

***Nursing care in an African context:
A qualitative study from
Haydom Lutheran Hospital, Tanzania***

***Thesis submitted in partial fulfilment of the requirements for
the Cand. San. Degree***

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Abstract

The purpose of this qualitative study is to focus on nursing care at Haydom Lutheran Hospital (HLH) in Tanzania, with an emphasis on aspects of nursing care that emerged as different from a Norwegian hospital setting. The data's was primarily collected through three months of participant observations and four in depth qualitative interviews of nurses. The fieldwork was carried out at the Intensive care ward (ICU) supplemented by corresponding participation at the medical and surgical ward. Relatives' presence and contribution in the care of patients, smalltalk and laughter as well as the handling of limitation in terms of equipment were the most manifest differences. Other aspects that emerged as different were the handling of time and the organisation of work. The thesis includes points on assets and challenges of nursing care at HLH.

Sammendrag

Hensikten med denne kvalitative studien er å fokusere på sykepleie ved Haydom Lutheran Hospital (HLH) i Tanzania, med hovedvekt på sykepleieomsorg som fremstod som annerledes enn ved norske sykehus. Datasamlingen bygger primært på 3 måneder deltakende observasjon og fire kvalitative dybde intervju av sykepleiere. Feltarbeidet ble hovedsakelig gjort ved sykehusets intensiv avdeling i tillegg til kortere perioder ved medisinsk og kirurgisk avdeling. Pårørendes tilstedeværelse og deltakelse, sykepleiernes kommunikasjon gjennom småprat, latter og håndteringen av utfordringer knyttet til begrenset utstyr var de mest framtrede forskjeller. Oppgaveutførelsen, håndteringen av tid og arbeidsorganiseringen fremstod også som annerledes. Oppgaven peker også på ressurser og utfordringer ved sykepleieomsorg ved HLH.

1. Introduction

The focus of this thesis is nursing care at Haydom Lutheran Hospital (HLH), Tanzania, a Norwegian mission hospital founded in 1954, with an emphasis on aspects of nursing care that emerged as different from a typical Norwegian hospital setting. It is important to emphasize at the very onset of this thesis that this obviously is no attempt to draw an objective picture of nursing care at HLH, and the findings can not be generalized to other African settings. The observations and recordings are inherently coloured by the vantage point of the observer; a Norwegian nurse with practice solely from Norwegian hospital settings, with lack of knowledge on Swahili and other local languages in the area who took part in nursing care at HLH for three months during the autumn of 2002. It is the assumption however, that despite the severe research challenges, this work would still have some value as a commentary on nursing care for readers in a northern European – as well as an East African context.

This project is part of the NUFU programme *Gender, generation and communication in times of AIDS: The potential of 'modern' and 'traditional' institutions*.

The NUFU programme makes up an initiative from a group of Tanzanian and Norwegian researchers engaged with issues of HIV prevention and AIDS care in a context of a dramatically developing HIV/AIDS situation in East Africa. The programme activity involves institution building-, capacity building-, research (with an emphasis on intervention research) and dissemination on both the East African and the Scandinavian side. The programme activity was on the onset organised in three separate but related components, physically located in Mbulu/Hanang and Moshi/Arusha in northern Tanzania and in Kigoma in western Tanzania. The projects particularly target women, youth and orphans. (Application to NUFU, 2000:6)

I have to empathize that HLH is a hospital in continued development, and this thesis is solely built upon the fieldwork experience conducted from the autumn 2002.

Nursing care in this these is to be understood as all the aspects a nurse has to consider in her work; it is the nurse attitude towards the patient as well as her evaluations of the situation and actions for - or towards the patient. In the words of Kari Martinsen (1989); nursing care contains practical care, relational care and moral care.

2. Literature review

2.1 Health care in Tanzania

Tanzania's history is coloured by German and later British colonialism (with independence granted in 1963), as well as by former President Julius Nyerere's policies. Nyerere laid grounds for the development of a peaceful nation located in east-Africa, a nation with ambitious political aims. Moland (2002) writes:

Development in post-independence Tanzania was defined by Julius Nyerere as a strategy to address the three enemies of the nation: poverty, disease and ignorance (Nyerere 1998) (2002: 20)

The enhancement of both education and health services were located at the heart of Nyerere's policy charts.

People try their best to participate in development, for instance through education and training programs of various kinds; these are viewed as a means to better their material situation, at the same time, to become developed and modern, thereby escaping social identity as backward and ignorant. (Moland: 2002: 19)

In the first years after independence patients would get free treatment for treatable health problems at Government driven health centres. Along with large parts of sub-Saharan Africa the challenges to development have been many and severe the past decades. Market economic principles were introduced not the least through the structural adjustment programmes launched by the World Bank. Moland (2002) writes:

The policy changes towards a market economy in the late 80s, which involved the weakening of Government hegemony over the distribution of health and social services combined with the introduction of patient fees in public hospitals, opened up the field of health care to private initiatives. (2002: 252)

Hinderaker (2003) describes the structure of the Tanzanian health care system in the following way: Health services are largely provided by governmental, voluntary agencies and private companies, and are structured by the Government by the Ministry of Health. The lowest level is The *Village Health Services* where a few health workers provide health care in the homes. The *dispensary services* make up the next level; often with a delivery room and a Nurse/Midwife to provide health services for coming mothers. Further up the *Health Centres* are staffed by Clinical Officers, Nurses and Midwives and have beds and some medical equipment. There is a *district*

hospital in each district, and there are also private hospitals, for example HLH, which give specialist services such as surgical services. The highest level is made up by the four *Consultant Hospitals* which are large teaching hospitals with a number of specialist services.

2.1.1 The challenge of health and health care in poor settings

Despite efforts put into effective equitable and affordable health care services, the health status of people in sub-Saharan Africa is not improving according to Habte, Dussault and Dovlo (2004). They write that Africa is the only continent that has not fully benefited from the biomedical sciences in terms of reducing the disease burden through health tools and technologies. Habte et al (2004) moreover point out that the major limiting factor to improved health outcomes is not only a lack of financial resources or health technologies but the lack of implementation capacity which depends on the presence of a functional health system.

Mbananga, Mniki, Oelofse, Makapan and Lubisi (2004) writes that communication and understanding between health providers and consumers of health services is important to improve health care in South Africa, and that understandable language is valuable to engage patients in the decision-making process regarding their health problems. The official languages of Tanzania are according to Aschehoug and Gyldendal (1998) Swahili and English, but the people in Tanzania speak as much as approximately 100 different languages. Language plurality is a challenge for nurses in the communication with patients.

Reproductive health challenges in sub-Saharan Africa create a particular burden for pregnant women, babies and small children. Vulnerability of death in childhood is particularly connected to infectious diseases and accidents. Mutasingwa (2000) e.g. writes that hundreds of children in Dar es Salaam (Tanzania) die or are permanently disabled as a result of accidental injuries. Small children are however more at risk from home injuries than road accidents. He points out that:

... burn injuries that occurs mostly at home were found to be a major problem among children under ten years of age. (Mutasingwa, 2000: 51)

Patients in sub-Saharan Africa are simply threatened by large numbers of diseases and types of atrocity which are rarely seen in the West, a burden that comes in addition to the global disease challenges, like diabetes and cancer.

Agyepong and Kangeya-Kayonda (2004) write that approximately 90 % of the between 1 and 2 million global deaths related to malaria occurs in sub-Saharan Africa, especially affecting children under five years of age.

In his research on perinatal mortality and anemias in pregnancy in rural Northern Tanzania Hinderaker found that the:

main cause of perinatal and neonatal deaths were infection related (39%), asphyxia related (23%), and immaturity related (14%) (2003: 68)

He also writes that in 1995 malaria was the most common ailment causing people to seek health services at HLH, and was also the most common cause of death. (Hinderaker, 2003)

Also according to Samba (2004) malaria continues to be a major cause of ill-health in Africa south of the Sahara. Pregnant women and small children are especially vulnerable. An enormous challenge for health care is the fact that malaria is such a common disease that people who become sick do not visit health care facilities. The economy of communities as well as on household level is thus influenced by keeping people from work, creating processes of increasing.

A study carried out by Alilio Rønn, Mhina, Msuya, Mahundi, Whyte, Bygber, and Krasnik (2004) at the district health services in Muheza District, North-eastern Tanzania points out disease panorama:

A total of 105 (94%) of 112 deceased were seen at the district health facility during the 2 week before death. Conditions that caused death for two thirds (63%) were malaria, pneumonia, tuberculosis or delivery complications, all of which are target illness/conditions for district health services in Tanzania and for which effective therapy exist. (The American Society of Tropical Medicine and Hygiene, 2004: 51)

At HLH the following is written about most common diseases:

The most common diseases in the area are: malaria, which is often multiresistant; tuberculosis; respiratory tract infections; gastroenteritis and diarrheal diseases like amoebiasis and giardiasis; relapsing fever, often following a serious course in pregnant women; HIV infection.” (HLH at the internet 2004)

According to Habte et al (2004) sub-Saharan Africa and the international health community is facing the challenges of an extraordinary disease burden affecting the health status of Africans. The panorama of diseases, injuries and patients condition differ starkly from Western settings. Especially infectious diseases like malaria, tuberculosis, AIDS etc are causing innumerable deaths. Disease scenario has immense consequences for the nurses' daily work.

Other aspects affecting and increasing the burden of health and health care is according to Gilks (2001) people's health seeking behaviour; disease presentation and the quality of the health care in poor countries, and points out the challenges to effective health care services in countries with highly insufficient resources.

2.1.2 Earlier research on nursing care in African contexts

Most of the literature found about nursing care in an African context is connected to the HIV/AIDS epidemic. The HIV/AIDS epidemic is not a focus of this study, but many of the aspects of nursing care which is topical for the epidemic is also topical for the care of patients in general, and makes this body of literature relevant in this context.

In Africa, as elsewhere, nurses play a most important role in the health care system, and make up the majority of professional health care providers. (Phaladze, 2003; Walusimbi and Okonsky, 2004). Despite the fact that nurses occupy most posts in the official health care system, Phaladze (2003) notes from Botswana that they rarely participate in the health-care policy process and thus does not influence resource allocation. The nurses' minimal impact on the policy process and in budget decisions was noted to result in implementation problems, thus compromising service provision. (Phaladze, 2003)

Moland (2002) carried out part of her fieldwork in the maternity ward at the regional hospital in Kilimanjaro, Tanzania and she partly writes about the power structures of the hospital. She describes the medical doctor's authority and the respect patient and nurse give to the doctor's decisions. On the other hand she notes the manner in which

nurses can control information they get from the patient by withholding it from the doctor. Moland (2002) writes about the position of nurses in the Tanzanian society:

A nurse represents not only medical knowledge, but also modern life. Knowledge in this context works through the modern as an *ideal* and through the medical *practice*, and it is this combination of the modern ideal and professional knowledge that gives the knowledge status as authoritative. (Moland, 2002: 168)

Professional authority thus becomes social authority and has an economic aspect as well, especially in the mix of professional obligation and the nurse's private economy.

Withholding services, though illegal, is a strategy that the nurses use in order to obtain gifts that will supplement their low income. The nurses have the power in that they control a service that women in labour depend upon. It is the patient's dependence on the nurses that creates a situation of inequality. And it is this dependence that motivates the women to give gifts. (Moland 2002: 144)

It is the nurses themselves who have to change the nurses' impact on the health care politics as well as the nursing role to improve the nursing care for patients'; this is emphasized by more authors. Mapanga and Mapanga, (2000) writes about the challenging realities that call for nurses' initiative to advance in preparation to attain cost effective nursing practice and to adapt to the changing society and provide socially and culturally relevant nursing care.

In her article: "Nurses fighting the HIV/AIDS epidemic in Africa", Ngcongco's (1998) argues for a new and more active nursing role not the least by demands of the HIV/AIDS epidemic:

Nurses involved in HIV/AIDS care must contend with many practical, professional and ideological issues. In doing so they must also be activists for social justice and human rights in health care, especially in countries where poverty and lack of knowledge are inextricably linked to the spread of HIV. (International Nursing Review, 1998: 85)

Nurses provide first line health care and are practicing at all levels in the health care system. Nursing practice make a unique contribution which compliments other health disciplines' contributions to the improved health and wellbeing of people. The practice of nursing assists individuals, groups and communities to increasing self-care to enhance health promotion. (Mapanga and Mapanga, 2000)

Juntunen writes about nursing care at Ilembula Lutheran Hospital in Tanzania:

The goals of caring were to maintain the patient's health, to prevent his/her condition deteriorating and to create and maintain a good relationship with the patient and his/her relatives. (Journal of Advanced Nursing 1996: 540)

Juntunen (1996) points out that the main constructs of nursing care in Ilembula Lutheran Hospital is protection (through health education), encouragement (as building and maintaining co-operation with patients and relatives) and comfort (by explaining and touching).

Documentation of the patients' condition is often considered as an important aspect of nursing care. Nyangena and Bruce (2000) carried out a descriptive survey using a retrospective and prospective record review in a large academic hospital in Johannesburg, South Africa with the aim to describe the nature of care to patients with blunt chest injuries. The results indicated that nurses are good providers of care but poor in prescribing and documenting care.

Diverse studies points out the meaning of good communication skills among nurses. Savage (2002) used a case study to identify guidelines for provision of culturally congruent nursing care to the Chagga people in Tanzania. She points out that nurses should be aware of the importance of respectful communication, to obtain an accurate treatment history, and to ensure that social and spiritual care is provided.

Lie (1994) has carried out action research to improve the quality of HIV/AIDS counselling in Kilimanjaro and Arusha districts of Tanzania. In her studies from Mt. Meru hospital and Mawenzi hospital in northern Tanzania, she found that the interviewees and the focus group members were more concerned about the social consequences of HIV/AIDS than the technical facts; the major problem with HIV/AIDS was stigma and fear of rejection.

The findings indicate that confidentiality is central and that hospital counsellors must balance the fact-giving approach with a person-centred approach, exploring the client's problem conception and finding who in the client's network can give the further necessary psycho-social support. (Lie, 1994: 15-16)

Communication between nurses and patients is also emphasized by Hinderaker, Olsen Bergsjo, Gasheka, Lie, Havnen and Kvale (2003). They write that to reach the goals of preventing stillbirths and neonatal deaths in the community in rural Tanzania, effort should be put on improvement of the communication between midwife and women at the antenatal clinics, preparing the women-and their families-for the delivery and to be prepared for complications.

Nurses' competence in the field of communication has been studied by Murira, Lutzen, Lindmark and Christenson (2003) in Zimbabwe. They conducted their study to explore communication between pregnant women and health care providers at an antenatal clinic. The study results emphasize that the attitudes reflected by the communication styles must be viewed in relationship to the culture and tradition of Zimbabwe. Knowledge of culture and tradition lead to a better understanding of appropriate communication strategies to promote healthy pregnancy.

Nurses' behaviour towards the patients is also an important aspect of the nurses' communication with patients and could be the 'key' to provide better health care among the people in the community. Lamina, Sule-Odu and Jagun (2004) carried out a cross-sectional study on pregnant women in Olabisi Onabanjo University Teaching Hospital (Nigeria) to assess factors militating against delivery at the teaching hospital. They found that the higher the educational level, the more women opt for hospital delivery. One reason for women not coming to the hospital for delivery was 'bad' attitude of the hospital staff. They argue that this indicates the need for hospital staff to be more user-friendly to encourage better patronage.

Moland (2002) also points out the challenges for health care related to nurses' attitudes in the labour room, in a Tanzanian hospital:

The judgements of the nurses rest on a close alliance between biomedicine and morality. In the labour room it is the knowledge and position of the nurses that gives them authority to pass judgement not only on the progress of labour, but also on values and norms. Referring to professional knowledge, rules and general procedures, the nurses often ignore or devalue the experiences and the needs and wishes expressed by the individual woman during childbirth. (Moland 2002: 150)

Relatives play an important role in the care for patients in sub-Saharan Africa. Despite nurses' care for patients, the daily care for most patients is provided by relatives and friends in homes as well as in hospitals. This aspect is brought up by a number of authors (see e.g. Juntunen, 1996; Haram, 1999; Moland, 2002; Chimwaza and Watkins, 2004).

