a female ward for labour and post-natal cases. There was a long corridor in front of the rooms where a few benches had been arranged for clients waiting to be seen. The clinic was new and Adjoa had intentions of expanding the facility. Our conversation was short but fruitful because Adjoa confirmed her interest in sharing her stories and assured me that she was willing to make time for me whenever necessary. We both agreed to hold our first tape-recorded conversation in February. In between our first meeting and first tape-recorded conversations we had several short telephone conversations. The most encouraging part of our relationship was

that Adjoa created that space for us to stay connected by being the first, on most days, to either call me or send a message to find out how I was doing. Her calls made me feel very welcomed to also call her without any inhibition. Our research relationship grew steadily over a few weeks as we waited to have our conversations.

Beginning our Conversations

It was in February 2017, Adjoa and I had agreed to hold our first tape-recorded conversation on a Tuesday morning at 10am. She had told me she had her sick mother to take care of in the mornings before she left for work. Adjoa started her maternity home a little over one year ago and the clinic attendance was quite low. She had told me that she was working on getting her maternity home on the National Health Insurance Scheme (NHIS). That meant that pregnant women who attended her clinic could access the free maternal health care service with their NHIS card. She was hopeful, that would attract more clients since she was the only private midwife in the community.

My excitement about our conversations started weeks before that day. I was really excited and anxious to hear Adjoa's stories. The few occasions that we met were interesting times for me because she would heartily talk about what was going on in her life. I had noticed from our short interactions that she had a way of talking about experiences with passion and could draw her listener into the stories as she narrated them. Adjoa was a very sociable and down to earth person who was spontaneous in sharing her stories. Prior to our conversation every interaction I had with her was worth recording. She had told me about her initial plan to have a shop when she retired from active service and how her children told her to do what she does best, that is working with pregnant women. She told me that her children only feared that she would run the clinic at a loss because of her generosity. They had offered to provide administrative

assistance at no charge just to ensure she does not attend to clients free of charge. I already felt like I had known her for a long time. I knew the pieces of our interactions were all going to come in to perspective once we started talking about her experiences more intentionally.

I arrived at the clinic at a quarter to 10 am. I was welcomed and given a seat by Adjoa's assistant. I sat under one of the shade trees on the compound to wait. As I waited I went through my emails as a way of reducing any possible anxiety of waiting. After about 30 minutes Adjoa's assistant came to see me; she said it was very unusual for Adjoa to be late for an appointment and was wondering what had gone wrong. I became a little anxious and I said a silent prayer that our meeting should come on. I did not want to call Adjoa as I thought that would put pressure on her.

My anxiety was reduced when after about another 10 minutes Adjoa called explaining that she had been caught up in a very unusual traffic due to road works and would be there soon. I was happy to hear that our conversation would begin as planned. I gladly assured her that I was happy to wait for her. In a later conversation as she spoke about intuition Adjoa made reference to her delay that day as a result of failure to follow her inner voice. Eventually Adjoa arrived, and invited me into her office right away. Within some few minutes we had started talking about her experiences as a midwife. I invited Adjoa to tell me more about her life as a young girl and anything in her childhood that she could connect to her life as a midwife.

Connecting Past to Present

Adjoa's introduction of who she was took her back to her village days where she grew up many years ago. She also spoke about the people who helped shape her early childhood and about the characteristics of the time in which she lived. Temporality, sociality and place were explored in all my conversations with Adjoa as she spontaneously talked about the places where

her experiences took place, the people involved and the time it took place. She told me about her grandmother who was instrumental in her upbringing as far as inculcating in her the right values such as respect, hard work, and truthfulness were concerned " *You cannot live with my grandmother and be lazy or disrespectful. We worked on the farm and you were expected to work hard be it a boy or girl."* Adjoa lived during the time when girl-child education was not a priority even for some city girls, let alone a village girl.

As I read over our transcribed conversations and wrote her narrative account I see more clearly how these three dimensions are intertwined in shaping her experience. Adjoa told me how she traces her core values as a midwife back to the village and her upbringing. She said, "*I come from a poor family. My parents and grandparents were all farmers. Even money for school was a problem. I was fortunate to go to school. It took the free education policy of Dr. Kwame Nkrumah (the first president of Ghana) for me to get the opportunity to go to school, if not I wouldn't have gone to school. I wouldn't have become a midwife. ..... thinking about this privilege keeps me humble, it makes me want to help people all the time considering that I have received help too."* The campaign for girl-child education has been ongoing for more than two decades with significant results. Traditionally the place of a girl child is in the kitchen where she is groomed to be a wife, a mother and a homemaker. Knowing this about girl-child education makes me appreciate the importance of Adjoa's statement of being fortunate to be educated.

Adjoa described herself as a very determined person noting that even with the free education policy it took determination and perseverance for her to be allowed to go to school. She had to prove to her family that she could do well in school and become somebody with a narrative different from what she had been exposed to in the village. At the same time she had worked hard at home to live up to what was traditionally and socially expected of her as a

girl/woman. That determination to always rise above the status quo and progress in life is what has brought her this far. "*I have always been a very determined person in life. If I set out to do something I do it with determination. So wherever I find myself, I compare myself with my former state and determine to do my best and become better. This has greatly influenced my work as a midwife.*" Having won the second best midwife award at a point in her career I think she had lived her determination to be better at what she does.

Adjoa linked her success as a midwife and her award to how she was brought up. In a later conversation as Adjoa read the citation that came with the award I had goose bumps. The words in one of the paragraphs evoked strong emotions. It sends a sense of recognition for a work selflessly well done. It read, *"…… You have served this region for almost 34 years as a Nurse/Midwife. In all these years, you have shown loving care to all the patients who have passed through your hands. Your determination to bring comfort and love to people especially those in the deprived area have seen you leaving the city to stay with them, denying yourself of social amenities like electricity and pipe borne water. Your preparedness to serve your clients anytime be it day or night have seen an increase in antenatal cases at the health center. Your leadership style and readiness to learn from others made you a role model for others to emulate….."* The words described Adjoa and summarized her experiences. The cost of the sacrifices she made to be there for women in the rural areas who needed help cannot be quantified. I can only imagine the many lives she may have touched working in those deprived communities and the satisfaction it brought not only to her clients but to her as a midwife cannot be erased. The memories of her experience will forever be part of the stories she lives by. I was glad to hear her tell her stories but writing them makes me appreciate the work of midwives in the rural areas even more.

As I reflected on Adjoa's story while writing her account, I have come to appreciate how determination pushed her to achieve that which her natural social environment and circumstances would not automatically give her. However, I am also reminded that like my own story, it takes more than a personal determination to rise above challenges. I pondered over the people who have directly or indirectly guided me through my journey to birth my dreams. I looked across Adjoa's account to see what other circumstances or relationships have supported her determination to become who she is. Adjoa had, on many occasions, spoken about her faith in God, a primary school teacher, and how the village environment itself shaped her life. She recalls "*At that time if you were a girl in the village, education was not part of a conscious plan for you. It was no big deal if you didn't want to go to school. What was important was your preparation for marriage. I wanted to go to school before marriage so one of my teachers, my primary six teacher saw that I was very interested in education and told my parents to encourage me to go to school. I used to do better than most of the boys in class. Knowing that my teacher believed in me was a form of motivation. I also see it as the grace of God. I could have been like any other village girl, go into marriage early and give birth to plenty of children (we both laughed) but that wasn't what I wanted."*

Though Adjoa and I were from different backgrounds and had different experiences I also found many similarities between Adjoa's account and my own stories of becoming a midwife. As we spoke I suddenly became more appreciative of the opportunities that I had hitherto taken for granted. I felt strongly that I had a responsibility to give back and to help others become what they too can become. I was challenged by Adjoa's story. I shared with Adjoa how my biology teacher in secondary school was the person who told me about how I could enter nursing school. I had told my teacher about how I admired a military nurse who lived

close to my house and hence my intention to join the army. It is amazing how much what we see and admire influences what we follow and become. It makes me wonder about the values and characteristics and attitudes being modeled for the next generation of midwives to emulate.

Adjoa and I talked and reflected on the different people in our lives that have directly or indirectly inspired us to be who we are and who we are becoming. Adjoa spoke about a midwife she worked with during her training as a nurse who motivated her and involved her in midwifery work even as a student nurse. I spoke about my midwifery tutor who taught with such passion that I was inspired not only to become a midwife but a midwifery educator. Adjoa talked about how as a young girl in the village she perceived midwifery as an important profession because of an experience she had. "*I saw a woman in labour in the village when I was a young school girl. There was a woman in the village who assisted the women to give birth. I don't know if she was a TBA… One day I was sent to go and call her because someone in the house was in labour. I was asked to run ….the pregnant woman was moaning in pain; I just knew it was a serious thing. When I went the woman (TBA) wasn't home so I came back home to report. I was instructed to go and search for the woman and come with her. When eventually she came, everybody in the house became relieved. I just knew that her profession was an important one. That was the first time I considered midwifery as an important profession."* I pondered over her account and wondered what feelings the presence of a midwife evokes when she arrives at the labour and delivery unit. This woman Adjoa talked about was a TBA because Adjoa mentioned that she was not educated.

My ponderings reminded me of some of the stories women during data collection for my master's thesis shared with me. They (mothers) knew the good midwives and prayed to meet particular ones when in labour. One of my participants in this study (Martha) had also mentioned

how some women in labour would come to first check if she was on duty before they go for their bags to come and deliver. I am sure if I were to deliver again I too would do everything to avoid the midwife who attended to me during my first delivery.

Writing Adjoa's narrative account, I continue to reflect on the different stages of my career and the different people who at each stage inspired me directly or indirectly. I continue to think of those who may be inspired by me too. It has suddenly placed on me a sense of responsibility not to fail because my failure may affect others too. I am becoming aware of how important it is to model the right attitudes for my students to emulate and translate in the care they will render to women. I am beginning to consider that responsibility as a form of motivation to progress and to have the right attitudes.

In a later conversation Adjoa revisited the topic of her background as a village girl and talked about the influence it has on how she relates with her clients even to date. She told me how she worked in several rural communities and villages without looking down on them but have understood and collaborated with them. Adjoa believes that her ability to respectfully relate with people of all manner of backgrounds is from her upbringing in the village. "*As for me I compare myself with where I have come from. I just see that it is the grace of God that has brought me this far so when I see my fellow woman I cannot look down or disrespect the person in any way. It is something that some midwifes don't know. I think that if you have not lived in the village like some of us who grew up in the village you will not understand the life there and you may not be successful working there unless you are prepared to learn…."* Adjoa noted that understanding the circumstances under which people live is key to meeting their needs. I knew she was talking about the social context of care. The social context encompasses culture, beliefs and values and how life is generally constructed. This understanding is vital in building

relationships between midwife and client without which care will not be meaningful to the recipient.

Healthcare is delivered within a specific social context. Although the principles guiding the actual care, that is, "what to do" may be the same across all cultures and social context, the "how to do" must be situated in context all the time. I am wondering whether midwifery education can or has addressed this challenge that midwives seem to have. As I write I am beginning to think about the context differently. It is not just the physical place where the individual woman lives or her social environment but rather the embodiment of who she is or has become as a result of her physical and social environment, her biological makeup, her circumstances and experiences in life. I wonder how these collectively shape a woman into who she is becoming as a mother and who the midwife is, or what role the woman expects her to play in this transition. I can imagine that when a woman walks into the labour ward she comes in with all these influences. The midwife irrespective of where she operates whether rural or urban must be conscious of this.

Being positioned appropriately to play the expected role as a midwife depends on the relationship she develops with her client. Adjoa's words continue to make me wonder how this understanding can be reached. "*You have to understand the rural life to appreciate their behaviour and meet their needs. Unfortunately there is nothing in our training as midwives that prepare us for that. As for me I am a typical village girl. I was brought up with farming so wherever I go I want to implement that too. I always had a farm. It makes them see that I identify with them. So when the people see that I have interest in what they do they open up."*

Adjoa goes on to give an example to explain her point about understanding the village life. "*Sometimes a woman can be brought from the farm to the labour ward because she went to the*

farm and got into labour or the husband was on the farm so he comes with his wife in his farm clothes he doesn't look well dressed. I just accept them but some midwives may actually disrespect them because of how they are dressed. Some may even comment on their appearance in a disrespectful manner. "

Adjoa noted that to avoid such embarrassment some women might simply choose to deliver at home. She told me how sometimes the layette the mothers brought to the labour wards may not be up to the standard we teach and learn in school but that is what she could afford. "*Even their layette they will describe it as rags. But for some of them the rags are all they have. I just educate them to wash and keep it clean. Because I understand that farming and village life I could relate with them better. I saw myself as one of them"*. Adjoa continued to talk about the ideal things we teach and learn and school and what actually the realities were. "*You can't go and talk about why women do not bring menstrual pads to the labour ward in the village. Some don't know what it is and cannot even afford it …. We are not all equal but God has plans for all of us. It is like our fingers, they are not all equal but each has its unique role. Even when something is not done well like someone comes and is not clean, it is your work, all you have to do is to receive the person, welcome him or her and then find a way to educate or advise her. If there is something you can give to the woman to change the dirty clothes, you give.*"

I listened to Adjoa attentively and pondered over her words. I pondered over how seemingly simple actions or inactions can have far reaching effect on maternal and newborn outcomes. For a moment we were both silent. I thought deeply about some of the practical examples she had given. I again thought about what goes into the preparation of midwives for practice. I wondered and thought aloud whether midwifery education adequately captures the

possible different social contexts of practice. Adjoa responded, "*the training should draw their attention to culture and other things that affect the practice…..*"

Laying Career Foundation through Education

After her middle school education Adjoa, who had always wanted to be a nurse gained admission into nursing in one of the few nursing schools in the country at that time. According to her, she entered nursing training at the time when the Qualified Registered Nursing programme was being phased out. In her school she was among the first six students who were admitted to start the enrolled nursing programme. Talking about how she developed interest in nursing and midwifery Adjoa told me "*I have always admired nurses. I admired how when someone is sick they take time to take care of the person and how the sick is cared for even at home. Especially how children are cared for with love and compassion I found it admirable. I had the impression that nurses were caring. So I decided to be a nurse.*"

Her nursing education was a combination of working and schooling at the same time and that exposed her further to midwifery practice. She was in school during a period when there was shortage of nurses and midwives. This compelled the active involvement of students in patient care. It appears as if nursing and midwifery education was based on a model that directly connected theory and practice. It is easy to understand that it is possible to run such a model when there are fewer number of students. In Adjoa's class there were only six students, she explained how the curriculum for their training allowed them to work and school at the same time. According to Adjoa it helped her to gain experience while in school. It was significant in her personal development as a nurse and her interest in midwifery. As someone involved in nursing and midwifery education I also wonder if the increasing number of students in nursing and midwifery schools will make the implementation of such a model possible. I continue to

wonder what in her education has contributed to her being very committed and her attitude to her work and her passion for midwifery.

Adjoa described how she was given the opportunity to work with women going through labour as a student nurse. "*We used to go for night duty at the labour ward as student nurses so I developed interest to do midwifery too. I saw some cases. We went to the labour ward and attend to pregnant women. There was one midwife working there who took special interest in me so when she gets cases from the sub district sometimes she would have to go all the way into the communities. She was elderly so sometimes she will give the delivery bag to one of us* (students) *and ask you to go with the ambulance."*

According to Adjoa, she would be sent by the midwife to go and bring the pregnant woman to the hospital to be attended to by the midwife. However she carried the delivery bag with her so that if in the process of bringing the woman to the hospital she got into the second stage she could deliver the baby, cut the cord and bring baby and mother to the hospital. According to Adjoa on one such occasion she had to conduct the delivery all by herself. That incident significantly unlocked her confidence for midwifery. When she arrived at the client's house to get her to the hospital the client told her she felt that the baby was at the point of birth and would not make it to the hospital. Adjoa said she tried to talk to the woman to hold on for a while so they could get to the labour word.

According to Adjoa, in her ignorance she thought that delivery could be controlled by human will until such a time that the woman found a comfortable place or until she is ready to push. She said it took her personal childbirth experience to fully understand how expulsive and involuntary labour contractions could be during the second stage of labour, adding that all her labour and deliveries had been short and quick (precipitate labour).

Recognizing that she could not get the woman to the hospital she conducted the delivery based on what she had seen the midwife do at the labour ward. "*When I saw that the woman was not ready to get into the car and had sat down pushing I got my things out of my delivery bag and set up trembling to deliver the baby. I was shaking but was composed and very careful. I just did what I saw the midwife do. I had been with her on several occasions. She really involved me a lot in her work. So I cut the cord, delivered the placenta, and took the baby and mother to the hospital. I felt proud of myself. When I got back the midwife started calling me "my midwife". I was happy. All these increased my interest in midwifery right from the time I went into nursing."*

As we talked about Adjoa's childhood and upbringing through to her nursing education I could see the different layers of exposure, opportunity, determination, faith and hard work that laid the foundation for her work as a midwife. It also made me think of my childhood experiences and upbringing differently. I could now connect the pieces of my past to my present and even envisage a future. In a state of reflecting during our conversation Adjoa made this statement "*In fact as I think about it now my childhood and upbringing had made the midwifery work interesting for me. I don't see working hard as a burden."* I perceived that she was beginning to connect her past to her life as a midwife.

