PROFESSIONAL AND LAY CARE IN THE TANZANIAN VILLAGE OF ILEMBULA

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Abstract

The purpose of this ethnographic study is to describe and analyse professional and lay care in the Bena cultural context in the Tanzanian village of Ilembula. The study focuses on care as a cultural phenomenon. The structure of the study is based on M.M. Leininger's (1991) Culture Care Theory In the first phase of the study, care was described from a professional perspective. The data were collected by interviewing and observing trained nurses (n=6) in the wards of Ilembula Lutheran Hospital. The study material was complemented with the data obtained from informants' diaries and institutional documents. The data were analysed by using qualitative ethnonursing analysis. In the second phase of the study, the focus was on lay care. The fieldwork was done in the Ilembula village and Ilembula Lutheran Hospital. The data were collected by interviewing villagers (n=49) and relatives (n=12) of patients admitted to Ilembula Lutheran Hospital, and by observing their care practices. The data were analysed by qualitative content analyses with regard to the cultural context.

Curing and caring were the characteristics of professional care, as described by the nurse informants. Curing was linked to skills and knowledge obtained in nurse training and it was demonstrated through technical interventions, medication and health education. Caring referred to a natural mother-child relationship and reflected the traditional cultural knowledge. Caring was demonstrated in primary care, meaning a mother's responsibilities in taking care of a small baby, encouragement and comfort. The patient's recovery and maintenance of health were the goals of professional care. Respect and protection were the characteristics of lay care, reflecting the worldview and cultural values of the Bena. The aim of respect was to maintain family unity and to ensure wellbeing, while protection focused on the sensitive phases of the Bena life span. The main meaning of lay care for the informants was health maintenance and improvement of health. Health included physical, mental and reproductive aspects, and enabled them to respond to the culturally determined role expectations.

The aim of this ethnographic study was to demonstrate that care is integral to much more comprehensive socio-cultural issues in the context of a Tanzanian village. The study demonstrates the meaning of cultural and social factors, such as cultural values and lifeways, kinship, economic, educational, and ethnohistory in both professional and lay care. The findings can be utilised in transcultural nursing education and in clinical nursing practice, especially in developing patient education from a transcultural perspective, not only in Tanzania, but internationally.

Keywords: cultural care, lay care, professional care, Bena, Tanzania, ethnography, field-work

Juntunen, Anitta, Ammatillinen ja maallikkohoitaminen tansanialaisessa Ilembulan kylässä
Hoitotieteen ja terveyshallinnon laitos, Oulun yliopisto, 90401 Oulu

Tiivistelmä

Tämän etnografisen tutkimuksen tarkoituksena on kuvata ja analysoida ammatillista ja maallikkohoitamista benojen kulttuurisessa kontekstissa tansanialaisessa Ilembulan kylässä. Tutkimus kohdentuu hoitamiseen kulttuurisena ilmiönä. Tutkimuksen rakenne perustuu M.M. Leiningerin (1991) kulttuurisen hoitamisen teorialle. Ensimmäisessä vaiheessa tarkastelin ammatillista hoitamista. Keräsin aineiston haastattelemalla ja havainnoimalla sairaanhoitajia (n=6) Ilembulan luterilaisessa sairaalassa. Täydensin tutkimusaineistoa tiedonantajien päiväkirjoilla ja sairaalan toimintaa kuvaavilla dokumenteilla. Analysoin aineiston laadullisella etnonursing –sisällönanalyysillä. Toinen vaihe kohdentuu maallikkohoitamiseen. Keräsin aineiston haastattelemalla kyläläisiä (n=49) ja sairaalassa olevien potilaiden omaisia (n=12) sekä havainnoimalla omaisten toimintaa potilaiden hoitamisessa. Analysoin aineiston laadullisella sisällön analyysillä huomioiden kulttuurisen kontekstin.

Parantaminen ja huolenpito olivat luonteenomaista sairaanhoitajien kuvaamalle ammatilliselle hoitamiselle. Parantaminen liittyi taitoon ja tietoon, jota hankittiin sairaanhoitajakoulutuksessa ja se havainnollistui teknisissä toimenpiteissä, lääkehoidon toteutuksessa ja terveyskasvatuksessa. Huolenpito perustui luonnollisen äiti-lapsi –suhteen elementteihin ja heijasti perinteistä kulttuurista tietoa. Huolenpitoa havainnollisti äidin velvollisuus huolehtia pienen lapsen tarpeista ja terveellisestä ympäristöstä, sekä rohkaisu ja lohduttaminen. Potilaan toipuminen ja terveyden ylläpito olivat ammatillisen hoitamisen päämäärä. Maallikkohoitamiselle oli luonteenomaista kunnioitus ja suojelu, jotka heijastivat benojen maailmankuvaa ja kulttuurisia arvoja. Kunnioituksen päämääränä oli perheyhteyden ylläpito ja hyvinvoinnin vahvistaminen, kun taas suojelu kohdentui benojen herkkinä pitämiin elämänkaaren vaiheisiin. Maallikkohoitamisen päämäärä informanteille oli terveyden edistäminen ja ylläpito.

Tutkimuksen tavoitteena oli osoittaa, kuinka hoitaminen liittyy laajempaan sosiokulttuuriseen kontekstiin tansanialaisessa Ilembulan kylässä. Tutkimus paljastaa kulttuuristen ja sosiaalisten tekijöiden, kuten kulttuuristen arvojen ja elämäntavan, sukulaisuuden, taloudellisten ja koulutuksellisten tekijöiden ja etnohistorian merkityksen sekä ammatillisessa että maallikkohoitamisessa. Tuloksia voidaan hyödyntää transkulttuurisen hoitotyön koulutuksessa ja hoitotyön käytännössä, erityisesti potilasohjauksen kehittämisessä transkulttuurisesta näkökulmasta sekä Tansaniassa että kansainvälisesti.

Asiasanat: kulttuurinen hoitaminen, maallikkohoitaminen, ammatillinen hoitaminen
Bena, Tansania, etnografia, kenttätyö

To Almaz and Tatu

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The motivation for this work dates back to the 3-year period that I spent working as a nurse tutor at Ilembula Nurses' and Midwives' Training School, employed by Tehy, the Union of Health and Social Care Services. This study was carried out at the Department of Nursing and Health Administration, University of Oulu. I wish to thank my supervisors, Ms Sirpa Janhonen and Ms Merja Nikkonen, for their scientific guidance, criticism and encouraging attitude, which have been invaluable in the course of this study. Ms Merja Nikkonen has inspired me from the very beginning of the 8-year research process.

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Kajaani in June 2001

Anitta Juntunen

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBHC	Community Based Health Care
CCM	Party of the Revolution (Chama cha Mapinduzi)
CDD	National Control of Diarrhoea Diseases
ED	Essential Drug Programme
ELCT	Evangelic Lutheran Churches of Tanzania
EPI	Expanded Programme of Immunization
ERP	Economic Recovery Programme
ESAP	Economic and Social Action Programme
FPP	Family Planning Programme
GDP	Gross Domestic Product
GNP	Gross National Product
HDI	Human Development Index
HFA 2000	Health for All by the Year 2000
HIV	Human Immunodeficiency Virus
MCH	Maternal and Child Health Programme
NCCR	National Convention and Constructional Reform
NGO	Non-Governmental Organization
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
TANU	Tanganyika African Union
UNDP	United Nations Development Programme
UPE	Universal Primary Education
WHO	World Health Organization

List of original papers

I Juntunen A & Nikkonen M (1996) Professional nursing care in Tanzania: a descriptive study of nursing care in Ilembula Lutheran Hospital in Tanzania. Journal of Advanced Nursing 24: 536-544.

II Juntunen A (2000) Cultural Encounter in the Field in the Tanzanian Village of Ilembula. Vård i Norden 56(20): 45-49.

III Juntunen A & Nikkonen M & Janhonen S (2001) Respect as the Main Caring Activity among the Bena in Ilembula Village in Tanzania. International Journal of Nursing Practice. (Submitted).

IV Juntunen A & Nikkonen M & Janhonen S (2000) Utilising the Concept of Protection in Health Maintenance Among the Bena in Tanzania. Journal of Transcultural Nursing 11: 174-181.

Contents

1 Introduction

This study examines care as a cultural phenomenon among the Bena living in the village of Ilembula, which is situated in the Iringa region, Njombe district in the southern highland of Tanzania. (Appendix 1.) Care is studied in both professional and lay contexts. Care refers to culturally and professionally learnt actions and interventions, the aim of which is to assist others at times of need or to help them to maintain their well-being and health. (Leininger 1991, 1995a.) The study is based on knowledge of nursing and anthropology.

The roots of the study are in my 5-year experience as a development co-operation worker in the health care sector in Kenya from 1985 till 1987 and in Tanzania from 1989 till 1992. In Tanzania, I worked as a nurse tutor. During my stay in Ilembula, I daily came across situations which were difficult to understand and cope with due to my cultural background: communication patterns, concept of time, concept of family, role of women, beliefs concerning health and causes of illnesses, lack of material facilities, and misunderstandings due to my poor skill in Swahili.

In Ilembula, I became interested in the relationship between professional care and lay care. I noticed that the nurses directly or indirectly criticized the patients whom they knew to be practising care based on lay knowledge and traditions, e.g. using local herbs or consulting *waganga* (traditional healers). On the other hand, the health professionals, if they themselves or their family members had long-lasting health ailments, were suspicious of the effectiveness of hospital care based on Western knowledge and chose freely between lay methods and hospital care. Ilembula Lutheran Hospital had made some efforts to establish co-operation with the community, the aim of which was to improve community involvement in health matters. However, the co-operation was not on a firm basis, since the limited resources of the hospital were allocated to curative and preventive services in the hospital. These facts made me ask many questions. What actually is care? Why is lay care so popular? Why is there a gap between professional care and lay care, or does such a gap exist in reality?

I got some answers to my questions from studies about traditional healing and medicine in Tanzania. Harjula's (1981) study of a Meru medicine man in the north of Tanzania, Swantz's (Swantz L 1990) study of medicine men among the Zaromo in Daressalaam and Nisula's (1993) study of the spirits of illnesses on the island of Zanzibar

made me realise how healing relates with the worldview of the Bantu (Tempels 1969, van Pelt 1982, Pennington 1985, Anderson 1986, Gehman 1990, Masolo 1994, Mbiti 1994). African ethnomedicine has been studied extensively by medical anthropologists, whose papers showed not only some common characteristics but also variation in the existing traditional healing practices (Good 1987, Van der Geest & Whyte 1988, 1989, Whyte 1988, Prins 1989, Vaughan 1991, Gelfand *et al*. 1993, Pool 1994, Kutalek 2000.) The papers showed that traditional healing often includes elements characteristic of care, e.g. it is comprised of thoughts, emotions, actions, knowing and being (Benner 1984, Benner & Wrubel 1989, Leininger 1991), but none of the papers focused on the phenomenon of care in a Tanzanian context. The few internationally known studies about professional nursing care in Tanzania focused on certain sectors of care or care of some special groups, such as the measures to reduce infant mortality (Karungula 1992) and the knowledge, attitudes and perceived support of Tanzanian nurses when caring for AIDS patients (Kohi & Horrocks 1994). The papers of Swantz (Swantz M-L 1983) and Vuorela (1987) enlarged my view of the role and position of women in Tanzanian village societies.

As a nurse tutor, I could not include local cultural aspects in my instruction, since I knew very little about the Tanzanian lifeway or the Bena health beliefs and practices. This made the cultural barrier between me and the student nurses impossible to cross. The nurse training curricula (Ministry of Health 1989, 1993) in Tanzania included elements of WHO's HFA 2000 program. (Juntunen 1994, 1997, Juntunen & Nikkonen 1996.) WHO has played a leading role in proposing the use of existing community resources, including traditional health practitioners, to achieve the goal of HFA 2000 program. (WHO 1995a,b.) According to the declaration of Alma Ata (WHO 1978), health care services should be culturally oriented, since PHC as essential health care is based on practical, scientifically sound and socially acceptable methods. Few studies on the traditional health practice have been made in Africa in order to modify the national health policies to meet the requirements of the HFA 2000 program (Staugård 1989, Sukati 1997). According to both studies, implementation of community involvement and provision of accessible and acceptable health services by the local people need to be strengthened.

The purpose of this ethnographic study is to describe and analyse professional and lay care in the Bena cultural context in the Tanzanian village of Ilembula. The structure of the study is based on the cultural care framework. Madeleine Leininger has developed transcultural care as the domain of nursing science since the 1960's. Transcultural nursing is a body of knowledge that helps nurses to provide culturally relevant care. (Boyle 1999.) Transcultural scholars view care/caring as a universal phenomenon, the forms of which vary in different cultures. (Leininger 1978, Meriläinen 1996.) Transcultural care is concerned with the implementation of nursing care in a manner that is sensitive to the needs of individuals, families and groups who represent diverse cultural populations within society (Boyle & Andrews 1995, Leininger 1995a.) Besides Leininger, some other nurse researchers have developed concepts and theories describing transcultural care. (Orque *et al.* 1983, Boyle & Andrews 1989, Dobson 1991, Giger & Davidhizar 1991.)

The research process proceeded as described in Fig. 1:

I stage 1993-1994	II stage 1995-1998	III stage 1999-2000
Studying cultural anthropology and transcultural nursing. The 1st fieldwork: a study on the views of care held by the professional nurses in Ilembula Lutheran Hospital. The Bantu nurses expressed their ideas and shared their experiences about professional care. I observed professional nursing care in Ilembula Lutheran Hospital Analysis of the data and writing of the research report. Writing of article I.	Studying cultural anthropology and transcultural nursing. The 2nd fieldwork: a study on the views of care held by the Bena in the Ilembula village: Ilembula villagers the relatives taking care of the Bena patients in Ilembula Lutheran Hospital The villagers shared their experiences and expressed their ideas about care. I observed the care practices at traditional healers' surgeries, homes and hospital wards. Analysis of the data and writing of the research report. Writing of articles II, III, IV.	Analysis of care of the Bena in the Ilembula village from the cultural perspective based on the data collected during the previous fieldworks. Writing of the final research report.

Fig. 1. Main stages of the research process.

The study offers tools for a broader understanding of the foundations of care in a rural Tanzanian village. This study enables the development of cultural competence in clinical nursing practice and nursing education, not only in Tanzania, but internationally.

The research report contains a summary and four articles. In the summary, I first present the main ideas of culture care frameworks and the main points of Leininger's Culture Care Theory (1991, 1995a, 1997), which are relevant to study. The context of the phenomenon of care in this study is Tanzania, which is introduced through the Sunrise Model developed by Leininger (1991, 1995a, 1997) in chapter 3. The concepts of professional nursing care and lay care are demonstrated in chapter 4. The purpose of the study and the research questions are in chapter 5 and chapter 6 includes a description of the ethnographic research approach and Ilembula as a context of fieldwork. The last part of the summary contains the results and discussion. The first article examines the professional nursing care practised in Ilembula Lutheran Hospital. The second article reflects on different aspects of cultural encounters experienced during the second fieldwork period. The third and the fourth articles deal with lay care practices considered meaningful by the Bena in the Ilembula village.

2 Care as a cultural phenomenon

Care was first viewed as a cultural phenomenon in the mid-1950's, when Madeleine Leininger recognised that care and culture were the two major and significant missing phenomena in nursing. As the outcome of her research, Leininger developed transcultural care as a domain of nursing science, and created her Culture Care Theory. (Leininger 1970, 1978, 1984, 1991, 1995a, 1995b.) Transcultural scholars refer to care as a universal phenomenon that transcends cultural boundaries (Brink 1999), and their aim is to incorporate transcultural nursing into nursing curricula and clinical practices through a research-based knowledge of cultures (Leininger 1995a).

2.1 Cultural care frameworks

Since the 1960's, care has been studied from the cultural perspective by several transcultural nurse researchers, who were influenced by Leininger and her Culture Care Theory, e.g. Orque *et al*. (1983), Boyle & Andrews (1989, 1995), Dobson (1991), Giger & Davidhizar (1991). Transcultural scholars challenge nurses to move from a unicultural perspective to a multicultural, holistic perspective. They have developed theoretical cultural care frameworks, the aim of which is to enable nurses to provide care that confirms the clients' cultural perceptions of what care should be. Their arguments for theoretical frameworks are influenced by experiences of nursing practice in multicultural American contexts. (Orque *et al*. 1983, Boyle & Andrews 1989, Dobson 1991, Giger & Davidhizar 1991, Leininger 1990, 1991, 1995a,b Baker 1997.) The main focus of cultural care frameworks is to assist nurses to avoid ethnocentric assessments, so that they can provide care that is responsive to the recipient's cultural perspective. (Baker 1997.)

Transcultural scholars underline the identification of cultural factors and their effect on an individual's behaviour in order to provide culturally appropriate care. They also stress the ethical aspects of nurse-patient encounters by stating that nurses need theoretical knowledge enabling them to understand their own cultural values, beliefs and practices in order to prevent cultural biases, cultural clashes, cultural pain and imposition of practices, major cultural conflicts and unethical care. Transcultural scholars share the opinion that the nurse, when planning nursing care, should pay attention to gender identity and roles,

communication modes, language, interpersonal relationships, space, the patient's subculture, and the environmental context. (Orque *et al*. 1983, Boyle & Andrews 1989, Dobson 1991, Giger & Davidhizar 1991, Leininger 1991, 1995a.) Orque (1983) and Giger & Davidhizar (1991) point out that these factors lead to variation between members of the same ethnic group. Leininger (1995) and Orque *et al*. (1983) agree that the nurse should know his/her own culture with its variabilities, strengths, and assets. It is useful, in order to make the assessment culturally valid and more relevant to the patient, that the nurse recognises his/her own cultural biases and prejudices. This makes him/her aware of his/her subconscious behaviour. For this study, Leininger's (1978, 1997) division of care into professional and lay care is meaningful.

2.2 Leininger's Culture Care Theory

The structure of this study is based on Leininger's Culture Care Theory (1991, 1995a, 1995b, 1997). Leininger (1991, 1995a) underlines the meaning and importance of culture in explaining an individual's health and caring behaviour, and her Culture Care Theory is the only nursing theory that focuses on culture. (Rosenbaum 1997.) The roots of the theory are in clinical nursing practice: Leininger discovered that patients from diverse cultures valued care more than the nurses did. Gradually, Leininger became convinced about the need for a theoretical framework to discover, explain, and predict dimensions of care, and developed the Culture Care Theory as the outcome of studies performed in numerous Western and non-Western cultures. (Leininger 1997.)

In her Culture Care Theory, Leininger states that caring is the essence of nursing and unique to nursing. (Leininger 1978, 1981, 1984, 1988, 1991, 1995a,b, Reynolds 1995.) Leininger (1997) actually criticizes the four nursing metaparadigm concepts of person, environment, health and nursing (Fawcett 1989.) First, Leininger considers nursing a discipline and a profession, and the term 'nursing' thus cannot explain the phenomenon of nursing. Instead, care has the greatest epistemic and ontologic explanatory power to explain nursing. Leininger (1995a) views 'caring' as the verb counterpart to the noun 'care' and refers it to a feeling of compassion, interest and concern for people (Leininger 1970, Morse *et al*. 1990, Reynolds 1995, McCance *et al*. 1997). When Leininger's definition of care is compared to other transcultural scholars' definitions, it appears that her view of care is wider than, for example, that of Orque *et al*. (1983), who describe care as goal-oriented nursing activities, in which the nurses recognise the patients' ethnic and cultural features and integrate them into the nursing process. Second, the term 'person' is too limited and culture-bound to explain nursing, as the concept of 'person' does not exist in every culture. Leininger (1997) argues that nurses sometimes use 'person' to refer to families, groups, communities and collectivities, although each of the concepts is different in meaning from the term 'person'. Third, the concept of 'health' is not distinct to nursing as many disciplines use the term. (Leininger 1997.) Fourth, instead of 'environment' Leininger uses the concept 'environmental context', which includes events with meanings and interpretations given to them in particular physical, ecological, sociopolitical and/or cultural settings. (Leininger 1991, 1995a,b, 1997.)

Care always occurs in a cultural context. Culture is viewed as a framework people use to solve human problems. (Orque *et al*. 1983, Leininger 1991.) In that sense, culture is universal. It is also diverse, as Leininger (1991, 1995a, 1995b, 1997) refers culture to the specific pattern of behaviour which distinguishes any society from others. Transcultural scholars define culture by stressing behavioural aspects as an explicit form of it. Leininger (1997, 38) states that culture refers to "the lifeways of an individual or a group with reference to values, beliefs, norms, patterns, and practices" and agrees that culture is learnt by group members and transmitted to other group members or intergenerationally. Leininger (1991, 1995a) distinguishes between emic and etic perspectives of culture. Emic refers to a insider's views and knowledge of the culture, while etic means the outsider's viewpoints of the culture and reflects more on the professional angles of nursing. Apart from culture and environmental context, ethnohistory is also meaningful when examining care from the cultural perspective. (Leininger 1995a.) The environmental context, which includes physical, ecological, sociopolitical and cultural settings, gives meaning to human expressions of care. Ethnohistory refers to the past events and experiences of individuals or groups, which explain human lifeways within particular cultural contexts over short or long periods.

Leininger (1991, 1995a, 1995b, 1997) has formulated several theoretical assumptions and orientational definitions to guide nurses in their discovery of culture care phenomena. The assumptions and definitions are derived from the theoretical conceptualizations and philosophical positions of the Culture Care Theory, and they are used as guides to systematic study of the theory. Strictly constructed theoretical formulations would be incongruent with the purposes of the qualitative paradigm. The following assumptions concerning care/caring were significant when planning the study:

- care (caring) is essential to curing and healing, for there can be no curing without caring
- every human culture has lay (generic, folk or indigenous) care knowledge and practices and usually some professional care knowledge and practices, which vary transculturally
- culture care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, educational, economic, technological ethnohistorical, and environmental contexts of cultures
- a client who expreriences nursing care that fails to be reasonably congruent with his/her beliefs, values, and caring lifeways will show signs of cultural conflict, noncompliance, stress and ethical or moral concern
- the qualitative paradigm provides ways of knowing and discovering the epistemic and ontological dimensions of human care transculturally

Leininger (1997) states that orientational definitions are more appropriate in the qualitative research paradigm than the rigid operational definitions typical of quantitative studies. Orientational definitions are used as guides for studying the domain related to the theory. The following orientational definitions (Leininger 1995a, 1995b) structure this study:

- cultural and social structure dimensions refer to the dynamic, holistic, and interrelated features of culture (or subculture) related to religion or spirituality, kinship (social), political (and legal), economic, education, technology, cultural values, language and ethnohistorical factors of different cultures
- professional care systems refer to formally taught, learnt and transmitted professional care, health, illness, wellness and related knowledge and practical skills that prevail in professional institutions
- lay care systems refer to culturally learnt and transmitted knowledge and skills used to provide assistive, supportive, enabling or facilitative acts towards or for another individual or group to improve a human lifeway, health condition or to deal with handicaps and death.

