NURSES AS WORKING MOTHERS AND THEIR SOCIAL REPRODUCTIVE ROLES: AN EXPLORATORY STUDY OF NURSES IN WINDHOEK, NAMIBIA

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Abstract

This study explored the extension of female reproductive roles into the nursing profession. The deficit of information in Namibia pertaining to the convergence of dual reproductive and productive roles and linkages to the nursing profession deemed it essential to justify an exploration into such duality of roles. This study was a qualitative study with data being collected through in-depth interviews with female nurses who identified as working mothers. A phenomenological approach to Narrative Research Methodology was used. The main aim of this approach was to seek in-depth data concerning how nurses perceive their dual roles in production and reproduction. A purposive sampling technique was used to identify the research participants. The data gathered during the course of in-depth interviewing was analysed manually through the identification and development of relevant conceptual themes. Linkages between nurturing roles and financial independence, balancing reproductive and productive roles, the creation of gender balances based on dual roles and gender power relations as a result of paid productive Labour outside the home were at the helm of this study. There was present, a balancing of familial responsibilities associated with gender-based stereotypes as well as the existence of female nursing practice within a gender-based hierarchy. Findings indicated that nursing is viewed as a selfless profession requiring a commitment to care. The socialization of females into stereotypical roles was found to take place during the formative years of childhood. There was an agreement in relation to the fact that characteristics that are devoid of compassion and commitment to care disqualify one from successful nursing. Therefore patient-centred care and ascriptions

to intensive mothering ideologies in nursing were discovered to be at the helm of the feminization of caring in the profession.

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List Of Abbreviations and Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti-Retroviral Therapy
HIV	Human Immuno Deficiency Virus
PMTCT	Prevention of Mother to Child Transmission
PCR …….	Polymerase Chain Reaction
SWAPO	South West Africa People’s Organisation
TB	Tuberculosis
UNAM	University of Namibia

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Dedication

I dedicate this thesis to my precious children, Eminence Achieng Kojwang and Sepo Ochieng Kojwang. I would also like to dedicate this thesis to my parents Dr. Harrison Ochieng Kojwang and Mrs. Annastancia Sitwala Kojwang, to my brothers Omondi Simasiku Kojwang and Odhiambo Konga Kojwang and to my grandparents, Mr. Walter Ojwang and Mrs. Rhoda Ojwang. I would also like to dedicate this work to my late grandparents Mr. Josias Konga and Mrs Esnard Kahundu Konga. I would like to further dedicate this work to all my family members, friends and mentors who are too numerous to mention.

Declarations

I, Risper Auma Ochieng Kojwang, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution.

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Chapter 1

1.1 Introduction and Background to the Study

The concept of the working mother relies on gendered notions of child rearing. Women are socially constructed to be emotional, nurturing and caring, with men on the other hand being more rational, scientific and systematic in decision making (Porter, 2008, p.512). Porter (2008, p.513) further iterates the fact that the social construction of feminine roles within the professional health care domain are characterized by subtle subservience in contrast to men who pay more attention to detail. The caring and feminine nature of nursing has been translated into the role of a mother with the all-important role of raising, nurturing and educating those under her care (Rodrigues & Higarashi, 2014).

Women have transitioned from the traditionally socialized roles of exclusive maternal nurturers to agents of financial independence; a role that was traditionally reserved for men (Jackson, n.d., p.130). Female nurses in particular form an interesting group of individuals whose dual roles of re productivity and productivity form an extension of care from the domestic set up into the clinical setting. Letvak (2001) asserts the fact that nursing is viewed as an extension of the reproductive roles women play in the home to their productive roles as professional nurses. In addition, the balancing of dual reproductive and productive roles is emphasized by Kasapoglu & Akbal (2017) who state that female nurses tend to balance familial responsibilities with nursing which results in a convergence between reproductive and productive roles.

Gender stereotypes have been identified as the determining factor concerning the essentialized nature of the nursing profession that is at most, strongly associated with tender, feminized notions of care and the display of warmth and affection. According to Im (n.d.), nursing is viewed as a position with predominantly feminine characteristics. As such, the stereotypes connected to the role of wife and mother apply to the profession. The social context of the nursing profession furthers the gendered stereotype of feminized care by attributing such gender- based perceptions to the influence of socio-cultural norms. McIntosh et al (2015), argue that gender perceptions within nursing are products of social processes, with individuals conforming to socio-cultural norms. As a result, individuals are subject to socialization that reinforces beliefs and behaviours that are determined by the social environment.

In terms of the historic view of gender roles in Namibia, a lot can be said about the gender disparities that were reinforced by the colonial administration. According to Hubbard & Solomon (n.d.), the migrant labour system meant that women faced an increased workload as they assumed tasks traditionally reserved for men in addition to their usual productive and reproductive responsibilities. In addition, this did not necessarily translate into increased decision-making power on the part of women as men still controlled the household's major economic resources during their frequent visits home (Ibid). Despite the rudimentary view of the role of women as less influential than men did not deter Finnish missionaries from enabling professional training of young women in areas such as nursing (Pihlaja, 2017). It must be noted that in spite of the European, Christian ideals of socially subjugating women, the productive capabilities of women were explored and realized through professional training opportunities such as nursing (Pihlaja, 2017). After independence, Namibia inherited a racially fractured health system that utilised hospital-based care; a shift from curative to preventative care was a result of the end of the racially fractured system before independence (Van Rooy et al, 2015).

As such, Socio-cultural norms tend to influence gender-differentiated appropriateness towards physical contact within the nursing profession. As a result of this differentiation, gender stereotypes are thus negated and tend to generalize the appropriateness of physical contact with patients to females, whilst challenging the aspect of 'touch' with males. This notion of physical contact based on the limiting nature of gendered stereotypes is clarified by Harding et al (2014) who states that gender stereotypes are used to distance men from physical nurturing by enforcing the acceptability of female nurses intimately touching patients which is an act that is seen as foreign and strange to men. Differences between the sexes based on stereotypical views of gendered expectations prompt essentialists to look at the determining factors as socially grounded forces. These culturally and socially defined differences are communicated by Crompton & Lyonette (2005) who assert that differences between the sexes are related to physical, physiological and/or spiritual differences. Newman et al (2011) also look at these differences based on the occupation of culturally defined occupational roles by both sexes based on gender. The imposition of differences based on feminine and masculine role expectations and the socially and culturally defined modes of propagation that enable such differences bring to light the social construction of such roles based on gender hierarchies and patterns of inequality. Nentwich & Kelan (2014) argue that symbolisms are attached to activities termed as either 'masculine' or 'feminine' and as a result, whatever is gendered ‘feminine is often devalued, with the ‘masculine’ identity often receiving higher status. McIntosh differentiate between masculinity and femininity in the nursing profession by stating that masculine attributes are often associated with senior positions within nursing such as management that is characterized by male stereotypes such as strength, aggressiveness, assertiveness, self-control and leadership.

Based on the differences perpetuated by the ‘masculine’ and ‘feminine’ gendered activities, nursing practice actually goes against the stereotype of exclusive feminized care. According to Shah et al (2017), the demand for male nurses in more high-tech specialities enables successful performance in areas such as Intensive Care and Operation abilities that require more physical strength. Men are attracted to nursing specialities such as Intensive Care, Accident, Emergency or Operating Theatres where patient contact is based on technical prowess and not for the provision of nurturing and empathetic care (Christensen et al, 2014). According to Burgos-Saelzer (2013), male nurses feel more comfortable performing high-pressure, technological areas of specialty, which they view as a challenge. Such is viewed as a gendered product of the euphoria men experience when working with technology (Ibid).

Gender-based hierarchies nevertheless within the nursing profession are said to mimic the social relationships within the family unit. The dominance of patriarchal role expectations of leadership and subservience characterize the oppressive and stereotypical nature of the nursing profession. Wall (n.d.) illustrate the dominance of patriarchal role expectations by stating that, nurses participate in a gender-based hierarchy with similarities to interpersonal relationships in the family; as a result, the physician is identifiable as the father, with the nurse as the mother with the patients being associated with children. The reference to nurses being like “good mothers” means that they are very often expected to consider the needs of patients above their own as a result (Ibid).

The influence of capitalism over the reproductive roles of women has proven to be essential to understanding the duality of nursing and motherhood. The oppressiveness of capitalist societies towards the perceived lower status of women, have been historically attributed to economically determined forces. Despite this leaning towards economic determinism, feminists like Juliet Mitchell have rejected this notion of reducing the problem of relegation to economic justifications. According to Mitchell (1966), the woman’s social weakness has made her a slave to productive work, despite her physical weakness serving as a way of excluding her from physically demanding work. In addition, the woman’s subordination is socially instituted as her presence in the workforce does little to erode her oppression in the family. In terms of the benefits of female reproductive labour towards capitalist accumulation, women’s labour in the home creates the surplus value by which capitalism maintains its power (MR Online, 2018).

The oppressiveness of the division of labour has been described as a force that perpetuates the subordination of women. According to Duffy (2007, p.315), reproductive labour has been linked to the gendered division of labour that actually perpetuates the subordination of women. Women are disadvantaged in the labour market due to their responsibilities towards unpaid work in the home in addition to periodic or long-term absences and the extra burden of unpaid household duties in the home; such duties are known to plague the lives of wage-earning women (Duffy, 2007). Dalla Costa & James (1972) challenge the burden of unpaid work in the home by stating that women should be socialized to destroy the role of the housewife, resulting in the end of the privatized female. Zetkin (1896) also argues for the liberation of women by stating that proletarian women should carry out their domestic duties in the interests of the liberation of the working classes which can only be realized by better conditions within the family unit which result in their effectiveness in the home and render them capable of fighting for proletarian liberation. The need to be liberated from the disadvantage of unpaid labour in the home is also argued by Brown & Jones (1968), who assert that women not actualizing their capabilities by supporting themselves ultimately remain in degrading circumstances; therefore, there is a need to fight against general discrimination and job discrimination against women that goes against them striving to become professionals.

The shift from private to public life has been directly aligned to female nurses who balance their reproductive roles as mothers and their productive roles in the clinical set up. Despite the shift to a more self-actualized role resulting in financial independence, it has been found that it is not possible to completely detach nursing practice from motherhood. Merighi et al (2011), argue that despite adopting productive roles, nurses in public hospitals are not detachable from housework responsibilities and care for their children. Income earning as a form of economic independence accompanies the roles of nurses in the development of their children whose interests are intrinsically incorporated into their lives. This lack of misalignment between household responsibilities and the demands of a professional nursing career has been seen to represent a double burden of dual responsibilities at home and at work. Rodrigues et al (2014) state that, a multitude of roles such as being a mother, a wife and a professional create an overlap of functions inclusive of physical and mental fatigue. Despite working, mothers remain the primary caregivers of children and the house. Jaradat (2017) also argues that in Palestine, women assuming day shift schedules reported more mental distress than male nurses, which was attributable to family and child care responsibilities in addition to nursing work. The dual reproductive and productive roles experienced by female nurses are thus representative of role strain and having to prioritize one role over another resulting in mental strain. Based on the supportive literature, the researcher embarked upon an exploratory study into the social reproductive roles of nurses as working mothers.

1.2 Statement of the Problem

Female nurses are expected to be nurturers and caregivers in both their productive roles at work as well as in their social reproductive roles at home. In Namibia, not much is known about the linkages between female reproductive roles in the home and the extension of such roles into the nursing profession. Pihlaja (2017) conducted a study in Namibia which attempted to understand the entry of females into the nursing profession. She discovered it to be influenced by the gender stereotypes of caring and emotive qualities expected of females. Wesson et al (2017) also conducted a study of nurses within Namibian State Health facilities. The findings indicated the experiences of nurses in the workplace in relation to monetary pay, perceptions of shift work and workplace satisfaction and dissatisfaction. Even though both studies took into consideration nursing practice, there was no mention of the extension of the reproductive roles of females into the nursing profession. Keeping in mind the deficit of information related to the convergence of the dual reproductive and productive roles and their linkages with nursing, this study should be able to address the present knowledge gap.

1.3 Research Questions

The main research questions for the study are as follows:

1.3.1 How are the socialized roles of women as caregivers and nurturers connected to the gendered stereotypes of the nursing profession?

1.3.2 Is there a link between women as nurturers and the power dynamics of their financial independence?

1.3.3 How do women balance their social roles as productive caregivers and their reproductive roles in the home?

1.3.4 Do these roles create a gender balance with men who also work outside the home?

1.3.5 Does the paid productive labour outside the home alter gender power relations?

1.4 Significance of the Study

The study contributed towards discovering the linkages between female nursing practice and the reproductive roles of individual nurses. The findings of the study should thus provide the basis for further research.

1.5 Theoretical Framework

The experiences of nurses juggling motherhood and work in Windhoek is central to this study. This study pinpoints the convergence between female nurse's productive roles outside the home and their reproductive roles inside the home. Production and reproduction illustrate the reproductive roles of female nurses, keeping in mind the socialization of the caring roles of females.

The concept of productive and reproductive roles can be attributed to Juliet Mitchell who coined the terms. According to Mitchell (1966), women's reproductive roles have been viewed as complementing the roles of men in production. The universality of the family has been substantiated by the biological function of maternal roles of women. Although the roles of reproduction are tantamount to the existence of the family unit, the oppressive nature of exclusion from productive roles outside of the home have been evident (Ibid).

It is essential to note that historically, the convergence of the productive and reproductive roles of women were not normalized. There was in existence a sex-based divide that biologically determined female reproductive roles in the home and male productive roles outside the home. The ending of the pre-industrial era segmented the roles of men and women by placing prestige upon the ideals of the "housewife concept" that increased the social standing of women who remained in the home as wives and mothers over those who worked in the factories (Davis, 1983, p.24). Davis (Ibid) further argues that the shifting of manufacturing from the home to the factory meant that womanhood was strongly associated with wife and mother ideals. As wives, women became servants to their husbands and as mothers they became passive vehicles for reproduction.

In addition, Social Constructivism and Symbolic Interactionism are areas that dig into ideas related to the former concept of meaning in relation to coordination with other human beings and the latter ideal that focuses on the interpretation of the world at an earlier stage in life (Ering et al, 2014). Based on the Social Constructivist paradigm, individuals create meaning of the world based on personal experiences and the development of knowledge and meaning is thus based on their interaction with the environment (Pereira, 2011). Women are socially constructed to be selfless and empathetic; traits that extend into the emotive, stereotypical role of nursing (Porter, 2008). The Symbolic Interactionist perspective on the other hand states that individuals are more prone to act in relation to their interpretation of the world. Society is constructed through human interpretation of priorities in line with the dual roles of working and rearing dependents (Ering et al, 2014). Nurses also exercise their reproductive roles as mothers who consider the principles of family and society through their role in the education of dependents for the latter to develop socially acceptable characteristics (Rodrigues & Higarashi, 2014). According to Letvak (2001), nursing is thus viewed as an extension of the reproductive roles that women play in the home to the productive roles that they take on as professional nurses. Kasapoglu & Akbal (2017), argue that female nurses tend to balance familial responsibilities with nursing hence resulting in a convergence between reproductive and productive roles of mothers who are nurses.

The historicism of gender roles in Namibia also forms an important element in understanding the convergence of reproductive roles and productive roles among nurses in the public health care domain. The status of women in Namibia is an area that historically articulates factors that have influenced how women have managed life in the productive sphere during the pre-colonial phase, the colonial phase and the post-colonial phase. The story of the roles of women and their status would not be complete without understanding the origins of gender relations and power dynamics in Namibia. The gendered division of labour during the pre-colonial phase of Namibia's history was a centre-piece of the agrarian economy (Jauch et al, 2009). In addition, Jauch et al (2009) state that, pre-colonial Namibia consisted of familial subsistence economies, with women providing the primary source of labour, especially in crop growing societies. Men controlled the labour of women, controlled social surpluses produced by primary female labour as well as controlling women's sexuality and fertility. Men controlled key productive assets despite women producing most of the labour within the subsistence economy.

Despite the unequal balance of power among men and women, Jauch et al (2009) argue that the gendered division of labour was commonplace within the agricultural subsistence economy with men being responsible for hunting and care of cattle and women being responsible for child rearing, food preparation and crop tending. The communal relations of production within the agricultural subsistence economy actually provided a climate that was conducive considering the fact that women were equal contributors towards the wellbeing of the family and the community (Swapo Party Women's Council, 1983, p. 4).

The story of the institutionalising of patriarchy as a form of regulating the productive roles of men and women speak clearly about the status of women and how the colonial-era shaped the gendered power relations among predominant indigenous groups in Namibia. According to LaFont (2010), the colonial administration perpetuated and promoted patriarchy through the manipulation of customary laws. Contrary to the pre-colonial climate of gender equality and sensitivity, women who held positions of power and authority were accommodated. In addition, LaFont (2010), argues that the practice of colonialism orchestrated practices that fitted customary laws with colonial beliefs as well as colonial economic and political needs. Women were thus classified as minors who could not vote or own land and needed spousal permission before entering into legal contracts.

The influence of patriarchal control over the productive roles of women went hand in hand with the enthroning of the capitalist economy that allowed for the limited mobility of women, by subduing them to the functions of the subsistent agricultural economy (Becker, 2007). The re-construction of gender relations based on colonial terms placed indigenous women as a social category within "tribal areas" and as a result, such women were involved in agriculture or animal husbandry in order to subsidise the system of cheap male migrant labour. Women were placed within the domestic traditional spheres of society with men within the public sphere, predominantly as migrant labourers (Becker, 2007). The divisions present between the monopoly of the capitalist industrialised economy and the subdued subsistent economy; mainly attributed to disenfranchised indigenous groups in Namibia, shows the inception of the migrant labour system as a result of the colonial system capitalising on cheap, male indigenous labour as drivers of the colonial economic interests, thus altering the roles that women played in the home.

A direct result of the link between gender power relations and the growth of the capitalist economic interests of the colonial administration ensured that women maintained their place in the home as subsistent productive agents. Becker (2007) states the fact that patriarchal systems of male dominance were perpetuated by the alliance of colonial officials and conservative male elders and leaders who selectively chose African cultural precedents in relation to gender norms to justify the subjugation of women. Ovambo women's mobility was seen as a taboo and was against the traditional laws and customs and was resisted through the reconstruction of gender roles based on the ideologies of colonial interests and indigenous, traditional laws and customs (Becker, 2007).

The conception of the factors that facilitated the apprehension of indigenous land to suit the capitalist interests of the colonial administration were as a result of the geographical division of land in Namibia. The division of the land into Native Reserves that made up 25 per cent of the land, with 75 per cent of the land sold to Europeans, preserved the long-term supply chains of migrant labour for the farming, mining and fishing sectors (Jauch et al, 2009) The apprehension of land thus resulted in the Southern, Eastern and Central parts of Namibia utilising 9000 Ovambo migrant workers (Ibid). The use of cheap, male migrant labour perpetuated the involvement of women in productive labour in the home, with men assuming productive roles out of the home as a result. The altering of the productive roles of women as a result of the migrant labour systems resulted in women taking full control of the economic responsibilities of the household.

The status of women did not merely involve the gendered tasks within the home, it went beyond the gender prescribed responsibilities. According to Hubbard & Solomon (n.d.), the migrant labour system meant that women faced an increased workload as they assumed tasks traditionally reserved for men in addition to their usual productive and reproductive responsibilities. In addition, this did not necessarily translate into increased decision-making power on the part of women as men still controlled the household's major economic resources during frequent visits home (Hubbard & Solomon, n.d.).

The post-independent era in Namibia brought about positive changes, most especially those concerning women. With the ushering in of independence, Namibian women gained considerable power and visibility; taking into consideration the liberation struggle and how it pushed women out of the background (Husselmann, 2017, p.66). According to Husselmann (2017, p.66), women were able to enter into professions other than the stereotypical jobs they had been confined to perform such as domestic work, subsistence farming, secretarial work. The influx of trained exiles resulted in the rapid feminisation of jobs and professions. As a result, Namibian women were not subjected to exercising the limited roles they played during the colonial period.

Despite the elevation of women's productive capacity, certain barriers obscured the positive image afforded to women who overcame rudimentary forms of work that occurred during the pre-independent era. The disintegration of and diversion from traditional gender roles by women who returned from exile resulted in those same women having problems being accepted by their families. What aggravated this notion was the fact that these women were seen as impediments towards a society that was trying to return to pre-independent traditional value systems (Husselmann, 2017, p.67).

Despite the deviation from traditional value systems on the part of women, there have been occurrences that have boosted the status of women in Namibia. Hubbard (2010) states that as a result of the acquisition of independence in Namibia, there has been a decline in fertility rates with such a decline accompanying a rise in women's education and empowerment. In addition, the total fertility rate at independence was approximately at a figure of 5.4 children per woman and declined to 3.6 children per woman which has been seen as low when compared to the figures represented in Southern African countries (Hubbard,2010). In terms of academic achievement, the status of women has been boosted based on the fact that there has been an increase in female school enrolment over the years. This has been demonstrated through the fact that by 2009, equal numbers of boys and girls in school was reported (Hubbard,2010). Moreover, flexible policies on learner pregnancies with an emphasis on the continuation of education has allowed for female empowerment in order to allow for negotiating power and financial security (Hubbard,2010).

1.6 Limitations of the Study

Arranging interviews in between shifts as well as potential rescheduling of interviews presented some difficulties. Transportation costs involved in accessing the nurses and vice versa also represented certain setbacks; most especially those of a financial nature. Based on these logistical challenges, the researcher came up with the solution of interviewing the nurses during weekends and off periods. The choice to interview the nurses in their homes resulted in sufficient time to intensively probe and critically engage with the nurses due to the in-depth nature of the interviews. The nurses were also more than happy to contribute towards the interview process as they were free to talk about their experiences managing dual reproductive and productive roles.

1.7 Delimitation of the Study

The study was limited to Windhoek and included female nurses who are mothers. The findings were therefore not generalized to all nurses beyond Windhoek.

Chapter 2

Literature Review

2.1 Introduction

The purpose of this literature review is to understand how female nurses balance family life and professional life. In order to understand this balancing of roles it is essential to understand the factors that lead to productivity and the management of such duality. Nursing is generally viewed as an extension of the reproductive roles of women in the home. As a result, balancing of familial responsibilities with nursing, create a convergence of reproductive and productive roles.

It is a fact that the nursing profession is subject to gender-based stereotypes that result in masculine and feminine roles within the profession. Essential-ism as such, is as a result of socio-cultural norms and processes that exclude male nurses from nurturing, caring and emotiveness that stereotypically centres altruism as the core element of functionality within the profession. As a result of this form of gender segregation, socially grounded forces result in technical areas of nursing being ascribed to men, with altruistic areas requiring care and empathy being attached to women in the profession. This ascription of gender-based roles thus dispel the stereotype of nursing being exclusively feminized by ascribing men to high- tech, low touch areas of nursing. This essentialist nature of the profession, has led to nursing being subject to gender hierarchies that mirror interpersonal relationships in the family. As a result of the patriarchal and hierarchical placement of roles, the doctor is associated with the father, the nurse with the mother and the patients as children.

Understanding the productive and reproductive roles of nurses requires a historical look at the experiences of women. It has been noted that capitalism and the division of labour have resulted in the social oppression of women. As such, oppression is not based on exclusion from beneficial productive activities as Marx and Engels stated concerning the liberation of the woman being made possible through inclusion in productive activities outside of the home. Inclusion in productive activities thus supports feminist views that ally with the socialization of women's unpaid reproductive labour in the home. This is seen to represent a wave that sees the ending of the notion of the privatized female by enabling a more self-actualized existence.

What can be stated is that, productive roles of nursing are non-detachable from the reproductive roles enacted in the home. The balancing of dual reproductive and productive roles thus leads to role strain. This role strain is therefore manifested in fatigue and psycho-somatic symptoms as a result of having to prioritize dual roles. The conflict between managing the care of children, spouse and home go hand in hand with the demands of the nursing profession that also require a full-time commitment to the care of patients.

2.2 Gender Stereotypes and Essentialism towards Women in the Nursing Profession

Gender stereotypes and essential-ism are concepts that are present within the nursing profession. In order to understand stereotyping and essential -ism it is vital to understand what these concepts mean. Gender stereotyping occurs as a result of socializing factors instead of being exclusively determined by biology. According to McIntosh (2010), gender stereotyping occurs within a socialized context. Gender identities are thus a product of social construction and are often an unconscious system of beliefs, attitudes and institutions where the distinctions between people's intrinsic worth are based on the grounds of their sex. Haines et al (2016) argue that, gender stereotypes are defined multidimensionally through separate gender components such as traits, roles, behaviours, physical characteristics and occupations. In addition, the multidimensional approach to gender allows for the recognition of aspects of gender that are relevant in different circumstances. As such, aspects of gender may be subject to change over time. Aranda et al (2015), justify the fluidity of gender roles by iterating the fact that, men entering the nursing profession challenges the gender stereotypes characterising the feminization of the profession. As men and women’s roles change, gender-role adaptation results in female nurses being perceived as having both feminine and masculine traits with male nurses also ascribing to communality (Ibid).

The nursing profession and its association with the social context of stereotyping is explained by, McIntosh et al (2015) who state that gender perceptions within nursing are products of social processes, with individuals conforming to socio-cultural norms.