Professional Training and Work Experience

Following Adjoa's successful nursing education in 1971 she secured a job at one of the hospitals in the mines within the Western Region. It was a company mine and so the hospital was not under the government control. Though the salary and working conditions were good Adjoa worked there for only six months and left to work in the regional hospital until she left for midwifery training. She explained why she left after six months, "*I was afraid of the trains. That was the only transport to the mining area but I was afraid of being on the train over the hills and*

valleys. The train will sometimes derail go backwards for a long time before it can take off and move forward to climb the hill. This didn't sit well with me. It didn't make me enjoy the place. Because of this I left the mine hospital in 1972 to a government hospital." At the regional hospital Adjoa said she worked in all the departments in the hospital with the exception of the maternity unit. Interestingly the maternity unit was the place she really wanted to work. The longest unit she worked in was the paediatric unit. Her experience at the paediatric unit increased her interest in caring for children but at that time there was no paediatric-nursing programme. She hoped that one day she would become a midwife so she could care for mothers and babies. Still living with the childbirth experiences she had during her nursing education, Adjoa looked forward to have the opportunity to pursue midwifery.

Sometime in 1974 Adjoa received a transfer letter to go to a small village to work for six months. Though skeptical about the unexpected transfer, Adjoa was ready to go for the experience. Little did she know that it was going to be a life changing experience for her and would significantly shape her future. According to Adjoa it was a new clinic that had been built in between two districts. The small village separated the two districts in the region; the Nzema East from the Nzema West districts. Adjoa narrates, "*There was a dispute some years back about the ownership of that small village. The East and West both claimed ownership. The Member of Parliament decided that since both districts wanted health facilities and the government could afford only one clinic, it should be located at an in-between village to serve both East and West Nzema districts. So the clinic was sited there and I was posted to the place together with another nurse. The journey to the village is something I shall never forget."* I could not begin to imagine what made the journey memorable for Adjoa but I was sure it had nothing to do with going on the train because I knew there was a river that had a bridge across instead of rail lines. I was

interested in the story surrounding this journey. I never thought of journeys when I think about midwives and the work they do. I listened in anticipation as she took her time to recall her momentous journey.

The Unforgettable Journey

The journey to her new station started at 7 am one morning in 1974. Adjoa was a few months from her 25th birthday and on her way to start a new life in a village in-between two districts far away in the Western Region and away from family and friends. All she knew about this place was that it was a small village. She had been told the road from the regional capital to the place was very bad and that she had to travel in a tipper truck and had to cross a river and continue further to get there. That sounded to me like an adventure rather a journey to a clinic. As she continued her narration I remembered that this was the same Adjoa who left her work at the mines because travelling on the railway had scared her. Now she finds herself crossing a river to get to her work place. It seemed to me that this time she had no choice. Her decision to be a midwife had presented her with unimagined circumstances. Adjoa did not talk about her disapproval of this transfer. Could it be that her determination to overcome every challenge in life gave her courage to embrace the unknown? Or was it the lack of options; having moved from a private to a government institution within two years of beginning her career that made her accept this transfer without any attempt to refuse? Was it her love for nursing and midwifery that made her want to go wherever her services were needed? I can only imagine what the circumstances were.

Adjoa recalls that it took her some days after she was ready to go to get a truck and a driver who was willing to take her together with the other nurse to the village. Adjoa further described the journey that took more than 12 hours to make. "*We set off from Takoradi and*

drove to the Ankobra river that is where the real journey began. When we got to Ankobra we had to go on a ferry. After the ferry, there was no road so the car had to go through farmlands, mostly coconut plantations. The driver had to maneuver his way through the bushes and the forest for a long distance to join the current main road and then connect through some meandering route through some villages to a town called Nkroful…." Today that same journey can be done in less than three hours due to development. Adjoa and the colleague had no idea how they would identify the village when they arrived. Unlike present times, there was no way they could use Google map to locate the town to have a sense of where they were going. The many towns along the stretch did not have signboards. The driver was at a loss as to where they were going just like the two nurses on the truck. Adjoa described her shock and disappointment when they finally arrived and together with the other nurse they both cried.

Recounting their arrival Adjoa said, "*Apparently the village was a very small village, smaller than I expected so we did not recognise it when we got there and it was getting dark so we passed it. We drove some kilometers away before we got to know we had passed it. I did not imagine it to be like it was. It was made up of few houses all made of mud and rusted aluminum sheets. There were no proper houses. You can easily mistake it as the outskirts of the village before it. The houses roofed with aluminum sheets were not even up to ten. The whole village was sandwiched between the vast sea (Atlantic Ocean) and a large stretch of coconut plantation. There was nothing in the village. No wonder we did not recognise it and passed. We had to return to locate the actual place. We returned but 200 meters into the village our truck got stuck in the sand. Because it was by the sea, the land was very sandy. You can imagine a tipper truck stuck in the sand with only two women sitting in front of the car helpless. We had some of our things on our lap. Our breakables were on our laps because the road was so bad. It was so sad!*

The driver could not go further so we had to remove our things and carry them to the quarters. We were pleading with the driver to spend the night so we can get help in the morning but he refused to spend the night in the village."

As I listened to Adjoa I could only imagine the journey and the shock they received after they had gone through this adventurous journey only to arrive at a small village. It is almost as if it was not worth the journey. Adjoa continued, "*My friend and I were so sad. I felt so lost. I was quite young at that time (24 years). We started to cry. We just couldn't help it. As for my other colleague she cried more than me. She had never lived in a village."* Adjoa and I laughed, it sounded funny, we could laugh over it now but I am sure there was nothing funny about it then.

Even when Adjoa was narrating the account it did not sound funny to me. I felt drained emotionally. Time had passed and so we could find humor talking about it. Adjoa continued her story and told me how the day ended. "*I had to console my friend. The place was dark! No light. Nothing. We could hear different birds chirping, and the sound of the waves on the dark sea. We were told that there was no light in the village so we went with lanterns and kerosene. The person who took us to the nurses' quarters showed us our individual rooms but we were just afraid to be in separate rooms so we decided to share the same room. We moved the mattresses to one room on the floor side by side and packed our things in the other room."*

Adjoa's recount of her transfer journey reminded me of my first transfer to Sunyani in the Brong Ahafo Region in 1990, right after my nursing education. I was 21years, I had never travelled that far from home and for the first time I was going to live on my own and start life as a worker. I had chosen the place mainly because I was told there was accommodation at the nurses' quarters and also it was the regional capital. At that time I did not want to be posted to a village. I remember taking that long journey that took more than three hours because of road

works. I was told then that some few years before I went there it took over six hours to make a journey that presently takes one and a half hours. Though my journey did not take me across a river or through farmlands, there was resonance in Adjoa's story concerning arriving at a place only to realize it is not what you expected. I remember feeling lost and discouraged. I wondered if I made the right choice. Did I make the right choice about career and about the place? I told about how when I was much younger between the age of eight and ten years I had dreams of becoming a flight attendant (I knew them as air hostess then). I remember my father use to take me to the only airport we had in Ghana (still the only international airport) to watch planes land and take off. I would see the flight attendants smartly dressed and thought it would be wonderful to fly to and across nations. I dreamt of travelling and wanted to be like them. That was until I saw the army nurse and my dream about career changed. Adjoa and I laughed as we shared our stories.

Come to think of it Sunyani, the regional capital, was by far better developed than where Adjoa went. It was the nurses' quarters and the room that was allocated to me that made my first night a nightmare. It was a room that nobody had lived in for some time. The window nets were torn and birds had made their nest in the windows and could fly in and out of the room. To make it worse the old wardrobes in the room had become home for mice. I told Adjoa about my first night in Sunyani as we spoke about how the reception of new staff has always been inappropriate in most places.

There was no official to welcome Adjoa and her friend, no help to get their things into the truck. The person who met them to hand over the keys to the quarters left them in the dark. As I listened to her account, I wondered if it was worth the risk. Though located in a small village the clinic was earmarked to serve two districts. In the absence of the clinic all the people in both

districts would not have access to health care. They would have to take the journey Adjoa took if not the full distance at least half way to get to the nearest clinic. As I reflected about the benefit of the clinic, my focus shifted from the small village to the health needs that would be met. I also begun to think about the maternal and child health needs of the communities, considering that both Adjoa and her colleagues were not midwives. I asked myself why send two nurses, when there are obvious maternal and child health needs to be met. It is interesting how unprepared we usually are for some of these experiences because they are the stories that are usually not told. When I admired the army nurse, I admired her smartness, her uniform, her car and how she carried herself. I did not know her story. I was glad to hear Adjoa's narratives. I now understand and appreciate the words in her citation deeply.

I wondered why no midwife was sent with the team. Based on my conversations with Adjoa and the other participants I can only assume that because of the shortage of midwives at that time only two nurses could be sent. Adjoa concluded her story about the journey by saying, "*When we were going to the village our transfer letter indicated that we were going to be there for six months but we ended up spending six years."* No way! I exclaimed, as Adjoa continued to tell me how she wrote several letters requesting for release but was never granted until one day she hired a truck, carried her things and left the village following her colleague who had left in a similar way a year previously. In another conversation I invited Adjoa to talk in detail about her work in the village.

A Nurse in a Midwife's Shoes

When Adjoa and I talked again, we talked more about her work in the small village. My concern was about how she was able to meet the maternal health needs of women in the village without midwifery education. I was concerned about the source of knowledge that guided her.

Adjoa reminded me that once there was a clinic, people just assumed that the staff could address every health issue. She had to run clinics for pregnant women and conduct deliveries. It was her knowledge from nursing school and what she learnt while assisting the elderly midwife at the hospital attached to the training school that she relied on.

The experience of carrying the delivery bag to homes to assist women to deliver their babies was her primary source. "*I wasn't a midwife then but I was working as a midwife. I did deliveries and other midwifery things. I knew I had to do midwifery. It was from there that I went to do midwifery. I remembered everything I did when I was assisting the midwife as a nursing student. The only thing is that every pregnancy and birth is different but I didn't know that then but somehow I always figured out what to do. It was even the same after midwifery training there are some things you will not be taught, you just find a way around it when you meet one."*

Adjoa spoke about the use of an inner voice and explained, *"Sometimes you need to concentrate and listen to your inner voice. It helps you to be alert when you least expect. That is what we call intuition right? The intuition really helps. For example, you remember I came late for us to have our first conversation? It was because I failed to respond to my inner voice. That morning I decided to pick up something from town on my way here. There is usually no traffic on that road in the morning. A voice within me said you have a meeting with Mrs. Ampofo if you go to town first before coming something will hold you up in town and cause you to miss the appointment. I just brushed it off because what I knew was that there was nothing on that road that will delay me so I went to town and fell into an unusual traffic."*

Adjoa told me that even as a midwife she has followed her intuitions on many occasions to deliver care and to save lives. She believes that it is a gift that is divine and operates based on commitment. She used it when she was not a midwife and continued using as a midwife. "*I*

believe that in this world everybody is gifted with divine grace to operate. If you love what you do you will always be directed what to do. Sometimes before you go to the client a voice will speak to you to start some form of preparation in anticipation of something that you would not have ordinarily anticipated. You just prepare as if you knew something would go wrong. For example somebody comes to the deliver for the first time, she has no history of birth so you can't tell if the person will bleed after delivery or not or the second stage will delay. So you have to prepare and your intuition will guide you specifically on what to do." I could identify with Adjoa that the inner voice is not restricted to midwifery practice. I have also had occasions where I have followed my intuitions and acted in ways I would not have ordinarily thought of. What I have wondered is how to call one's intuition into action when needed. I see it to be involuntary and not within the control of the midwife but the results could guide you in future. I wonder whether there are levels of intuition, is it something that can be developed? I have heard so much about intuition as a midwife I wish I could understand how it works better. However, although I do not fully understand this whole phenomenon of intuition I cannot deny its existence.

Apart from her past experience with the midwife back at nursing school, and following her intuitions, Adjoa also talked about how the relationship she built with the women and the entire community facilitated her work. She was of the opinion that getting to know and understand the people is an important key to work within the community. Although she did not directly attribute her success with her relationship with the people in the community she implied by her narration that it facilitated her work. She had to identify with the community through language and in the work they did "*I had to learn the Nzema language. Most of them could speak Twi but they are a group of people who would want you to speak their language (Nzema) even if*

they speak Twi so I had to learn the Nzema. When they came to the clinic they spoke Nzema. If you don't speak you continue to be a stranger to them so I had to learn. I did some farming too. It is something I love to do. Even here you can see I have a small garden. I think in the village it makes the people feel you are part of them."

As I reflect on the notion of belongingness being a part of something or a group as in Adjoa's case, it portrays a sense of belongingness and security. I wonder if this sense of belongingness and security was only important to ensure that the community patronized the clinic. I can only imagine what impact it had on her also. I think Adjoa also found something she was familiar with in a strange land. As time elapsed Adjoa learned and spoke Nzema language, further breaking down the walls that made her to be perceived as a stranger. As part of developing her sense of belongingness, Adjoa kept a farm and she occasionally hired some of the locals to work on it. Her farm being part of her out-of-work activity kept her occupied and helped her to enjoy her stay better. I imagine how much the farm reminded her and connected her to her village life as a child. This must have deepened her sense of belongingness.

Writing this account has enlightened me about the importance of identity and belongingness in new ways. In the cities where I worked identity and belongingness do not seem to feature in the life of a midwife in relation to her clients and community at large. If it is there it is more related to the institution where one works and members of the health team. However I have come to understand its prominence in the narratives of working in smaller or village communities. To lay more emphasis on the point, Adjoa told me of a midwife who was sent to take care of the maternity needs of the community but could not relate well with the community. Adjoa recalls, "*At a point they brought a midwife but there were so many conflicts. The clients wanted me to attend to them when they come but I told them there is a midwife to attend to them.*

Unfortunately the midwife had poor interpersonal relationship so the clients didn't want to go to her and that created some conflict. The midwife could not speak the language. She also looked down on them and was fond of shouting on the clients so the community was not happy with her. She eventually left."

Adjoa's success in working in that particular community and in others she told me about was not solely due to her ability to take care of pregnant women and conduct deliveries. It seems to me that her ability to relate to the community in familiar ways was what ensured her success. This is an important consideration in pushing forward the agenda of ensuring that a skilled birth attendant attends to every birth. It is not only the skills of the midwife that will ensure the realization of this goal though very important. Attention needs to be paid to the individual midwives who are sent to particular places to provide care. I am beginning to think of ways to ensure that midwives are not just transferred or posted and sent away with mere letters to travel several kilometers to arrive at places without any form of orientation. I am thinking of ways to psychologically prepare midwives, especially newly qualified midwives, before they are sent out to unfamiliar places. I also see that Adjoa's past experience of living and growing up in the village also helped her to adjust fast and to stay on for six years instead of six months.

When the midwife became the client

Adjoa shared her experiences as a midwife and how her work at different places deepened her knowledge and understanding of midwifery care. Midwifery school gave Adjoa some knowledge to provide quality care to her clients. However, her experiences as a midwife working in different places and under varying circumstances was what actually grounded her understanding of what childbirth experience is all about. Added to this understanding was her childbirth experience that I write about in a later paragraph. After school she worked at the

regional hospital for a couple of years before she was transferred to a district hospital. Soon after she had resumed working in the district hospital she began to appreciate the difference between working as a midwife at a district hospital and a regional hospital. The difference she spoke about was not so much related to the physical structure of the set up but the responsibilities a midwife carries and what it takes to meet those responsibilities. According to Adjoa, "*To me all midwives do not work equally. Working in the smaller facility is exceptional. The work and experiences of those who work at the bigger facilities is completely different from those who work in the smaller. At the village clinics and health centers the midwife is the doctor, gynaecologist. In fact she is everything. When you are working there it is your responsibility to ensure that you save lives."* She goes on to talk about how the midwife needs more skills to work in facilities where she is alone. "*In the bigger hospitals you can say that you are waiting for the doctor… to take the decisions about a client. In the rural area it is not the case at all. There is no way you can get a doctor. Even in some smaller hospitals where there are doctors there is usually only one doctor and there are times he may be in theatre carrying out an operation."*

Because Adjoa had to work mostly alone she had to rely on her past experience of attending to pregnant women in addition to the new knowledge she obtained from midwifery school. Adjoa clearly acknowledged the importance of midwifery education and how it complements the knowledge that a midwife needs to practice as a professional. She articulated this by saying "*Going to midwifery school does have influence on how you work as a midwife. In that if you haven't had midwifery training you can still assist women to give birth just like the TBAs but you will definitely lack some things. If you consider the TBAs for instance, they really know how to take care of the emotional needs of clients when in labour. They really have time for their clients. But for example when it comes to infection prevention they lack that knowledge.*

It is through midwifery training that you get to learn some of these things. Based on that knowledge you can also educate your client. You tell them about basic personal hygiene issues. Though before midwifery I knew about personal hygiene because I was a nurse, midwifery provided me with deeper knowledge. It also helped me with my relationship with clients."

Her past experiences also helped her to appreciate better the concepts that she learned in school. *My past experience with midwifery really helped me in school and after school when I went back to the village. I could easily make sense of what I was being taught..*"

Adjoa's exposure to midwifery practice had already stirred up a desire and a passion for midwifery even before she went to school. Coming back to the village to work as a midwife soon after school was like a continuation. Although she needed midwifery education to progress in her career, she told me that was not her motivation for going to school. "*As for me I loved midwifery right from the word go. When you love what you do it makes it easy for you to do because you do it with love. I don't even think about the money though I need it. My satisfaction comes from doing the work. I had so much passion and love for the work".* Love and passion for midwifery were anchors in Adjoa's life as a midwife. It is interesting how she traces her satisfaction to the doing of the work and not necessary the monetary benefits. I wonder what her attitude would have been if her satisfaction had depended on money. I wonder because during that time nurses and midwives were among the most poorly paid government workers in Ghana. It was also during a period that logistics for health care were difficult to come by. I can only imagine that not only would she have been frustrated but also probably her clients would have had their share of the frustration. Instead of being frustrated Adjoa developed resilience and courage to go through every challenge. "*Those of us who worked in the rural areas it was up to us and our God. You will do things that you didn't think you could do. What I have seen is that*

those of us who worked in the rural areas have courage. You have to develop courage. I developed courage if not I wouldn't have survived."