Leininger has presented the Sunrise Model (Fig. 2) to visualise the different dimensions of her Culture Care Theory. It is designated to depict a total view of the different, but very closely related dimensions of the theory. I use the Sunrise Model in this study as a cognitive map to orient and depict the different dimensions of the theory. Leininger (1991, 1997) has included in the Sunrise Model the modes of cultural care preservation/ maintenance, culture care accommodation/negotiation and culture care repatterning/restructing, which I have excluded from my study. My aim is to demonstrate how care is integral to socio-cultural issues in the context of Ilembula village rather than create a model of culturally congruent care of the Bena in Ilembula.

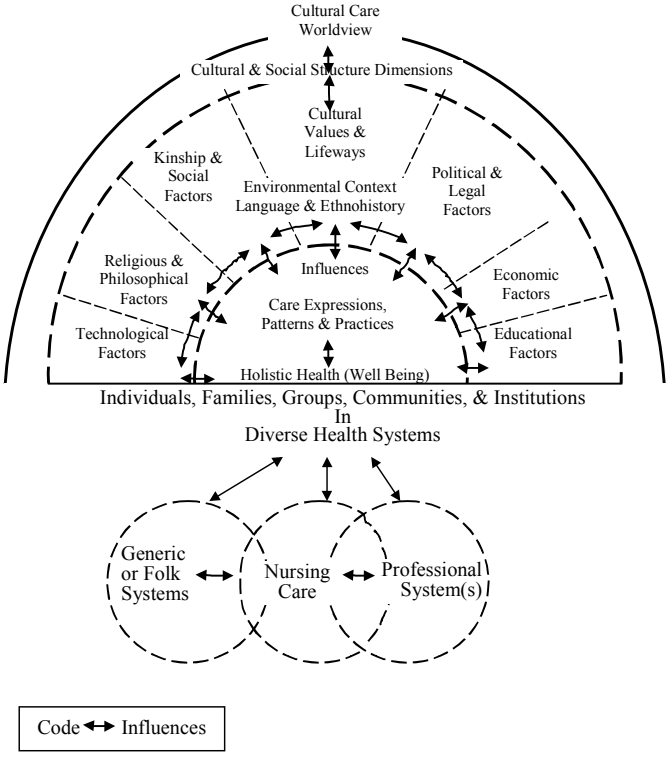

Fig. 2. Leininger's Sunrise Model to depict the Culture Care Theory as applied in this study.

3 Cultural and social factors explaining care in Tanzania

3.1 Environment and population

The mainland territory and the islands of Zanzibar and Pemba make up the United Republic of Tanzania. It is situated in East Africa, immediately south of the Equator, and has a total area of 925 200 square kilometres. Although Tanzania lies in the tropics, the altitude affects its climate. Rainfall in most of the country is irregular, varying greatly in both amount and distribution over the year. Large areas have rather poor soil with a low nutrient status. Fertile soils are limited to volcanic areas in the northern highlands and the river valleys. (Finnida 1995, World Atlas 1999.)

Tanzania's population was 29.9 million in 1997, and was growing at a rate of 2.8%. (World Atlas 1999.) Over half of the people (57%) are aged 0-19 years, and 43% of this group are adolescents (10 to 19 years old). The majority (75%) of Tanzanians live in rural areas. The low level of industrialisation explains the low rate of urbanisation. The largest part of the population are Bantu, whose migration along the river Congo took place before AD 1000. The term 'Bantu' refers to various tribes or groups of people speaking Bantu languages; more than 90% of Tanzanians speak Bantu languages. The Bantu in Tanzania consist of some 120 different tribes, which are identified by common names and have different languages and more or less exclusive territories. People in each tribe possess the heritage of a common culture, such as historical traditions, laws, customs, values and beliefs. Most of the groups are small: the largest, Sukuma, account for 12.4% of the total population. Benas and Hehes, who live in the southern highlands, together make up 7% of the total population. There are a remarkable number of people of Asian origin, dominating the trade sector. The official languages of Tanzania are Swahili and English, the latter still important in trade, commerce and higher learning. (Morgan 1972, Groliers Electronic Encyclopedia 1991, Finnida 1995, Ministry of Health 1996, World Atlas 1999.)

3.2 Cultural values and lifeways

In this study, I explain cultural values and lifeways as they were first described by Temples (1969), who was known as a founder of Bantu Philosophy. He was followed by many African philosophers (ie. Mbiti 1994) whose philosophical views could be considered ethnophilosophy or African Philosophy. (Chachage 1994). - In general, African ontology is anthropocentric. Although there are different categories: God, spirits, man, animals and plants, phenomena and objects without biological life, man is at the centre of the world. (Mbiti 1994). Anderson (1986) explains the African worldview as a triangle in which man is at the centre surrounded by various powers and beings that influence his life. At the top is God, the Creator. On one side of the triangle are the living-dead ancestors, on the other side the divinities. At the base of the triangle are the lower magical powers or spirits that may trouble man. Man as a human is aware of his position in relation to the other forms of existence, since a balance must be maintained and since all modes must keep their proper place and distance from each other. This anthropocentric ontology implies complete unity or solidarity, which nothing can break up or destroy. (Mbiti 1994.)

Temple's (1969) explanation of Bantu ontology consists of the same categories as Mbiti's, but his emphasis lies on the hierarchy of forces. He claims that the central value in different Bantu cultures is life, which is also called force or vital force. The goal of Bantu is to acquire vital force to make life stronger. All beings are seen as forces which interact, and the interaction is based on the principle of hierarchy of forces: God is at the top, followed by ancestors (forefathers, founders of clan, the dead of the tribe in an order of seniority) and the living human beings above animals, plants and minerals. (Chachage 1994, Masolo 1994.) Specially gifted human beings, such as medicine men and witches, who use their intelligence, are capable of manipulating and using the spirits for good or harm for their communities. Such results can be good, as in the case of protective medicines, or evil, as in the case of killing by magic. In order to achieve the effect, the person practising magic voluntarily arranges the interaction between a specific force that will act as the efficient cause, like a snake, tree, or charms, and the force of the victim-to-be. (Van Pelt 1982, Masolo 1994.)

Mbiti (1994) states that the traditional African religions view God as the Creator, Originator, Sustainer and the source of energy for man and the universe. The spirits are either created superhuman beings or ancestral spirits, meaning the spirits of departed human beings. Spirits exist everywhere, but they are most likely to be found in big trees, bushes, forests, rivers and mountains. The spirits chest the destiny of man. Man includes both the human who are alive and those to be born. Animals, plants and natural phenomena and objects constitute the environment in which man lives, and he can establish a mystical relationship with them. (Van Pelt 1982, Pennington 1985, Gehman 1990, Masolo 1994, Mbiti 1994.) Spirits need matter to give form and matter needs spirit to give it force, being and reality; so spirits need humans and humans need spirits. (Richards 1985.) On that basis African traditional societies believe in spiritual causation of diseases. (Obeng 1994.)

The traditional African concept of time is based on ontology. Mbiti (1994) explains that the concept of time may help to explain beliefs, attitudes, practices and the general way of life of African people. African time is two-dimensional, with a long past and the

present. A linear concept of time with an indefinite past, the present and an infinite future is foreign to African thinking in which the future as an actual time is absent apart from the present up to two years hence. (Mbiti 1994.)

In Swahili, the two time dimensions are called *sasa* and *zamani*. Both of them have quality and quantity. People speak of them as big, small, little, short, long, etc. in relation to a particular event. *Sasa* refers to the events that have just taken place or are taking place now at the moment or are just about to take place in the near future. *Sasa* time can extend into the future for about six months or, at the most, one year. *Zamani* time overlaps *sasa* time to some extent in the present, but it also goes back very far into the past time. It absorbs, holds, and stores all the events that have ever occurred. It is more significant than *sasa* because it stretches endlessly back into the past. It includes the time of myth when all the stories of creation took place and when the great and famous heroes of the past performed their exploits. (Anderson 1986, Mbiti 1994.)

Time is conceived of as it relates to events, and it must be experienced in order to make sense or to become real. The mathematical division of time has little relevance for Africans; e.g. the events which occur within a given period are more important than the actual number of hours or days within the same period. The rising of the sun is an event recognised by the whole community, but it does not matter whether the sun rises at 5 am or 7 am as long as it rises. The African is not a slave of time; s/he makes as much time as he wants. For example, it is not uncommon to find Africans spending the day conversing with friends because the event and feeling of communal participation are important, and time is of less consequence. (Pennington 1985, Mbiti 1994, Sarmela 1984.)

Rhythmic reckoning of time is typical among the Bantu. The African in his traditional setting does not use a calendar of numbers, since numbers are ideas, not events. Instead, the traditional African counts time daily and yearly by a series of rhythmic events. The day is divided into milking time, grazing time, resting time, drinking time, home returning time and evening milking time. The months are marked by the events in the phases of the moon and the year is determined by the cycle of seasonal events, such as the rainy season followed by the dry season. This rhythmic calendar is complete when the cycle of rhythm closes. For example, the new year can only start when the rain comes and the planting can begin again. (Anderson 1986, Mbiti 1994.)

Mbiti (1994) calls the natural sequence of human life “ontological rhythm”. The stages in human life are marked by “rites of passage”. A man is not considered to be a full human being until he has gone through the whole process of his own physical birth, naming ceremonies, other initiation rites at puberty and finally marriage followed by the birth of a new child. Then he is a real human being and a complete person because he has participated fully in the ontological rhythm of life and has contributed to the continuation of life of the family.

Death is a process that removes a person gradually from the *sasa* to the *zamani*. After the physical death, a person continues to exist in the *sasa* for as long as the rest of the living members of his family remember and recognise him by name. Through procreation, the dead person’s name is passed on to a grandchild and he can live on in *sasa* through a grandson who bears his name. Mbiti (1994) calls him/her living-dead, because s/he is physically dead but alive in the memory of those who knew him/her and in the world of spirits. This state of being remembered is called “personal immortality”. When there is no longer anyone alive who remembers the living dead personally by

name, s/he sinks beyond the horizon of *sasa* into *zamani* and the process of dying is completed. The living dead enter into the state of "collective immortality" that is a state of the spirits who are no longer formal members of human families and with whom people have lost personal contacts. The community of spirits function as intermediaries between God and man. Many of the spirits are feared, and magical rituals are performed either to get their help or seek protection from them if they are angry. The state of spirits is the destiny of man in African ontology. (Pennington 1985, Anderson 1986, Mbiti 1994.)

3.3 Religious and philosophical factors

The main religions in Tanzania are Christians (45%), Islams (35%) and others, e.g. traditional African religions (20%). (Electronic Encyclopedia 1999.) Invasion of colonialism brought both islam and christianity to Tanganyika. In East Africa, Arabs were first to conquer the coast in 12th century and later extended their influence into inner Tanganyika through slave trade. Christianity was brought by Western colonial officers and missionaries in 19th century. (Buchert 1994.)

Apart from religions, the post-colonial Tanganyika was touched by a nationalist movement, the common overall objectives of which were modernisation and attainment of majority African rule, including Africanisation of the government and state institutes. (Havnevik 1993.) As the outcome of sosio-political and economical crises and conflicts with some western countries, e.g. Britain, West Germany and USA, the government was forced to turn to socialist countries. Tanzania committed itself to the path of African Socialism in 1967 by announcing Arusha Declaration. The Arusha Declaration enunciated the long-term goals for Tanzania, which were *ujamaa* (familyhood) and self-reliance: hard work for the common good. (Havnevik 1994, Buchert 1994, Chambua 1994.) President Nyerere described *ujamaa* socialism as an attitude of mind, the foundation and objective of which was the extended family on the basis of African tradition. (Havnevik 1993.)

Both Bantu Philosophy and African Socialism have been criticised by using similar arguments. Chachage (1994) criticises Bantu Philosophy, which in his opinion was systematized by the colonial agents and served for 'civilization' and 'christianization' of Africans. Chachage (1994) and Chambua (1994) point out, how African Socialism, developed by the politicians and other intellectuals of independent African countries, based on the idea of modernization. It was essential to defend the African social structures and values, while at the same time modernity in terms of technology, law and economics was accepted. In Tanzania the ideas of African Socialism were institutionalized in the state and party systems, and the central issue was to struggle against poverty, ignorance and disease. Only the state had the capacity to bring modernization by encouraging unity among people, industrialization and development in agriculture. The nationalist leaders were committed to modernization, and the general tendency was to view people as ignorant, primitive, superstitious, lazy, resistant to change and backward. (Chachage 1994.)

3.4 Kinship and social factors

The deep sense of kinship has been one of the strongest forces in traditional Bantu life. The kinship system is based on descent and marriage. Kinship controls the social relationships between people in a community, governs the marital customs and regulations and determines the behaviour of one individual towards another. The kinship system is like a vast network stretching horizontally in every direction to embrace everybody in a local group. It also extends vertically to include the departed and those yet to be born. All those who can trace their origin back to a common ancestor belong to the same kinship group, the members of which have a special relationship. Clan is the major subdivision of a tribe. The clan system is not uniform in Africa; e.g. clans may be matriarchal or patriarchal. Normally, clans are totemic. (Mbiti 1994.)

The concept of family has a much wider meaning in Africa than it has in Europe. In traditional society, the family includes children, parents, grandparents, uncles, aunts, brothers and sisters, who may have their own children and other immediate relatives. The household in Africa is what European societies call family. The African household could be called "the family at night", as it consists of the people who spend the night in the same house, usually parents with their children and sometimes the grandparents. They discuss the private affairs of their household and the parents transfer traditional knowledge to the children. (Van Pelt 1982, Mbiti 1994.)

Bena, as the majority of Bantu in mainland Tanzania, belong to patrilineal societies, which means that their descent is followed through males and the property belongs to the male family members. The wife is seen primarily as the mother of one's children. The terminology used to indicate the different relatives is strongly influenced by the differences in generation, sex and proximity. For example, the father's brothers are called fathers, but his sisters are not called mothers. The mother's sisters are called mothers but her brothers are not called fathers. The children of the father's brothers are called brothers and sisters, but the children of his sisters are cousins. The relations are not just in terms; they are expressed in the daily behaviour towards each other. (Van Pelt 1982, Juntunen 1994, 1997.)

The institution of marriage is religious, because it forms a link with the living dead: the names which children bear link them with their grandparents. Marriage is social, because marriage and the procreation of children go together. A marriage is only complete when the first child is born. Marriage is economic because of the distribution and payment of bride wealth. The payments of bride wealth has several meanings: a surety payment for good behaviour on both sides, compensation to the wife's family for the loss of her labour and payment for the cost of bringing her up, establishment of the husband's legal title to his wife's children, a seal of the marriage contract between the two families and a reminder to the girl's parents that although she has left their home, she is not dead since the cattle and goats are living symbols of their daughter's continuing existence. (Anderson 1986.) Getting married to two or more wives was a custom found all over Africa, though in some societies it used to be less common than in others. The custom fits well the social structure of traditional life; e.g. a large number of children increases the immortality of the family. (Mbiti 1994.)

In the present-day Tanzania, the description of familyhood based on traditional African philosophy is too idealistic, when compairing it to the writings of Swantz (1983, 1985, 1998a, 1998b) and Vuorela (1987). The traditional family structure is breaking especially in big cities, and women run single-head families with little or no support from their relatives.

3.5 Political and legal factors

The present Tanzania, previous Tanganyika, was a part of the German East Africa during 1890-1918. In the mandate agreement of 1922, the United Nations accorded Britain the right to administration in Tanganyika. In 1961, Tanzania gained independence from British rule. TANU had organised the nationalist movement starting in the 1950's, and its leader, Julius Nyerere, became the first president of the country. The broad support of TANU, the high level of political consciousness and a common language (Swahili) contributed to national unity after the independence. When TANU adopted the Arusha Declaration in 1967, it became the ruling party. In 1977, TANU and the ruling party of Zanzibar were combined into a new party, CCM and Tanzania adopted a single-party system. (Havnevik 1993, Finnida 1995.)

The main preoccupation of the nation's policy-makers during 1961-1980 was to lift the majority of the population from illiteracy, poverty and disease. With the aim of achieving economic independence, the government pursued a policy of nationalising the important economic sectors, particularly the major industries, distribution and marketing. In planning, the central issues were re-allocation of resources to minimise regional inequalities, provision for basic needs, price control and access to basic social services. (Unicef 1990, Havnevik 1993, Buchert 1994.)

The Arusha Declaration inspired a fundamental change in the country's rural development policy. The government started to promote the grouping of dispersed villages and homesteads into *ujamaa* (= familyhood) villages. The introduction of communal production systems and the expansion and improvement of community services accompanied the *ujamaa* policy into rural areas. In 1973, the *ujamaa* villagisation policy was proclaimed to be more or less compulsory, and millions of peasant families were moved to new village sites, which were often unsuitable for productive farming. (Swantz M-L 1985, Havnevik 1993, Buchert 1994, Finnida 1995.) As the outcome of the failure of the *ujamaa* villagization policy and decreased economical growth Tanzania was forced to follow the guidelines of the World Bank. Among other changes, it meant also political liberalisation. In 1992, Tanzania changed into a multi-party parliamentary republic. The first multi-party parliamentary election was held in October 1995. Eleven parties were represented, and CCM won the elections.

The administrative structure in Tanzania is decentralised. The country is governed by a president. At the national level, there is a central administration responsible for affairs common to both the mainland and Zanzibar; the latter has also its own administration. The country is divided into 20 regions on the mainland and 5 on the islands. Each region has its own administration. The regions are divided into districts that serve as the principal administrative units. The districts are further divided into divisions and wards. A

ward consists of at least three villages that have their own village councils. Parallel to the administrative structures, the leading party, CCM, has had its own administrative structure, which goes down to cells consisting of 10 houses. (Unicef 1990, Finnida 1995.) Legally, women have equal rights with men, but the legislation recognises a customary law under which women do not have equal rights to land or to the custody of children. (Swantz M-L 1985, Ngaiza *et al.* 1991, Ndagala 1996.) In the African context, Tanzania has had a relatively free judical system and a good human rights record. (Finnida 1995.)

3.6 Economical factors

During the first decade of independence, Tanzania's economy grew satisfactorily. The growth stagnated in the second half of the 1970s due to the oil crisis, the break-up of the East African community, the war with Uganda, repeated droughts and the failure of the villagisation policy. Economic recovery was resumed in the second half of the 1980's. Several economic adjustment programmes were implemented, primarily according to the policies of the World Bank, but their impact remained limited. Economic growth increased after the introduction of ERP in 1986-1989 and ESAP in 1989-1992. These were standard structural adjustment programmes, aiming at restoring balance in the Tanzanian economy and creating a basis for sustainable growth through liberalisation of various sub-markets from excessive state control. The public sector reform has progressed slowly after the introduction of the Privatisation Masterplan in 1993. (Ndulu 1994, Finnida 1995.)

Structural adjustment programmes in Tanzania have had several interpretations. In the economic sphere, the growth of a new breed of entrepreneurs offering and distributing new products to the market has emerged. The ERP as a political programme has its own implications. The Liberal/Western ideology with its emphasis on individual achievement and selfinterest was not in line with the previous *ujamaa* (socialist) ideology, which emphasised modesty and reference to such ideals as sharing wellbeing and developing the nation. So far, the ERPs have had several effects: a clear division between the rich and the poor, awareness of regional, religious, racial and ethnic factors; increasing unemployment especially among young people; and growing public awareness through the emergence of private media and multi-party politics, which facilitates more open communication. (Mmuya 1994.) On the other hand, the recent economic change has encouraged people to take matters into their own hands and try to improve their life situations in real and tangible ways. The concept of self-reliance has hence got a new meaning different from the ideological catchword of the socialist regime. (Tripp & Swantz 1996.)

While efforts have been made to increase the public revenue and to cut the costs of administration, the budget still relies heavily on donor finance. According to the UNDP's Human Development Report (1999), in 1997 Tanzania was the 17th out of a total of 174 countries when measured by GDP per capita. It ranks higher on the UNDP's HDI although its position on HDI has been going down in 1990's. (UNDP 1994, 1999.) This can be explained by the fact that many service facilities operate at low levels of efficiency and, at the same time, many previously free services now have to be paid for and the poorest groups of the population cannot afford them. (Kiwara 1994.) On the other hand,

the statistical system has been criticised for being based on western economic thinking, which corresponds inadequately to the situation prevailing in Tanzania, e.g. the ways of measuring are inadequate, what is measured reflects inadequately people's actual state of sustenance, the measured units are wrongly identified and the measures are inappropriate. (Swantz M-L 1998a.)

Tanzania's economy relies mainly on agriculture. Maize, cassava, sorghum, rice, millet, wheat and beans are the main crops. The agricultural sector contributes 75% - 80% of all export income (Finnida 1995.). Coffee, tea, cotton, sisal, cashew nuts, cloves, pyrethrum and tobacco are the major export articles (Kaduma 1994.). Some diamonds, gold, gems, salt, phosphorite, tin, coal, kaolin and iron are mined for export and local use (Nanyaro 1994.) The major import articles are machinery, vehicles, industrial goods, consumer goods, building materials, fuels, metals and chemicals. Tanzania is, to a large extent, a peasant society with one of the lowest per capita incomes in the world and heavily dependent on foreign aid. (Likwelile *et al*. 1994).

Traditionally women have had the responsibility for food production and men for cash production. (Buchert 1994.) Economic necessity has made it possible for women to justify entering into occupations and small businesses, which were previously not considered part of the female jurisdiction in a society where occupations are highly gendered. While the majority of women are engaged in low-income projects, such as making pastries, women have also been entering into more profitable businesses from the mid-1980's onwards. Especially professional and middle-income women have been leaving their salaried positions and establishing tailoring and dry cleaning businesses, flour mills, secretarial service companies, hair salons, export and import businesses, bakeries and other small manufacturing and service industries. In some cases, husbands go as far as preventing the wives from engaging in income- generating activities because of the fear that economic independence will make women arrogant and less submissive. The traditionally accepted view that all property belongs to the husband, even though acquired by the wife, makes it impossible for women to have access to loans. (Vuorela 1987, Ngaiza *et al.* 1991, Tripp & Swantz 1996.)