Individuals are subject to socialization that reinforces beliefs and behaviours that are determined by the social environment. The foundation of nursing practice through related academic programs also aligns with gender biases and stereotypes that have historically excluded men from the profession. This is clearly illustrated by Kouta & Kaite (2011), who express the fact that gender bias and role stereotyping are existent in nursing education programs which are mainly composed of women. Nursing practice has for a long time been known to exclude men as they are viewed as lacking the capacity to mother and care. Nursing practice is thus sexualized to the extent of viewing male handling of patients as inappropriate. In addition, gender stereotypes are also associated with the physical aspect of 'touch' confined within a feminized notion of nursing. Harding et al (2014), visualize the stereotypical action of 'touch' by stating that, gender stereotypes are used to distance men from physical nurturing by enforcing the acceptability of female nurses intimately touching patients; an act that is seen as strange and foreign to men. The perceived effect of touch is thus misinterpreted and associated with suspicion and inappropriate behaviour on the part of men.

The dual reproductive and productive roles of female nurses and the stereotypical nature of the profession has been subject to its role as a "job for women". The gender stereotype of nursing has been clarified by Letvak (2001), who states that the nursing profession conforms to the stereotype of nurturing, self-sacrificing and meeting the needs of others. Nursing is viewed as an extension of the socially accepted female qualities that are enacted in the home. Selfless qualities that involve care for others are likened to the fulfilling of the reproductive roles of child rearing in the home as well as the caring factor involving patients in the clinical setting. Im (n.d.), argues that, nursing as a profession is viewed as a position with predominantly feminine characteristics. The stereotypes connected to the role of wife and mother apply to the profession. In addition, there are nursing scholars who state that a lot of the issues related to stereotyping facing nurses are as a result of the feminine image of nursing; this is particularly rampant in societies where women are relegated to secondary status (Ibid). Kasapoglu & Akbal (2017), argue that female nurses tend to lean towards collectivism and self-less character traits that form the stereotypical nature of the nursing profession. Based on the extension of reproductive roles of nurturing and care into the profession, female nurses prioritize familial roles over professional roles. As a result of conformity to the gendered stereotypes of nursing, the main basis of functionality on their part involves the balancing of working time and the responsibilities of motherhood (Ibid).

Looking into the differences between the sexes through gender stereotyping, essentialists also look at such differences as being socially determined. In view of the segmented roles of the sexes, Crompton& Lyonette (2005) state that, differences between the sexes are related to physical, physiological and/or spiritual differences. Newman et al (2011), clarify the fact that, men and women are subject to gender segregation that expects both sexes to occupy culturally defined occupational roles based on gender. Gender Essential-ism reflects gender segregation by perceiving women as naturally inclined towards personal service, nurturance and social interaction. Men on the other hand are perceived to be more competent at mechanical and managerial tasks (Ibid). Clow et al (2014), challenge this essentialist view of nursing by arguing that, historically, men were engaged in nursing work before Florence Nightingale emphasized the female orientation of the nursing profession. They were involved through the military or through religious orders thus the action of feminizing the profession resulted in a power transfer of nursing responsibilities exclusively to women from an occupation that had been formerly associated with male participation.

It is further noted that as per the feminist viewpoints, sex differences between men and women are socially constructed through gender hierarchies and patterns of inequality. Gender hierarchies are further elaborated by Nentwich & Kelan (2014) who argue that, symbolisms are attached to activities termed as either ‘masculine’ or ‘feminine’. As a result of this differentiation whatever is gendered 'feminine' is often devalued. The 'masculine' identity often receives higher status. As such, the latter is perceived as more professional and representative of competence. This essentialist view of gendered hierarchies is present in the nursing profession which is stereotypically feminine in nature. The involvement of masculinity in the profession sheds light on the gender hierarchies present within the nursing environment. Masculine attributes tie in with the values of senior positions within the nursing profession. Masculine traits applicable for nursing management are thus characterized in male stereotypes such as strength, aggressiveness, assertiveness, self-control and leadership (McIntosh, 2010).

Despite the view of nursing as a selfless extension of care from the home to the clinical setting, lack of self-awareness in relation to the creation of gender roles tends to be less of a priority on the part of nurses. Nurses may have a level of self-actualization that deems them unaware of the oppressive, stereotypical nature of the profession. This is made clear by Wall (n.d.), who clearly articulates the fact that nurses tend to be unaware, uncritical and unreflective of their social position as a result of patriarchal power that deems the man as the head. As a result of their minimal attentiveness to the dominance of patriarchal systems in their lives, gender formation as a result takes minimal priority. Nurses tend to participate in a gender-based hierarchy that has similarities with interpersonal relationships in the family; as a result, the physician is identifiable as the father with the nurse as the mother. Patients are thus associated with children, extending the idea of nurses being like "good mothers," who are often expected to put the needs of their patients ahead of their own (Wall, n.d.). This relegation of nurses as being subject to patriarchal systems that deem them as inferior to men who are not socially identifiable in terms of selfless, caring roles cements the prevailing gender stereotypes. It brings into context the idea of men being able to assume roles that exercise their assertiveness with women taking on roles that are pre-determined by the social structure of the family unit. The agentic characteristics of male nurses are illustrated by O'Connor (2015) who argues that male nurses position themselves within a hegemonic masculine order by being aware of their place in a gendered order. They distance themselves from the feminine caring narrative by asserting patriarchy and suppressing subordinated and marginalised masculinity. Despite their identification as nurses, men tend to carry over their masculine identity into the profession by recognizing and acknowledging their place in the gendered hierarchy. Joyce & Walker (2016), mention the gravitation of male nurses towards more agentic roles within nursing practice by stating that, male nurses tend to dominate in higher-paid, impersonal, technologically sophisticated specialisms with women leaning towards roles associated with caring, nurturing and empathy. This articulates the fact that masculine presence in the female-dominated profession does not necessarily mean that all men conform to the gendered stereotypes of caring and nurturing.

2.3 Symbolic Interactionist and Social Constructivist Views of Gender Roles

Social constructivism and symbolic interactionism are definitive concepts that take into consideration how social actors respond to environmental factors that influence their perspectives about their social experiences. Social constructivists construct subjective representations of reality that are dependent upon the observer's interpretation (Knol, 2011, p.2). In line with the interpretation of reality, social constructivists do not support biological determinants as factors that explain the position of women within the family unit (Stanford Encyclopaedia of Philosophy, 2013, p.6). Social constructivists rather try to understand and explore how culture and society shape even the most ostensibly natural differences between men and women (Ibid). Symbolic interactionists on the other hand, act towards things based on the meanings that these things have for them, with the meaning of such things arising through social interaction. The created meanings are thus modified through an interpretive process that the actors use to deal with the encountered social situation (Crotty, 1998, p.72).

2.3.1 Symbolic Interactionism and Gender Roles

Symbolic interactionism prioritizes the meanings of symbols in everyday interaction. Taking into consideration the gendered aspect, symbolic interactionism aims to understand human behaviour by analysing the critical role of symbols in human interaction. This is certainly relevant to the discussion of masculinity and femininity, because the characteristics and practices of both are socially constructed, reproduced, and reinforced through daily interaction (Boundless Sociology, n.d.). The feminine and masculine characteristics ascribed to men and women are generally influenced by external factors that influence the interpretation of symbols and meanings in everyday life. Abele (2003) argues that, gender is assigned to the biological sexes within a psychological context. As a socially ascribed concept, gender roles and expectations are in a state of dynamic change. The development and maintenance of gender stereotypes are affected by cultural, historical and situational circumstances that influence the roles that men and women play in society (Ibid).

Dual reproductive and productive roles of women who work as nurses are characteristic of the emotive and nurturing qualities based on their interpretation of the world. Therefore, the roles and responsibilities assumed by women are socially constructed through an interpretation of priorities necessary for the fulfilling of reproductive roles in the home and an extension of those same qualities in the clinical setting (Ering et al, 2014). Rodrigues & Higarashi (2014) state that nurses who are predominantly women, exercise their reproductive roles as mothers who consider the principles of family and society through their involvement in the education of their dependants for the development of socially acceptable characteristics. As such, the symbols used in the interpretation of the ascription of gender specific roles are clearly evident in the concept of family and how society is socially constructed and open to interpretation based on gender role expectations. Based on the influence of the social, cultural, historical and situational circumstances open for interpretation, it is clear that the external world necessitates and avails the use of symbols that not only determine but differentiate between masculine and feminine role expectations. Gruppe (1979), asserts that symbolic interactionism supports the acceptance of the reality of the external symbolic world as well as the reality of the individual experiences and interpretive abilities of the actors who assume certain gender-specific roles based on individual experiences.

The role of the family unit is fundamental to the enactment of certain roles in relation to dual reproductive and productive roles. According to Phuong (2008), symbolic interactionists view the family as a system of complex interactions based on the differing roles of each member, who enact particular roles that are affected by any change in the system. It is imperative to understand how people take the role of the other (role taking), how they construct their own roles (role making), the anticipation of how others respond to their role (alter casting) and role playing or enacting their particular role (Ibid). Taking into consideration the gender roles of women in comparison to those of men, certain characteristics are used as determinants for reproductive and productive role expectations. According to Eagly et al. (2004), gender roles pave the way for stereotypes that characterize the roles of men and women.

Role formation and adaptation are imperative for the symbolic interpretation of the world. The formation of roles deemed unique to gender differentiated expectations have identified gender stereotypes as ways of substantiating this differentiation. According to Tellhed (2018), even though gender similarity may be a factor in terms of most measures of ability and personality, it is widely believed that men and women are psychologically different. Gender stereotypes are associated with concepts of agency and communion as has been prescribed by an overlapping of competence and warmth in the stereotype content model. Tellhed (2018), further states that masculine-stereotyped agency is generally associated with self-focus through one striving for competence or mastery motivation through status, power and respect. Feminine stereotyped communion is associated with an "other focus" through the displaying of warmth or being friendly and moral behaviour to enable one to belong with and care for others. The perceived psychological differences between men and women deem communal characteristics to be typical of women who are generally concerned about the welfare of others, are affectionate, kind, interpersonally sensitive and nurturing. Men on the other hand are known to be more agentic with characteristics that involve assertion, control and confidence (Phuong, 2008).

The sympathetic and selfless roles that are generally ascribed to women justify their reproductive roles in the home and the enactment of those roles in the workplace. Phuong (2008), points to the fact that, female participation in the labour market has resulted in role conflict and role strain based on the multiple roles that working women have to adopt both at work and in the home. Such role conflict and role strain are as a result of sex role stereotypes and cultural messages that shape the prioritization of women's roles. The clashing between communal roles and the need to adopt agentic roles through the enactment of productive roles outside the home place women in extremely difficult positions of trying to maintain efficient family life in addition to fulfilling professional demands (Ibid).

Almani et al (2012) clarify the fact that working mothers take the selfless roles of putting the needs of their families before them. The pressure as a result of the need for economic emancipation and attention to family life creates conflicting priorities. Role strain has also been reported in the assuming of leadership roles by women who tend to be stereotyped as being more communal despite their enactment of agentic traits. According to Lindburg (2014), social role theory explains the effects of gendered expectations on female leaders dictated by the typical and divergent traits and behaviours of each sex. Effective female leaders usually face the accusation of violating gender expectations through the exhibiting of male stereotypical, agentic qualities. Failure to exhibit more female-stereotypical, communal qualities results in a waning of their popularity.

2.3.2 Social Constructivism and Gender Roles

Social constructivism on the other hand, takes into consideration the effects of social and cultural influences on an individual. The sociocultural effects of social constructivism generally take place during the critical socialization period of childhood. The moulding of certain characteristics usually take shape during this critical period. Drawing reference from Vygotsky's sociocultural theory, Turuk (2008), asserts that during the childhood socialization process, a child learns to depend on parents who instruct the child on what actions or characteristics to adopt. In terms of the external factors that influence the interpretation and acquisition of knowledge, sociocultural influences are at the helm of the knowledge gaining process of social constructivism. Kim (2001) defines social constructivism in lieu of the fact that knowledge comes about through the interaction of people and their environment and knowledge is embedded within cultures. Inter subjectivity as a result of cultural and historical factors shape the construction of knowledge. As a result, an awareness of inter subjective meanings based on cultural and historical factors enable an understanding of new information within the community (Ibid). Inter subjectivity as such denotes the individual interpretation of environmental, social and circumstantial events that shape the awareness of knowledge and acquired characteristics based on the influence of the sociocultural environment.

The nursing profession has been at the helm of social factors that emphasize the communal nature of the practice. As a result, the link between nursing and the self-less character traits are viewed as being compatible. The concept of relational caring as the social context within which the expectations of nursing are to be fulfilled still remains a priority. According to Grinspun (2010), relational caring occurs in conjunction with cognitive and physical caring. This concept of care is a direct result of the three pillars of caring that involve the cognitive, physical and relational aspect. Caring as a role that is central to nursing can be viewed as a cultural factor that serves as a platform for the learning process on the part of nurses. In view of sociocultural influences and the gaining of knowledge based on gendered expectations, socialization shapes stereotypes in productive roles as a direct result of the reproductive roles enacted and taught within the family unit. Crespi (2003), states that the gender socialization process not only determines the exclusivity of the reproductive roles of women; the socialization process aids in creating and defining gender stereotypes concerning productive roles. Females tend to be socialized to be sensitive, gentle, dependent, and emotional. They are encouraged to complement these attributes with jobs such as secretarial work, teaching, nursing, being flight attendants and being a housewife (Ibid).

2.4 Reproductive and Productive Labour

2.4.1 Historical Background of Reproductive and Productive Labour and Juliet Mitchell's Criticism of Marxist Theory

The reproductive and productive labour of women are important in understanding the roles that women played in capitalist societies. According to Mitchell (1966), woman's lesser capacity for physically demanding work and lesser capacity for violence determined her subordination. Coercion during the industrial revolution solidified the socially instituted inferiority of women by employing them to operate machinery based on their slight muscular strength, despite their identification as the physically weaker sex. Woman's social weakness thus made her a slave to productive work despite her physical weakness serving as a way of excluding her from physically demanding work (Mitchell,1966). The fact that woman's subordination was socially instituted meant that her presence in the workforce did not actually erode her oppression in the family. In terms of the reproduction of children, women were at the mercy of their biology and were thus absent from productive labour based on their physiological ability to bear children. According to Mitchell (1966), women's absence from production was not only based on physical weakness in the context of coercion-but also by their role in reproduction. Bearing children, bringing them up and maintaining the home actually formed the core of women's reproductive roles. As such, the universality of the family enforced these elements of reproduction (Mitchell,1966). Mitchell (1966) further states that the advent of contraception was seen to threaten to dissociate sexual experiences from reproductive experiences through voluntary childbearing as a means of deeming childbearing as no longer being the sole vocation of the woman (Ibid).

Despite the view of women's oppression as a result of socially instituted inferiority, Mitchell challenged Marx and Engels view of the liberation of women based on economic terms; through participation in public industry. Mitchell (1966) saw the position of women as being dissociated from or subsidiary to the discussion of the family which is subordinated as merely a precondition of private property. Engel's solution for the problem of feminine oppression was through partaking in production on a large scale. Engels thus reduced the problem of the woman to her capacity to work, with physiological weakness as the primary cause of her oppression (Ibid). According to Bryson (2005), Mitchell rejected crude economic determinism and explored the role of sexuality and the workings of the unconscious in understanding change. In addition, the situation of women was determined by four structures: not only the structure of production, traditionally analysed by Marxist theory, but the interconnected and family-based structures of reproduction, sexuality and the socialization of children. Bryson (2005), also states that each structure operated independently and was also capable of playing a political role through advocating for autonomous organizations that recognized the dissolution of patriarchy through feminist struggle. Mitchell thus viewed the function of women in capitalist society as representative of the bourgeoisie family. The situation of women was viewed as more complicated than that of any other social group as they were viewed as being marginalized in economic, social and political aspects but at the same time fundamental to human relations (Zhou,2017). Therefore, according to Cock (n.d.), Mitchell viewed the dualistic mode of production and patriarchy by identifying two autonomous areas: the economic mode of production and the mode of patriarchy. The patriarchal mode of production was identified as a theoretic model of class relations between a class of patriarchs, who as heads of households, control access of other household members to the means of production, and a class of patriarchal dependants, wives and working children, who gain access to the means of production and consumption by providing surplus labour to the class of patriarchs (Cock, n.d.). The unequal balances between the patriarchs and the dependants clearly outlined the subjugation of women beyond mere economic terms, the social dimensions of the oppression of those subject to patriarchy signalled a shift away from economic determinism as the justification for such oppression.

2.4.2 The Division of Labour

In terms of the division of labour, reproductive and productive labour are defined within the context of use- value and exchange-value. Use-value is an important necessitating factor when it comes to the realization of exchange value in capitalist societies (Benston, 1969). Benston (1969) furthers the concept of exchange and use-value by stating that, all things produced in the home are termed as possessing simple use-value and not exchange-value. Such household production involves human labour that does not result in commodities of exchange- value outside of the home. Marxist feminists articulate socially necessary labour as collective labour that meets individual needs for sustenance and daily renewal as well as birthing and rearing the next generation (Brenner, 2019). Social reproduction is thus defined by the following activities: how food, clothing and shelter are made available for immediate consumption; the maintenance and socialization of children; care of the elderly and infants; how adults receive social and emotional support; how sexuality is experienced. Productive labour on the other hand is one that can be exchanged for labour. Tong (2009), relates productive labour to capitalism by stating that, capitalism based on a system of exchange relations is described as a commodity or market society where everything including one's own labour power has a price; as a result, all transactions are actually exchange transactions.

Differentiating between use value and exchange value is an essential element when examining the relations between men and women and what constitutes work. According to Paltasingh & Lingam (2014), production involves income generating activity resulting in the creation of exchange values. Reproductive labour involves work in the home such as subsistence agriculture and results in the creation of use values. Mitchell (1966), defines the status of women in production and reproduction by iterating the differences between the sexes and the resultant division of labour. As such, from the onset of early social development the superior physical prowess of men gave them a means to tackle nature as opposed to women who were denied this opportunity based on their physical weakness compared to that of men. Women were thus involved in menial tasks involving the maintenance of the home, with men making up the workforce out of the home (Ibid). Engels (1972), talks about the division of labour and its link to domestic labour in the home that is associated with women and the acquisition of the necessities of life by men whose roles involved the tending and taming of animals including the commodities and slaves received in exchange. This reflects clearly how the changes to the division of labour outside of the home resulted in women’s domestic labour not being of equal value to that of men (Marx/Engels, 1884). Dalla Costa & James (1972), challenge the division of labour that has led to a lack of recognizing the value of women's domestic labour outside of the home. They further state that, women's reproductive roles make them outlets for the oppression men suffer in their productive roles out of the home; man's hunger for power is as a result of the domination of the capitalist organization of work. The denial of personal autonomy on the part of women, leads them to focus more on the domestic sphere that does not result in any value outside of the home (Ibid).

Despite the oppressiveness women suffer based on the inequality of the division of labour, the contributions of women's reproductive labour towards capitalist accumulation are unavoidable. According to Mitchell (1966) reproduction is a sad mimicry of production as parenthood becomes a substitute for work where the child is seen as an object created by the mother in the same way as a commodity is created by a worker. Moreover, the autonomy of the child threatens the activity that claims to continually create it as a mere possession of the parent. Therefore, anything the child does is a threat to the mother herself who renounced her autonomy through the misconception of her reproductive role (Mitchell ,1966). In relation to the importance of the reproductive roles of women, their labour in the home creates the surplus value by which capitalism maintains its power. As such, the continued and undisrupted reproduction of the working population is a mainstay of the development and expansion of capitalism (MR Online, 2018). In addition, the production of the female subject is the result of a historical shift of economic imperative, which set its focus on women, whose bodies were responsible for the reproduction of the working population. Therefore, the goal was to require a transformation of the body into a work-machine, and the subjugation of women to the reproduction of the working population (MR Online,2018).

2.4.3 Reproductive Role of Intensive Mothering

Intensive mothering as a socially constructed concept is heavily influenced by capitalist and patriarchal ideologies that determine the reproductive roles of women. As such, intensive mothering is based on traditional, gender-based division of labour as a result of mothering and family ideologies that coincide with the ideologies of capitalism (Arendell, 1999, p.6). Femininity on the other hand is also tied in with the intensive mothering ideology as it is also a trait that is socially constructed and imposed upon the female being (Ibid). N'guessan (2011), supports the notion of socially imposed value systems of society to illustrate the fact that, society constructs and differentiates males from females based on the grounds of "otherness". In addition, this differentiation is based upon the imposition of a gender hierarchy. According to Beauvoir (1949), the concept of femininity is socially, culturally and ideologically constructed and imposed on the female as a result.

In light of the intertwining of intensive mothering and femininity, it is obvious that the nature of motherhood ideologies is connected to patriarchal expectations that create a framework within which the "good mother" as a socially constructed identity operates. The power of the good mother discourse ensures the fulfilment of child rearing responsibilities, the regulation of families and family life as well as the reproduction of the next generation of citizens (Goodwin & Huppatz, n.d.). Contemporary Western mothering in the 20th century has seen childhood become the most intensely governed sector of personal existence. Keeping within the confines of normative standards of mothering has been used to ensure limited state interference in the mothering role (Holloway, 2001, p.3). The use of child welfare, school and juvenile justice and the education and surveillance of parents have served as dominant ideologies to ensure the social acceptability of mothering (Ibid).

In terms of conformity, women take on roles that are moulded and influenced by external, socializing factors. Women take on the roles of subjectivity by taking on the aspirations, norms and desires that are articulated by wider political forces (Holloway, 2001, p.3). Nevertheless, the sex/gender system defines a social descending male/female gender organization where the condition of the female is determined by a patriarchal world view. Man is seen as the noble sex while the woman is the oppressed being under the patriarchal system that justifies male domination and female subordination. According to N'guessan (2011), the woman thus complies with male dominant culture by enacting or becoming the victim of the oppressive feminine identity based on the prescriptions of the dominant social environment. Johnston & Swanson (2003, p.22), expand on the dominant culture ideology by stating that, patriarchal ideologies of mothering deny women identities and self -outside of motherhood. These forms of hegemony also create a universal standard of White, middle class mother's roles as experiences to aspire towards, with the dominant culture rewarding good mothers or sanctioning bad mothers (Ibid). According to Bell (2004), deviancy discourses are linked to mothers who do not conform to the narrative of heterosexual marriage, followed by the birth of children and full-time devoted motherhood. Those who fall outside of the intensive mothering ideology encompass welfare mothers, single mothers, lesbian mothers, birth mothers, adoptive mothers, reproductive technology recipients and mothers of children with disabilities.

Despite the oppressive nature of the dominant patriarchal ideologies governing good mother discourses, there are certain divisive class and racially motivated elements that accentuate the social exclusion of and creation of those associated with bad mother discourses. Racially and class biased social constructions of good and bad mothers have created divisions among the oppressed weaker sex. The negative effects of labelling and stereotyping have been reflected through the view of Black single mothers as deviant alongside White single mothers who are troubled but redeemable (Johnson & Swanson, 2003, p.22). Social policy regulation has viewed two classes of women within the umbrella of motherhood; the normative group who represent the White middle class along with socially acceptable standards and the undeserving group who represent the poor minority and immigrant families in the United States (Arendell, 1999, p.33). According to Arendell (1999), the latter group have the former group's standards of acceptability imposed on them by state and social welfare agencies. As a result, social policy has been able to reinforce the ideologies of the good mother, thus benefiting more White women (Ibid).

2.4.4 Intensive Mothering and Productive Roles

The issue of financial independence and the intensive mothering ideology has brought with it contrasting experiences; most notably within the modelling of such experiences around the boundaries of social class. Rippeyoung (2013), states that middle class women are able to embody expectations of intensive mothering by giving more of themselves towards above average commitment to child care. Full-time mothering takes over the need to juggle work and intensive mothering due to a lot of women within the middle class being partnered with men who can financially support them (Ibid).

In contrast, young, low-income mothers who fall outside the dominant ideology of intensive mothering tend to prioritize the fulfilment of their family's material needs. In addition, such mothers are often intensely scrutinized by the state and the public when it comes to their abilities to intensively mother their children (Rippeyoung, 2013, p.7). Slightly straying from the dominant view of socially acceptable mothering has added to the deviancy discourses associated with mothers who cannot be full-time mothers. Maternal employment is seen as a deviant shift from intensive mothering as mothers who do not follow this ideology contend with judgements from others and their own feelings of ambivalence and guilt about leaving their children. Drawing on baseline evaluations of good parenting, Ishizuka (n.d.p.4) iterates the fact that mothers who form part of dual-income couples receive more criticism for not being fully involved in the home as opposed to fathers who seem to receive more praise for their parental involvement.

2.5 Feminist Views of Reproductive Labour

Feminist perspectives on dual reproductive and productive roles focus mainly on gender inequalities, gender segregation and the division of labour at work and in the home. Feminists generally focus on the structures that aggravate gender inequalities and gender segregation. The main rationale of the feminist viewpoint, is to idealize circumstances that create an equilibrium between the sexes within productive and reproductive spheres (Paltasingh & Lingam, 2014, p.45). Despite an interface between paid and unpaid women’s work, what remains essential is what actually constitutes work (Ibid). Productive work is often recognizable as income-generating and is associated with male participation with reproductive roles being ascribed to women. Gender stereotypes are thus created with the purposes of excluding women from opportunities that enable them to rise beyond the subordinate roles of reproduction.

