

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF DATA

4.1 INTRODUCTION

In this chapter the findings of the research study are presented and discussed, relating to the two main themes of multiple world views and change and continuity. Three main categories were identified within the theme of multiple world views and ten categories were identified within the theme of change and continuity (see Table 4.1). These discussions and findings emerged from the literature review, and the data obtained from semistructured interviews. The discussion relates to the possible impact that the findings may have on health, nursing practice or health care provision.

4.2 BACKGROUND TO THE FINDINGS

When discussing the findings of a research study, there exists the risk of making judgmental comments from a biomedical perspective without remembering “*the fallibility and malleability of biomedical models of illness and treatment regimes and of the fact that these models are themselves culturally constructed*” (Green 1999:219). While the author has tried to avoid ethnocentric judgements which are “*patronizing and dismissive of indigenous health knowledge*” and is aware that there is no “*infallible yardstick of correct health knowledge*” (Green 1999:221), comments cannot be entirely objective.

In analysing the data from interviews with urban Pares of Moshi, two main themes were identified which have a major impact on their health beliefs. These were multiple world views and continuity versus change. Health beliefs arise out of worldviews and are currently subject to major changes, often brought about by rapid urbanization and globalization. The multiple worldviews currently used by urban Pares are the magico-religious, holistic and scientific paradigms. Each of these paradigms has different views of health, causes of illness, care and treatment. The theme of continuity versus change includes issues in which there is apparent continuity, potential for change, or actual change. The change may be perceived

positively or negatively by urban Pares, in terms of progress or the potential of producing conflict and contradiction.

Quotations from informants are in parentheses, indented, and identified by codes A to I. In a series of quotations, the use of a new line indicates a quotation from a different informant. All the informants were urban Pares; the questions were generally formulated to request the personal views of the individual informant. Sometimes, in addition to, or instead of a personal view, they were asked what they thought urban Pares generally believe (see paragraphs 3.7.1.2 and 4.4.4). While the researcher is aware that qualitative approaches are usually concerned with informants' personal experience, their perceptions and impressions were also considered to be of interest for this study. It was also recognised that informants might not be willing to admit to personal beliefs in evil forces, for example, but would more readily attribute beliefs to other people. When talking about themselves as a tribe they usually use the third person rather than the first person, for example, an informant reported that

“they have built health centres ...”

meaning that “we Pares have built health centres ...”.

The quotations are verbatim; at times there are changes of tense and subject within one sentence, and the style is not polished. This has not been ‘corrected’; the aim was to represent the informants' speech as accurately as possible. Words that are underlined are in Swahili, the national language of Tanzania, unless stated to be Kipare, the traditional tribal language of the Pare tribe. An overview of the themes derived from the data is provided in Table 4.1.

4.3 MULTIPLE WORLD VIEWS

All of the world views described in paragraph 2.4, are reported to be held to differing extents. Urban Pares' beliefs which fall within the magico-religious paradigm include belief in God, ancestral spirits, the power of the evil eye and witchcraft, and a pollution belief which appears to be congruent with the traditional Chagga cosmology (paragraph 2.5.4). This paradigm provides urban Pares with some of their beliefs about causation of disease, and treatments which focus on supernatural intervention.