Haram writes about the burden of care carried out by relatives, from Meru in Arusha Region, Tanzania:

For obvious reasons, to give care and comfort for the AIDS-ill is a heavy burden both financially and emotionally, and it is also a highly time-consuming task. Male relatives (fathers and brothers) usually take the economic responsibility involved in the care of

the patient. Woman (mothers, sisters and sisters-in-law), have the daily care. They cook, feed and clean the decaying body, and wash their stained sheets and clothes. They are also usually those who comfort. (Haram, 1999: 194)

Zimba and McInerney (2001) write that nurses must be aware of the knowledge and attitudes of those relatives who are taking care of patients', as their knowledge is a major factor in the promotion of adherence to care and treatment regimens. The need for teaching given to relatives is magnified with the increasing numbers of patients with HIV/AIDS who are given care at home: The main focus of the governmental home based care programmes in Tanzania is to reduce overcrowding in hospitals as well as to involve the community in providing care for patients (Sepulveda Habiyambere, Amandua, Borok, Kikule, Mudanga, Ngoma and Solomon 2003). This indicates the importance and challenges of nurses in hospitals as well as in the communities' in the communication of care and health messages.

Nurses own knowledge is most important in the area of passing over health knowledge to patients and relatives as well as health information to the communities. Adelekan, Jolayemi, Ndom, Adegboye, Babatunde, Tunde-Ayimode, Yusuff and Makanjuola (1995) investigated health care staff attitudes and knowledge in a Nigerian teaching hospital. They concluded:

This study revealed the existence of important knowledge gaps on HIV/AIDS-related issues in varying degrees among doctors and nurses. The attitude of these HWs (health workers) with regard to their involvement in the care of PWAs (patients with AIDS) were also largely negative and suggested a lack of preparedness in coping with an increasing work load in this area. (AIDS care, 1995: 71-72)

Adelekan et.al. (1995) suggested that an educational programme should be instituted for all groups of health care staff on a regular basis. Adebajo, Bamgbala and Oyediran (2003) carried out a study to examine the knowledge, beliefs and attitudes of nurses towards patients with HIV/AIDS in Nigeria. They found that knowledge depended on education, experience and refresher courses, and that attitude towards these patients was poor. Adebajo et al (2003) emphasize that it is important that health care providers are properly informed in order to improve their quality of care for the patients with HIV/AIDS. Kohi and Horroks (1994) found similar results from a study in Tanzania, they also emphasize that proper knowledge is the key for nurses to change their attitude towards patients.

That knowledge and education is the key to change nurses attitude towards patients can be viewed through the enormous focus on HIV/AIDS in sub-Saharan Africa. According to Walusimbi and Okonsky (2004) it appears like this focus has increased the knowledge and changed the attitudes among nurses at Mulago Hospital, Uganda. The results revealed that knowledgeable respondents had less fear of contagion and that nurses and midwives had positive attitudes toward patients with HIV/AIDS despite the fear of contagion.

Education seems to be one of the most important aspects to improve nursing care towards patients. Fichardt and Viljoen (2000) points out that a key step in the development of any educational programme is to identify learning needs of potential students in order to develop a relevant educational programme. For registered nurses this implies to build upon the students' knowledge and skills and emphasize on the teaching of advanced knowledge and skills.

More levels of knowledge and skills should be investigated to be able to build up educational programs. Eriksen (2001) carried out a study at the Tanzanian Hospital KCMC where she studied post operative infections and prevention of infections. The Tanzanian nurses' knowledge of infection prevention was explored and viewed through science knowledge of infections and transmission.

Hand washing is often mentioned as the single most important way to prevent infections. Knowledge of infection prevention is usually not emphasised in the health professions training in Tanzania. Many of the staff were unfamiliar with different prevention methods for example the importance of hand washing. (Eriksen, 2001: 36)

Regular educational programs for nurses to specialize in care for patients with a special disease or conditions is most common in hospitals; the effect of such education in developing countries is explored by Wilimas, Donahue, Chammas, Fouladi, Bowers and Ribeiro (2003). They point out that specialised education is changing the nurses' care for patients. They have explored the importance of care provided by paediatric nurses, especially towards children with cancer. One of the results of the nurse paediatric training programs viewed that nurses in the program shared their knowledge with other nurses and improved nursing practices. They also found that programs to teach subspecialty nursing in developing countries are effective and improve medical care.

“Internal hospital training programs” also improve nursing care. This was pointed out by Lugina, Johansson, Lindmark and Christensson (2002) through their study of the effects of a theoretical framework for midwives to become good resource and support persons for postpartum women in Dar es Salaam, Tanzania.

Eriksen (2001) also point to the manner in which nurses benefit from the hospitals internal education:

The investigator noticed an increasing awareness and interest in the field of infection prevention. The investigator was invited to speak about the study and infection control at both the school of nursing and for nurses at different departments at KCMC. After the lecture given to nurses at S1, several infection prevention measures were improved. (Eriksen 2001: 47)

To benefit from knowledge nurses need the practical possibilities in the environment where they work. Eriksen (2001) explains poor hand washing with poor equipment for hand washing at the hospital, and she refers to another study from Muhimbili Medical Centre, Tanzania which shows that pathogens cultures from patient infections were similar to random samples taken from towels, sinks, antiseptic containers and beds on the ward.

The need for continued training is not the least important in connection with advanced equipment and specialized wards like intensive care units. Through a retrospective study of medical records at the multidisciplinary intensive care unit (ICU) at the Ouagadougou national hospital (Burkina Faso), Ouedraogo Niakara, Simpore, Barro, Ouedraogo and Sanou (2002) found low bed occupancy and a high mortality rate, particularly in the first days and particularly among farmers. Their results indicate a need for reorganization, with special emphasis on personnel availability and training.

Intensive care services often include use of medical technical equipment which demands education and training to be employed safely. Faponle and Erhabor (2002) note that the aim of improving patient's care by introducing equipment (like the pulse oximeter) can only be achieved by including staff training in the use of the equipment.

Mavalankar (2004) have written the article “Managing equipment for Emergency Obstetric care in rural hospitals” based on experience from various projects in developing countries in Asia and Africa. He writes:

Most health managers, doctors and nurses in developing countries are not familiar with the basic concepts of equipment management. Little political or administrative attention

is paid to this area. As a result, precious resources are wasted in terms of unused and unusable equipment. (International journal of gynaecology and obstetrics, 2004: 96)

They emphasize that the equipment should match the skills of the staff. This pertains to nurses as well as other staff members.

Several studies points out that knowledge is important but not enough in improving nursing care towards patients. Kohi and Horroks (1994) point out that a supportive work environment for nurses is important to change nurses' attitude towards patients.

Uys (2000) who carried out her study among nursing students from KwaZulu-Natal in South Africa found that the students saw the challenges of the future in the areas of quality of care, improved training, recognition of the profession, and management, and dealing with the problem of HIV/AIDS. The quality of care for HIV positive patients were mentioned as one of the greatest challenges facing nursing. And as one of the informants said: "Getting rid of the fear that you are going to get AIDS. Learning to treat them as being normal" (Uys, 2000: 85).

Fear for own health while caring for patients is an important area to grasp, especially when it comes to care for patients with HIV/AIDS or other infectious diseases with few treatment availabilities. Nurses' fear of contracting HIV during work was explored by Ncama and Uys (2003) who carried out a qualitative study, among trauma nurses in the province of Kwazulu-Natal. The nurses' main concern was their working environment, through needlestick injuries. To cope with the fear education and supportive networks have been recommended, as well as improving the quality and availability of protective materials and equipment.

Nurses' fear for own health and the nurses' working environment are important aspects of nurse management. This aspect has been studied by Minnaar (2003). She focused on nurse managers' and nurses' view regarding caring in the workplace in KwaZulu-Natal (South Africa). It was found that to ensure caring and healing of patients in health services it is of the utmost importance for nurse managers to ensure a healthy and caring environment in the management of nurses. Nurse Managers and nurses should all accept responsibility for finding means to improve communication and, in particular, participative leadership strategies in the hospitals.

3. Methods

Qualitative research methods were employed in this study to focus on nursing care. Participant observation and qualitative interviews were particularly employed as research tools.

This chapter will be divided into three main parts. The first part will focus on choice of methods, and present the methods participant observation and qualitative interviews. In the second part the focus will be on how the present study was carried out, including modification of original plans, aspects related to ethical clearance, research permit as well as access to the field. This part will also present the employment of the research methods in the study as well as analysis of the collected materials. The third part will contain an evaluation of the researcher's role, methodological challenges and ethical dilemmas related to the study.

3.1.1 Rationale for choosing a qualitative approach

Participant observation seemed to be the optimal method for the study in question as I wished to gain knowledge of nursing care in Tanzania, not only in the sense of what nurses themselves would tell me, a white, Western educated nurse, about their work and care giving role. I was also interested in gaining knowledge on what was actually done practically at the wards, i.e. gaining knowledge on how the care was given to particular patients. This meant that the researcher should preferably be present at the ward to see and record situations where nurses care for their patients. The choice of participant observation was also reached with a true recognition of the obstacles faced by my lack of knowledge of Swahili or any of the many local languages employed in the research area.

By taking part in the daily work, I would get a chance to get in close contact with both the nurses, who were speaking English at least part of the time, as well as the patients and their relatives. In this way I got the possibility to take part in concrete care situation, see the nurses' work, observe patients' and relatives' actions and reactions.

The observations in the practical context itself, moreover gave me the opportunity to comment on and make inquiry about particular practical situations in aftermath.

3.1.2 Participant observation

Lipson (in Morse 1991) describes how the participant observer commonly gathers data through both informal interviewing and through on-site participation. According to Jorgensen participant observation depends on observation as a basic strategy for gathering facts. He notes however that:

Participant observers employ interview strategies, ranging from highly informal, causal conversation to formal interviews and questionnaires. The participant observer usually has access to a wide range of human communications and artefacts. (Jorgensen, 1989: 94)

This inherent ‘triangulation’ of strategies for data collection implies a mobilisation of many of the researcher’s senses; what is seen, heard, smelled, felt and so on is all deemed valuable in the process of data collection. The importance of gathering information beyond the spoken word is indeed given substantial significance. Particular voice- and facial expressions, and body language are e.g. observed and recorded. It is assumed that to be in the situation, is particularly well suited to gather information on such sources of immediate bodily information.

Schein (2001) describes participant observation as a kind of action research, which in its pure form assumes that the researcher becomes ‘totally involved’, and at the same time remains distanced and attempts to minimize their impact on the participants. The researcher has to commute between the close relation to the research subject and the distance from the subject of interest. (Heggen and Fjell, 1998)

The researcher uses himself/herself as a research tool to study the subject of interest. The informants’ evaluation of the researcher is influencing the data’s in a particular way when ethnographic methods are employed. Informants make judgments on many levels about what is safe or acceptable to tell the researchers:

At first, they may judge the researcher in terms of such external characteristics as cultural background, age, gender and social status, obvious personality features, and, perhaps, professional background. As relationships deepen, the personality and culture of the researcher have more impact than “externally obvious” characteristics.” Lipson (in Morse 1991:78)

The researcher's gender, age, race, status etc- etc. as well as knowledge and experience linked to a particular field of inquiry will influence on what he/ she is able to grasp in the field. A researcher's attitude/ability to handle "the unknown", and the ability to observe and continuously ask questions to get the informants' opinions of particular situations, is moreover decisive in a participant observation context. According to Heggen and Fjell (1998) participating makes it possible to construct data from observation, conversation and documents. Participant observation is hence not about collecting and finding data, but the researcher uses him-/herself in constructing or creating data.

In carrying out participant observation is it important that the researcher participate in the field for an extended period of time while he/she systematically maps social processes. (Heggen and Fjell, 1998). What one in this particular instance will gain will necessarily also be coloured by a number of severe limitations such as for example; the atmosphere between the researcher and diverse persons in the field, the time spent in the field, the actual wards incorporated in the study, what shift the researcher took part, the season of the year etc.

By participating in the daily work at the hospital for a longer period of time the researcher will however gain a somewhat deeper knowledge of the hospitals inner life. In principle: the longer period the more knowledge is gained. At one point the ongoing activity and concerns in the field will become so familiar that you stop questioning them. One can become so blinded by routines that one sees little new (Field in Morse, 1991).

In a qualitative inquiry the researcher is to learn about the informants' concepts and practices as it is experienced, defined and made meaningful by him or her (Jorgensen, 1989). Heggen and Fjell (1998) write that health workers, especially nurses and doctors, are trained in systematic observation during years of educational training, and may therefore have an advantage when engaging in ethnographic research. On the other hand Lipson writes:

While simply being a good clinician does not a good ethnographer make, there are skills common to both endeavors: good interviewing and careful listening; astute observation and interpretation on several levels simultaneously (e.g., verbal and nonverbal behaviour, meaning, and context); and intentional use of self. Although the goals of ethnographic research are different from clinical nursing goals, the skills and

qualities that enhance rapport and trust are similar and will yield better data, whether for research or clinical assessment (in Morse 1991:77)

Throughout the process of participating observation the researcher is to write down what is seen, heard and experienced during fieldwork. The researcher is to write so-called 'thick descriptions' that reveal the large and recurring topics, as well as the diversity, the shades, the ambiguities and contradictions. (Heggen and Fjell, 1998)

Ultimately, the methodology of participating observation aims to generate practical and theoretical truths about human life grounded in the realities of daily existence. (Jorgensen, 1989: 14)

According to Heggen and Fjell (1998) participant observation research is characterised by openness and reflection which is important in the continuously ongoing analysing process. The purpose of analysing the data continuously is to find pattern or connections in the data material that can be attempted validated through the fieldwork. During the process of analyses the researcher is hence to search for recurring themes which are to be grouped into central categories which are eventually to create a systematic overview of the data in a manner that creates new knowledge on the topic.

Analytic strategies include looking for essential features, patterns, relationships, processes, and sequences, comparing and contrasting, as well as formulating types and classes. Analysis leads directly to making sense of field data or theorizing. (Jorgensen, 1989: 115-116)

3.1.3 Qualitative interviews

In depth qualitative interviews was in this study carried out with nurses at HLH and added to the information gained during the participant observation. Qualitative interviews are characterised by open-ended question, flexibility, sensitiveness and an informal atmosphere to grasp the interviewee's point of view (Kvale 2001). The interviews imply researcher's sensitivity to the informants' reactions on the questions or themes brought up in the interview.

The qualitative interview is commonly guided by an interview- or topic guide. Kvale (2001) writes that an interview guide should contain the subjects of the interest and the order of the subjects. The questions could be asked strictly as noted in the guide, or the guide could be used in a more flexible manner to as a broad reminder for the

researcher. New themes or information brought up during an interview session can result in follow up questions and may end a round of new information and new questions in the proceeding interviews with the same or other informants.

Kvale (2001) points out that it varies starkly how many interviews are necessary to carry out concerning a particular theme of investigation. The numbers of informants in a qualitative study will vary from one study to the next. Too few informants will make it difficult to draw links between the different parts of the information given and too many may limit the possibility to analyse the data properly. Knowledge in qualitative interviews is created between the researchers and the informants' views. (Kvale 2001)

The interviews are carried out between two persons and have an intimate character in the sense that it is to grasp 'deeper' knowledge of the informant's experiences or 'life world'. The researcher has to create the potential for this close contact before and during the interview to so that the informant's open up to the questions asked. If the atmosphere is not sufficiently relaxed or the theme is particularly difficult, informants may re-hold information and the value of the interview can be limited. On the other hand; the informant can also end up giving too much personal and emotional information during an interview session, and may end up feeling sad or empty afterwards. There is often a need to strike a balance between the two (Kvale, 2001).

According to Kvale (2001) the ideal informant does not exist. He notes that some interviewees seem to be more informative than others, and may end up functioning as 'key-informants' in the study. However, such informants do not necessarily provide the 'best' information and knowledge. Some people are more difficult to interview than others, but the interviewer's task is to motivate and help any informant to be articulate about the subject in question.

Kvale (2001) writes about strategies or methods of analyzing the interviews. The aim of analysis is to organize the interview text, condense the meaning, and bring up what is immanent/inherent (implicit) in what is said. Kvale (2001) describes five methods of analyzing; condensation of opinion, categorisation of opinion, narrative structuring, interpretation of opinion and opinion generation.