Duffy (2007, p.315), iterates the fact that, reproductive labour has been linked to the gendered division of labour that actually perpetuates the subordination of women. According to feminist scholars, women are disadvantaged in the labour market due to their responsibilities towards unpaid work in the home. In addition, periodic or long-term absences and the extra burden of unpaid household duties in the home are burdens that plague the lives of wage-earning women (Ibid). Women's reproductive roles have been viewed as complementing the roles of men in production. The universality of the family has been substantiated by the biological function of maternal roles of women. Although the roles of reproduction are tantamount to the existence of the family unit, the oppressive nature of exclusion from productive roles outside of the home have been evident. The concept of separateness in terms of equality with men who are more self-actualized triggers a causal chain of subjugation as a result of responsibilities related to maternal roles, the family, absence from production and public life and sexual inequality (Mitchell, 1966).

2.5.1 Marxist Feminist Views of Reproductive Labour

Marxist feminists focus on the recognition of women's domestic labour as paid labour. The socialisation of housework has been at the helm of Marxist feminism. The reproductive roles of women are thus linked to the oppressive practices that relegate women to functionality within the home. They reproduce the means necessary to drive the means of production but are paradoxically excluded from controlling the means of production as a result (International Bolshevik Tendency, n.d., p.9). Kollontai (1921), goes against the lack of individuality ascribed to women by stating that, women are relegated to being an extension of men as opposed to being recognized as individuals with diverse social characteristics. Women are thus judged on the basis and terms of their sexual lives. Women are characterized as part of the collective stereotypes that deny the existence of opportunities for women to enact their diverse personality traits and abilities. They are pushed into the line of thinking that incapacitates their independence in favour of the socially accepted individuality of men. Adjustments to the economic roles of women and their independent involvement in production will weaken the notion of denying the individuality of women (Ibid). Benston (1969) supports the socialization of domestic labour by stating that, women's liberation is achievable by converting the work done in the home as private production into work to be done in the public economy. In addition, child-rearing should no longer be the sole responsibility of the parents. Society should be responsible for children and the economic dependence of women and children on the husband-father should end. Moving domestic labour into the public sector will eradicate the material basis for discrimination against women (Ibid). De Beauvoir (1949) supports women's active engagement in public life by arguing that, it is through work that a woman closes the gap separating her from the male. Female independence means that the woman ceases to be a parasite and therefore kills the need for a masculine mediator between her and the universe. Productivity means that a woman's responsibilities become relative to the goals she pursues and to the money and rights she appropriates (Ibid).

The shift from private life to public life is viewed as a beneficial way for women to acknowledge that their work can be recognised outside of the home as remunerable work. Dalla Costa & James (1972) argue that, women should be socialised to destroy the role of the housewife thus resulting in the ending of the tradition of the privatized female. The role of spouse and mother of those who have participated in activities in the outside world should come to an end (Ibid). The presence of women should not be confined to the private sphere but should be participatory in the public domain as well. Zetkin (1896) argues for the impact women can make in improving the social order by stating that, proletarian women should carry out their domestic duties in the interests of the liberation of the working classes. This can only be realized by better conditions within the family unit which result in their effectiveness in the home and render them capable of fighting for proletarian liberation (Ibid). The importance of socializing the private life of the housewife is brought into context by Beale (n.d.) who argues that, domestic activities such as caring for children and the house result in women leading a sterile existence. An existence characterised by a mate who indulges in public life and shares his understanding of the world with her; as such, she is reduced to a biological function leading a parasitic existence synonymous with legalized prostitution (Ibid). The role that women play in the reproduction of the means necessary to drive the production process mean that, gender as a category and class as a category stand as catalysts for the oppression of women. There needs to be a clear demarcation between the relations of production, where the gender ideology plays an important role, alongside the means and forces of production (Paltasingh & Lakshmi, 2014, p.47). What stands out is the fact that sex inequality actually reinforces class inequality, with class divisions accentuated by gender discrimination (Ibid).

2.5.2 Radical Feminist Views of Reproductive Labour

Radical feminists take a different route by fighting against male dominance or patriarchy. Radical feminism is enshrined in the fact that male power and supremacy are at the helm of the oppression of women in society. The radical feminist movement originated from anti-war sentiments and the civil rights movement of the 1960s. Forms of resistance against the left and the civil rights movement based on the perpetuation of male dominance and an anti-feminist stance, prompted the need to raise women's awareness of oppression (Greene, 2011, p.268). According to Firestone (1970), the origins of sex class are as a result of the fact that men and women were created different but not equally privileged. Reproductive functions and domination of one group over another created the sex class system. As such, the biological family represents unequal power distribution. The biological family as a reproductive unit involving males, females and infants has resulted in a form of social organization that creates an unequal balance between the sexes. Women have been at the mercy of their biology (Ibid). Before the advent of birth control the constant experiences of painful childbirth, menopause, wet nursing and care for infants have made women and children dependent on males for their physical survival. Natural reproductive differences between the sexes have also led to the division of labour at the origins of class in addition to enabling a caste paradigm or discrimination based on biological characteristics (Firestone, 1970). Atkinson (1968), states that men suffer from 'metaphysical cannibalism" which is the need for inhabiting the role of the oppressor as such it is only men who can cure themselves by recognizing their role in the very foundation of all human oppression. Keeping in mind the limiting aspect of the family unit is paramount to understanding the radical feminist perspective. The family according to this school of thought is viewed as the primary source of the oppression of women as men perpetuate such injustice through their reliance on free domestic labour in the home; which is provided by women (Giddens, 2006, p.471). The nuclear family being a unit of subjugation has brought forth the need to create a platform to fight against the dominance of male supremacy. Radical feminism has thus been inspired by the creation of exclusive conscious raising women's groups facilitating discussions about housework, the act of fulfilling men's emotional and sexual needs, menstruation, pregnancy, childbirth and menopause (Lorber, n.d., p.16). Such conscious raising mechanisms have been seen to bring to light a theory of gender inequality as a result of oppression. The manifestations of male supremacy are seen to not only inhabit the nuclear family as a generalized unit of oppression; they are geared towards the reproductive roles and responsibilities of women within such a unit. Men are seen to control women's roles in reproduction and child rearing based on the fact that women depend on men materially for their protection and their livelihood (Giddens, 2006, p.471). The nuclear family thus creates a dependency syndrome that relegates women to their reproductive roles of child bearing and rearing, while men exercise their roles as providers without sharing in the reproductive responsibilities of child rearing.

The socialization of reproductive labour is also tantamount to the radical feminist perspective. Millett (1968) recognizes the disadvantaged status of women and the reproductive roles that render them secondary to men in the enactment of productivity. As a result, patriarchy imposes upon women a subordinate role that renders them systemically ignorant of their lack of knowledge related to the functioning of the tools necessary for the mechanisms of heavy industries central to the capitalist economy. Women's domestic and personal service has no market value; despite participation in the production of commodities through employment, they do not control or comprehend the process they are involved in (Ibid). Brown & Jones (1968), express the importance of the women casting off disadvantage related to absence from productive labour by arguing that, women not actualizing their capabilities by supporting themselves ultimately remain in degrading circumstances; therefore, there is a need to fight against general discrimination and job discrimination against women that goes against them striving to become professionals. Guaranteed annual income is directly relevant for women as such (Ibid). Hanisch (1970), advocates for the inclusion of women in public life by arguing that independence is only achievable through participation in the public workforce; in addition, this means fighting for public childcare, restructuring of the workplace with woman's equality in mind and an insistence on men sharing the housework and childcare responsibilities in the home so that women do not have to do it all. Patriarchy has been blamed for the oppression that women face in relation to reproductive roles that inhibit their participation in productive labour. Hartmann (1979) states that the negative consequences of patriarchy accentuate the subordination and oppression of women who take on the brunt of sole child rearing responsibilities, with men rarely appearing to equally contribute towards such reproductive roles. As such, children raised in this manner tend to learn their position in the gender hierarchy. As a result, patriarchy in this sense takes on a more socialized mode of propagation that does not ascribe to biological determinism alone.

2.6 The Nursing Profession and its Link to Femininity and Gender Roles

Looking at the nursing profession would be incomplete without taking into consideration the gender stereotypes and gender roles that characterise this profession. As has been mentioned earlier on in the chapter concerning symbolic interactionism, women tend to take on more communal roles that entail intensely emotional attributes such as sensitivity, kindness and compassion. This is in comparison to the agentic roles such as rigidity, rationality and lack of intense emotional attribution that women use to complement the communal roles they play, actually resulting in dual productive and reproductive roles.

Keeping in mind the work and family life balance, yields the fact that feminized professions such as nursing are seen to yield less power as compared to masculinized professions like medicine that tend to lean towards the task dimension that is characterised by agency and competence (Aranda et al, 2015). In Namibia, the nursing profession does not shy away from the stereotypes that associate it with the nurturing and caring factor associated with the reproductive roles of women. The social perception of nursing as a feminized profession is a commonly held view among female nurses in

Namibia. According to Pihlaja (2017, 35), A commonly held view among female nurses ascribes to factors that are characteristic of "a good nurse" such as compassion and selflessness. Inter-generational female role models such as aunts, grandmothers and mothers have also been cited as beings who influence women's' decisions to pursue nursing and its view as a feminine profession. As such, the nursing profession has been defined by the gender stereotypes that associate care and nurturing with womanhood. According to Burgos-Saelzer (2013), Florence Nightingale's influence on the feminization of nursing has been profound. Reform according to Florence Nightingale involved taking power from the hands of men and placing it in the hands of trained women in order for them to be more responsible for everything related to nursing. Green (2012) argues that the conformities of nursing to the concept of care result in a differentiation between the social characteristics of women and those of men; as a result, women generally dominate in nurturing roles and service occupations which aids in the acquisition of altruistic, relational and moral dispositions. Men by contrast tend to participate in roles within the competitive public sphere and tend to be more oppositional, autonomous and self-interested (Ibid). Nursing as a profession is viewed as a professional option that is devoid of challenges, responsibility, status, comfortable working conditions, career opportunities and high wages. Medicine in comparison to nursing, is a more agentic profession as it is viewed as a more prestigious choice (Saied et al, 2016). In terms of the value systems that perpetuate gender stereotypes, patriarchal culture and traditional values have had an impact on the self-concept and self-esteem of nurses themselves, thus exacerbating the gender stereotypes that feminize the nursing profession (Aranda et al, 2015). Ogle (2004) discusses the condescending perception of nursing practice by stating that, portrayals of nurses in adverts featured in medicine and nursing journals are often stereotypical and demeaning. Nurses are often analogized as ministering angels, domestic workers, and the doctor's handmaiden and as subordinate professionals. The media has played a major role in the definition of gender stereotypes that characterise women's entry and participation in the nursing profession. According to Saied (2016) the media has played a major role in shaping the community's understanding of nursing and nurses. The media portrays nurses as doctor's handmaidens, angels of mercy, sexy, feminine and caring; in addition, nurses are viewed as lacking autonomy, as opposed to other health care providers who think critically and possess knowledge and skills. Davies (2003) relates the subordinate femininity of the nursing profession to prevailing masculinity by arguing that, nursing involves caring which is a fundamental feminine attribute that does not exist independently of masculinity. At the turn of the 19th century, femininity equated to dependency and subordination in relation to masculinity. Nursing was termed as subordinate to medicine which was representative of a masculine profession (Ibid). Bashford (1997) states that the proposal to redefine nursing as remunerative labour in 19^{th} century Australia was met with opposition by speakers who ascribed to masculinity as a dominant ideology. Based on this, it is stated that, nurses were viewed as religious, philanthropic women, as angels who desired and needed self-sacrifice and who consecrated themselves to their work (Ibid). The lack of uniqueness related to nursing emphasized the self-less nature of the profession. According to Pringle (1998), nurses were associated with ideals related to spirituality, philanthropy, self-sacrifice and vocation and were not associated with ideas concerning science and professionalism. According to Aranda et al (2015), social perceptions of nursing are anchored towards the traditional gender stereotypes that emphasize the feminization of the profession. Nursing is thus considered a female career with nurses being described as “caring for others”, “vocational”, “altruistic”, “sensitive”, and “serving others”. Taking into consideration the gender stereotype content theory established by Fiske actually distinguishes between feminine and masculine roles and characteristics which are all part of the psychosocial process. The selfless, caring nature associated with femininity are attributes that are strongly associated with communality, a dimension related to showing concern and consideration towards others. According to Rodrigues & Higarashi (2014), the nursing profession has been linked to the female figure with an almost immediate association between the concepts of providing care and exercising women’s gender roles, especially those of mothers. Therefore, the nursing profession is not immune to the gender stereotypes that ascribe sex specific roles resulting in the feminization of the nursing profession.

2.6.1 Historical Background of Nursing in Namibia

The background of nursing practice is Namibia is one that is historically significant due to the apartheid regime that characterized the effects of colonialism on ethnic minorities along racial lines. According to Van Rooy et al (2015), the apartheid regime characterised Namibia’s racially fractured health system. In addition, there were gaps present in access to health care between rural and urban dwellers and rich and poor populations (Ibid). Van Rooy et al (2015), also emphasized the fact that over the last two decades after independence, the access of the non-White population to health care was improved, with an upgrade of the primary health care system through better responsiveness towards the needs of the population. As a result of independence, there was a shift from hospital-based care to more curative care (A. Konga, telephonic interview, March 10, 2020). After independence in 1990, public health services became more oriented towards primary health care, preventative measures and treatment; that were affordable, easily accessible and efficient (Van Rooy et al, 2015). In light of the improvements towards health care service delivery, historically, the subjugated social position of women during the colonial era was heavily influenced by European ideologies on Christianity in addition to the limited migration of Black women as a result of the migrant labour system (Pihlaja,2017). Based on the restrictive ideologies that reinforced the social subjugation of women, Finnish missionaries in the Northern regions of Namibia necessitated and enabled the professional training of young women in the nursing profession (Pihlaja,2017).

2.7 Key Performance Areas of Nursing Practice and The Connection with Gender Stereotypes and Essentialism

Nursing as a process involves four types of labour that involve physical, emotional, cognitive and organisational labour (Jackson.). The association of the feminine identity with emotional labour is an area that has widely characterised the nursing profession. Spouse et al (2008), describe the concept of 'feminine professionalism' whose components are similar to emotional labour with 'self-giving' emphasized over power seeking in an altruistic model traditionally described as vocation in nursing. Nursing is associated with an emotive aspect that emphasizes feminized care giving with a "good mother" discourse. Shepherd (2014) argues that the caring aspect of child and family health nurses responsible for the guidance and teaching of mothers in relation to child rearing are known to represent dual roles of care, coupled with scientific knowledge and professional expertise. The advice and counsel given by the child and family health nurses reveal ascription to good mother ideologies on the part of nurses (Ibid). Thus, the emotive nature of motherhood that is perceived to occur naturally in women justifies an association with the care required to be a good mother. Despite the emphasis on relational caring and the need for physical labour as an aspect of nursing, Ross (2017), states that the concept of masculinity associated with male nurses have acted as barriers to men entering the nursing profession. The feminization of touch has deemed it as caring behaviour for women and inappropriate on the part of men. Management, education and technology are areas that attract male nurses ultimately distancing them from the feminine image of nursing by moving into high-tech, low touch specialities (Ibid) Male nurses are known to be judged according to gender specifics when it comes to the provision of intimate care especially in obstetric care. Provision of care in an area that expresses the vulnerability of the female patient has been viewed as a negotiation with set limits and boundaries (Christensen et al, 2014).

Shah et al (2017), agree with the demand for male nurses in more high-tech specialities based on the fact that, despite nursing being a dominantly female-oriented profession, male presence in the nursing profession goes against the stereotype of female exclusivity in nursing. Due to the high-tech specialities and the potential for men to successfully perform in such areas of specialisation such as intensive care, operation abilities and physical strength actually increase the demand for male nurses in such specialities. Christensen et al (2014), dispel the stereotype of female-only nursing practice by stating that, critics have often viewed the male nurse as non-masculine, effeminate and homosexual. Despite this, men have been attracted to nursing specialities such as

Intensive Care, Accident, Emergency or Operating Theatres; as such, patient contact is based on technical prowess and not the provision of nurturing and empathetic care. Wolfenden (2011) challenges the voluntary entrance into the more technical aspect of nursing by arguing that men enter into the more technical areas of nursing as a way of experiencing an adrenaline rush. Entrance into such areas is usually based on societal expectations as a result of denial into more altruistic areas due to perceived unsuitability. Male nurses are perceived as not being able to care for patients like their female counterparts can (Ibid). Burgos-Saelzer (2013) iterates the entry into more technical areas of nursing by stating that male nurses are described as feeling more comfortable performing high-pressure, technological areas of speciality, which they view as a challenge. This is viewed as a gendered product of the euphoria men experience when working with technology (Ibid). The fact that male nurses are mainly attributable to impersonal, high-tech nursing is not to be interpreted as total exclusion from the relational, caring aspect of the profession. Bartfay & Bartfay (2016), support the presence of male nurses in the caring roles by acknowledging men's historical contributions to the profession. As a result, in the third century B.C.E. in India, formal training schools for nurses only accepted qualified male applicants whose functions were similar to many nursing functions today. Such performance areas involved knowledge of the preparation and administration of drugs, understanding the relationship between the mind and body to promote health, being intelligent, understanding and loyal, skill in bathing and physical therapy and the provision of wound care. During the Middle Ages, it was noted that more monks, friars and deacons cared for the poor and sick, as opposed to nuns or deaconesses (Ibid). Despite the strong association of men to the caring factor of nursing, the gendered pronouns that segment male nurses from the socially recognizable female nurse is still an issue. According to Achora (2016), the stereotypical use of the gendered term "male nurse" instead of "nurse" to identify men who are nurses actually isolate male nurses from their female colleagues, causing stress. As such, these stereotypes that isolate male nurses have compromised on the quality of care administered to patients. Irrespective of the lack of a universalised identity when referring to male and female nurses, being a male nurse has proven to be advantageous. As such, the stereotypical and essentialist view of nursing being an exclusively feminine career carries weight only to a certain extent. According to Dwinnels (2017), physically demanding nursing work in psychiatric and mental wards put male nurses at an advantage when it comes to men's physical attributes. Therefore, men also fit into the nursing profession despite an emphasis on the feminization of such a career choice.

2.8 International Experiences: Working and Living Experiences of Nurses and Links to Dual Reproductive and Productive Roles

The working and living experiences of nurses globally involve the dual relationship between reproductive and productive roles. According to Firmin & Pathammavong (2012), nurses as working mothers deal with multiple priorities involving career, family, altruism and professionalism. As such, there is an interface between extrinsic motivation involving making money and the prestige of a medical position and intrinsic motivation entailing an investment of their lives to the needs of others. Merighi et al (2011) agree with this dual perspective by arguing that, despite adopting productive roles, nurses in public hospitals are not detachable from housework responsibilities and care for their children. Income earning as a form of economic independence as a result accompanies the roles of nurses in the development of their children whose interests are intrinsically incorporated into their lives. Rodrigues et al (2014), argue that, nursing goes beyond care for the sick, it is irrevocably related to the concept of caring and qualities directly related to the role of a mother. A mother is associated with caring, nourishing and educating. In addition, a multitude of roles such as being a mother, a wife and a professional create an overlap of functions inclusive of physical and mental fatigue; despite working, mothers remain the primary caregivers of children and the house (Ibid). A study assessing workplace stress among Palestinian nurses revealed that, women assuming day shift schedules reported more mental distress than male nurses. This was attributed to family and child care responsibilities in addition to nursing work (Jaradat, 2017). Jaradat (2012), further states that, female nurses reported higher frequencies of psychosomatic symptoms related to social and familial aspects. Reasons pertaining to increased levels of psychosomatic symptoms were based on the important roles female nurses play in household matters, nursing and caring. Ahmed et al (2015), argue that, levels of fatigue are negatively correlated with nurse's performance; effects of such include diminished memory, slow reaction time, increased irritability, compromised problem solving and critical thinking and decreased concentration and judgement. Therefore, as fatigue levels increase, performance levels decrease (Ibid). Rodrigues & Higarashi (2014), state that there is a personal sense of the act of providing care, derived from the experience of being a mother in addition to the implications of this conjunction of dual roles. This conjunction of professionalism and the reproductive role of mothering thus illustrates the extension of the nurturing and caring factor into the work environment. Despite the extension of communal roles of selflessness to the work environment, strain as a result of conflicting and unmet reproductive responsibilities in the home exacerbate the level of role strain female nurses experience. As a result, the manifestation of feelings of distress at having to delegate the responsibilities for children to others in order to fulfil the commitments of professional activity has resulted in the assuming rather of the zeal for patients (Ibid). The negative consequences of dual roles are argued by Wesson et al (2017), who articulate the fact that public sector hospitals and maternity units in Namibia are hubs of extreme stress for nurses. Despite the communal traits of passionately attending to patient care, negative interactions with patients have been a reality; cases of ignoring requests for care, rudeness, disrespect and physical abuse have been characteristic of nurses who face the workplace overload all too common in Namibian public hospitals (Ibid). Research done concerning provider and client perspectives of maternal healthcare in Namibia reveal that the greatest grievance among maternal healthcare nurses is due to heavy workloads. Data captured in relation to workplace satisfaction has shown a 13 per cent difference between workplace satisfaction and dissatisfaction (Wesson et al, 2017). Kasapoglu & Akbal (2017), further the concept of role strain and overload by arguing that the traditional curriculum of nursing schools in Turkey actually support the patriarchy of medicine. This is further aggravated by an unconditional commitment to patients and doctors which weakens the ability of nurses to fight for more equity. In addition, double burn out at home and at work result in fatigue that deters active engagement in rights-seeking practices (Ibid). As such, nurses suffer from the double burden of fulfilling their roles in the clinical set-up in addition to their roles as mothers in the home set up as well.

2.9 Summary

The literature reviewed in this chapter managed to communicate the convergence of the dual reproductive and productive roles of female nurses. In order to understand the convergence of these roles, it was essential to understand the socio-cultural determinants of gender-stereotypes in the nursing profession as well as understanding how these gender- differentiated roles result in the creation of gender hierarchies within the profession. The segmentation of gender roles based on nurturing and care as feminised and high-tech nursing as masculine, led to the essentialism present within the field of nursing. The presence of the patriarchal dominance of medicine above the perceived subservience of nursing also confirmed the presence of gender stereotypes within the profession and the mirroring of interpersonal relationships in the home that present the patriarchally dominant male. The oppressiveness of nursing under the shadow of the patriarchy of medicine was also noted as a factor that aggravated the subservient nature of the profession in addition to the emphasis on feminised care as a stereotype ascribed to nursing. Feminist scholarship not only acknowledged the social oppression of the woman, but also denounced the reduction of female oppression towards economic determinism alone. The socialization of unpaid, reproductive outside of the home signalled the end of the privatised female as a result. Moreover, what is important to note is that the non-detach ability of nursing as a career and the reproductive roles enacted in the home signalled role strain on the part of nurses who tried to balance reproductive and productive roles.

Chapter 3

Research Methodology

3.1 Introduction

The study made use of Narrative Research Methodology in order to gain an in-depth understanding if the convergence between the reproductive and productive roles of female nurses at Katutura State Hospital. The sample size for the study involved 15 female nurses who were purposively sampled due to their familiarity with the topic of enquiry, resulting in in-depth responses. In addition, the purposive sampling technique ensured that the participants could confidently contribute towards the research process. The use of a recording device and note taking was utilized based on the personal specifications of the nurses who were interviewed.

3.2 Research Design

Under the phenomenological approach, Narrative Research Methodology was used. The main emphasis of this approach was to seek to understand in-depth, how nurses perceive their dual roles in production and reproduction. According to Neuman (2014), narrative refers to a type of qualitative data, a form of inquiry and data gathering, a way to discuss and present data, a set of qualitative data analysis techniques, and a kind of theoretical explanation. In addition, Neuman (2014), defines narrative practice as a story like form through which people subjectively experience and give meaning to their daily lives and actions. The narrative organizes information, events, and experiences that flow across time. Narrative methodology played a very important role in the data collection process as the nurses were able to express fully their experiences actively mothering dependants and committing to their productive roles in the clinical set up. The use of in-depth interviewing and further probing allowed for detailed explanations of certain life events and experiences as a result.

3.3 Population

The population of the study involved female nurses who work at Katutura State Hospital in Windhoek. The main idea behind selecting appropriate candidates was to purposely select nurses who fit the criteria of being mothers as qualifying factors related to their participation in the study. Population is described by Brink (2006), as the entire group of persons or objects that are of interest to the researcher, who meet the criteria which the researcher is interested in studying. According to Burns & Grove (1993), the population means all elements (individuals, objects, events, or substances) that meet sample criteria for inclusion in a study; sometimes referred to as target population. Asiamah et al (2017), define population as an entire group about which some information is required to be ascertained. Participants in the general population must share at least a single attribute of interest (Ibid). Selecting the appropriate population required interpersonal communication with nurses as well as referrals to potential participants who fit the criteria of the target population as required by the researcher.