Table 4.1: Overview of themes and categories derived from interview data

4.3	MULTIPLE WORLD VIEWS
4.3.1	Magico-religious paradigm
4.3.1.1	Belief in God
4.3.1.1.1	God as a cause of illness
4.3.1.1.2	Prayer in the management of illness
4.3.1.2	Belief in ancestral spirits
4.3.1.2.1	Ancestral spirits as a cause of illness
4.3.1.2.2	Management of ancestral displeasure
4.3.1.2.3	The role of the family or clan in the management of ancestral displeasure
4.3.1.3	Belief in evil forces
4.3.1.3.1	Evil eye
4.3.1.3.2	Belief in witchcraft
4.3.1.3.3	Evil forces causing illness
4.3.1.3.4	Prevention of witchcraft attack
4.3.1.3.5	Management of illness caused by evil forces
4.3.1.3.6	Pollution belief
4.3.2	Holistic paradigm
4.3.2.1	View of health and illness
4.3.2.1.1	Health as physical well-being
4.3.2.1.2	Health as security and survival
4.3.2.2	Maintaining health
4.3.2.3	Breastfeeding
4.3.2.4	View of illness
4.3.2.5	View of rationale for use of herbal treatments
4.3.2.6	Traditional care of the sick
4.3.2.6.1	Social and psychological care
4.3.2.6.2	Physical care – food
4.3.2.6.2.1	Respecting the patient's wishes
4.3.2.6.2.2	Special foods during illness
4.3.2.6.2.3	Special care after childbirth
4.3.2.6.3	The sick role and role of the carers
4.3.2.6.3.1	Co-operation
4.3.2.6.3.2	Factors in care
4.3.2.6.3.3	Family roles
4.3.2.6.4	Economic concerns
4.3.2.7	Overall impact of traditional care practices
4.3.2.8	Treatment in the holistic paradigm; folk medicine
4.3.2.8.1	Types of treatment used in herbalism
4.3.2.8.2	Herbalists
4.3.2.9	Traditional birth attendants
4.3.3	Scientific paradigm
4.3.3.1	Conceptualizations of health: beliefs consistent with the scientific paradigm
4.3.3.2	Maintaining health: beliefs consistent with the scientific paradigm
4.3.3.3	Conceptualizations of illness congruent with the scientific paradigm
4.3.3.4	Factors causing illness: beliefs consistent with the scientific paradigm
4.3.3.5	Management of illness consistent with the scientific paradigm
4.3.3.6	Use of health facilities of the scientific paradigm
4.3.4	The use of different paradigms
4.4	CHANGE AND CONTINUITY
4.4.1	Continuity in sense of identity in urban Pares
4.4.2	Changing worldviews
4.4.3	Change in spiritual beliefs and practices
4.4.4	Conflicting perspectives on health maintenance
4.4.5	Changing and conflicting beliefs on disease causation
4.4.6	Change in meaning of traditional rituals
4.4.7	Change in patterns of treatment
4.4.8	Change and continuity in care patterns
4.4.9	Potential for change towards provision of culturally congruent care
4.4.10	Conflict between stated health beliefs and their implementation

The holistic paradigm beliefs are seen in practice in such behaviour as the use of traditional herbal remedies and the holistic care given to sick people by their families. The scientific paradigm beliefs subscribed to include causation and treatment of many diseases.

While informants' reports tend to suggest that the scientific paradigm is currently dominant, the other paradigms appear to be influential and certainly co-exist. In accordance with Green (1999:43), there is some "*permeability and ... overlapping*" in aetiological categories; "*any instance of illness can be 'natural' or 'unnatural' depending upon the circumstances of the illness*" (Janzen and Prins 1981:430 in Green 1999:49). As discussed in paragraph 3.7.1.2, there was a possibility of bias in the data collection process as the interviewer was known to be associated with the provision of health care in the scientific paradigm. "*Informants may be willing to speak more openly to outsiders about natural causes than about witchcraft*" (Green 1999:225).

4.3.1 Magico-religious paradigm

The magico-religious paradigm involves a belief in the power of supernatural forces. God or other deities, spirits of different sorts, and witches or sorcerers are considered able to exert their influence on human beings, and produce ill-health. Even the look of a jealous person, referred to as 'evil eye', may have a harmful effect (Boyle and Andrews 1989:26-28; Holland and Hogg 2001:19-22).

4.3.1.1 Magico-religious paradigm: belief in God

The informants all reported a belief in the power of God in relation to health and illness. This is confirmed by their reports of the importance of prayer in the care of the sick.

"Prayer is valuable because no-one is more powerful than God" (Informant F).

Religion appears to be an important part of life for many Pares, which is congruent with Leininger's findings in African-American culture referred to in paragraph 2.5.4.

Informants reported that even before the introduction of Christianity and Islam, there was a belief in a higher power.

“From long ago, as we were growing up we were told by our elders that there is a God who lives up above ... they were believing in this, in Kipare [the tribal language of the Pares] they say ‘Mrungu wa guu’, meaning the God who lives there up above ... the question of believing in God existed long ago even before the Europeans brought Christianity and Islam; patients were prayed for ...” (Informant C).

“Long ago, in Pare district before the coming of religions [like Islam and Christianity] ... for example when you woke up in the morning, you look in the sky and you thank God. You have seen God” (Informant E).

4.3.1.1.1 God causing illness

Some informants made an association between illness and God’s will, in the sense of allowing or preventing illness or using it as punishment.

“The Pares where I come from believe illness is to do with God’s will. We don’t believe that it is because of somebody [bewitching you] or because we didn’t do traditional rituals [for the ancestors]” (Informant I).

“Diseases are the will of God” (Informant D).

According to Green (1999:237), saying that illness is God’s will is a “*code for naturalistic explanation*”. This view is supported by Fierman (1981) in his study of the Tanzanian Sambia tribe, discussed by Green (1999:42-43). However, some urban Pares appear to infer more than chance when they speak of God’s will, suggesting that God intervenes to punish or help in different situations.

“[When Pares are asked about their beliefs in the causation of AIDS] religious people think it is because of our increasing sinfulness ... God punishes us for disobeying Him” (Informant C).