Adjoa also talked about the opportunity to learn from other midwives as another source of knowledge. According to her, after midwifery school she was now eligible, by virtue of being a qualified midwife to attend midwifery workshops and meetings that prior to her training she was not invited to attend. Adjoa relayed to me that at such meetings the learning does not only take place in the halls or conference rooms but in the corridors, dining rooms and during the off session interactions. She said a great deal of knowledge from rich experience is shared. Some of these experiences brought to life what they were being taught in the formal sessions because the midwives who had had practical experiences could talk about them differently. *"We (midwives) also learn from each other through our interactions outside meetings. .. a whole lot is learnt. Some will narrate some of their experiences and what they did to solve the situation. When I hear the accounts from others I learn from it and keep it in mind. There is a whole lot that we do as midwives but sometimes we are afraid to document them because it is difficult to explain it. So it is not only in the class room that we get knowledge."*

Different Childbirth Experiences: Experience as a Client

In a conversation with Adjoa she shared with me the details of some of the childbirth experiences she had mentioned in our previous conversations. She started with her own childbirth experience. Adjoa was not only a midwife. She was also a wife and had played these roles, working with and attending to women. Adjoa was working at the paediatric ward at the regional hospital when she was pregnant for the second time and discovered that she was carrying twins. She had been working as if she was not pregnant and her doctor had told her on a few occasions to take things easy but she told me as long as she reported to work that was not

possible. She explained, "*I couldn't sit still to see people suffer. By nature I cannot sit down to see others suffering or something going wrong I just can't be there unconcerned. So throughout my pregnancy I wasn't resting. I will always forget about myself and help others."* This is not a trait that can be found in every nurse or midwife. I do not think it is usually developed through nursing or midwifery education or experience at work. I pondered over what in Adjoa's past could have contributed to this trait. I can only assume that her upbringing in the village could have made her the way she was. "*In fact my childhood up bringing had made the midwifery work interesting for me……. As for me I compare myself with where I have come from."* I also know that in the typical village, there is that communal spirit where they seem to have a responsibility towards one another. It makes it difficult to sit down and look on unconcerned when others need help. Adjoa kept working to the best of her ability until one day during her early third trimester she was on duty when she started experiencing some lower abdominal pains. She reported to her doctor and was asked to be admitted immediately, but she, not being a midwife, did not understand what the possible outcome of what she considered a slight lower abdominal pain could be. She went home to put her house in order before coming to be hospitalized.

The events following were narrated by Adjoa, "*The midwife came all the way to the nurses' quarters to come and bang at the door. She waited and escorted me to the ward to be admitted. I was admitted and given a ward but I sat at the nurses' station helping out with some of the work. I was sitting there when I felt strong contractions and I ruptured membranes (water broke). I was quickly assisted to the second stage room. The first twin was coming with the foot. The midwife was confused, she sent for the doctor but within some few minutes the first twin was born and then the second one followed. They were very small.*" According to Adjoa, the babies weighed 1.1kg and 1.2kg respectively. The babies were born preterm and needed to be nursed in

an incubator but the incubators were out of order. Adjoa had to practically learn how to nurse her preterm babies herself. She was determined to let them survive and they did. She said that is how she came to know what prematurity was all about.

Many years after going through preterm labour and nursing her preterm babies she had to support a young woman who went through a similar experience. Adjoa said she relied on her own experience of nursing preterm babies to support the woman. While working in a village clinic as a midwife, one of her clients had attended antenatal clinic in the morning. Her pregnancy was less than 28 weeks and she was in good health. Later in the evening the woman was rushed to the clinic in labour. Apparently she went into labour after receiving news that her husband who was a driver was involved in a car accident. She had no details of his condition but she had no time to find out because she started having contraction when she got the news. Adjoa said she started praying and hoping that the slight contractions would cease. I could understand Adjoa's anxiety because with a gestational age of 24 weeks in a village with no incubator, the chances of the baby surviving was small.

The contractions became stronger and stronger until the woman delivered. Adjoa said although she had raised her preterm babies, she initially had doubts about the babies surviving. However she was determined to do all she could to help. The woman whose husband was in a critical condition in a hospital far from the village was not prepared to be transferred to a facility with neonatal intensive care unit. Although that would have been the best option for the baby, Adjoa could not go against the wishes of the mother to send the baby. In a state of dilemma she decided to help the woman take care of her preterm baby in the village, according to Adjoa it was from her personal experience that she nursed baby and supported the mother. "*I had to manage this tiny preterm baby in a facility where there was no incubator. I would just wrap the*

baby over and over……. I had to find a way to feed the baby ……Some of the things I did you will not find them in any book. I remembered what I did for my babies to survive and did the same things I tried everything possible and eventually the baby survived…….. If the lady had delivered at home, that baby wouldn't have survived; they would have said that the baby is too small to have a normal life. …. the parents say that among their three children this one born preterm is very smart and is different." As Adjoa spoke I could only think of how the management of preterm babies is no longer book knowledge to her but is embodied in who she is as a midwife because of her personal experience. Adjoa profoundly described this form of embodied knowledge in ways that captures how I understand it. She said, "*So that experience of taking care of my own preterm babies and how I nursed them. The anxiety, fear and every possible emotion that go with having a preterm baby, I had experienced it personally and it helped me to relate with mothers with preterm babies with understanding and empathy. So when this woman at the village gave birth to her preterm baby who weighed less than 1 kg. I was able to help her nurse the baby. When I had mine I mastered courage and took care of them myself. That experience helps me to support such mothers."*

As I ponder over this statement I have some questions that I may not find answers to now but will continue to wonder about. I am wondering how else this embodied knowledge could be developed since not every midwife would have a personal experience birth or labour. Could it be that the embodied knowledge does not necessarily come for a specific experience that is similar to that of a client's? Are there different ways by which knowledge can be embodied? I can only imagine that an experience of nursing a woman with preterm a baby for the first time can also result in developing embodied knowledge.

My conversation with Adjoa made me reflect on my own childbirth experience and how I literally carried it to every labour that I attended to thereafter. Because of the unsatisfactory childbirth experience that I had with my first delivery I unconsciously developed a strong passion to ensure that every pregnant woman I attended to left with an experience I could be proud of. I describe it as unconscious because it became part of me and was effortless. I only became conscious of it at moments when the clients verbalized their satisfaction or appreciation for the care they received. Their circumstances needed not to be the same as mine.

Different Childbirth Experiences: Dealing with Avoidable Death

One of the devastating issues in maternal and child health is dealing with maternal mortality. It is not only an issue for the affected family but also had emotional implications for the midwife. Adjoa, like the other participants expressed the importance of producing a monthly report that did not reflect either maternal or infant mortality. Such a record brings to question the competency of the midwife. Having this in mind Adjoa had always worked hard to save lives and to refer her clients promptly whenever necessary. In a conversation she said to me, "*I have had several experiences that I am still living with; I just cannot forget them. But there was this one that happened when I was working at a district hospital. A pregnant woman was admitted because her blood pressure was high and she had proteinuria. Her condition wasn't that bad initially. I attended to her during the day shift and left."* I was not sure how the story was going to end but I started getting anxious and was hoping that it had a happy ending. I had realized from my conversations with my other participants that they had avoided talking about death. They had on many occasions brushed over it and talked about the clients in critical conditions that they had managed to help save their lives. I am unsure what the inhibitions were but I can only think of the emotions associated with death as a possible inhibition. Culturally, death is not

a topic that is freely discussed. I listened as Adjoa went on to tell me that when she came back on her shift the next day the woman's condition was getting worse. The night shift reported that she had a seizure during the night and the blood pressure was still very high in spite of all the medication she had been given. After another seizure Adjoa decided to call the doctor to come and review her.

Though the woman was unconscious Adjoa realized that she was in labour. Conducting delivery when the client is unconscious was difficult. Adjoa continued to describe what happened. "*Because the woman was not fully conscious I couldn't get her to respond to anything. It was a twin delivery. The first twin came out somehow, though not conscious she pushed for the second twin to be delivered then she started to bleed. I did everything to get the bleeding under control; it was a tough one. Because it was at the district hospital we were able to transfuse her. The second pint of blood was in situ when I closed my shift but I was so glad that the woman's condition was much stable."* At this point in our conversation I was relieved by how the story seemed to have ended and my anxiety had reduced. However, the expression on Adjoa's told me the story was not over. As I mentioned earlier Adjoa has a way of narrating her experiences to capture the attention of the listener. She had always taken her time and had paused for moments each time she shared an account. I suddenly became anxious again. Please don't tell me she died, I said softly. Oh God! No she did not die. I said within me forgetting that the incident had already happened and that neither Adjoa nor I could change how it ended. Continuing her account, Adjoa recalls that she came back the next morning to find the woman in relatively fine condition except for the blood pressure that was still high. The twins were doing well and that made her (Adjoa) happy too.

Though the woman was still under observation and treatment she felt that the worst was over. It is worth noting that at the district hospital there was no intensive care unit so the woman was being nursed at the general female ward with no sophisticated monitoring machines. By the end of Adjoa's shift the second day she could see much more improvement in the woman's condition. Adjoa told me the woman was the last person she spoke with before she left the ward. She had gone to inform her that her shift the next day was in the afternoon and assured her that she is sure she will be able to take a few steps around her bed. The woman expressed her gratitude to her for the care and support she had given her. Adjoa recalls telling the woman as she walked out of the ward that "*Atta Maame (mother of twins) I am waiting for you to recover fully and go home so I can attend the recovery party. She laughed as I closed and went home. I came for the afternoon shift on the third day. When I got to the ward her bed was empty. My heart missed a beat but I thought she had been moved to another bed. To my shock I was told her condition changed during the night; she had series of fits and died in the early hours of the day. I was in shock. It was so painful as if she was a relative. All of us (staff) were sad. I admitted her and spent time with her, I delivered the babies, saw her in a very critical condition and was very happy at her fast recovery. I never expected her to die. It really got to me. I wasn't myself the whole day. It was even more painful when I think of how much I suffered on her that evening and thought she was out of danger. I always still remember. I just don't like death, especially maternal death. I never got maternal death at any of my stations, (one-nurse-stations). I always work hard not to spoil my record. I monitored labour well; if I see it's beyond me I refer to a higher place."*

I had at this point become so sad too. I do not know the woman, I never nursed her but I felt a connection, I could situate myself in the labour ward. I know the joy of seeing a client in

critical condition recover and walk out of the ward better than she came. It is more satisfying to me than a bag of money. I know how much a simple thank you or God bless you from such a client meant. I also know how it feels to lose a client. I have seen a mother leave a newborn baby behind because she passed on. I have seen the confusion; the look on a husband's face when he is told his wife is no more. I have seen a father look at a newborn son wondering who will nurse this innocent life and what he will tell him when he asks of his mother one day. As I write this account I am overcome by emotions. Emotions in midwifery are real but often not expressed.

Writing Adjoa's story has been emotional as our third conversation was. This was when she shared the stories of life and death with me. Stories when mothers died and babies lived. Mothers died with their dreams and aspirations. They died with their stories of birth. No one can tell their stories for them. We can only imagine what hopes they had for their unborn children. They exchanged their lives to give life. Perhaps the closest I can get to hear their stories is from Adjoa's experience. I have intentionally used plural, I speak of mothers instead of a mother because Adjoa told me yet another story.

This happened in a village clinic she worked in as the midwife. A river had cut off part of the village so when it rains nobody could cross to the other side. Adjoa remembers this woman who lived across the river and occasionally came to sell farm produce. She was the wife of one of the farm labourers. Adjoa had taken interest in the woman because she bought foodstuff from her and noticed she was pregnant. Although the woman would not willingly attend antenatal clinic for financial reasons (there was no NHIS or free maternal health at the time), Adjoa had managed to attend to her and detected she was pregnant with twins. She referred her to the district hospital, spoke with her husband and was prepared to go with her to the district but the woman and her husband were not prepared to go. One market day Adjoa, upon seeing the

woman suspected she was in labour. Adjoa recalls, "*When I observed her I realized she was in labour but she denied. She did not want to admit that she was in labour. I did not examine her but by just looking at her face I could tell that labour had started. I asked her to stay at the clinic so we send someone to go and get her things from across the river but she insisted she wanted to go so she left. Apparently she went home and delivered at the TBA at around 7 pm, then she started bleeding. She bled for a long time and died. I waited at the clinic but she didn't come back so the next day I inquired from the market women and they said she had delivered."* On the third day, Adjoa decided to go across the river to visit mother and baby, perceiving that they may not come for postnatal care because of financial constraints. Adjoa narrated the chilling scene she walked into. "*I got there and had the shock of my life! The woman had been prepared for burial. She was laid on a mat on the floor; she had been covered with a white cloth. She was just about to be carried to the graveyard. I was very confused, very sad the whole day. I was completely disorganized the entire day."* The effect of maternal death is not well felt when it appears in statistics but hearing a narration of death makes it real. When I turned off the tape recorder that day I felt very sad. I wish the stories about the two women had ended differently.

Workshops and Protocols

Adjoa had told me about her midwifery education and the experience she had built over the years from different places and under different, sometimes challenging circumstances. She had mentioned to me that she attended many workshops and had many certificates to show. In one of our conversations she mentioned that she received an award as the second best midwife in the region some few years ago. We had agreed to look at the certificates and the citation in a later conversation. When we met to have our fourth and last tape-recorded conversation, Adjoa brought two rubber files containing pictures and certificates. That day she came dressed up in her

blue and white private midwives' uniform. It was a light blue trouser and a blue short sleeve shirt with a white Peter Pan collar. She wore her black midwifery belt with a silver metal crest. She looked far younger than her age. She said she dressed up so she could take a picture with me. She had all along been very excited about our conversations. Adjoa said no one had ever asked her to tell her story. Sharing her experiences with me has brought to her memory a lot of work she had done. I was also very happy I had the opportunity to listen and write her story. I had enjoyed every moment I spent with her. I now see how difficult it is to write her full story in a single thesis. I do know that I cannot capture everything about her life as a midwife. We started by talking about her award.

We went on to talk about the many workshops she had attended. Adjoa explained to me that the workshops were very important to her because she mostly worked in the rural areas where she usually worked alone. The training workshops equipped her with the skills to deal with obstetric complications. Also helped her to recognise when to refer in case of complications. She said, "*The advantage of the one man station is that every workshop you will be invited because the authorities know that such a midwife needs to be well equipped.*" The talk about workshop, has been linked to place of work. It appeared as if the workshops were more designed to for midwives who would have need for the skills that were taught during the training. I wondered about the midwives who worked in the big hospitals who may be transferred suddenly to a rural facility just as happened to Adjoa. How would they be equally equipped for such future transfer to rural areas? I also wondered how the selection for transfer is done and how does a midwife appointed for transfer equip herself with the skills needed for rural work. I wondered because the workshops are not constantly ongoing. I could only think again about the need for preparation or a form of orientation for midwives before they are transferred.

When Adjoa talked during this conversation and showed the certificates I realized that there were some workshops that she had attended more than once and had multiple certificates for them. I sought clarification from Adjoa concerning this observation. She responded by saying, "*You know midwifery, thinks keep changing; Every now and then there is something new. You have to keep updating your knowledge. If you don't do that you will be using old ideas. You know things get better with time, there are new findings all the time."* She talked about the importance of lifelong learning "*If you are a nurse or a midwife you must understand that learning is lifelong. Even when you are out of school that is when you need to learn the most."* It struck me that Adjoa was not highly educated in terms of academic certificate but I had come to respect her thinking and intellectual perceptions about midwifery.

Another dimension about attending workshops was the forum it created for midwives to interact and share their experiences. "*At the workshops too we share experience and that is very important. You get to know what others have gone though and learnt. We share a lot during those meetings. People will talk about problems they have encountered and how they went about it. Most of the things shared among the midwives are from their personal experience you will not find in books."* I could see the different forms of knowledge that is realized during such gathering of midwives. The training sessions brought empirical knowledge to the midwives while the informal interactions among themselves outside the formal training meetings brought tacit knowledge.

In addition to the training workshops Adjoa also spoke about the use of protocols as an important component of the knowledge for midwives. She gave credit to how it had helped in the care of women and has helped to save lives. According to her "*The protocols have helped a lot because in the past when there were no protocols you wouldn't know what to do. But now you*

are guided every step." Adjoa spoke about how the use of the partograph, a clinical tool for monitoring the progress of labour, helped her to promptly detect the deviation from normal progress of labour and directed her as to what to do to save women and their newborns. She gave another example about how the protocol has even changed misconception about eclampsia. "*For example in the past there were a lot of beliefs about eclampsia. It was believed to be a curse of the gods if there were displeased with the pregnant woman. Such a case will not be brought to the hospital. The woman is not supposed to be touched by anybody, else the anger of the gods will be extended. With education that perception has changed and now women are seeking treatment for it. The protocol for the management of eclampsia now helps. It shows you what you have to do at every step."* She added that although she had the protocols displayed on the walls of the clinic but after using them over a period she had become so familiar with using them that she no longer looked at it. What I understood from what she talked about regarding the use of protocols was that with continuous use the midwife develops experience and with time that knowledge becomes embodied. "*I no longer have to go and refer to it each time I have a case. When I get a case I just act. The thing is if you don't use the knowledge you don't get the confidence."*

Through the stories that Adjoa shared I can see how her personality, upbringing, education and experience had worked together to make her a competent, hard working midwife for years. Adjoa's work experiences both in the rural and urban centers had presented her with different opportunities to care for women in different places and under different circumstances. Through that she developed rich experience and gathered knowledge that had helped her to assist many women and saved many lives Although she admits that there are some frustrations in the profession depending on where you work saying, "*The workload is too much especially in the*

big hospitals so most midwifes will not have time spending on one client. It is there that usually the disrespect issue comes from. Sometimes too the midwife may be frustrated because the resources she needs to work efficiently are not available. It affects one's ability to work. Some midwives may, out of frustration, shout on the client as if it is their fault. All these affect your attitude. You just have to find a way to master your emotions." Despite all these challenges and frustration her love for the profession never decreased. She explained that "As for me I loved midwifery right from the word go. When you love what you do, it makes it easy for you to do because you do it with love. You don't even think about the money, your satisfaction comes from doing the work." She continues to practice midwifery in her own maternity home.