3.2 The present study

3.2.1 Modification of original plans

My initial plan was to focus more closely on nursing care to HIV positive patients and I had also planned to include interviews with HIV patients, asking them about the care they received. Since HIV-testing was not carried out routinely at the hospital, but only after suspicion of infection, and since personnel therefore generally didn't know if a patient was HIV infected or not, the vantage point for focusing more narrowly on HIV/AIDS was not feasible. I had moreover suggested a brief comparative study at Mbulu District Hospital, but due to challenges related to distance, time and transport; I decided to stick to HLH throughout the field period to gain as comprehensive a material as possible from this institution.

3.2.2 Ethical clearance and research permit

The project was cleared by the Regional Committee for Medical Research Ethics in Western Norway (REK III) (Cf. appendix A) and by the Muhimbili University College of Health Sciences (MUCHS), at the University of Dar es Salaam, Tanzania (Cf. appendix B), and was later approved by both Regional and Local authorities. I received 'Residency permit' from the Tanzanian national authorities (Cf appendix C) before the research was initiated.

I got access to the field through the NUFU programme; "Gender, generation and communication in times of AIDS: The potential of "modern" and "traditional" institutions." The contact with the hospital was made through my supervisor Astrid Blystad and other individuals linked to the NUFU project that has contacts at HLH. The project plan was sent to the hospital and was accepted before we arrived in Tanzania.

The hospital director and his wife welcomed me and two other Norwegian students in Health Sciences. They were informed about our projects and gave us the official permission to carry out our research. The director as well as the matron at the hospital introduced us to the hospital staff the next morning. They also initiated the first

contact with a 'contact nurse' (a nurse in charge), and ensured permission to participate in the ward activities and to recruit nurses as informants for the qualitative interviews. The nurse in charge recruited nurses as informant for the interviews

Nurses who gave me permission to interview them were informed about the following ethical principles:

- Their option to accept or reject the offer to be interviewed.
- The confidential handling of the information they shared with me
- That all presentation of data will be carried so that informants will remain anonymous in the study.
- That they might withdraw from the study without any explanation at any time.
- That they didn't have to answer questions they felt uncomfortable with

3.2.3 Participant observation

I used different approaches to gain knowledge on nursing care at HLH. Participant observation during the daily work at the hospital wards made up the fundament for the data collection. I was at the hospital for 3 months, joining nurses from three of the hospital wards in their daily work. I followed nurses during all shifts: during the day, evening, and night shifts, working days as well as on Sundays. While I was joining nurses in their daily work, I continuously carried out informal conversations and informal interviews with them.

The major part of the fieldwork was carried out at the Intensive care ward (ICU) supplemented by corresponding participations at the medical and surgical ward. I talked to the nurse in charge, informed about the project and made appointments before I came to each ward. All the employees at the wards were informed about the reasons of my presence by the nurses in charge.

I wished to spend the working days together with the nurses and take part in their daily work. The first day I was told that it would be difficult for me to participate in patients' morning bath, and was told that the reason was that I didn't speak Swahili, and therefore couldn't speak with the patients. I was also told that I couldn't follow a

nurse during morning bath because the patient was usually helped by only one nurse. This made me feel disappointed and wondering how it was possible to carry out the study without such participating. But the next day I nonetheless ended up taking part in the morning bath of the patients together with a nursing student, and after that I took part alongside nurses as participant observer or guided by a nurse for the rest of the field work.

I participated guided by nurses in all sorts of tasks at the ward, from collecting hot water, equipment, medication and bed sheets from different parts of the hospital area, through bedside work towards patients and administrative functions like collecting and noting down the results of laboratory slides in patients records.

Since I lived at the hospital campus, where the missionaries, some doctors, nurses, hospital employees, nursing students, and most visitors and students from the West stayed, I was practically 'in the field' 24 hours a day as the focus of attention at the campus was the hospital, its patients and employees. From time to time I returned to the hospital after duty to play with the children or to chat with the nurses. Several of the employed nurses invited me to their homes to meet their family, where additional relevant information was gained.

The nurses were my main source of information throughout the fieldwork period, but other health workers and hospital staff were enhancing my knowledge about nursing care at HLH as well. Some of the nurses I joined at the wards were also part of the hospital AIDS committee, and through them and the hospital managers, I was able to join the committee. During trips with the committee I gained more knowledge about the nurses' role as preventive health workers, bringing health information to people in the villages, and the challenges they faced in such tasks

To facilitate a deeper understanding the data was categorized in two parts; practical aspects of nursing care and relational aspects of nursing care. This was done by grouping the themes together and making up the categories and patterns.

3.2.4 Qualitative interviews

To obtain knowledge about nursing care for patients beyond what was observed while attending nursing work at the wards; I carried out four more formal qualitative in depth interviews with nurses employed at HLH. The main focus of these interviews was nurses' positive and negative experiences of working as a nurse, nursing education, and potential for further education.

The interviews were all carried out in the flat that I shared with another nurse researcher and her husband, and sometimes with more nursing students. It was important for the informants to carry out the interviews during their working time, and the nurse in charge was most helpful organizing this as well as informing and asking informants to participate.

All four informants gave written consent to take part in the study. The interviews lasted for approximately one hour. I tried to create a pleasant atmosphere during the interview. Before the interview I repeated the purpose of the study and the ethical principles that guided the data collection and gave them the interview guide. I served tea and cakes and made them decide whether to use the tape recorder or not. The tape recorder wasn't popular, so I wrote their answers by hand concurrently during the interview, and asked questions to ensure that I had got the content right.

The interview guide (appendix D) acted as a flexible guide during the interviews. The topics listed in the interview guide were raised, but the guide was not strictly followed. The nurses talked on the various issues, and answered the questions, but it was difficult to visualise a clear picture of situations due to the fact that no patient examples was expressed.

The interviews of nurses were analyzed by comparing the interviews with each other in search for commonalities and differences. Even though four interviews are few they may contain data of value, hence they were reviewed closely. The results from this analyses indicated that the interviews revealed little or no new knowledge and I decided to carry out no more interviews.

The project of comparing these findings with observations at the ward was however the most central piece of the work. In the presentation of the study findings, the

interview material is not presented separately, but is subsumed under the presentations of the various themes.

3.3 Evaluation of the methodological approach

3.3.1 The researcher's role

I will give a brief presentation of myself, challenges I met during the collection of data and an evaluation of my own role. As Lipson (in Morse 1991) states the researcher employs the "Self" to the extent that it is vital that the reader gains a minimum of knowledge of the person conducting the inquiry.

At the time of the research I was a 39 year old, female Norwegian nurse. I am married and the mother of three teenagers who all were in Norway while I was in Tanzania. My nursing education was completed in 1988. I have special training as nurse anaesthetist and administration. I have been working in an intensive care unit with premature and seriously ill newborn babies, with elderly people who live at home, as well as in an institution for elderly people. Most of my career has been spent working in the Haukeland University Hospitals' acute wards. I have had employment as nurse in charge as well as assistant unit nursing officer. I have particularly been preoccupied with professional standards of the nursing care in the orthopaedic unit at Haukeland University hospital, Norway and have been interested in the nurses' practical encounters with the patients. This background and professional interest create an important backdrop for the engagement in the present study.

3.3.2 Methodical challenges

In any qualitative study the researcher will naturally colour the kinds of encounters he/she is able to obtain with the informants. In my case, my background as a white woman, Norwegian nurse anaesthetist and a researcher would naturally be seen as a potential disqualifier with regards to access to the field and to gain "correct" information. As in any study it seemed likely that the informants would be inclined to

give me the answers they thought I would like to hear. In this case the nurses would possibly be likely to tell me about and show me the ways of acting and addressing patients they had been taught at the nursing school. Examples of this were observed from time to time, especially at the two wards where I participated for only two weeks each. But, the nurses whom I shared whole working days appeared to become relaxed and free, as I did myself, telling me about their concern for patients, their frustration at work, their working conditions and how they planned their work in diverse ways. Some of the nurses I accompanied more often became particularly important sources of information. Some of them gave me substantial information during concrete situations and spontaneously initiated talk or reflections on care.

Sometimes I also experienced nurses who asked me not to tell anybody else what he or she had said to me, and some nurses said that they shouldn't have told me something they had said. This kind of information is obviously not presented in this thesis or the information is expressed in a general way.

As stated above I found that the interviews had limited value in the sense of adding to already gained information. I experienced that it was the asking of questions during and after practical working situations that gave me the most valuable information and insight.

3.3.3 Challenges of involvement and distance

From the researchers' point of view many challenging nursing situations occurred during the course of the fieldwork such as babies dying from disease easy to treat in richer parts of the world. In a couple of cases where it turned out that I could do something about the situation, I ended up interfering, e.g. explaining a nursing student how to ventilate an intubated baby. In such cases, nurses at the ward would be the authorised instructors.

Some nurses told me that they wished to learn about nursing care as Western nurses' practice it in intensive care units, making me feel uncertain about how to get involved and at the same time try to keep a distance. Sometimes nurses asked me to teach them a particular procedure, especially in connection with the judgement of observations

and the practical solutions to be chosen. As expected in a participant observation study my interference may have changed the situation somewhat.

By taking part in nurse's daily work, I tried to become a part of the nursing staff. After a while I felt fairly well accepted and trusted to carry out nursing tasks as an assistant to the nurse I participated with. But I nonetheless remained an outsider throughout the fieldwork; nurses and ward attendants in friendly manner laughed at my awkward ways of going about particular chores, or the way I said something.

Initially I tried to make some brief notes at the ward, but since this was so different from the work most nurses did it was more disturbing to my contact with the personnel than helpful, and I decided to rather use the spare time to make field notes.

3.3.4 Challenges of language

At HLH most patients spoke Swahili, but use of the various ethnic languages was common. Most nurses used their local language as well as Swahili and English. Nurses often spoke to the patients and relatives in their own language and then translated what the patient said for the sake of the doctors and Western nurses.

Communication was a huge challenge to me. I wanted to be part of the nursing team and struggled a lot to understand situations where I didn't understand what was said, although nurses often translated to help me. Nurses and other hospital employee primarily spoke Swahili or the local languages, but central messages were translated to me, and the nurses always answered me when I asked about their opinion of a situation, about what had been said, what had happened and the like.

Practical nursing care has its own 'language' however, and after some days in the 'field', I often experienced that I worked together with the contact nurse like in a team knowing what to do without saying a word. In these situations words could even be disturbing. Body language like a grimace or the wink of an eye could say more than words.

3.3.5 Challenges of culture

Culture differences and similarities were observable at many levels. At HLH there seemed to be several cultures, there is a hospital ‘culture’, a Norwegian Christian ‘culture’ in addition to the numerous ‘cultures’ represented by the lives of the people working at the hospital, as well as the ‘culture’ of the patients and their relatives who were largely coming in from the surrounding villages. The cultures of the various ethnic groups in the area make up the most visible contrast to the hospital setting in terms of dress, decoration, language, food etc.

The hospital culture will in a number of ways remind us somewhat of Norwegian hospitals “some years ago” both with regards to technical standard and ways of organizing the workforce. Doctors and administration are in charge and create the platforms from which the work is carried out, while nurses and nursing leaders follow the mandate as far as possible. Since economic support, expert knowledge and administration are largely canalised through the Norwegian Lutheran Mission, the Christian culture in some ways dominates, although actual influence of the various ‘cultures’ depends on the viewing angle of the hospitals dynamics.

I have tried to get acquainted with some central aspects of these cultures by reading the existing literature and through continuous talk with people throughout the fieldwork.

3.3.6 Evaluation of researcher’s role

As one of many Norwegian women visiting HLH, I think I was perceived basically as another outsider, which in many ways was quite fortunate. It was however noted that I participated in all kinds of work at the wards and was present nearly daily for three months. The nurses hence learned to know me, they appeared to become fairly free in my presence, and I felt that I became quite close to some of them. Since my presence at HLH was limited in time there was still many things that were not shared with me as a foreigner. It is moreover likely that the staff would strive to perform somewhat better work when I was present, as would be natural in any research setting.

I had heard and read a lot about the Tanzanian culture, but the smell, the heat, the sights that met us in HLH were both exiting and frightening; dress, conduct and the very different landscape created stark contrast to what I knew from Norway, but I very soon got accustomed to the new setting, and managed to focus on nursing care.

All in all, I do feel that I managed to gain a fair overview of the practical work of nurses, the position and engagement of the patients and their relatives, nurses as well more sporadic glimpses of the work of the other categories of health workers. I believe that trough the fieldwork I grasped some central aspects of the atmosphere and workings of the hospital, not the least in terms of nursing care for patients.

4. Haydom Lutheran Hospital

This chapter will present some central aspects of the facilities and services of HLH, and will simultaneously function as an introduction and guide to the practical examples in chapter 5. The main emphasis will be placed on the hospital services, procedures etc. that differ from those in a common Norwegian hospital setting.

4.1 A brief presentation of Haydom Lutheran Hospital

HLH is a church hospital in Mbulu District in northern Tanzania, run by the Evangelical Lutheran Church of Tanzania together with Norwegian missionaries since 1953. The Norwegian Lutheran Mission was asked by the existing colonial authorities to build a hospital with about 50 beds, mainly to develop a relatively remote area that had recently been cleared of the tsetse flies. Today HLH has 350 beds, and nearly 400 inpatients. (HLH at the internet 2004)

The hospital area consists of large one-floor buildings and surrounding yard areas. In addition to the hospital buildings, the hospital area contains a nursing school (boarding school), dwellings for employees and visitors, and a large garage. Every ward in the hospital has its own separate building structures, and there are separate buildings for operating theatres, x-ray unit, outpatient clinics, examination rooms and offices for doctors. There is also a separate administration building and a hospital pharmacy (the drugstore). Most patients have relatives accommodated in separate housing, also on the hospital grounds. This is due to the fact that relatives perform a major part of the cooking and caring for the patients. Living within the hospital confines allows them to cook, rest and sleep at a period when they are key care takers of their relatives.

The hospital has a surgical ward with reception, a medical ward, a tuberculosis (TB) ward, a paediatric ward, a maternity ward and an intensive care ward. The need for security against theft and armed robbery has made it necessary to secure the hospital area with double metal fences as well as a guarded entrance.

During my stay at the hospital I worked at all major sections of the hospital except for the operating theatre, but the primary field data were acquired through participation in the daily tasks on the intensive care ward, supplemented by participation in the medical and surgical wards.

4.2 The physical layout of the wards

The intensive care unit is an open atrium-like ward having a nominal capacity of 18 patients, a number which is often exceeded. The ward consists of one large room and a smaller room with space for two patients (infection sluice room) and a single room. The main patient room is L-shaped. There is no separate nurses' office, but the main patient room has an office table and cabinets containing medicine and medical equipment as well as a washbasin. The patients with the gravest conditions, including patients recovering from surgery, are placed close to the office table. The ward does not separate male and female patients. In addition to the patient areas there is a sluice room and a kitchen, which, like all the ward kitchens in the hospital, is used for cleaning and sterilising equipment, and not for cooking or preparing food. The ward contains three patient bathrooms (one with toilet and washbasin) and separate staff and patient toilets. Unlike in the other wards, the toilets in the intensive care ward are all western-style water toilets.

The medical ward is divided into two sections, separating male and female patients. The physical layout is a square, with an open atrium containing a large tree at the centre. The medical ward takes up three sides of the square while the fourth side houses the drugstore. Of the three sides utilised by the ward, one is used for offices, toilets and service rooms such as the kitchen and sluice room, while the other two are patient areas, with male and female patients occupying one side each. The ward has two offices: one for the male and one for the female section of the ward. The ward toilets are of the latrine (hole-in-floor) type with flushing water. Both the female and male sections of the ward contain a room for patients with heart and lung diseases, as well as a larger area for general medical diseases. The male section of the ward also has a (very dark) room for psychiatric patients. In the corridor outside these rooms there are some beds for patients who have been discharged from the hospital but are

waiting for relatives to pay for their hospital treatment. The patient areas are generally crowded with beds, some only 20-30 cm apart.

The surgical ward also has separate rooms for men and women, and here too we find an office, a kitchen, a sluice room, and male and female bathrooms with toilet. As in the medical ward, there is little space between beds.

The reception consists of a large hall and an office used by the doctor/clinical officer for the examination of new patients. There are also two large bathrooms and some administration offices (radio connection with ambulances etc.) linked to the hall. The hall has benches for patients who are waiting and trolleys used for resting and transporting patients.