3.7 Technological factors

In Tanzania technological development has been considered important in achieving higher standards of living and in determining international competitivness. In order to strenghten technological development, 'The National Science and Technology Policy for Tanzania' was published in 1985. It covers sectors such as agriculture, industry, health, natural resources, energy, transport, communications, and education and manpower. As the outcome of the recommendations of the policy, the Tanzania Commission for Science and Technology started functioning in 1988. Technological capability building requires investments, which the economic policy reforms in Tanzania, however, have not facilitated. (Wangwe 1994.) One reason for difficulties and expensive costs of keeping technical equipment in operation in developing countries is the small size of their industrial sectors. (Bloom & Temple-Bird 1994.)

The successful adoptation of a technology involves a number of activities in addition to the purchase of hardware. For example, the staff need to be trained, maintenance needs to be organized and safety procedures must be written. (Bloom & Temple-Bird 1994.) Wangwe (1994) states that the distinction between the development of indigenenous technology and the acquisation of imported technologies should not be carried too far. The capabilities needed to absorb more advanced foreign technology have much in common with those capabilities needed to create new technology. The challenge facing Tanzania, in technological context, is whether and under what conditions it can enhance its capacity to benefit from advances in technology. (Wangwe 1994.)

3.8 Educational factors

Formal western type education, which was introduced to Tanganyika by missionary organisations of different denominations, has supplemented the traditional forms of education since the 1840's. The domain of knowledge transmitted in traditional education was the prevailing norms and practices of indigenous societies, which were taught to the new generations by the elders. The purposes of the traditional education were to transmit a common culture and the prevailing gender-based division of labour. Missionary organisations introduced competing values into indigenous societies, as the primary objective was to "civilise" and Christianise the "pagan" populations. During the German era, the government started to establish schools to educate administrative and technical personnel. Government schools were located on the coast, and they emphasised Swahili as the language of communication and supported the spread of Islam. Government schools recruited their students from Arab and Indian communities rather than African ones. The colonial education system for Africans consisted of practical and vocational training for male farmers, while girls were taught home crafts. The opportunities for more academic education for potential civil servants were limited. Very rare opportunities for university education were available at Makere in Uganda (Unicef 1990, Buchert 1994, Ishumi 1994, 1995.)

The development of a national educational system free from racial segregation started shortly after the independence. The new, stable education policy, known as "Education for Self-Reliance", was established in 1967, and it followed the principles of the Arusha Declaration. The new education system aimed to promote mass education in order to improve the production and productivity of the rural sector and to involve the general public in policy-making processes. The expansion of primary education to universal primary education (UPE) brought adult literacy classes and distance learning. (Unicef 1990, Buchert 1994.) The adult literacy rate was estimated to be 90% in 1986 (Ministry of Education and Culture 1992), but UNDP (1999) estimated it to be 72% in 1997.

Every child in Tanzania is entitled to primary education. The official age for enrolment in school is seven years, but the majority of children start school later. The teaching language is Swahili in primary schools (grades 1 to 7), and English in secondary schools (forms 1 to 6). Besides vocational schools and colleges there are two universities with an annual intake limited to about 1000 students. The transition rate from primary to secondary school is low, although it has improved because of the liberalisation of

secondary education and the establishment of non-government schools. The majority of Tanzania's secondary schools are private, most of them owned by different churches. (Ministry of Education and Culture 1992, Buchert 1994, Galabawa 1994, Munishi 1995.) The Tanzanian education system is pyramid-shaped, meaning that the selection for higher level education from the lower level education is based on academic achievement. In reality, it is not based on merit only, but partly on nepotism or favouritism (Bukuku 1994.).

A growing educational crisis continues in Tanzania. School entry and participation rates have stagnated or reversed in some regions and districts. The low morale of teachers and the poor conditions of work, few teaching materials and books, poor management, and inefficient methods of education have impaired the quality of education at all levels. There is also educational discrimination based on gender. The major constraints on girls' education are the cost of schooling, cultural and religious beliefs against girls' participation in formal education, limited economic opportunities for girls in the labour market as compared with boys, and school factors, including teacher quality, curriculum and scarcity of resources. (Unicef 1990, Galabawa 1994.)

3.9 Tanzanian health care system

3.9.1 Present health situation

National health indicators reflect the poor socio-economic situation, as seen in Table 1.

Table 1. Health Statistics. (Ministry of Health 1996.)

Parameter	Value
Total Fertility Rate	6.7
Maternal Mortality Rate	200-400/100 000
Crude Birth Rate	46/1000
Infant Mortality Rate	100/1000
Under Five Mortality Rate	155/1000
Life Expectancy at birth (female)	51 years
Life Expectancy at birth (male)	49 years

The prevailing health problems are communicable diseases and obstetric complications, which together account for approximately 70% of overall hospital attendance. The leading causes for maternal deaths are haemorrhage, complicated labour, severe anaemia due to malaria, hookworms or malnutrition (lack of iron), sepsis, and hypertensive disorders. Infectious bacterial diseases, such as diarrhoea, pneumonia, tuberculosis and meningitis, are the main causes for attendance at health facilities. Diarrhoea, cholera, dysentery and typhoid are transmitted via facial-oral routes due to inadequate clean water supply, poor sanitary practices, food handling and child feeding. HIV infection has become a major threat to health, and the number of AIDS patients is

increasing annually; in some parts of the country, 10% of the adults are HIV-positive (Kilewo *et al*. 1994). The number of reported AIDS patients was 281/100 000 in 1997 (UNDP 1999.).

Of parasitic diseases, malaria is the leading problem, causing deaths as well as work absenteeism, reduced output and costs to the health care system. Attacks of malaria are more serious for young children than adults. The prevalence of other parasitic diseases, such as hookworms, bilharzia, trypanosomiasis and intestinal worms, is high. Nutrition-related health problems are common in all age groups, but children under five years and pregnant or lactating women are more severely affected. Malnutrition can be categorised into protein energy malnutrition, nutritional anaemia, iodine deficiency and vitamin A deficiency. (Kiwara 1994, Kiangi 1995.)

Industrial and occupational health problems have not received much attention on company level. Rules for the protection of workers enforcement in factories or on plantations neither exist nor are followed, and the workers' knowledge of workplace hazards is scant. Imported raw materials bear warning instructions written in foreign languages, being meaningless to those handling them. The handling of neurotoxic pesticides and fungicides without protection on coffee, cotton or tobacco plantations is a serious occupational hazard. (Kiwara 1994.) The incidence of non-communicable diseases, such as cancers, hypertension, diabetes and dental problems, is growing, especially in Daressalaam. (Kiwara 1994, Kiangi 1995.) Mental health did not receive much attention in public health programmes until late in the 1980's, because of the appearance of drugs such as cocaine, madrax, and bhang. Psychiatric records show that drugs are being used in much widely than it was previously thought. (Kiwara 1994.)

3.9.2 Development of present Tanzanian health care system and health policy

At the early stages of the independence in 1961, there were 22 health centres and 875 small, meagrely staffed and equipped dispensaries operated by local authorities. The average number of people served by each dispensary was 11 700. There were about 100 hospitals, 40 of them run by voluntary agencies, such as churches. The physicians, working in the country numbered 415, only 12 of whom were Tanzanians, and there were 380 rural medical aides. Total number of nurses was 1400. (Aarnikko *et al*. 1980, Unicef 1990.) - The present national health care system includes 8500 village health posts, 3000 MCH clinics, 2644 dispensaries, 260 health centres, 98 district hospitals, 17 regional hospitals and 4 referral hospitals. (Finnida 1992.). The population per health facility is 7500:1 and the statistics show that there is a shortage of trained health care professionals in the country, e.g. population per nursing staff 1000:1 and per physician 23 000:1 (Ministry of Health 1996.). The government health units often face a shortage of trained manpower, inadequate facilities and drugs, and low staff motivation. A user fee for government hospital services was introduced in 1993. Private health facilities are being established in increasing numbers, especially in urban areas. (Chiduo 1991, Kiwara 1994.)

The National Health Policy is based on the country's ideological framework. It was first outlined in the Arusha Declaration in 1967 and reformulated in 1971 and 1991. After the attainment of independence, the first Five-Year Plan (1964-1968) was issued, in which health service plans were considered a central part of the national development plans. The Ministry of Health expanded the services in rural areas through construction of rural health centres and dispensaries and training of paramedical staff. In 1962, a medical school was started in Daressalaam. While the construction of hospitals and the pace of adding hospital beds slowed down, the number of dispensaries, rural health centres and rural medical aides rose dramatically. Thus, commitment to the PHC was initiated well before the international Alma Ata Declaration. (Unicef 1990, Chiduo 1991, Kiwara 1994, Tripp & Swantz 1996.)

The second five-year development plan (1969-1974) was developed on the basis of Arusha Declaration, which emphasised the policy of self-reliance and equitable distribution and access to public services and resources in the country. A major step in this plan was the orientation of health services towards preventive services, to decrease the spread of communicable diseases. (Ministry of Health 1990.) The village health worker programme was started in the early 1970's to complement the institutionally provided health care services. The programme soon run into several problems: inadequate supervision, lack of community support, and unsuitable candidates for training. (Unicef 1990.)

The third five-year development plan (1976-1981) emphasised the need to provide clean water, services in rural communities and training of paramedical staff. These were vital issues for the implementation of the primary health care approach that was declared internationally in Alma Ata in 1978. (WHO 1978.) An evaluation of health care services was conducted. According to it, 72 per cent of the rural population lived within 5 kilometres of a health care facility and 93 per cent within 10 kilometres. (Unicef 1990.) At the end of the 1970's, the 20-year Long-Term Plan (1981-2000) was worked out. Its major objectives in the health care sector are the strengthening of preventive services, human resources and community participation, which are also implied in the specific objectives of the National Health Policy approved in 1991. (Ministry of Health 1985, Sabai 1995.)

The 15-year party programme (1987-2002) and the other party guidelines on economic development have shown the need to improve and maintain the quality of health care services for the whole population. (Ministry of Health 1990.) A predominant feature in the Tanzanian health sector is the programmatic approach to the prevention and promotion of health in the country. Such programmes, as EPI, ED, MCH, FPP, CDD, ORT, Tanzania School Health Programme, and AIDS Control Programme, have been co-ordinated by the Ministry of Health and financed by donors. They have facilitated the handling of major public health problems successfully. The sustainability of these programmes is a problem, because they are too vertical and the financing has come from outside. (Kiwara 1994.) In the 1990's, through various Structural Adjustment Programmes, the government actually allows NGOs and the private sector to provide health services at cost. This may have a definite impact on equity and access to services for the poor. (Munishi 1995.)

3.9.3 Traditional system of health care

The traditional African system of health care is holistic and interwoven with religion, which is a way of life, and daily living. (Mashaba 1995.) Health and sickness are seen in a wide context of individual well-being in the social and spiritual environment. The causes of illness are usually attributed to the violation of a taboo or an insult of an ancestor or spirits, and the illness has to be healed by acts of reconciliation. Bantu cultures have been recognised for their knowledge of healing herbs. Some of the characteristics of ancient Egyptian medicine are suggestive of more recent African medicine. Egyptian medicine was highly developed and a wide variety of disorders were treated by pathologists, who gave pragmatic explanations about illnesses or considered them to be caused by spiritual or magic causes. (Feierman & Janzen 1992, Mbiti 1994.)

The invasion of colonialism affected the traditional health care. Arabs had a well established system of Arabic or Islamic medicine, called *unani*, which reflects partial syncretism between prophetic medicine and the Galenic humoral medicine of Greece. The Islamic health philosophy emphasised preventive methods, such as diet, hygiene and virtuous life in the framework of a strict moral code and, in some settings, exorcism of spiritual possession. Prophetic doctrines constituted the basis for interpreting illness, assimilated with local beliefs and conceptions. Contrary to the African medical system, Islamic medicine has a developed institute for training professional medical practitioners. (Feierman & Janzen 1992, Swantz L 1990, Serkkola 1994, Swantz M-L 1995.)

Western colonial officers and missionaries fought for a modern form of allopathic medicine, which narrowly emphasised illness as a reaction to a pathological condition or agent. When the germs were discovered, drugs could be found or created that counteracted the diseases carried by outside agents. European medicine based on this paradigm was introduced to Africa, which had the reputation of being "white man's grave" due to malaria, sleeping sickness, smallpox, typhus, and cholera, which needed to be conquered in the name of civilisation and progress. (Vaughan 1989, Feierman & Janzen 1992.) During the German colonial rule 1890-1918, curative hospital services were therefore established in urban centres, intended to serve the families of the military and civilian administrative personnel. In the 1920's, after the British control had been established, the small government hospitals were expanded, and some of them had separate wards for Africans. Certain responsibilities were decentralised to tribal chiefs, designated as Native Authorities, who set up small dispensaries in rural areas for first aid and simple treatment, and small schools were organised to train dispensary personnel. Religious European missionaries developed hospitals for Africans mostly in rural areas. (Mandara 1991.) During the colonial era, practitioners of traditional African medicine were forced underground by persecution and witch hunting. (Prins 1989.)

In present-day Tanzania, traditional medicine operates alongside the modern health care system (Mandara 1991, Juntunen 1994, 1997, Juntunen & Nikkonen 1996.) Soon after the independence, traditional healers were legally allowed to continue their activities. Traditional healers represent the folk sector of healing. The folk sector includes non-professional specialists, whose methods of treatment are not heterogeneous and who share the basic cultural values and world views. (Kleinman 1980, Ware *et al*. 1992, Helman 1998.) According to the law (Cap. 92.20 Medical Practitioners and Dentists Ordinance, Tanzanian Laws, in: Swantz L 1990), a person practising traditional healing

has to be well known in the community and accepted by the community. It has been estimated by the Ministry of Health (1992) that there are more than 40 000 traditional healers in Tanzania. A Traditional Medicine Research Unit was established to operate under the University of Daressalaam in 1974. (Good 1987.) Now, African medicine is in a process of professionalization, which includes the creation of traditional healers' associations and their engagement within the national health services. Prins (1989) states that this is part of the politics of independence, as new meritocracies seek to solidify bases from which to vie for power. The syncretistic mixture of traditional medicine and traditional African religion makes it very difficult for the Christian churches to cooperate with traditional medicine. (Flessa 1997.)

When a Tanzanian gets ill s/he will choose between traditional medicine practised by traditional doctors and western medicine provided by modern western doctors. In this case, a common denominator is the social condition under which the majority of the population live. Traditional medicine is often perceived to be the only efficient cure for some illnesses, such as convulsion and measles, but patients with such problems as fever or headache go to western doctors (Gilson *et al*. 1994.). In Tanzania, 75% of the population live in rural areas, where the family bonds are strong. The families decide and choose where and when their member will go when s/he is sick.

4 Professional and lay care systems from cultural point of perspective

Both professional and lay care are always in some extent culture-bound (Helman 1998) and thus must be viewed in their context, as transcultural scholars suggest. (Orque *et al*. 1983, Dobson 1991, Giger & Davidhizar 1991, Boyle & Andrews 1995, Leininger 1995a.) In transcultural nursing, Leininger (1995a) divides health care systems into professional and lay (folk, indigenous) care, while medical anthropologists, e.g. Kleinman (1980), have suggested that in any complex society one can identify three overlapping, and interconnected, sectors of health care. The popular sector includes all the therapeutic options that people utilize, without payment and without consulting either folk healers or medical practitioners; the folk sector includes a mixture of sacred and secular folk healers, and the professional sector comprises the organized, legally sanctioned medical and paramedical professions, including nurses.

Universality of western professional care system has been criticised in various studies, which have illustrated significant differences between different western professional care systems. (Illich 1976, Payer 1989, Leininger 1991, Helman 1998.) For example, differences in medical care in different Western countries have been identified in the criteria of diagnosis, the treatments prescribed, and in cultural attitudes to certain types of behaviour and how they should be dealt with. (Payer 1989, Helman 1998.) The definitions of neither normal nor abnormal behaviour are absolute; rather, they are determined by the prevailing social norms. (Tishelman & Sachs 1998, Brink 1999.) In the same way, the definitions of health and disease are culturally determined. (Heggenhaugen & Shore 1986, Scott & Meyer 1994.) It is clearly demonstrated in culture-bound syndromes called folk illnesses, which mean the unique disorders recognized mainly by members of a particular culture and which are treated by a culturally spesific way, for example *susto* in Latin America, *amok* in Malaysia, *move san* in Haiti, or *colds* and *chills* in English speaking world. (Boyle & Andrews 1995, Helman 1998, Miller 2000.) Folk illnesses have symbolic meanings for those who suffer from them, e.g. they may express the individual's conflicts with family, reactions to changes in his natural environment, or link him to supernatural forces. (Helman 1998.) Health in professional systems is defined by reference to certain physical and biochemical parameters (Helman 1998), although in nursing it is widely accepted that health does not merely refer to a state of being (WHO

1978), but includes the process of becoming, referring to the person's growth and development as a human being. (Dobson 1991, Eriksson 1994.) Leininger (1997) defines health as a state of wellbeing that is culturally constituted and enables individuals and groups to function in their daily lives. Others, e.g. Orque *et al*. (1983) and Boyle & Andrews (1995), describe health as a state of harmony between human beings or the universe.

Professional care in this study refers, as Leininger (1991) defines it, to health care based on formally taught scientific knowledge and skills as it is practised by trained professional, such as nurses, while lay care is based on traditional knowledge, beliefs, experience and skills and is practised in families and communities. Professional and lay care systems can be differentiated through the *worldview* the care is based on (Leininger 1978, 1991, Helman 1985, 1998, Richards 1985, Benner & Wrubel 1989, Boyle & Andrews 1995, Cusveller 1998, Holland 1999), the *focus of care* (Tripp-Reimer 1984, Helman 1998, Brink 1999, Kennedy 1999), *care orientations* (Illich 1976, Swantz L 1990, Leininger 1991, 1995a, Serkkola 1994, Mashaba 1995, Lutzen & Tishelman 1996, Fagerstrom *et al*. 1998, Helman 1998, Miller 2000) and the *components of care* (Illich 1976, Bloom & Temple-Bird 1994, Bevan 1998, Greenhalgh *et al*. 1998, Helman 1998), as I have summarized in Table 2.

Table 2. Summary of the comparison of professional and lay care systems.

Professional care systems	Aspects of care	Lay care systems
Scientific, biomedical, rational, technical	Worldview	Holistic, mystical, spiritual, traditional
Disease Patient's body system/ organ as an object of care	Focus of care	Illness and the causes of it Vertical or horisontal relationships between an individual and his family/ community
Specialist-orientation Application of general principles to individual situations Control of diseases, micro-organisms and risk factors	Care orientations	Arises from the context: lifeway, values, beliefs, life experiences, worldviews; depends on an individual Reconciliation between people Local languages
Controlling and monitoring behaviours of an individual and the population Dependence of equipment and pharmaceutical preparations	Components of care	Meeting of affective and anticipatory needs Story telling, local herbs, rituals

Worldview refers to the set of the metaphorical explanations used by people to explain life events, such as catching a disease, and offer solutions to life's mysteries, for example such as falling ill. (Boyle & Anrews 1995.) A worldview creates security, and helps to attribute meaning to life and to determine which experiences and events are meaningful and which are not (Helman 1985, Richards 1985). Thus all beliefs and values regarding health care are derived from a person's basic worldview. (Boyle & Andrews 1995.) Professionally trained health care experts learn to use scientific, rational, technical and evidence-based explanations, the roots of which are in biomedicine and the western,

scientific worldview (Leininger 1991, Honkasalo 1994, Cusveller 1998, Holland 1999.) The beliefs and explanations of lay care systems reflect spiritual, mystical, or traditional worldviews, holism being a common characteristic of them. (Leininger 1978, 1991, Benner & Wrubel 1989, Pentikäinen 1994, Boyle & Andrews 1995, Helman 1998.)

Focus of care in professional system is a disease that is evident through the underlying pathology and is considered as an autonomic, ontological 'being'. (Tripp-Reimer 1984, Honko 1994, Brink 1999.) The main interest is in a person's body system or an organ affected by micro-organisms or any other causative agents. (Honko 1994, Helman 1998.) In lay care systems, the focus is illness with its causes, which, as Harjula (1994) states, resembles the rationality found in professional care systems. Illness means the experience of symptoms; the person has no scientifically found pathology although s/he considers him/herself ill due to, for example, an evil eye. (Tripp-Reimer 1984, Brink 1999.) Separation of illnesses into physical and mental categories is only due to the prevalence of western dualistic thinking, as Kennedy (1999) points out. Often in the lay care systems the cause for an health ailment is found from disturbances in an individual's relationships with his/her ancestors, relatives or people living in the same community. (Tripp-Reimer 1984, Harjula 1986, 1994.) Sickness is a state when an illness becomes a social phenomenon through either visibility or communication. (Tripp-Reimer 1984, Brink 1999.) Professional care system is legislated to label a person ill, incurable or fully recovered, which labels can have important effects from an individual's perspective. (Helman 1998.)

In professional care systems, *care orientations* are described as specialist-centered (Honko 1994, Helman 1998) although different types of practitioners are found also in lay care systems. (Swantz L 1990, Pentikäinen 1994, Serkkola 1994, Helman 1998, Miller 2000.) Professional care systems are orientated by a rational, systematic and linear way of thinking. This is seen in applications of general principles to individual situations, or vice versa, subsuming individual cases under general laws. These are proven, for example, in control of diseases and microorganisms (Illich 1976) and in models of nursing processes and nursing diagnoses. (Lutzen & Tishelman 1996, Fagerstrom *et al*. 1998, Holland 1999.) The terms and treatments used by health professionals are strange to common people. (Leininger 1991, 1995a.) Lay care orientations arise from the life context of an individual. Life ways, values, beliefs, life experiences, environment influence healing and care practices and worldviews, which are known by people. Thus the terms and treatments used are familiar to them. (Leininger 1991, 1995a, Honko 1994.) Illnesses are also examined in the social context, referring, for example, quarrelling between people or stealing from another (Helman 1998), and reconciliation between an individual and the one against whom s/he has made a mistake is a condition for recovery. (Honko 1994, Mashaba 1995.)