These quotations imply a fatalistic viewpoint. Fatalistic beliefs (that God or ‘fate’ allocates events) have been suggested as a reason for lack of effectiveness of health promotion campaigns in other African countries, such as in Cameroon (Azevedo et al

1991 quoted by Green 1999:221). It is not clear how big an impact fatalistic beliefs have in Tanzania.

4.3.1.1.2 *Prayer in the management of illness*

Informants reported that prayer is important to many Pares in management of the sick, whether they are Christian or Muslim.

“The Pares are of two religious groups; there are Christians and Muslims. Those who are Christian rely on prayer a great deal. And Muslims normally stand and pray to their God, but if the patient is very ill they call the Sheikh and he says prayers. But there are also some heathens who have no religion at all ... they rely on sacrifices” (Informant A).

“They believe if the patient is sick, that praying to God is one of the treatments” (Informant C).

Different individuals and denominational groups place different emphasis on prayer. Some rely on it for healing, to help prevent problems and defend against evil forces while others find it a comfort and encouragement. Most reported that prayer should continue along with other treatments. Prayer is a valued and available resource which nurses can include in their nursing care plans. The recognition of man’s spiritual dimension, people’s willingness to discuss it, and appreciation of prayer may not be so important to people of other cultures, such as Anglo-American and Chinese-American culture (Leininger 1991:355, 361).

The presence of hospital chaplains appears to be appreciated by some informants.

“I think [a particular hospital] is better because often spiritual leaders, priests or pastors come to see the patient and pray for them. ... they don’t have many pastors, but they try” (Informant C).

4.3.1.2 *Magico-religious paradigm: belief in ancestral spirits*

Informants gave a wide variety of responses when asked about beliefs in ancestral displeasure as a cause of illness. Some said that all urban Pares believe in it, some said that few urban Pares believe in it (see paragraph 4.4.3). Most informants reported

that this belief is less prevalent than belief in witchcraft; the following response was typical of most of them.

“The practice of sacrificing to ancestors is there, but it’s not everyone who is involved. It depends on the clan. There are those who have stopped traditional practices completely. ... Witchcraft is there in town and in the rural villages”

(Informant F).

Changes in spiritual beliefs and practices are discussed in paragraphs 4.4.3, 4.4.5 and 4.4.6; informants attributed changes to the introduction of Christianity and modernization.

4.3.1.2.1 Ancestral spirits causing illness

Ancestral spirits are reported to be responsible for attacks of illness or social problems caused by displeasure about inappropriate behaviour of living relatives. This includes the breaking of taboos, especially related to sexual practices, neglect of relatives and neglect of rituals related to ancestors. This is congruent with findings from other African tribes such as the Ibo and Yoruba of Nigeria (Green 1999:43-44) and the Chaggas of Tanzania (Howard & Millard 1997:155).

“Maybe I am sick and the hospitals have not found out what is wrong with me ... some people will suggest that I go to perform the traditional rituals. When they are performing the rituals they pray that the ancestors will give some light on the problem so that even at the hospital they will be able to help. They believe that the ancestors have made the illness invisible to the doctors. ... you will meet many who have this kind of belief” (Informant E).

“There were those who thought that when you got particular problems it meant that the ancestors were angry, especially those who are not Christian, the heathens. These days they don’t believe in it, only a few people” (Informant A).

4.3.1.2.2 Management of ancestral displeasure

Informants reported that the sacrifice of a goat in a special wooded area is the usual practice. Sometimes milk or beer may be poured out at the grave of the ancestor.

“Oh! [in respect to making sacrifices to ancestors], as for me personally I don’t know because we don’t have that tradition in our family, but I have seen that other people do it, they say that because today this one is very ill the ancestor is angry, he hasn’t been taken anything and so they take him a goat, they take milk and meat, this and that, they take it to the ancestor’s grave to pacify him so that he stops being angry and people don’t get ill. ... It’s a wooded area and if you go there, there are many traditional things. Now they go there, and every day it must be clean, and they say the wood makes a loud noise ... they take the child right to the grave of his ancestor, they will pour out milk there ...” (Informant B).

Other informants reported that some Pares keep the skull of a deceased ancestor.

“We Pares keep the skull of the dead ancestor and slaughter a goat and give it to the owner of the skull so that he can share it with other ancestors” (Informant G).

4.3.1.2.3 The role of the family or clan in the management of ancestral displeasure

Informants report that the management of ancestral displeasure appears to be a family issue rather than a personal issue. It involves the family meeting together in their original home in Pare district, discussing, perhaps visiting a special place set apart for that clan (or group of families with the same surname) and performing certain rituals on behalf of, or with the affected individual.