3.4 Sample

Purposive sampling was adopted as the subjects who are already mothers were able to knowledgeably contribute towards experiences and perceptions about the duality of reproductive and productive roles. Brink (2006) describes purposive sampling as a form of non-probability sampling that is based on the judgement of the researcher regarding subjects or objects that are typical or representative of the study phenomenon, or who are especially knowledgeable about the question at hand. The use of a purposive sampling technique proved to be adequate as the nurses were very detailed in their responses and most of them were able to give deep insights into balancing career and motherhood, income and socially and culturally defined gender roles as well the demands of the nursing profession and linkages to unpaid domestic labour in the home. In order to avoid saturation which would most likely lead to the unnecessary repetition of responses across all cases, the sample size did not exceed 15 research participants. Despite the need to avoid saturation, it must be noted that all the nurses expressed the same sort of emotive characteristics typical of juggling productivity and re productivity. It was not uncommon to also discover heavy emphasis on care and affection as naturally occurring accompaniments to the reproductive roles of motherhood and the productive roles of nursing. Based on the similarity of responses there was a point of saturation as the uniqueness of the responses began to wane as the data collection progressed. Data saturation was thus described as the point at which new data no longer emerge during the data collection process (Brink,2006).

3.4.1 Sampling Criteria

The selection of participants for the study was taken into consideration. The following criteria for inclusion in the study involved the following specifications:

- Female nurses who work at Katutura State Hospital in Windhoek;
- Should be mothers in not only a biological sense but also socially (through adoption or care of other dependants);
- Should understand the purpose of the data collection beforehand due to the emotive nature of the questions in the interview guide.

3.5 Research Instruments

The use of a semi-structured interview guide was considered as it was seen to give adequate responses in relation to female nurses and their perceptions and experiences with dual reproductive and productive roles. According to Minichiello et al (1995), focused or semi-structured interviews are used as part of the qualitatively-oriented in-depth interviewing model. This process entails researchers using the broad topic in which they are interested to guide the interview. An interview guide or schedule is developed around a list of topics without fixed wording or fixed ordering of questions. The content of the interview is focused on the issues that are central to the research question, but the type of questioning and discussion allow for greater flexibility than does the survey style interview (Minichiello et al, 1995). Welman et al (2005), state that in semi-structured interviews, the researcher has a list of themes and questions to be covered, although they may vary from one interview to the next. The semi-structured interview was conducted with the aid of a voice recorder and note taking in order to seek to understand the reasoning behind the experiences and perceptions of the research participants. This method was further adopted in order to allow for the exploration of themes within the research process. The use of pre-determined open-ended questions concerning gender balances and social dynamics, power dynamics in productive roles as well as reproductive roles and gender stereotypes allowed for a discussion of these themes in relation to how nurses as working mothers perceive and experience their dual roles of re productivity and productivity. Despite the flexibility of the questions asked, probing techniques were also adopted in order to allow for more clarity and expansion of responses given. Probing also allowed for active engagement between the researcher and the nurses as it was vital to not only seek more detail but to allow the nurses to comfortably open up during the in-depth interviewing process. According to Minichiello et al (1995), probing questions are used to elicit information more fully than the original questions which introduced a topic. Probing is sanctioned as part of the research process that differentiates in-depth interviewing from normal everyday conversations. It is an indicator that the researcher is aware that he/she cannot take for granted the common sense understanding that people share because these may be differently interpreted by informant and interviewer (Ibid).

3.6 Procedure

It was essential to pilot the research instrument by conducting a small number of interviews with informants who fit the criteria of the research participants. By doing this, it was clear what areas needed further clarification and amendments to ensure the questions yielded answers that are relevant to the research process. During the piloting phase, five interviews were conducted. Two of those interviews involved the use of a recording device while the other three involved note taking. There was clearly more discomfort during the voice recorded interviews due to concerns about confidentiality. Despite the ethical concerns, the confidentiality of the recorded interviews was guaranteed through the use of the ethical considerations stipulated in the informed consent form. According to Welman et al (2005), the purpose of a pilot study is to detect possible flaws in the measurement such as ambiguous instructions, inadequate time limits; identifying unclear or ambiguously formulated items where the actual questions are put to the participants, and they are then asked to indicate how they have interpreted the formulated questions. In addition, it serves as an opportunity for researchers and assistants to notice non-verbal behaviour such as discomfort or embarrassment about the content or the wording of the questions (Welman et al, 2005). Piloting the research instrument allowed for clarification into the general understanding of the questions being asked and the non-verbal reactions such as facial expressions and tone of voice based on the questions and the techniques used such as probing and seeking more emphasis of responses. The data collection process made use of face-to-face interviews and responses were recorded on a recording device in addition to note taking for participants who did not want their voices recorded. Interviews were conducted in the homes of the participants after working hours.

3.7 Data Analysis

During the analytical stage it was important to transcribe the audio interviews to text in order to pick up important themes. It was essential to transcribe the data verbatim or word for word, based on information captured from the recording device and from notes taken during the interviews. The coding method used entailed the linking of relevant conceptual themes in relation to dual reproductive and productive roles based on the research questions of the study. Minichiello et al (1995), state the importance of themes expressed in the interview transcript by arguing that themes can be expressed in single words, phrases, sentences, paragraphs or entire documents. When the researcher uses themes as the unit of analysis, he or she is primarily looking for the expression of an idea irrespective of its grammatical location. It is often made up of concepts which are linked together either by the informant and/or the interviewer (Ibid). The use of conceptual themes proved to be very helpful and aided in the categorization of data and the formation of themes that enabled the presentation of narrative data collected during the in-depth interviewing process. The use of case summaries of each research participant allowed for the linking of information from interview transcripts with conceptual themes that were relevant to the main research questions (Minichiello, V et al, 1995, p.262).

3.8. Research Ethics

Permission to conduct the research as well as ethical clearance was sought from UNAM. Informed consent was obtained from the research participants and it was indicated that participation in the study was voluntary. Anonymity was ensured through the use of pseudonyms and confidentiality and privacy was ensured as well. Informed consent from the participants to participate in the study was sought and participants were reminded of their right to withdraw from the study at any time without any negative consequences. Note taking was the mode of recording for those who refused to have their voices recorded. The data was kept in a secure folder with a secure password that was only be accessible by the principal researcher in addition to the exclusion of the identity of the participants.

Chapter 4

Presentation of Findings

4.1 Introduction

The aim of the study was to explore how female nurses experience their reproductive roles in the home and their productive roles in the clinical set-up. The researcher made use of semi-structured, face to face interviews through the use of a voice recorder and note taking for the participants who did not want their voices recorded. The data from the interviews was analysed through the development of conceptual themes. These conceptual themes were gathered not only from the responses, but were also guided by the research questions which in turn, enabled the producing of interview questions.

The main research question involved an exploration into what linkages are present between female nursing practice and the reproductive roles of the individual nurses. The following are the research questions that guided the interview questions within the interview guide:

- How are the socialised roles of women as caregivers and nurturers connected to the gender stereotypes of the nursing profession?
- Is there a link between women as nurturers and the power dynamics of their financial independence?
- How do women balance their social roles as productive caregivers and their reproductive roles in the home?

- Do these roles create a gender balance with men who also work outside the home?
- Does paid productive labour outside the home alter gender power relations?

The findings of the study drew inspiration from the creation of themes that arose based on the research questions that served as a guide throughout the data collection process. The following sub-headings represented the conceptual themes that developed as a result of the types of questions asked based in addition to the guidance of the main research questions:

- The gender socialisation process based on the socio-cultural environment;
- Income and the balancing of gender roles;
- Balancing dual reproductive and productive roles;
- Gender stereotypes and essential ism in the nursing profession: feminized care giving and the "good mother" discourse;
- The emotional qualities of a "good nurse";
- The productive activities of the nurses;
- Nurse perspectives on day-to-day activities;
- Causes of deviancy discourses in nursing;
- Emotional qualities of the "good mother" as a socially constructed identity;
- Challenging dominant patriarchal ideologies of the 'good mother" discourse: deviancy discourses.

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4.1.1 Response Rate

The nurses who fit the criteria necessary for participation in the study actually cooperated with the researcher and understood the ascription to ethical considerations related to privacy, confidentiality and anonymity. Once the ethical considerations related to the collection, storage and usage of the data were communicated to the participants, their cooperation did not pose any challenges. Though the interview process was very lengthy and detailed, the responses given actually answered the questions and contributed towards the development of the necessary conceptual themes. Despite the depth of responses given, a point of saturation was reached where the responses given were similar.

4.1.2 Socio-Demographic Data

The demographic data of the nurses interviewed was gathered during the data collection process. This data included their age, marital status, rank and the type of facility they work for. The following demographic characteristics are depicted in **Table 1**. below.

Table 1. Nurses' Demographic Data

Nurse	Age	Marital status	Rank	Type of facility
1	24	Co-habiting	Post-Natal Nurse	State
2	30	Single	Paediatric Nurse	State
3	54	Married	Midwife	State
4	49	Married	Disease Surveillance Nurse	State
5	48	Married	Nurse Mentor	State
6	34	Married	Midwife	State
7	33	Married	ART Nurse	State
8	28	Co-habiting	Antenatal Nurse	State
9	30	Married	PMTCT Nurse	State
10	27	Married	Nurse In-Charge	State
11	38	Co-habiting	Head Injury Nurse	State
12	30	Co-habiting	TB Ward Nurse	State
13	45	Co-habiting	Casualty Nurse	State
14	22	Co-habiting	Enrolled Nurse	State
15	25	Married	Enrolled Nurse PMTCT	State

4.2 Interpretation of Male and Female Upbringing

4.2.1 The Gender Socialization Process Based on The Sociocultural Environment

During the course of data collection, it was found that childhood socialization informed gendered expectations related to the assumption of specific tasks in the home. The formative years of childhood represented important information that informed mindsets in relation to socially and culturally influenced definitions of femininity in view of the contrasting expectations of those who were comparatively referred to as identifying with masculine identities. The stereotypical roles of subservience and work in a domestic capacity characterized feminized responsibilities that would eventually be translated into motherhood as a socially constructed identity and nursing as an essentialized profession. The findings revealed that the formative years of childhood were influenced by an induction into more selfless and assertive roles for survival. Gender differences were seen to exist concerning domestic tasks that excluded boys who took on more physically exerting work outdoors. Differentiation concerning female work and male work were pointed out. In addition, similarity of treatment despite clear differences in the role expectations of boys and girls were also evident as is pointed out below:

> Girls and boys were treated the same. For me, the work I did involved washing dishes and cooking, washing clothes. Girls did these chores because boys didn't know how to do them. The boys did not feel the need to do house work. Boys would spend more time taking care of the animals and tending the farm. (24-year-old post-natal nurse)

The stereotypical view of females adopting subservient roles, with men taking on the roles of beneficiaries of such subservience was clear in the findings. It was noted that it was normal to take on multiple responsibilities of care and assuming male roles. This clearly reflected an element of role strain based on the duality of communality and agency. One nurse pointed out this element of strain below:

> I could see myself as a female because of my roles of preparing meals and tending the house. I knew as a girl, I had to make sure the house is functional. I had to make sure the cooking was done. As a female, I had to be responsible for

> the home as boys were not allowed to cook. They would only be called to eat. As a girl I would do boy's work like tending to animals. As a result, women have greater roles and responsibilities. As a girl, you knew what you had to do. You knew that you had to ensure that your siblings and cousins had eaten. (49-year-old Disease surveillance nurse)

Despite the segmentation of male and female role expectations, the duality of both roles was more subtly pointed out below:

> I knew that boys in our community were more into outdoors work. They were always out of the home. Girls were more into chores like cooking, cleaning and washing. I could observe differences between girls and boys. My life was more of tending the home and helping my grandmother with cooking, cleaning and washing. She taught me a lot. I would also do outside work like cleaning the yard and feeding the animals. I think I assumed both roles when it came to work done. (27-Year-Old Nurse-In-Charge)

What spoke volumes was the fact that girls were seen to be indoctrinated into believing that what they observed about being female was natural. As such, they were indoctrinated into believing that communal roles are what justify what it means to be a female. This was pointed out below:

> As a girl, you get used to the environment. You think that everything you are taught or are going through is normal. My duties that time entailed me being hard working. I was very obedient but bitter at heart. The perpetrators didn't realize that I was bitter. I never grew up with my parents. I was always keeping myself busy. I was

> very unhappy. I would visit my mum and step-dad and find them fighting. Now that I am married life is better. I was very diligent and eager to learn new things. I would learn from our neighbours who were girls. The community played a big role. As a girl you would pound mahangu for the elders as you were a girl and it was expected. You couldn't run away. You would help the elderly and take water to their homesteads. (49-Year-Old Disease Surveillance Nurse)

The perceived normalcy of socially expected female roles were pointed out in the following narrative:

> Like in our set up, now mostly we were just pounding mahangu, go fetch water. We just learnt all these girl roles like as a young lady you have to know how to cook, you have to know how to pound mahangu, you have to know how to at least greet the visitors if someone is coming to the house. (34-Year-Old Mid-Wife)

It was also found that females operate within a highly restricted environment that does not necessitate the sense of adventure and wonder that boys were able to experience. Restrictions placed on females emphasized the perceived vulnerability of the girl child while acknowledging the fact that boys were seen as being able to survive for longer periods out of the home. This was pointed out below:

> But socially, boys could be playing whatever after sunset but with us, your mother would not even allow you to go out. Because they believe you can't survive out there in the dark. She would always worry if you have to visit a place for a long time. My brother could go for the whole holiday, like a month at my

> uncle's or whatever. I always had to return home first. (28-Year-Old Ante-Natal Nurse)

It is evident that the unequal balance of male and female role expectations characterized childhood and upbringing. What speaks clearly is the fact that the assumption of maternal roles was associated with being female in addition to the adoption of altruistic roles that involved a selfless fulfilment of the needs of others. This was emphasized below:

> I would say that as a girl, you tend to have more responsibilities than that of a boy. As a girl child you try to play the role of a mother even if you are not a mother yet. When you are growing up, there will be things that will make you more responsible even when you are under age. You will be taking the roles of the mother in the house just to look after everybody's needs. (48-Year-Old Nurse Mentor)

Based on the findings, the experience of assuming maternal roles before assuming them biologically was evident. In addition, the home was viewed as a preparatory ground for anticipated, biologically and socially determined motherhood in the future. It can further be stated that the adoption of motherly roles was representative of a mental picture of what to expect as a future mother and wife. This was confirmed below:

> I am the first child of the family, so there was a lot of responsibility, taking care of the younger ones, taking care of the house. So, I assumed the role of a second mother in the house. So, I got to know a lot of things, then I passed the

> knowledge onto my sisters and brother. It is actually good because when I got married, I moved to Botswana, it was just me and my husband alone. So, there was no family member or anybody so when I was pregnant it was just the two of us at home. Even when I was delivering, it was just the two of us alone. So, when I was pregnant, I would get advice from my midwife friend, she has already passed on. She showed me what to do and how to it. Based on how I grew up, my mother basically taught me everything, so it was not that bad. When I gave birth, I was the one who bathed my child myself. I did the same for all my kids but ideally you are supposed to have someone bathe the child because your body is still very weak and sensitive. I did all my things myself and due to my previous experience of how I grew up. I saw my grandmother doing it to my younger ones and my mother doing it also to my uncle's children. So, it was really helpful actually. (33-Year-Old ART Nurse)

The formation of core values that influenced motherhood and conjugal life were reiterated. It was found that the dominance of communal roles during the formative years of childhood resonated clearly. In addition, core values of communality were used to inform the socially expected roles of females as is stated below:

> Core values helped me grow. They prepared me for motherhood, marriage and being a grandmother. As a daughter, I had to take over tasks that my mother was doing. My siblings and I would assume tasks while my mother guided us and gave us instructions. (54-Year-Old Mid-Wife)

The perceived effect of domestic tasks for the foreseeable future were viewed as shaping how one lives out their life in the future. This was interpreted as resulting in one adopting beneficial life skills by encouraging self-sufficiency. This furthered the concept of navigating through life by the adoption of necessary survival skills as was pointed out in the following statement:

> So, as a young girl all you know is to collect firewood, to go to school and then to come cook for the family. By five years old, you are supposed to know how to put a pot on three stones. For me, it has a very big impact on how you turn out. How you as a young woman would be later. You would actually use those experiences to navigate through life.
>
> (28-Year-Old Ante-Natal Nurse)

4.3 The Socialization of Female Domestic Labour: from Private Production to Public Economy

It is clear from the research findings that female role expectations have had an effect on the extension of such roles out of the home. This is confirmed by Dalla Costa & James (1972), who state that the shift from private life to public life is viewed as a beneficial way for women to acknowledge that their work can be recognised outside of the home as remunerative work. Women should be socialised to destroy the role of the housewife thus resulting in the ending of the tradition of the privatized female. The role of spouse and mother of those who have participated in activities in the outside world should come to an end (Ibid). De Beauvoir (1949) also confirms the benefits of this shift from private to public life by stating that it is through work that the gap between males and females is diminished. Productivity means that a woman's responsibilities become relative to the goals she pursues and to the money and rights she appropriates. In the context of the study, income earned has resulted in increased dependability and self-actualization. In addition, gender balances and power sharing among spouses came into fruition as a result.

4.3.1 Income and the Balancing of Gender Roles

Based on the research findings, the effects of income earned had an effect on gender roles and gender role expectations in the home. It was found that income led to a mutual understanding and sharing of childcare and other domestic responsibilities. What resulted was a relationship of understanding and mutual caring in addition to the interchangeability of communal and agentic roles between spouses. This was pointed out below:

> Somehow the relationship was good because my husband was coming from that background of caring. He was someone who could understand and when I'm not in he would jump and he would take care of the household needs. He was such a caring person that even when I was out, he would babysit; he would make sure that the kids were taken care of. Even when I am coming from night duty as a nurse, he will make sure that I am not disturbed so that I have a good sleep; so that when I go back to work at least I have a fresher mind. The fact you know, working night duty and overtime, it was actually fetching more coins and when I put those resources together, it was able to make everyone around me happy. So,

> then I would not see the negative part of going to work and no money. So long as I have gone to work and I have left them having good life, it really put my heart at peace. My spouse was happy and even when my overtime payout cheque was out, he would be the one at the forefront. (48-Year-Old Nurse Mentor)

Income was seen to encourage individualistic decision-making. The effects of income earning were able to balance relations between men and women as a result of co-dependency, thus lessening the burden of dependence on one income alone. In addition, income led to more positive experiences socially and commanded respect from a wider scope of individuals. The benefits of financial independence were stated below:

> Earning money has been good. I am able to buy what I need to survive. Making money makes me feel more mature and able to do what I want. I don't need to depend on anyone. I decide where to live and no one decides that for me. I don't need to follow anyone. I feel free and more respected with an income. I relied on help from family members and I would sell maize to make a bit of money. Now I feel more independent. I am not at the mercy of anyone. Making money has made life easy in the home. My partner treats me well because the burden is not just on him anymore. He is happy that I also pay for water and electricity. We buy food and we eat well now. My relationship is happier now. I feel more useful now. I can do my part and know that I have done something good. (24-Year-Old Post-Natal Nurse)

In terms of power sharing, it was noted that income led to equitable contributions towards the financial survival of the family. In addition, power sharing was likened to a partnership as well as being able to result in a self-actualized existence harnessing stronger decision making. The benefits of income earned were mentioned in the following quote:

> It has helped my marriage as well. My husband and I share the expenses and get along well. I feel more independent and I am able to do my bit to ensure our survival. Income has really opened doors for me. It has made me feel more at peace and more responsible. I can help pay for the mortgage and educate my kids. There is more peace at home as my husband doesn't complain too much about expenses. The kids are happy and I can purchase the things they need. We are able to save money and invest in other things like building a home in the village. Life is a bit easier than before. (27, Nurse In-charge)

In terms of power sharing, the following was stated:

"I feel stronger and more in control. I may have a salary but I still discuss things with my husband. We plan together. Its 50-50 now. We are partners now. It makes me feel more empowered and at ease. "(27-year-old Nurse In-charge)

One of the nurses also pointed out the following:

> Earning an income has balanced our relationship. We both expect from each other. He knows that he should take care of the kid's needs too. We both work together to care for our kids. We equitably contribute towards the welfare of our kids. (38-Year-Old Head Injury Nurse)

Being able to work and earn an income enabled collective decision-making. In addition, equal levels of influence were reported even though consulting when making financial decisions mirrored the dominant patriarchal image of the man as the head of the home.

This was confirmed by one of the nurses in the following statement:

> There is mutual respect as I also contribute towards the maintenance of the house. We make individual and collective decisions with my husband. There is a mutual understanding between my husband and I. I consult my husband before I spend my money. (49-Year-Old Disease Surveillance Nurse)

The following in relation to collective decision making was also mentioned:

"As a family person, you have to consult. You have a husband and kids so you have to make decisions together. If you are not in agreement, you have to consult one another". (34-year-old Midwife)

In terms of social interaction between spouses, income allowed for mutual, spousal support and support for extended family. Effective communication was also mentioned as a result of co-dependency and was in turn representative of power sharing.

The following was narrated:

> There are no negative experiences. It enables me to support my husband. It is difficult to carry all the burden of the whole family. We have an extended family that we are supporting, like my sisters. We are paying for the school fees of my youngest sister. She goes to a private university, which is not a joke. So, it costs

a lot. We have our construction that is taking place back home. It's a very big house and this one we live in will also be ours. We are paying the mortgage; we have children that attend private schools and we also need to survive. We need to eat; we need to live. It is really good because we are able to support each other. There is no issue of this is your money and this is my money. It is our money. Whatever comes in, we work on it. So, if this one cannot pay, the other one will be able to. That's where the issue of communication comes in., we plan how we will spend our money. (34-Year-Old Mid-Wife)

The reaffirmation of the benefits of mutual support and communication was mentioned in the following statement:

We do things together. We sit and discuss the way forward. We are strong together, I guess. He is very supportive of me. He respects me as a wife and as a mother to our kids. It has definitely made us close. We make decisions together. He is happy that I also have my own money. I can also take care of the expenses, so it makes him comfortable. He knows that even if he is not there, the kids and I will be fine. (30-Year-Old PMTCT Nurse)

One of the nurses also mentioned the positive aspects of income by aligning it with being a self-starter. The following quote illustrates her point:

Money has made we want to explore. It has empowered me to stand up for what I believe in. If I want to buy a car, I will do it. I am empowered that with this little money, I am able to help others do greater things. By doing so, people keep coming to my home. It makes me more independent. I can't just rely on my husband. I plan what needs to be done. I am independent. My husband knows that I can manage and run the home even if he is not there. (49-Year-Old Disease Surveillance Nurse)

Despite equality in decision making and mutual understanding, there was also a case of conflict as a result of the female spouse having more economic stability with the male taking on more casual labour. The interface between seasonal income and regularized income was illustrated in the context of the social relations between spouses in the family unit. This was affirmed by a nurse who stated the following:

"At home, my partner helps me where he can. He is not employed but sells electronics when he can. He gets very frustrated at times, but he respects me. Sometimes he feels intimidated but relationships have ups and downs." (30-Year-Old TB Ward Nurse)

The gender balances between men and women based on income earned were also negatively contextualized based on the non-inclusiveness of spousal input when it comes to decision-making. This analysis signalled an acknowledgement of the patriarchal image of the man as the overall financial decision maker in the home. This was clarified by one of the nurses who stated the following:

Feeling independent means there is a big gap because I started making decisions without his input, which is bad. I have to be open and truthful. Due to marriage, I feel obligated to consult with him before making major financial decisions. At times I feel guilty about informing him about how the money was spent. I feel I need to inform him because at times I need help from him as well. He is very traditional. (49-Year-Old Disease Surveillance Nurse)

4.3.2 Balancing Dual Reproductive and Productive Roles

The balancing of dual reproductive and productive roles formed a very important part of understanding how female nurses who are mothers are able to manage their responsibilities at home and in the clinical set up. The findings show that there was a conflict of interest between work demands and family life. In as much as there was a need to show more affection despite the need to ensure economic stability, role strain as a result of fulfilling professional and familial interests represented an unwelcome reality. It was also found that agentic roles were spilling over into an atmosphere that required an enactment of communal roles; this spill over was characterized by the carrying over of clinical duty requirements into the home after hours when a maximization of time spent with dependants should have taken first priority. As such, there was an interface between self-interest and selflessness. This was confirmed in the following statement:

> At work I concentrate on my duties. It has affected my decision making in life because I was so pre-occupied with my job. I just wanted to get work done and at home I would find myself working as well as trying to fill the gap at work. I neglected my children. I was so busy at work, that I forgot my responsibilities. I would carry my work home based on the decisions I had made to achieve. Everything at work has to be perfect despite everything not being perfect at home. At times you don't even have time to attend to the children's homework. The work takes the place of your family. My heart is divided; my heart is split. Nowadays I need to attend to housework such as ironing, cleaning, cooking.