Components of care refer to activities, which dominate care. Illich (1976) claims that in professional care systems controlling of behaviour and monitoring of body functions is important. This is applied especially by medicalizing deviant behaviour, as well as many of the normal stages of the life span, such as pregnancy and childbirth. Professional care is dependant on pharmaceutical preparations and medical equipment, (Bloom & Temple-Bird 1994, Helman 1998) which, according to Illich (1976) and Honko (1994) reduce people's autonomy and make them dependent on the medical profession. In professional nursing care, the physical components of care, such as monitoring and comforting

behaviours, are dominant. (Leino-Kilpi 1990, Bevan 1998, Greenhalgh *et al*. 1998.) Lay care systems are concerned with meeting a person's affective and anticipatory needs. (Greenhalgh *et al*. 1998.) The illness is viewed in an individual's life context, which means that words or a story a person tells about his/her life situation play an important role in care. (Honkasalo 1994.) Also rituals and traditionally known remedies such as locally derived drugs are used. (Laitila 1994, Helman 1998.)

As a summary, this study examines care as a cultural phenomenon among the Bena in the Tanzanian village of Ilembula. The theoretical background of the study consists of Leininger's Culture Care Theory (1991, 1995a, 1995b, 1997.) The factors explaining care in the Ilembula village are viewed through the Sunrise Model, which was developed by Leininger (1991, 1995a, 1995b, 1997) to depict the different dimensions of social and cultural structure presented in the Culture Care Theory. (Fig. 3.)

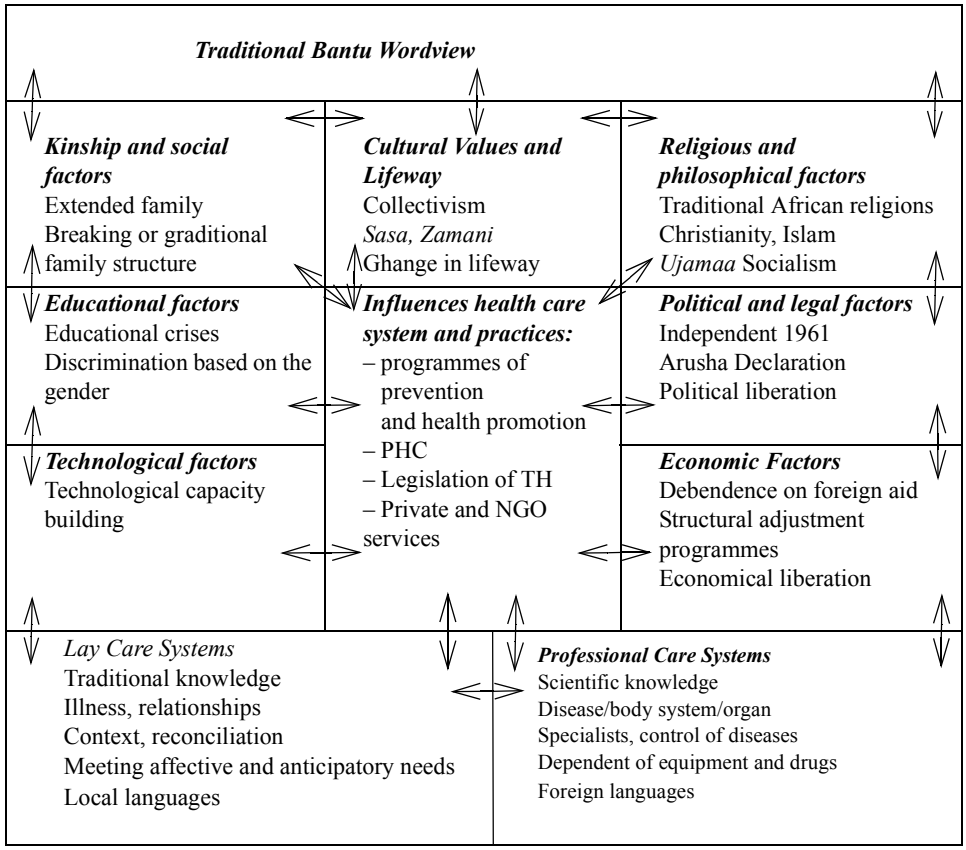

Fig. 3. Summary of the theoretical framework of professional and lay care in the context of the Tanzanian village of Ilembula.

5. Purpose of the study and the research questions

The purpose of the study is to describe and analyse professional and lay care in a Bena cultural context in the Ilembula village in Tanzania. The aim is to demonstrate how care is integral to much wider socio-cultural issues in the context of a Tanzanian village.

The research questions are:

1. How is professional care seen by the Bantu nurses in Ilembula Lutheran Hospital? (article I)
2. How is lay care described and practiced by Ilembula villagers? (articles I, III, IV)

6 Ethnography as a research approach

6.1 Character and background commitments to ethnography

This study has an anthropological perspective, because I define care as a culturally and professionally determined phenomenon. Ethnography is applicable in this study because it enables me to elicit information from the Bena in their own cultural context and gives me a chance to analyze care from the cultural actor's point of view. (Silverman 1993, Holstein and Gubrium 1994.)

The background of ethnography is wide and it draws on many disciplines. That is why there is no explicit definition of ethnography. In its widest sense, ethnography (etnos=people, race; grafia=writing, description) is defined as a systematic process, through which models of culture or subculture are observed, described, documented and analyzed. (Pelto & Pelto 1978, Agar 1980, Nikkonen & Janhonen 1995.) Usually, it is viewed as a research approach based on fieldwork with participatory observations and open interviews. (Nisula 1996). Fieldwork has historically been characteristic of anthropology, because foreign cultures without prior written documents have been the main focus of anthropological interest. (Nisula 1994, 1996.) Geertz (1972) claimed that cultures can be compared to written texts, and anthropologists are the writers of such texts. On this basis, ethnography is defined as a research process and a textual product. (Agar 1995, Van Maanen 1995.) Muecke (1994) is of opinion that ethnography is not a method; it is a product. Atkinson (1990) considers ethnography a scientific genre, a scientific style of its own. In this study, I understand ethnography as a method of study and a result of such study, including the intepretation of findings and the written research report.

The background commitments of this ethnographic study relate to the role of the researcher and the degree of the informants' participation. Classic ethnographers (e.g. Malinowski 1922, Mead 1929) concentrated on systematic observation of social environments to find their structures and functions. Fieldwork was a combination of the researcher's actions, such as observation, listening, asking questions, writing field notes and taking care of social relations in different environments. Writing up the ethnographic study consisted of describing in details the items of the environment where the research had been conducted. (Spradley 1979, Pelto & Pelto 1980, Hammersley & Atkinson 1983,

Werner & Schoepfle 1986.) Reseachers did not consider the fact that informants told them about their life experiences from their own point of view or that sometimes their descriptions possibly rather created than reflected the truth of their life. (Cohen & Omeri 1994, Nikkonen 1996, Kutalek 2000.)

Views about the roles of the researcher and the informants in an ethnographic research process were influenced by sociologists, who adopted ethnography in various ways, depending on their perspective, such as phenomenology, ethnomethodology or symbolic interactionism. (Mackenzie 1994.) Qualitative ethnographic approaches typically aim to elicit meaning and understanding from situations and actions through interpretation and explanation of behavior. It is accepted that everyone creates his or her own reality, and all knowledge is considered contextual, which means that the informants respond according to their interpretation and understanding of specific situations. This means that research should be a cultural description which does not impose the researcher's own arbitrary and simplistic categories on the complex reality. (Hammersley & Atkinson 1983, Thomas 1993, Mackenzie 1994, Baker 1997.)

Ethnographers do not work in a vacuum, they work with people. (Pool 1994.) I kept in mind that the role of the researcher is in central focus when ethnography is viewed as an endeavor to learn, what knowledge people use to interpret their experiences in their cultural context. (Aamodt 1989.) One way for a researcher to increase self-awareness of being part of rather than separate from the data is reflected in his/her personal experiences and feelings throughout the process of fieldwork. (Lipson 1989.) The researcher him/herself is the most sensitive and important instrument, and his/her interpersonal skills are therefore critically important while being on the field. (Fetterman 1989, Lipson 1989, Van Maanen 1995.) This fits in with Pool's (1994) statement that ethnographic texts do not mirrow other cultures but are products of intercultural communication.

In this ethnographic research process, my fieldwork was based on informal conversations, formal interviews and participation in some of the informants' life situations, writing up the data and analyzing it. I consider informants active participators, who reflected their own reality through interpersonal interaction, narratives and stories. My focus was on the interactive process, with the aim of making sense of, and gaining meaning about, each social situation. (Aamodt 1989, Anderson 1991.) The central question in this ethnography was how to respond to the explanations and life experiences presented by the informants. (Marcus & Fisher 1986, Geertz 1988, Van Maanen 1995, Atkinson 1990.) From the methodological aspect, my focus was to point out the interpretations through which the reality of social environment was built up instead of detailed observations and descriptions of people's social life. (Silverman 1993, Holstein and Gubrium 1994.)

In nursing, ethnography and ethnonursing have been used mainly by transcultural nurse researchers, who have studied cultural care practices of different ethnic groups. E.g. Omeri (1997) has studied Iranian immigrants in Australia, Corbett (1999) infant feeding styles of West Indian women, Nahas & Amasheh (1999) postpartum depression among Jordanian Australian women, and Sawyer (1999) the transition of motherhood of African American women. In Finland, Meriläinen (1986) did pioneering work on nursing research by studying the populations' health care practices from cultural aspect. Nikkonen (1996) used ethnography in her study of long-term psychiatric patients' lifeway when moving

from mental hospital to a community, Jokinen (1999) when studying the life path of a family of a child with asthma, and Hirvonen (2000) in her study of Finnish teenage mothers.

6.2 Ethnonursing

In the first phase of the research project I used the ethnonursing method, which is the ethnographic approach applied in nursing science, developed by M.M. Leininger. She formulated the qualitative ethnonursing research method in order to generate substantive and in-depth transcultural nursing knowledge. Leininger's aim was to guide nurses to practise nursing with a cultural care and health focus and to shift nurses' views from the emphasis on medical disease and from the reliance on quantitative research methods. (Leininger 1995a.) I used the ethnonursing method in the first phase of the study, because it enabled me to concentrate on professional nursing care from the cultural aspect.

Leininger's aim was to form a holistic picture of cultures and subcultures, and she has generalized her research findings by making lists of the cultural care values, meanings and action modes of each culture studied. Then it is possible to compare the findings and to develop transcultural care constructs. (Leininger 1991.) The goal of ethnonursing is to understand the diversity and universality of care, and for that purpose, it is important to differentiate between emic and etic data. Emic refers to the insider's viewpoint of the culture, while etic means the outsider's viewpoints of the culture and reflects more on the professional angles of nursing. (Leininger 1987, 1991.) The present ethnographic methodology stresses the importance of both, emic and etic, points of view (Boyle 1994), as in this study.

In my opinion, in the basis of the first phase of the study, it would have been impossible to produce a holistic description of the Bena cultural care practices, since the care practices of the Bena in Ilembula are not homogeneous. I used the ethnography in the second phase of the study because of its flexibility, which allows changes as the research proceeds, and data collection from perspectives other than nursing.

6.3 Ilembula as the context of the fieldwork

6.3.1 Environment and population

My description of Ilembula as a context of fieldwork is based on interviews and observations made during the second period of fieldork. (Juntunen 1997.) The Ilembula village consist of three rural villages: Ilembula kati with Iponda, Igelehedza and Igula. (Appendix 2.) The villages are located close to each other within a circle of less than 10 km in diameter. Iponda is situated on the other side of the river Halali, 1–2 km from Ilembula kati. Ilembula kati is the centre of the villages with a bus stop, a big market, a post office, shops and a hospital. Iponda is part of Ilembula kati, and it has fewer facilities than the other villages, e.g. there are no shops, schools or clinics. Igula is another village,

where the population earn their living from farming. The Ilembula villages lie at on the altitude of 1400 meters. The climate is dry since the annual rainfall during the rain season from December to April is 600–800 millimeters. The other seasons are the cold season after the rains from June till August, when the temperature falls close to zero during the nights; and the windy, dusty season from August till November when the rains are expected.

The total population of the Ilembula village is estimated to be over 5000, and the majority of people living in the Ilembula villages are Bena. The Benas have occupied the southern highland in the Iringa region, and especially the Njombe district is known as Bena land. The other tribes living in Ilembula villages are Hehe, Nyakusa, Sangu and Kinga, which are neighbouring tribes to Benas. Representatives of the other tribes have been posted in hospital, schools or government administration, or are married to Bena. The Bena have their own language, called Bena, but the majority of people also speak Swahili and the educated ones know English.

6.3.2 Cultural lifeways

The houses in Ilembula are build of clay or local bricks, and they are composed of a small, usually meagrely furnished sitting room and 1–2 bedrooms. The roofs are made of grass, or iron sheets if the family is wealthy enough. The compound has a separate kitchen with 3-stone stoves and a board for utensils, a bathroom, a store and a shed for hens and goats. If the house does not have sufficiently big a store, the harvest is kept inside the sitting or sleeping rooms, attracting insects, rats and cockroaches. During the nights, the cows are kept in a fence near the houses. The majority of houses have a separate toilet building outside the compound, made by digging a hole and building walls and a roof around it using either grass or iron sheets. During a last few years, many big, nicely built brick houses have risen in the villages for those who were born in Ilembula and have been successful in their lives in big cities.

The basic diet of the Ilembula Bena consist of *ugali* (maize porridge) and *maharague* (beans). Women usually prepare tea for breakfast, and it is taken with *mandazi*, a wheat flour pastry braised in oil. At lunch time, people eat *ugali* with beans and green vegetables cooked with onions and tomatoes, or *kande*, a mixture of maize and beans. For dinner, people usually have the same food as at lunch time. If there are celebrations, hens and/or goats are slaughtered and served with rice or potatoes. Milk is used as a spice. The eating patterns do differ from house to house. In some houses, the mother, other women and children share the meals, while the adult men eat separately, whereas in other families the husband eats together with the last born male child or all male children, or the husband eats alone and the mother eats with the children. It is considered very impolite if a quest leaves the house without eating. People eat from the same serving plates by using fingers. The hands are washed with water and soap before and after the meals.

The day is divided into day and night, 12 hours each, like all over Tanzania. The daytime starts in the morning when the sun rises and ends in the evening by the sunset, when the night starts. When it is 7 a.m. European time, Ilembula people say it is 1 o'clock in the morning; and at 7 p.m., it is 1 o'clock at night. People greet each other by using specific greetings appliable to the time of day.

The annual work rotation is determined by rains. Cultivation starts with the rains in December or January, when the fields are ploughed by digging or using cows and a locally made wooden plow. Planting is done soon after ploughing. February, March and April are the weeding time. Beans are ready for harvest in April, legumes in April – May, sunflowers in April – July and maize in July – September. The rains are over by May, and in June dry beans and legumes are stored. In June, toilets are fixed if they have collapsed during the rains. In September, the preparations for the rainy season are started by collecting firewood, preparing roofs and painting houses with clay in order to eliminate fleas and other insects. In October – November, the fields are prepared for cultivation by cleaning and burning the dry, long maize stems. Villagers, especially neighbours, form groups and work together, helping each other in farming, collecting firewood, fetching water and herding the cattle.

Drinking is said to be common in Ilembula, although drunken people are not a common sight. People drink bambu juice called *ulanzi* during the rainy season, when bambu trees produce fluid. It contains sugar, and when it is left to stand for 2–3 days it turns into alcohol. In *ulanzi* time, people suffer from diarrhoea, and it is said they forget to eat due to drinking, which is not without consequences. If a mother has small children she forgets to feed them. Another common type of drink is *pombe*, made by women in 200-litre drums by boiling maize seeds for eight hours. Usually people sit after the work and drink together; it is the duty of the one in whose house or fields people have worked to offer drinks to the others. *Ulanzi*, *pombe* or *togwa*, a soft drink, are part of celebrations, such as girls' puberty rituals or weddings. Drinking is common among both sexes, but teenage children are not expected to be seen drunk in public or in front of their parents. Drinking, similarly to polygamy, became more common in the 1960's after the independence, when the church gave up its land and lost its controlling power over the people living in the church area.

6.3.3 Religious factors

Religion is important for the Ilembula people. Different religions and denominations are found in the villages. Islam had been brought to the area before Christianity by slave traders. The first German missionaries working under the Evangelic-Lutheran Church, arrived in Ilembula in 1906. In the beginning, the Lutheran missonaries concentrated on preaching the Gospel in vernacular languages to pagans (i.e. people supporting the traditional African religions) living in and around the village. The missionaries soon started to teach Christianity in catechism schools to those who wanted to be converted. A small dispensary was founded to treat minor health problems, such as wounds. The Gothic -style Lutheran Church building was completed in 1912. It was established in the mission area reaching 2–3 km to east, south, west and north of the Halali river. The

villagers had handed the area over to the mission, which paid annual land taxes to the government. Local people were allowed to stay in the mission area and cultivate their lands for their own benefit without being Christians, but if they were converted to Christianity, they had to inform the Government officers about it, and they then paid taxes directly to the church. The mission set rules for people living in its area: they were not allowed to drink alcohol, polygamy was forbidden, and people were asked to work for the church. If people broke the rules, they had to move out of the church area.

The cooperation between different Lutheran churches expanded, and Swedish missionaries, some of them medical doctors, arrived at Ilembula in 1950, the very year when the Ilembula Lutheran Hospital was established. The Finnish missionaries, medical doctors and nurses, arrived in the 1960's. Ilembula Nurses and Midwives Training School was established in 1967 by a Swedish missionary nurse. Now, a B-grade nursing and midwifery school with 100 students and a 240-bed hospital are run by the Southern Diocese of the Evangelic-Lutheran Churches of Tanzania. Ilembula is a well-known village in Tanzania because of the mission's outcome in hospital services and nursing education.

At the present, the Lutheran and Roman Catholic churches are the dominant ones. The Catholic church has expanded its social activities by opening a nursery school and a homecraft centre in Igelehedza. Other Christian churches, such as Assemblies of God, Pentecostal Church, Seventh Day Adventists and Jehova's Wittnesses are small but function actively. They all have their own church buildings; the Lutheran Church has many churches. People attend Sunday services regularly and women's, youth's and children's groups are active. A small minority are Moslems, and there is one mosque, located in Igelehedza. There are obvious representatives of the traditional African religion, even among those who attend Christian church services regurlarly.

6.3.4 Kinship and social factors

A typical household in Ilembula consists of a husband, a wife and 5–6 children. There are also many single-head households, run by a woman who is either divorced or single and lives with her children or whose husband is working outside Ilembula. Polygamist families are also found; the wives usually live separately in their own houses and cultivate their own fields. Recently, the number of orphan children has started to increase, usually as a result of death of both parents due to AIDS.

To establish a family is a goal for a Bena man in the Ilembula villages. Marriage is an agreement between two families, although the man decides whom he is going to take as his wife. Formerly, a boy chose a girl when they both had reached the puberty and informed his parents about his intention to marry. His father then let the girl's parents know about the plan, and the marriage negotiations started if the girl's family accepted the husband candidate. At the present, the man selects the girl he wants to marry, and if his father is not able to come and inform the girl's parents, a friend can come instead of the father.

The main topic in the negotiations is the amount of dowry the fiancé and his family are expected to pay and the timetable for remitting it. The dowry is paid in the form of money and/or domestic animals; other gifts, such as a hoe, blankets and sheets, are also included in the dowry. The day when the dowry is paid is a day of celebration, and the families from both sides are expected to attend by sharing a meal and drinking the local alcohol, after which the couple is a married couple according to the customary law. Christians confirm their marriage in official church weddings, which are usually held in September – December after the harvest. Sometimes the man is allowed to take his fiancée and stay with her after paying the amount of the dowry both sides have agreed on. In such a case, the girl's family has a right to say their opinion on matters concerning their daughter; e.g. if the daughter dies, they have a right to bury her. If a couple divorces, the wife's family has to refund half of the dowry to the husband's family. If the couple has children, the wife's family will repay half of the dowry and the children are taken care of by the parents of their father. Also, the divorce has to be agreed on in negotiations dealing with its causes between the families.

At present, it is common for unmarried girls to become mothers at a young age. It is considered a shame in the community if an unmarried girl becomes pregnant, and as soon as it is discovered, her father wants to know the father of the child. If the girl is not willing to tell it, the matter is left until she delivers. Then her father tries to force her to tell the name of the man who made her pregnant, and if the girl still refuses, the matter is left and the child is considered to belong to the mother's family. If the girl tells the name of the father, her father informs the family of the child's father and tries to find out about possibilities for marriage. If the parents of the expected child are not willing to marry, the father's family pay some dowry, and the mother usually takes care of the child until it is 5–6 years old; then the child is allowed to move to the father.

The relationship between a husband and a wife is based on mutual respect, and both know their responsibilities and duties. The father's and mother's roles and tasks in the family are clearly defined. The man is the head of the household and his duties are to build houses, stores and toilets, prepare roofs, plough, take care of and milk cows, buy fertilizers and pay the children's school fees, and he should bring money to be used by his wife. The man gives instructions to his wife and children, and he is expected to listen to the wife's suggestions and plans while having the final word over them. The woman caters of the basic needs of the family. She cooks, collects firewood, fetches water, washes clothes and cleans the houses and the compound; a man who interferes with the kitchen and other household activities is not respected in the community. The wife assists her husband in other activities, fetching water when the husband is building, collecting grass for preparing roofs, and attending to ploughing if it is done with a hoe. Her responsibilities in farming include planting, weeding, harvesting, carrying the harvest home and storing it, but it is not uncommon for men to attend to harvest work. If the woman feels tired, she is allowed to have a rest, but it is also a known fact among women that if a woman does not work hard, she and her children will suffer. A wife is not expected to ask after or criticise her husband's doings. In polygamic families, the husband rotates regularly from one wife to another, so that the whole family know when the husband comes and leaves each house. The wives work on their own, except at the times of hardship, such as illness, when they all help each other.