Chapter Five: Resonant Threads Across the Narrative Accounts

In this chapter I unpack what I learned as I recorded, listened, read, inquired into, and wrote the narrative accounts of the four participating midwives. The four midwives shared their experiences with the emotions of fear, joy, loneliness, anxiety, and guilt that characterised their experiences. They talked about the different times and places where their experiences occurred. Looking back at how I came to this research, I am reminded that I wondered about what the experiences of Ghanaian midwives who care for women in labour are. I wondered, how do these experiences reflect their professional knowledge landscapes and their personal practical knowledge? How did their experiences across time, place, and in diverse contexts impact their care for women in labour? What forms of knowledge did midwives caring for women during childbirth have? These questions shaped my research puzzle around understanding the experiences of Ghanaian midwives. I explored how place, time, and social interactions shaped the stories of all four participants while constantly reflecting on my research puzzle to determine what meaning I made of their accounts. The process is not complete until meaning is drawn from

experience. It is through the retelling of the experiences that understanding and meaning are drawn.

I composed each narrative account drawing attention to narrative threads within each participant's personal practical knowledge and their personal and professional knowledge landscapes. In this chapter I discuss a narrative thread identified across the four narrative accounts as I read, wondered about, and re-read each account, and called to my memory the relationships I shared with each participant: Happy, Anna, Martha, and Adjoa.

This interwoven narrative thread that echoes across the accounts is discussed in light of existing literature. As Dewey (1934) posits "we engage in inquiry to restore harmony and relieve the breaks and tensions of disequilibrium" (p. 15). I recall my earlier experience where during an interview a panel member, who had been a victim of an unfortunate childbirth experience, was of the strong opinion that midwives' attitudes are a direct result of how they are educated. By educated, she was drawing attention to their experiences in higher education. This perception, generally held by many, creates tensions of disequilibrium. It overshadows at times, the tremendous work of midwives and the difficult circumstances under which some are called to work. I am hopeful that as I look across the narrative accounts some meaning will be brought to light that can provide insights into midwifery practice.

Finding Resonance Across Narrative Accounts

Reading through each narrative account I was cognisant of the uniqueness of each person's experiences and the insights that could be gained from each of the storied lives. The storied experiences shared by participants illuminated different aspects of a midwife's life that are not easily identified by just encountering a midwife at the hospital, clinic, or labour ward. It took the uniqueness of the relational engagement to bring forth intriguing aspects of a midwife's

experience. After looking across the narrative accounts, I found one particularly prominent and important resonant thread: the personal practical knowledge of midwives as shaped by, and expressed in, their professional knowledge landscapes.

The narrative thread of: professional knowledge landscapes of midwives.

Looking across all four narrative accounts I became attentive to multiple types of knowledge for midwifery practice. Not only did I identify different types of knowledge, I came to understand more about how each midwife came to hold knowledge. As all participants told their stories of becoming and working as midwives, each shared stories of developing her knowledge as a midwife. Drawing on the literature (Connelly & Clandinin, 1988; Clandinin & Connelly, 1995) I conceptualized knowledge as personal practical knowledge and the professional knowledge landscapes of midwives.

Knowledge has been conceptualised in different ways. To discuss midwives' knowledge, I return to chapter two of this dissertation, where I discussed different conceptualizations of knowledge. Polanyi (1958), writing about personal knowledge, categorised knowledge into propositional and non- propositional knowledge, explaining propositional knowledge as being derived through research and scholarship and non-propositional knowledge from experience. Polanyi further posits non-propositional knowledge as tacit knowledge. Connelly and Clandinin (1988; 1995; 1996) researched the phenomenon of teacher knowledge and developed narrative concepts of teacher knowledge as comprising both professional knowledge landscapes and personal practical knowledge. Fenstermacher (1994) described two types of knowledge: formal knowledge and practical knowledge, where formal knowledge was knowledge that was primarily known and constructed by researchers, and practical knowledge was mainly known and produced by teachers themselves. Other conceptions of knowledge discussed in chapter two

include: experiential knowledge (Dewey, 1938; Schoen, 1983; Johnson, 1989); narrative knowledge (Polkinghorne, 1991; Bruner, 1986); tacit knowledge (Polanyi, 1966; Ryle, 1945); and personal practical knowledge (Elbaz, 1993; Fenstermacher, 1994; Connelly & Clandinin 1988; Schoen, 1987).

As I take a reflective turn to discuss the narrative thread of midwives' professional knowledge landscapes I return to these conceptions as I also think of knowledge narratively. Guided by Connelly and Clandinin's (1988) concept of personal practical knowledge and Clandinin and Connelly's (1996) concept of professional knowledge landscape, I conceptualised midwives' knowledge in two ways. Clandinin and Connelly's (1996) concept of teachers' professional knowledge landscape is generative for my study as I explore the knowledge landscapes of midwives. Clandinin and Connelly (1995) were concerned with the environments or contexts in which teachers work. They referred to teachers' work contexts using a metaphor of a knowledge landscape. Using the landscape metaphor, they sought to "capture the exceedingly complex intellectual, personal and physical environment for teachers' work" (Connelly, Clandinin & Fang He, 1997, p. 673).

As participants shared their experiences of working as midwives they told stories about the different places and contexts in which they worked at different periods of their career. I conceptualize midwives' work environments as their professional knowledge landscapes. While place is part of a professional knowledge landscape, a professional knowledge landscape is more than place. I discuss the different types of knowledge on these landscapes, the different people, relationships, events and things in the knowledge landscapes and the different ways that people, places and things are in relationship within the landscape. The aim for this discussion is not to determine which professional knowledge landscape is the best or most appropriate but to show

the differences that exist in midwifery professional knowledge landscapes and to show how each influences the experiences of midwifery practice, as well as the life of each midwife.

From the accounts of all four participants I identified three professional knowledge landscapes where participants worked. The midwives in the study worked both in rural and urban settings as well as in private maternity homes. I identified from their accounts several differences in the professional knowledge landscape that characterised midwifery practice in these context.

Professional knowledge landscape in rural communities

Firstly, I discuss the professional knowledge landscape of midwives in relation to rural communities in Ghana, being mindful of the three-dimensional narrative inquiry space. As participants shared their experiences of working in the rural areas and smaller clinics, I recognised the different interactions that characterised their experiences and how their personal practical knowledge was expressed in their professional knowledge landscape as they cared for women during labour.

The importance of place: the rural physical environment

I begin by turning my attention to the implications that place (the physical/geographical location) had on the experiences of the participants. The rural communities as described by participants are poorly resourced. All participants in the study had the opportunity of working in different rural communities. The health facilities in the rural communities, as recounted by participants, were inadequately staffed. They individually indicated how they were usually the only health professionals at post especially immediately after their midwifery certification. Being alone at post, they had the responsibility to meet the health needs of several communities. The "one-man- station" phenomenon as they described, is particular to the rural professional knowledge landscape. It is worth noting that since some of their experiences took place some

years back, the situation may have changed. However from my knowledge of the midwifery practice in the Western Region and from the accounts that participants shared, there still remain some "one-man-stations" in rural communities.

The midwives described the rural environments where they worked as having a lack of basic social necessities, such as potable drinking water and electricity. Martha commented, *"It wasn't easy for me initially. There was no light (electricity). I am someone who had spent all my life in towns and cities so it was very difficult for me to adjust initially."* Though the transfers to such communities came unexpectedly to participants, they each accepted the challenge, recognising the need to bring health care closer to communities. Their acceptance to serve meant that some sacrifices had to be made. According to the midwives, rural work calls for sacrifices. They narrated how they had to make several adjustments to their personal and family lives so that other people could benefit from their knowledge and skills. Happy explained, "*Before I left for my first transfer I went and brought my mother from my village to come and stay with them* (husband and children) *at Takoradi. I never sent them with me to any of my transfers. I thought the up and down will not be good for them, especially the children's education."* With reference to one of the villages where she worked, Happy noted, "*Even that place if you want to refer* (a client)*, there is no car. Sometimes in the morning all the cars will leave the town."* Similarly Adjoa noted, "*Sometimes too the midwife may be frustrated because the resources she needs to work efficiently are not available. It affects one's ability to work."* However, as they told their stories they came to the conclusion that they had acquired personal practical knowledge as they worked in these places. Although Adjoa and Happy grew up in villages, and therefore had past experiences that helped them to adjust, they acknowledged challenges that are associated with working as midwives within a rural professional knowledge landscape.

Building relationships within a rural professional knowledge landscape

When I attended to the relationships and interactions participants described in their accounts I noted the sense of belonging among community members. This sense of belonging comes from knowing and trusting each other. People who migrate into the community are initially seen as strangers until they have proven themselves worthy of full acceptance by their conduct. Adjoa recalls how she had to learn the Nzema language in order to be accepted as part of the rural community where she worked. According to her "*I had to learn the Nzema language*. *Most of them* (the community members) *could speak Twi but they are a group of people who would want you to speak their language* (Nzema) *even if they speak Twi so I had to learn the Nzema. When they came to the clinic they spoke Nzema. If you don't speak you continue to be a stranger to them so I had to learn. I did some farming too. It is something I love to do. Even here [referring to the place where we were engaged in conversation] you can see I have a small garden. I think in the village it makes the people feel you are part of them.*"

The acceptance of the midwives into the various rural communities was not solely dependent on the decision by the regional or district health management team to send a nurse or a midwife to meet an identifiable need for the services of a health professional. It also depended on the communities' readiness and willingness to accept the services of them. From the narrative accounts, I discerned a clear sense of a strong community involvement in the relationships that developed in the professional knowledge landscape.

Martha narrated how she had to consciously work to build relationships with an entire community in order to get clients to solicit her services. She told how an entire community refused to attend a clinic built for them until she reached out to them. She did not only reach out to mothers but to the community. "*I needed the community to collaborate with me so I had to think of how best to do that… I could be there for over one month with no deliveries. I wanted*

that to change so I had to do that to win them… I did community sensitization. It wasn't easy, hmm! I had to go into the community to talk with them over and over to convince them to attend the clinic." Martha's account introduces another dimension of midwifery relationships in the professional knowledge landscape. It introduces the importance of other people in addition to the pregnant woman and the childbearing family as part of the professional knowledge landscape.

As I read the narrative accounts over and over and thought back on my conversations with them, I began to understand how relationships are contextualised and conceptualised by the midwives depending on their professional knowledge landscape. I am beginning to imagine the uniqueness of relationships within the rural professional knowledge landscape of midwives. Relationship is a core concept in midwifery practice. The concept has received the attention of many researchers for several decades yet its promotion in practice has not been without many challenges (Lundgren & Berg, 2007; Hunter et al. 2008). Lundgren and Berg (2007) stated that despite the available evidence that points to the importance of relationships, in practice little attention is paid to improve the midwife-mother relationship. Whereas a lot of studies have been done relating to the midwife-mother relationship, there was a paucity of research much was found regarding community collaboration for successful midwifery practice. Perhaps, attention has not been drawn to its importance in the rural professional knowledge landscape.

Not only is the cooperation of the community important, but there are other significant people within the professional knowledge landscape who can facilitate or challenge the work of a midwife within the rural areas. Participants identified some of these people as they narrated their rural experiences. All four midwifes mentioned relationships they built with significant individuals who included men (husbands) and opinion leaders such as the Nackabah priests and Traditional Birth Attendants (TBA). There were clear indications that the failure to establish

such relationships would have ripple effects on the relationships between midwives and mothers. Happy believes that the strong involvement of key personalities like the Nackabah priests is more of a cultural thing in the villages. *"Culture is still working and is important in midwifery. The women go to different places in some communities. Here they go to 'Nackabah'* (a religious sect dominant in the Western Region); *they are given all sorts of concoctions to take when in labour before they come to you. They will go for special prayers from the Nackabah priest before they come in labour, it's part of their culture. When they are pregnant they go round to prayer camps and all that. But when they come and there is a problem with the delivery then it is on you, the midwife, and if they feel it is the midwife's fault then you are the one in trouble. The effect of culture is strong in the villages."*

Martha also noted that women preferred to go to the Nackabah priest to deliver or to deliver at home with a TBA and would only come to the clinic when there were complications. To prevent maternal mortality Martha had to build relationships with the TBAs and the priests so she could reach out to the women. She shared her experience with Nackabah Priests "*so when I am called to attend to the women at the worship place, I would take the opportunity to teach them* (the priests) *the right things to be done and get them to refer cases to me and where possible I move the women to the clinic to correct anything that was not done well."* Martha further described some of the ways by which she gradually gained the acceptance and recognition of the entire community. "*Some still wanted home delivery so I did domiciliary midwifery. Even some will deliver at home before they call me but when they call, I go to attend to them. I went wherever I was called to render service. Sometimes the person may need infusion but will still refuse to come to the clinic so I had to go to the home to set up an intravenous line and monitor the person at home and move to the clinic to see my clients there too."* These

relationships are unique to the rural midwifery professional knowledge landscape and shaped the midwives' personal practical knowledge in particular ways.

Getting to know an entire community and the opinion leaders in addition to individual clients required time. This time and attention of getting to know the entire community was a critical element in building trust. Adjoa said, *"you have to take time to know them, to study their culture, know the dos and don'ts and win them so you can educate them about the harmful ones."* Adjoa further explained the importance of building relationships in the rural setting. "*At a point they brought a midwife but there were so many conflicts. The clients wanted me to attend to them when they come but I told them there is a midwife to attend to them. Unfortunately the midwife had poor interpersonal relationships so the clients didn't want to go to her and that created some conflict. The midwife could not speak the language. She also looked down on them and was fond of shouting on the clients so the community was not happy with her. She eventually left."*

In spite of the importance of building good relationships with community leaders and other influential people, the ultimate relationship in midwifery practice is the midwife- mother relationship. In the rural midwives' professional knowledge landscape, the midwife-mother relationship is built with intentionality. The environment provides the midwife with the opportunity to know her clients. The opportunity of continuity of care as a result of only one midwife attending to the pregnant woman during antenatal, labour and delivery, and the postnatal period, helps nurture strong midwife-mother relationships built on trust and mutual respect. Anna noted, "*You know at the smaller place you build a cordial relationship with clients because you may be the only one so you* (midwife) *interact with the client quite often. It makes the woman develop trust in the midwife because they know that the same midwife who attends to*

them during antenatal will care for them during labour so they become confident in you." In this statement Anna was highlighting the importance of continuity of care by the same midwife. As the same midwife attends to a pregnant woman, over time she is able to build trust with the woman and gets to know her well enough to care for her based on her individual needs. By the time the woman is in labour, she and her midwife have developed a plan of care that takes into consideration the woman's particular needs.

Happy, reflecting on her experiences, said, "*My relationships with my clients have always been good… As a midwife your clients have to know you and trust you. You the midwife must also know your client well".* The notion of "*knowing your client*", as Happy stated, suggests a form of intimacy. Perhaps this is what Clarke (1996) referred to as professional intimacy. The expression professional intimacy is appropriate considering the depth of private information the midwife will be entrusted with. This also calls for trust because the midwife, by virtue of her role, is entrusted with information that needs to be held in confidence. Anna explained, "*I have time for my clients because I see that it makes them happy. I also learn from them and get to know what they want. It's all about attitude. It makes both the client and you, the midwife, happy. The client has to be drawn close and not be pushed away. Midwifery work is about relationship. When the clients are happy they will keep coming to you."* Besides Anna's personal desire to get to know her clients, she also commented on how, in rural communities, relationship is paramount to a sustained clinic attendance. According to Anna, *"In the villages the people will not attend the clinic on time… They consider the clinic to be theirs and that they should have access whenever they want. You just have to learn to be nice and tolerant…I had to learn that so I could work with them. You can't be rude or disrespectful ... Such things don't happen in the village or smaller communities. If you do that you will lose your clients. Even the men will discourage their*

wives from coming. But because of the cordial relationship I built, I could get them to gradually change. You need to have time and patience for every client."

It is clear that relationship is centrally important in the professional knowledge landscape in rural settings. Relationships within this landscape are more complex and include many more people than the childbearing family. Additionally, the environmental and contextual factors create the opportunity for continuity of care that further deepens the relationships in the professional knowledge landscapes in rural settings.

The midwives in the study also indicated some level of interactions with other members of the health team. However, it is important to note that such interactions were few and mainly occurred when referrals had to be made. Martha in one of her *"one-man-stations"* had to rely on a Motorola service to seek assistance from doctors. Other participants mentioned instances at the district level where they made referrals and accompanied clients to hospitals. Martha narrated how she interacted with others saying, "*I went to my station six months after school so I needed support. I didn't have much experience so what I did was - there were some midwives in the district, so I took advantage of the Motorola to connect with them and it helped me a lot. I sometimes called the two midwives or a doctor for them to direct me."*

Thinking about relationship also reminds me of how the International Confederation of Midwives' code of ethics for midwives emphasizes the importance of midwifery relationships. Through the development of partnerships by midwives and individual women, relevant information is shared that leads to informed decision-making, consent to an evolving plan of care and acceptance of responsibility for the outcomes of their choices (ICM, 2008). The stories of relationships that the midwives in this study shared were of great significance to their success as midwives. As all four participants shared their stories about how they built relationships with

women, families, and communities, it deepened my understanding around the importance of deep relationships in midwifery. I also understood the concept of relationship in midwifery differently, as not being limited to the midwife and mother but extended to families, entire communities and social systems within the rural community professional knowledge landscape.