> Neglecting the home is not good. Carrying frustrations from work was an issue. When I would get home the kids would embrace me and follow me to the room, prompting me to turn them away due to fatigue from work. I was unable to equally distribute the time between my family and Katutura work. If I am not in Katutura, I should leave that responsibility in the workplace and focus on my family. Earning means you are spending more money and spoiling the kids. The children don't just want to be spent on. They want you to be affectionate with them. My children need love more than material. Love has been missing and love is about giving. (49-Year-Old Disease Surveillance Nurse)

The importance of balancing motherhood and a career as a nurse was stated in the following quote:

So, as a working mother, I actually try to learn to be able to balance my roles as a career woman and also as a mother in the house. Sometimes for instance I will be very tired then you hear someone ask if there is food in the house. You just have to do something. Or you hear, mummy we want this, mummy we want that. But mummy is actually tired. Then you actually see which one is a priority. You need to try and make them happy at the end of the day. Sometimes you don't even hear what they are saying but at least let them talk so they feel like you are listening to them. Kids want food; they want to be satisfied. You have to show them love. (33-Year-Old ART Nurse)

"You have to work hard. Even if you are at work and you are tired, sometimes you just think, maybe about resigning. Think about your children and your house. You have a bond to pay. Just work hard." (34-Year-Old Midwife)

It was also pointed out that the management of responsibilities such as delegating household responsibilities during working hours was an expected occurrence. This determined the idea of fulfilling the role of a mother, a wife and a nurse in the workplace. One nurse iterated this fact below:

The children understand the nature of my job and I also have to organize childcare or alternative childcare arrangements due to shift work. During working hours, I call home and give instructions to those at home as well as giving instructions at work. E.g., delegating care, preparation of food, home-making. Long shifts drive the need to arrange for after school care. I have to balance work and family life. I pay extra costs for childcare. You need a job even though you want to be with your kids. You need to juggle motherhood and work. Other options involve leaving kids at home. Your children and spouse expect you to fulfil your roles as a mother, wife and the workplace requires that you fulfil your professional duties. (54-year-old Midwife)

There was also mention of the importance of spousal support in light of the management of dual reproductive and productive roles in the following quote:

> He was aware of the nature of my work. If I am working night duty, I will prepare food before going to work. I always take care of the household responsibilities before going for shift work. I do my husband's laundry and other

> chores. My husband is very understanding. He would always take me to work and bring me back home before I got my own car. When I would return from the night shift, I would prepare food before going to sleep in order to ensure lunch is available for my husband and kids. (54-year-old Midwife)

Balancing duality led to feelings of being torn between the needs of the children at home and the patients in the clinical set up. It was found that there was an inability to fully entrust the care of children onto others. One nurse mentioned the following:

> I would do night duty or knocking off late and as a parent when I started having my own children it impacted my life in a sense that if I have to go on staying on duty and I don’t have someone to care for my child, you feel like your child should be cared for. I felt like there was going to be a deficiency in that. It kind of affected me even though I was able to provide everything. I felt like I should be there to fend for my kids. I reached a point where I would hire and fire nannies because they were not meeting my standards. So, it was really hard at one point. I would even phone my employer to say I cannot make it to work. You can’t carry your child to work so it was really tough to a point where I couldn’t balance the two. You wonder who will fend for your kids if you stay home and if you go to work, who will take care of your children? (48-year-old Nurse mentor)

> As I was growing up, I was in the nursing career and it affected me as I didn't have a choice as to where I would work and whether I would be off on the weekends. So mostly, my weekends were such that I would be working during the week, then weekends I am on. Meaning when I am at work on weekends, we kind of miss each other because when I am at work, they are home. The time that I am off during the week, that's when the kids are in school. So that also made me say that when you are with your kids, they are not really accustomed to being with a mother. They are more attached to the nannies. (48-year-old Nurse mentor)

4.3.3 Gender Stereotypes and Essentialism in The Nursing Profession: Feminized Care Giving and the "Good Mother" Discourse

The findings indicate that the nursing profession is subject to culturally defined occupational roles based on gender. The nurses that were interviewed viewed nursing as an extension of the "good mother" as a socially constructed identity within the clinical set up. It is clear from the findings that the nursing profession is reliant upon the stereotypical, feminized notion of care, compassion and overall selflessness. This further accounts for the fact that nursing cannot be separated from motherhood as the two are viewed as interchangeable irrespective of location; be it at home or in the healthcare environment. The high presence of emotion within the profession was very clear in the findings, indicating that it was not possible to separate relational caring from the altruistic view of the profession as a result of the extension of motherly roles of care into the workplace. As such, being a mother was viewed as an advantage in the enactment of the productive roles of nurses in the clinical environment. The strong association with altruism and being a support system was mentioned in the following excerpt:

> I am a mother at home and at work; I am more of a dependable person. Patients look to me to provide care and to manage their day-to-day needs. Being a nurse means being a support system. You have to be on hand to help ease suffering and to provide counsel. Nurses have roles that go beyond bedside nursing. They are also listening ears and helpers. (30-Year-Old TB Ward Nurse)

Changing patient's diapers, feeding the patients and turning the patients. Caring for patients relates to motherhood. (38-Year-Old Head Injury Nurse)

It still comes back to the fact that if you are a good mother in the house, it will just reflect naturally. You actually don't have to work for it. It just comes naturally. (33-Year-Old ART Nurse)

The interchangeability of nursing and motherhood also emphasized both concepts as being dependent on each other. Self-sacrificing was at the helm of this interchangeability. In addition, it was found that survival as a nurse which is in itself a remunerative position required acting in a communal manner in order to satisfy agentic or extrinsic motivation; which is income earning and survival. One of the nurses in turn, stated the following:

Working as a nurse is good for me. Caring and being faithful are important for a nurse. You can't be mean. You have to be kind. Being a mother allows you to survive as a nurse. Being a mother and a nurse, you have to be available to show care.

> Having a good heart has made nursing the job for me. I like to think of others and how they feel. A mother can't be selfish. My character as a kind person makes my job rewarding. I have a passion for it. *(24-Year-Old Post-Natal Nurse)*

One nurse also pointed out the interchangeability of nursing and motherhood by stating the following:

> I would say in the set up where I am working, I am a midwife. As a midwife, you are more of a mother. You have to take care of those small babies; you have to take care of the mothers and their babies. Just like, when this mother is not there, the way you are taking care of these babies is similar to taking care of your own child. Anything you do, you must do it like you would do for your own baby. (34-Year-Old Mid-Wife)

Nursing in the paediatric ward was viewed from the point of being a pillar of strength and commitment to care based on the vulnerability of sick children and consideration related to the emotional wellbeing of parents of sick children. The findings indicated a propensity to not only professionally satisfy the demands of the roles of a nurse but to be mindful of the physical and emotional needs of the patients. Being emotionally aware of the needs of the patients was key in successfully managing the demands of the profession. An elaboration revealed the following:

> Showing love and care to the children in the ward is key. A lot of them are in the ward for a long time. They get stressed and don't understand why they are there. As a nurse, you become a mother to sick kids. Their mums are also usually with them so you also have to become a pillar of strength to the mothers of the sick kids. You have to show love and concern. It's hard having a sick child in the hospital.

> I am a mother to my kids at home and to the sick kids in the ward. You have to have a loving heart and be strong at the same time. It's not just about money. You have to be open to caring about the other person. People don't choose sickness; it happens. As a nurse, you should be committed to offering the best care. (27-Year-Old Nurse In-Charge in Paediatric Ward)

In relation to the altruistic nature of nursing, it was found that the profession necessitates a trusting relationship that benefits the patients. The act of prioritizing the needs of patients above self-interests pinpointed the importance of self-sacrifice. Nursing was seen as facilitating the physical, emotional and social well-being of the patients; which are in close relation to the pillars of care that guide the nursing profession. This was confirmed this in the following statement:

> The act of caring and protecting the vulnerable is essential. The patients are like my children. You should be able to speak for patients and advise them and show them tender loving care. The patients depend on me. You should be there for the patients. You need to explain what treatment you are giving them and how it will help them. You need to develop a good relationship with your patients. Patients develop trust in you as a nurse, so you need to view a person in a holistic way. You need to take care of their physical, emotional and social needs and incorporate all these elements. That's where you spend most of your time as you tend to spend 8-12 hours and even more. You have to create a conducive environment for yourself, your colleagues and your patients. You have to create a good environment. (54-Year-Old Mid-Wife)

The social context of the nursing profession in relation to caring, openness and genuine concern was expressed by Nurse 9 who stated the following:

> As a registered nurse at the Prevention of Mother to Child Transmission department, you have to be on hand to support pregnant mothers. I also have to test and counsel mothers and it requires a caring and open heart. I deal with many mothers coming for ante-natal and post-natal care and you have to show concern for them. It's the same with children. You have to love them and be there for them. The mothers look up to us to advise and help them before and after birth. It's very rewarding. (30-Year-Old PMTCT Nurse)

It was also found that compassion informed entry into the nursing profession. Care was analogized based on the act of being a caring mother and thus conformed to the essentialist view of the profession. Even though the determining factor of entry was based on negative experiences as a result of emotionally daunting experiences during childhood, the essentialist views nonetheless stood out. Caring and its strong relation to motherhood informed entry and was mentioned by one nurse in the following comment:

> I am a very caring mother. As a nurse and someone who has compassion, informed my decision to become a nurse. I had no love growing up and being a nurse made me want to care. I used to cry at night as a child. Crying during the day was hard as I would be beaten. I always wanted to be a nurse; to help those who can't help themselves. I have to ensure that everyone under my care is well dressed and well taken care of. Being a caring person made me want to be a nurse. I have always loved kids. I can't recall being called beautiful as a child. (49-Year-Old Disease Surveillance Nurse)

The essentialist view of the nursing profession was further reiterated as being tied to motherhood as a socially constructed identity. Nursing in this sense was viewed as a profession that relies on the emotive nature of motherhood and a commitment to selfless sacrifice and consideration for others. The stereotypical view of the profession was confirmed by its strong dependence on qualities that are likened to childcare needs and management of the emotional, physical and social wellbeing of those under the care of the nurses; nurses whose roles are interchangeable between the home and the healthcare domain. Nurse 8 pointed out the importance of mothering in the context of nursing by stating the following:

> You understand, you sympathise with the patient about the situation. I think you get to be softer, more caring, compassionate. When you do things, it is as if you are doing them for your own child; regardless of how old the patient is. You think if this was your child, because this person has a mother. If it was my child, I would like him/her to be treated this way and therefore I will treat this person well; after all they have a mother. Even though they are old enough, you become a mother to them. (28-Year-Old Ante-Natal Nurse)

4.3.3.1 The Emotional Qualities of A "Good Nurse"

4.3.3.1.1 Altruism and Emotiveness

The emotional qualities necessary to be a successful nurse were also mentioned in the findings. The nurses expressed the fact that being able to understand the recipients of care and their needs, epitomised what it means to be successful in the profession. Being slow to anger by not being overly reactive were seen as qualities that made the profession bearable. Recognising the multitude of clients emanating from different cultural and social backgrounds displayed the ethics of care by being unbiased when it comes to service rendered. The findings indicate that altruism in the profession was what made it rewarding and emotiveness was an unavoidable area when it comes to nursing within the clinical set up. The following was indicated:

> When you put yourself in the shoes of that person you ask yourself, what if tomorrow I will be the one to be the patient and I am no longer in the caring position? You will want to make sure that person is fed, that person is given a bath, that person is given medication, that person is feeling better. So, when you see somebody feeling better you feel like you have impacted somebody's life and you have touched someone's life. It's like you are an angel. It also feels good when somebody tells you that if it was not for that nurse they were not going to get out of hospital. The fact that people still appreciate you by thanking you and saying they are so grateful you helped them. (48-Year-Old Nurse Mentor)

4.3.3.1.2 Understanding and Prioritizing Patient Needs

Openness to understanding the needs of others as well as prioritizing the needs of recipients of care as well as the responses to care were vital elements in the emotional aspects of the nursing profession. It was essential to understand the sense of altruism present in the profession by being compassionate, being able to listen to others and to be able to objectively accept criticism.

One nurse stated the following:

> You should be open to understanding other's needs. It's not about you. It's about the recipient of care. Are you delivering the right care? What is the response? Is it good? You need to put yourself in the shoes of the other person. You also need to avail your time and effort for the welfare of the patients. You should have a good heart and should accept criticism. (30-Year-Old PMTCT Nurse)

4.3.3.1.3 Modes of Communication Between Patients and Doctors

Understanding the needs of patients also brought to light the fact that nurses are not only angels of mercy; they form the communication modes between the patients and the doctors. The roles of nurses were mentioned as incorporating fundamental relationships with patients encompassing trust as such relations were more frequent than doctor-patient interactions. The following was indicated:

> Patients know that nurses are there to assist them and report anything odd to the doctors. I think that nurses also act as communication lines between the patients and the doctors. It is the nurse who knows the patients more than the doctor. The nurse communicates the problem, gives a full report and records and makes observations. So, the patient always relates well to the nurses as they are present most of the time. They communicate what happens to the patients. The doctor comes in, checks the patient, then leaves the patient in the hands of the nurse. (30-Year-Old Paediatric Nurse)

4.3.3.1.4 Openness Towards a Selfless Mindset

Nursing practice was characterised as being a profession that displays open and effective communication, trustworthiness and looking beyond oneself. The mindset of a person was also mentioned as having an influence on the aspect of care and trustworthiness. One nurse pointed to the following fact:

> A nurse has to be open to interacting and should be an effective communicator. It is important to be trustworthy and to have a wide scope of knowledge. A nurse should always understand the other person and learn to show genuine concern for the needs of others. Such qualities come naturally but can also be learnt. It's about being receptive to looking beyond oneself. (30-Year-Old TB Ward Nurse)

4.3.3.1.5 Humanizing Patient Experiences

The findings indicated that the nursing profession humanises the experiences of patients as opposed to the mere assigning of identifying codes. It was about understanding the narrative behind every patient's experience. One nurse pointed to the following fact:

> For every patient, there is a different story behind their problem. That story is what changes you. You change a lot as you experience a lot. As nurses, we take up all the stress of other people and we get filled with them over the years. It is as if you are a balloon expanding. Every time someone tells you about this and that. At times it is for you to listen, at times it is just to ask you for an opinion, sometimes they are so frustrated and they put their frustrations on you for getting a bad response at Wanaheda Clinic. So, you will take the blame for others as

> well. You will be filled with everything and anything. Regardless of that, everybody has a different story. (28-Year-Old Ante-Natal Nurse)

4.3.3.1.6 Recognizing Diversity in Patient Experiences

The selfless role of understanding the multiplicity of patient experiences was associated with love, care and compassion. It was necessary to look at the profession from the point of view of human interaction and not just as a basis for remuneration. One of the nurses mentioned the following fact:

> You have to be loving, compassionate and have a caring heart. You need to love people. People have different conditions. You have to be a people person. It's not just for money, it's for the well-being of the patients. Nursing is a sacrifice. You do a lot to ensure the work is done. Be a good listener and accept people as they are. You can't be judgemental. (49-Year-Old Disease Surveillance Nurse)

4.3.3.1.7 Selflessness Through Association and Social Background

The display of selfless attributes was informed by association, social background and a mindset that is controlled by the influence of the pre-existing environment. The environment was perceived as vital in influencing the mindset. The caring factor was thus attributable to the transformation of the mind and the propensity to care was associated with inter-personal relationships within the pre-existing environment.

This was indicated in the following statement:

> They are created by association and the environment. The people you associate with may have a good or bad influence. Your background may pull you down since you carry that character with you. A foundation of love results in that caring factor based on a transformation of the mind. The mind is influenced by the environment. Meeting new people can help raise positive attributes. Transformation creates meaning that results in care. (49-Year-Old Disease Surveillance Nurse)

4.3.3.1.8 Eliminating Bias

Disregarding biased attitudes toward the nursing profession was also mentioned as a key element when it comes to survival in the profession. Fulfilling the demands of nursing was characterised by embracing a bilateral view of the positive and negative attributes. Being more objective concerning the profession resulted in being able to positively impact the lives of patients. One of the nurses stated the following fact:

> The moment that you decide that you want to do nursing, you have to try to embrace the job. Both the positive and negative parts; then you won't have problems. You have to be passionate about what you are doing. That is when you will be able to impact other people's lives positively. Nursing actually shapes people's lives. You don't have to say or do anything, people will know that you are actually a nurse. (33-Year-Old ART Nurse)

One nurse also reaffirmed the insignificance of bias in the profession by stating that, *"in nursing, you are working with different people with different values and beliefs. So, you have to be in the same uniformity. If you are not in the same uniformity, things will not go accordingly." (34-Year-Old Midwife)*

4.3.3.1.9 Equating Nursing Care with Motherhood

Nursing was described based on a reflection of domestic tasks in the home; the sorts of tasks that a mother might assume in the patriarchal family unit. The profession was likened to mothering the patients. It was analogised as encompassing the selfless care of patients in the clinical set up as the equivalent of the care of children in the home. This clearly represented the application of communal roles (compassion, care and empathy) to a perceived communal setting (clinical set up that necessitates communality) with an agentic result which is profit. One nurse pointed to this fact of communality by stating that, "*you help bathe them and dress them. A nurse is like a mother because she has to care for the patient all the time. A good nurse has to be strong and caring at the same time". (24-Year-Old Post-Natal Nurse)*

4.3.3.1.10 Displaying Communality

One nurse reaffirmed the importance of communal characteristics by stating the following:

> Love, care and honesty spell out who a nurse is. You can't nurse if you can't associate yourself with others. You need to be a people person. You must be committed to understanding and helping others. It doesn't happen for everyone though. You need to be on hand to assist others. Sick patients didn't ask to be sick. A nurse should understand that. (27-Year-Old Nurse In-Charge at Paediatric Ward)

4.4 The Productive Activities of The Nurses

Identifying the productive activities of the nurses represented varied degrees of responsibilities within the clinical set up. The identification of the types of responsibilities assumed and their allocation as either agentic or communal was important. It was found that though the profession is subject to gender stereotypes of feminised care, there are areas within nursing practice that are either agentic, communal or inclusive of both types of roles. Communal roles were characterised as involving warmth, care and an investment into the well-being of others by caring, helping and belonging with others based on an 'other-focus. Agentic roles were said to entail a 'self-focus through an assertion of status, power and respect in the quest for mastery, motivation and competence (Tellhed et al, 2018). In addition, communal roles were identified as aligning with feminised care giving roles that led to the assumption that women are communal as they are commonly identified with care giving roles such as nursing (Ibid).

The nurses interviewed either assumed leadership and mentor ship roles, caring roles, psychosocial roles, administrative roles and educational roles in addition to general clinical roles within the medical establishment. Even though the productive roles of the nurses were identifiable as communal based on the strong association with relational caring, there were other roles they played that were also depersonalised. These roles encompassed managerial and leadership characteristics that complemented their day-to day roles that also required an investment into the emotional and physical wellbeing of the patients. The following table displays the types of roles played and their identification as either agentic or communal.

Table 2 Nurse Productivity and The Types of Roles Adopted

Areas of Productivity	**Types of Roles**
Mentorship and skills transfer	Agentic
Health education, counselling and caring	Communal and agentic
Managing emotional and psychological needs of patients	Communal
Management of clinical data	Agentic
Administration, leadership, delegation and care	Agentic and communal
Physical, emotional and social needs	Communal

During the interview process, the different dimensions of the nursing profession revealed the diversity of the profession. It was important to understand the multidisciplinary arm of nursing based on an identification of the different responsibilities related to the profession. The data was categorised according to the types of activities the nurses engaged in as not all the nurses were involved in patient-centred care, as per the stereotypical view of feminised nursing practice. The different activities marked the need to identify communal and agentic roles as well as a combination of both roles based on specific areas of productivity. The narrations of the agentic and communal dimensions to the nursing profession were elaborated in the section pertaining to the day-to-day activities of the nurses. The main activities identified involved the following:

- Mentorship and skills transfer;
- Health education, counselling and caring;
- Managing the psychological and emotional needs of patients;
- Management of clinical data;
- Administration, delegation, leadership and care;
- Managing physical, emotional and social needs.

4.4.1 Mentorship and Skills Transfer

Mentorship and skills transfer entailed orientating new nursing recruits into the clinical set-up. This not only involved induction into caring; there was an emphasis on ensuring an understanding of the principles of nursing practice and the need to create a balance between motherhood and the profession, most especially for entrants who were also mothers. The impartation of nursing knowledge and principles mirrored the agentic nature of leadership through induction of new recruits into a profession that requires full time commitment to care in addition to administrative and managerial tasks as well.

4.4.2 Health Education, Counselling and Caring

Health education, counselling and caring involved an emphasis on adherence counselling within the antenatal clinic. Adherence to ART medication and the importance of testing for infectious diseases such as HIV involved health education activities as a way of sensitizing pregnant mothers and mothers who have delivered about HIV prevention. The emphasis on the encouragement of partner testing and self-adherence involved an investment into ensuring the wellbeing of the patients as well as the impartation of knowledge related to testing and adherence. Health education also required leadership in relation to not only motivating for health-seeking practices but also teaching and ensuring an understanding of investing in self-care in relation to treatment and adherence.

4.4.3 Managing the Emotional and Psychological Needs of Patients

The management of the emotional and physical needs of patients was identified as purely communal. The selflessness of the emotional and physical dimension of nursing involved relating to patients in a holistic manner. The main area of expertise involved an investment into care supported by the need to have a passion for the profession. The need to counsel patients going through difficult circumstances such as impending death due to terminal illnesses required an investment into understanding and managing the psychological needs of the patients. This area of nursing was categorised as communal based on an investment into the emotional and psychological needs of the patients. Moreover, the attention given to empathy, passion and viewing the profession as a way of life emphasized the elimination of self in the profession.

4.4.4 Management of Clinical Data

The management of clinical data within the Disease Surveillance Unit involved a more depersonalised approach to nursing practice. The agentic nature of mastery, status, power and respect resonated with the self-image of being a focal person within the Disease Surveillance Unit. Regular collection, analysis, dissemination and communication of truthful data required the integral role of not only inter-personally dealing with figures of authority and nurses from various departments. It also required an emphasis on quality assurance on the part of the focal nurse who had to consider self-efficacy in leadership, spot teaching and truthfulness of data related to infectious disease cases within the clinical set-up.

4.4.5 Administration, Leadership, Delegation and Care

The roles of the administration, leadership, delegation and care involved both agentic and communal roles. The enactment of care as a midwife at the maternity unit actually signalled an investment into the well-being of the patients. The administrative roles and delegation of responsibilities to other nurses in the ward reflected the agentic nature of being the in-charge on duty. This resonated with the concept of power, status and respect through the enactment of effective inter-departmental managerial skills.

4.4.6 Managing Physical, Emotional and Social Needs

The management of the physical, emotional and social needs of patients was identified as purely communal. This involved ensuring patient comfort, counselling distressed patients and prioritising interaction as a way of understanding patient experience. The selflessness and the investment into the emotional and physical comfort of the patients illustrated the need to encourage patients to accept the circumstances surrounding their compromised health as well as general motivation of patients who were emotionally distressed as a result of illness.