Children are important in Ilembula families – actually a marriage is confirmed only when the woman delivers. The mother takes care of children of both sexes until they are 7–8 years old, after which sons follow their fathers. Mothers carry children aged under 2 years on their backs wherever they go. Small children are taught some household tasks, e.g. fetching water with their mother and bringing firewood into the kitchen, and later in life women are helped by their daughters and men by their sons. Children must show respect to their parents by greeting them properly, being obedient and following their advice and sometimes very detailed instructions. The other aims in child rearing include teaching them to be polite by greeting people and not calling them by using disrespectful expressions and to work hard.

6.3.5 Economical factors

The majority of people living in Ilembula have no regular income. Three fourths of the population are farmers cultivating maize and legumes for their daily use on farms 3–4 acres in size on the average, and they do not get any income from farming, since soil in Ilembula area is sandy and too poor for growing cash crops. If there is an urgent need for money, people are forced to sell their daily consumable crops or animals or try to find extra work. If fertilizers and insecticides are used, one acre produces 8–10 bags of maize (one bag = 90–100 kg), but the common harvest is 6–7 bags/acre. Without manure or chemical fertilizers and insecticides, the harvest is 2–3 bags/acre. The average harvest of legumes is 300–500 kg/acre. Other crops to grow are peanuts, sunflower, cassava, and sweet potato. One adult person consumes 3 bags of maize/year, and the average number of people living in each household is 6–8 persons, which means that the harvest is not sufficient for their annual consumption. The harvest is affected by rains, which often do not start as expected in November–December, or sometimes stop in the middle of the rainy season for 2–3 weeks, drying up the plants. Sometimes heavy rains rinse off the soil with seeds and fertilizers.

If women need some extra income, they often collect and sell extra firewood or prepare and sell *pombe* or *togwa*. Other ways of getting money are baking *mandazi* or preparing mats, baskets or pots. Some women plant sunflower to produce cooking oil for selling or grow peanuts and beans as cash crops. Children also earn money in order to help their parents to pay their school fees, buy a school uniform and soap. School-aged children may make money by collecting and selling firewood or by selling *mandazi*. The household products are sold in different places: in front of the house, by the roadsides, near bus stands or in the market.

Apart from cultivation, people keep animals; usually a house has 2–3 local hens which do not produce eggs and 2–3 pigs which can be fed by the leftovers of maize. Some people have a few goats and/or sheep and 1–4 cows producing ½–1 liter of milk daily. There are a few farmers who have bigger farms with 20–40 cows producing milk. The rest of the population earn their living in small business or are civil servants or employed by the hospital. They also have fields to cultivate maize and beans for their daily consumption. The majority of houses have a small vegetable garden.

6.3.6 Educational factors

The Evangelic-Lutheran Mission's outcome in primary education in Ilembula village was well-known in Tanzania at the time of the independence. Some years after their arrival in 1906, the missionaries founded schools, where Christians, pagans and Muslims in and around Ilembula were taught reading and writing. After the independence, the Government employed civil servants, some in high positions, who had got primary education at the mission school in Ilembula.

At the present, many of the villagers have attended primary school; illiterate people are estimated account for less than 20% of the population. More than one thousand pupils are registered in the three primary schools, one in each village. Three nursery schools preparing children for primary education are run by the hospital, the village government and the Roman Catholic Church. The official age for starting primary school is 7 years, but many parents only send their children to school when they are older, even as old as 12 years. The aim of primary school education is to make the children literate and give them basic knowledge of farming and house-keeping. English is taught from class 3 onwards prepare the children for further studies in secondary or vocational schools.

School attendance was said to be good in the Ilembula and Igelehedza primary schools, but in the Igula primary school the average number of pupils attending regurlarly is 90 out of 210 children. The reasons for poor attendance in Igula are said to be the parents' attitude towards education, costs of schooling, illnesses in families, and poor school management. Sometimes the parents whose children do not attend primary school are called to the village court to explain the reasons for neglecting the education of their children.

6.3.7 Technological factors

Ilembula is a rural village without modern technology. The most common technical equipment seen on the roads and paths are men's bicycles, and radios are own by many households. Farmers usually plough with cows or hoes when the rains have started. The services of two tractors can be rented; one is privately owned and the other is run by the Roman Catholic mission. A national company has supplied the village with electricity since 1998, before it a generator produced electricity for the needs of the hospital and nursing training school for 4 hours in the mornings and 3 hours in the evenings. Villagers use portable kerosine lamps for lighting when the darkness falls around 7 p.m. The household kitchens have a 3-stone system for cooking, consuming much firewood.

Unicef and the Government started the Wangingombe National Water Project in 1977. Ilembula, Igelehedza and Igula got water lines and tens of public water taps in 1981. At the same time, people were taught to keep small kitchen gardens for green vegetables, and as a consequence, malnutrition in the Ilembula villages soon became uncommon. Nowadays, the water supply is inconvenient due to a lack of maintenance of the pipelines. Especially Iponda has a poor water supply, as it gets its water from a different line than the other villages. The quality of water is poor; it is surface water heavily polluted both

bacteriologically (human and animal wastes) and chemically (fertilizers), the sources of which are the Mbukwa and Mtitafu rivers about 50–60 km from Ilembula. When there is no water in the taps, women carry it from the Halali river.

The main road to Zambia bypasses the centre of Ilembula at a distance of 5 km. The nearest railway station and bank are in Makambako, 35 km from the village centre. Public transport and vehicles have improved during the last few years as a consequence of free marketing. There is a regular quick bus service to the main road and Makambako, and the prices of the tickets are reasonable compared to the local economic resources. Postal services are sometimes inconvenient, as the post usually arrives 3 times a week. There is one telephone for inland calls in a post office; the hospital has a radio transmitter and the Finnish, Swedish and German missionaries have their own radio transmitters.

6.3.8 Political and legal factors

Each village has a village chairman, selected by villagers, who is in charge of the village. It is a position of honour, since they are neither paid, nor trained for their job. A village executive officer, who is selected by the administrative committee under the District Council and employed by the government, is subordinate to the village chairman. The position is applied for, and it does not require qualifications or training. All villages have their own village office, and village government elected by the village people. The village government has representatives from every part of the village. Each village has 7 committees: financial, security, social development, health, education, shop and building committees, functioning under the village goverment. Members for the different committees are appointed by the village government. The smallest administrative body is a 10-cell leader, nominated by the inhabitants of 10–20 houses. The 10-cell leaders work in close cooperation with the village leaders. Their duty is, to supervise people to attend to village activities and to follow the set of village rules issued by the village government. Also, they serve as a communication link between their cells and village leaders, primary school teachers and health workers. Apart from these duties, they are expected to assist the people living in their area to solve problems. Women are also selected to be 10-cell leaders, because they are more readily available than men. The village administration is presented in Fig. 4.

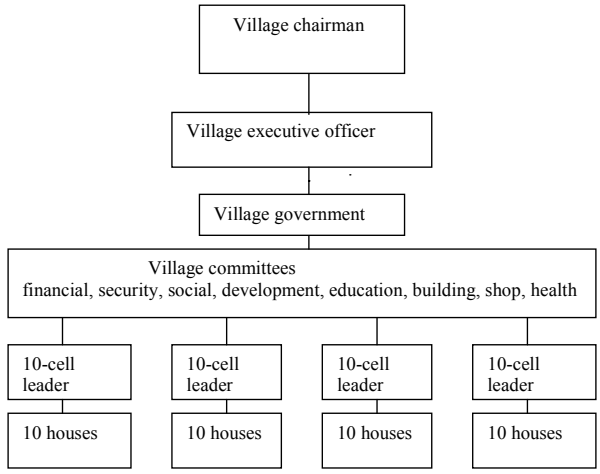

Fig. 4. Village administration.

The village governments are responsible to the *wadi* leaders. The Ilembula *wadi* consists of 12 villages with a population of 32 000–35 000, and has its head office in Ilembula. The division officers, especially the division executive officer, represent the division at the district level. There are different experts employed by the *wadi*: health officer, argicultural officer, development officer, forest officer, water officer, education officer and veterinary. Some positions, including the agricultural and development officers' post, have been repealed by the national government due to economic depression.

All village people are expected to attend to the village activities, the aim of which is to develop the community. Formerly, villages paid a lot of attention to cultivation, since argiculture was considered the backbone of the country, but nowadays building activities are given more attention. The list kept in the village office shows the annual rotation of village activities. All villagers, except businessmen, hospital staff and teachers, are requested to work for 4 hours on 3 weekdays for the development of the village. In reality, the list is not well followed since illiterate women are most active in attending the village activities because they can be frightened of the village court or the police.

Politics does not play an important role in the life of the Ilembula people, although two political parties, CCM and NCCR, are active in the village. People are frustrated and dissappointed with politicians, who promised a lot during their election campaigns but did not keep their promises after the elections. The selection of representatives for the village government and committee is not done on a political basis. CCM won the first local multiparty elections, and in 1995 one CCM representative born in Ilembula was elected to the Parliament from the Njombe district.

6.3.9 Health care practices

When getting ill, an Ilembulian may use professional or lay health care practices, depending on the traditions of his/her family and the type of the illness. In case of a mild illness, a person may use family based practices only, or buy some drugs from the pharmacy. In case of severe or long lasting illness, s/he may consider using either professional or lay care remedies, or both of them.

Ilembula Lutheran Hospital offers general and specialised medical services. The hospital has 5 wards (female, male pediatric, maternity, isolation), MCH, outpatient and eye clinics, an operating theatre, a dental unit, laboratory and x-ray departments, and a pharmacy. European and Tanzanian medical doctors and medical assistants provide medical treatments.

Preventive services are available in the hospital's MCH clinic and in the village by village health workers and village midviwes, who are appointed by the village government. The village health workers are supposed to organize a health checkup once a month for all 1 to 5-year-old children, when they are weighed and the weights are recorded on their clinic cards. Village midwives (traditional birth attendants) are to help pregnant mothers during labour. They have been supplied a kit by the government, but they and the village health workers are not paid. They sometimes attend training courses, which is too little to keep their motivation. The health committees are supposed to check once a year, usually after the rains, that all houses in the village have taken preventive actions: "painted" the houses, built latrines and made a shelf to keep the utensils.

Traditional healer (*mganga*, sing.; *waganga*, pl.), as used in this study refers to a medicine man or woman whose practice of caring and curing is based on the traditional knowedge of the Bena ethnic group. (ef. Swantz L 1990.) *Mganga*, a Swahili word, refers to a traditional or native medical practitioner. (Perrott 1982.) Twelve *waganga* (traditional healers) were known to practise traditional healing in the community, but according to the healers' own estimates, the number is about 30, because the hospital attracts healers who do not want to establish a practice of their own. Many villagers used the English word "witch doctor" instead of *mganga* to point out the traditional healers' use of magic in their practice. On that basis, one herbalist denied being a *mganga*, because she neither consults the spirits nor the divinities when helping sick people. None of the operating *waganga* had been born in Ilembula. Five of them lived in Igelehedza, three in Ilembula and four in Igula; there were no well-known healers in Iponda, but one man holding a key position in the village was a *mganga* student. Usually, *waganga* in Ilembula have no labels or signs informing outsiders where they stay and what conditions they can treat, as in towns. Two *waganga* had written their name and title *"mganga ya kinyeji"* or *"daktari"* either on the wall or the door of their houses. The majority of healers have their houses and practices within 5–15 minutes' walk from the hospital.

The *waganga* represented both sexes, although men were in a majority. Female *waganga* were believed to have stronger drugs, and they were not so commonly known in the community as men. *Waganga* were either middle-aged or old; two of them were said to have started their practice as early as during the German era. The *waganga* in Ilembula have a long experience, the time they had practised the art of traditional healing varied from 4 to 72 years and only two *waganga* had less than 20 years of experience. All were married and had children, and the male healers were polygamous with 2–8 wives. The

waganga had little formal education: three were illiterate, one had got a training and worked as an acrigultural officer a long time ago, and one used to work as a cook in the nursing school before she started healing. Healing was not the only source of income for the *waganga*, since they cultivated and kept domestic animals with their families. Two *waganga* were known to have a drinking problem.

Traditional healing as an institution is respected in the community, but the respect a *mganga* receives is based on his/her performance. The common opinion was, however, that the *waganga* in Ilembula are not very expert since they operate on a general level. The statement was supported by the *waganga* themselves, some of whom said that healers possess certain grades known by people and those on a higher rank have more powerful treatments than the others. None of the *waganga* were specialized in managing certain conditions, although the female *waganga* seemed to be more concerned with reproductive problems. Some informants shared a strong opinion that the Ilembula *waganga* just want to make money because the hospital supplies them with customers. Village health committees generally expressed their dissappointment with *waganga*, because they are not cooperative, e.g. they have not sent representatives to the village health committees, although this has been recommended by the Ministry of Health. Nor do the *waganga* cooperate with each other; each *mganga* may have 1–2 co-*waganga* with whom they discuss treatments and problems encountered at work.

Eight of the *waganga* hold licenses, which means that they are registered traditional healers. The registered *waganga* considered themselves modern and educated, since they attended seminars. The license has to be renewed every year and it costs 10 000 Ths, which is why the *waganga* had expired licenses. The *waganga* in Ilembula were organized, and one of them was selected to be *"mwena kiti ya waganga wa jadi"*, a chairman of traditional healers. According to him, *waganga* often discuss clients complains related to charges in their meetings.

Also, pastors of different Christian denominations and a Muslim *imani* pray for healing of sick people. Islamic medical practitioners are not found in the village.

6.4 Data collection and analysis

Often in ethnographic research, different types of data collected in different situations are combined. (Hammersley & Atkinson 1983.) The type of data chosen depends on the research questions (Pyörälä 1994.) Summary of data collection, analysis and reports of this study are presented in Table 3.

Table 3. Data collection and analysis, and reports.

Phases of the research project	Time of the data collection	Data and data collection methods	Method of analysis	Reporting
Stage 1				
Caring as viewed by trained nurses in Ilembula Lutheran Hospital context	December 1993–January 1994	Nurses (N=6) interviews, participatory observations, diaries, institutional documents	Ethnonursing analysis of interviews, participatory observations and diaries	Article I, summary of the dissertation
Stage 2				
Part 1				
Caring as viewed by Ilembulians	August–December 1996	Villagers (N=49) interviews, field observations	Content analysis of interviews and field observations	Articles II, III, IV, summary of the dissertation
Part 2				
Caring as viewed by the relatives of Bena patients in Ilembula Lutheran Hospital	December 1996–January 1997	interviews of relatives (N=12), field observations	Content analysis of the interviews and field observations	Articles III, IV, summary of the dissertation

6.4.1 Professional nurses' aspect

In the first stage of the study, while examining professional nursing care (article I), I collected data in Ilembula Lutheran Hospital in December 1993. The main data collection methods were participant observation, interviews and diaries. In addition, I used hospital statistics and other institutional documents and took photos to gain more information. My aim was to examine professional nursing care in a developing country in a Bantu cultural context.

In the ethnographic research approach, informants are selected on the basis of their knowledge of the phenomenon studied. (Spradley 1979, Agar 1981, Leininger 1985.) Especially the key informants should have good, relevant knowledge of the domain of the study and be able to interpret the meanings of their own cultural phenomena. (Pelto & Pelto 1978.) Because the aim of ethnography is not to generalize the findings, the number of informants is usually small.

The sample for the study was selected according to criteria specified before my departure to Ilembula. Some informants were recommended by the superior staff of the hospital. Leininger (1985) states that the researcher can utilize the views of others when choosing the sample. The six nurses (5 nurse-midwives, 1 general nurse) who were selected as key informants in this study had 3–13 years of working experience as nurses, they worked in different units of the hospital, and one of them was male. The units they worked in were: female ward, male ward, pediatric ward, maternity ward, operating theatre and mother-child clinic. Two of the informants were grade A nurses and four were

in charge of their units. The female informants were unmarried, while the male informant was married. Three of the informants had children. The nurses came from three different Bantu tribes. There were four Benas, the dominating tribe in the area, one Hehe and one Nyakusa, which are the neighbouring tribes to Benas. I knew all the informants from the time I lived in Ilembula and I had worked with all of them; one nurse was my former student.

The data were collected through participant observation and interviews. The nurses kept personal working diaries for 5 days. They were asked to write down events, experiences, feelings and ideas concerning their nursing work. Besides that, hospital documents were used and photos taken. These data collection methods enabled me to collect both, etic and emic data.

I worked on duty as a pair with each informant. On the general wards, I participated in nursing activities with the informants. In the operating theatre, mobile MCH clinic and labour room, I was mainly an observer due to the type of care given and the special skills needed in those units. The participant observation was structured. Questions like ”what is happening” and ”who is acting” enhanced the importance of the social situation. Other question like ”what do the nurses do” and ”why do the nurses what they do” were focused on the professional nursing care. Observation included behavior and the circumstances in which the behavior took place. I wrote down key words and short comments in Finnish, English or Swahili during the observation and wrote the summary reports immediately after each duty. (Pelto & Pelto 1978, Spradley 1980, Robertson *et al*. 1984, Leininger 1991.)

The nurses were interviewed 2 or 3 days after the participant observation. The interviews enabled me to find the reasons for the nurses' behavior during the observation. Ten semi-structured questions, which were based on the purpose of the study and my previous experience in the same nursing environment, were prepared in advance. In the course of the interview, I asked additional questions on the basis of the information gained through participant observation and the nurses' work diaries. The interviews, which were conducted in English, lasted for 1–1½ hours and were recorded. The informants suggested the time and place for the interview.

The data analysis proceeded according to Leininger's (1991) four phases of analysis for qualitative data. First I collected, described and documented raw data of interviews, participatory observation and diaries; the second phase consisted of the identification of descriptions in relation to the nurses'view of care; the third phase included a formulation of patterns of care and an analysis of the context in which they occured, and, finally, the major constructs of care were formulated. Institutional documents enriched the data. The data collection and analysis are described in article I.

6.4.2 Villagers' aspect

In the second stage of the study, while examining the lay care practised among the Bena in the Ilembula village, I collected data in Ilembula in August–December 1996. The data were collected through interviews, participant observation and personal diaries. My aim was to examine lay people's care practices and beliefs related to them.

In order to obtain a representative sample in view of the informants' experience, roles, sex, status and age, I got help from some hospital staff members and research assistants. The informants were selected from different groups of people in order to gain in-depth data. The data were collected in two parts: first in the village and later in Ilembula Lutheran Hospital. In the first part, the total number of informants was 49, 14 of whom were key informants. The key informants were persons known to have deep knowledge and experience in the domain of the study, and they were interviewed 2–5 times. General informants provided common information about the phenomenon studied, and they were interviewed 1–2 times. The informants represented farmers (16), traditional healers (10), trained hospital staff (7), village administrators (5), teachers (5), village health workers (3), and traditional birth attendants (3). The majority of informants were middle-aged or elderly; 21 of them were men, 28 women. All except two of the informants were living in the Ilembula villages, since I was recommended by some key informants to interview a traditional healer and a teacher/pastor, both of whom were Benas living outside Ilembula. They were known to have deep knowledge in the domain of the study.

In the second stage, to gain more knowledge about the care patterns and practices prevalent among the Bena, I interviewed and observed 12 relatives, who were taking care of Bena patients on the wards of Ilembula Lutheran Hospital. The interviews and observation were done while I participated in nursing work for 4–5 hours daily for 5 days on each hospital ward.

My Swahili language skill was not sufficient for scientific work, and altogether four research assistants were needed. The first, a young man who had experience as a research assistant, was recommeded by the hospital administrators. The other three were trained nurses; two were suggested by traditional healers who were not willing to talk in the presence of a male assistant, and one was selected by myself. (article II.) The research assistants made arrangements with the interviewees and translated the researcher's questions into Swahili or Bena and the interviewee's answers into English. During the interviews, it turned out to be important that I knew Swahili satisfactorily, because the assistants did not translate all the information I considered valuable. Because the interviews were recorded, I was able to check the validity of the translations with the research assistants and the key informants (2), who knew English. I interviewed 10 key or general informants in English language. (article II.)

I conducted the interviews in people's homes, workplaces, traditional healers' offices and hospital wards at the time the interviewees suggested. The interviews lasted for 1–1½ hours and I recorded them after getting a permission from the informants. During the interviews I made some notes and observations about gestures, the surrounding, contexts and my own feelings and reactions. It was obvious that the interviewees were very sensitive in intepreting my gestures, facial expressions and tone of voice. (article II.)

My role as a researcher was mainly that of an observer in participatory observation. When traditional healer's practices, I observed their behavior and the relationship between the healer and the client and the methods the healer used to treat the client; and on the wards I observed the role of a relative as a caretaker. While doing the fieldwork, I attended social events, such as church services or weddings, in the village.

The data of interviews of field observations were analyzed by using the method of inductive qualitative content analysis. (Appleton 1995, Leininger 1995a.) The reduction of raw data enabled me to cluster the expressions and meanings referring to care and to

formulate themes to go deeper with the informants to understand their view of care. In these two phases, I understood, through the informants descriptions of care, how important health maintenance was for the Bena. In the third phase, I categorized the care actions and interventions, and analysed the context in which they were observed or described. Finally, I abstracted the major themes and research findings and discussed them with two key informants. The process of data collection and analysis are described in the articles II, III and IV.

6.5 Ethical considerations

Ethical questions require special attention in the study of a culture in which the researcher is an outsider. During both data collection periods, I first had the permission from the administrators of Ilembula Lutheran Hospital, and in the second stage also from the Ilembula village leaders. I obtained a permission from the Ministry of Health of Tanzania, Health Systems Research Unit, after introducing my research plan.

The fieldwork with the data collection methods, which was based on an interactive process and participation, was demanding for my ethical consciousness as a researcher. When finding the informants, I kept in mind that the villagers, as autonomous individuals or members of their families, had the right to decide whether to permit an invasion of their personal privacy for research purposes. (Fetterman 1989, Lipson 1994.) My subjects were sometimes very sensitive from the cultural point of view, and my position as a representive of modern western education staying at the mission station required special consideration. I told the informants the purpose and goals of my research, but I did not pay enough attention to discussing the profits of attending the research. (article II.)

I advised and guided the research assistants, as members of the community, not to coerce or manipulate the informants and to keep the information discussed confidential. (Gregory 1990, House 1990.) During the fieldwork, I came across the fact that I, as a nurse, represented ”the white dominant group” (Orque *et al*. 1983, 6). In order to be able to participate, communicate, and intepret the data with the informants, I reflected on my role, behavior, actions and reactions as a researher in my daily field notes. (Lipson 1994.) (article II.) After the interviews, I exchanged views with a research assistant about the course of the interview, its atmosphere, and the reactions and actions to them. This helped me to develop as a researcher in the course of the fieldwork and to maintain mutual trust between myself, the informants and the research assistants. The ethical aspects of the fieldwork and the cultural encounter are reflected in article II.