Knowledge for midwives: Professional knowledge landscape in rural communities

In this study I identified two categories of knowledge that dominate the professional knowledge landscape of midwives. These are the knowledge for midwives and midwife knowledge. In chapter two, I described the "knowledge for midwives" as the professional knowledge that is handed over to midwives through formal education, training workshops, and protocol guidelines. Professional knowledge is highly objective, explicit and easily communicated. This type of knowledge is what Polanyi (1958) referred to as propositional knowledge or the "know that" type of knowledge. Midwife knowledge refers to the personal practical knowledge of midwives, which is experiential, embodied, and narrative knowledge. Personal practical knowledge of midwives is non-propositional and represents the "know how" of midwifery knowledge.

Both professional knowledge, that is, knowledge for midwives, and personal practical knowledge of midwives shape the rural professional knowledge landscape of midwives. All four participants shared stories of how, as nurses, they were confronted with the responsibilities of working as midwives without the requisite professional qualifications and skills needed to adequately care for women in labour. At different periods in their stories, each participant realized the need for professional knowledge and each pursued formal midwifery education. Their stories underscore the importance of acquiring professional knowledge irrespective of the professional knowledge landscape within which she was working.

Professional knowledge as evidenced by each participant's account was developed through formal midwifery training and education. By training I am referring to the programmes that are offered mostly for practicing midwives to teach them specific skills needed to be competent and proficient in their jobs as midwives and to update them on current trends and innovations. These workshops and protocol guidelines are underpinned by research and policies. On the other hand, I use education as the formal classroom experience that student midwives receive that is mainly focussed on theoretical knowledge. It is important for me to add that midwifery education is a combination of theoretical knowledge and practical skill acquisition.

All four participants shared their experiences of attending workshops and using protocol guidelines in similar ways. Happy underscored the importance of workshops and how difficult it was to take time off her busy schedule to attend when she worked in the villages. "*The workshops are very good but it is difficult to find time to attend these workshops. When you are under somebody you have to ask permission. ……. at a one-man-station I have to get someone to be there so I go.*" After attending so many workshops with many certificates to show, Happy mentioned some of the benefits of the training workshops and how it has increased her personal practical knowledge when she said, *"They have workshops on new things that are coming up so we get to know…We only get to know the new things when we go for workshops.*" Happy, who now owns a maternity home, partly attributes her decision to set up her private practice to the professional knowledge she received through attending workshops. Anna, a beneficiary of many skills training workshops, also commented, "*The workshops are very important for we midwives but not everyone wants to attend. Midwifery things keep changing so if you don't take advantage you will be practicing with old knowledge."* Likewise Martha and Adjoa told how the many workshops they attended facilitated the care they provided for women during labour in profound

ways, that is, they drew attention to how their personal practical knowledge was enhanced by the professional knowledge for midwives they received at workshops.

Situating the importance of training workshops in the context of the rural professional knowledge landscape for midwifery practice, participants talked about how important workshops are to enhancing their personal practical knowledge. According to Martha, *"The workshops help us to get to know the new innovations. It is a major opportunity for midwives to continue to learn."* Narrating further about her professional development Martha traced her success as a professional midwife to the out-of-school-training workshops. Similarly Adjoa noted, "*It's not only in the classroom that we get* (professional) *knowledge. When we attend workshops a whole lot is learned. The protocols and training workshops makes your mind sharper. It provides information on what to do and so you act fast."* Training workshops and the use of clinical protocols remain key to quality health care delivery irrespective of whether the professional knowledge landscape is situated in rural, urban, or private settings. The use of clinical protocols allows health care providers to offer appropriate care and treatment with many benefits to both the provider and the client (Heymann, 1994).

Martha spoke about how she would put together her monthly reports, "*Sometimes the person may need infusion but will still refuse to come to the clinic so I had to go to the home to set up an intravenous line and monitor the person at home and move to the clinic to see my clients there too. I would put together my monthly report and send to the district director for him to know what was going on."* The other three participants also highlighted the importance of their monthly reports and how it reflected their training needs and evidence of utilization of protocols and previously acquired professional skills. In these monthly reports midwives had to

show evidence of professional knowledge. Their accounts of practice had to conform to standard, evidence-based best practices.

Participants described how protocol guidelines helped them to know the interventions to carry out when there were complications. I recall Anna telling me about her work at a district hospital, "*When I got to this hospital on my first day I thought there would be doctors. I was confronted with a case of eclampsia. I saw the patient having seizures, I quickly organized myself and prepared the regimen of Magnesium sulfate* (*MgSO4*) *and administered it as per the protocol."*

Over the years the global efforts to reduce maternal and infant mortality has increased the need for midwives to be equipped with lifesaving skills. The emergence of new conditions such as HIV, the widened scope of midwifery practice, global policies and agendas as well as innovations in science and technology have necessitated the change in curriculum content for midwives. A few decades ago midwives did not have the mandate to carry out interventions such as vacuum extraction and manual removal of the placenta. Such new mandates were implemented to avoid delays leading to death or serious morbidities (Thaddeus & Maine, 1994; Barnes-Josiah, Mynitti, & Augustin, 1998). The additional professional knowledge and skills midwives receive through training also increases their professional autonomy to practice.

Today midwifery is seen as an answer to the challenges of meeting the maternal and newborn care for all women and newborn infants globally (Sakala, & Newburn, 2014). The aforementioned trends have led to a shift in the professional knowledge of midwives to accommodate the explicit knowledge needed in meeting the new trends. Midwifery education, training workshops and the use of protocol guidelines provide professional knowledge for practice that cannot be compromised. These feed into the professional knowledge landscape of

midwives even in the rural communities. They bring standards and uniformity in professional midwifery knowledge and practice.

Professional knowledge landscape in urban communities: working in district and regional hospitals

I identified a different professional knowledge landscape in district and regional hospitals. While I recognize there are other types of clinics and hospitals in the urban communities, I focus on district and regional hospitals because the experiences of participants were in these hospitals.

The importance of place: the urban physical environment

The experiences of all participants while they worked in urban district or regional hospitals were significantly different from their rural experiences. The district and regional hospitals where participants worked were mostly located in metropolitan and cosmopolitan areas. These physical locations were typically larger communities with more developed social infrastructures and many vibrant and diverse economic activities compared with the rural areas. The urban areas had large populations of people from various cultural backgrounds. People co-existed in the urban areas without necessarily knowing each other or being directly involved in the social and economic activities in the place. Thus relationships among the inhabitants were not closely knit. Because of the diverse nature of the urban population, it was not common to have identifiable individuals as opinion leaders who were influential in health issues and the day-to-day activities of the towns and cities. Decisions about staffing of hospitals are the sole responsibility of health management teams. Decisions about when and where to seek health care is mainly made by individuals or families.

It is not uncommon to find people working and living in different communities; at times the places of home and work can be several kilometers apart. While working at regional or

district hospitals, participants indicated that they did not live close to the hospitals. The exception was Martha who, at the time of the research conversations, lived in the hospital compound. Having accommodation off the hospital compound gave them clear working hours with distinct duty shifts. Living a distance from the hospitals, with clear working hours, had consequences for how they related to their professional knowledge landscape. Adjoa, recounting one of her experiences in the district hospital, narrated how she came back to work after a shift to find that a client she nursed had died. Adjoa said she had a conversation with her client before she went home at the end of her shift. This statement indicates some clear separation between work and home. According to Adjoa, she told the client before she left the ward, *"Atta Maame* (mother of twins) *I am waiting for you to recover fully and go home so I can attend the recovery party. She laughed as I closed and went home. I came for the afternoon shift on the third day. When I got to the ward her bed was empty… I was told her condition changed during the night; she had series of fits and died in the early hours of the day."* Midwives, within this professional knowledge landscape by virtue of where they lived and work, except in few cases, did not work 24 hours on call. While this gave them time to spend with family and be involved in other social activities, it changed their relationships on the professional knowledge landscapes.

Additionally, because of the large population size and socio-economic development, most urban communities have more than one health facility including private clinics. This was typical of the regional capital. Clients, therefore, have a choice regarding where to seek health care unlike the rural settings where one clinic served several communities. This too changed the professional knowledge landscape of midwives.

The midwives in this study did not complain about the lack of social amenities although development in many of the district capitals was not optimal. With regards to adjustments

needed to work within the urban communities, not much was said as compared to working in the rural professional knowledge landscape. I can only imagine that since all four participants had their immediate families living in towns and cities, and had lived and been schooled in towns and cities, adjusting to urban life was not a significant issue in their accounts. They shared stories of how they experienced significant differences working in rural and urban areas. Adjoa noted that the urban professional knowledge landscape was different from the rural professional knowledge landscape. "*To me all midwives do not work equally. The work and experiences of those who work at the bigger facilities is completely different from those who work in the smaller."*

Physical facilities of urban hospitals were relatively large such that they accommodated different units of maternity services, including separate antenatal units, labour wards and postpartum units, to mention a few. The participants noted working in specific units at specific times. This too significantly shaped the professional knowledge landscape in urban and regional hospitals.

Building relationships in the urban professional knowledge landscape

In district and regional hospitals, participants did not have the option of caring for women from antenatal through to puerperium. Because they were assigned to specific units at particular periods of time, building relationships with clients with attention to continuity of care was not possible. In this professional knowledge landscape midwives usually had only a few hours to get to know their clients after the clients arrived to deliver. The number of clients who utilized midwifery services in the district and regional hospitals were usually many, especially on the antenatal units. The success of the midwife - woman relationships, as the participants spoke of them, seemed to be contextualised differently depending on how busy/ big the health facility was. Adjoa stated, "*What I have noticed from experience is that in the big hospital both the client*

and the midwife do not feel relaxed. The women are many especially at the antenatal… They (clients) *are in a hurry to go home or to go and attend to their businesses so they want to be seen fast.* "

During my Master's thesis, when I had conversations with pregnant women, some narrated how they went to the antenatal clinic as early as 5am so they could be ahead in the usually long antenatal queue. They wanted to see the midwife early enough to leave and attend to their daily activities. This resonates with Adjoa's statement that "*Most of them* (clients) *don't have time to relax and ask questions and get to know the midwife. They want to be seen quickly, told that everything is alright so they can go…. At the same time the midwives are also overwhelmed with the numbers. They* (midwives) *want to attend to everyone within a specific period of time* (suggesting that they wanted to see them within their shift)*. They don't want delays. Building of relationship is not a priority".* Again the nature of the relationship and the success of it were influenced by geographical location and in some cases could be affected by social status. This was a significant shift in the relationships within the people on the professional knowledge landscape.

The lack of opportunity for the continuity of care of pregnant women through antenatal, labour and postpartum brings to my memory my experience with Akosua, the 17 year- old girl perceived as difficult and uncooperative during labour (See Chapter 1). The hospital where this experience took place was a regional hospital. Perhaps if the same midwife she met during the antenatal period had seen Akosua, her story during labour would have been different. I am wondering how different Akosua's childbirth experience would have been if she had received maternity care in a village at a health centre. I also wonder how many women have had similar experiences because of the professional knowledge landscape where they received care.

Services in the professional knowledge landscape in the urban and regional hospitals are departmentalized into specific units to enhance effective and efficient work. Adjoa described how she worked at different units while working at the regional hospital. "*At the regional hospital I was moved from one place to the other: casualty unit, paediatric unit, male and female medical wards. I worked the longest at the female medical ward and the paediatric wards… I worked at the labour ward for some time and then to the laying-in ward and then to obstetric and gynaecology unit, then antenatal unit."* In the district and regional hospitals different units provided maternity services. Being able to work on multiple units is evidence of the broad scope of midwifery practice and also shows how the professional knowledge landscape is quite different than in the rural professional knowledge landscapes. Martha noted, "*The work of the midwife is very broad but it also depends on where you work. If you are working at a one-man station you take care of general cases just like a general nurse. You do suturing, take care of all general cases, then you care for pregnant women, gynaecological cases you counsel them and refer to gynaecologist or obstetrician. When a woman is pregnant the midwife cares for the woman until she gives birth. You will be with the woman during labour and care for her and the baby for six months after delivery… It is not the same at the district and the big hospital. There you work at a particular unit at a time."* As I reflected on Martha's words and how she experienced these distinctly different professional knowledge landscapes, I see links between Martha's comment and Anna's statement about being "*all round*" on the rural professional knowledge landscape. "*I realized then that if you worked in a one-man station and you are not all round, you will get into trouble."* Although Anna was referring to her work in the village, I see the different experiences she had when she was transferred from the regional hospital to a health center in a village.

Staffing in district and regional hospitals is different from the health posts and health centers in rural communities with consequences for the relationships in the professional knowledge landscapes. The participants' accounts present the professional knowledge landscape working in district and regional hospitals as characterized by indirect or unintended specialization in specific midwifery skills depending on the unit and the length of time spent in a particular unit. Martha talked about her decision to work part time at a private maternity home to support her colleague midwife who, having spent her entire career at a regional hospital, had not experienced the labour ward. According to Martha, " *the midwife who started the private maternity home where I work part time asked me to help her set up the clinic… throughout her career she worked at the regional hospital and spent many years at the antenatal clinic. She has no labour ward experience so she asked me to help."* The staffing arrangement meant that the professional knowledge landscape was constructed in ways that meant there was specialization rather than continuity of care.

Another characteristic of midwives' professional knowledge landscape in urban areas are the relationships with members of various health professions. There are doctors, including specialists such as obstetricians and surgeons. There are also pharmacists, laboratory technicians, administrators, social workers and many other professionals. These other professionals also inhabit midwives' professional knowledge landscapes. Within the nursing and midwifery professionals working in urban settings, there are also different categories of nurses and midwives. These professionals also inhabit the professional knowledge landscapes.

Within the complex urban professional knowledge landscape, there are authority protocols and standardized processes for making decisions. Thus the relationships and interactions in this professional knowledge landscape are more complex than the professional

knowledge landscapes in rural settings. The decisions about management of health services do not rest with midwives. As participants worked in these hospitals, they worked in collaboration with these different professionals. Unlike the rural professional knowledge landscape where collaboration was mostly between midwives, community members, TBAs and clients, the collaboration in urban settings involved many more professionals. Happy commented on the presence of doctors in this professional knowledge landscape. "*You know in the village you are alone there, but at the urban, you know, they are all the time with doctors so at the rural you do your own things."*

In the professional knowledge landscape in the district and regional hospitals, collaboration was between various professionals. The dynamics of these relationships are different and call for different knowledge in order for midwives to collaborate within the distinctive professional knowledge landscapes. Anna shared some of her experiences as she worked with doctors in rural professional knowledge landscapes, "*Even when I work with doctors, unless it is beyond me, I don't go calling them every now and then about just anything. The doctors don't stay there all the time so I work hard to prevent complications. I detect them early so that I refer as soon as possible. If you are a midwife and for every little thing you go running to call a doctor, they (doctors) will not even respect you as a midwife. Your in-charge can't trust you when you are on duty even if you are a senior."*

According to Happy she learned from doctors as she worked at the district hospital after her midwifery education. "*I still had to learn to practice what I learnt in school… I remember on the labour ward whenever I do vaginal examination (VE) I will feel something bulging then I will say aaai! there is something there oo, forgetting that that was the membranes. So I will complain*

to the doctor, he will come and check and say ooo mama it's the membranes, its bulging so do artificial rupture of membranes then I will do it and do the delivery."

Similarly Martha spoke about her work at the district hospital and her interaction with doctors. "*I teach my midwives at the hospital and also the attendants at the maternity home. I even teach the doctors."* Adjoa also had this to say, "*In the bigger hospitals you can say that you are waiting for the doctor… to take the decisions about a client. In the rural area it is not the case at all. There is no way you can get a doctor. Even in some smaller* (district) *hospitals where there are doctors there is usually only one doctor and there are times he may be in theatre carrying out an operation."*

As I reflect on Anna's statement "*The doctors don't stay there all the time so I work hard to prevent complications"* and Adjoa's assertion that there were times that the doctor was not be readily available *"There is usually only one doctor and there are times he may be in theatre carrying out an operation."* I too considered the influence of time on the experiences in the urban professional knowledge landscape. While I understand that there were doctors at the district and regional hospitals, sometimes midwives were left to decide on the plan of action in a particular situation. It was at these moments that midwives were required to draw on their personal practical knowledge. While it is not clear how frequently these situations arose, it is important to know that their experiences in the professional knowledge landscape of district and regional hospitals were sometimes ones in which they worked alone, drawing on their own personal practical knowledge.

Exploring knowledge for midwives: Professional knowledge landscapes in district and regional hospitals

The participants shared their experiences of coming to appreciate the scope of midwifery practice as broader and more complex than just delivering babies. The stories around the scope

of midwifery practice, and the realization of the need for formal education and skills training drew my attention to the importance of the global agenda of having skilled attendants at every childbirth (WHO, 2017). Midwifery has been associated with more efficient uses of resources and improved psychosocial outcomes when provided by midwives, who were educated, trained, licensed and regulated (Renfrew, 2014). Knowledge for midwives on the professional knowledge landscape for urban and regional hospitals was similar to that on the professional knowledge landscape of rural communities. Professional knowledge was obtained through formal education, training workshops, and protocol guidelines. Whereas the professional knowledge needed to practice midwifery cuts across the two professional knowledge landscapes discussed so far, there are differences in the level of utilization of knowledge for midwives. At the district and regional hospitals midwives work in collaboration with other health professionals.