4.5 Nurse Perspectives on Day-To-Day Activities

The findings of the study were very clear when it came to the day-to-day productive activities of the nurses interviewed. It was found that strong emotional bonds with patients were very important as the nurses were the main modes of communication between the patients and the doctors. Even though there were certain areas of responsibility that were de-personalized, there was a strong need to understand the experiences of those under care. Nursing practice was strongly associated with interpersonal communication and a commitment towards empathy and understanding; hence the strong attachment to relational caring. It was found that nursing is associated with caring in a holistic manner in addition to the management of psychological distress and the harnessing of counselling skills to be able to deal with patients successfully. One nurse reiterated this selfless approach to nursing by stating the following:

> Nursing is basically just caring. As a nurse, you are trained to be there for that person, that is about to die, or for that person who is diagnosed with a chronic illness. It's not only about sick people. There are people that are having psychological problems. You need those counselling skills. (33-Year-Old ART Nurse)

In addition, it was found that though there was a passion for the emotiveness of the profession, nursing was viewed in a condescending manner based on its association with subservience to the doctor who is the overall decision maker. Despite the strong association with communication on the part of the nurses, the doctor who would take on a depersonalised role by not filling the roles that nurses fill in terms of client-provider communication stood out. This image mirrored the doctor as the patriarchally dominant figure, with the nurse as the subservient hand maiden. The following was narrated:

> Being a nurse means you can't rest. You have to care for the patients. When the patient feels pain, you have to see how you can make them comfortable. You have to give the right medication and inform the doctor of any complications. You always have to report to the doctor so he knows how to deal with the patients. You speak for the patients most of the time. (24-Year-Old Post-Natal Nurse)

One nurse also described the condescending nature of nursing to medicine by stating the following:

> When something happens to a patient, you have to answer. You are accountable and subordinate at the same time. You are responsible for the patient and you

> still have to explain the condition of the patient. It is hard to work on a patient. You are always scrutinised and blamed if something goes wrong. (30-year-old Paediatric nurse)

The subservience of the nursing profession to medicine also resonated in the fact that despite advanced knowledge of the care and needs of patients, doctors, although less knowledgeable of the day to day needs of the patients are still highly regarded and looked upon as figures of authority within the clinical set up. One of the nurses stated the following fact:

> That's why if you ask any question doctor related, pharmacy related, there is no one who knows better about how much medication you should take a day and for how long than a nurse. Most doctors don't know. They only know the ones they have dealt with. When the doctor is with you, you are almost like an advisor. Most of them don't know most of the procedures. You must now direct. It is as if you become a doctor. You must push them to do something. If the Panado is finished in the hospital, it is your fault. If Nevirapine for the babies who are infected is finished, it is your fault. If there is no family planning, it is the nurses. How is that my problem if there is no stock? It is a procurement story. It is a pharmacy problem. So, you must be able to answer if there is no Panado in the hospital (28-Year-Old Ante-Natal Nurse)

The multiple roles that nurses played also stood out in the findings. It was not just about patient-centred care; administrative duties that enabled efficient care were also part of the day-to-day activities. The strain of working multiple roles was mentioned by a nurse who stated the following:

> Like for my department, ART, I work with a health assistant and I require her to call all our lost to follow-ups. I am the nurse that's there. I am the one who prescribes, I am the pharmacy, I am the counsellor, I am the phlebotomist, everything is just in one. That's why my colleagues don't like working in that department. There is a lot of work and you are writing maybe three or four registers for each client. So, for them when they come, when dealing with one or two clients, by the time they reach the third client, they are already making mistakes with recording. You know in nursing, what you did not record is not done. (33-Year-Old ART Nurse)

Despite the daily practicalities of the nursing profession, encouragement of patients in relation to adherence to treatment informed the supportive roles that nurses play in the clinical establishment. Communication was viewed as a key ingredient in successful nursing in conjunction with education, counselling and caring in relation to better health seeking practices on the part of the patients. One nurse narrated the following:

> I am a registered nurse at the in-patient TB ward. I deal with dispensing of TB and ARV medication. I am a phlebotomist and do lab referrals for polymerase chain reaction PCR testing and other necessary blood work. I monitor patient progress and ensure patient adherence to TB and HIV medication. I also counsel patients on adherence to medication upon discharge. In addition, I also manage patients on injectable TB medication which requires a hospital stay; especially when the condition cannot be managed at home. I also assist with the management of referrals of patients from other regions as well. (30-year-old TB ward nurse)

The importance of health education was also reiterated in the following statement:

> As a registered PMTCT nurse, I deal directly with patients on a day-to-day basis. I coordinate counselling and testing of pregnant mothers and mothers who have delivered both vaginally and via caesarean section. The idea is to test for HIV and other STIs in order to protect the unborn babies as well as new born babies. We also screen mothers during pre- and post-delivery. You find that a lot of patients benefit from health education related to prevention and the importance of testing. We also encourage their partners to be involved in testing and knowing the status of their partners. My role is vital as I stand in and encourage healthy lifestyles and the importance of keeping the baby healthy by taking treatment seriously. I also advise mothers who are HIV positive to adhere to treatment. (30-Year-Old PMTCT Nurse)

More agentic approaches to the nursing profession also came out clearly in the findings. As opposed to the stereotype of caring and the empathy of feminized care, the more managerial characteristics of the profession were also a factor. This agentic element of nursing stood out as an element that depersonalizes the ideology of communal roles that prioritise the physical, emotional and mental well-being of patients. As such, patient-centred care was in sharp contrast to the extrinsic motivation of managerial nursing that is more concerned with self-actualised benefits. One nurse narrated the following:

> I don't do a lot of what others do. I am Disease Surveillance Focal person. I search for information about infectious diseases, I look at hospital documents to verify data related to infectious diseases. I need to present reliable and truthful data. I am involved with on-going disease surveillance and it requires collecting,

> analysing, interpreting and communicating data. I also disseminate it for the furthering of solutions. I ensure that leaders use data to facilitate necessary action. I always make sure data reflects a true picture of what is happening in the hospital. I educate other nurses about surveillance. I share information with doctors and the rest of the health team. I do spot teaching during visiting time to equip nurses with information about diseases. I get in touch with nurses about reporting systems. I educate them on case investigation forms. I emphasize truthfulness of case definitions for categorizing diseases. I am currently doing project work related to epidemiology. Knowledge and understanding are a necessity. Infectious diseases should be contained and preventive measures taken into consideration. (49-Year-Old Disease Surveillance Nurse)

One nurse communicated the managerial dimension of nursing by narrating the following:

> I play the role of a nurse manager in the ward. I ensure the nurses on duty assume their day-to-day tasks. I also oversee observations done on patients. I ensure that all patients are attended to. I am always there earlier to make sure that patient files are in order. I also report to doctors who come for their rounds. It is a lot of work. You have to be alert and ready to answer questions from the doctors and the medical superintendent who also does periodic checks. My role is more administrative as I have to coordinate and manage nurses who deal with the patients. It is harder because you have to answer on behalf of the ward. You have to manage those doing bedside nursing to ensure tasks are done timeously and in the right way. (27-Year-Old Nurse In-Charge)

4.6 Ethical and Unethical Conduct in The Nursing Profession

During the data collection phase, it was necessary to understand what the nurses perceive as ethical and unethical conduct within the nursing profession. The justification for this approach was to get a clear picture about characteristics deemed as negative for nurses and the solutions to acts of deviance that do not reflect well on the image of nursing. The main areas that stood out concerning acts contrary to what a "good nurse" reflects were uncaring attitudes, lack of compassion, verbal abuse, inattentiveness to the needs of patients, rudeness, inappropriate dress code and public conduct, aggressiveness and a lack of confidentiality among other findings.

4.6.1 Aggressiveness

Displays of aggressiveness towards patients stood out as an inability to recognise the human element necessary for the profession. The ill-treatment of patients who cannot care for themselves was mentioned as aligned with an insensitivity towards the needs of those under care. One nurse narrated the following:

> I have known some cases where some nurses have displayed some negative qualities. To the point that sometimes they would scream at the patients. I remember at one point there was a situation whereby there was a nurse who would tell a person that, "you are eating this food, so you should not ask for a bed pan!" "You just eat, don't ask, don't call me, I don't want to come and take your bed pan!" But how, since you have to make sure the person feeds and

> excretes. So, I'll go to this person and I will help this person. Sometimes this person will call you but he/she avoids the other nurse who will shout. (48-Year-Old Nurse Mentor)

4.6.2 Lack of Passion for the Nursing Profession

Not having a passion for the profession also stood out as a negative characteristic. Entry into nursing was mentioned as being determined by money and not genuine passion. The image of the nursing profession was thus viewed as one that is damaged as "everybody" is a nurse and the passion for the profession has diminished. As such, passion for the profession was deemed as one that should be intrinsically based with agency forming a small element of what it means to be a nurse. One nurse emphasised this concern in the following narration:

> Some people are getting into nursing because of the money. They are not getting into it because of the passion; which is creating a negative impact. For you to become a nurse, you need to learn to control yourself. These days, people just do things which create a negative image. Previously, people used to respect nurses so much. The moment you say you are a nurse; you are like a queen in your community. But now it is just a song. The respect is no longer there, because everybody is a nurse. But those years, even when we were growing up, the moment they know you are a nurse, they say how lucky you are. Your mother will be proud, everybody will be proud that they have somebody like that. So, the image has actually been damaged. (33-Year-Old ART Nurse)

4.6.3 Poor Communication Skills

Weak communication skills were also identified as triggers to bad attitudes towards patients. Poor communication was mentioned as having an effect on the understanding of and negative behaviours towards patients. One nurse narrated the following fact:

> Patients are the ones who teach nurses how to behave towards them. It more or less has to do with the communication. Most of the nurses have really had it rough. Their communication skills affect their behaviour and their attitudes on how to respond to certain people. Sometimes you must just learn to keep quiet. Sometimes if the patients get angry, you stay nice and calm because they will eventually calm down. So, the negative characteristics have to do with the attitude. (28-Year-Old Ante-Natal Nurse)

Not having a passion for the profession was also mentioned as a negative characteristic that affected the care of patients negatively. This was narrated in the following statement:

> A nurse who sees nursing as just a job is not ideal. One has to understand that they are there to ensure the sufficient care of the patients. Showing negative vibes actually makes the patients feel helpless and unable to ask for help. (30-Year-Old Paediatric Nurse)

4.6.4 Insensitivity and Selfishness and Disregard for Confidentiality

Lack of compassion, insensitivity and selfishness were identified as characteristics that negatively affect patient-centred care. This lack of professionalism deviated from the need to not only respect patients, but from the need to desist from a lack of patient confidentiality. One nurse stated the following:

> A generally bad and uncaring attitude and not being willing to assist patients in need of care; not showing compassion and thinking you are doing the patients a favour is a terrible thing. Being unprofessional and being too relaxed shows that a person is negative. Discussing patients with others and not being discreet about patient information is unethical (30-Year-Old TB Ward Nurse)

4.6.5 Displacement of Remunerative Grievances

Linking remunerative grievances with the care of patients was also cited as an issue. It was found that the blame game of attributing workplace grievances towards patients is a problem in addition to volatility and strained workplace relations. One nurse narrated the following:

> Being too volatile and not listening to others. Always fighting and refusing to resolve issues peacefully. Lack of concern over overall work and the care of patients is a problem. Not showing love and compassion and not engaging with patients is an issue. One has to understand the patients and their needs. You can't constantly mistreat patients because you are stressed over money and double

> shifts. A nurse has to be on hand to help the patients, not blame them for the workload. Responding rudely to requests for care is wrong. One has to be open to assisting. Taking an oath means availing your time and commitment, not complaining and being bitter. (30-year-old PMTCT nurse)

4.6.6 Lack of Compassion for Patients and Non-Recognition of Professional Fluidity

A lack of compassion was also identified as a barrier to effective patient care. Poor communication, lack of accountability and ownership of responsibility were also mentioned as going hand in hand with deviant attitudes towards patients. Verbal abuse and perceived coercion to effectively perform duties translated into the negative attributes of nurses who don't conform to the selflessness required in the profession. In addition, inattentiveness to the fluidity of the profession in conjunction with the recognition of nursing as a facilitator of a continuous learning process also emphasized characteristics that are negative for a nurse. One nurse emphasized the following:

> Being too proud and not needing others. Being content in a negative way. A lack of confidence. Not loving and caring since those are the most important qualities. Not having compassion is not good for the clients as they are the reasons you are a nurse. Shouting, verbal abuse and being a bad listener. Being coerced to work despite being trained to be independent. Not consulting others in times of need is a problem. Not working as a team, as nursing is a changing process. It's necessary to learn from others. Not communicating in written or verbal form. A

> nurse who doesn't own what she is doing to positively influence the environment. One should be responsible for their duties. Not being able to delegate, results in a lack of ownership. Not being a leader, as we all learn from each other through refreshing our knowledge. Nursing is on-going and learning is necessary. (49-Year-Old Disease Surveillance Nurse)

4.6.7 Self-Centeredness, Disrespect and Insensitivity

Negative characteristics incompatible with the nursing profession were identified as self-centeredness and the allowance of external factors as influencers of the importance of the caring factor of the profession. Disrespect, insensitivity and negative talk about patients were identified. The inability to dissociate the personal experiences of nurses from the relational perspective of nursing on the part of the nurses, was cited as an issue that negatively affects the profession. One nurse iterated the following:

> Nurses can't be aggressive. They have to have a clean heart and should be honest. Being disrespectful and insensitive are bad habits. Gossiping and saying bad things about patients is not good. Not performing duties well and on time makes things hard. I think these bad characteristics are caused by bad relationships and sad life experiences. Some nurses fight because they are angry about what is happening in their own lives. (24-Year-Old Post-Natal Nurse)

One nurse pointed to the lack of professionalism by narrating the following:

> *"Maybe you are gossiping. You are not working hard. Some people are just there on duty and they are not actually working. They are just interested in gossiping." (34-Year-Old Midwife)*

4.6.8 Neglecting the Conventional Image of a Nurse

The public image of the nurse was also a factor and any image contrary to the conventional picture of a nurse was identified as deviant. Characteristics deemed as negative for a nurse involved dissociating with the strict alignment of nursing with the appropriate and full uniform in addition to the neglect of neat and simple touches to physical appearance. The inattention paid to detail based on the conservative Florence Nightingale image of nursing was also mentioned. One nurse narrated the following:

> The way nursing worked those years, even when I started my nursing back home, as a nurse, you need to respect your uniform. You cannot be a nurse in uniform and be found eating in public. But here, it is just the norm. There is nothing wrong with it. Even the way nurses dressed previously is not the way they dress now. You find nurses with their Brazilian hair touching their clothes. As a nurse you are not supposed to dress like that. You are not supposed to wear drop earrings. These days, their earrings reach their shoulders. This is actually giving a negative image of what nursing really is. Of how Florence Nightingale actually started the whole nursing career. When I was in first year at UNAM, our lecturer then was old, in her seventies. She still had that thing of Florence Nightingale in

> her where you can only wear stud earrings, your hair must be tied, you must be neatly dressed, don't wear open shoes when you are in uniform. Even with uniform, people wear sandals to work. Even green or white shoes. These days that the weather is hot, the ministry is not providing shoes; if you wear an open shoe, it should be formal. (33-Year-Old ART Nurse)

4.7 Causes of Deviancy Discourses in Nursing

The probing of unethical conduct in nursing necessitated the need to understand the triggers of such deviancy within the profession. The causes of negative characteristics that do not conform to the caring narrative were diverse and included traumatic experiences, environmental factors, upbringing, mismatch between training and practice, under staffing as well as problems related to dissatisfaction with remuneration. The nurses were very open to describing and mentioning the causes of deviancy discourses to the best of their abilities.

4.7.1 Changing Value Systems

It was found that value systems have changed, resulting in the corrupted image of the profession, directly attributable to the foundation of nursing practice within training institutions. Value systems related to the former strict acknowledgement of dress code and the proper conduct and etiquette of the profession were identified as corrupting influences that plague the nursing profession. Moreover, the misalignment of the nursing profession with the conservative Florence Nightingale image of the nursing profession was emphasised as altering the original and credible image of the profession that was formerly accorded respect within society. In addition, the findings indicate the fact that the susceptibility of society to change over time has resulted in an altering of the nursing profession as a result. One nurse stressed this by narrating the following:

> In all these training institutions, foundation really matters. Like I said, the person who taught me in general nursing when I got to UNAM in 2011 had that Florence Nightingale belief about how proper nurses should dress. How a proper nurse should behave at work. She had it and she imbibed it in us. But unfortunately, after she retired and they got a younger one, things actually changed. People go with their hair dropped, touching their uniform, long earrings and wear open shoes to work. (33-Year-Old ART Nurse)

4.7.2 Upbringing and negative social circles

Issues related to upbringing and the influences of negative social circles were also identified as triggers of characteristics that are negative for a nurse. In addition, lack of clarity in relation to the demands of the profession and choosing the profession by chance were mentioned as negative attributes. The lack of preparedness for nursing by an absolute disregard for passionately entering based on an innate calling was cited as the cause of deviancy within the profession. This was narrated by a nurse who stated the following:

> Upbringing and bad role models are a cause. Not understanding the demands of the profession before training as well as the fact that some people opt for nursing

> because there are no other courses available. At times, nursing is actually not for them. (27-Year-Old Nurse In-Charge)

4.7.3 Under Staffing and Insufficient Pay

The findings further showed that under staffing, lack of motivation and no salary increments, being over-worked, delays in overtime pay outs and lack of managerial support and performance appraisal, caused the negative characteristics that do not reflect a positive image of the nursing profession. This was narrated by a nurse in the following statement:

> A working environment that is not conducive, shortage of staff and resignation that creates a gap. Work is no longer done timeously and correctly. Sixty patients managed by one nurse is a problem and leads to the ineffectiveness of the dispensation of medication. It also leads to delays in administration and dosage of medication. Over-working also leads to negativity. A lack of appraisals also leads to this. Delays in payment of overtime affects the effectiveness of performance. Discouragement and a lack of encouragement is an issue. Lack of motivational speakers to reassure nurses that things will improve is a problem. A lack of salary increments, lead to de-motivation. Lack of good management involvement as they expect performance without understanding what the nurses are going through. Consistent supervision is still lacking as proper supervision will lead to recommendations for improvements. (49-Year-Old Disease Surveillance Nurse)

4.7.4 Fatigue and Imbalanced Ratios of Nurses to Patients

Fatigue and a mismatch between the number of patients to attend to and the availability of nurses to counter the numerical mismatch was also identified as an issue. It was found that overcrowding and under staffing led to fatigue within the profession in addition to unmet expectations from figures in leadership. One nurse stated the element of physical strain in the following statement:

> *"Empty promises from our leaders and supervisors are a problem. Overcrowding due to too many patients in addition to the fact that we are tired. The lack of medication to give to patients is also an issue." (38-Year-Old Head Injury Nurse)*

Workplace frustrations were also mentioned by one nurse in the following statement:

> *"Frustrations at work and delays in overtime payments; a lack of proper supervision and being blamed when things go wrong. At times, there are not enough staff members and it takes a long time to accomplish tasks." (30-Year-Old TB Ward Nurse)*

4.7.5 Lack of Personal Time and Nurse Dehumanisation

The realities of the nursing profession as a sacrifice that compromises on personal time and reflection during working hours was also mentioned as a reason for deviancy discourses. A multitude of expectations related to patient demands and the management of emergencies were cited as triggers due to expectations of patients being overridden by the need to attend to cases that require quick thinking and critical attention as a result. Expectations related to workplace presence throughout and a complete disregard for the humanised view of nurses were identifiable as causes for the characteristics that are deemed as negative for the nursing profession. One nurse gave a detailed account of strain in the following statement:

> It comes from frustrations and those frustrations are broad. They are a lot. It comes from like in a state hospital, in maternity, it comes from shortages and being overworked. I am working at Katutura but on weekends I go to work where I am not stationed. Instead of having my off days, I have to go and work on the weekends. You are tired, overworked, underpaid, burnout basically and you get all these clients who are coming in and you must be "Jesus", you must be, "Holy Jesus Christ", and do right by them. They can shout at you as much as they can and you must just stand there and take it. Sometimes it is not even your fault. Sometimes you can see that there are five of us on duty, but maybe we have a difficult delivery. A difficult delivery requires a whole team. Since it is for the sake of the baby, for the sake of the mother not to die there. Different people have different experiences. So, you need everybody's input. You need

everybody to do this and that. You must decide who gets what medicine, you must prepare for the baby when it comes out. It will need resuscitation because those things you evaluate beforehand. People in the queue outside will storm into the resuscitation room to say that the nurses are chatting. They feel like you are not doing anything. They make you feel agitated. It makes you wonder if you are not human enough to sit for a cup of coffee. You work from seven am to seven pm. We are expected to be there the whole time. When they see you walking to the bathroom, they assume you are just walking around. We work through our lunch. I have never seen a nurse at maternity taking a lunch break. If they are eating, they do it standing instead of going to the tea room. If I go to the tea room and stay for five minutes, I am blamed for keeping the patients waiting. (28-Year-Old Ante-Natal Nurse)

4.7.6 Negative Life Experiences

Issues related to bad life experiences, problems in intimate relationships, lack of love, substance abuse and addiction and selfishness and defensiveness were mentioned as triggers of negativity within the nursing profession. One nurse mentioned the fact that, "*painful life experiences such as bad family life and absent partners are a cause. Substance abuse and addiction can also create a negative character. Not living in a stable environment, being too critical of others; being too defensive and not accepting that mistakes can be made.* "(*30-Year-Old PMTCT Nurse)*

4.8 Emotional Qualities of the "Good Mother" as a Socially Constructed Identity

The "good mother" as a socially constructed identity formed a significant component of the findings related to the emotional qualities that shape what it means to be a mother. The qualities mentioned by the nurses who were interviewed emphasized not just physical presence, but the display of nurturing, care and compassion as the main qualities that translate into what motherhood means to them. The act of selflessly attending to the needs of dependants and not being fully mindful of self-interests, characterised the idea of motherhood as a socialized identity that goes beyond mere birthing of dependants. The nurses were very clear about the need to think of the welfare of their offspring and identifying as mothers before identifying as anything else. This brought into context the fact that motherhood forms a fundamental part of what it means to identify as a female

4.8.1 Display of Love and Care

The act of loving and showing care was mentioned as a natural attribute related to the role a mother play. The act of sacrificing and being dependable formed what it means to conform to the definition of motherhood as was mentioned by one nurse below:

> You have to show love. You have to think of others before yourself. It's not easy but mothers have to sacrifice a lot for others. You can't be selfish. The hardships I faced growing up made me learn to get along with others. Hard life made me realise that a mother is important. I didn't get enough of my mother's love. No

> one can love like a mother. Not having a mother made me want to care and show love. You feel for others. (24-Year-Old Post-Natal Nurse)

4.8.2 Compromising of Self-Interests

Being able to think of others before oneself stood out and emphasized the communality of feminized motherhood. Motherhood was seen to represent a compromising of self-interests with an investment into the creation of a conducive environment at the expense of individualising one's own demands. Concern over the feelings of others above one's own feelings illustrated the intrinsic nature of motherhood; constant concern for the welfare of others above self as a way of effectively displaying motherhood. One nurse illustrated this clearly by stating the following:

> I am not a quarrelsome person. I try to create mutual understanding. I try to bring understanding without offending the other person. I am not a very reactive person. Remarks people make about me don't make me probe into the matter. I ignore such things. I am not a confrontational person. I avoid conflict and I withdraw easily. This has helped me interact well with my children and my colleagues at work. (54-Year-Old Midwife)

4.8.3 Fatigue and Inattention to Self

The findings further confirmed the inattention to self as an identity outside the social context of motherhood by analogising fatigue as an expected result of intensively mothering dependants, fulfilling the professional demands of a nursing career and being a wife. One nurse pointed to the following fact:

> At home, the energy is not always there. At times I feel down and I am so exhausted. Motherhood can be overwhelming, especially with work, then I am also studying. My husband doesn't really like eating outside. The girls also don't like soup in sachets. They want soup that has been prepared from scratch. Sometimes you just feel tired. I am not always having the energy. (33-Year-Old ART Nurse)

The highly emotive nature of motherhood was also emphasized as being aligned to love and selflessness. The results indicated that motherhood is more about the dependants and less about the mother; with the role of the mother being that of cultivating an environment that necessitates the display of love and care. One nurse elaborated on this self-sacrificing role by stating the following:

> The role of a mother requires a lot of responsibilities. You have to love your children. They are important and come first. I was raised with love and I am doing the same for my daughter. It's not just me anymore. My child matters all the time. When she is sick, I worry. I feel bad when I can't give her something. It eats me up. I can't imagine not being there for her. I believe you can't be satisfied until you give your child love and care. (30-Year-Old Paediatric Nurse)

4.8.4 Affection Through Socially Determined Means

The element of self-less caring went beyond care for biological children, it was socially affirmed by care for others who become recipients of motherly care by circumstance and not by biological predisposition. One nurse described the following fact:

> One, you have to love and be open to care. Caring is important as well as thinking of others. You can’t be self-centred all the time. You have others under your care, even if they are not your biological children. Think of others before you think of yourself. Being a mum means being strong for your kids. (30-Year-Old PMTCT Nurse)

4.8.5 Cognitive Parenting

Nurturing the cognitive development of dependants stood out as an important and integral element of successful mothering. It was found that verbalised interaction with children was a way of successfully bonding with them emotionally. One nurse illustrated the importance of verbalising affection for cognitive development by stating the importance of communication as a way of connecting with her children. She stressed the fact that connecting with and encouraging her children and others through difficulties formed the most important aspects of the emotional qualities necessary for successful motherhood. Cognitive nurturing was also mentioned as a result of viewing motherhood as a friendship rather than a domineering relationship between the dependent and the parent. (49-Year-Old Disease Surveillance Nurse).

Another nurse also illustrated this point by elaborating on the following:

> I am a mum but I am a friend to my children as well. I cannot just be a mum. My role as a mother has to come from friendship. I have to be friends with my kids. From work when the uniform is off and I put it in the laundry and then I'm in the shower after doing workouts. We put on music and they always imitate what I do. They copy every step, climb on me. We run around in circles as if I am part of them. It's like we are of the same age and they feel so good and I feel it is a good thing to have. Me being a mother is the cornerstone of who I am. For most of the changes I have made in my life, I think it is because of being a mother. I wouldn't do anything if I couldn't think for every decision now, would it be right for my children? (28-Year-Old Ante-Natal Nurse)

4.8.6 Providing Counsel

The aspect of providing counsel and showing love in the face of less than desirable circumstances were pointed out as important elements of the "good mother" discourse. Being a teacher, support system and being available to listen and mould dependants stood out as important virtues. One nurse emphasized this by stating the following:

> Being able to show love even when times are hard is a very important quality. Not straying away from your responsibility even if resources are not readily available. Being a listener and always ready to advise your child is important. A

> mother is not only a nurturer, she also teaches and moulds the child. She should be a strong support system. (30-Year-Old TB Ward Nurse)

4.8.7 Linking Income and Positive Parenting Outcomes

In addition, the findings also indicated the importance of the agentic role of income generation as fulfilling the communal role of motherhood. It was found that income earned actually enabled more bonding time with kids. An increase in purchasing power as a result of working and earning an income actually maximised on the quality of time spent caring for and fulfilling the material needs of dependants. One nurse stated the following:

> One of the emotional qualities I had was that I was somebody that was kind and because when I am actually with my children, I will make sure that I will maximise. I will go to the point of spoiling them to make sure I make up for lost time. Meaning that whenever they need some toys, I will really make sure that I give them that quality. I also make sure that I will take them to places like show grounds, they will go and enjoy themselves, go and swim. Those were some of the things and buy them nice toys which they will always remember and will say," mummy did this for me". Every time they will have those fresh memories of having me around. (48-Year-Old Nurse Mentor)

4.9 Challenging Dominant Patriarchal Ideologies of the "Good Mother" Discourse: Deviancy Discourses

The research findings concerning negative characteristics that don't mirror the socially acceptable image of motherhood were also mentioned by the nurses. It was found that straying away from the selfless nature of motherhood was a fundamental indicator of deviating from what it means to be a "good mother." It was clear that the responses given conformed to the dominant patriarchal images of motherhood as a socialized role. The nurses were very critical of actions that involved child neglect, substance abuse, emotional instability, violence and lack of compassion as encompassing among others, the deviancy discourses surrounding mothers who stray from the intensive mothering ideologies.