7 Results

7.1 Professional care as seen by the Bantu Nurses in Ilembula Lutheran Hospital

On the basis of the empiric data, professional care for the nurse informants in Ilembula Lutheran Hospital meant: first, curing, and second, caring that involved transferring the culturally determined expectations of a mother's role as a caretaker to professional nursing care. (Fig. 5). These meanings were expressed in the nurses' encounters with patients and relatives and their actions and views about professional nursing care (article 1).

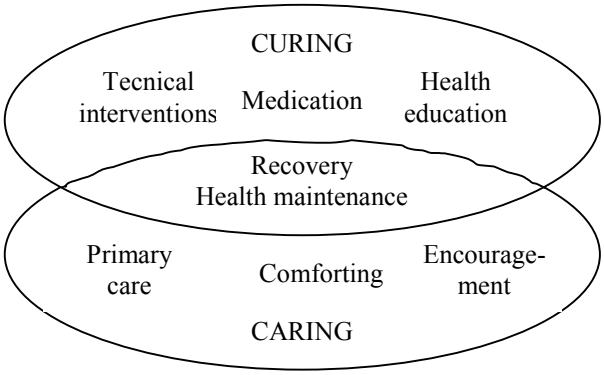

Fig. 5. Summary of the meanings and expressions of professional care as reported by nurses.

7.1.1 Curing

From the nurse informants' opinions emerged the curing component. The patients' recovery, good health, and ability to maintain health were said to be the goals of professional nursing care. The nurses considered medication and technical interventions, such as inserting cannulas or nasogastric tubes, giving injections, and applying splints, as means for helping and curing incapacitated patients. The nurses expressed their frustration because, in their opinion, the hospital was not adequately equipped to allow nursing procedures. The nurses spent a great deal of their working time for medication and technical interventions, or activities related to them.

Apart from technical interventions, health education was important for achieving this goal. The nurses considered themselves enlightened with knowledge related to nutrition, hygiene, micro-organisms, medicines or family planning, and shared the opinion that people need health education because of their ignorance. They emphasised the importance of the assessment of a patient's need for performing technical interventions and belief assessment for tailoring health education.

The nurses viewed protection of life as their moral responsibility. This led to the use of authority over the patients, which was seen in situations where a patient's life was in danger due to lay healing practices, or when they were not able or willing to obey the nurses' instructions. The nurses were distant when the patient was dying or a mother had a still birth or when the patient had AIDS. The informants explained that they were afraid of the reactions of the patients or their relatives, or they did not want to add to their burden by paying attention to what was happening or had happened.

The nurse informants considered themselves trained health care professionals and viewed themselves as members of the medical team. To be allowed to perform technical interventions or medicate patients, they depended on the orders of the medical personnel, which was criticised by some informants, who wanted to widen the role of nursing care more to the medical side. The nurses emphasised training as a way to acquire the knowledge and skills which the profession required. Outward signs of being trained to a profession, such as the certificate of a training institute, the registration, and the right to wear a uniform were considered important. They were public evidence of the profession, approved by the Ministry of Health. The professional status with the knowledge and skills had motivated the informants to applying to nurse training. Nursing was not a way to make money for the informants.

7.1.2 Caring

The nurse informants compared mothers to nurses and shared the opinion that every mother is a nurse, because she practises primary care. Primary care meant taking care of the basic needs of a child and running a household in a way that maintains health in the family. The informants strongly supported the opinion that taking care of a child includes interventions found in professional nursing care, such as comforting, touching, presence, protection, and health maintenance. This reflected the view that taking care requires skills which are acquired naturally and which normally belong to motherhood.

Comforting and engouragement were observed every day in the nurse-patient encounters. It occurred prior to nursing or medical interventions whenever a patient felt himself unsure or awkward, and its aim was to reduce the patient's fear. The meaning of touching was to reduce fears and to make the patient feel an esteemed person. The nurses built up the relationship with the patients and their relatives by greeting, talking politely and kindly, listening, looking into their eyes and touching them – all activities showing the nurse's presence. Story-telling, giving pain killers and a promise to contact a doctor were used to reassure and comfort the patients and their relatives. The nurses emphasised personal characteristics, such as friendliness, and calling as indispensable attributes of the care profession.

7.2 Lay care as seen by the villagers

On the basis of the empiric data, the main meanings of lay care for the Bena in the Ilembula village were health maintenance (articles III, IV) and improvement of health. Health maintenance and improvement were identified through the caring activities of respect and protection, which reflected the worldview and cultural values of the Bena. Respect was expressed in the villagers' beliefs and views about care and observed on the hospital wards in encountering the relatives and in activities with the patients. The aim of respect was to maintain family unity and ensure well-being. Respectful activities were observed in communication patterns, obedience, sharing the hardships of life, innocence, rituals, taking care of the parents' basic needs, and teaching Bena cultural beliefs and taboos. (article III.) Protection was expressed in the villagers' beliefs and views about care. Protection was focused on some sensitive phases of the Bena life span with the aim of ensuring reproductive, physical and mental health. (article IV.) Protective actions consisted of taking local herbs, avoiding sex, hiding menstruation and early pregnancy from others, omitting greeting during pregnancy, avoiding contacts with magic during menstruation and pregnancy, avoiding kitchen work and using one's own utensils in early puerperium. (article IV.) The meaning of improving health was given to certain lay care activities, such as taking local herbs or attending rituals, when somebody suffered from illnesses. A summary of lay care activities focusing on health maintenance and/or improvement is presented in Fig. 6.

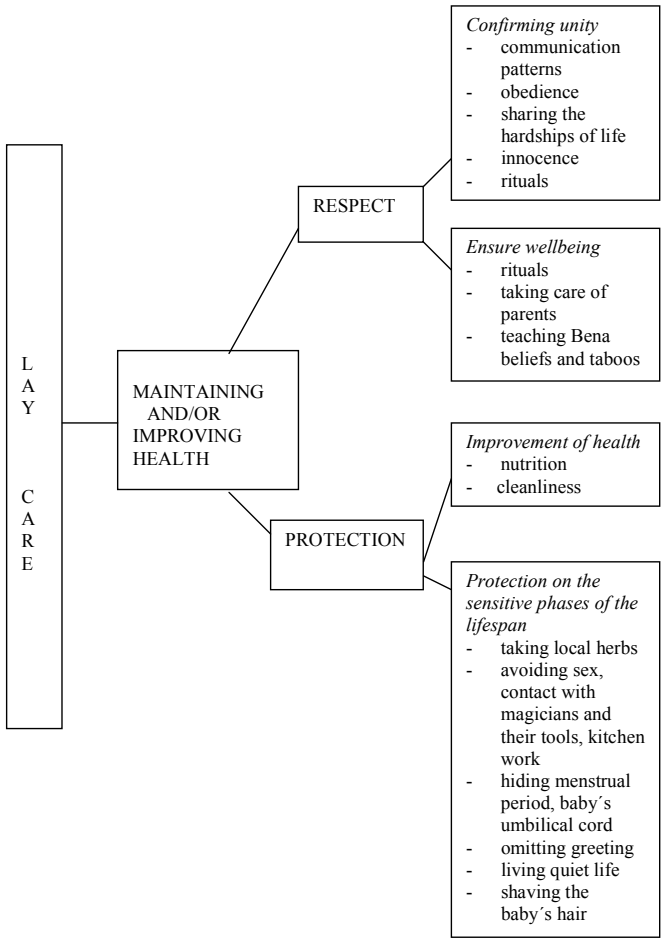

Fig. 6. Summary of the lay care activities focusing on health maintenance and health improvement among the Bena in the village of Ilembula *(see articles III, IV)*

7.2.1 Respect

The Bena informants in the village and on the hospital wards described, when expressing their views about the phenomenon of care, activities based on respect. Respect was meaningful, because it ensured unity within the extended family (article III) and the physical, economic and social well-being of an individual and his/her offspring. The basis of family unity was the worldview of the Bena, according to which the living-dead ancestors have a power either to bless or punish their descendants. The following characteristics of respectful caring activities (article III) were reported:

1) Maintaining integrity within the extended family. The Ilembulians pointed out in the interviews and I observed on the hospital wards that illnesses, excluding minor health ailments, were not a private matter. The extended family was involved if the patient's condition was not improved by home remedies. The reasons for this were the needs to share the costs of the treatment, to tell the patient's illness history to the nurses, doctors, or *mganga*, and to take care of the patient's basic needs, which required the contribution of many people.

Care meant maintaining integrity within the extended family, because the capable family members shared the hardships caused by the illness, which often meant economic or material support, but also assistance in other matters, such as arranging transport, taking care of the patient or his/her children and household. The family members visited the patient regularly to say *pole* (condolences) and to find out about his/her progress. They did this in order to ensure support from the extended family in the future, when they might have troubles themselves, or to prove that they did not cause the illness by means of witchcraft.

2) Moral responsibility**.** One characteristic of respect was moral responsibility. It was expressed best in the attitude known as *kuhangaika*, 'being anxious'. The family became anxious if the patient did not show signs of improvement and found all the available specialists and remedies it could afford. This often meant consulting one *mganga* after another besides hospitals and private clinics, buying medicines and, depending on the cause of the illness found by a *mganga*, performing rituals among the extended family.

The family's moral responsibility for care was seen in their efforts to meet the patient's wishes in order to ensure his recovery, which reflected collective and harmonious aspects of the worldview. The villagers said that a sick person was never left alone. At home, somebody, e.g. a child, was constantly nearby to hear the patient's wishes, although s/he might eat from a separate plate. In the hospital, the relatives taking care of the patient explained the interaction between their caring actions and the patient's condition, e.g. the patient had temperature because the relative delayed giving him/her a bed bath. The relatives stayed in the hospital for even 2–3 months, if the patient's condition required a long hospital treatment. The relatives were very careful in catering to the needs and wishes of elderly family members, because by doing so they believed to be blessed by the living-dead ancestors after the death of the elder. The moral responsibility for care was stressed by the informants who had noticed that some relatives, e.g. daughters-in-law, were not willing to take care of their mothers-in-law. The informants believed that such persons would be given troubles, e.g. illnesses, because of their behaviour.

3) Role division. Role division was characteristic of respectful caring actions. This was emphasised by the Ilembulians in the interviews, and I observed it on the hospital wards. After first taking self-care remedies, such as local herbs or chemical drugs, the patient occationally turned to a grandmother or grandfather, who knew the herbs used traditionally in the family. If he became severely ill or had long lasting ailments, the head of the household had to be aware of it, and he usually informed the head of the extended family. Then the patient could be sent to hospital or the family might decide to consult a *mganga*, or both.

When the patient was unable to attend to his daily needs, the members of the extended family were expected to assist him according to their age and sex. If a woman required bedside care, any of the grown-up female relatives could accompany her in the hospital,

or at home, or sometimes at a *mganga*. Her husband and grown-up daughters were also allowed to give her bedside care. The main duty of the head of the family was to pay the expenses or to find money to cover the costs. When a male person needed bedside care, a male relative, a wife or a grown-up son gave it, and the extended family paid the costs. A child was taken care of by any of the grown-up relatives, including the fathers. The position of the firstborn son was significant when one of the parents fell ill. He was expected to come and arrange everything to ensure good care, either alone or with the other parent. The role division in taking care was based on the beliefs related to *baridi* (*baridi ya ngala*; in kibena), i.e. emotional coldness (see 6.3.3.). (articles III, IV.)

4) Being present. Respect meant encounter with an emphasis on being present. The reason for this was found to be the tradition that the patient was not allowed to be left alone, since there was always a possibility that s/he would die without anybody hearing his/her last words. S/he might have got involved in witchcraft or made other serious mistakes causing, for example, *litego* (see 6.3.3.), and wanted to confess this. (article III.)

Being present began with greetings, the expression of *pole* and asking about the patient's condition. It included giving time, sitting together, and eating or drinking tea together, or staying quiet but physically close to the patient. The one taking care of the patient, either alone or with one or two family members, fed and bathed him/her if necessary, washed linen, changed clothes and slept near him/her. S/he also assisted the nurses by keeping an eye on the intravenous fluid infusions, urinary catheter, feeding via a nasogastric tube, collecting specimen, transporting the patient to the x-ray department and monitorng his general condition, especially in postoperative stage. Succour, which here refers to assistance given by relatives at times of need, was an important element of being present.

The relative was a mediator: s/he informed physicians and nurses about the history of the patient's illness and transferred their orders to the patient. However, it was even more important to keep the rest of the family informed about the progress of the patient's condition and the prescriptions given by the health professionals. The patients and their relatives expected reassurance, medication and technical interventions from nurses.

Being present was the key aspect of the encounter of *waganga* with their patients, whom they called *wageni*, guests. They gave time to the patient, sometimes even 2–3 days to find the cause of the ailment, listened to him/her, made observations about his/her way of speaking or tone of voice and gestures. The waganga found it important to know where the patient came from, because they were aware that the meanings of the word patients used to describe symptoms varied, depending on where they came from. A client had to be open and honest to a *mganga*. Those *waganga* who used divination techniques or spirit possession, were experienced in telling the problem of a patient after discovering it from his speech. *Waganga* were easily available and accessible in the community, being ready to serve people at any time of the day.

7.2.2 Protection

On the basis of the empiric data, numerous beliefs expressed by the professional and lay informants were related to health maintenance and/or improvement of health. The analysis of beliefs proved that their focus was on nutrition and cleanliness, phases of the moon, behavioural taboos and attributes, body secretions and supernatural forces. They all reflected the worldview of the Bena, as did the experiences of activities maintaining and/or improving health, such as taking local herbs in order to neutralise a harmful agent or to protect from it, avoiding contacts with harmful secretions referring to reproduction or magic, following behavioural rules, and attending rituals. (Fig. 7). The expressions and experiences of the beliefs varied in intensity among the informants, but their existence and meaning was well known by all of them. The beliefs reflected the physical, mental and reproductive components of health. (Articles III, IV).

Nutrition and cleanliness. The Bena informants considered nutrition and cleanliness important means of maintaining and improving health. This is interpreted to be the outcome of health education in schools and clinics. A healthy daily diet consists of meat, vegetables, eggs, and milk in addition to ugali. The main benefit for children is physical growth and development with good health, and for adults a healthy diet gives strength to work hard for their families. Handwashing before meals, clean drinking water and cleanliness in food preparation protect from diseases, enable working capacity and save money. Personal hygiene prevents smells and is part of the daily activities. Sweeping of the floors and the compound every morning helps to maintain a healthy environment, as does the renovation of the walls of mud houses, which prevents tick fever, and the building of new latrines every year after the rains.

Phases of the Moon. The Bena understand childhood to be a sensitive stage of the life span from the aspect of the development of intelligence. That is why the villagers were concerned about *degedege,* convulsions, in early childhood. The informants thought that every child has convulsions when the new moon starts to grow, and convulsions indicate the development of epilepsy. Some informants specify that bad weather in the moon, observed from the crescent that does not lie horizontally, causes convulsions. Local herbs, whose origin, dose and type of administration is based on family knowledge, were commonly used in Ilembulian families, including educated and Christian families. The holistic worldview of the Bena, in which every created part of nature holds energy that influences the other creatures, is demonstrated by the use of local herbs, which are believed to neutralise the magnetic-like effect of the moon on sensitive infants.

Expressions of factors deteriorating health	Experience of activities maintaining/improving health	Meaning of activities maintaining/ improving health
Nutrition and cleanliness	Growing vegetables and eating them daily Sedimentation of drinking water, hand washing Daily personal hygiene Keeping the environment clean Renovation of houses, building a latrine once a year	Daily intake of meat, eggs, milk and vegetables builds up the body, gives energy to perform the daily work for the benefit of the family Ensures physical growth and development, maintains and improves physical health Prevents unpleasant odours Ensures well-being Saves money
Phases of the moon	Taking local herbs to protect from convulsions, which, in early childhood, indicate the development of epilepsy and impaired learning capacity	Maintains mental health Protects from epilepsy Ensures learning in school and later carrying out the roles and responsibilities based on sex and age
Behavioural attributes and taboos	Following behavioural rules referring to familial obedience, communication patterns, sharing the hardships of life, innocence, attending rituals, taking care of one's parents, keeping a physical distance to one's parents	Behavioural rules protect from *baridi* affecting an individual, *lana* affecting an individual and his offsprings and *litego*, affecting the family
Body secretions	Restrictions for a mother in the postpartum stage Sexual contact forbidden during menstruation, lactation and menopause Hiding signs of bleeding Taking local herbs for protection	Contact with puerperal bleeding is harmful to a husband and fertile women. Menstrual blood makes a woman dirty, weak, and sensitive to spirits; causes male infertility Seminal fluid replaces breast milk > malnutrition to a lactating child; obesity in menopause.
Supernatural forces: witchcraft and spirits	Following behavioural rules related to menstruation, pregnancy, and postpartum. Taking local herbs for protection, or local oxitocins to hasten labour; Attending rituals	Spirits and witchcraft may cause a long-lasting, slowly progressing illness and may affect male/ female reproductive capacity, making labour difficult, or affecting the state of mind

Fig. 7. Expressions, meanings and experiences of health maintenance and improvement of health for the Bena in Ilembula village.

Behavioural attributes and taboos. The Bena informants emphasised the importance of each individual's 'good behaviour' within the family and in social relationships. The core idea is to pay full attention to the others instead of expressing one's own feelings or opinions openly, which is considered egocentric. Good behaviour involves fulfilling of the moral expectations based on cultural values, such as unity and respect for life, and knowledge of the culturally defined sex- and age-based roles. Good behaviour ensures harmonious co-existence, but breaking the behavioural rules and taboos is punished by God or ancestral spirits through illnesses and failures in life.

Coldness, *mepo* or *baridi ya ngala* (Bena; known also as *baridi*), was defined by the informants as the outcome of disrespect or disobedience and/or neglect of close family members. *Baridi* is a slowly progressing emotional condition with various signs and symptoms, starting from feeling weak, cold and restless, and ending by in physical deformities. When the first AIDS -patients were seen in the village, people thought they were ill due to *baridi*. Some informants had the opinion that incest leads to *baridi.* Beliefs related to *baridi* explain the physical distance between parents and children and the role division in bedside care. A curse, *lana*, is the most severe baridi called *baridi ya lana*. It means a curse cast by the parents on their children, who have hurt them. The outcomes of *lana*, loss of employment and/or property, singleness, mental illness, physical deformities, and incest, reflected economic, family and moral values. A trap, *litego,* was the outcome of making a mistake against another family member, such as stealing a cow or sleeping with somebody's wife. It reflected the collective values of the Bena, since according to it, the members of family started to die one after another due to accidents or sudden illnesses. It also reflected the worldview of supernatural forces, since *litego* was the outcome of a ritual that required witchcraft.

Body Secretions. The informants agreed on the possible health effects of body secretions. The secretions related to reproduction required caution, while others, such as excrement, urine and particularly saliva, were only found unpleasant.

The strongest beliefs reflect the energy that puerperal bleeding is said to comprise. Contact with puerperal bleeding is believed to affect the husband's physical health by causing slowly progressing, painful distension of the abdomen, which could lead to death within a few years. Such contact could also cause milder abdominal discomfort to the rest of the family, except the fertile-aged women in the family, who are in danger of becoming infertile. To avoid these consequences, the mother is taken care of by elderly female relatives, has a separate plate, mug and thermos that she only uses in the puerperal period, and does not attend the kitchen work for at least seven days after labour. Apart from puerperal bleeding, a recently delivered mother has to be careful with her baby's umbilical cord, which could weaken the mother's fertility if it touches the baby's genitals when it has dried and drops off. The baby's umbilical cord and hair are considered strong and thus harmful if witches or wizards get hold of them in one way or another for their evil purposes. According to the informants, the beliefs of the strength of puerperal bleeding used to control the relationship between wives in polygamous families. The trained informants appreciated the belief as allowing recently delivered mothers freedom from kitchenwork, which enables them to rest after their labour.

'Menarche' signifies a transition from childhood to mature womanhood, as female informants were taught in the menarche rituals. The Bena women in Ilembula consider menstruating women dirty and weak because menstrual bleeding itself is dirty.

Traditionally, women were forbidden sexual intercourse during menstruation, because the dirty blood was said to cause infertility to the male partner by blocking the route of seminal fluid. During their menses, women were weak in the sense of being vulnerable to spirits, because they had lost blood. Due to this, women should avoid contacts with *waganga* able to manipulate spirits and their magic tools. Menstrual blood itself is strong and could increase the power of the local herbs used in witchcraft. That is why women are very careful in maintaining their personal hygiene and handling the used pads.

The beliefs related to semen reflects the interaction between fluids and persons, the emphasis being on reproduction. Seminal fluid is stronger than the breast milk that it replaces when a lactating mother makes love, causing the child feeding on such poor quality breast milk to become malnourished. Traditionally, Ilembulian Bena men left the village for two years for employment, often far from home, and returned when the wife had finished breast-feeding. Nowadays, a child is given a protective local drug once before his parents sleep together for the first time after the delivery. The expecting mother is advised to take local drugs to protect her foetus after she stops having sex before the labour in case her husband runs after other women, which could be fatal to the baby. For the same reason, the baby should be given local herbs before the father sees him or her for the first time. If the baby is covered with vernix caseosa, Ilembulians believe that the baby is dirty and laugh at his/her mother, who has had sex too close to the labour.

Methods known to be western are viewed in a cultural context. One male informant was of the opinion that the parents could sleep together as soon as the mother has recovered from the labour and got her stimulation back, if the man uses *mpira*, a condom. By the same means, women could continue sexual life with their husbands after the menopause or after getting grand-children. The Bena share the opinion that menopausal women get distension of the abdomen indicating cancer when they have sex, because the semen accumulates in their abdomen. Some informants were of the opinion that men are also affected and get a swelling of the scrotum, because there is nowhere for the semen to go. Two educated male informants said that these beliefs were a way to oppress women, and had been invented by men who wanted to find an excuse to marry a younger wife.