4.3 Practical Services at the hospital

4.3.1 Infrastructure: communication

Walking was the common way of nurses' and ward personnel fetching doctors or making contact with others at the hospital. The hospital had no pagers and during my stay there I witnessed no internal telephone being used although there is an internal telephone system. Nurses do also walk to the drugstore to order necessary drugs and later to collect them, thus have to leave the ward to contact other health personnel for patient services, urgent or ordinary, at night as well as during the day.

There is virtually no internal hospital transport service and members of the nursing staff have to assist with transport of patients for medical examinations, x-rays etc. The lack of a transport service means, for example, that the nurses have to deliver laboratory orders themselves. The only internal hospital transport service I observed was the laundry service, taking clean sheets and clothes to special clothing rooms in the wards.

The hospital has an external telephone line and a radio for ambulance communication.

4.3.2 Laundry

The hospital beds have thick, soft sheets in white/grey or red/lilac. The bedding consists of sheets and blankets and occasionally pillows with pillow-cases. The hospital laundry handles all laundry from the wards, the operating theatre and the rest of the hospital, mainly sheets, and it is washed in large washing machines. The laundry is dried in the open air, either hung out or spread on the ground. There is no alternative for rainy days; the wards will have to live with moist- or wet sheets.

There is a shortage of sheets, and due to the lack of clean sheets in the mornings, many beds are made without a change of sheets. In such instances the sheet will be turned over, or the top sheet may be turned around to place dirty parts over the legs and the cleaner part near the face. From time to time, when there are no clean bed sheets at all, blankets will be used, even if they are too small to cover the mattress. When there is a severe lack of clean sheets, a dry sheet will not be changed even if it smells of urine. Paper nappies or disposable bedclothes are not available at the hospital. Incontinent patients commonly have urinary catheters to prevent wet bed sheets.

4.3.2 Ward cleaning and water supply

The rooms of the wards have grey cement floors. Floors are cleaned every morning after the morning bath, and sometimes also at other times of the day, using hot water and soap to soak the floors before they are wiped. The floors dry fast in the warm, dry climate. The bathrooms are cleaned by letting hot soapy water flow over the washbasins, toilets and floor; the toilets are cleaned using a brush.

The wards have few washbasins compared with a Western hospital. The washbasins have cold water only and are equipped with small wet pieces of soap. The intensive care unit has a single basin for washing hands in the patient areas. The two other wards have washbasins in the offices, but there is no possibility for washing hands without leaving the patient area. Most toilets do not have washbasins. The bathrooms do, however, have water taps on the wall. All wards have sinks/washbasins in the kitchen and the sluice room. Hot water is fetched in a wide assortment of plastic tubs

from a tap outside the laundry. The nursing students, ward attendants, nurse assistants and (sometimes) nurses spend a substantial amount of time waiting in a queue to collect hot water in the morning.

In the intensive care unit the beds are fully cleaned before re-use. Attendants will clean everything from the mattress to the wheels. If there were few patients in the intensive care unit all the staff, except for the doctors, would help each other with the cleaning of equipment, walls, curtains etc.

4.3.4 Drugstore

The hospital has its own pharmacy (the drugstore) which stocks drugs as well as equipment such as washing powder, needles and urinary catheters. When the drugstore runs out of equipment, the nurses and other staff have to improvise.

Medication is prescribed by doctors or clinical officers when they make their rounds. The medicine locker has a limited amount of drugs, which means that nurses have to make a daily visit (except Sundays) to the drugstore to collect medication. After the doctor's round, the nurse in charge of medication enters the medication prescriptions in various books. The written prescriptions for each patient are taken to the drugstore along with the ordering books and ampoules and syringes etc. for change. This procedure is rather time-consuming for the nurses. When the nurses collect their orders they have to check the collected medication against the order and finally check the number of tablets supplied. This tedious procedure may explain why tablets dropped on the floor have been observed being reinserted in the container. Tablets are rarely thrown away even though they may be contaminated. Fluids for intravenous (IV) infusions are made locally at the hospital (in the operating theatre), and are stored in re-sterilised glass bottles.

The procedure for handling and changing sterile equipment is rather different from a Western hospital. An intravenous set for example is only replaced if it has been soiled by blood. If the fluid flow stops or runs too slowly, a needle will be used to pierce the bottle seal, allowing air to enter the bottle. The needle in the intravenous set is not replaced when a new bottle of fluid is added.

4.3.5 Hospital kitchen

There is a kitchen in the hospital where tea is prepared for the employees. On all duties, members of staff are served hot tea with lots of sugar at tea-time. Staff has to supply their own meals or have them brought by relatives. The meals are consumed in the ward kitchen or in the hospital canteen.

A few patients get meals prepared by the hospital, ordered by the doctors/clinical officers, but most patients depend on cooking services carried out by relatives. The relatives cook in the area of the hospital in which they are accommodated. Facilities consist of fireplaces on the ground. Firewood, charcoal pots and the ingredients for the cooking have to be brought in to the hospital.

4.3.6 Medical technical equipment and know-how in the wards

HLH is given new or second-hand medical technical equipment from Western hospitals. From a “Western” point of view, the amount of medical technical equipment available to assist nurses and doctors in the continuous observation and treatment in the wards is limited. In some cases, technical knowledge and practical training in the use of the available equipment is also far more limited. For example, the hospital has a respirator which no one can use properly. There is also an ECG monitor seldom in use. There are furthermore a few frequently used transportable pulse oxymeters (finger probes) used to measure pulse rate but not pulse wave. The hospital is unable to perform an arterial blood gas analysis to verify the pulse-oxymeter reading. During my stay, a Western doctor brought a machine for automatic measuring of blood pressure to the medical ward. Members of the nursing staff were shown how to operate it, but they were not taught the limits and technical function of the machine.

The supply of oxygen comes from a machine that extracts oxygen from the air, but the concentration of oxygen is limited (maximum of 40-50%). The intensive care unit has two or three such machines, while the other wards have no access to oxygen treatment. If a patient in one of the other wards needs oxygen treatment he or she will be transferred to the intensive care unit.

Suction equipment is also limited to the intensive care unit, and if patients in other wards need suction they will be transferred to the ICU. The suction-machines are mobile, need electrical connection and are located in the operating theatre and the intensive care unit.

4.4. Nurses' education and working conditions

4.4.1 Education

The nurses at HLH have several levels of professional titles, based on experience, education and responsibility. The list below shows the hierarchy of nursing titles:

- Matron, Patron, Nurse Officer I and II are titles given by the hospital to nurses with long experience and special functions.
- Nurse Officer III implies completion of five years' training for psychiatric nurses, midwives, nurse anaesthetists and nurse leaders (upgrade for skilled nurses with three years nursing education)
- Nurse Officer IV, or Midwife IV implies completion of a four-year course at the Haydom nursing school (started 1984)
- Nurse Assistant implies two years training. Nurse assistants are allowed to perform some types of injections, measure blood pressure and give patients body washes.
- Ward Attendants have no particular training. Their main occupation is to make beds, carry out cleaning and related tasks.

All ward employees have uniforms, the men wearing shirts and trousers and the women dresses, but in different colours. Nurses wear a nursing uniform, the titles and numbers embroidered on the shoulders indicating their level of education and their responsibilities.

As in Norwegian education, nursing education in Tanzania has changed over the years. Experienced nurses who qualified less recently will have completed standard 7 (seven years' of elementary school) and attended a one-year pre-nursing school before embarking on their nursing studies. More graduates will have completed four years of secondary school after standard 7 before starting their nursing studies.

Many nurses at the hospital have a desire to extend their qualifications. The nurse anaesthetist course seems to be the most popular one, but intensive-care nursing would stately also have been if it were available. The matron says she would like her staff to have additional qualifications, but the hospital can't afford to let many nurses acquire this type of competence. The emphasis during the year in which this study was carried out was on the upgrading of assistant clinical officers and doctors.

4.4.2 In-house education

Every Thursday, with a few exceptions, a nurse, doctor or clinical officer gives a joint lecture at the hospital. In-house education on the wards was however fairly rare during my stay but nurses explained that a teacher at the nursing school would occasionally instruct them in the use of new equipment in the intensive care unit. The technical medical equipment obviously had no focus of the in-house education and the nurses were unable to explain the functions and limits of the present equipment.

4.4.3 Working conditions and organisation of work for nurses

Nursing students pay tuition fees and commit themselves to work for two years at the hospital after their graduation. Compared with the wages at other Tanzanian hospitals, the salary for nurses was said to be relatively low (about 40-60.000 TSH = 320-480 Norwegian kroner per month). As in most Tanzanian families, many nurses and their families have plots of agriculture land and cultivate large parts of what they consume. It is not uncommon for nurses to leave the hospital after the two mandatory years of service.

Nurses are given a one-month holiday each year (resting month). Women giving birth get three months off – provided there are three years between each birth. If there are fewer than three years between the children, the mothers are entitled to a six-week maternity leave. After the maternity leave the mother works a combination of day and afternoon duties, allowing her to nurse her baby. New fathers get a couple of days off.

The organisation of the work is systematised in a written monthly duty roster. Most nurses have one ward as their primary place of work, but they may at times be assigned to work in other wards. They work six days a week and every other Sunday on day-, afternoon- and night duties. More than ten working days in a row is common. The following are examples of the monthly rosters for three nurses:

“Keys for duties; D=Day shift, A=Afternoon shift, N=Nightshift and F=Free/off

- 1. FAADAAADNNNFFAADADDDNNNNFFFAAD*
- 2. DDFDDDDDDNNNNFFFAADDAAANNNNFF*
- 3. NNNFFDAADDDAADDDADDDNNNNFFFAAA”*

The morning duty lasts from 07.30 to 14.30, afternoon duty from 14.00 to 21.30 and night duty from 21.00 to 7.30 or 08.00. On the night duties there are one or two nurses on each ward: in the medical ward there is one nurse, while the surgical ward and intensive care unit have two nurses each. One of these nurses is always “on call”. This nurse is highly experienced, has keys to the little drugstore for the supply of equipment and is therefore able to help the other nurses if they need assistance.

The nurse in charge has no office, and manages the staff by taking part in the daily duties in the ward rather than administrative work like making written plans for the working day. The nurse in charge works only daytime shifts, six days a week including every second Sunday. A nurse in charge will take part in the doctor’s rounds, will have an overview of the patients and decide which jobs the different members of staff are to carry out each day. Compared with a Norwegian working environment, their work would seem to correspond to that of a team leader.

At 8 o’clock every morning (except Sundays) all hospital employees leave the wards for morning prayer and information at the nursing school. This meeting usually lasts for about one hour but if there is a lot of information or a lecture is given, it may take two or three hours. Only the intensive care ward will have a nurse stationed on the ward, but many nurses may leave the meeting after prayers to take care of the patients.

4.4.4 Reporting

The handover of information from one duty to the next is done largely by verbal report: In the intensive care unit, the nurse walks from one bed to the next and reads aloud in English from the written report of each patient to inform the next-duty staff. The report is written in a rough book, containing the reports of all patients at the ward. If there are questions regarding the previous duty, both questions and answers will commonly be stated in Swahili. However, due to the frequent presence of foreign students, health workers and visitors, the official language of the hospital is English.

The written report in the rough book makes up a short evaluation and includes the name, diagnoses and a little information about how the patient has fared during the duty – with comments such as “slept well”, “condition bad”. At the two other wards the report is given in the nurses’ office, where the nurse reads aloud from the written report mentioning patients or situations needing special attention, such as patients who are due for medical examination, surgery or an x-ray on the day in question. None of the written patient documentation (patient notes) contains any major qualitative observations. The patient notes hence provide little information about nursing observations and activities.

I asked one of the ward sisters how they report qualitative nursing data about the patients (such as the appearance of the wound, the respiratory state or how the patient is coping and functioning), and he explained that:

- a written report (in the **rough book**) should be given from one duty to the next, but that this is frequently omitted. The nurses have no special form for entries in the **patient journal**, only a small space on the form for observation of vital signs.
- a verbal report is given in English (as above), supplemented in Swahili from one duty to the next.
- both written and oral reports focus on the patient’s general condition.

4.5 Patients and relatives

Distance, transport, financial circumstances as well as assessment of the condition of the patient, are all factors affecting when and how the patient comes to the hospital. There was substantial variation, but many patients had been seriously ill or injured for days or even weeks before they arrived. Patients use many different types of transport to get to the hospital, including walking, being carried by relatives or driven by ox-cart; they may also come by bus, ambulance or in rare instances sent by a private car. The great majority of patients are accompanied by relatives, many of whom help during transport, and stay on to take part in the personal care and cooking for the patient as well as for the patient's treatment.

4.5.1 Patients' conditions

The patients naturally come to the hospital with a great variety of injuries and diseases. Many of these conditions, such as malaria, tuberculosis, snakebite, injuries caused by predator attacks etc, were foreign to me as a Norwegian nurse. Also the increasing numbers of HIV/AIDS patients were a new experience. The fact that many of the patients were coming to the hospital so long after they had fallen ill or been injured and were in a very bad state – indeed often in the later stages of disease - were also a new experience to me.

4.5.2 Role of relatives

There are relatives sitting by nearly every bed, helping the patients by keeping an eye on intravenous bottles, helping patients to the toilet or to bathroom. Relatives generally give patients bed baths, cook for and feed the patients, wash their clothes and often carry medication between the nurse and the patient. Moreover, relatives often assist by transporting, lifting and holding patients, or by holding equipment such as the oxygen hose and the intravenous bottle. Because they are commonly seated close to or even on the bed, they are often close spectators to the treatment of their relatives and other patients as well.

In the intensive care unit, it is the nurses or nurse assistants who give patients bed baths and who deliver medication to them. In this ward the nursing personnel sometimes help each other, unlike in the other wards where the relatives assist. Preparing food and feeding patients are still the responsibilities of the relatives.

Relatives assist the staff in several other ways: They perform the function served by the “bell” in Norwegian hospitals, calling nurses and doctors to the patient. This makes it necessary for the relatives to stay in the ward during the night. They sleep on the floor, under the bed or in the patient’s bed (mothers). They hold the patient during difficult procedures or when the patient is confused. Relatives often accompany patients at examinations, x-rays or transport to the operating theatre, and help them during the move to the examination bench. They inform nurses, doctors and clinical officers of symptoms and condition and ask questions about treatment, condition etc, on behalf of the patient.

The many differences in facilities and structures between HLH and a Norwegian Hospital entail differences in nursing practise and patient care. The next two chapters will focus on nursing care and nurses roles at HLH.

5. Nursing care at Haydom Lutheran Hospital

This chapter focuses on nursing care to patients at HLH and on nursing procedures. The presentation in the preceding chapter of facilities at the wards, nurses' education and working conditions as well as the patients' conditions, the relatives' roles etc. indicate that nursing at HLH takes place in a setting that in a number of ways is very different from a Norwegian hospital.

There are obviously a number of possible ways to focus study of nursing in hospital care, as a large number of appropriate topics will have presented themselves during months of fieldwork. I intend however to focus on a few of the ways in which nursing care at HLH emerged as different from that in a Norwegian hospital. I will in this chapter first focus on the communication dynamics between nurses and patients, before I turn to the handling of more practical aspects of the nursing profession. In the next chapter I shall concentrate on the relationship between nurses and other groups taking part in the care and treatment of patients.

Nursing care and knowledge is communicated in many different ways: by what is said, what is done or expressed through practical chores, through the organisation of the work or in their attitudes or perspectives on care. One important way to address nursing care is to access how nurses' at HLH address challenges in their daily work.

I will in the presentation draw upon some of the examples more than once, as they appear to be relevant in several contexts. The focus will be on differences in nursing care, not on what seems better or worse, right or wrong.

5.1 Characteristics of care and communication.

Aspects of the relations between those involved in nursing care and patients will be the major focus of this first part of this chapter. The communication with patients through continuous chatting and laughter will be focused. In an environment with many patients and relatives present in the patient areas and occasional substantial

limitations in terms of equipment, creativity is also an important part of the nurse-patient communication.