“For example, when misfortunes happen ... they say ‘maybe our grandfather is angry’. But this is done in a good way, not like praying to the dead, but coming together, the people of the clan, and asking yourselves why you have been neglecting each other. They cook some food and make some liquor, such as dengelua [locally brewed rum], and share it” (Informant C).

This felt need is one reported reason that an urban Pare might seek early discharge from hospital against medical advice (see paragraph 2.4.3). A local spiritual worker when interviewed reported, *“For instance, if the patient is sick for a long time in hospital without seeing any relief, it is possible for them to go and make a sacrifice at*

home. On asking permission they are not open to explain to the doctor. But it's possible they will consult with ancestral spirits" (Mbowe 2003).

4.3.1.3 Magico-religious paradigm: belief in evil forces

4.3.1.3.1 Evil eye

Informants reported that there are some urban Pares who believe in the power of the evil eye.

"Some people believe in it [evil eye] but they are few" (Informant A).

"Traditionally the mother is not allowed to breastfeed in public, because it is believed that some people have the evil eye" (Informant E).

"To tell the truth, people still believe, the Pare believe that if someone should look at you with an evil eye, you will get problems or misfortune, bad luck. People still have this belief, and evil eye is not to do with eyes, it is jealousy. They ask 'Why is he doing better than you?' Perhaps he is wealthy, or his children. They are educated, or more clever, yes there is that belief. When someone is jealous of you, you may get problems" (Informant C).

Belief in the evil eye is reported widely in anthropological literature, for example by Green (1999:229), Howard and Millard (1997:20-21) and Leininger (1991:184). Someone who is not aware of these beliefs can unwittingly cause distress, for example by admiring a child, or using certain expressions, such as "you will see ..." (Howard & Millard 1997:20-21).

4.3.1.3.2 Belief in witchcraft

Informants gave different views as to the prevalence of beliefs in witchcraft, ranging from their being widespread to rare, with no informant personally reporting belief in or use of such practices.

"[In town] people believe witchcraft still exists and it is continuing ... here in town there are some Pares who are cunning and who pretend to be witchdoctors, they deceive people ... there will always be people like that, and they won't come to an end. But they are few, most people believe in hospitals

... I can not go along with the belief that illness can come from witchcraft. No! I am not like that” (Informant C).

“[People who believe in witchcraft] they are everywhere, here in town and also in Pare district. Actually all over the world. ... Both Christianity and Islam do not deny it but teach that those who practise it will be burned in hell. Because they admit to the presence of witchcraft, there must be witchcraft” (Informant E).

It has been suggested that *“witchcraft is such a loaded term, it should be dropped from the anthropologist’s vocabulary”* (Janzen’s views described in Green 1999:238). It has also been suggested that *“witchcraft, sorcery, and other personalistic beliefs are all part of the same conceptual universe as pollution, indigenous germ theory, and environmental dangers”* (Green 1999:238). However, informants described *uchawi*, translated as witchcraft, not only as the power or words and oaths, as Janzen suggests, (Green 1999:238) but also involving spiritual forces, with connections to the devil (see paragraph 4.3.4).

4.3.1.3.3 Evil forces causing illness

One informant reported the belief that witchcraft does not affect everyone.

“You only get problems caused by witchcraft if you believe in it or fear it, but if you have no fear or do not believe in the effectiveness of witchcraft you are safe” (Informant F).

Informants noted that jealousy and anger are common motivators for people to seek to use witchcraft against another person.

“This thing of ancestors becoming angry, nowadays it is not much believed in, but witchcraft is very common. They say so and so quarrelled with so and so, that is why they are sick. Some people are known for threatening other people’s lives ... witchcraft is still here in town. No-one should cheat you that they don’t practice witchcraft” (Informant B).

“Witchcraft is seen as a big problem now, even educated people believe that they have been bewitched. They say things like ‘I think so and so bewitched me because he wants to take over my job’. This is so common where there is a more educated person working under someone less educated” (Informant G).

In addition, informants linked certain problems such as AIDS, infertility, poverty, fits in children and mental illness with supernatural causation.

“[Mental illness is caused] if someone gets sick from malaria and does not fully recover, and others can get these problems if they think they have been bewitched. ...Fits in children, infertility, mental illness and worms are illnesses that are not understood by hospital doctors” (Informant F).

“And you can’t believe that even this disease of AIDS, people are still taking their patients to the traditional doctors, that they go there to be treated because they think they were bewitched” (Informant B).

“They believe that a sorcerer can kill, cause barrenness, make you poor, yes they believe a sorcerer can cause problems” (Informant E).