Supernatural forces. The informants shared the beliefs related to supernatural forces, i.e. powers capable of deteriorating health and well-being, usually indirectly. Supernatural forces, witchcraft and spirits, reflect the holistic and collective worldview, in which living humans and invisible forces and spirits are in interaction. Witchcraft is divided into bad magic causing illnesses and failures, good magic ensuring success and happiness, and protective magic preventing illnesses and ensuring normal pregnancy and easy labour. Five types of evil spirits are known to exist in Ilembula: *miungu* (ancestral spirits; evil only when annoyed by a living descendent), *mashetani* (demons), *mapepo* and *majini* (Muslim spirits), and *Christian spirits*, and they emphasise the spiritual aspect of the worldview. Inexplicable misfortunes and illnesses are often explained by supernatural forces.

The reasons for bewitching are envy and quarrelling. The informants explained that the object of envy is one who has had a better fortune in his/her life in terms of prosperity, employment, marriage or study merits. The state of air, *hali ya hewa,* made by wizards/ witches in the area may affect a newcomer, especially if s/he is well off. Possession by spirits is interpreted as a punishment for a person who has broken behavioural taboos, or as a result of envy. Illnesses caused by bewitching and spirits resemble each other, but

vary in severity. They are typically long-lasting and insidious, but the spirits are also said to cause more severe health ailments, including hemiplegia, mental problems and socially unacceptable behaviour. *Waganga* explained that diseases sent by spirits were getting more common because of children's misbehaviour.

The informants' concepts of supernatural forces were not homogeneous. The Christians or educated informants were of the opinion that witchcraft only affects those who believe in it, but even they considered the existence and power of spirits was real. *Waganga*, some of whom were also said to be witches/wizards, claimed to be able to know if the illness was caused by supernatural forces, and was hence categorised as an illnesses imposed by people. The informants shared the view that hospital remedies cannot cure illnesses caused by supernatural forces. The only way to prevent them is to try to live in peace with everybody, which is considered a demanding ideal, however.

7.3 Summary of findings

As a summary, the characteristics of professional care as reported by Bantu nurses and the lay care reported by the villagers in the Tanzanian village of Ilembula are presented in Figure 8. Curing and caring were the characteristics of professional care. Curing was demonstrated through technical interventions, medication and health education. Caring reflected traditional cultural knowledge and it was demonstrated in primary care, encouragement, and comfort. The patient's recovery and maintenance of health were the goals of professional care. Respect and protection were the characteristics of lay care, both reflecting the worldview and cultural values of the Bena. The aim of practices demonstrated respect was to maintain family unity and ensure wellbeing, while protection was focused on the sensitive phases of the Bena life span. The main meaning of lay care for the informants was health maintenance and improvement of health.

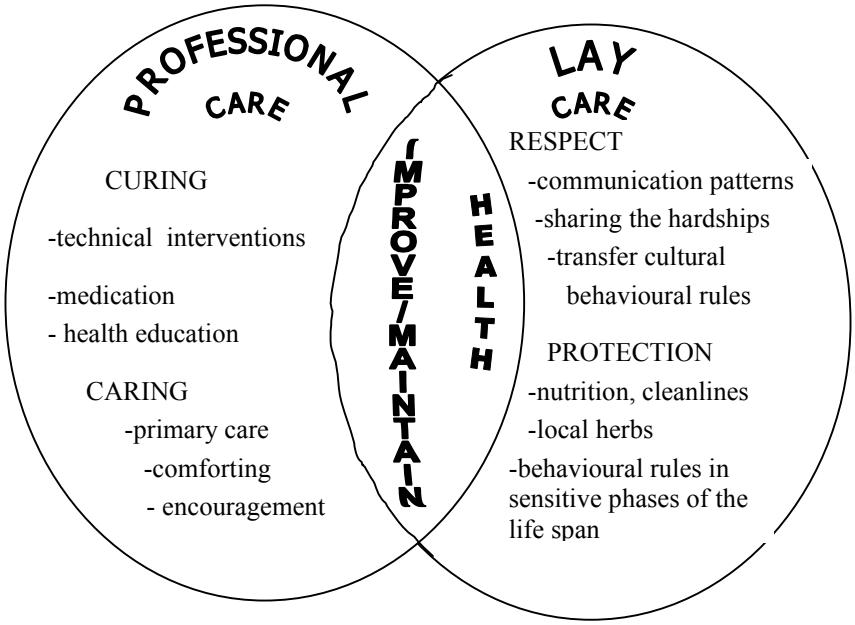

Fig. 8. The summary of characteristics of professional care as reported by nurses and lay care as reported by the villagers in Ilembula.

8. Discussion

8.1. Validity of the study

The purpose of this study was to describe and analyse professional nursing care and lay care in the Bena cultural context in the Tanzanian village of Ilembula. The aim was to present that care is integral to much wider socio-cultural issues in the context of the Ilembula village. In my opinion, ethnography was the only relevant research approach. There was no prior knowledge about the phenomenon of care among the Bena or any other Bantu subgroup. The ethnographic research approach enabled me to study care from a holistic perspective, including both professional and lay angles. Ethnography as well as Leininger's ethnonursing method made it possible to examine care in its context. Qualitative research approach is observed to provide wider perspective than quantitative approach to phenomena studied in developing countries. (Muecke 1997.)

In an ethnographic research report, the researcher is expected to present clearly his/her motives, the background commitments and the approach of the study, and how the data is collected and analysed, because this enables the reader to evaluate the research process. (Grönfors 1982, Lipson 1989, Syrjäläinen 1994, Mackenzie 1994, Meleis 1996.) Due to this, I have explained my practical starting points and theoretical aspects, the purpose of the study, the research questions, the methodology and the research methods based on them. By applying the ethnographic approach with data collection methods suitable for it, I found answers to my questions. In the first stage of the study, I describe care as practised by the professional Bantu nurses in Ilembula Lutheran Hospital. In the second stage of the study, I describe care as the Ilembula villagers see it. Finally, I describe and analyse care from professional and lay aspects. This enables me to find the characteristics of care and the meanings of care expressions and to discover how the socio-cultural context influences care.

For evaluating ethnography, or any qualitative research, Lincoln & Cuba (1985), Guba (1990), Syrjäläinen (1994), Meleis (1996) and Thorne (1997) have presented particular criteria. I assess the validity of my research process by Leininger's (1991, 1995a, 1997) criteria for evaluating ethnography and ethnonursing research. The criteria mainly concern qualitative data collection and they are: credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability. (articles I, II, III, IV).

Credibility refers to the accurary or credibility of the findings, or it can be described as a "truth formulating process" between the researcher and the informants (Lincoln & Guba, 1985, Leininger 1991, 1995a, 1997.) All nurse informants and some informants from the village knew my background and remembered me from the time I worked in Ilembula, but for the majority of the informants and villagers I was "a *mzungu* (a European) making a research about health matters" or "a *mzungu* writing a book of us". At the very beginning of the fieldwork, "bush radio" spread information about me to the villagers, who usually greeted me in a friendly way when I was walking around. As soon as I started the fieldwork, I noticed the same as Kutalek (2000) when studying traditional medicine in Njombe: people told me what they believed I wanted to hear. The majority of the informants were excited about the interview: a white woman coming to their house for the first time in their lives and making questions, which sometimes turned out to be on sensitive topics, such as menstruation. Usually, I first discussed the everyday life of the informant and then moved on to specific themes. A few informants felt free to present their views ever since the beginning of the interview, but it often required 2–3 meetings, not necessarily in the form of an interview, but meeting accidentally in the village, before the informants' tension subsided. On the other hand, I sometimes found it uncomfortable to take my informants' time. My relationship with some of the informants became very close in spite of the fact that I could not enter further into my informants' world with them because I was not one of them and I was not fluent in their language. I had to keep on interpreting what they were telling me in terms of what I already knew and expected, being aware of my Western background and the influence of my former experience and professional knowledge. In terms of credibility, listening to the informants turned out to be important, but even more important was to encourage them to ask questions from me.

Collecting data from a variety of sources increases credibility. (Robertson *et al*. 1984.) The main part of the data were collected through interviews and participatory observation, which are essential data collection methods in qualitative ethnography. (Leininger 1985.) I also used documents and took photos to gain more information. In the first phase of the study, the nurses wrote a personal diary for 5 days of their feelings, actions and experiences concerning their work.

Interview is frequently used in ethnographic research because it evokes unexpected information from the interviewees. (Spradley 1980.) At the first stage of data collection, I had prepared some semi-structured questions, which I supplemented with open-ended questions based on my observations and diaries. In the second stage of the data collection, I used themes and open-ended questions. Participant observation was valuable because it meant studying people in their natural environment and included behaviour and the circumstances in which the behaviour was seen (Spradley 1980, Robertson *et al*. 1984.) In terms of credibility, in the second stage of the study, I had to pay attention to my research assistants. They had an important role in getting into contact with the villagers and facilitating interviews. Their role was ambivalent, because they did two things: opened up new areas of research which led to new understanding, and caused confusion by some of their translations and interpretations.

Confirmability in this study means reaffirming what I saw, heard or experienced about the phenomenon, and the study findings should be based on the empirical data, not on my opinions. (Lincoln & Guba 1989, Leininger 1991, 1995a, 1997.) There were altogether 67 informants, with different backgrounds, including age, sex, and vocation or profession,

and one third of them were interviewed several times. The same questions were presented to many informants, although the questions also differed according to age, sex and position of the informants. Also, the number of research assistants (4) was relevant in terms of confirmability. I discussed the findings, after analysing the data, with 1–2 key informants at the end of both periods of fieldwork. Throughout the second period of fieldwork, I shared my observations, interpretations and initial conclusions with the research assistants, interviewees and some other informants from either the village or the hospital.

Meaning in context means that the data become understandable with relevant meanings to the informants within their familiar and natural living and environmental context. To be able to meet this criterion, the researcher has to understand the situations and activities described and be able to transfer them to a wider context. (Leininger 1991, 1995a, 1997.) I met and interviewed people in different environments and situations, and aimed at getting wide knowledge of the community itself. My former knowledge and experience of the culture enabled me to find the meanings in their context. The use of Swahili language would have made the data more vivid, but the English language probably did not restrict the finding of meaning-in-context data. When writing the research report, I made a special effort to keep the information given by the informants unchanged. On the other hand, the data collection was a learning process to me, and I did not only learn about the Bena, but also about my own Finnish culture.

Recurrent patterning refers to documented evidence of repeated patterns, themes, and acts over time reflecting the consistency of lifeways or patterned behaviours. (Leininger 1991, 1995a, 1997.) These criteria require collection of the data over a long period. I spend two relatively short periods in Ilembula. My previous stay and working there are not entirely relevant in this context, because at that time I did not pay systematic attention to care. In order to meet this criterion, I interviewed different people in different situations and environments. By doing so I gained information about different aspects.

Saturation refers to content-rich knowledge about the phenomenon studied. It means that the researcher has conducted an exhaustive investigation and there is no further data or insights coming from the informants or situations. (Leininger 1991, 1995a, 1997.) I continued data collection in both stages of the study until the key informants did not produce any new information. I preferred the quality of informants to the quantity of informants, and with the same aim, I collected the data through various methods.

Transferability refers to whether or not the findings of the study will have similar meanings and relevance in another similar situation or context. (Leininger 1991, 1995a, 1997.) The purpose of a qualitative study is to elicit in-depth knowledge about the phenomenon studied not knowledge that can be generalised. This data was collected in a poor rural Tanzanian village. However, the principles of taking care of healthy and sick people, based on the lay interpretations of illness and methods of curing illnesses, can be transferred to some other Bantu cultural context in Africa to some extent, but not in detail. Professional care was studied in a mission hospital, and some of the findings cannot be transferred to government or private hospitals in Tanzania, because the management and material and technical facilities in those hospitals differ from mission hospitals.

8.2. Discussion of the findings

8.2.1. Professional nurses' aspect of care

In the first stage of the research project, I studied professional care as the trained nurses in Ilembula Lutheran Hospital saw it. My purpose was to find new knowledge of the professional nursing care practised in a Bena cultural context in a developing country, Tanzania. The study is based on the phenomenon of care as presented by Leininger in her Culture Care Theory (1991, 1995a, 1997.) The findings indicated that nursing was based on formal training on the one hand and on a natural mother-child relationship reflecting traditional cultural knowledge on the other hand. Health maintenance and improvement of health were distinguished as being characteristic of both features of professional nursing care. There are few previous studies about professional nursing care in Tanzania or any other African developing country from the cultural perspective. Care in an African context has not been the main focus of interest for transcultural scholars, either. I examined the findings of the first stage of the research project on the basis of the social and cultural structure factors presented by Leininger (1991) in the Sunrise Model. Also, I utilized the perspectives expressed in transcultural, ethnographic or sosiological studies made in Tanzania and other African countries, and in nursing studies related to care in professional contexts.

Cultural values and lifeways. Professional nursing care was based on formal western training and influenced by traditional cultural knowledge. The former reflects the scientific and rational worldview (Sarmela 1984) and the latter the African Bantu worldview (Mbiti 1994.) The nurses' focus is on the patient's disease, and they concentrate on medication, nursing procedures and health education, the aim of which is to cure the disease, to prevent the patient's condition from deteriorating or to maintain his/her health. The African antropocentric Bantu worldview causes nurses to create and maintain a good relationship with the patient and his/her relatives and to protect them from traditional harmful health practices.

Actions and interventions categorised as primary care, encouragement and comfort, reflect the influence of the worldview and cultural values on care. Encouragement and comfort are seen as ways used by the nurses to build up the relationship and to maintain co-operation with the patients and their families. This reflects the holistic worldview of the Bantu, in which all creatures influence one another. (Harjula 1981, Van Pelt 1982, Mbiti 1994.) This is seen in the importance of greeting and expressing condolences. The nurses stressed the patient's need for self-esteem, especially prior to frightening technical interventions, which reflects the understanding of the patient as the starting point of care and the viewing of the situation from the patient's own framework. (Lutzen & Tisselman, 1996, Eriksson 1994.) The findings support Mitchell's (1996) statement that professional care has been influenced by lay care knowledge. Also, cultural influence is observed in meeting dying patients or their family members. The nurses are distant and do not mention death due to their fear of meeting the patients' or their relatives reactions. This reflects the worldview of the Bantu, who consider death as a normal phenomenon only in old age. (Mbiti 1994.)

Religious and philosophical factors. Superior attitude of nurses is observed in the content and methods of health education. Nurses fight against people's ignorance about nutrition and hygiene, harmful taboos, and the dangers of using local herbs. The attitude was influenced by christian missionary work, in which traditional African religion is labelled as paganism and traditional healing practises are criticised as dangerous. (Flessa 1997, Pasanen 2000.) On the other hand, common people were labelled as 'ignorant' by developers of *ujamaa* socialism, as Chachage (1994) points out. The nurses appreciated education and were eager to apply for further training because they view education as a means to develop and help, not only themselves, but also the nation. Health education is individualised (Orque *et al*. 1983, Giger & Davidhizar 1995, Leininger 1995, Abdullah 1995, Meleis 1997, Lipson 1999) in the sense that the patient's tribal background and opinions are considered. The finding can be interpretated that the nurses were guided by stereotypes related to ignorance of different tribes.

Educational factors. The professional orientations and components of care are explained by the nurse education. The emphasis in the nurse training curricula (Ministry of Health 1989, 1993) is on the concept of disease and nursing interventions. The students are taught the causes, symptoms, signs and treatments of diseases besides nursing procedures. This influences the clinical nursing practice in Ilembula Lutheran Hospital. Health education and technical interventions are done by the nurses to the patient, which reflects traditional and technical nursing, emphasising the authority of the nurses in patient care. (Leininger 1991, Janhonen 1992.) The role of the nurse in traditional nursing is, as an expert, to plan and carry out specialised care for a passive recipient called patient. (Leininger 1991.) The nurses spent a lot of time on measuring and counting various medications (Holden 1991, Leininger 1991) and tended to view professional nursing care as equal to medical care. The nurses were, however, disturbed because they had to wait the orders from doctors and wanted to widen the role of nursing more to the medical side, as Serkkola (1994) found nurses doing in Somalia. This reflects the fact that the domain of nursing care is not clarified in nursing education and in clinical nursing practise.

The nurses' rational and technical care orientation was observed in their tendency to underline the importance of need assessment (Fagerstrom *et al*. 1998) and belief assessment. The nurses considered belief assessment very important, the aim of which is to discover harmful beliefs and practices. The nurses officially opposed traditional healers' practice and told the patients not to consult them, although they themselves in certain situations sought advice or assistance from them, usually in secret. The finding was similar to that reported by Upvall (1995) in Swaziland. This reflects the incorporation of the nurses into Western style nursing (Engebretson 1996), which begins during the nurse training. Actually, the students' separation from their home background with its associations with the traditional lifestyle, beliefs and medicines begins when they start secondary schools, the majority of which are boarding school. (Holden 1991, Swantz M-L 1998b.)

The nurses had observed that the villagers had not changed their everyday life practices to promote health as they had been taught in health education sessions. However, the teaching is on a superficial level and does not include practical applications based upon the availability of materials and local practices and beliefs. (Hildebrandt 1996, Kater 1996.) Another reason is what Tuominen *et al.* (1996) found when studying

the valuation of health by rural people in three Tanzanian villages: matters directly related to survival (nutrition and housing) were most often mentioned. Health as the most important item was mentioned by 9 % of the 354 interviewees while 20 % ranked it amongst the two most important issues. Health for Ilembulians was a practical matter: it meant strength to work and earn money, which enabled them to meet their daily needs and the schooling of their children.

Legal factors. The status of being a professional nurse with outward sings, such as the right to wear a uniform, the certificate and registration approved by the Ministry of Health prove nursing education to be, for the female nurses, a means to social ascent from male oppression and village life with the traditional activities of farming and giving birth. (Swantz M-L 1983, 1998b, Vuorela 1987.)

Economic factors. Professional nursing care does not mean big money, which in connection with the on-going social breakdown and the financial problems of families, attracts nurses to establish businesses (Ngaiza *et al*. 1991, Tripp & Swantz M-L 1996) also in Ilembula. The nurses in Ilembula Lutheran Hospital were not corrupted: they did not require extra payments for the services they did for the patients, as nurses often do in big cities. The reasons for this were the lower cost of living in the village, the relatives participating in the patient's care on the wards and the social norms of the mission hospital.

Technological factors. The nurses felt themselves powerless and unable to work effectively. The contextual analysis showed that the reasons for this were the lack of material facilities and the lack of support from the hospital administration. The nurses had incorporated themselves into the Western style of nursing, which requires aseptic techniques, disposable materials and different kinds of equipment. Jordan (1987) states that high technology exported to hospitals in developing countries tends to produce a hierarchical distribution of decision-making power and the transformation of social relationships. The nursing administration has a heavy responsibility to maintain the material resources by controlling the use of bed linen, instruments and nursing equipment and the consumption of drugs and milk powder. The matrons spend much of their working time by arranging stores and keeping stocks. Occasionally they have to interview nurses to find out how drugs or equipment disappear. Holden's (1991) description of the role of European colonial nurses in Uganda has similarities to the responsibility of the matrons in Ilembula.

Ethnohistory. Southern Diocece of Evangelical Lutheran Churches of Tanzania has set its own principles of moral conduct, which were expressed in *barua ya kuajiriwa.* Ilembula Lutheran Hospital, a mission hospital under ELCT, request as an employer the newly employed workers to sign *barua ya kuajiriwa*, the aim of which is also to guide and protect the staff in their private life. However, it caused feelings of frustration among the staff of Ilembula Lutheran Hospital. As pointed out by Holden (1991), however the importance of the sexual and moral integrity of nurses is well documented in the history of the development of modern nursing in, for example, Britain as well as in Finland. (Sorvettula 1998.)

8.2.2. Villagers' aspect of care

In the second stage of the study, I described and analysed lay care as viewed by the Bena in the village of Ilembula. My purpose was to find new knowledge of culturally determined factors to describe lay care. Theoretical framework was care as described by Leininger in her Culture Care Theory. On the basis of the empiric data, the main meaning of care was health maintenance. Health maintenance was identified through the caring activities of respect and protection, which reflected the worldview and cultural values of the Bena. I explain the findings on the basis of Leininger's (1991) Sunrise Model. There are no previous transcultural studies of lay care among the Bena or any Bantu subgroups, which makes it impossible to compare the findings to the results of other studies done in a context similar to Ilembula. That is why my views of lay care are based on ethnographic studies performed in the African context, and I also utilise the findings of transcultural nursing studies.

Cultural values and lifeways. The worldview of the Bena in the Ilembula village is described on the basis of the study as holistic, harmonious, magical, and spiritual, which are the characteristics of the traditional anthropocentric Bantu worldview. (Van Pelt 1982, Anderson 1986, Mbiti 1994.) The worldview and cultural values are seen in the beliefs related to the focus of care, the care orientations, and the components of care.

The holistic and harmonious worldview is reflected in the focus of lay care, which consists of family unity, and physical, mental and reproductive health. Such components of care as respectful behaviour, presence, succour and family participation are also explained by the holistic and harmonious worldview. This is observed in the encounters with others (Van Pelt 1982, Mbiti 1994), for example, the greeting patterns and the expression of condolences, *pole*. Apart from behaviour, the attitude towards nature is also explained by the holistic worldview. The Ilembulians believed that nature has a remedy for all health ailments. The Bena in Ilembula used *dawa ya kinyeji,* local herbs, in health maintenance, i.e. to protect themselves and their families from illnesses caused by others, and also to cure illnesses. Prins (1992) presents the idea behind it: the human body belongs to the earth elements, which is why pharmacopoeia derived from nature is believed to cure it. The use of local drugs is explained by the belief originating from ancient Egyptian medicine: for every human illness there is a plant that possesses the property of neutralizing its effect. (Waite 1992, Gefald *et al*. 1993.)

Explanations of the causes of illnesses demonstrated the holistic worldview. The causes of illnesses were categorised as natural, also called normal illnesses or illnesses sent by God; illnesses send by others involving supernatural forces, such as witchcraft or spirits as a source of the health ailment; and violation of tribal customs and taboos. The finding is similar to several studies of African health care systems (Murdock 1980, Van Pelt 1982, Feierman & Janzen 1992, Mbiti 1994, Pool 1994.) Natural illnesses reflect the symbiosis and balance between the human being and his physical environment, while illnesses caused by supernatural forces refer to the control of insecurity in the community and before the ancestors, as do also illnesses due to the violation of behavioural taboos. (Richards 1985, Helman 1985, Hiltunen 1986, Davids-Roberts 1992, Greenwood 1992, Feierman & Janzen 1992, Mbiti 1994.) Violation of tribal customs and taboos, such as sex, property and verbal taboos, may make a person feel guilt, which can be extremely uncomfortable and painful, and can be interpreted as a form of somatic illness. (Murdock

1980, Harjula 1986.) The influence of the holistic worldview and traditional knowledge partly explain why the villagers have not adopted to a greater extent the means of health maintenance taught by health care professionals. On the other hand, many traditional practices, e.g. those related to female reproduction, have changed.