5.1.1 Small talk with patients

Whenever nurses at HLH were caring for patients or performing procedures they would nearly always simultaneously be talking or chatting with the patients. Nurses were observed communicating verbally in most ordinary care situations, providing small talk and information, as well as support and comfort in the specific situation. The HLH nursing staff is quite skilled in practical procedure performance. The nurses get substantial practical experience during their daily work; inserting intravenous needles, dressing wounds, inserting urinary catheters etc. This practical competence facilitates a true focus on the patient, as observed in the continuous flow of talk and comfort while procedures were carried out. This is illustrated by the following example:

A young woman with severe burns on her legs from the hips downwards has to have her urinary catheter and her bed sheets changed because the bag of the urinary catheter has been removed, and urine is leaking into the bed. Both the catheter and the hose of the bag are occluded by green pus and the bed is soaking wet. The nurse is talking to the patient and her mother, explaining and preparing them for the procedure to come. We remove the cage keeping the sheets and blanket off the wounds. The patient feels cold and indicates that she is reluctant to face the coming procedure. The nurse talks calmly to her. He has brought two pairs of sterile gloves, the first pair he uses to remove the catheter, checking the catheter balloon several times to be sure it is emptied, before he removes it, carefully keeping eye contact with the patient. The patient is whining, and he stops and waits a bit before he removes the catheter. The patient's legs are covered with infected wounds. It is very painful for her to move her legs, but the nurse is patient and tells her that she has to move the knees further apart. The nurse puts oil on the catheter, inserts it with good precision and connects it to a new bag, while talking and listening calmly to the patient and her mother.

This continuous small talk with the patient characterises most patient-nurse encounters. Sometimes the procedure may be problematic due to lack of equipment and the nurse has to make choices and needs to prepare and comfort the patient. An example follows:

A teenage boy is having an intramuscular injection. The fluid is thick, white and difficult to inject, so the nurse explains to the boy that she has to use a big needle because it is better to give him one stitch with a big needle than three stitches with a finer needle. But unfortunately she has to give him three stitches with big needles (changed needle twice) because the needle is occluded. The nurse talks calmly to the boy throughout the procedure, trying to make him relax. But the boy is unable to relax,

so she spends some additional time to comfort the boy. Afterwards the nurse tells me that she waited with this injection until the end because she knew it would be difficult.

Continuously small talk indeed appeared as a highly characteristic feature of the nurse- patient interaction, and did not appear to be linked to my presence, but was observed also in the nurse-patient encounters where I was not a part of the care situation. As I got used to situations of continuous chatting in nurse- patient interaction, I became highly aware of situations where talking was absent. I will refer to one example of a serious situation where all the nurses and other health workers said very little; there was only whispering to be heard, and nearly all communication was taking place through the careful handling of the patient:

A little boy is suffering from burns all over his body (petrol-related burns). He is looking at us with big frightened eyes, but is not uttering a sound. He is given venous cannula infusion and is transferred to the intensive care unit where he gets Pethidin, a urinary catheter and a shelter to keep him warm. All nurses are working calmly, speaking in hushed tones, and moving the child carefully. The next morning the boy is dead.

On a few occasions, moreover, I observed real exceptions to the general talkative encounters between nurses and patients. During the encounter below communication appeared different and difficult:

A newly qualified female nurse is putting a dressing on a woman with a femur amputation. The wound is open (all the stitches are gone) and infected. The woman is in great pain and is complaining. The patient tries to move away from the nurse and her voice is high pitched and appears angry. The nurse gets irritated and tells the patient to hold the leg (stump) in the right position, but there is no small talk while the wound is being dressed nor after the dressing is completed.

The continuously chatting appeared as different from Norwegian nursing setting. This particular aspect of the encounters between nurse and patient obviously became very visible to me because I couldn't understand the spoken words. I paid substantial attention to the voice range, eye look, facial expression as well as hands and body movement while the words flow between nurse and patient.

5.1.2 Humour

My impression of the general atmosphere in the hospital is one of people talking and laughing everywhere. Compared with a Norwegian Hospital, the atmosphere is very light and extremely social. Members of the hospital staff are continuously making

jokes about each other and of the Western people present, and they will sit down together for a chat whenever there is an opportunity. On a national holiday, when there were few patients in the intensive care unit, the ward staff cleaned the carpets, walls, equipment etc. amidst continuous happy chatter and laughter. Laughter and humour simply appeared to be a part of the daily work and discussions usually appeared vehement and loud. Nurses often translated to me, telling me about what had been discussed and the different opinions, and they were commonly expressed in a light tone revealing why people had laughed.

Many nurses in the three wards state that their nurse in charge is a good leader who takes care of his or her employees and listens to them. This assessment refers to discussions about how he or she handles who is going to perform which duty on a specific day, or to the help that is given if a nurse needs rest or support or faces difficult patient situations. The fact that these leaders are also humorous with a positive and light attitude towards their employees is not directly brought up by the nurses, but to appeared to be an important aspect. There is a lot of jocular exchange taking place between the nursing leaders and their employees.

Communication between nurses, patients and their relatives also appeared to be open and characterized by frequent exchange of funny comments. Humour indeed appeared to be a natural part of communication in large number of situations in which nurses were caring for their patients. The following is an example from a wound-dressing situation:

The female nurse enters the patient's room, greets the teenage girl and her mother, and hides the bed with a folding screen, talking to the patient as she helps her to remove her clothes. One of the arms is difficult to get out of the dress, and both the girl and the nurse laugh about the completely stuck arm. The nurse removes the bandages, looks at the wound, which looks pink and clean, and washes it with a compress/gauze on a forceps wetted with normal saline. She tells the patient how nicely the wound has healed and the girl nods and smiles. The nurse cleans the wound, changes the bandages, continuously talking with the patient. In fact they both joke and laugh all the time as she carries out her task.

The next example is from an ordinary morning bath:

The nursing student uses a small table for the equipment and a folding screen to shield the bed from other patients and relatives. Like most nurses, he talks continuously and calmly with the patient during the bed bath, and there is plenty of smiling, joking and laughter. The laughter increases when the student accidentally spills water onto the bed and has to change the bed linen. Several times during the day patients and

relatives point to the bed and start laughing when the student enters this part of the ward.

Smiles and laughter may also appear in difficult situations, as in the case below:

We are working at the intensive care ward when a man starts talking to the nurse and both of them keep talking and laughing. After a few minutes nearly all of the patients and relatives nearby are laughing. The nurse explains to me that the man wanted to move to the surgical ward because there are so many patients dying here. "You see" she says, "Many patients are afraid of coming to this ward because they think of it as a terminal ward where they are going to die". "But this man's condition is good," I told her. "I know, but the patients don't know that it depends on their condition, and they are afraid" she answers.

5.1.3 Time

The nurses spend more time caring for patients in specific situations than most Norwegian nurses would do. What a Norwegian nurse would regard as "efficient" use of time is perceived differently in HLH.

Sometimes nurses told me that they were busy, but I could not see them bustling around or looking stressed. The nurses did not walk quickly or in a rushing manner, they simply walked at an ordinary walking speed. Even when the nurses said they were extremely busy, they didn't run or shout to get things moving quicker. Even when expressing that they are busy, they nearly always spent all the time they felt they needed in situations where they were caring for patients. To me it seemed as if 'being busy' meant 'lots of work to do' or 'too few nurses to do the work', but that it had little impact on the speed at which the work was being performed by the nurses.

Below is one example:

A young woman with severe burns is having a bath. The patient wants her mother to be present before she gets into the bath-tub. The nurse waits for the mother for about half an hour even if he has lots of other things to do. The nurse hardly gets any tea-break that day.

Indeed, seen through Norwegian nursing eyes, nurses in HLH nearly always seemed to have lots of time. While they were waiting for something, they would talk with the patient, with the relatives or with other members of staff. I never heard anyone talking about using time more efficiently or hurrying, although that could obviously have taken place without me grasping it. The nurses spent a lot of time explaining things to

me, and neither on such occasions did I hear anyone saying it disturbed their work, even if I was quite aware that it sometimes did.

In Norway most patients arrive at the hospital in the daytime unless the patient's condition is acute. At HLH patients often arrive and get an examination or treatment for ordinary diseases during night duties. The inconvenience that would have been perceived had this happened in a Norwegian setting was never mentioned verbally and was very probably not experienced by staff or patients.

A number of small children were brought by their parents from the outpatient clinic and started to arrive at the surgical ward from 3.30 a.m. onwards for regular intramuscular injections. The two nurses greeted them and gave them injections without complaint, even though the morning medication and the report for the day duty staff were a bit delayed.

A three-year old girl is accompanied by her father because she is not able to walk properly. They arrive in the middle of the night, but both the clinical officer and the nurse assures me that a nightly arrival presents no problem, and they welcome the father and his daughter properly.

During morning prayer there is only one nurse on the wards – in the intensive care unit. From time to time there are no nurses present at all. As was indicated in the previous chapter, the way the hospital is organised implies that the nurses have to leave the wards for many reasons; to order and collect medication or equipment, to fetch hot water, to contact a doctor/clinical officer, to accompany patients to the x-ray unit or the operating theatre etc.

The amount of time spent on work performance seemed to be of less importance than in a Norwegian setting, and sometimes it was perceived by me as 'inefficient'. An example from the drugstore;

I arrive at drugstore and ask the employee at duty for new razor blades. He asks me to go to the other door. I cannot see anyone inside so I knock on the door and call "hallo". After a while the woman inside approaches me slowly. She is serving me and two other customers simultaneously, and it takes a long time before I am back at the ward with the two new razor blades.

Occasionally nurses are moreover late for duty or simply disappear from the ward:

The nurse in charge left the ward to contact a doctor to discuss a patient, and when he returns to the ward, only one of three of the afternoon-duty staff are present. While he is giving the report he notices the table-mat with equipment from a dressing. A female nurse, assigned from another ward, has not cleaned up after dressing, and she has not been in the ward for the last one and a half hours. The nurse in charge seems irritated for a second, but puts the equipment away and continues with the report.

Once I accompanied a nurse while she visited patients who were her relatives or friends and carried messages between relatives at two different wards for about an hour during her duty. On that day her duty was wound-dressing, but she explained that the equipment wasn't ready yet.

When the daily work had been completed in the intensive care unit, the more experienced nurses often looked after the patients by walking around the ward. Most nurses would follow up the newly operated patients, but nurses from other wards and inexperienced nurses sometimes failed to do this, as is seen in the example below:

There is only one hour left of the day duty, and the two newly qualified nurses are sitting talking. I ask them if we should do a round to check the patient's condition. The answer is "no – the patients or relatives will call if necessary".

In the next section we shall turn the attention to a few particular phenomenon dealt with by nurses worldwide, but that nonetheless gained particular attributes that emerged quite different from Norwegian settings.

5.1.4 Care related to pain

Taking care of patients in pain is a very different matter at HLH than in hospitals in Norway. Of course the limited availability of drugs, the equipment and treatment paths mean that options remain very different.

At HLH analgesic drugs are administered as tablets or intramuscular injections in the wards. Pethidin is the analgesic drug used for intramuscular injection and is only used in the intensive care unit. There are other analgesic tablets, but Paracetamol is the most commonly used analgesic. Epidurals are used for anaesthesia in the operating theatre only, but are not employed postoperatively. Newly operated patients get intramuscular injections. Patients needing analgesia for more than one day after surgery will be given Paracetamol tablets to treat their pain. Analgesia or other pain treatment is seldom used before procedures like intubation, insertion of a urinary catheter, insertion of an intravenous catheter or removal of a thorax drain. Local analgesics are not available in the wards and nurses do use oil when inserting urine catheter.

In a setting where so little analgesia is available, particular demands are put on nursing care. Since many nursing procedures cause pain it is important for the nurses be able to perform them quickly and with good practical performance to reduce the pain to a minimum. As stated earlier nurses in HLH get a lot of practical experience in executing procedures and are excellent in their performance. The following is an example of inserting an intravenous cannula:

A small child in reception is sitting on its mother's lap, the child is crying and the mother looks terrified. The child is having an intravenous cannula inserted and the male nurse puts the needle in effectively and with high precision, calming both child and mother.

In Norway breast milk or sugar water is sometimes used for babies to reduce the pain caused by blood sampling, at HLH I made many observations of mothers' breast-feeding their children after painful procedures.

The prompt response to some acute pain situations may provide pain relief, even if the procedure itself temporarily increases the pain. Here is an example:

The patient had a prostatectomy four weeks ago, but is still on rinsing. He is in major pain due to the catheter being blocked by coagula. The nurse flushes the catheter with saline water as the rinsing will stop the pain when the coagulum has been removed. But the pain is increasing during the procedure, because of the pressure. Afterwards the nurse explains to him and his relative the importance of drinking lots of drinking water, tea and other drinks to avoid new occlusion.

Another way is for nurses to use their competence by distracting the patient from the pain by small talk and comforting. The following example illustrates this:

A teenage boy has been operated on for bladder stones. The nurse talks calmly to the boy as she removes the bandage and listens to what he says. The bandage is stuck and the boy is highly uneasy. She tries a bit harder to remove the bandage, but it is completely stuck. She uses some of the washing water to wet it, and carefully removes the bandage. There is a drain (finger of a glove), which she removes before taking away the rest of the bandages. The boy complains and she talks to him, calmly and carefully. She washes the operating wound, covers it with compresses and plaster. The boy is communicating the pain this procedure causes but, the nurse talks to him and strokes his cheek.

HLH doesn't have a medical anaesthetist. It only has nurse anaesthetists who work in the operating theatre and assist patients in acute situations at the wards. It is the surgeon who orders any postoperative analgesic treatment.

The recognition of pain in patients is the same at HLH as in Norway; and nurses are aware that you cannot simply look at the patient to tell if he is in pain or not. To

evaluate the level of pain you have to ask the patient. But nurses have differing approaches to the administration of analgesic drugs like Paracetamol to patients with pain. Some follow the doctor's orders strictly and supply the patient with the exact number of tablets, while others supply them only when the patient complains of severe pain. Analgesics are furthermore used only for a short period of time. Nurses explain that they are afraid patients will build up dependency even after the first dose of Pethidin. Paracetamol is also only used for a few days so as 'to avoid liver problems'. There are also differences in the reasons for giving analgesics – as prevention or as treatment for pain. Below I will give some examples. The two first concerns the same patient in two different situations: having a bed bath and having a bath in a tub:

The nurse wants to wash a little boy with serious burns of his upper body, using normal saline on compresses. When it starts to hurt the nurse asks another nurse to give him intramuscular Pethidin. She also asks for a doctor to come and have a look at the patient's wounds. The nurse waits until the child is nearly asleep before she starts cleaning the wounds.

The same patient is having a bath a few days later and a Norwegian nursing student wants to know if the boy has been given any medication for pain. "No, it is just a bath" the nurse answers. There is no sound from the child. His stomach, chest, face, ears and left arm are burned. The nurse brings salt and disinfection solution. "He has to stay in the bath for about 45 minutes, and we have to put this into the water" she says. "Does it reduce the pain?" I ask. "No, it is even more painful" she says.

Sometimes patients get analgesics following a painful procedure, as in this example:

The femur bone stump is protruding 5-7 cm from the wound. The whole patch of skin that is meant to cover the wound after amputation has loosened and is infected. There are two more wounds, they look better, but are very painful. The woman is not able to sit any more, and is nearly fainting. The woman complains and the nurse asks another nurse to give the patient some analgesic.

For many emergency procedures, including intubation, I observed no use of analgesia. Once I observed a nurse anaesthetist using Valium to sedate a patient before intubation, but no analgesic was used. Neither doctors who could prescribe drugs ordered analgesic in such cases.

I observed relatives finding it difficult to handle the situation when their patient was in pain. Sometimes they had to participate or comfort the patient, but sometimes they could not bear to watch their relative in so much pain, and had to leave the ward. The latter was the case in the example of the man with an occluded catheter.

Even health personnel occasionally find it hard to bear a patient's pain, as in the following example during the dressing of burns:

The nurse is cleaning the enormous wounds of a young woman. He says rather desperately; "there is lots of dead tissue here". The dressing is painful to the patient, and the nurse knows it will take time to dress the entire wound and will cause the patient lots of pain. He also knows that her general situation is getting worse. He stops when the patient asks him to. There is much more wound to clean, and we have to turn her legs a bit to do it properly. It is terribly painful for the patient, and she says that she can't stand it anymore. The nurse explains calmly to the patient and her mother that he will have to do some more. He continues, the patient cries and the mother shouts at her daughter. There is despair in the nurse's eyes, he continues a bit and then stops. "This is enough. She is going for surgical cleaning" he says.