4.9.1 Absence During Important Developmental Milestones

Not being present during the most important milestones of child development was mentioned as a negative attribute that did not reflect what it means to conform to intensive mothering ideologies. One nurse indicated the following:

> It's the fact that when you are not there you may not really know how your child is growing. So, I feel, when you are like at work you are forever having the fear that is my child okay? You feel like you are not doing much for the kids and the fact that you are not there to bond with the kids. You feel like you are not there for the kids. (48-Year-Old Nurse Mentor)

4.9.2 Linking Motherhood and External Factors

It was also found that allowing external factors and experiences to determine what type of a mother one becomes were problematic when it comes to deviancy discourses. Not viewing motherhood as a socialized identity was also mentioned as a challenge to effective mothering. One nurse stated the following:

> A mother is a natural nurturer and it is unusual to be indifferent to your children. Taking out anger on the kids is a real danger and results in the slow development in kids. Allowing issues such as failed relationships to affect your interaction with your kids actually creates a rift. Your kids can't relate to you because you are more focused on temporary relationships. Mothers should be there for the emotional needs of their kids. Being selfish is a terrible thing. Attitudes cause these problems. Not being willing to learn from and move on from negative experiences is also a cause. Being too involved in other areas and ignoring the needs of your kids is an issue. Motherhood is an identity and should not be disregarded. (30-Year-Old TB Ward Nurse).

4.9.3 Inattentiveness to The Needs of Dependants Through Self-Interests

The lack of positive emotional traits were pinpointed as areas that reflected deviancy discourses. Paying attention to one's own needs and neglecting the needs of dependants were mentioned. One nurse indicated the following:

> Being a busy body. You are alone and busy. Not having time for family. Anger, unhappiness, not appreciating your family and your kids. Being unfaithful and ungrateful and being incapable of building a healthy relationship. Inattention to your kids and family. Not loving, not showing affection, not being able to embrace others. Living in a bubble. Such traits distance your kids from you. They are very negative attributes. (49-Year-Old Disease Surveillance Nurse)

4.9.4 Oppressive and Restrictive Childhood Experiences

It was also found that oppressive restrictions during the formative years of childhood were capable of creating negative qualities that go beyond the definition of the "good mother." Living in a constricting environment that does not allow for positive self-expression was also mentioned as a cause of such deviancy discourses in addition to verbal abuse as a cause of such suppression that does not benefit the positive image of motherhood. Traumatic experiences, heartbreaks and disappointments were also to blame for the lack of emotion necessary for effective mothering. One nurse narrated the following:

> Bitterness is a big problem. Don't blame your kids for what is happening in your life. It really causes pain and sorrow. Not showing love is a result of bitterness. Being too consumed with issues that only cause more pain. A mother cannot give up and allow a bad character to take control. You have to be tough and caring at the same time. (30-Year-Old PMTCT Nurse)

4.9.5 Mistreatment of Dependants

Mistreatment and holding children accountable for failed relationships were also mentioned. One nurse stated the following:

> A mother can't be selfish. It's not a natural thing. A mother has to show love and not hate. A mother cannot drink in bars while her children are starving at home. I have seen irresponsible mothers who don't care about their children. Some even mistreat their children because their fathers are not there. Some even leave their children with relatives and disappear. That is very bad. They don't deserve to be called mothers. (24-Year-Old Post-Natal Nurse).

4.9.6 Misleading Societal Expectations

Societal expectations were seen to actually enforce the creation of deviancy discourses resulting in the profiling of absent mothers; with an absent father being viewed as a typical occurrence. As such, women were described as being subject to intensive mothering ideologies that judge mothers who are unable to care for their children. One nurse narrated the following fact:

> A mother cannot just abandon her child. There is a natural bond between a mother and child. It’s unnatural to hate your children. Things happen but you cannot give up. You have to do what you can for your child to be happy and safe. You can have fun but don’t forget that you are a mother. Mothers go through a lot but they have to love and care. Child neglect is the worst thing a mother can do. I have seen children with mothers who abandoned them. It causes so much pain. Those children did not choose to be born. If you have children, care for them, love them. They are your children and they know and depend on you. It is a crime to hate your kids because you are unhappy. I have seen such things and it makes me sad. Society expects mothers to be there for their children. Absent fathers are not really profiled like absent mothers these days. Women have to conform all the time. A bad mother is always judged, while a bad father is seen as a typical thing. It’s very bad but that’s reality. I don’t like it, but that’s what society thinks. (30-Year-Old Paediatric Nurse)

4.9.7 Substance Abuse, Neglect, Abandonment and Poor Upbringing

Social ills such as substance abuse and abandonment during pregnancy were seen as causes of deviancy discourses. One nurse narrated the following:

> I think things like alcohol abuse. If you are that mother who is not always in the home but is in the Cuca shop. You come home late. Do you really expect a positive attitude from the children? Do you really expect things to be done if you

> are not spending time at the house? Or maybe you go around. (34-year-old Mid-wife)

Bitterness as a result of abandonment and neglect were blamed for the displacement of anger on children that goes against the definition of socially acceptable motherhood. Inability to control emotions such as anger and selfishness were mentioned as troublesome aspects of deviancy. Using anger was also mentioned as having long-term consequences on the social and emotional intelligence of children. One nurse stated the following:

> A mother must not be selfish, because if you are selfish, you only think about yourself. The way I was brought up, my mother always said her children must come out more flamboyant and better than her; they must look their best. That is the same thing I normally do for my children. Before I buy one thing for myself, I have already bought five to ten things for them. So, you need to have that heart. Whereas some women are just concerned about themselves. That is why many people become mothers for the wrong reasons. As a mother you must learn to control your anger. I get angry so easily, but then sometimes you just try to breathe in and out, take a deep breath and let this thing pass. Because there are some things that you say in anger that when the anger has cooled down, you cannot take back what you have said. Any negativity that you pronounce onto the life of the child will keep reflecting even when the child grows up. It actually affects the social way of life. That's why some of them end up having a low self-esteem. (33-Year-Old ART Nurse)

The selfishness associated with deviancy discourses were also mentioned in the following statement:

> Giving birth and turning away from children; dumping of babies; leaving children with grandparents; leaving children with their father and not caring; eating without ensuring the kids eat; not correcting the children and spoiling and not disciplining the children. (38-Year-Old Head Injury Nurse)

The causes of such behaviour were associated with a lack of income, type of upbringing and a bad economy that can make people bad mothers as they end up selling their bodies.

4.9.8 Lack of Openness and Mutual Understanding

The absence of an open and mutual understanding with children was seen to impede what it means to conform to intensive mothering ideologies. One nurse indicated the following:

> A lack of trust and open communication with your children leads to them opening up to others as opposed to opening up to you as a mother. Children end up hiding a lot as they are not free. They end up not trusting you enough to open up to you. (54-Year-Old Midwife)

Causes of this lack of trust and openness were subject to a variety of reasons, mainly in line with new ways of living, new workplaces and workmates that can create negative attributes based on adjustment to a new setting. Environmental factors were also mentioned as triggers that can affect lifestyle and change one's value systems. Moving from rural to urban areas were likened to changing cultural dynamics that could lead to deviancy discourses and as well as unmet societal expectations as a result of non-conformity to “good mother” discourses. Financial commitments and constraints were also cited as triggers due to added stress and expected responsibilities from family members that would create negative attitudes.

4.10 Summary of Findings

The qualitative data based on the responses from the nurses who are mothers was collected through the use of a semi-structured interview guide. In-depth interviewing and probing were used to generate in-depth responses from the participants. A narrative approach was used to present and analyse the responses given during the data collection phase. The responses were categorized and coded based on the creation of conceptual themes.

The experiences of dual reproductive and productive roles were categorised into the following conceptual themes:

- The gender socialization process based on the socio-cultural environment;
- Income and the balancing of gender roles;
- Balancing dual reproductive and productive roles;
- Gender stereotypes and essentialism in the nursing profession: feminized care giving and the “good mother” discourse;

- The emotional qualities of a “good nurse”;
- The productive activities of the nurses;
- Nurse perspectives on day-to-day activities;
- Ethical and unethical conduct in the nursing profession;
- Causes of deviancy discourses in nursing;
- Emotional qualities of the “good mother” as a socially constructed identity;
- Challenging dominant patriarchal ideologies of the “good mother” discourse: deviancy discourses

The research findings indicated that childhood socialization actually perpetuated gender differentiation concerning the assumption of tasks in the home. Income was found to actually positively enhance gender relations between spouses and resulted in equality and unity in financial decision making. Despite the equalising of gender power relations as a result of income earned, role strain as a result of active engagement in reproductive roles in the home and the fulfilling of the extension of such roles in the clinical set up were a fact. The essentialised nature of the nursing profession translated clearly the feminized perception of nursing and the patriarchy of medicine over the profession. The feminized notion of care in the profession went as far as ascribing successful nursing to conformity towards intensive mothering ideologies. Any deviation from the socially acceptable characteristics of feminized care met resistance by being associated with deviancy discourses. Though the day-to-day activities of the nurses were filled with stress related to under staffing and limited pay, the satisfaction of being intrinsically involved in the lives of the patients was an added bonus. Unethical conduct according to the nurses was thus alluded to non-conformity to altruism which is a central component of the nursing profession. As a result, the solution to any deviation from what was socially expected of nurses involved a rigorous selection process involving a strong propensity to care, strict adherence to dress code and overall physical appearance that matches the stereotypical description of a nurse. The idea of conventionalising the profession and its image was an important element that some of the nurses were passionate about as a result.

Chapter 5

Discussion Of Research Findings

5.1 Introduction

The main purpose of this section was to discuss the findings of the study. There was a lot of input from the nurses concerning their personal experiences pertaining to their management of dual reproductive and productive roles. In order to understand their experiences as nurses and mothers, it was vital to understand socialization during the formative years of childhood, their perspectives on the gendered stereotypes of the nursing profession, income and the balancing of gender roles, the emotional qualities necessary for the nursing profession, motherhood as a socially constructed identity, deviancy discourses related to motherhood as well as ethical and unethical conduct and their day to day experiences as nurses. The main research questions of this study were answered based on the information that was gathered during the in-depth interviewing process. The main areas of the discussion tried to understand the convergence between female nurse's productive roles outside the home and their reproductive roles in the home. As such, the main research questions from Chapter One were as follows: "How are the socialized roles of women as caregivers and nurturers connected to the gendered stereotypes of the nursing profession?"; "Is there a link between women as nurturers and the power dynamics of their financial independence?" How do women balance their social roles as productive caregivers and their reproductive roles in the home?" Do these roles create a gender balance with men who also work outside the home?" Does paid productive labour outside the home alter gender power relations?"

In order to understand the convergence of reproductive and productive roles, it was essential to discuss the findings by understanding the following key areas that were to be covered in the discussion under the following sub headings: gender socialization and the gendered stereotypes of the nursing profession through feminized care giving and the "good mother" discourse; balancing dual reproductive and productive roles and income, gender power relations and the balancing of gender roles.

5.2 Gender Socialization and The Gendered Stereotypes of The Nursing Profession Through Feminized Care Giving and the "Good Mother" Discourse

The findings of the study resonated with the fact that childhood socialization formed a critical part of gendered roles and expectations during the formative years of childhood. Tasks in and out of the home were pointed towards the appropriateness of certain responsibilities for male and female children. Some of the nurses interviewed stated that the propensity to care was determined by the assuming of maternal roles such as care of younger siblings before actually experiencing motherhood in a physiological sense. The roles that they would play in the nursing profession mirrored the caring and highly emotive dimension to the social expectations of females and the role expectations of nurses. According to Grinspun (2010), relational caring occurs in conjunction with cognitive and physical caring. This concept of care is a direct result of the three pillars of caring that involve the cognitive, physical and relational aspect. Crespi (2003) also stated that the gender socialization process not only determines the exclusivity of the reproductive roles of women; the socialization process aids in creating and defining gender stereotypes concerning productive roles. Females tend to be socialized to be sensitive, gentle, dependent and emotional; they are encouraged to complement these attributes with jobs such as secretarial work, teaching, nursing, being flight attendants and housewives (Crespi,2003).

It was clear in the findings that, females were expected to adopt roles of subservience as a way of positively expressing socially and culturally defined femininity. The environment played an integral role in not only shaping, but indoctrinating girls into believing the perceived normalcy of female subservience in conjunction with the need to recognise male recipience towards such submission. This confirms what Phuong (2008) mentioned in relation to feminine stereotyped communion which is associated with an "other focus" through the displaying of warmth or being friendly and moral behaviour to enable one to belong with and care for others. Phuong (2008) furthered the fact that the perceived psychological differences between men and women deem communal characteristics to be typical of women who are generally concerned about the welfare of others, are affectionate, kind, interpersonally sensitive and nurturing. Men on the other hand are known to be more agentic with characteristics that involve assertion, control and confidence. This concept of differences between male and female role expectations was clear as most of the nurses knew that role expectations were segmented. Males in most cases were not allowed to cook and perform other domestic tasks such as childcare. Such roles were assumed by females as they were expected to perform such roles based on familial and societal expectations. The segmentation of male and female role expectations was argued by Crompton & Lyonette (2005), who stated that, differences between the sexes are related to physical, physiological and/or spiritual differences. Newman et al (2011) furthered this argument by stating that, men and women are subject to gender segregation that expects both sexes to occupy culturally defined occupational roles based on gender. Gender essentialism reflects gender segregation by perceiving women as naturally inclined towards personal service, nurturance and social interaction. N'guessan (2011) confirmed this differentiation of gender roles by stating that, society constructs and differentiates males from females based on the grounds of "otherness", with this differentiation being based on the imposition of a gender hierarchy. This concept of differentiation came out clearly in the findings as some of the nurses identified clearly the differences between what was expected of males and females. It was noted that gender socialization determined and influenced the socially and culturally defined roles of motherhood and conjugal life. The role expectations of servitude and care resonated very clearly as emotiveness and nurturing went hand in hand with the social construction of femininity during the critical gender socialization period of childhood.

The critical identifying marker during the data collection phase was the association of nursing with motherhood not only as a biologically determined role, but as a socially constructed role, based on the demands of a patriarchal society. The interchangeability of motherhood and nursing was very clear as the clinical set up was associated with the family unit with patients likened to children in need of care. The communal roles of selflessness and consciousness of cognitive caring of dependants was also closely aligned to physical, emotional and social well-being of the patients in the clinical setting. Letvak (2001), stated that the nursing profession conforms to the stereotype of nurturing, self-sacrificing and meeting the needs of others. This confirmed the fact that nursing is an extension of socially acceptable female qualities enacted in the home. Im (n.d.) also argued that nursing as a profession is viewed as a position with predominantly feminine characteristics. The stereotypes connected to the role of wife and mother apply to the profession. A lot of the issues related to stereotyping facing nurses are as a result of the feminine image of nursing. Based on the findings, there was a strong association of motherhood as a role that informed entry into the nursing profession. There were cases where it was impossible to practice nursing if one was not a mother in a biological or social sense through the adoption of children or the care of relations. It was clear that the demands of the profession were perceived as easily achievable through experiencing the biological and social dimensions of motherhood. Maternal roles were prioritised as key when it came to successfully functioning as a nurse in the healthcare set up. As such, the carrying over of motherly roles of care resulted in a balancing of and the interchangeability of nursing and motherhood. Kasapoglu & Akbal (2017), argued that female nurses tend to lean towards collectivism and selfless character traits that form the stereotypical nature of the nursing profession; female nurses tend to prioritize familial roles over professional roles. As a result of conformity to the gendered stereotypes of nursing, the main basis of functionality on their part involves the balancing of working time and the responsibilities of motherhood. Rodrigues & Higarashi (2014), argued that the nursing profession has been linked to the female figure with an almost immediate association between the concepts of providing care and exercising women's gender roles, especially those of mothers. Shepherd (2014) also agreed with the association of nursing with "good mother" ideologies by stating that the caring aspect of child and family health nurses responsible for the guidance and teaching of mothers in relation to child rearing are known to represent dual roles of care, coupled with scientific knowledge and professional expertise. The advice and counsel given by the child and family health nurses reveal ascription to good mother ideologies on the part of nurses.

The altruistic state of the nursing profession resonated clearly in the findings. Some of the nurses were very clear about the vulnerability of patients and viewed them as children, irrespective of age. The fact that the patients depended on care from the nurses stood out. The ideologies surrounding empathy and understanding formed a very important element in relation to the interpersonal communication necessary between the patients and the nurses as health care providers. Despite the positive perception of the bond between the nurses and the patients, patriarchal images of the condescending view of the nursing profession stood out. The patriarchy of medicine over nursing mirrored the attention to the cognitive needs of the patients as well as children within the family unit. Being a nurse was a reflection of the dominance of the doctor as the patriarchal figure and the nurse as the "good mother". This was further emphasized by the nurses acting as modes of communication between the doctors and the patients; an image that is subject to the relations between mothers and dependants, as mothers who actively care for children actually understand the former's needs. Wall (n.d.) also argued that, nurses tend to participate in a gender-based hierarchy that has similarities with interpersonal relationships in the family; as a result, the physician is identifiable as the father with the nurse as the mother. Patients are thus associated with children, extending the idea of nurses being like "good mothers", who are often expected to put the needs of their patients ahead of their own. Aranda et al (2015) also reaffirmed the fact that, in terms of the value systems that perpetuate gender stereotypes, patriarchal culture and traditional values have had an impact on the self-concept and self-esteem of nurses themselves, thus exacerbating the gender stereotypes that feminize the nursing profession. This stood out clearly in the findings as some of the nurses expressly stated that they knew more about the conditions of patients, the procedures necessary and the types of medication to be dispensed. This fact was viewed negatively by the nurses as they felt a sense of injustice due to the commonly held prestige of medicine over the nursing profession. The idea of doctors demanding explanations for the condition of patients and deficits in the supply of necessary drugs, was a reflection of the injustice imposed by the patriarchal dominance of medicine. Ogle (2004) confirmed this condescension and the rudimentary view of nursing by stating that portrayals of nurses in adverts featured in medicine and nursing journals are often stereotypical and demeaning. Nurses are often analogized as ministering angels, domestic workers, the doctor's handmaiden and as subordinate professionals. According to Saied (2016), the media has played a major role in shaping the community's understanding of nursing and nurses; nurses are thus viewed as lacking autonomy, as opposed to other health care providers who think critically and possess knowledge and skills.

Based on the findings related to the changing values related to nursing practice, there was present, a contradiction of the values of conservativeness, etiquette and alignment with strict dress code that are identifiable with the highly feminised perception of nursing. These compromised values of authenticity and originality within the nursing profession drew inspiration from the Florence Nightingale image of the profession.

Despite the ideals related to the strict, conservative and feminized image of the profession the findings indicated a shift away from the stereotypical and subservient view of the profession through an association with relaxed attitudes towards physical appearance, dress code and feminized etiquette and the concept of care within the profession. The shifting from the conservative and conventional image of nursing to the liberated nurse who does not have to adhere to the stereotypical view of nursing through dress, proper behaviour and strict adherence to etiquette marked a change in value systems. This value system change was in direct contrast towards the highly feminized and condescending view of the nursing profession in light of the dominance and patriarchy of medicine over nursing.

Despite the fact that nurses are portrayed as lacking the skills necessary to critically evaluate and resolve issues, the literature on the simplicity of nurses is misaligned with the findings. Based on the perspectives of the nurses, nursing required a multi-faceted approach to functionality within the clinical set up. There was a case in the findings where nurses identified as being able to carry out the roles a doctor would play, especially during follow-up days. Further probing indicated the fact that when there was no doctor available at the ante-natal clinic, this compelled the nurses to take on the roles that the doctors would usually take. This signified the fact that nursing cannot be limited to the stereotypically subservient role that is widely displayed in society. It was further found that nursing could be associated with the more agentic aspects of medicine as well. In addition, there were cases of nurses taking on roles requiring knowledge of pharmacology and the right dosage of medication, laboratory referrals and the types of tests to be conducted as well as the administrative management of client data. The agentic part of nursing was also very clear in the findings and was not subject to the stereotypes of feminised care. There were some nurses who functioned and leaned more towards the managerial and administrative areas of nursing that did not rely heavily on patient-centred care. As such, activities such as electronic data management, mentor ship and leadership, disease surveillance and ward management actually reflected a depersonalised approach to the nursing profession. These findings were contrary to literature associating altruism in nursing as female with high-tech and managerial nursing as stereotypically male in nature. The findings opposed the views of Joyce & Walker (2016) who stated that male nurses tend to dominate in higher-paid, impersonal, technologically sophisticated specialisms, with women leaning towards roles associated with caring, nurturing and empathy. The findings thus challenged the gravitation of women to more altruistic dimensions of nursing and challenged the stereotype of females exclusively ascribing to communal roles within nursing.

5.3 Balancing Dual Reproductive and Productive Roles

The results related to the balancing of dual reproductive and productive roles revealed an interface between the demands of family life and those of a professional nature. There were elements of strain concerning the satisfaction of conjugal and mothering roles as well as fulfilling what it means to be a nurse in the clinical set up. Despite the self-actualizing effect of income earned, there was present, a spill over of agentic roles into an environment that should allow for the enactment of communal roles that require care and affection for others. The findings further indicated the compromising of roles that required selflessness; in this case motherhood, which led to a compromising of love and affection. The immediate consequences were summed up to involve feelings of child neglect, inattention to cognitive nurturing and emotional dissociation with dependants. This tug of war between financial independence and fulfilling maternal roles in the family unit resulted in role strain that led to feelings of compromise; by having to do away with actively mothering and in turn, grudgingly fulfilling productive roles in order to fulfil the material needs of the family unit. This confirms what Almani et al (2012) argued by clarifying the fact that working mothers take the selfless roles of putting the needs of their families before them. The pressure as a result of the need for economic emancipation and attention to family life creates conflicting priorities. Based on the perspectives of the nurses, detaching the responsibilities of motherhood from productive roles was impossible as there were linkages between both roles, deeming them complimentary.

There were cases where the workplace was described as a hub for activities related to motherhood, conjugal life and nursing duties. The unification of these multiple roles was characterised by the delegation of tasks in the home despite being at work. This communicated clearly the fact that being at work, actively caring for patients did not mean that the enactment of reproductive roles came to an end. Actively engaging in the lives of dependants and others in the family unit did not translate into a detachment of motherhood from the professional, clinical set up as a factor. The spill over of domesticity into an environment that requires productivity and the displaying of altruism was an unavoidable occurrence. Rodrigues & Higarashi (2014), stated that there is a personal sense of the act of providing care, derived from the experience of being a mother in addition to the implications of this conjunction of dual roles. This conjunction of professionalism and the reproductive role of motherhood thus illustrates the extension of the nurturing and caring factor into the work environment.

Despite the extension of communal roles of selflessness to the work environment, strain as a result of conflicting and unmet reproductive responsibilities in the home exacerbate the level of role strain female nurses experience. As a result, the manifestation of feelings of distress at having to delegate the responsibilities for children to others in order to fulfil commitments of professional activity has resulted in the assuming rather of zeal for patients (Rodrigues & Higarashi, 2014). According to Firmin & Pathammavong (2012), nurses as working mothers deal with multiple priorities involving career, family, altruism and professionalism. As such, there is an interface between extrinsic motivation involving income and the prestige of a medical position and intrinsic motivation entailing an investment of their lives to the needs of others. Merighi et al (2011) also concurred with the multiplicity of roles by stating that, despite adopting productive roles, nurses in public hospitals are not detachable from housework responsibilities and care for their children. Income earning as a form of economic independence as a result accompanies the roles of nurses in the development of their children whose interests are intrinsically incorporated into their lives.

In addition to the lack of separation when it comes to the enactment of dual reproductive and productive roles, being torn between the needs of dependants at home and the needs of the patients in the clinical set up was an issue that stood out. The nurses were very clear about the strain experienced when attempting to prioritise the needs of those who are dependent on them for care and affection. The decisions to prioritise more time affectionately caring for their children over remuneration were not to be avoided in conversations related to the need for a higher quality of life as a result of increased productivity. As a result of this unity between financial power and the professional demands that enable such power, it was clear that a neglect of duties would compromise on the ability to sufficiently care for dependants, with income as an added bonus allowing for a higher quality of life. Fatigue and general tiredness were reported as immediate consequences of the enactment of dual reproductive and productive roles. There were fears of children bonding with those delegated to provide care in the absence of their mothers who would often be at work fulfilling the demands of their nursing careers. The neglect of emotional presence and active care of dependants was an issue that characterised disgruntlement. Missing important milestones in child development was also identified as a disadvantage when it comes to the enactment of productive roles.