“[Infertility] is illness and sometimes it is believed to be due to witchcraft” (Informant G).

The report that fits in children are associated with supernatural causes is congruent with findings of research in central Tanzania (Jilek-Aall et al 1997:783-795).

It has been argued that *“pragmatism and socially beneficial ‘functions’ can be found in personalistic thought, including witchcraft beliefs, so disdained and dreaded by all but some anthropologists”* (Green 1999:238). However it may be that widespread belief in the use of evil forces and the practice of witchcraft is dysfunctional in a community (see paragraph 4.3.4).

4.3.1.3.4 Prevention of witchcraft attack

Informants reported that witchcraft attacks can be made against a newborn baby using its umbilical cord. The mother in law is responsible for taking the umbilical cord as soon as it separates, and for preventing its use by someone who is jealous of the new baby.

“Our third child was born here and my mother kept the cord so that nobody could harm the baby or the mother” (Informant G).

This is congruent with the findings of Moland (2002:82), who reports that *“In Chagga as well as in Pare, the stump of the umbilical cord (kitovu) is left on the baby to dry*

and fall off. This residue is considered to contain powerful substances. ... If a bit of it is mixed with food the person consuming it will die.”

Another preventive action was also reported, related to the belief that one's possessions such as clothes can be used in witchcraft practices.

“... this is why girls are reluctant to sleep in other people's houses for fear that they will steal their underwear and take them to the witchdoctors and make them infertile. It is very hard to see a Pare woman hanging her underwear outside for this reason” (Informant G).

4.3.1.3.5 Management of illness caused by evil forces

When an illness is considered to be caused by witchcraft, the patient may be taken to a traditional healer. Informants reported that some folk practitioners are purely herbalists, or traditional birth attendants, while others deal with both herbal cures and illnesses related to evil forces.

“[Infertility] is illness and sometimes it is believed to be due to witchcraft. I wanted to marry you, but you refused and got married to another man – now I cause you to be barren. And many women go to witchdoctors so that he can help them to become fertile again” (Informant G).

Informants reported that the traditional healers involved in illnesses related to evil forces use different modalities such as dancing, making cuts, inhaling smoke, and divination (*'kupiga bao'*), and that some of them are also involved in producing illness.

“They [traditional healers] use things called 'jini' or evil spirits to harm the victim” (Informant G).

“It is believed that some of these doctors can give you something [like an illness] and cause you pain or disability and give you something else to cure the problem” (Informant C).

Some informants expressed concern that some types of traditional healers may cheat people and delay effective treatment, as in the case of claiming to be able to cure AIDS or pretending that the cause of the illness is supernatural.

“Because that doctor is looking for money, he will tell you that Mr M has badly bewitched your child there, or he is sick because the neighbour passed there and gave him the evil eye ... many times, when they see that now he has got worse, and that that medicine he is being given by the traditional doctor is not helping, they take him to the hospital, but by the time they reach the hospital, they will already have delayed and so they have lost time there with the traditional doctor. So these things are still there; it takes a long time, I think, to lose these things” (Informant B).

Mental illness may be treated by a traditional healer if witchcraft is suspected, although some informants suggested it was better to go to hospital, particularly if there is a family history of mental illness.

Some spiritual workers are involved in exorcising evil spirits, and there are cases where a remarkable change of condition is noted following such exorcism. A spiritual worker reported that *“You can find before he is confused, noisy or non-communicative, afterwards, he has some sort of hope, and he is friendly, joyful, behaving in a good manner”* (Mbowe 2003).

4.3.1.3.6 Pollution belief

Several informants spoke of the belief in the importance of abstinence from sexual intercourse while breast feeding; they spoke of the risk of the breast milk becoming unclean. This appears to be similar to the traditional beliefs in Chagga cosmology described in paragraph 2.4.3, and pollution beliefs in different parts of Africa (Green 1999:66, 80, 113, 124).

“They [the breastfeeding mother and her husband] were not allowed to meet so that the milk was not contaminated. They thought this could cause the mother to become dry or give very little milk” (Informant G).

This informant spoke of the traditional practice of a newly delivered mother identifying another woman for her husband to have sexual intercourse with during the period of breastfeeding.

“Long ago, when a wife had just had a baby, she would find a young woman to entertain her husband” (Informant G).

If a woman becomes pregnant while breastfeeding almost all the informants reported belief in adverse effects to the breastfeeding infant such as delayed walking, diarrhoea, fever and loss of weight. They recommended that a woman stop breastfeeding as soon as she becomes pregnant.

“If a mother gets pregnant early by bad luck, then the child would be stopped from breastfeeding” (Informant A).

“If you continue breastfeeding, the baby will be taking bad milk, this is what they believe” (Informant I).