5.1.5 Care related to death.

There are many differences in the handling of death between HLH and a Norwegian hospital. In Norway, hospital deaths are commonly caused by accidents, acute heart/lung disease, untreatable cancer or acute complications to acute or chronic diseases, where rescue is impossible. It is mainly old people who die. In HLH there are many small children dying from diseases that are treatable in Norway. Deaths caused by malnutrition, complications during home births, malaria, pneumonia and AIDS etc. are common.

Both at HLH and in Norway relatives commonly feel extreme sorrow and pain when a person close to them dies. But one particular aspect of the handling of death occurred to me as being very different in HLH; relatives often became frightened by death or rather by the dead body:

An old man is dead, and the members of the nursing staff are preparing the body for transport. The relatives run away and disappear. I ask why, and the answer is; "they are sad and scared".

Here is another example where the dead person seemed to be abandoned by the relatives:

The nurse is giving medication and calls out the name of a young man with HIV. There are none of his relatives present and he seems to be asleep. A relative of another patient collects the tablets and brings them to the patient, but comes back and asks us to check if the patient is alive. We do, and find him dead.

The fear was told be culturally grounded and was also said to differ starkly between the various ethnic groups in the area. The first death I experienced in HLH was indeed handled very similarly to a Norwegian setting:

An old man got acutely ill, resuscitation was started, the person died. Relatives were informed and taken to see their dead family member lying in the bed before being accompanied by a nurse out of the ward.

Another aspect that emerge as different from a Norwegian setting was the fact that the nurses appeared to calmly continue with their work when relatives were weeping loudly and did not “participate” in the relatives sorrow in the manner known to Norwegian nurses:

The relatives of an old woman with severe breathing problems are holding her in a sitting position; there is a lot of red scum coming out of her mouth and suddenly she stops breathing and dies. The relatives lay her down and everybody is silent. Then a female relative starts to cry and the relatives all leave the room. A nurse, the other patients and their relatives continue with their normal activities.

Another aspect of illness and particularly sad outcomes of illness that occurred as highly foreign to me was the fact that nurses were often confronted with the poor outcomes of home treatment or of local treatment by healers and communicated their frustration over such incidences to the patients’ relatives . Their frustration and anger linked to such instances were revealed in various ways. The following example indicates such frustration:

A nurse is concerned because a one-week old baby born at home is being treated for very low haemoglobin. He says with a frustrated voice: “Look at the mother; she isn’t able to sit upright. Home deliveries are dangerous.”

An 11-year old boy is dead and I assist a nurse to prepare the body for transport. The family supplies a pink sheet to cover the body. The boy’s mother and grandmother enter the room. The mother leans over the child, cries and holds him. The body is turned over, and some fluid comes out of the boy’s mouth. His mother falls down to the floor and the grandmother and I try to get her up. The nurse finds a 1.5 cm long stick in the fluid coming from the child’s mouth, and he asks the relatives if they have given the boy local medicine. They first say yes but then deny it. The boy’s mother starts to shout and cry and throws herself on floor again. Another nurse comes by and helps us to get her up and out of the room. After a while the boy’s father arrives. He says nothing, just stands there watching us wrap the boy in the sheet, lash plastic hose to tighten the sheet all around the body and head, lift him onto a trolley and take him to the bier room. The nurse tells him what he found in the boy’s mouth. The father leaves and comes back with the two women, all of them denying that the child had been given local medication, but the nurses don’t believe them.

5.1.6 Practical solutions in contexts of scarcity

As revealed in chapter 4 HLH has limited amounts of equipment. It was therefore a noteworthy phenomenon to observe how nurses addressed situations where equipment wasn't available by creatively searching for practical solutions. The handling of scarcity might involve the re-use of equipment meant for one-time use like syringes and needles or making use of items available instead of throwing them away. For example the hose of the intravenous set is used for packing dead bodies and urinary catheters for re-holding blood during vein puncture.

When nurses gave patients their medication they would ask patients or relatives to bring something to drink to ease the swallowing of tablets. Some nurses would bring a can of water to give to patients without anything to drink, and others would lend the patient a medicine glass (available in one of the wards) to drink from. The whole medication is an example of a procedure which in many respects differs from the Norwegian procedure due to the lack of medicine glasses, lack of availability of clean glasses and water etc. Nurses however try to organise the available equipment before and during the medication round to ensure that every patient gets the right medication and something to drink. Here is one example:

I walk to the drugstore with a female nurse to collect the medication that has been ordered. Some of the medication, Bactrim and Paracetamol, is not ready and we will have to come back and collect these later. Before returning to the patients, the nurse puts all the patient medication forms into the loose-leaf binder. The medication containers, the binder and a can of water for the patients are all placed on a trolley. The nurse uses the lid of one of the containers to take the tablets to the patients, and tells me that the ward doesn't have medication trays. She then announces the name of the patient out loud and pours the tablets from the lid into the patient's or the relative's hand. She gives the patients all the prescribed medication. She then takes the medication trolley to the office before returning to the drugstore to collect the rest of the order and finally returns to the respective patients with the medication collected.

In addition to equipment there is shortage of medication which makes every pill of greater value:

A male nurse accidentally drops a box of tablets on the floor in the nursing office. Nearly all the tablets fall out of the box. The nurse, a student, a relative and I put the tablets back into the box. The nurse closes the box and puts it in the medication cabinet. After sweeping the floor, two whole tablets are picked up by the nurse and put into the medication box.

Other examples follow; to dilute antibiotic and anti-malaria injections the nurses use some of the patient's intravenous solution, because there are few syringes of more

than 5 ml, and no infusion-bags with smaller amounts (50-100ml). The procedures for dressing wounds are moreover very different from those in Norway. The dressing equipment used is different as well as the procedure. There is an absence of healing ointments. I never saw the skin surrounding the wound being covered with ointment during wound-dressing, or any tube containing healing ointment. On the other hand the patients' skin seemed strong and healthy. To prevent pressure wounds nurses massaged the skin with water or oil.

Nurses meet challenges with different solutions in HLH. Nursing experience appears to make a big difference when it comes to making choices in relation to the practical chores in a context of limited equipment. These differences were clearly exposed when injecting and during wound dressing. If there is a lack of dressing or injection equipment some nurses will use whatever they need for the first dressings/injections and borrow from other wards for the rest; others will make an overview of wounds needing dressing or injections and check the equipment present, ordering more if possible, and finally dividing the equipment among the patients, ensuring there is enough for everyone or use combinations of the two approaches.

Due to the scarcity the performance of nursing procedures in HLH are placed under some pressure to succeed. Unsuccessful procedures mean a waste of precious equipment and problems for other patients and nurses. Nurses often have to search for equipment like needles, syringes, intravenous cannula, and compresses, a situation that is exacerbated when the drugstore is closed at night and on Sundays. Then the nurses have to perform procedures without changing the equipment.

For example at times if they are unable to hit the vein they cannot change the intravenous cannula, but have to try new veins until they succeed or the cannula is no longer useable. Nurses simply cannot change equipment after a single use; a suction catheter would be used for intubated patients and then 'cleaned' by sucking sterile water through it from an open bowl. The re-use of syringes and needles requires special preparation: When the syringes have been used the nurses remove the needle, disconnect the piston from the holder, and put it all in an open vessel with disinfection solution. After sterilising, the nurses check the needles to see if they are sharp enough (by looking at the tip). The accepted ones are put in a metal box for sterilization in the operation theatre, and the discarded ones are put in a different box. The syringes are

checked by testing to see if a piston fits a holder; those that do not fit are put in the basket to be changed at the drugstore. Everything is handled by hand.

At HLH the washing of hands is relatively rare in the case of patients, doctors/clinical officers and nurses. One reason for this is that there are few washbasins and the few that are available are not in the patient rooms. In the surgical ward, nurses prepare a trolley on which the nurse brings washing bowl, lukewarm water in a jug, soap and a towel for doctors to wash their hands.

Bedclothes are washed in washing machines, but washcloths are washed in the sluice room, by the staff, using cold water and washing powder, and dried on a line over the sink. There are not enough washcloths for all patients in the ward, so the staff have to wash them using the method described above (sometimes they put it in disinfection solution for a few minutes first), giving the next patient a wet washcloth.

There are many sterile procedures in the hospital; most are performed in the operating theatre where I was not present. In the three wards I observed many attempted sterile procedures that failed to be sterile. Here is an example of giving a patient urinary catheter;

A female patient is in need of a catheter because she is going for an operation. The instrument tray is washed with disinfection solution and prepared with sterile gallipots, kidney dish, forceps, compresses, catheter, syringe, and needle and sterile water. The nurse uses a compress with disinfection solution on a forceps for washing. The catheter is sterile packed and opened. The nurse uses sterile gloves and sterile technique while she collects the catheter and inserts it easily in the urethra. A syringe with sterile water is used to fill the catheter balloon. Both her gloves and all the equipment are contaminated by urine. No urine bag is used, the urine leaks into a kidney dish, and afterwards the nurse uses a cone formed plug.

One reason for contamination during sterile procedures was that there is no sterile packing to keep the sterile equipment while the procedure is performed, and the lack of urine bags is another reason.

HIV/AIDS and hepatitis are common at the hospital. Nurses in the intensive care ward used gloves while they gave patients their morning bath, the same pair of gloves being used for all the patients. They rarely washed their hands between the patients. On the other hand there are not enough gloves to be able to discard them after a single use.

I am assisting male nurse in the intensive care unit and he expresses a good knowledge of hygiene. He explains that there are too few gloves and that the wards have to clean the used gloves in a disinfection solution, rinse them in cold water and dries them by

hanging them over a clothesline in the sluice room. To put on these gloves we have to blow air into them and/or use powder, which gets lumpy and hurts.

I observed the use of gloves closely and asked nurses about fear of getting infected. I observed several nurses inserting intravenous cannula without gloves, but the same nurses would use gloves on other occasions. Even if they knew the patient had HIV/hepatitis they would give injections/ insert cannula without gloves. Some nurses and doctors tell me that they don't use gloves because they are too big, hot, or no longer good because they have been re-washed. Sometimes there simply are no gloves.

Nurses' practical solutions are often good solutions to the practical problems, but may sometimes create problems of hygiene;

The nurse is seeing to a patient's urinary catheter. On this particular day there is no urine bag available in the hospital. She takes a plastic hose, cutting it with scissors to obtain the right length. The urinary catheter is connected to the plastic hose, and put into an open urine basin.

6. Cooperation in care settings

In this chapter there will be a brief turn to the collaboration taking place between different actors in care situations. The most conspicuous difference is the participation and presence of relatives close to the patients' beds, day and night, but there are also notable differences in terms of cooperation between health personnel, as well as in the organisation of the work. Let us first look at the relationship between nurse and patient relatives.

Nurse to relatives' relation

Close contact between the nurse and the patient's mother is observed in the following example.

The patient is a girl of about 6-7 suffering from snakebite on the leg treated by fasciotomy. An experienced nurse tries to remove the bandage and, in pain, the girl tries to push away the nurse's hand. She cries, screams and clings to me and her mother, who tells her off. The nurse asks another nurse to give the girl Pethidin and indicates the dose. The intramuscular injection is a painful experience, and after waiting for the analgesic effect the nurse starts to remove the last pieces of the bandages. The girl protests but seems more relaxed. We wait a bit more, the nurse and mother talking together continuously. The mother holds the leg and the nurse starts washing, and the girl seems all right. The wound is bleeding freshly, some areas hurt and the girl screams. The wound is then covered with compresses/gauzes and the nurse asks me to bring roller bandages from surgical ward. When I return the mother and the nurse are still talking. Having the roller bandages strapped on tightly is painful, but the girl copes.

Because there are many patients on each ward (20-60+) and relatives often act as intermediaries, the nurses have to organise the patients' papers and ensure that the medication is given to the correct patient and that the patients swallow their tablets.

Relatives participate indirectly in the treatment of their patient. I will give an example observed when the wounds of a teenager boy were being dressed. His father played an active role in the dressing and also in other aspects of his son's treatment:

The nurse has brought gloves for the father and herself. The nurse speaks to the boy and his father, prepares the equipment and removes the dirty bandage with help from the father (who holds the leg). The father squeezes out pus from the two wounds on the inside of the knee and from a wound lower at the leg. A wound opens on the outside of the leg. There is some pus from the lower opening on the inside of the knee, the father presses around this opening and a lot of pus is comes out in a jet. After cleaning and bandaging the father asks for another dressing after physiotherapy. The nurse says she will inform the afternoon duty.

During my stay in the wards at HLH I observed lots of relatives being instructed on how to take care of the patient. The instructions were not only directed at relatives; nursing students and ward attendants were instructed by nurses in the observation and care of patients. If the number of staff allowed it, the staff would observe and care for the patients.

The ward will rely on the relatives work when it comes to cooking and feeding the patients' as well as cleaning of the patients' clothes and other personal service towards the patient. The nurses do not however always find the relatives' help valuable. Several nurses in the intensive care unit tell me that "the relatives disturb us". All members of staff spend lots of time asking relatives to leave the ward, or accompany them out. Even in connection with duties often performed by relatives in other wards, like the bed bath, the nurses want relatives to leave the ward and come back when the morning bath is completed. This is because the narrow space between beds makes it difficult for members of staff to do their job and the presence of relatives makes the problem worse. The intensive care unit has formalised visiting hours and posted a written notice on the main door. Visiting hours imply that more than one relative is allowed to be present beside the bed.

The number of relatives is sometimes a problem, especially in emergency situations. The following example indicates that relatives may have little understanding of situations, or are most concerned about their own relatives:

A nurse returns from the medical ward with a patient on a trolley and about 10-15 relatives. The patient is moved from the trolley onto the bed. In this chaos, while we are trying to find suction equipment for the patient's throat, another patient's relative tries to catch my attention to look at his patients' infusion.

Sometimes relatives were observed to unwittingly do things that could be potentially harmful to the patient:

An old man has just had a prostatectomy operation. His male relative is sitting by the bed observing the bottles for intravenous infusion and bladder rinse. He tells us when to change the bottles. I change most of them and am a bit concerned about the speed at which they are being emptied, so I keep an eye on the intravenous set regulation clip and reduce the amount of fluid passing. But the next time I look at it, it is fully opened again. So I ask the nurse if he is opening it or if there is something wrong with the regulation clip. He explains that relatives often open the clip because they think that the faster the infusion runs the sooner the patient will get better. He talks to the relative and tells him not to open the clip. Later on during this duty the intravenous bottle is empty again and is changed. This time the nurse gives a clear message to the relative, who looks a bit offended.

Another aspect of the relatives presence is that the burden placed upon them is sometimes too heavy for them. A nurse reported that a mother had been given a lot of responsibility for her daughter. Relatives have their own need of care especially when the patient is in a bad state. This was expressed by one nurse in the case of the mother of a young woman with severe burns. The mother was obviously exhausted and very miserable due to her daughter's terminal condition, and did not receive the care needed. Hospital treatment may moreover appear frightening for some relatives, like for the father of a girl who was getting her wounds dressed:

The father is standing by the bed. The blood, wounds and his daughter's crying make him feel ill. The nurse asks the girl if her father can go outside for a while, but the daughter wants him to stay by her. So he stands facing the other way, holding her hand with one hand while the other rests on the night table supporting his head.

In the reception there is seldom any differentiation in how patients are handled, regardless of their condition. No precedence is given unless the patient's relatives are very active:

A young male relative accompanying an old man in a wheelchair tried to catch the health personnel's attention but was ignored. The patient was in great pain from a recent fracture of the femur and the relative tried to contact the clinical officer and the nurses. However, there were many patients and relatives in the reception, and since he didn't make further fuss he was ignored by the health personnel.

Patients who come without relatives to the hospital are often assisted by other patients' relatives. Nurses particularly explain that relatives from one specific ethnic group tend to hide because they hope the patient will get food for free and will avoid the payment for the treatment. Other relatives may not be able to assist their patients properly as they are ill themselves. One case was observed where a child with malnutrition was accompanied by his mother who, as the nurse put it was "not very capable mentally".

In the midst of such challenges relatives continue to be very much present at the wards and make up an intimate part of the environment at the hospital.