The ideologies of the emotional qualities of the "good mother", also stood out. The perspectives of the nurses were very important in understanding the extension of motherhood into nursing practice. Care and affection were viewed as natural attributes of motherhood. In addition, the intrinsic nature of motherhood by compromising on the individualising of demands was viewed as a virtuous quality. Despite ascribing to emotiveness, the nurses continually mentioned the role strain they experienced based on attempts to maximise on quality time spent with dependants and the demands of working life. According to Jaradat (2017), a study assessing workplace stress among Palestinian nurses revealed that women assuming day shift schedules reported more mental distress than male nurses. This was attributed to family and child care responsibilities in addition to nursing work. Female nurses reported higher frequencies of psychosomatic symptoms related to social and familial aspects. Reasons pertaining to increased levels of psychosomatic symptoms were based on the important roles female nurses play in household matters, nursing and caring.

The consequences of role strain were also an issue as the nurses complained about under staffing and the fulfilling of duties that reflect a work overload. In addition, it was also clear in the findings that the ratio of patients to nurses was also imbalanced and increased the level of dissatisfaction that nurses felt. Fatigue was noted as a direct consequence and was confirmed by Ahmed et al (2015) who argued that, levels of fatigue are negatively correlated with nurse's performance. Effects include diminished memory, slow reaction time, increased irritability, compromised problem solving and critical thinking and decreased concentration and judgement; therefore, as fatigue levels increase, performance levels decrease (Ibid). The consequences were also clarified in the findings based on the multiplicity of roles that nurses play in the healthcare domain. Roles that include pharmacological responsibilities related to prescribing and dispensing medication, standing in for absent doctors, phlebotomy, administrative duties and general nursing duties. This communicated the level of strain and the need to maintain a calm temperament despite the need to fulfil the demanding roles of the nursing profession. Wesson et al (2017), articulated the fact that, public sector hospitals and maternity units are hubs of extreme stress for nurses. Despite the communal traits of passionately attending to patient care, negative interactions with patients have been a reality; cases of ignoring requests for care, rudeness, disrespect and physical abuse have been characteristic of nurses who face the workplace overload all too common in Namibian public hospitals.

5.4 Income, Gender Power Relations and The Balancing of Gender Roles

The effects of income earned formed an important factor concerning the relations between men and women and brought to light the power dynamics of gender relations. It was also important to understand the self- actualizing role that income played in the balancing of gender relations as a result. Based on the findings, it was revealed that income resulted in mutual understanding and the sharing of childcare and other domestic responsibilities in the household. It was found that there was an interchangeability of communal and agentic roles between spouses as a result of career and income earned on the part of nurses. This was reflected in circumstances pertaining to male spouses taking over childcare responsibilities that are communal in nature despite men being mainly associated with more agentic roles that are not associated with a selfless investment into the emotional needs of others. Hanisch (1970) supported the inclusion of women in public life by stating that independence is only achievable through participation in the public workforce; this means fighting for public childcare, restructuring of the workplace with woman's equality in mind and an insistence on men sharing the housework and childcare responsibilities in the home so that women do not have to do it all.

It was also found that income earned encouraged individualistic decision making by balancing out relations based on co-dependency; thus, lessening the burden of dependence on one income. The benefits of income were characterised by feelings of independence, self-sufficiency and the ability to positively contribute towards the survival of the household. What stood out was the unification of spouses through collective decision making as a result of financial power and stability. In addition, power sharing based on equitable contributions towards the economic survival of the family was a result of career and income earned. What resulted was a necessitation of collective decision making based on equal levels of influence between spouses. De Beauvoir (1949) supported the role of women and the bridging of the gap separating them from self-actualized males by stating that, it is through work that a woman closes the gap separating her from the male. Female independence means that the woman ceases to be a parasite and therefore kills the need for a masculine mediator between her and the universe. Therefore, productivity means that a woman's responsibilities become relative to the goals she pursues and to the money and rights she appropriates. Dalla Costa & James also agreed with the shift from private to public life by arguing that, women should be socialised to destroy the role of the housewife thus resulting in the ending of the tradition of the privatized female. The role of spouse and mother of those who have participated in activities of the outside world should come to an end.

It was clear in the findings that income earned not only led to a harmonious co-existence between spouses but also resulted in more respect, recognition as a dependable person and effective communication as a result of co-dependency. It was also noted that it was necessary for the male spouse to understand the benefits of independence based on the fact that the absence of a patriarchally dominant figure does not necessary equate to one being destitute. What was deemed as important was the fact that the remaining female spouse would be able to manage life successfully without the perceived beneficial presence of the patriarchal figure.

In light of the value that financial stability brought towards spousal relationships, it was clear that income earned on the part of the female figure did not automatically translate into harmonious co-existence. The findings indicated an interface between seasonal income and regularized income; with the man ascribing to the former which was described as resulting in perceived intimidation on the part of the man. The lack of full autonomy on the part of man in comparison to the autonomy of the female brought to light perceived unequal gender balances, in addition to the "unnatural" nature of such an occurrence based on feelings of intimidation as a result of reliance on female labour and the financial gains of such. This mirrored the fact that the male as a patriarchally dominant figure can assume a role of dependence on the female whose labour power actually maintains the financial survival of the family unit. The dependence on female labour, most especially female reproductive labour stood out as an important virtue when it came to the maintenance of order in and out of the home. This dependence on the woman stood out clearly in relation to the literature concerning the importance of unpaid domestic labour towards the maintenance of capitalist accumulation. The fact that the reproductive roles were seen to extend into the clinical setting, thus resulting in duality of motherly and career roles justified this beneficial role towards capitalist accumulation. According to MR Online (2018), women's labour in the home creates the surplus value by which capitalism maintains its power. In addition, the continued and undisrupted reproduction of the working population has been a mainstay of the development and expansion of capitalism over the last few centuries (MR Online, 2018). Despite the stereotypical subservience of women in general, the nurses interviewed stated the fact that their important productive roles as agents of financial independence created a feeling of being able to attend to the needs of dependants in the home, inclusive of male spouses, hence the necessity tied to their dual reproductive and productive roles. The socialization of their domestic roles into the clinical set up represented a sense of power, control and dependability. The absence of condescension despite financial independence was also clear as there was a consciousness of the perceived demeaning nature of dependency on the part of the benefiting husband/male partner.

Moreover, gender balances as a result of financial capabilities were also negated based on the absence of spousal input; the influence of the patriarchal figure in financial decision making. The failure to consult with the dominant male head mirrored the image of the man as the dominant figure and illustrated gender relations based on capitalist views of production and reproduction. Mitchell (1966) confirmed the subjugation of women by stating that, the social cult of maternity is matched by the real socio-economic powerlessness of the mother based on the fact that the mother and child are subject to the father. The family thus represents the converse of women's quest for creation in the child with man's retreat from his work into the family.

Chapter 6

Conclusion and Recommendations

6.1 Introduction

The purpose of this chapter is to summarise the findings as have been discussed in the discussion section. Based on the findings, conclusions are also drawn, in addition to recommendations related to the curbing of negative characteristics related to nursing practice. The recommendations are based on the viewpoints given by the nurses during the interview process and are based on solutions to characteristics that do not reflect well on the responsibilities of the nursing profession.

6.2 Summary of Findings

The summary of findings related to the management of dual reproductive and productive roles are covered in this section. The main rationale of the study was to explore the linkages between female nursing practice and the reproductive roles of the individual nurses. In order to understand such linkages, it was important to understand gender socialization and the gendered stereotypes of the nursing profession through feminized care giving and the "good mother" discourse; the balancing of dual reproductive and productive roles and income gender power relations and the balancing of gender roles. The following sub-section summarises the findings based on the aforementioned sub-topics as a result of the research questions.

6.2.1 Gender Socialization and The Gendered Stereotypes of The Nursing Profession Through Feminized Care Giving and the "Good Mother" Discourse

The findings indicated that gender socialization informs segmented gender roles and expectations. The assuming of maternal roles during the critical childhood socialization period, actually informed entry into the nursing profession. Nursing was seen to represent the emotive dimensions of the socially expected roles of females and was linked to the essentialized socialization period. The creation of gender stereotypes in the nursing profession led to essentialism as a result of gender differentiation during childhood socialization. The normalcy of female subservience towards male dominance clarified the differentiated agentic and communal characteristics as had been enacted in the home. Gender segregation thus resulted in socially and culturally defined occupational roles. Motherhood and nursing were interchangeably compatible as the reproductive role spilt over into the professional role that also required an enactment of domesticity. Nursing was thus highly feminized and widely associated with maternal roles enacted in the home. Nursing also reflected subservience towards the patriarchally dominant male as enacted during the critical childhood socialization period. The patriarchy of medicine overrode the subservient role of nursing by emphasizing emotiveness and empathy as core areas of functionality within the nursing profession. Despite communality, nursing defied the stereotype of non-conformity to agency as the findings display a multiplicity of roles and the adoption of agentic roles such as management. As a result, agency in nursing is not exclusively related to male nurses.

6.2.2 Balancing Dual Reproductive and Productive Roles

The balancing of dual roles was reportedly linked to role strain as experienced by the nurses. What was found was an interface between family life and the demands of a career. The resulting consequences of role strain based on the duality of the reproductive and productive were feelings of child neglect, inattention to cognitive nurturing and emotional dissociation from dependants. Economic emancipation and attention to family life also resulted in conflicting priorities. In addition, nursing and motherhood were deemed as non-detachable as the profession also required an enactment of reproductive roles of care and affection. The conjunction of professionalism and motherhood actually illustrated the extension of domesticity into the professional environment. Based on this spill over, role strain was found to exacerbate the demands of family and child care responsibilities and work.

6.2.3 Income, Gender Power Relations and The Balancing of Gender Roles

The findings related to gender power relations and income yielded responses mirroring self- actualization. The self-actualizing effect of income earned, positively impacted gender relations between spouses. Income actually resulted in unified decision making and an interchangeability of gender roles. This interchangeability was reflected in males occupying more altruistic roles of childcare. The balancing of gender relations based on co-dependency between spouses was also as a result of income earned on the part of the nurses. Collective decision making based on financial power and economic stability were directly attributed to income, in addition to mutual respect and recognition of independence. In addition, income killed the need to be fully dependent on a patriarchally dominant figure in the home. Moreover, dependence on the enactment of the reproductive roles actually mirrored the benefits of unpaid, reproductive labour towards capitalist accumulation. Therefore, the socialization of domestic roles into the workplace signified a sense of power, control and dependability. The overriding of female financial decision making by inattentiveness to male influence also mirrored the guilt associated with defying the authority of the male figure as well.

6.3 Conclusions

This section includes itemised conclusions based on the research findings as have been discussed and summarised in the discussion. Conclusions based on gender socialization and the gendered stereotypes of the nursing profession through feminized care giving and the "good mother" discourse are covered. In addition, conclusions related to the balancing of dual reproductive and productive roles and income, gender power relations and the balancing of gender roles are also included in the itemised conclusions.

6.3.1 Conclusions on Gender Socialization and The Gendered Stereotypes of the Nursing Profession Through Feminized Care Giving and the "Good Mother" Discourse

The findings indicate the presence of a relationship between childhood and the enactment of gender segregated roles in adulthood; predominantly occurring in the clinical set up. This re-enactment of reproductive roles in the domestic set up have been discovered to actually trigger the essentializing of the nursing profession. The differentiation of gender roles through socially and culturally defined characteristics reflect the gender stereotypes that differentiate between masculine and feminine occupational role expectations. The creation of gender stereotypes in the nursing profession have thus propelled the line of thought that associates nurturing with the highly feminized view of the nursing profession. The perceived emotiveness of the nursing profession, coupled with the ascription to altruism has led to the identification of agentic and communal roles with males typically aligning themselves with the former role of agency. Despite this segmentation of gender specific roles within the nursing profession, female nurses have also been found to lean towards agency in nursing by adopting managerial and leadership roles. As a result, the findings have been able to challenge the stereotype that associates female nurses with altruistic nursing practice. The presence of men in the profession does not necessarily mean that they are the only ones aligned towards high-tech, de-personalized nursing practice. As a result of childhood socialization, nursing is still subject to the emotional and nurturing practices that are commonly associated with femininity.

6.3.2 Conclusions on The Balancing of Dual Reproductive and Productive Roles

The findings of the study have indicated the presence of role strain based on the balancing of family life and career. The effects of role strain have been found to impact negatively, the emotional and cognitive care of dependants, in addition to feelings of child neglect as a result of the conflicting priorities of nursing and the care of the home and family. Such role strain has reportedly led to feelings of fatigue based on the fulfilling of roles in and out of the home. Despite the benefits of economic emancipation and self-sufficiency, dual roles of productivity and re productivity have led to an alignment with income that necessitates the proper care of children and home. Without which, the sufficient care of the home and dependants would be virtually impossible. Therefore, the extension of domestic roles to the clinical set up actually bring to light the aspects of strain and fatigue that plague the lives of the nurses on a daily basis.

6.3.3 Conclusions on Income, Gender Power Relations and The Balancing of Gender Roles

The study has shown that income has made its mark as an equalizer of gender roles. The impacting nature of income on gender power relations have solidified the concept of power sharing between spouses through collective decision making and the self-actualizing effect of dependability. The effect of financial power as a result of economic emancipation has demonstrated clearly, the interchangeability of gender roles. Exclusive ascription to communality is thus not limited to females, males have also demonstrated an ability to display elements of domesticity in the home as well. Income has been linked to the lack of dependency upon the stereotypically dominant male by equalizing financial power and the responsibilities that come with it. The equilibrium created as a result of income as an equalizer of gender power relations has reflected the socialization of domestic roles by attributing such to a sense of control and overall dependability. Despite the patriarchal image of dominance as perceived to be the male role, there is still a desire to fulfil the demands of such a stereotypical image by ascribing guilt towards non-participation of the perceived head of the family in financial decision making. Nevertheless, income has not only allowed for an extension of reproductive roles into the clinical set up, it has also allowed for the liberation associated with a higher standard of living.

6.4 Recommendations

The following recommendations are based on the research findings concerning solutions to the negative characteristics that impact negatively on the integral roles that nurses play in the clinical set up. The researcher recommended these solutions based purely on the perspectives of the nurses.

6.4.1 The researcher recommends the prompt and timeous processing of monthly and overtime payments as a way of enhancing nurse productivity and morale in the workplace.

6.4.2 The researcher recommends the screening of prospective nursing students and employees in order to ensure strict alignment to the principles of nursing. In addition, this form of scrutiny will ensure that entrants into the profession actually, have a passion for nursing.

6.4.3 The researcher recommends support from hospital management and the Nursing Council which should be used to create opportunities for performance appraisal based on the fact that the clinical environment is not devoid of under staffing and overcrowding that leads to mental fatigue on the part of the nurses.

6.4.4 The researcher recommends an emphasis on the fulfilment of training needs in order to advance the capacity of nurses and reduce the frustration involved with unmet and unfulfilled capacity needs.

6.4.5 The researcher recommends monthly and quarterly meetings that are incorporated into the clinical schedule as a way of ensuring the airing and resolving of complaints from nurses.

6.4.6 The researcher recommends inter-departmental engagement with the nurses in order to ensure equal participation in the functionality and improvement of clinical services.

6.4.7 The researcher recommends an emphasis on exposure to international nursing practices as a way of harnessing unity of purpose through capacity building on the part of the nurses.

6.4.8 The researcher recommends the prioritization of the managerial training needs of the nurses as nursing is a diverse field with diverse role expectations.

6.4.9 The researcher recommends in-service training related to the ethics of care with the anticipated result of curbing unethical practices that disadvantage patient care.

6.4.10 The researcher recommends an emphasis on strict alignment to dress code as a way of conservatively recognizing the importance of the nursing profession towards the needs of the community.

6.4.11 The researcher recommends an assessment into the numerical mismatch between patients and nurses through the re prioritization of inter-departmental needs within the clinical set up.

6.4.12 The researcher recommends a recognition of the fundamental roles that female nurses play beyond mere re-enactments of female role expectations. There should be a harnessing of the managerial acknowledgement of nursing roles beyond altruism by crediting activities that reflect diversity of expertise and propensity to perform critical duties within the clinical set up.

6.5 Final Conclusions

This study has achieved its main aim of discovering linkages between female nursing practice and the reproductive roles of individual nurses. This has enabled an understanding of the extension of female reproductive roles into their productive roles as nurses. The study has managed to link the social context of re productivity into the productive roles of nursing. The linkages between the cultural and social dynamics of gender roles into the stereotypical nature of the nursing profession have also been established. In addition, the study has been able to explore the dual reproductive and productive roles of the female nurses by understanding the resultant effects on childcare and familial responsibilities, spousal support and relations as well as monetary effects.

Moreover, there has been an exploration into the power dynamics of financial independence as a way of explaining gender power relations as a result of income. The effects of which have not only led to financial independence and dependability, but towards power sharing and collective decision making amongst spouses. Despite the gender- equalizing effect of income earned, the patriarchy of medicine over nursing remains an ongoing issue. It can be said that the dominance of medicine over nursing actually perpetuates the condescension of the nursing profession, despite the multiplicity of roles that not only require empathetic care, but mastery, leadership, power and respect through the enactment of managerial roles. The fact that nurses are able to fully comprehend the conditions of patients and understand diagnoses and the prescription of medication does not necessarily equate towards nursing beyond the communal, selfless image. This is further brought to light by the mere fact that the nurses acting as advisors to doctors who should exercise their medical roles effectively and authoritatively, does little to upgrade the view of the nursing profession as one that requires mastery, quick thinking and control. The patriarchal nature of medicine thus overshadows the nursing profession, irrespective of the fact that nurses actually bear the brunt of patient care, treatment, dispensation of medication as well as playing the roles of modes of communication between the patients and the doctors.

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8. Appendices

Appendix 1

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ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: FHSS /396/2018 **Date: 20July, 2018**

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy And Guidelines. Ethical Approval Is Given In Respect Of Undertakings Contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Nurses As Working Mothers And Their Social Reproductive Roles: An Exploratory Study Of Nurses In Windhoek

Researcher: RISPER KOJWANG

Student Number: (200302981

Supervisor(s): Dr. Lucy Edwards-Jauch

Faculty: Faculty of Humanities and Social Sciences

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
(d) The UREC retains the right to:
(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
(ii) Request for an ethical compliance report at any point during the course of the research;

UREC wishes you the best in your research.

Dr. J.E de Villiers: UREC Chairperson

Ms. P. Claassen: UREC Secretary

Appendix 2

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Informed Consent Form

Informed Consent Form for Female nurses from Katutura State Hospital in Windhoek who have been invited to participate in a research project titled "Nurses as Working Mothers and their Social Reproductive Roles: An Exploratory Study of Nurses in Windhoek".

Name of Principle Investigator: Risper Auma Ochieng Kojwang
Name of Organization: University of Namibia
Type of Degree: Master of Arts in Sociology
Name of Sponsor: N/A
Name of Project and Version: Nurses as Working Mothers and their Social Reproductive Roles: An Exploratory Study of Nurses in Windhoek

Part I: Information Sheet

Introduction

Good day. My name is Ms. Risper Auma Ochieng Kojwang and I am a Masters student from the University of Namibia. I am conducting a research project concerning "Nurses as Working Mothers and their Social Reproductive Roles: An Exploratory Study of Nurses in Windhoek". This project will explore the experiences that nurses have juggling motherhood and the nursing profession at the same time. I would like to assure you that you will be furnished with information about the study as well as an invitation to be part of this project. Your decision for participation in this project is entirely voluntary and you can withdraw from the study at any time and your withdrawal will not result in any negative consequences. As we go along, feel free to ask questions if this consent form contains words and terms, you may not understand. An explanation will be given at your request.

Purpose of the research

The nursing profession in general tends to involve more women than men. Women tend to extend their roles as empathetic care givers into the profession as it is often a requirement. The goal of this project is to explore how nurses who are mothers view their roles of extending care to patients in addition to child rearing in the home. I believe that you are eligible to create an understanding of your experiences managing the roles of a mother and a nurse. The main idea is to find out from your side, what your perceptions and experiences are in this regard.

Type of Research Intervention

This study will involve your voluntary participation in a one-on-one in-depth interview which should take approximately one hour.

Participant Selection

You have been invited to participate in this study as your experience as a nurse and a mother will contribute greatly to an understanding of nurses as working mothers.

Voluntary Participation

Your participation in this study is entirely voluntary and you can choose whether or not you will participate. Withdrawal from the study will not result in any negative consequences.

Procedures

The interview process will be entirely confidential and will be held in a private, quiet place at your convenience. Please note that if you want someone else to be present that will not be a problem. You are free to skip any questions you do not feel comfortable answering and can stop the interview at any time should you not feel comfortable. The entire interview will be recorded and will not be accessed by anyone else but me. Your name will not be used in any way so as to protect your identity. The contents of the recording will be deleted immediately after the study process.

Duration

The study will take place over the course of a year. You will be interviewed only once and the interview will take approximately one hour.

Risks

During the interview process, if you feel uncomfortable about discussing sensitive topics or those of a personal nature, you are free to decline answering any questions that you are not comfortable with. In addition, you will not be compelled to explain why you cannot answer certain questions.

Benefits

Although there will be no direct benefit to you, your contribution will help to understand the experiences of women who juggle motherhood and nursing.

Reimbursements

You will not be provided with an incentive to take part in the study.

Confidentiality

No information about you will be shared with anyone else other than myself. The information you provide will be kept confidential and private. Any information about you will have a pseudonym in place of your real name.

Sharing the Results

Everything you share today will be entirely confidential and will not be shared with anyone. Nothing you say will be attributed to your name.

Right to Refuse or Withdraw

You have the right to withdraw from the study should you so wish. You can stop participation at any time during the interview process. After the interview feel free to review your answers and to retain or amend the responses you have given. Your feedback concerning your agreement or disagreement with the way the information you give has been presented will be welcomed.

Who to Contact?

If you have any questions, feel free to contact me. You may contact me using any of the following modes; mobile: +264-81-4353480 or email: auma18@yahoo.com.
You can also contact my supervisor, Dr. Lucy Edwards- Jauch at mobile:
+ 264-61-2063139 or email: ledwards@unam.na

This study has been approved by the Research Ethics Committee at The University of Namibia.

Part II: Certificate of Consent

I have been invited to participate in a study about, "**Nurses as Working Mothers and their Social Reproductive Roles: An Exploratory Study of Nurses in Windhoek, Namibia**". I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have, have been asked and have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant__________________

Signature of Participant ___________________

Date ___________________________

Day/month/year

I have also consented/ not consented to the use of voice recordings during the interview. By not consenting to voice recordings, I agree to have notes taken instead of having my voice recorded during the interview process.

Print Name of Participant__________________

Signature of Participant ___________________

Date ___________________________

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. **In-depth one on one interview**
2. **Right to discontinue interview at any time**
3. **Right to amend or remove any response given**

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent________________________

Signature of Researcher /person taking the consent__________________________

Date ___________________________

Day/month/year

Appendix 3: Interview Guide

Name of Interviewer:
Name of Interviewee:
Place of Interview:
Date of Interview:

Demographic data:

Age:

Marital Status:

Rank:

Type of Facility:

Questions

1. How would you describe your life as a young girl?

   [How did your experiences growing up, shape your role as a mother?]

2. What can you say about the most important roles you learnt to adopt growing up?

3. How would you describe the environment in which you grew up?

   [What notable characteristics in your childhood environment shaped your perception of what being a female entail?]

4. How would you describe your upbringing as a girl compared to that of boys?

   [What differences do you believe exist when it comes to your upbringing as a female compared to that of males?]

5. How has working and earning an income affected your life?

   [What areas of your life have been directly affected by your financial independence?]

   [How have you handled the effects of income earned on your life?]

6. What can you say about your working life and income earning in terms of decision making on your part?

   [What areas of your decision making in the workplace stand out in light of your experiences as an income earner?]

7. How would you describe the treatment you receive in and out of the home as a result of you working and earning an income?

   [What are the negative and/or positive changes you have experienced as a result of working and earning an income?]

8. How has working and earning an income affected your relationship with your spouse/partner?

   [What can you say about your social interaction with your spouse/partner based on your role as an income earner?]

   [What areas of the social interaction you have with your spouse have affected your perception of the role you play as an income earner?]

9. What can you say about your reproductive role as a mother?

   [What aspects of motherhood would you say define your role as a mother?]

10. What can you say about your role as a mother and its effects on your responsibilities at work?

    [What areas of the responsibility's motherhood can you relate to nursing practice?]

11. What emotional qualities enable you to fulfil your role as a mother effectively?

    [What linkages are there between your upbringing as a female and its effects on your role as a mother?]

12. What characteristics are not deemed as good for a mother?

    [What causes the negative characteristics that are not compatible with the definition of motherhood?

    [What environmental factors create the negative characteristics that go against the role that a mother is expected to play in society?]

13. What kind of productive activities does your role as a nurse entail?

    [How would you link your productive role as a nurse with your reproductive role as a mother?]

14. What kind of emotional qualities are required to be a successful nurse?

    [What do you think creates the emotional qualities necessary for the nursing profession?]

15. What kinds of characteristics are deemed as negative for a nurse?

[What factors trigger these negative characteristics?]

[What solutions do you believe are necessary in curbing negative characteristics that are not good for the responsibilities of the nursing profession?]