Midwives in district and regional hospitals work with strict institutional policies, and are conscious of professional boundaries that follow from the policies and disciplines of health study. The professional knowledge landscape is strongly shaped by the multiple health professionals who live within the landscape. Midwives are less likely to intervene during complications if they can call in a doctor to intervene. Some procedures such as manual removal of placenta or vacuum extraction would be performed by midwives in rural areas, in cases where a referral was not possible. However, if the need arises in district or regional hospitals midwives call a doctor.

As participants shared their experiences they indicated how even in district and regional hospitals, they sometimes rely on their personal practical knowledge without calling other specialists when they were confronted with complications in the absence of a doctor. They called

forth their personal practical knowledge to manage such situations. However, in the district and regional hospitals they usually elicited the assistance of the doctors and their colleague midwives, even when they could have acted on their own.

Apart from the availability of doctors, the presence of supervisors such as administrators, nurse/midwifery managers, and senior colleagues also reduced the expression of personal practical knowledge because supervisors expected protocols to be followed strictly. The strict adherence to protocol guidelines and procedure manuals tended to restrict the innovation of midwives (Mahran et al, 2007). They recorded fewer experiences where they drew on their personal practical knowledge in the professional knowledge landscape in district and regional hospitals.

Considering that in the professional knowledge landscape of district and regional hospitals, midwives are aware of the ways they can express their personal practical knowledge, I wondered about the kind of stories (see the following section) that filled this professional knowledge landscape. Midwives sometimes lived cover stories as they expressed their personal practical knowledge. Anna shared an experience where she used her personal practical knowledge to help a baby in distress while she waited for the doctor. Eventually the doctor came. The baby was delivered in good condition. The doctor was surprised at the sudden improvement of the baby's condition but Anna could not tell him exactly what she did. She had a secret story but told a cover story. Anna explained, "*While I was working in the hospital I had a woman who came in labour. On auscultation the fetal heart (FH) sound was very weak; it was actually falling. The woman was an elderly primip. The doctor could not be reached. I had devised a way of dealing with low FH while working in the village. No one taught me but I had good results all the times I used it. It was my own 'kusum'. I had also read that when a baby is getting into*

distress you give the mother oxygen. So in this case we gave oxygen as well in addition to my 'kusum'. Within a short time, the FH started to pick up and eventually was stabilized. As soon as the uterus was cut open the baby was brought out crying. The doctor said, 'didn't we say the fetus was in distress?' Then someone said, not to the hearing of the doctor though, that Anna had performed her magic again. Even the morning staff said I had done magic. The baby did so well till discharge. I still know where that particular client lives. That pregnancy was the woman's first after so many years of marriage and after she did not have another one ever. Can you imagine if she had lost that baby at birth? That would have been it. The doctor was indeed surprised at the sudden change in condition."

The above account shows that even in the professional knowledge landscape in district and regional hospitals midwives' personal practical knowledge is expressed when a physician is not available. Midwives do live secret and cover stories in the professional knowledge landscape in the urban district and regional hospitals. Midwives' personal practical knowledge is expressed but this was not captured in their nurses' notes and reports.

Professional knowledge landscape of midwives working in private maternity homes

The professional knowledge landscape of midwives working in private maternity homes/clinic is the third professional knowledge landscape identified in this study. Though similar to the professional knowledge landscape in rural communities, it has its distinct characteristics. All four midwives at the time of the study worked in maternity homes either on full time or part time basis. Two participants, Happy and Adjoa, were owners of the maternity homes while Anna and Martha work as midwives at clinics.

The importance of place: the physical location of maternity home

All four maternity homes where participants worked were situated in vibrant communities within less than two hours drive from the regional capital. Happy's maternity home was located in a community that appeared to be heavily populated given the many houses and the busy untarred road full of people moving about or clustered along the road. The community was once a village but, with development and growth of the suburbs in around the outskirts of the regional capital and improved road networks, it has become closer to the capital. Although many people who are not original natives of the village have moved to settle in the community, the village setting has not been completely transformed. Driving through the community, I saw houses in the center of the community that are typical of a village. Some parts are still farmlands. It is easy to identify that the place is a village that is developing into a town. Because of the nature of the community, Happy, on several occasions, referred to the place as her village. "*When I started my clinic in this my village the people would come with all sorts of conditions, not only labour, and I would attend to them but the payment was a problem."* In another conversation Happy spoke about why she chose to build her clinic in that particular community. She said, "*I bought this land many years ago. You know I don't come from this region but throughout my career I have worked in the Western Region so I decided to settle here when I retire. The time I bought the land here was a complete village just that people from outside have bought lands and are building big, big houses and have shops and other jobs here. But the village is still within and the villagers still behave the same. The culture and the taboos are still working."* The maternity homes where Anna and Adjoa worked were also located in suburbs of the regional capital. These places had complete features of a town in terms of population, and infrastructure development. The influence of place on the professional knowledge landscape of

midwives in the private maternity homes was dependent on the type of social environment in which the clinic is sited, that is, whether it is a town or village.

Building relationships in the private maternity home professional knowledge landscape

Happy and Adjoa, who had both retired from government service, traced their decision to start private maternity homes to their experiences over the years. According to them, their work in the villages provided them rich experiences that served as motivation for starting their own private work. Happy said, "*It is that experience that has helped me to run my own clinic. I take it that this is what the village work gave me. I don't need anything else."*

The participants alluded to the fact that starting a private maternity home was not a simple venture. It required commitment and dedication. Unlike the government facilities, the responsibility (both financial and physical) was on the midwife. The income generated is used to finance the activities of the maternity home, as Anna mentions: "*The private clinics charge directly for the services so if you are not nice you will lose your clients."* Anna's words draw attention again to the importance of the relationships that the midwife developed with others who inhabited the professional knowledge landscape in a private setting. The participants linked the success of private maternity homes to the relationships that the midwife built with the members in the communities where they worked. "*Most workers including midwives are compelled to be nice at the private clinic. If not, they will not be paid. It is the client attendance that determines the income you generate. Interestingly it is the same people who work in the government sector who work at the private. The key thing is to respect your client".*

There were other features that shaped the professional knowledge landscapes in private settings. Anna explained, *"within the community, they like the private hospitals. Here, even if your things are in a "Polythane bag" we accept it, the most important thing is for you to give*

birth and go home safely unlike other areas where you have to put your things into a suitcase." The relationships are ones in which midwives must go out into the community to provide service.

Anna also described the relationships in the professional knowledge landscape of private clinics as important for determining the patronage of clinic by community members. According to her, "*When you are in private practice your attitude is very important to retain your clients. When you are nice to them and smile at them, then you will do well. If you work in the community your attitude and how you relate with the people is important. If you are good, the community will love you and they will not have anything bad to say about you. The community members talk among themselves. They know where the good midwives or clinics are. They would either recommend you or discourage people from coming to you."* Anna underscored further the importance of relationships in the professional knowledge landscape. *"A woman (midwife) who left here before I came was talking to the clients anyhow, no privacy, when she talked, everyone even outside could hear, so they reported her to the employer and he also got to know that he was gradually losing clients, so he sacked her."* Happy also stated *"the close relationship is important; that is the difference between the private and government. The woman will know you well in the private and one-man station."* Anna, compared it with her experience at the village saying "*So in the community where the maternity is, it is like a small village, you can't fight with them, else they will sabotage you. In the same way, if you work in a private hospital and you fight with your patient, they will report you bitterly to your employer and you will be sacked."*

Social interactions in this professional knowledge landscape were similar to that of the village settings. The midwives had close relationships with their clients as they usually attended to them from pregnancy through to childbirth and beyond. In all four maternity homes,

participants were the only professional midwives and were assisted by people trained on the job. Midwives in this professional knowledge landscape had little or no interactions with doctors and other health professionals unless they referred their clients to the hospital.

Social interactions extended beyond the community and the clients to include other midwives and doctors working at referral centers. Participants expressed their dissatisfaction with relationships with other colleague midwives at the referral centers. Anna said, "*Sometimes I send referred cases to the regional hospital. I have to stand there for a long time and no one will mind you. I just have to reassure the client that the midwife is busy and will attend to us. But even when you are busy once someone comes and says I am coming with a referral patient, you should have time to attend to them. They will not mind you until they have finished with everything."*

Participants spoke of having meaningful relationships with the midwives' association and benefited from such interactions in different ways. These relationships also shaped their professional knowledge landscape in the private settings. The midwives also mentioned their involvement in the private midwives' association as being helpful. Happy noted benefits she derived from being a member of the association. She recounted the many occasions she attended workshops, and opportunities she had to interact with other midwives who shared their personal experiences with her. According to Happy, "*I joined the association before I retired from public service. When you join as a public midwife, me I joined as a public midwife. Some people retired before they joined. Why I joined was that, when I wanted to open the clinic I saw the national president and my director. Because when you need something you must be an active member then they will help you. So when you join you will be learning things. They* (Association) *have workshops. When we come together and you see that your sister is not doing the right thing you*

teach her. If I had not joined the association and I just started the clinic like this I don't think I would have succeeded. Even those in the government they don't even have time to be part. Sometimes they (Association) *call us to tell us to go for workshops on the new things that have come. Our phone numbers are there so they call us. So I benefited a lot from this association. It is very good".* As I pondered what Happy and other participants shared about relationships in this professional knowledge landscape, I perceived that the primary reason was first and foremost to ensure that they succeeded as private midwives and maintained their clientele.

Exploring knowledge for midwives: Professional knowledge landscape in private maternity home settings

Midwife's knowledge is comprised of both professional knowledge and personal practical knowledge. The professional knowledge delivered to midwives becomes part of each midwife's personal practical knowledge, in particular and unique ways. Participants attributed their decisions to operate or manage a private clinic to the knowledge they gained from the numerous training workshop as well as their personal experiences of working in the one-man-stations. Happy narrated "…. *That is why some of us decided to come and do something for our own self* (private maternity home) *so we can practice what we have learnt from the many training workshops. I can practice in the village to help. All of us cannot go to the big hospitals so the people that are here we can help them. It is that experience that has helped me to run my own clinic. I take it that this is what the village work gave me. I don't need anything else."*

Happy explained her motivation for opening a private maternity home "*The private idea started when I was planning to come home on retirement. I don't know if I told you that I was practicing nursing and trading at the same time. At a point I told myself, "God now I cannot carry things going up and down selling". A lot of courses I took in midwifery, family planning,*

the workshops and my experience. Am I to come on retirement and put it under the table? I decided that I will open a private clinic and help people."

Anna said, "*In the village you are the only person so you have to do it well for the client's safety because when a problem comes who are they going to blame? They know who is responsible, you are the only person. that is why at the village you work hard to save your clients. It is the same as my place* (maternity home)*."* According to Martha, *"The attendants there lack skills and knowledge in a lot of things. Everyone working there is considered a midwife and even dresses as such but they are not. It is time that the private homes employ professionals. There are some skills that are difficult to get if you are not a professional."* From the experiences that the midwives shared there appears to be some similarities in the knowledge used. It is similar to the rural professional knowledge landscape. Midwives worked there alone, and were responsible for their actions. They mostly relied on their experiences and their professional knowledge, in part because they do not work under the scrutiny of administrators and supervisors, especially those who own the maternity homes. They were free to work with their personal practical knowledge without fear. Their cover stories were usually told when they referred complicated cases to the referral centers. Happy said, "*We cannot tell the doctors everything that we may have done if it is not part of the protocol. Once everything works well and the woman and her baby are both fine you don't have a problem."* Their secret stories were mostly shared at their association meetings during informal conversations, so that others also learned. Since the midwives spoke about how professional knowledge gained through workshops and protocols have helped them to work at the private maternity homes, I can only assume that they do have some secret stories on this professional knowledge landscape. Martha spoke about the use of the partograph as an important tool that every midwife must use irrespective of where

she works. "*There are some skills that are difficult to get if you are not a professional."* Martha mentioned the use of the partograph; a clinical tool for the management of labour as one skill that is lacking at places where the attendants are not professional midwives. She said, "*For example the use of the partograph. It is the midwife who understands and can use it. Most of the maternity homes do not use it. At my private maternity home for example I have started using the partograph. It is high time that every maternity home gets a midwife who will run 24 hours. The ethics of the profession needs to be guarded*." Both knowledge for midwives and midwives knowledge have their rightful places on the professional knowledge landscape of the private midwives.

Living secret and cover stories in the professional knowledge landscapes in urban, rural and private settings

In chapter two, I introduced three kinds of stories that filled the professional knowledge landscapes of teachers based on the work by Clandinin and Connelly (1996). They described secret stories, sacred stories and cover stories. Secret stories are the in-classroom stories where teachers' life and practice are not under scrutiny. Clandinin and Connelly (1996) described the relationship between theory and practice on the professional knowledge landscape as having the quality of a sacred story (Crites, 1971). They saw the story that theory drives practice, and that practice is applied theory, as having an unquestioned quality that shaped the professional knowledge landscape. Cover stories are the stories teachers tell concerning the generally accepted expectations of what they have to do as teachers, and how they do what is expected of them as teachers. Cover stories are based on what is prescribed by the system and handed over to teachers. Clandinin and Connelly (1996) are of the view that teachers tell cover stories to portray that they know what policies they are expected to implement while in reality their actual practice

is interlaced with their personal practical knowledge, a reflection of their embodied narrative knowledge.

Similarly, in this study midwives had secret and cover stories. In their out of labour ward places and monthly reports, midwives told cover stories to portray that they knew what policies they are expected to implement, even if they may not be implementing them in the expected or prescribed ways. When participants shared stories of their use of protocol guidelines to intervene during complicated labour cases they sometimes shared cover stories when their actions did not conform to the dominant stories of protocol. The cover stories were part of the monthly reports produced by midwives to their district health management team as they gave account of their activities at the *"one-man-stations"*.

Halldorsdottir and Karlsdottir (2011) noted that using protocols for maternity care have become common. They argue that these guidelines must be seen as positive because they increase evidence-based practice. In as much as I agree with their assertion I also recognise the inadequacies of solely relying on protocols. Most of these protocols provide the technical or "know what" aspect of care and do not provide the midwife the "how", that is the art of midwifery care. As Martha clearly stated "*The protocol spells out what you have to do but you need to know how to do what the protocol is prescribing. The protocols are good and really helpful but it is not enough to get the work done. You have to learn how to do it. Your knowledge must be comprehensive.*" From the stories shared concerning the use of protocols all the midwives spoke in relation to experience and to the importance of their personal practical knowledge. Thinking about the use of protocol in relation to a midwife's experiential knowledge brings to mind Mahran et al's (2007) argument that protocols present a risk of restricting the freedom of professionals and reduce professional innovation. As I considered the experiences of

the four participants, I wondered about the ways that reliance on protocols or procedures does not account for teacher knowledge, or the ways in which each midwife holds personal practical knowledge.

Happy shared an experience of using a particular protocol and how she decided afterwards to use her discretion in the future rather than the protocol. The stories around the use of protocols and professional knowledge, knowledge for midwives, from training workshops, and from literature are stories that could be told outside the labour wards, to administrators, to doctors and other members of the health team with confidence and without fear of being questioned about the appropriateness of their actions. These cover stories were mostly captured in their formal documentations and monthly reports. The actions in their cover stories are usually well documented in clients' folders and are expressed in monthly reports in summarized forms. As I reflect on our conversations I can identify the cover stories as the formally accepted forms of practice by which a midwives' actions would be scrutinized and judged when necessary. I have also come to understand that midwives working in rural communities sometimes live out cover stories when they file their monthly reports and that they sometimes live secret stories in the professional knowledge landscape.

In addition to training, all four participants shared stories about their midwifery education. During the period when the participants were engaging in the research, midwifery education was almost compulsory for career progression. Because of the shortage of midwives all four midwives in the study had the burden of attending to pregnant women and conducting deliveries before receiving formal midwifery training. All participants mentioned that irrespective of the midwifery skills they had acquired informally, they became conscious of the gaps that the lack of formal midwifery education created in their professional knowledge. Martha

had this to say, "*As for midwifery school I put in all my effort… I saw the need to upgrade myself.*" What was seen as inadequate professional knowledge denied them the right to be called midwives although they took on midwifery duties.

Across all four narrative accounts the midwives justified their need at that time for formal midwifery education. Their justification came from the positions held, the places they worked, their future aspirations, or a combination of all three. Martha wanted to go to school so she could fulfill her dream as a midwifery teacher. "*I wanted to go and do the SRN… My career is nursing/midwifery but my real passion is teaching. I wanted to be a teacher. Because of that as a midwife I am always ready to learn and teach."* Happy had similar reasons. "*I knew that if something went wrong while I am taking care of a woman I will be in trouble so I had to go to midwifery school."* Adjoa said, *"I wasn't a midwife then but I was working as a midwife. I did deliveries and other midwifery things. I knew I had to get midwifery education.*" Anna's statements were similar.

As I continue to explore the professional knowledge landscape of midwives I reflect on the role of place with regards to midwives' professional and personal practical knowledge. I understand, in part, how the geographical location of a midwife can determine how she will access and utilize the professional knowledge, that is, knowledge given to midwives, on the professional knowledge landscape. Based on their place of work in the rural communities where they mostly worked alone they needed to have comprehensive knowledge and skills to facilitate their work. Their place of work also to a large extent determined how they could or could not attend school or training workshops even if they so desired. It also determined the opportunities they had to utilize the knowledge they acquired. Happy spoke about the importance of creating opportunities to utilize knowledge when she said "*That is why some of us decided to come and*

do something for our own self (her private maternity home) *so we can practice what we have learnt from the many training workshops. I can practice in the village to help."* Although the issue of professional knowledge was well articulated by participants I also see in all the narrative accounts their personal practical knowledge in the professional knowledge landscape in the rural communities. I discuss this in subsequent paragraphs.