Nurse to nurse relations

In Norway, nurses work in teams on the wards, discharging all duties concerning their group of patients. An example of this is the way nurses help each other during morning baths, where the experienced nurses teach the less experienced and there are discussions about what they have observed and how care can be best provided for the

patients. In HLH nurses largely organise the work after the model where each nurse is responsible for a specific duty, such as dressing, medication, doctor's round or injections. There are usually simply not enough nurses to carry out nursing tasks together, but the issue is partly linked to a nursing culture where everyone is taught to manage their own. Working together in the care of a patient was seldom observed at HLH, but some nurses were observed to do it regularly. Here is one example of cooperation between three nurses and a doctor:

The patient is a little boy with severe burns on the upper body, ears and face as well as on the arm and one hand. The morning bath is being performed by an experienced nurse, and she plans to carry out the operation using a compress and normal saline. When she starts the procedure the boy starts to cry and the nurse contacts the nurse in charge with a request to use Pethidin against the pain. Having obtained approval for this she calls for the injection nurse and requests the Pethidin injection. The boy screams when given the intramuscular injection and continues to cry for a while which makes the boy's mother start to cry as well. The nurse in charge moves over to the folding screen and starts to talk to the mother in Swahili. I am told by the other nurse, in English, that the mother is afraid the boy is going to die and is being told that he will survive. The boy gradually stops crying, breathes more slowly and seems to be asleep. The nurse starts washing him carefully and systematically. She has asked for a doctor to come and have a look at the boy's wounds and when the doctor arrives he is examined. After the bath a "cage" covered with sheet and blanket is placed over the boy's body. "He is cold and needs a heating lamp," the nurse says.

Here is an example of a duty in which an emergency situation occurs and collaboration between health workers rescues the patient:

It is the evening duty, the nurse, a ward assistant and myself are the persons present in the ward. The newly qualified male nurse in the intensive care unit is a good observer. He is observing a newly operated patient and is monitoring the breathing, level of consciousness, bleeding and pain. Then suddenly there is an emergency situation; a young woman can hardly breathe. Nurse anaesthetist and clinical officer are called up and the patient examined and treatment started. All medical orders are verbal, so the nurses need a good memory. The female nurse anaesthetist organizes the work of the team and the patient is soon stabilized. She prepares for intubation and the male nurse assists her. The clinical officer also tries to help because it is difficult. The husband and clinical officer hold the patient and the nurse anaesthetist inserts the tube with the assistance of the male nurse. The two nurses then insert a urinary catheter. I don't know how, but the members of staff have also managed to contact personnel from x-ray, who bring an x-ray machine to take a chest x-ray. The clinical officer came to me some days later and told me that the patient recovered well.

In cases where the nurse responsible for a patient fails to perform the work properly, a more experienced nurse will commonly take care of the patient. Newly educated nurses might lack knowledge need in specialized wards like ICU, and more experienced nurses will act as security for patients, as in the following case:

A newly qualified female nurse in the intensive care unit is receiving a patient from the operation theatre. She gets a report from the nurse anaesthetist and checks the intravenous infusions and urinary catheter. The nurse tells a nurse assistant to measure vital signs (pulse, blood pressure, temperature and respiration count). However, the nurse fails to look at the results and does not check the patient again, but I see the nurse in charge checking the patient and her papers.

Nurses' collaboration with other health personnel

Nurses cooperate with doctors or clinical officers during the doctor's round and on examination of new patients on arrival at the hospital, and in emergency situations. The nurse in charge is nearly always the nurse accompanying the doctor on his or her round, and makes active suggestions regarding examination and treatment. During the doctor's round the doctor is the one who talks to patient, relatives and nurses, the communication is dominated by questions, answers and doctors order in English or Swahili, and appeared more rigid than the general conversation at the ward. Doctors where not to be disturbed except when special patient situations occurred.

Nurses (and relatives) often transport patients to the x-ray unit and sometimes cooperate with x-ray personnel during the examination. Cooperation between nurse assistants and ward attendants is close in the daily work. Nurse in charge are organizing the work for all employee at the ward, and the different tasks has to be coordinated. Ward attendants e.g. have to collect enough hot water before nurses and nurse assistant can help patients during morning bath. The patient's bed will be made by a ward attendant, nurse or nurse assistance while the patient is in the bath room.

Sometimes health workers express different opinions about a patient's situation. I will give some examples of situations where nurses have a different opinion from other health workers.

A young woman admitted to hospital for intravenous antibiotic infusion is in good general condition. The newly qualified male nurse talks to her and then walks over to the office to talk to the clinical officer. He tells the clinical officer that patients who are not in need of hospital treatment should be given their medication and discharged. He explain to me that the clinical officers often fail to ask the patient if they are able to swallow tablets and just order intravenous treatment. The nurse then collects the tablets from the medication cabinet and wraps them in a piece of paper, gives them to the patient and sends her home.

An old woman with a large tumour on her neck has an urgent blood screen prescribed by the clinical officer. When the man from the laboratory arrives in the nurses' office an argument starts in Swahili between the laboratory employee and the nurse. Finally, the patient's blood samples are taken. The nurse later explains that they disagreed about the urgency of the situation.

7. Discussion

In this chapter I will discuss some central aspects of nursing care as I observed them in my study at HLH. I will focus on nursing care at HLH, viewed and discussed mainly through the theoretical framework of Martinsen, Abdellah and Johansen.

7.1 Nursing care in an African context

Nursing communication

My focus has been on nursing care at HLH and not the least on some major differences that emerged in comparison with a Norwegian nursing setting. Let us start with the discussion on the small talk and the humour that was brought up in the beginning of chapter 5. We shall proceed with a discussion of aspects of the handling of time and creativity.

Nurses at HLH often said that they were happy to care for the patients. They did mention the fear of getting infections diseases from patients for example, but at the same time they emphasised the need to care for patients even if there was a risk of infection. One of the nurses said: *“What if it was you – who would help you? Nursing comes from the bottom of your heart.”* Nurses often told me that they felt sorry for the patients, and tended to excuse ‘unacceptable’ patient behaviour. They would say the patient’s lack of cooperation and bad behaviour was related to disease or other reasons. My general experience from participating in nursing care in the wards was that most nurses in HLH meet patients with care, using small talk and humour, spending what is deemed the necessary time and handle them carefully.

Anitta Juntunen (1995) shared a similar general experience in her research at Ilembula Lutheran Hospital, and writes:

The constructs of caring were protection, encouragement and giving comfort. Caring was a matter of taking moral responsibility for the patient and caring for him. (Journal of Advanced Nursing, 1996: 543)

Let us again try to address more concretely how nursing manifested itself at HLH. Nurses and other members of staff were noted to talk together during all kinds of work. Patients and relatives also participate in the continuous small talk. I was unable to understand most of the words, but the body language and expressions told me a lot, as did the nurses' translations and explanations.

The communicating group consisted not only of the nurse, patient and the patient relatives, but was extended to include other members of staff as well as other patients and their relatives. The continuous buzz of people's voices was so normal that the rare experiences I had with silence were special, as in the example in section 0 concerning a boy with severe burns, where even other patients, relatives and hospital staff were quiet, and nurses cared for him with a minimum of words and movement.

In Tanzania, meeting another person calls for a complex set of greetings, and the hospital area is no different in this respect. Every person walking through the door would induce an elaborate exchange of greetings and the same would happen when the nurse came to see a patient for medication, wound dressing and so on. Working as a nurse at HLH involved, as we have seen, a lot of walking; to find a doctor, collect medication, bedclothes, the results of blood tests etc. During these walks the nurse would meet many people, he or she would greet them and sometimes stop to talk. This conduct was accepted among all staff, and only Western people would regard it as a waste of working-time. Lots of information was shared in these interludes and some of it was communicated to other members of staff when the nurse was back on the ward.

Juntunen (1996) writes about 'encouragement' as part of Tanzanian nurses' view of nursing care as building and maintaining co-operation with patients and relatives:

The patients and their relatives were encouraged by greeting, smiling, looking into eyes, talking peacefully, and being kind and reassuring. (Journal of Advanced Nursing, 1996: 540)

Juntunen's findings are very similar to my experience, where greeting, small talk and body language assist the patients in the hospital setting.

The smiling, laughter and humour are particularly encouraging. Laughter and jokes are part of daily life at the hospital, providing a light atmosphere in which to carry out daily activities. Humour is used to cover embarrassing situations, making them easier

for patients, nurses or other health personnel. At other times it is just a case of having a good laugh at some funny accident that has occurred. Such incidents can amuse patients and health workers for a whole day. I also saw numerous cases where humour appeared to be employed where anger would have been the natural reaction in Norway. Whenever I did something wrong or stupid the nurses would have a good laugh, which made me feel included in the community.

Laughter seems to be an inherent aspect of this particular cultural context. It seems to be a way of enjoying life itself, and was certainly not found to be a 'coping strategy' bound to the hospital setting. Friendly greetings, the calm or joyful sharing of news and a good laugh was a central aspect of social life in the area. I have indicated how this light atmosphere appeared to help nurses, patients and relatives. In stark contrast to this nurses appeared to seldom speak openly about problems they met at work, for example in connection with a patient's death or where a nurse had made a mistake. Such situations often led to silence among the nurses, and if I tried to talk about the issue in hand I was met with silence. Sharing funny incidences with a foreign guest is obviously easier than sharing a serious issue or challenge, and sometimes discussions between nurses would stop abruptly when I entered the room. I don't know why, and didn't ask them. A few nurses told me about problems they had at work, but were very cautious when they did so. Some got scared of what they had told me and tried to retract what they had said. I will however argue that the observation of the general light and friendly tones at the wards, the smiles and laughter, was not primarily linked to the biased observations but is an inherent feature of the atmosphere at the hospital.

The Norwegian nurse and philosopher Kari Martinsen writes about language and body language:

... language, thinking and practical acts are woven inextricably together. In the nursing context we could say that we sense and talk at the same time. (1996: 102, my translation)

Martinsen (1996) also describes how living speech grows from sensual perception and practical nursing. However, the words we use are an expression of the nursing and medical tradition to which we belong. These traditions often indicate an incompatibility that is expressed in the language. Martinsen writes that the medical tradition:

is dominated by an abstract conceptual language in which words are firmly fixed in different classifications and not always tested in the concrete situation. (1996: 103, my translation)

At the other end of the spectrum, Martinsen (1996) describes the language of the nursing tradition as an everyday language used with various contextual meanings in concrete nursing situations involving the patients and the nursing community. The words used in everyday language are coloured by their expressive force – they call ‘the tune’. Both body and the spoken word are employed in patient-nurse situations. This open relationship where the nurse tries to understand the patient’s point of view differs greatly from the abstract conceptual language of the medical tradition.

As I have written in chapter 3 many languages are employed at HLH. Greetings between nurses, patient and relatives for example always take place in local vernaculars, in Swahili or in the language of a particular ethnic group. Also most of the communication during daily work at the wards was in Swahili or local language. The practical work was connected to the communication, movements and body language between nurses, patients, relatives, nurse assistants and ward attendants. The atmosphere was filled with sounds of laughter, small talk, people’s steps, and clink from equipment, etc. This appears to be a nursing context where language, thinking and practical handling is woven inextricably together in a manner described by Martinsen. This becomes especially manifest when contrasted with the bio-medical tradition explained by Martinsen to be at the other end of the spectrum.

Communication between nurses and doctors took place in English or Swahili, it was formal, organized and even rigid in its structure, the entire atmosphere changed with the communication of biomedical terms. The nurses explain and translate from local languages to Swahili or from Swahili to English between patients and doctors. During these talks nurses used a few words often based on a question and answer approach. Somewhere in between these two ‘opposite’ communication forms lies the communication between Tanzanian nurses and Norwegian nurses or Norwegian nursing students. Sometimes the communication appears like the bio-medical, and sometimes more like the nursing communication. During practical work nursing communication, appeared to be closed at hand but while nurses were translating to English and explaining their work, the communication moved closer to the bio-medical realm. Communication during walk, to the drugstore or other wards, or out

of work taking place between nurses and myself became something in between, sometimes free and spontaneous and sometimes more formal and rigid, depending on how close we had been working and the theme of the communication.

These transitions may be explained in terms of Martinsens descriptions of a nursing tradition that contains both bio-medical culture as well as nursing tradition with concrete nursing situations. In the concrete nursing situations where Norwegian nurses (or students) work together with the nurses, nurse assistants and ward attendants the communication and atmosphere is coloured by the characteristics of nursing communication. In situations such as the doctor's rounds where medically relevant information is discussed, the bio-medical communication is dominating. When it comes to discussion of nursing care, the communication is characterized by shifts depending on theme and who is talking.

'Basic nursing'

We have seen the presence and participation of relatives as the most visible difference between a Norwegian Hospital and HLH. The role of kin has to be more closely discussed because it is of importance for most aspects of the care given to patients. A lot of the daily activities carried out by nurses in Norwegian hospitals are regarded as basic, as the very essence of nursing. Many of these chores are however not part of nursing care in Tanzania. As described earlier in this thesis most patients are assisted by relatives who help during body washes and toilet visits, with food preparation and feeding. Only patients in the intensive care ward are given bed baths by nurses. However, in all the wards I visited, the nurses (and nurse assistants and ward attendants) made the beds. In respect of nutrition, nurses would sometimes tell relatives to bring drinks or special food for the patients, but this was not a central part of their daily work. Juntunen (1996) had similar experience:

Many of the nurses neglected the patients' basic care. During the period of participant observation, the researcher did not see nurses or nurse students giving basic care to the patients. Only on one morning were nurse students seen making beds on the female ward and only once did a nurse write in her diary about feeding disabled patients during the evening shift. (Journal of Advanced Nursing, 1996: 541)

I find it of importance to discuss Juntunen's argument regarding the 'neglect of basic care'. Basic nursing care is described by nursing theorist such as Henderson, Abdellah and Orem (Kim and Kollak 1999). They relate their nursing theories to 'the

fundamental needs of man' (Maslow's hierarchy), where physiological needs are considered basic. Abdellah's 21 nursing problems is a well known example of a Western nursing theory where physiological care is the first mentioned and is located on the top of the list. Examples of Abdellah's points follows below:

1. To maintain good hygiene, and physical comfort.
 6. To facilitate the maintenance of nutrition of all body cells.
 7. To facilitate the maintenance of elimination.
- (Jacqueline Fortin in Kim and Kollak, 1999: 31)

Looking after these 'fundamental needs of man' has formed the basis of nursing in most Western hospitals and serves as the lower limit of nursing standards. Abdellah has also included other nursing problems located lower in the list, such as:

14. To facilitate the maintenance of effective verbal and nonverbal communication.
 17. To create and/or maintain a therapeutic environment.
 20. To use community resources as an aid in solving problems arising from illness.
 21. To understand the role of social problems as influencing factors in the cause of illness.
- (Jacqueline Fortin in Kim and Kollak, 1999: 32)

The latter points of nursing care appeared to have a higher focus at HLH than in a Western hospital. This is shown in several aspects of nursing: communication, 'self-care' involving the patient's relatives, involvement in the patient's and relatives' view of the situation, assessment of possibilities in the patient's home environment, provision of health information to the local communities etc.

A nurse is hence, according to Abdellah, supposed to assist patients to look after their basic needs. An example of this is knowledge of nutrition in respect of what food to give to patients during their illness or injury recovery, and keeping the body free from pathogenic infections at the same time. In a country like Tanzania with a shortage of health personnel, the medical treatment given by nurses is of greater importance to the patients than in the West. Hence, the delegation of feeding and cleaning responsibilities to the relatives will benefit the patient group in general, in having more time for the treatment of patients, even if a professional nurse might well do a better job for the individual patient in terms of tending to basic needs such as feeding and cleaning.

Some of the 'basic human needs' can however be met by individuals without nursing training. The role of relatives at HLH makes carry out the role of nurses in a manner rather differently from Norwegian nurses. While a Norwegian nurse is expected to

care for the patient in respect of all nursing aspects, nurses at HLH will focus on medical treatment as well as professional nursing duties, on knowledge and skills such as wound dressing, administration of intravenous liquid and use of urinary catheters. However, if the situation demands it, the nurses will help patients breathing, change their position in the bed, and also give them tub baths or bed baths not the least in the intensive care unit. I did not experience that basic care was neglected at HLH but it is handled and judged differently from in Norwegian hospitals. Maybe there is a need to develop theories in the area of nursing care in an African context?