“If you breastfeed the baby he will have diarrhoea, he will become weak and he may even die” (Informant C).

Other informants spoke of changes in body temperature and failure to grow properly in a baby breastfed by a pregnant woman. The belief in the need for abstinence from sexual intercourse during breastfeeding may have negative consequences, in terms of infidelity and increased risk of acquiring sexually transmitted diseases. However, it may help to prolong the period of breastfeeding and thereby reduce the incidence of undernutrition. The belief in the need to stop breastfeeding as soon as a woman thinks she is pregnant may have a negative impact on the nutritional status of a young child. The traditional practices are apparently being modified especially in the urban setting (see paragraph 4.4.9).

4.3.2 Holistic paradigm

The holistic paradigm involves keeping a harmony between natural forces, between humans and the rest of nature, and realizing the importance of multiple factors in maintaining health or causing illness. Practices that are congruent with the holistic paradigm include individualized, holistic care, and the use of special foods (Boyle & Andrews 1989:29,34; Holland & Hogg 2001:22). In this study home care is included in the holistic paradigm because physical, emotional, economic and spiritual dimensions traditionally receive attention in this setting. The practices of Pare herbalists are included in the holistic paradigm in this study, although informants report that their practice is not related to a specific theory of restoring balance (see paragraph 4.3.2.5). *“Folk healers include shamans, herbalists ... [they] usually*

maintain a holistic approach and endeavour to treat the whole person within the context of the family” (Luckman 1999:50).

4.3.2.1 Holistic paradigm: view of health and illness

The first impression received from the answers about the meaning of the word *health* might suggest that urban Pares see health as something outside themselves (see paragraph 4.3.3.1). In order to clarify their understanding of the concept health, they were asked, “*if you say ‘I am healthy’, what do you mean?’*” The responses involved ideas such as being able to work, having strength, not losing weight, not being sick, eating well, sleeping well.

“... he tells you that he has good health meaning that he has no illnesses, and also he feels that he is strong enough to work. So it covers two ideas ...”
(Informant C).

4.3.2.1.1 Health as physical well-being

Many informants saw health as involving physical well-being and strength.

“We look and if we see that we are still able to do work such as cutting grass for the animals, fetching firewood, etc, we are fine” (Informant B).

While the majority of informants focused on physical health, several mentioned mental health.

“[Health is when] my mind is good ... I am able to understand someone and I don’t feel confused” (Informant C).

“Some people think health is having strength in the body, others say you are healthy when you do not have diseases, others say health is being well even in your mind” (Informant D).

When informants understood the question as relating to personal health, physical health, and to some extent mental health were included. Social, psychological and spiritual health were generally not mentioned although when discussing care of the sick, social, psychological and spiritual issues were clearly considered important (see 4.3.1.1.2 and 4.3.2.6.3). Health is seen in terms of normal functioning or absence of abnormal functioning, rather than as a broader notion such as that *“health is to do*

with human flourishing” (Seedhouse 2001:32). This may be a reflection of the difficult lives that many Pares live, in which work for survival is a major task. If health is taken to involve human flourishing and “*to become everything one is capable of becoming*” (Maslow in Jordaan & Jordaan 1992:655), it would be interesting to study what this might involve for an urban Pare. Generalising from western cultural values may be inappropriate.

4.3.2.1.2 *Health as security and survival*

Informants noted the importance of being able to work, in order to survive and provide for families.

“Health is important to me, because I have children who depend on me for everything” (Informant E).

“Health is our daily security” (Informant G).

Responses like these reflect the social responsibility felt by urban Pares for each other, in a society where other support systems such as social services and insurance schemes, are accessible to a minority of the population.

Being healthy is expected by some urban Pares to involve being wealthy (see paragraph 4.4.5) and being fat.

“They see I am fat; I look good and they decide that I am healthy. There is no going to a hospital to check, as long as you are not sick” (Informant B).

“A large belly (“kitambi”) is seen as something to be very proud of” (Informant G).

“If she does not work much and she is happy all the time she will be fat” (Informant F).

This suggests that a positive self-image includes fatness, as well as the social and economic factors discussed in paragraph 2.6.2.

The connection between health, wealth and fatness is not surprising in a society where malnutrition is still common (see paragraphs 1.2.4 and 2.6.2) (The United Republic of Tanzania, Ministry of Health 1999:99) and the poor delay seeking health care (see paragraph 4.3.2.6.4). Fatness may be a useful security against future food shortage.

However, obesity is one factor in the rising prevalence of non-communicable disease in Tanzania (Mwaluko et al in Mwaluko et al (eds) 1991:220).