Magic and mystical worldviews are seen in the beliefs concerning body secretions, and the phases of the moon. Particularly menstrual and puerperal bleeding were assigned special meanings, which are examined in the context of ancient Greek humoral medicine. (Greenwood 1992.) The humoral system is energetic, meaning that there are hot environmental substances containing much energy and cold substances containing little energy. Blood is one of the four Galenic humours considered hot, since its source is a natural element, fire. Heat is a symbol of life force and dangerous in excess, as in puerperium. The danger inherent in female sexuality is found in the ritual impurity of menstruating women, as intercourse with them would cause a cold illness. (Greenwood 1992, Douglas 2000.) The Bena in Ilembula believe that the moon has an influence on small children. Van Pelt (1982) explains that the Bantu are aware of the forces of the surrounding world, such as hypnotism, magnetism or telepathy, the exact nature of which is not yet known. Even natural phenomena, such as the phases of the moon, have their influence on man and animals, described as a magnetic attraction between different materials. This kind of thinking is most likely to be influenced by Islamic medicine, the developers of which worked on medicine and astronomy. (Ead 1998.)

The spiritual worldview was reflected by the majority of the informants, who explained their beliefs and experiences of spirits. Ancestral spirits have always existed, and Richards (1985) states that, for a family to be healthy, its continuity and wholeness must be continually experienced through the ancestors. Christian spirits have probably appeared in Ilembula within the last 10–20 years, which could be a sing of the revival of religious groupings and identities in Tanzania, as Hartmann (1994) observed. Muslim spirits, originating from the Indian Ocean, were the most scared and were believed to be very powerful. The historical events explain this: the Muslims from the coast spread their religion, trading and seeking people to be sold as slaves. In my opinion, a chance to be possessed by spirits related to a feeling of insecurity. Especially women expressed their fears of spirits in sensitive phases, such as menstruation, pregnancy and puerperium, referring to reproductive capacity. Janzen (1992) found that in the nineteenth century fertility got increasing attention in African traditional medicine, possibly because of the combination of insecurity due to the slave trade and the appearance of venereal diseases. The informants also said that especially Muslim spirits are capable of destroying business, which also, as an open field of competition, enhances feelings of insecurity.

The lay care of a sick Bena is individualised, which reflects the anthropocentric worldview. Lay care in the Bena cultural context in Ilembula refers to actions believed to ensure full recovery from illness by minimising the suffering, effort and pain of the patient. Thus, the main goal of the individualised care is to release the patient's energy for recovery. Lay care means paying attention to the patient's affective needs, and the caretakers recognise him/her as a person with self-esteem. The patient has a right to express his/her wishes concerning the care, e.g. the type of diet, linen, drugs and the maintenance of hygiene. The family member explain the deterioration of the patient's condition by his/her neglect, e.g. "s/he has a fever, because I/we forgot to give him/her a bath". The explanation is understandable in terms of the holistic worldview of every

action having an effect on the other living creatures. It also shows that care is considered a moral duty. The care of elderly family members was highly individualised because the relatives considered their death to be close at hand. (Mbiti 1994.)

Lay care was tailored for the individual, which I very clearly observed in the traditional healers' practices. The healers try to identify the causes of illnesses from the social context of their clients and their remedies depend on the causes of illnesses, meaning that the same local herb can be used to treat different conditions. The payments also varied, depending on the client's economic conditions or state of illness. The same has been described by Swantz L (1990) among the Zaromo in Tanzania and Gelfand *et al*. (1993) among the medical practitioners in Zimbabwe. Transcultural scholars, e.g. Tripp-Reimer (1984), Boyle & Andrews (1989), Leininger (1991, 1995a), and Lipson (1999), refer to individualised care when they underline the needs to understand of the cultural influence on the beliefs, values and practices of a society. Leininger (1991, 1995a) and Lipson (1999) use the term tailor-made care to refer to assessment and the provision of care fitting an individual's cultural beliefs, values and lifeway.

Kinship and social factors. The kinship's influence on care was remarkable. Holistic lay care is based on maintaining the integrity of the extended family. A human being is viewed as a member of a family, which includes both living and living-dead family members. A human being's doings influence directly or indirectly him/her and his/her offspring through the living-dead ancestors, who are believed to observe them and give their blessings or punish them. Respect of the elders means that the younger generation usually obey their parents at least to some degree and are careful in opposing the views of care expressed by their parents. Families have diverse expressions and meanings of care, depending on their beliefs and experiences. The roles related to care are learnt in the family, and each family has its own, secret knowledge of local herbs, which are not shared with others due to the belief that the herbs lose their effect if many people know about them. The influence of mothers and grandmothers on younger family members is significant in questions of health maintenance, reproduction and treatment of illnesses. They advise or urge the others to use certain remedies, and sometimes secretly give local herbs to children suffering from convulsions or to induce labour. Families have their own principles in seeking care if home remedies do not relieve symptoms; some families first consulted *waganga* and then the hospital, or vice versa. On the other hand, people may choose different methods on different occations, or they may use various combination of methods, as Swantz (Swantz M-L 1995) found the Zaramo doing. The change in the family structure affects the care practices. An increasing number of single-parent families often means economic problems and less support from the extended family, which means that the mother is struggling more or less on her own.

In case of an illness, the care actions and interventions carried out by the relatives influence the recovery, as described above. Thus, the care of a sick family member is a moral duty, which the Bena want to fulfil. The moral aspect of care is viewed in the arrangement of old or single family members, who usually leave with the children of their relatives. This is a way to share the burden related to raising up the children, and it ensures help when a family member suddenly falls ill. Somebody being present enables communication between those who participate in care. It often means that the client or his/her relative participate in drug processing, as found among the Zaromo in

Daressalaam (Swantz L 1990). The findings are supported by transcultural nursing literature, which shows that the kinship (Luna 1994, Omeri 1997, Nahas & Amanesh 1999) is a meaningful component of the cultural context.

Role division is an obvious component of lay care among the Bena in Ilembula. The roles in taking care of a patient and ensuring the health of the family reflected the gender roles observed in everyday life. Both sexes and all age groups have their own duties, rights and responsibilities: men had the traditional roles as protectors and economic providers for the family, women were home managers and nurturers of children. The role division has been identified by several ethnographers in diverse cultures, e.g. Leininger (1989) in Alabama among Afro-American villagers, Serkkola (1994) in Somalia, Omeri (1997) in her study of Iranian immigrants in Australia, Nkongho & Archbold (1999) among American Africans. The question of proximity, which is expressed in beliefs referring to *baridi*, a Bena folk illness, is also central in the role division. Fear of *baridi* controls a grown-up person's proximity to relatives of opposite sex and, in my opinion, protects from incest, which is a taboo in Ilembula. Mbiti (1994) states that sex has originally been considered sacred among the Bantu, and the beliefs of *baridi* support this notion.

One reason for the actions to maintain integrity was to ensure getting assistance from the extended family during illness. Serkkola (1994) found in his study about the meanings perceived for illness behaviour and the treatment and management of tuberculosis in pluralistic health care in Somalia that the patrilineal kinship system was the most important supporting factor and provided social security for those unable to participate in active life due to tuberculosis. The relatives took care of a sick family member in order to ensure the family assistance for themselves during possible illness. In a society where official social security systems do not exist, an individual depends on the support of the family, relatives or unofficial networks. (Serkkola 1994.) In Ilembula, unofficial networks did not play an important role in giving support to an individual or his/her family except to express sympathy.

Several transcultural studies about African Americans have proved that the family should not be excluded from the care of the patient. Nkongho & Archbold (1999) studied African America caregivers for older, sick relatives and found the maintenance of extended family integrity to be one of the familial reasons for caregiving. Sawyer (1999) found that expecting African American women expressed a desire for support from their partners and families. In the American context, one explanation for the family unity in care is the discrimination and racism people of African origin experience (Sawyer 1999), which is not the case in Ilembula, where the Bena represent the majority of the population. The common meaning of care, however, for the Bena in Ilembula and African Americans in the United States is social security.

Educational factors. The informants took education to mean *maendeleo,* development, with a better and more prosperous future. As a profit of education, people are said to become independent from traditional beliefs and customs. The educated informants believed that knowledge is a key to maintaining health in the community. The *waganga* who had attended seminars also appreciated knowledge about hygiene and cleanliness and applied it in their practice. The informants had observed within the last 10–20 years the disappearance of many traditional beliefs related to care because of health education in schools and clinics. One example of this is female genital mutilation in a form of

clitorodectomy among the Hehe-Bena-Sangu (Mumford 1934), where elderly women performed it as a part of initiation ceremonies. Now, among the Bena in Ilembula, it is done to mothers whose children have a long-lasting health ailment, which is believed to be caused by dirtiness of the genital area during birth.

It is generally acknowledged that formal education improves the health condition, even without special emphasis on health education. Especially high level of literacy among females has a strong connection with the standard of health in a society, since women are both providers and recipients of health care. (Tarimo 1991, Hurskainen 1994.) Care, education, expanding incomes, health, empowerment, and a clean environment build up human capabilities. In fact, the role of care in the formation of human capabilities and in human development is fundamental according to the Human Development Report. (UNDP 1999.)

Economic factors. The informants were of the opinion that economic factors affect care and health maintenance remarkably. Mothers have to work hard to get their family food and drinking water, to collect firewood and to wash clothes. They usually leave their children with the grandmother or on their own, and then they are not fed properly. On the other hand, the mothers working in business have young housegirls, who are unable to take proper care of children. The poorest families do not come to hospital for treatment because they cannot afford it. The cost of professional health care apart from attitude of medical personnel, distance and consultation hours can result in professional health care being more or less inaccessible for some members of a society, as van Vuuren & de Klerk (1996) observed in South Africa.The *waganga* have observed that people living in rural areas, like Ilembula, are poor and not able to pay full cost of treatment in money. Poverty makes it impossible to observe the instructions given in health education sessions: boil drinking water, eat meat and eggs regularly.

The Iringa region, to which Ilembula belongs, is not counted among the poorest regions in Tanzania. (Finnida 1995.) However, the majority of families in Ilembula have no regular income due to the low productivity in agriculture, they live in mud wall houses, and are not able to educate their children, which means that poverty repeats itself in all sectors of life. In spite of the important role of care in human well-being, care in Ilembula, as worldwide, is often identified with unpaid work by women. Wider economic meaning for care is given by UNDP (1999), which refers care to social reproduction essential for economic sustainability.

Ethnohistory. The founding of Ilembula Lutheran Hospital had changed the lay care, as the elderly informants said. First, the number of illnesses started to increase. Before the hospital, people were said to suffer from just a few health ailments, but the western doctors discovered several illnesses formerly unknown in the village, and did not call them in the Bena language, which made it impossible to know the illness and to find a local treatment for it. The hospital had introduced a new practice: not to visit a family whose child was ill with, for example, measles. That was found unbelievable: to leave the neighbours to suffer alone, even without saying *pole*. Also, the mothers had been forced to give birth by lying down instead of sitting, which made the village women avoid giving birth in the hospital. On the other hand, the villagers had started to trust the hospital drugs and accepted them as one choice in treating illnesses, but there had always been a tension between the western and local health care practices. The hospital staff were prejudiced against the traditional practice because of the poor hygiene; the villagers criticised the

hospital staff, who did not respect the local traditions and knowledge. The hospital staff had traditionally blamed *waganga* for cheating people and making money; *waganga* held the view that the hospital staff did not value their knowledge and skills, and blamed them for using spirits. In nursing care, there was no such gap, since relatives were expected and beleived to be able to take care of their patients admitted to the hospital.

Environmental context. The environment affects the illness and care patterns. In the village, gastrointestinal problems were among the most common illnesses, which means that health education and traditional prevention are not effective protective means. Traditionally, long-lasting stomach or back pains and fatigue were explained to be caused by other people, meaning witchcraft, or the breaking of behavioural rules. The water supply system is poorly maintained and the drinking water is heavily polluted surface water. The soil in the area is sandy and infertile, causing economic and nutritional problems, which affect health, although malnutrition in the village is rare. Collecting firewood and local herbs takes more effort and time year after year, since trees and local herbs are disappearing from the village area due to heavy consumption.

8.3. Criticism of Leininger's Culture Care Theory

The theoretical basis of this study consists of Leininger's Culture Care Theory and the Sunrise Model (1991, 1995a), which was developed by Leininger to illustrate the different dimensions of her theory. I found this theory relevant when planning the study. Leininger was the first nurse researcher to point out the importance of culture in explaining individual health and caring behaviours, and she developed transcultural care as one domain of nursing science. The roots of her theory lie in the clinical nursing practices of various cultures. Apart from them, Leininger's theory has influenced other transcultural nurse researchers. (Orque *et al*. 1983, Boyle & Andrews 1989, 1995, Dobson 1991, Giger & Davidhizar 1991.) In this study, the meaning of Leininger's theory and the Sunrise Model can be described as a cognitive map that enabled me to define the concept of culture and oriented me to discover the different dimensions of care and to figure out how integral care is to wider socio-cultural issues in the context of a Tanzanian village. Finally, I found Leininger's Culture Care Theory and the Sunrise Model able to give a structure to this study.

However, Leininger's Culture Care Theory is a macro-level theory that aims to provide a holistic view of cultures and subcultures. (Leininger 1991, 1995a.) While doing fieldwork, I found that Leininger's theory can also be criticized when explaining the phenomenon of care in a changing society, such as the Ilembula village. The way Leininger has generalized her research findings by making lists of the cultural care values, meanings and action modes of each culture studied can be criticized. First, it may result in a stereotypical view of a culture, which is not relevant if we consider the multiple realities existing in present-day cultures. Second, it does not consider the variation within cultures, including disability, socioeconomic status, gender, age, religion or education, which influence the ways in which people express their cultural orientation. (Boyle 1999,

Lipson 1999, Meleis 1999.) Third, every belief and behaviour has both cultural and individual determinants (Lipson 1999) or, as in the case of my study, both cultural and familial determinants.

This study is based on traditional cultural anthropology. That is why, apart from quoting Leininger, I have also quoted the studies by African ethnophilosophers, such as Tempels (1969), Van Pelt (1982) and Mbiti (1994), who aim at generalizing the features of Bantu-speaking people's cultures. Despite this, however, I am aware that each Bantu tribe has its own cultural heritage. Secondly, the Bena is a minor Bantu tribe, and there are very few former studies of them. Thirdly, Ilembulians explained to me their cultural values and life-style in accordance with the views of Van Pelt (1982), Masolo (1994) and Mbiti (1994.) Due to the theoretical framework, the findings of this study can be criticized, to some extent, as consisting of disappearing folklore.

In modern ethnography, which followed the postmodern breakthrough in anthropology, cultures are not viewed holistically. (Geertz 1988.) It is accepted that everyone creates his or her own reality, and all knowledge is considered contextual (Hammersley & Atkinson 1983, Thomas 1993). Leininger's Culture Care Theory is rigid and does not consider the dynamic aspects of culture. In nursing science, it is applicable to studying the meanings of narrow cultural phenomena, e.g. greeting or respect, in regard to care. On the basis of the findings of this study, I also question Leininger's division of care into professional care and lay care.

8.4. Conclusions

In summary, according to the results of this study the main conclusions are:

1. lay care of the Bena in the Ilembula village maintains and improves health in forms of protection and respect, while professional care maintains and improves health in forms of curing and caring
2. for the Bena in Ilembula village health means physical, mental and reproductive capacity and enables to carry culturally determined role expectations
3. lay care among the Bena in the Ilembula village is based on the traditional Bantu worldview and values, while professional nursing care reflects western scientific knowledge and values
4. the disparity between professional and lay care from the nursing aspect reflects the hegemony of medical power and knowledge over nursing
5. lay care activities maintain the cultural values and traditions and demonstrate women's role in transferring cultural knowledge
6. care means social security to the families in Ilembula
7. the lay care beliefs and practices vary between families
8. culturally competent care of the Bena in the Ilembula village only occurs when the individual's and his/her family's life context, including the worldview and values, are known and used in a meaningful way by the nurse

8.5. Implications for nursing and suggestions for further studies

This ethnographic study examines care as a cultural phenomenon among the Bena in the village of Ilembula in Tanzania. The focus of both, nursing science and anthropology, is to understand a human being, who creates his/her own culture and experiences it. Thus care can be studied as a cultural phenomenon, a culture of its own. The study is meaningful for Finnish nursing science because it creates theory for practise. The focus is to demonstrate what should be considered when nursing is practiced and nursing research conducted in another culture and transculturally. How to consider the premises of another culture? How another culture or other cultures are viewed in nursing care? What is needed in confirming the quality of nursing care when taking care of a patient in a diverse culture or a patient representing a different culture? Immigrants and refugees are coming to Finland in growing numbers. This study widens Finnish nurses' perspective in understanding and helping patients coming from diverse cultural backgrounds. Ethnographic study does not aim to give instructions of a better practice but to stimulate discussion and increase the actors' understanding of the situation by showing the points which have formerly been left with little or no attention.

This study opens a new chapter in the Finnish nursing research, since there are no previous studies examining care from the cultural perspective in a developing country here, in spite of the fact that Finnish nurses have been employed in the third world countries for decades. To me, as a representative of a different culture, it was important to examine the non-professional care practices existing in the community, since this study opened my eyes to realise how easy it is to simplify lay care in order to make it understandable. This fits the goal of the qualitative ethnography, which is to increase our knowledge of human life and to widen our understanding of human phenomena.

The findings support the following ways to promote culturally competent clinical nursing practice

1. the nurses working for the benefit of the Bena in the Ilembula village (or for any other cultural group anywhere else) should utilise the Bena cultural knowledge (or cultural knowledge relevant to the group concerned) and consider the context and lifeways of the Bena (or the group concerned) in health education. Even though some of the findings of this study, when examined critically, could be categorised as disappearing folklore, they are still in people's minds and influence their care decisions
2. the Bena cultural knowledge should be utilised when nurses teach young girls about menarche, take care of pregnant mothers, take care of malnourished children or patients with convulsions, or face patients with reproductive health problems
3. Western-type nursing training does not give enough skills for nurses to encounter patients with worldviews different from the dominant western worldview. A nursing education programme in Tanzania and other non-western countries should therefore contain local cultural knowledge presented systematically throughout the training
4. On-the-job training for newly employed nurses coming from outside the community and for nurses working in PHC should be culturally oriented in order to reduce the gap between the professional health care providers and the recipients of care

This ethnographic study does not examine the exact content of care in various culturally sensitive conditions and issues. More nursing research is therefore needed not only in hospital settings but also in the community to create caring patterns that are scientifically sound and culturally acceptable. We should therefore

1. Study care in culturally sensitive conditions, such as epilepsy, AIDS, infertility, and pregnancy
2. Deepen the findings of this study by examining care beliefs by using interpretive ethnography
3. Establish common ground for professional and lay care in Ilembula by developing a new model for co-operation between the traditional healers and the hospital staff by means of participatory methods
4. Strengthen women's influence on the formation of human capabilities and human development in a rural Tanzanian village from the feminist perspective
5. Analyse of the family as a care resource
6. Develop a cultural care model of the Bena in the Ilembula village.

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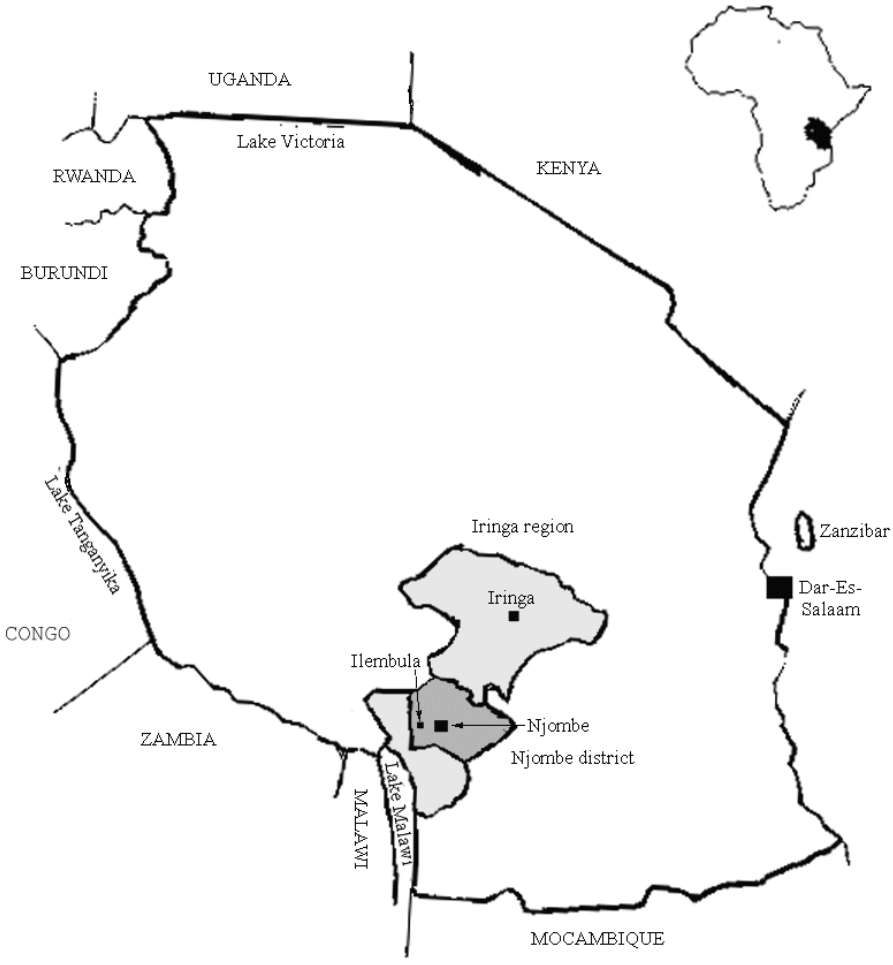
Appendices

APPENDIX 1

MAP OF TANZANIA



APPENDIX 2

MAP OF ILEMBULA VILLAGES