Relatives involvement in patient care

Most relatives' involvement is positive and necessary as shown above, but they may occasionally be harmful to the patient. Juntunen (1996) has written about the responsibility put on the patients' untrained relatives, not only in feeding and washing but also in caring for seriously ill and post-operative patients:

The nurses demonstrated and advised the relatives on how to take care of the patients, but they also commanded and blamed the relatives if they did not do it correctly. The relatives were blamed if they brought the patients breakfast so late that the doctor's round could not start in time or if there was found evidence of the use of local herbs. (Journal of Advanced Nursing, 1996: 541)

If some responsibilities were delegated to the relatives at HLH, for example holding the O₂-hose, the nurse would keep an eye on the patient and the relative. However, the nurses would blame and correct the relatives if they didn't follow the instructions given or evidence of the use of local herbs where found. This is a complex issue and there are many challenging aspects to consider, such as the possibility of organising the work differently so as to relieve the relatives from the medical part of the patient care by using more employees. The cultural aspects of communication and accepted behaviour should be considered as well as the financial and technical aspects, where the choice of equipment could make the responsibilities of relatives superfluous.

The dependency on relatives in the hospital has its positive sides and is necessary in some situations. But it was in the context of this study observed to disturb the health workers, and as noted above, it might even be dangerous for the patients at times. During my stay, ICU got a dividing door making it possible to control the coming and going of relatives. There was always one relative present at each bed to help the patient and health personnel. Still, there was a fairly constant flow of relatives passing

through, bringing food, relieving another relative or just coming to greet the patient and close relatives. To me it seemed like the Tanzanian nurses had a far higher threshold than Norwegian nurses when it came to experiencing disturbance.

Nursing and time management

The way nurses manage time is something a Norwegian nurse can't avoid noticing as markedly different. Examples of time spent waiting for analgesic effect before wound dressing, on small talk and in cooperating with patients and relatives during medication rounds, doctors' rounds and wound dressing were brought in previous chapters. The Norwegian nursing tradition stresses immensely the need to spend as much time with the patients as the situation demands. Nursing theories, like Abdellah's nursing problem introduced above, include time-consuming care exemplified e.g. the points of 'communication' and the 'creation of a therapeutic environment'. But calm and long bed side encounters are nonetheless seldom given priority in the daily work of a Norwegian nurse. This aspect of nursing is simply regarded as an aspect that cannot be given top priority and the day is rather filled with innumerable concrete chores that are regarded as a must to fulfil, which implies that the nurse has to hasten from one task to the next. A nurse in HLH however will deem the use of the necessary time spent on any one chore without rushing as the only possible way proper patient care can be carried out.

The hospital in principle follows time in the sense of measurement of absolute time in connection with the start of a duty, the end of the duty, morning prayer etc. The time perception of patients and relatives is, however, starkly different where time is far less a measured good. The nurses' work appears to often fall something in between these two end points.

Foucault (1977) writes about time and perception of time. His writing reveals how using time to control an activity is an old European tradition that started with the monks in the monasteries, subsequently spreading into colleges, factories and hospitals. Today, the attitude of controlling time, and filling time the proper elements is so instilled in Western minds that we even control ourselves by feeling guilty if we are not doing anything. The rigidity of controlling time is surely also present in a

Tanzanian environment as seen the fact that people are to report at particular time to hospital duties and people common use watches to keep track of time. The rigidity with which time is measured however is far less elaborated in Tanzania; people basically seem to do what is needed as and when the situation requires it. We are talking about time regimes that are continuously changing in all parts of the world, but the general dominating tendencies imply a distinction between two ways of organizing time.

The social anthropologist Anders Johansen (2001) has written on time, and draws a distinction between 'objective' and 'relative' time. Objective time is abstract and refers to time as measured in units (hour, minutes, year etc.). Relative time is perceived in relation events and activities.

Cultural time can be built upon concrete experiences, on ordinary activities in society and nature. In this context, time is a diversity of more or less regular and memorable events which serve as reference points for localising other events or activities. (Johansen, 2001: 32, my translation)

Such 'concrete situations' is at HLH made up by for example the wound-dressing procedure which starts when the operating theatre has delivered the container with sterile compresses to the cupboard in the ward. At that point the nurse prepares the equipment, walks over to the patient and performs the procedure. Medication starts with the doctor's round, after which the nurse enters the medication prescriptions in books, picks them up at the drug store, counts them, prepares the medication trolley and hands the medication out to the patients. X-rays are also prescribed during the doctors round, and all patients for x-ray are transferred to a 'waiting area' in the minor theatre, where they wait for personnel to collect them one by one. The patients don't know when they will have their x-ray or operation or medical examination; they merely sit (or lay on a trolley), often for hours while waiting for a health worker to call their names. These procedures are carried out every day, but not at the same time. The timing depends on concrete activities, rather than on the absolute timing. Also in a Norwegian hospital, daily work is organised around certain central activities, such doctor's round, preparing patients for operation, morning baths, making beds, medication round, dressings etc. However, fewer of these activities are organized and timed by the clock, that in a Norwegian setting. The morning prayer assembly was held at 8 o'clock every morning and staff came on duty according to the shift-plan.

According to Johansen (2001), the central issue is whether or not time is perceived as a resource. In a modern Western hospital it is important to calculate how many (or rather how few) nurses are necessary to carry out patient-targeted work on each duty and ward. The more nurses the higher the cost; as 'time is money'. Time-use is more easily planned for practical work than for complex duties such as communication and relational work between patient and nurse. Efficiency is however regarded as fundamental value and this approach is highly baked into nursing in a Norwegian setting where the aim is to carry out the work as fast as possible using the correct procedure to save more time for the more time consuming relational care. At the end of the hour there is however hardly any time left for the more caring and relational aspects of nursing in Norwegian settings.

Part of the background for the different approaches can be linked to the fact that equipment is a sparse resource in Tanzanian setting, and often is regarded to have a higher cost element than nurses and workers at the hospital. This has a distinct impact when it comes to local production (for example intravenous liquid), re-use and re-sterilisation of equipment; areas where time cost less than materials.

However, this can not remove the focus from the fact that nurses at HLH reside in a setting where people simply do not relate to time as a resource to the same extent as in Norwegian setting. Time is to a much further extent organized through concrete activities and people are accustomed to be waiting for visitors, for busses, at shops, at offices etc. and so also for medication and equipment at the hospital wards. To do the work when the time is ripe is hence a 'natural' approach to the execution of duties from the nurse's point of view with substantial consequences for the way patients' psychological and social needs are respected.

As we saw in chapter 5 nurses would sometimes tell me that they were busy, but they nonetheless never rushed their work. They continued at the same speed, occasionally skipping a tea break. On several occasions I observed nurses continuing to work after the end of their duty in order to complete a specific task. These, I will argue are examples of the dynamics between 'objective' and 'relative' time where the borders emerge as different in a Norwegian settings; the beginning of the duty is regulated by objective time but not leaving before the work is regulated by relative time.

The different ways in which nurses relates to time emerged in the course of this study very clear, and appeared to have immense impact on the potential a nurse has for playing out a genuine and natural caring attitude as well as to communicate true nursing care during practical procedures. Nursing care at HLH commonly revealed exemplary school book bed side care not the least due to the very embodiment of relative time.

8. Reflections of assets and challenges for nursing care

This chapter will attempt to summarise assets as well as challenges for nursing care at HLH. With humble regards to the obviously limits of the knowledge I gained during three months fieldwork I am very aware of the fact that I only had a glimpse into nursing care and hospital life. I shall still attempt to identify threads and make comment on issues which appeared as particular resources or assets as well as obstacles or challenges with regards to nursing care at HLH. Some of these aspects are only given brief attention in the previous chapters, but still have to be mentioned.

8.1 Assets of care

Nursing care as communication and involvement

It appeared like nurses at HLH were “involved performers” in more levels than what is common in a Norwegian nursing context. They often were quite well informed about the person they cared for which implies knowledge about the patient, his/her family, his/her role in the community in addition to the disease development and treatment possibilities. Nurses cared for persons that they knew, or knew someone who knew, in contrast to viewing the patient as case of a disease. Such knowledge was collected through continuously communication with patients and relatives as well as through the core function of a local community where substantial information continuously are shared among community individuals. The climate for the exchange of knowledge, as far as I could observe, was characterized by respect, encouragement and involvement through greeting, smalltalk, humour, spending enough time, etc. I am sure there were aspects of less constructive information as well, like gossiping and talking behind the others’ back, but this was more difficult for me to grasp. However, it is likely that the substantial knowledge of many of the patients contributes to- and facilitates the relaxed atmosphere of the many nurse-patient encounters in which smalltalk and laughing of funny episodes is an inherent part.

Practical performance as care

Most nurses at HLH appeared to be very skilled performers in terms of carrying out practical procedures. Relatively few procedures, lots of training and limited amount of equipment makes good practical performance both reachable and necessary, and give nurses' the opportunity to focus on communication and collaboration with the patient and relative. The fact that the practical aspects of nursing often almost 'go without thinking' contributes to a situation where most of the attention can be given to the patient and his or her wellbeing and to stories shared with the patient, rather than on the performance of a concrete procedure.

Relatives' role in the patient care

Relatives' participation is, as we have seen, vital for the patients recovering from illness even in a hospital setting. For the patient the relatives assistance does not constitute merely practical help, but also implies entertainment, encourage, and support from people whom one love and trust.

The removal of very time consuming tasks, such as the bathing and feeding the patients, contributes to a situation where nurses are given time to carry out their tasks using the time deemed necessary. One can hardly envisage how the scenario would have been if the limited nursing staff at HLH were to carry out all the tasks that a Norwegian nurse usually has responsibility for. The way work is organized, with relatives taking a considerable share of the work, it appears as if the many chores left for the nurses are manageable in a manner where the potential for true nursing care is facilitated.

Organization and working condition - background for nursing care

The nurse in charge is important for the daily organisation of the work and nursing care taking place at the wards. Nurses in charge are nurses with long experience having an overview of patients, the workers as well as the collaboration with other units and health workers to secure proper treatment and care for the patients. She or he also have responsibility for the milieu at the ward and without exception the nurse in charge appeared to be respected nurses and individuals both professionally and as persons.

The nurses appeared to be well informed of the rights as nurses, and were members of the hospital organisation. Generally, it appeared to me as if they had a high working moral. Due to necessary assistance at home, nurses are seldom absent from work because of their own, or their children's, sickness. The nurses were noteworthy flexible in response to special needs of their colleagues. One example is the working schedules for mothers returning from birth-leave which are organized in a manner where she can still take care off and nurse her baby. The working environment to me thus appeared enabling and facilitating.

8.2 Challenges of care

Written observations and reports

There seems to be limited cooperation between nurses in terms of ensuring patients' care. Written observations in the patient's journals were kept at a minimum; for examples documentation of quantitative nursing aspects and qualitative observation where thus dependent upon oral report. There is a very strong emphasis on the written word in a Western context, whereas the writing culture may not be as elaborate and as integrated in the hospital culture at HLH. The many immense advantages implied by the written report, in terms of closely following up signs of improvement or worsening of the patient's condition from one duty to the next, as well as the reduced likelihood of forgetting to pass on significant information, calls for more emphasis put on the written reports to ensure that exact information is brought on from one duty to the next.

Hygienic principles

There seems to be a potential for increasing the hygiene standards substantially. This has many advantages, not the least in the sense of preventing the spread of infections among the patients. The issue of hand washing is one example. In chapter 4.3.3 I have described the equipment for hand washing in HLH. Even if nurses wash their hands in the cold water, with the wet pieces of soap and dry their hands on the daily changed towel, they will still be left with substantial pathogen cultures on their hands. Since there are no sinks in most patient rooms at the wards it would be nearly impossible to

wash hands between each patient. Using the cold water with soap powder or, if possible, liquid soap would make immense improvement. The wet pieces of soap as well as towels should be left out in the dry climate. Equipment for hand washing could also be transported to the patient rooms.

Relatives' participation

Relatives' participation is central despite their lack of knowledge to ensure patients' correct and safe care and treatment. It seems to me that there should be an even clearer distinction between the professional work and the work left for relatives. One should possibly emphasize more strongly that the responsibility for the patient's care remains with the nurses and other hospital employees. It is thus important to inform the relatives about the expected goals and limits for their involvement in medical treatment.

On the other hand it appears like that nurses should keep even stronger in mind that the involvement and work at the ward can be extremely tough for the relatives.

Challenges of equipment

Salaries are relatively less expensive than imported equipment, in contrast with a Norwegian hospital where wages are a substantial cost issue. This is the main reason for re-use and sterilization of equipment originally manufactured for single use, but this often leads to poorer equipment that doesn't fulfil the equipments purpose. On the other hand, if the alternative is no equipment at all, the consequences could be even worse. In some instances however, it seemed like borders were crossed, such as when intubation in the intensive care unit were carried out without enough sterile catheters for sucking in the tube; which again may lead to occlusion and/or infection. This appears to be an even poorer outcome than no intubation. There were other similar cases observed.

Organisation and training

The hospital managers and the Matron did try to support nurses and other health professions to ensure good working conditions as well as ensure updated education. The lack of funds was one of reason explaining lack of progress. However it appeared to be some potential for continuously development of skill, for example by letting

newly educated and less experienced nurses work together with more experienced nurses. There also seem to be a potential for building a culture of training at the wards, such as through internal lectures. To get continuously updated and exact knowledge about diseases, treatment and medical technical equipment would make nurses feel that they 'grow' in their nursing role, and is certainly far less costly than external education.

8.3 Concluding remarks

During my fieldwork and the writing process I gained far more knowledge than can be expressed in the thesis. The main experience is the insight into the differences of the nursing care aspects in a Norwegian setting compared to the HLH setting. One important experience is that a Norwegian nurse has as much to learn from nurses at HLH as the other way around. With very limited resources the nurses at HLH reach goals of nursing care that are difficult to reach at a Norwegian hospital with all our resources and technical capabilities.

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Appendices

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Bergen, 26.06.02

To whom it may concern

CONFIRMATION (Project no. 095.02)

We hereby confirm that the research protocol *Challenges of care to HIV positive patients. A qualitative study in two hospitals in Mbulu district of Tanzania* has been evaluated by The Regional Committee for Medical Research Ethics in Western Norway (REK III).

The protocol is now cleared.

Sincerely,

Arne Salbu
Arne Salbu
secretary



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27th August, 2002

TO WHOM IT MAY CONCERN

Re: RESEARCH ASSOCIATESHIP AND ETHICAL CLEARANCE WITH RESPECT OF:

1. Karin Bell
2. Ragnhild Flasnes Mellingen
3. Bodil Bo Voga

I am introducing to you the above students from Bergen University in Norway who has been accepted to conduct Research at Mbulu District.

Ethical Clearance on their Research have been cleared with the College

A.A. Lyimo
for: PRINCIPAL

FOR PRINCIPAL
MUHIMBILI UNIVERSITY COLLEGE
OF HEALTH SCIENCES
P. O. Box 65001
DAR ES SALAAM

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REGIONAL COMMISSIONER'S OFFICE,
P.O. Box 3050,
ARUSHA.

20th
5 September, 2002

The District Commissioner,
S. L. P. 1,
MBULU.

RE: RESEARCH PERMIT

Vide original permit from the Principal Muhimbili University College of Health Sciences with reference No. MU/01/1022/Vol.XVI/9 dated 27th August, 2002; we wish to introduce to you:-

1. Karin Bcll
2. Ragnhild Flasnes Mellingen
3. Bodil Bo Voga

All of them are students from Bergen University in Norway. While in Mbulu District they will be based at Hydrom Hospital.

Please accord them with all the necessary assistance.

A handwritten signature in black ink, appearing to read 'Kassim Mamboleo'.

(Kassim Mamboleo)

for: REGIONAL ADMINISTRATIVE SECRETARY
ARUSHA

Interviews with nurses

1. Please tell me about your education.
 - Did you have any education before the school of nursing?
2. Please tell me about your working experience as a nurse?
3. Do you have any examples of the positive sides of nursing?
4. Is there anything you don't like, working as a nurse?
5. Please explain about your responsibilities as a nurse at the intensive care unit?
 - What are the main patient observations at the ward?
 - What kind of actions do you perform if the patients' condition degrades?
6. How do you handle the hygienic principles at the ICU?
7. Are you concerned of getting infectious diseases from patients?
 - HIV?
8. Does the hospital offer any internal education?
 - If so; where is the lectures given?
 - Is there any practical training at the wards or elsewhere

General follow up questions:

- Please tell me more about this
- Please give an example