4.3.2.2 Holistic paradigm: maintaining health

Some informants reported that they believed that avoiding worry and having the wisdom to accept problems helps to maintain health.

“To improve my health, the first thing is that I try to avoid thinking too much ...to relax and when I have problems to just be patient, to accept whatever situations come, for example when my wife died in 1998 it was a big problem, but I accepted it as it was” (Informant G).

This stated belief is reflected in Pare behaviour; Pares appear to show a calm approach to life, and accept difficulties with stoicism. This reflects important cultural values and the belief in an external locus of control (Luckman 1999:306). These values have arisen in the context of living in subsistence farming communities where the people and the land are the main resources available. Roads, health services, ambulance services and telephones are not available for most people. So for many people, there appears to be little that can be done to produce change, for example, in a health emergency, and stoicism may be the only realistic approach in the short term. However, a passive acceptance of problems may contribute to the slow pace of development, and might be interpreted as complacency by people from other cultures.

Some informants reported that they see no need for special exercise for Pares in their traditional mountain setting with heavy farming work.

“They don’t do exercises such as running or sports, but the kind of activities they are engaged in daily are enough to help their bodies ...” (Informant B).

Pare mountain farmers almost certainly get plenty of exercise in the course of their day to avoid obesity. Lack of exercise is thought to be a factor in some non-communicable diseases including hypertension and ischaemic heart disease, whose prevalence is increasing in Tanzania (Mwaluko et al in Mwaluko et al (eds) 1991:220 - 221).

4.3.2.3 *Breastfeeding*

Traditional beliefs and practices relating to breastfeeding and care of the newly delivered mother appear to be well known by urban Pares. There is special respect and care for newly delivered mothers and a positive attitude to prolonged breastfeeding. Informants identified several positive effects from the traditional care of the newly delivered mother.

“They set up this period of resting for four months so that she can regain her strength. The time is also meant to give the baby an opportunity to feed well and to be with the mother to establish a special bond” (Informant E).

All informants said they believed breastfeeding to be very important for the health of the baby and that newly delivered mothers are given special respect, care and protection. The mother is expected to breast feed for at least a year, and many informants spoke of 2 years.

“From long ago the Pare liked to breastfeed for a long time, ... they believe that the mother’s milk is good. ...They try hard to see that the child should not be weaned under the age of 2 years ...but you find that the problem that arises is this, the person has this intention, but she leaves the child at home [to go to work and] ... in the end the child forgets about breast feeding” (Informant C).

Infant milk formulas are available in the town and paid maternity leave for government employees is a total of 90 days. This recommendation for maternity leave is not uniformly applied by all employers.

4.3.2.4 *View of illness*

Informants reported that illness is associated with factors such as being unable to work, something being wrong in the body and the need to receive special care and attention.

“To the Pare a sick person is one who is in bed and cannot work” (Informant B).

“They understand illness; they call it nimuugi [in Kipare] which means a sick person. They know that a patient needs special care” (Informant E).

“Illness is when the body is in trouble, when you lose weight they say, ‘This one is sick. Why has he become so thin?’ or ‘Why is he coughing?’ ”
(Informant G).

These reports indicate that illness is a serious state which interferes significantly with normal activities. They suggest that minor illnesses or early signs of a serious illness may not always be given much attention. This impression is congruent with findings of late presentation of breast cancer in Kilimanjaro (Kiwale 2002:1).

Self-neglect and heavy drinking are seen as illnesses by some informants.

“If someone does not take good care of himself, they say he is sick. ‘He is dirty even when he is going to church.’... sometimes when somebody drinks too much they say he is not well” (Informant G).

Economic hardship associated with illness is discussed in paragraph 4.3.2.6.4.

4.3.2.5 Rationale for use of herbal treatments

When asked why Pares use herbal treatments, the informants responded that they are used because they have been found to work over a long period of time, by trial and error. Informants did not know of any theory of bodily imbalance or other explanation for use of these remedies.

“[in respect to use of herbal remedies] they use them because they see that they are working as a treatment” (Informant F).

Further discussion of herbal treatments is in section 4.3.2.8.

4.3.2.6 Traditional care of the sick

4.3.2.6.1 Social and psychological care

There is considerable importance given to the practice of visiting the sick; it is believed that it is important for the sick person not to feel lonely or rejected. Visitors come even from far away while someone is sick, and provide social support, diversion from thoughts about his illness as well as the practical help of bringing food and contributions of money to help with expenses. At times a patient receives more visitors than he can actually talk to.

“If you have a relative or there is a family member that you know, it is the custom when one of us is sick they must be cared for to show them love. We need to find out what is wrong with them ... if there are financial problems we should help... They don’t like them to feel lonely.... this behaviour [in town] is similar to what is happening at home [in Pare district]” (Informant C).