Midwives' Knowledge: Personal practical knowledge

Personal practical knowledge as I discussed in chapter two is a conceptualization of knowledge that brings together the work of many philosophers and researchers such as Dewey (1934), Polanyi (1958), Elbaz (1981; 1983), and Schoen, (1983) among others. Connelly and Clandinin (1988) defined personal practical knowledge as "a moral, affective, and aesthetic way of knowing life's educational situations" (p. 59). Clandinin (1985) asserts that, "Teachers develop and use a special kind of knowledge. The knowledge is neither theoretical, in the sense of theories of learning, teaching and curriculum, nor merely practical in the sense of knowing children" (p. 67). And yet, for Connelly and Clandinin (1988) personal practical knowledge is theoretical and practical, subjective and objective in that it is intersubjective.

Verloop et al (2001) suggests that personal practical knowledge comprises individual experiences, personal history, and personality differences. Though the description of personal practical knowledge suggests that it is constructed through individual personal experiences, there is at least one resonating thread across the storied accounts of all four midwives. Experiences shared by participants indicated the use of personal practical knowledge of midwives more extensively in the rural communities and in *"one-man stations"*. I can only imagine that as the midwives worked alone in these settings and interacted with different people, their experiential knowledge was built over time, and embodied in who they were as persons and in this way

became a reservoir of knowledge from which they drew from when confronted with situations, including those that lacked clear-cut solutions. Personal practical knowledge, as I discussed earlier, includes what Polanyi (1958) referred to as personal knowledge. All knowledge is personal to some extent. According to Polanyi (1966) knowledge is rooted in tacit knowledge. He believes that, as human beings, "We can know more than we can tell" (p. 4). Polanyi (1958), discussing non-propositional knowledge, introduced the concept of tacit knowledge. He argues that tacit knowledge is the kind of knowledge that is difficult to transfer to another person by means of writing, demonstrating or verbalizing. Tacit knowledge is considered as skills, ideas, and experiences that people have but are not codified and may not necessarily be easily expressed (Chugh, 2015). As I return to the narrative accounts of participants, I identify the personal practical knowledge, which is also for the most part tacit knowledge as shaped by, and expressed in, the professional knowledge landscapes of midwives working in rural communities as well as in some situations in urban settings. Personal practical knowledge is embodied knowledge, experiential, tacit, moral and emotional knowledge.

Martha in a conversation described midwives' personal practical knowledge as coming from multiple sources and was explicit about the difficulty in transmitting personal practical knowledge. She said, "*As for the knowledge it is not from one source. Midwives get knowledge through many ways ... Sometimes you know, you know something but you just don't know how or when you knew it and it is difficult to teach someone."* She linked personal practical knowledge to experience by saying, "*Different situations in life will teach you things. It is not only from school…sometimes the source may not even be related to midwifery at all".*

Reflecting on the idea of knowing something and not being able to tell how and when you learned it, as well as the difficulty in sharing such knowledge makes me appreciate personal

practical knowledge. It helps me to agree with Haldin-Herrgard (2000) that tacit knowledge cannot be given in lectures or found in textbooks, databases or manuals. Such knowledge is embodied and can be shared in actions during interactions and informal meetings of midwives. It can also be shared when students or newly qualified midwives work closely with experienced midwives in clinical areas as a form of apprenticeship or mentorship or in other forms of social interactions of midwives.

As I ponder over how personal practical knowledge is shared, I am beginning to understand the secret stories that midwives share in safe places where they are not under scrutiny. Adjoa talked about how some of these actions are kept among midwives. "*There is a whole lot that we do as midwives but sometimes we are afraid to document them because it is difficult to explain it. So it is not only in the class room that we get knowledge."* Happy also remarked, *"when we* (midwives) *meet, we gain a lot of knowledge we are always discussing among ourselves, … you hear someone say that 'some difficult labour that I had the other day! It was difficult and something told me I should do this or that and when I did it, everything was all right… You see, so you also pick that, when you are experiencing something you will remember that last time.*"

Through our conversations I also found other situations, which shaped personal practical knowledge, that is, when they interact with other people other than health professionals. Two instances of situations in which personal practical knowledge was shaped were through midwives' interactions with TBAs and with the birthing woman or client. All participants had various interactions with TBAs during their work in the rural areas. Though the midwives identified significant gaps in the professional knowledge and practices of TBAs, they also acknowledged that their ability to provide psychological care for birthing women was worth

learning. Martha, for example, noted, "*Sometimes we midwives get some knowledge from the people we interact with. Like the TBAs… I admired the way they talk and support a woman in labour."* According to Happy, "*you can learn from everyone even from your clients.*" Participants also saw their own childbirth experiences as a rich source of knowledge. Through such experiences they came to understand more deeply the process of childbirth and were able to care for their clients with a better understanding.

Reflecting on this narrative thread I have come to understand the importance of a midwifery professional knowledge landscape that shapes both knowledge for midwives and midwives' personal practical knowledge. Acknowledging the importance of personal practical knowledge, midwife knowledge, in addition to knowledge for midwives, is necessary to ensure care for women in labour. Removing the embodied nature of knowledge and experience from midwifery practice has the potential of mechanizing the process of childbirth and hence the art or beauty (aesthetics) of the profession. Each midwife's personal practical knowledge forms the basis of her midwife practice in the professional knowledge landscape. Because midwives working in rural communities are not constantly under the scrutiny of policy makers, administrators, and other members of the health team, they are free to use their personal practical knowledge in this professional knowledge landscape. Additionally because the midwives in the villages do not have the option of calling on obstetricians and other professionals for help or interventions, they are constantly presented with opportunities to experience new situations and consciously or unconsciously enhance their personal practical knowledge.

Knotting the thread

I return to the resonant narrative thread to see how a knot can be tied. I have come to understand how time, place, and social interactions have shaped the lives and practice of the four

participants in this study. I understand more deeply the different professional knowledge landscapes within which midwives work. I have identified the different relationships on these landscapes and how they influence midwifery practice and the lives of midwives differently. The different types of knowledge, that is, professional knowledge and personal practical knowledge, were expressed and developed differently on the landscapes. Personal practical knowledge was observed to be more prominent on the professional knowledge landscapes of rural communities and private maternity homes although they were identified on all three knowledge landscapes. On the other hand, though professional knowledge could be identified on all three professional knowledge landscapes, it dominated the professional landscape of urban communities.

I have also come to understand the uniqueness of each professional knowledge landscape and the importance of understanding them cannot be overemphasised. It is worth noting that a good relationship does not only facilitate the utilisation of both professional and personal practical knowledge but is also important for the creation of personal practical knowledge through experience.

Returning to my research puzzle, it is clear from the four narrative accounts that the experiences of the midwives were unique but similar. All midwives used multiple but similar types of knowledge in all three professional knowledge landscapes. Their personal experiences across time, with various people and in different places to a large extent shaped their professional lives and helped them to build the right relationships for care. These relationships were not limited to the women they cared for and their families but with colleagues, other members of the health care team and even communities.

Chapter Six

A Reflective Turn

Inquiring into midwives' experiences and identifying the different professional knowledge landscapes that characterize midwifery practice in Ghana has been important. Midwives are a significant workforce in the health sector and are key in global efforts towards reducing maternal mortality and improving maternal and family health. Inquiring into midwives' experiences with care is important to illuminate the different contexts in which they practice. In this last chapter, I reflect on what I have learned personally through this inquiry and how I imagine this inquiry will influence who I am becoming. I also discuss how this research contributes to midwifery knowledge as well as to its methodological importance. Through this discussion, the practical and social justification of this study are highlighted.

Returning to what I have learned: Personal justification

As I consider what meaning I have personally made from this inquiry I am reminded by Clandinin (2013) that through inquiry we end up constructing images of who we are, what we are about, as well as who others are and what they are about. By so doing we gain understanding

of ourselves, of others, and of the contexts in which we live and work. Reflecting on this statement, I began to think about who I was before this research and who I am becoming now. I reflected upon my perceptions about midwives. I look at this through two different lenses: as a woman who has personally received midwifery care during childbirth and as a midwife myself. The personal narratives of some of my experiences as a midwife, and a mother, deepened my interest to know what stories other midwives live and tell and how their experiences have shaped the care they provide for women in labour.

As a midwife, a mother, and an educator, my quest was to understand my own experiences and how my life has been shaped by these experiences. Over the years, I have wondered about the uniqueness of my personal experiences as a midwife. I have also wondered if/how my practices and subsequent teaching has been influenced by these experiences. I wonder often about what composes my personal practical knowledge and how it shapes what I do. Personally conducting this research was significant to me, as it has helped me to find meaning in my own experiences, and it has positively impact my role as a midwifery educator. Through the experiences shared by the midwives in this study I have come to understand that although my experiences were unique to me, there are resonances across the experiences told by participants and my experiences. I identify with the knowledge that lives within and structures midwives' professional knowledge landscape.

I return to my personal childbirth experience that I wrote about at the beginning of this research. Though it happened several years ago, I still wonder about what might have driven the actions of the midwife and why she related with me in such a manner. Though I still do not have answers to the questions I have concerning that experience, I now understand that perhaps the fundamental issue that characterized my unfortunate childbirth experience was the absence of

any relationship between the midwife and me. As participants shared their stories of how the relationships they built with their clients facilitated the care, they provided for them during labour, I understood how the absence of relationship could lead to disrespect and abuse. The significance of this understanding is that following this research my story about my childbirth experience has and will continue to shift. I anticipate re-telling and sharing my experience in the future not only as a recount of an event (or series of events), but also as a way to underscore the importance of the midwife-mother relationship. I have also come to understand the professional knowledge landscape on which this experience took place. I recognize the possibility that I might have had a different experience if it had taken place within a different professional knowledge landscape. In spite of this understanding, I still ponder over the midwife's actions with many questions in mind. I wonder what in her personal experience called forth such treatment for a woman in labour. What was her understanding of her role as a midwife? What was going through her mind at the time? In the absence of a relationship, could she not find appropriate way of caring for me? What knowledge guided her practice? What personal practical knowledge did she hold? Pondering over these questions, I continue to wonder.

As I reflect on stories of relationship and trust, I also think of the relationships my participants and I built together. We could not have gained trust and confidence in each other if I had met them only on one occasion. I recall how I had to patiently give Happy time to accept that I had no intentions of spying on her. As I began to relate the research relationships to the midwife-mother relationship I also considered ethics and time as important elements of relationships. Considerations of what constitutes ethical relationships within childbirth is critical given the nature of midwifery practice and the intimate nature of childbirth. Although childbirth is fundamental to women irrespective of culture, race, or social status, the experience of giving

birth is, to a large extent, influenced by culture, religion, socio-economic factors, and geographical location. As in any meaningful human relationship, an ethical relationship is critical in negotiating the boundaries for the midwife-mother relationship. Boundaries are not rigid, but rather evolve and are negotiated each time midwives engage with clients or other family and community members.

Bergum and Dossetor (2005) noted that the connection created between patient and caregiver shapes the moral space inhabited by them. Through this research, I have come to better appreciate the importance of this moral space as key to relationships. I have also come to understand the different professional knowledge landscapes within which midwives work. The complexities of the midwife-mother relationship also encompass others, such as family members, TBAs, other healthcare providers, and community members.

My understanding of the importance of time has deepened through this inquiry. I have come to understand time from two different perspectives: time as it relates to experience and time in relation to building a trusting relationship. My relationship with Happy, my first participant, began on a note of doubt and uncertainty as Happy sought to know me and to understand my intentions for conducting the research. Although I provided Happy with the necessary documentation and detailed explanation for the study, I needed to allow enough time for her to think through the information I provided. As I interacted with her over time, trust, confidence, and mutual respect was built. Reflecting on the role time played in my relationship with Happy, I see time as an important factor in the midwife-mother relationship. This was well articulated by my participants when they spoke about the importance of continuity of care. The notion of time in relation to continuity of interaction between the midwife and the woman brings to mind Dewey's (1938) assertion of continuity and interaction. In other words, the interaction

between the midwife and the mother over time serves as a learning period that enhances the care that is provided. Forster et al. (2016) concluded that continuity of care by a primary midwife from antenatal through to the postpartum period increases women's satisfaction with the care they received.

My understanding of time as a component of experience has also changed through this research. As participants shared their stories, it deepened my understanding of how experiences are constructed within and over time. It is clearer to me that time and place cannot be separated in recounting experiences; neither can the social interactions be ignored. Experiences take place within time, at a place or series of places and involve social interaction (Clandinin & Connelly, 2000).

I have also conceptualized three different professional knowledge landscapes for midwives working in Ghana. Prior to this inquiry I had not understood the working contexts for midwives in Ghana. I came to see how the physical place, social interactions and time all comprise part of the professional knowledge landscape and influence the care provided for women in labour. My new understandings of different professional knowledge landscapes with their unique characteristics have broadened my perception about midwives and midwifery practice. I now appreciate how midwifery education should prepare midwives to work in these different knowledge landscapes. Before this inquiry my approach to education was directed towards ensuring practical midwifery skill acquisition and knowledge for midwives while unconsciously disregarding the unique role of personal practical knowledge and the shaping influences of different professional knowledge landscapes.

I have also pondered other areas of midwifery practice and my life as a midwife that I need to understand better. As I ponder over why each participant earnestly looked forward to the

opportunity for formal midwifery education, I can only imagine that they probably realized that the scope of midwifery was far beyond what they could do without midwifery education. I am also wondering if their strong desire and effort to enter midwifery school had something to do with status. Was it more than knowledge acquisition that they desired? I wonder about this because all participants have lived and were schooled during a period when midwifery education was important for career progression. Since this is not the case presently, I wonder what the reasons are today. Many nurses and midwives still earnestly seek opportunities for higher education and enroll into baccalaureate, Master's degree, and doctoral programmes. As I think about this continuing trend many questions come to mind. What is their motivation? Is it different than what motivated the participants in my study to go to school? How is the acquisition of higher education impacting midwifery practice in Ghana? I continue to think about these questions.

From the experiences shared by participants I imagine that higher midwifery education can impact practice, add to midwifery personal practical knowledge and positively change midwives' attitudes. I have been awakened through this inquiry to my desire for higher education as I continue to think about ways I can contribute to improving midwifery practice in Ghana.

Contribution to midwifery knowledge: Theoretical and practical justifications

Although some studies have been conducted around midwives' experiences globally, a literature search did not provide information on contextual studies of midwives' experiences that narratively explored their professional knowledge landscapes. Additional searches did not reveal studies on the experiences of midwives in the Ghanaian context with regards to knowledge for midwives and midwives' knowledge. Nothing significant was found on how midwives in Ghana

come to know and practice in the different Ghanaian contexts. This study contributes knowledge about the narrative experiences of midwives in Ghana.

On the other hand, it is often not difficult to come across information about mothers' experiences with childbirth (Sawyer et al, 2011; McCrea & Wright, 1999). Justifiably the voice of mothers being the recipients of the care provided by midwives is important feedback to help improve midwifery practice. However, the voices of midwives and their daily encounters that reveal their experiences within their working contexts, the challenges around how midwives develop and express their personal practical knowledge seem to be missing from literature. In as much as it is justifiable to appreciate care from the perspective of recipients, it is also important to create the space for midwives to reflect on their experiences and how their experiences shape the care they provide. This inquiry gave four midwives the opportunity to reflect on their experiences.

Professional contexts understood as professional knowledge landscapes

The identification of three distinct professional knowledge landscapes for midwives in Ghana has implications for midwifery education, practice and research. To discuss the significance of this inquiry to midwifery education and practice, I return to the notion of midwives' attitudes being a direct result of their education. I argue that midwives' knowledge is shaped only in part by their training. This inquiry showed how past and ongoing experiences of midwives shape their personal practical knowledge. The influences of place, time, and social interactions on the knowledge midwives hold was made explicit by the experiences they shared.

Furthermore, illuminating the different professional knowledge landscape of midwives calls for a refocusing of the education of midwives to ensure that the preparation of future midwives take into consideration the different professional knowledge landscapes that exist. The

different forms of interactions as well as the different types of knowledge used on these landscapes should be discussed during midwifery education. During their training, students should be intentionally exposed to the different landscapes: the rural, urban and private knowledge landscapes. This will help prepare midwives to understand and to possess some of the personal practical knowledge to enable them to work effectively in different professional knowledge landscapes. It is important that during pre-service and post-service training of midwives, the distinctively different midwifery professional knowledge landscapes are discussed. Curriculum content should reflect the uniqueness of each landscape and the different relationships that are necessary within different knowledge landscapes. The potential challenges and limitations of each professional knowledge landscape, as well as types of knowledge that midwives develop and use on each landscape, should be addressed. Efforts need to be made to build interest in working in rural professional knowledge landscapes during midwifery training.

Moving between, and working within, different professional knowledge landscapes

The recognition of the different professional knowledge landscapes is also important for the placement/postings of practicing midwives irrespective of the number of years of practice. As midwives transition from one professional knowledge landscape to the other, there is a need for a programme of orientation as part of the transfer processes. The participants in this study shared how adjusting to new knowledge landscapes were challenging. They indicated how transitioning from one professional knowledge landscape to another required both physical and emotional adjustment. Some of the adjustments included learning new languages and other cultural practices. As the participants made clear, they received little or no support during the transition from one professional knowledge landscape to the other. Adjoa described one of her transfers with all the emotional challenges that came with it. "*My friend and I were so sad. I felt so lost. I*

was quite young at that time (24 years). *We started to cry. We just couldn't help it. As for my other colleague she cried more than me. She had never lived in a village."* While this move was about the place of work, rural as distinct from urban, there was no welcome or orientation to the new professional knowledge landscape of their work as midwives. Adjoa had to rely on her personal practical knowledge to find ways to learn how to work within this radically different professional knowledge landscape. Considering that the quality of adjustment to new environments has implications for midwifery practice highlights the importance of attending to the experiences of transition from one professional knowledge landscape to another. The insights brought forth by this inquiry should draw the attention of the Ghana Health Service to re-consider the preparations that go into the transfer of midwives especially to the rural communities. Adequate and appropriate pre transfer preparation is important to assist midwives to accept postings to rural communities. While there is no doubt that midwives are critical to the global agenda of reducing maternal and infant mortality, the number of midwives needed to achieve this goal remains high considering the critical shortage of health workers especially in sub-Saharan Africa (State of the World's Midwifery, 2014). Efforts to retain health professionals in rural areas has been difficult as most prefer to live and work in the urban areas (Agyei-Baffour et al 2011). Some of the reasons found in the literature regarding the acceptance of rural postings include poor working conditions, political and ethnic problems, poor security and social amenities, and low job satisfaction. In addition the personal characteristics and value systems of the health care providers were considered part of the motivation to engage in rural practice (Kruk, et al 2010; Agyei-Baffour et al 2011). The importance of getting knowledgeable midwives in all three professional knowledge landscapes is crucial and every effort must be made to positively enhance transition of midwives between landscapes.

Knowledge for midwives and midwives' knowledge

Another important meaning that this inquiry brought forth was the focus on knowledge in midwifery education. Different kinds of knowledge were highlighted: personal practical knowledge and professional knowledge landscapes that comprise teacher knowledge was shown to be distinct from knowledge for midwives. The centrality of knowledge to midwifery practice cannot be downplayed. Knowledge provides the midwife with the wisdom to know what to do and when to intervene during a normal physiological process such as labour (Kinnane, 2008). What midwives learn in classrooms, outside school in different contexts, over time, and in diverse places, influences what they know, and how they practice. The experiences shared by participants provided information on midwives' personal practical knowledge and their professional knowledge landscapes and the various types of knowledge that guide midwifery practice on each landscape.

The importance of knowledge is seen as being the bases for the actions a midwife will take and the decisions she will make in the face of complications. In this dissertation I identified midwives' knowledge and knowledge for midwives. The knowledge for midwives identified on all the professional knowledge landscapes is comprised of the curriculum content for midwifery education, the training workshops to update skills, and the use of protocol guidelines. Being more explicit and objective, it is much easier for knowledge for midwives to be transmitted or shared as well as evaluated. From the narrative accounts it can be implied that much more attention has been given to this type of knowledge. The benefits of knowledge for midwives are evident and documented. Participants showed evidence of certificates of the numerous training workshops they attended.

However, there was a second kind of knowledge, that is, the personal practical knowledge of midwives and how it was developed and used differently on each professional

knowledge landscape that formed a greater part of the secret stories carried by participants. From the narrative accounts it is evident that the personal practical knowledge or midwives' knowledge is authentic on the professional knowledge landscape of midwives and cannot be ignored. Since personal practical knowledge is mainly constructed through experience, midwifery training and practice should be structured such that midwives, both in training and practice, would have adequate exposure to varying experiences that would help them develop their personal practical knowledge and prepare them to work on any of the three professional knowledge landscapes I have explored.

Participants talked about their personal practical knowledge as primarily tacit, as experientially composed through practice and personal experiences including relationships with mothers, families, TBAs, community members and other members of the health team, as narrative and as contextual. As Hunter (2008) noted midwives believe that the art of their profession is what makes their practice and their ways of knowing unique; midwives' knowledge helps shape their lived experience of being midwives as well as their experiences of caring for women during childbirth (Hunter, 2008). This brings to mind a concept of professional wisdom. This relatively new concept of professional wisdom refers to the interplay of knowledge for midwives and experience. A professionally competent midwife is one who has professional wisdom and knows how to apply it (Halldorsdottir & Karlsdottir, 2011).

I continue to ponder over the importance of the combination of professional knowledge, knowledge for midwives, and personal practical knowledge on the future of midwifery practice in Ghana. As I think deeply and reflect on the experiences shared by participants, I wonder about ways that would enhance the development of personal practical knowledge.

Learning processes of composing and recomposing personal practical knowledge

As an educator I am beginning to perceive the reflective way of thinking as an important way of engaging my students to appreciate the attitudes associated with midwifery practice. As participants shared their experiences of providing care for women in labour I reflected on my practices in the past and my present activities as a midwifery educator. I believe that as I engage students to reflect on experiences they will learn. I began to understand differently how my interactions with my students intentionally or unintentionally could influence who they are becoming as midwives. I was reminded of how my practice and life have been indirectly influenced by other midwives and midwifery educators. This awakening came as my participants talked about how others have influenced their lives. The study of teachers' personal knowledge landscapes by Clandinin, Schaefer, and Downey (2014) revealed the important role played by family and cultural narratives in shaping the personal knowledge of teachers. Additionally teachers' relationship with diverse groups of people in different places including their early experiences in schooling contributed to who they had become as teachers (Clandinin, Schaefer & Downey, 2014). Similarly in this study, participants' narrative accounts show how their practical knowledge was shaped by their past experiences, their social and cultural interactions with families, clients and colleagues as well as the diverse places where they worked. This revelation further buttresses my earlier assertion that midwives' attitude and knowledge is shaped partly by their training. The findings from this study suggest a multiplicity of factors that individually and collectively shapes midwives' lives and knowledge. This calls for a broader way to conceptualize midwives' knowledge to ensure that all aspects that influence their knowledge and lives are attended to in the quest to improve care.

This inquiry is important in adding to the body of knowledge in midwifery practice and for furthering midwifery research because it provided meaning on how knowledge is developed

from the perspective of the midwives working in the Ghanaian context. Through this inquiry, the experiences shared by the participants about their knowledge brought forth some contextual, institutional, personal and other factors that shape midwives' knowledge. It did not only identify the different professional knowledge landscapes but described the complexities, the relationships and knowledge that are associated with each. Considering that not much work if any has been done on the professional knowledge landscape of midwives in Ghana this inquiry can serve as bases for further research into each professional knowledge landscape and personal practical knowledge. Further inquiry into professional knowledge landscape and personal practical knowledge involving different categories of midwives would be useful to further deepen the understanding of the phenomenon.

As I read and reread the narrative accounts I identified different ways that midwives have learned, ways that are important for midwifery education.

1. Reflective practice: As Schoen (1987; 1992) suggested, healthcare providers can maximize what they do well and amend their knowledge and practice deficits through reflection. A more conscious effort to develop personal practical knowledge brings to mind Schoen's (1983) concept of "reflection-in-action" which suggests an approach to professional education that recognizes the importance of learning through problem solving in the day-to-day experiences of professionals. According to Schoen, this type of knowledge, which he refers to as knowledge-in-action, is derived when a professional performs the actions of the day-to-day activities of the professional life. Since this type of knowledge (knowing-in-action) comes from the routines of everyday actions, and makes up the great bulk of what we know how to do in everyday and in professional life, more opportunities should be created especially during midwifery education, for midwives to develop this knowledge.

2. Mentoring: I continue to ponder over the importance of a more conscious effort at mentoring the next generation of midwives and modeling caring attitudes for them to see. I continue to also reflect on how participants talked about the importance of learning from other experienced midwives by just being with, and observing, them as they (experienced midwives) went about their day-to-day midwifery activities. Happy, for example, stated, "*If I see I don't have that experience, why don't I learn? I will learn. I always want to move with the seniors so that I learn… When you are proud you look down on people: you can't learn from anyone. Midwifery is not like that. If you want to be good you have to serve, then you learn … you can learn from everyone even from your clients"* Likewise, Martha also shared experience of working with a midwife who unconsciously prepared her for her work at her first "one-man station", "*I was there with that midwife alone and so she involved me in everything. I learnt a lot from her… I learnt a lot because I was always on duty. Initially I felt that she was being too hard on me, worrying me and restricting me unduly but at the end of the day I found it very, very necessary. I have come to realize that what she took me through was very good because after school I went to a one-nurse station".* Martha also spoke about how she has taken it upon herself to mentor other younger midwives "*I have closed but I had to stay on not only to speak with you but also to help. I recognized that the midwives on duty today are not experienced and we have some women in labour so I am around to help and teach."* Both Anna and Adjoa had similar accounts of being mentored, and of their experiences of mentoring others. Perhaps a more consciously structured mentoring process for student midwives and newly qualified midwives can be another way of providing opportunity for the development of personal practical knowledge of midwives. This mentoring process, if established, will benefit both the mentee and

the mentor and will have the potential of making a conscious effort towards positively changing the social narratives about midwives.

3. Reflections through narrative inquiry: From the experiences shared by midwives in this study it is clear that it is often difficult for midwives to find time out of their busy, demanding schedules to sit and reflect on their experiences. Human beings develop cognitively through reflection and are able to live and act in relation to others and learn from their experiences, mistakes and successes (Nakielski, 2005; Taylor 2010). This narrative inquiry provided participants the needed space to reflect on their experiences. Dewey (1938) noted, "every experience both takes up something from those which have gone before and modifies in some way the quality of those which come after" (p. 35). Through this inquiry I am beginning to think of the importance of reflective practice as a way to improve practice. Although the idea of reflective practice is not new to nursing and midwifery (Taylor 2000; Stickley and Freshwater 2002), I have not seen much of its use in midwifery education in Ghana. Engaging midwives in this study as they shared and reflected on their experiences has awakened me to the potential of using reflective practice actively in midwifery education.

The Importance of good midwifery care for all women

As I reflect on the many years each participant spent working in rural areas, as well as the hard-to-reach parts of the Western Region I am reminded of the vision statement of ICM (2008; 2017) "a world where every childbearing woman has access to a midwife's care for herself and her newborn" (p. 1). I can see how they have individually contributed to realizing this vision by working in villages and communities with few resources. As I think of this global vision by ICM I can only wonder about the many sacrifices other midwives have made in other parts of the country to achieve this vision. I also wonder how different or similar their experiences may be

especially within the last decade where there has been a conscious global effort to increase the midwifery workforce (WHO, 2004). Poor quality of maternal and newborn care not only result in mortality, it also contributes to the acute and chronic clinical and psychological morbidity (Koblinsky, Chowdhury, Moran & Ronsmans, 2012). The role of the trained midwife, especially in rural areas with limited access to health care, is crucial to maternal and newborn health as can be perceived from the four narrative accounts.

Private midwives also operate in communities to help meet the health demands of women and children yet they are confronted with many challenges such as establishing cordial and respectful relationship with midwives and doctors at referral centers. Further inquiry into the activities of private maternity homes and how they can effectively collaborate with the government sector can help strengthen their contribution to the national agenda to ensure that a skilled professional attends to every birthing mother.

As part of Ghana's commitment towards achieving the Sustainable Millennium Development Goals post 2015, the voices of midwives are needed for advocating on issues of gender equality and empowerment of all women and girls. Inquiring into the knowledge landscape of midwives is important in order to understand the relationship and contextual settings surrounding care of women by midwives. This research also has the potential to reveal some challenges, or innovations associated with midwifery practice in Ghana and may call forth further inquiry.

With the scope of midwifery constantly changing and becoming broader, the knowledge for midwifery practice is equally becoming broader and complex. Limiting the work of a midwife to delivering babies reduces the knowledge needed to practice. Moving away from the parochial conceptualization of the work of the midwife, an understanding of the epistemology of

the knowledge needed by midwives to operate effectively is an important topic to discuss. Since midwifery education has changed over the years, it will be interesting to know what the experiences of midwives who went through the direct entry midwifery programme with no previous exposure to midwifery would be like. While sharing their experiences all participants told stories of their upbringing and indicated that their previous exposure to midwifery before training was significant to who they became and are becoming as midwives.

Further Thoughts on Research in Midwifery Education

As I wonder about how midwifery education can contribute to changing the dominant social narratives about midwives' attitudes, I continue to think about reflective processes as relevant to personal practical knowledge development. In view of the possible contribution of this inquiry to social action and policy with regards to working in rural communities some further inquiry can be conducted with focus on diploma holding midwives whose first postings are to rural communities. The experiences recounted by participants revealed the complexities, contradictions, and inconsistencies associated with midwifery practice in Ghana. For example, midwives are expected to build relationships with their clients in order to understand the mothers and together develop a plan of care. Whereas all midwives may know the concept of relationship, the institutional and contextual factors do not fully facilitate the building of relationship especially in urban hospitals. Understanding that there are different professional knowledge landscapes is a first step to reconcile some of the inconsistencies and consider ways by which important contextual issues can be addressed.

This calls for a closer look at how midwife-mother relationship can be enhanced irrespective of where the interactions take place. These accounts also address contextual issues that are beyond the control of the midwife. For example, the decision to have one midwife at a

village clinic or several midwives working in specialised units at a district hospital is beyond the control of the individual midwife. My wonder, as I think about this, is how the concept of the midwife-mother relationship can be transformed from a theoretical concept that is known to all midwives to a practical experience. These are important issues to consider.

Contributions to Methodological Issues

Using narrative inquiry, as methodology to study the experiences of midwives is very significant considering the fact that narrative inquiry is a relatively new methodology in Ghana and in research in midwifery. The possible theoretical contribution that the use of narrative inquiry makes to the body of knowledge at large and to midwifery research in particular cannot be over emphasized. The narrative accounts of participants when read by other midwives will serve as bases for others to reflect on their own experiences and practice. As suggested by Clandinin and Connelly (2000), novices can reflect on stories being told and in the process develop their professional practice. Clandinin and Connelly (2000), Clandinin, Murphy, Huber, and Murray (2010), and Craig and Huber (2007) described narrative inquiry as a relational methodology. Being a relational methodology, narrative inquiry created the space for the midwives in this study to express the emotions that characterized their experiences as they show the affective aspect of midwives' experiences. This might not have become visible had I used another methodology. I am anticipating that the use of narrative inquiry in the field of midwifery will provoke some methodological discourse that will enhance the further development of this methodology. Being a relatively new methodology in midwifery research in Ghana, successfully using narrative inquiry to understand the experiences of midwives in Ghana produced information on the effectiveness of the methodology in contexts other than the once known in literature. This can further be explored to understand any possible uniqueness within the

Ghanaian context. Storytelling is not a new phenomenon in the Ghanaian culture. Traditionally Ghanaians have lived and told stories for as long as they have been a people. Most of the stories about life, cultural belief, morals as well as socio-political information that I have personally heard as a Ghanaian came through storytelling. What I consider to be new is the use of stories in research. As Crites (1971) posits, storytelling is one of the most important cultural expressions. Using narrative inquiry to study the experiences of midwives in Ghana brought out some cultural perspectives peculiar to midwifery care in Ghana. For example, the recognition that not only spouses or families, but by entire community can influence a pregnant woman's decision to seek care is significant.

Having successfully used narrative inquiry twice in midwifery research; first as a methodology to inquire into women's experiences with labour pain (Ampofo Asamoah & Caine, 2015) and the second time in this dissertation, I appreciate its appropriateness as a methodology in the Ghanaian context. Using narrative inquiry provided a space to hear the voices of midwife participants. I am also hopeful that the narrative accounts would draw attention to the silences about the experiences of midwives in Ghana especially for those who work in rural villages and in small facilities such as private maternity homes. Through the use of this methodology the emotional and social aspects of midwives' lives as they work with women in different places and at different times were highlighted. It has also illuminated the contributions that training midwives with the requisite knowledge and skills can bring to maternal health in Ghana. Using narrative inquiry also provided participants and I the opportunity to co-compose narrative accounts that captured how their experiences where shaped by place, time and social interactions. In this research, the methodology helped to describe the professional knowledge landscape of midwives. Through the conversations held and the relationships I built with

participants, they were able to share stories that showed the complexity of their experiences at different places and times. The highlights, as well as vivid accounts of what midwives undergo and endure to provide care to people who have less access to resources, calls for a rethinking of how transfers and postings of midwives are made to unfamiliar or rural communities and the need for some orientation prior to such transfers. I wonder if any other methodology would have provided participants and I with an opportunity to tell and retell their stories in such meaningful ways. The relational nature of narrative inquiry enhanced the relationships between participants and I and opened up opportunities for them to share their secret stories.

Final remarks

I return to consider how I came to this inquiry and what lessons I have learned as a midwife, an educator and a beginning researcher. My knowledge about midwives and midwifery practice has greatly deepened. I understand midwifery much more within this short time of inquiry compared to the many years I have worked as a midwife. Significantly, I have come to discover and understand that midwifery practice in Ghana takes place within different professional knowledge landscapes. I also understand that each landscape is unique and must be recognised as such in order to make the needed adjustments to enhance the quality of any childbirth experience to mothers and a fulfilling work experience for midwives. In addition, I understand the different types of knowledge midwives hold and how they come to hold and use this knowledge on the professional knowledge landscape. The concept of personal practical knowledge of midwives as expressed by participants has deepened my understanding of the importance of experience over time in different places and within different social contexts.

Through this inquiry I deepened my personal practical knowledge of narrative inquiry as a methodology to study experience. I have come to practically understand how to engage,

negotiate and sustain research relationships with participants. My relationship with participants was anchored by relational ethics and the ethics of everyday life (Clandinin, Caine, & Lessard, 2016). My engagement with participants helped me to reflect on my own experiences and to make meaning of them. As I reflect over the entire inquiry I see myself as becoming more equipped with a better understanding of what it takes to be a midwife and practice midwifery in Ghana. I anticipate that this will translate into my work as a midwifery educator and someone who speaks for the interest of the profession. I have gained understanding of who I am, of midwives, and of the contexts we live in. These new lessons make this inquiry meaningful to midwifery practice and education.

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