“The sick person is visited a lot, by all his relatives, his family and neighbours” (Informant A).

“In the visiting hours, morning, afternoon and evening, people come, family, relatives and friends, from many different parts, far and near, more than ten people come to visit at one time... this is our custom, from our ancestors which we follow because we think it is a good thing to help each other especially when some of us are sick” (Informant B).

The importance of visiting demonstrates the Pares’ belief in the interdependence of people and the importance of social contact. This is congruent with Leininger’s findings relating to African-American values (Leininger 1991:357). The traditional pattern of visiting appears to be firmly entrenched as a cultural pattern, even in urban Pares. When a patient is socially isolated and has no relatives and friends who can visit, it can be a social and psychological problem that nursing staff may not be able to address adequately with current staffing levels, and lack of other personnel or volunteers to act as visitors.

As discussed in paragraphs 4.3.1.3.3 and 4.3.1.3.5, infertility is seen by some informants as being a type of illness. Social and psychological care is extended in a special way to some infertile couples.

“Traditionally, we Pare give children to the childless, we say, since you are not getting children of your own, may I give you one so that you will not be so sad? If she agrees the child is treated as her own in all ways ... my cousins were given three children each ...” (Informant B).

This is within the social context in which legal adoption of non-related children is virtually unknown, and where children are not uncommonly brought up by relatives other than the birth parents.

“They can look after the child of a relative, but not of someone outside the family. They can take the child as their own, feed him, and send him to school” (Informant F).

4.3.2.6.2 *Physical care – food*

4.3.2.6.2.1 *Respecting the patient’s wishes*

The importance of respecting the patient’s wishes is a recurrent theme; informants report asking the patient what he would like to eat that day.

“It all depends on the preferences of the patient. When they bring tea to the patient in the morning they ask the patient what they should bring in the afternoon. For those that are at home, they just ask what would he like for lunch or dinner, and they can say it, e.g. milk, bananas, stiff maize porridge, rice, meat etc. A patient is not given just any food. ...[If it is a child who cannot say what he wants] the mother gives them the food that they used to like before becoming sick. If they fail she tries some other foods and sees which one the child likes most ... she can prepare ‘mtori’ [soup mixture of bananas with meat] or ‘kiburu’ [soup mixture of beans and bananas], sometimes she mixes milk with bean leaves or pumpkin leaves, crushed and mixed with the milk” (Informant B).

“Normally, the patient is given the food that they choose, for instance, I am sick here, I tell my wife I would like this or that or that thing today. Patients are highly respected; it is believed that recovery depends on the diet” (Informant D).

“When someone is admitted at the hospital, we ask them what they would like to eat and whatever they say, that is what we give them” (Informant E).

4.3.2.6.2.2 *Special foods during illness*

Pares interviewed spoke of the importance of food for the sick person, and the newly delivered mother. Many spoke of soft porridge, made to a drinking consistency. There may be sugar added.

“[This soft porridge] it is made with maize flour and sometimes millet flour. And long ago in past times it was made with flour from bananas which have been dried. ... they put in butter [or] sour milk” (Informant A).

‘Mtori’, a soft soup from pounded cooking bananas with meat in is also used, and chicken soup is considered to be ideal by several informants.

“For soup they prefer chicken. They also like soup from goat meat but it’s cheaper to slaughter a chicken” (Informant E).

“They used chicken mostly because they have many of them, so new mothers can eat a lot of chicken meat. She can consume more than twenty chickens after one birth. They make her chicken soup ...” (Informant H).

There is a widespread belief that in these cases, there is a need for soft food. *‘Ugali’* (stiff maize porridge) and *‘makande’* (mixture of maize kernels and beans) are not recommended, as the stomach is believed to be unable to break down food properly during illness.

“They should get soft porridge, they should get milk, because they say the stomach is not able to grind down hard food when someone is ill. They really believe this. Especially the newly delivered mother is not allowed to eat hard food” (Informant A).

Special cases may require particular food, including different available meats.

“When a woman has a fever and her baby is only 6 months old ... they will slaughter something like a goat for her, so that she gets goat soup. Now they believe that after taking that soup she will get strong enough to look after the baby. ... [For] an old person ... when he has left hospital and still needs care, they will even slaughter a cow. The cow can be slaughtered and they will eat it in order to get strength. Especially the fat. They can cut off a sheep’s tail and it can be boiled” (Informant C).

Informants reported similar beliefs about the type of food that is important during illness. Relatives and friends appear to take considerable trouble to provide food considered suitable for a sick person. Pare invalid food is not dissimilar to that recommended by early nursing textbooks (Culver & Brownell 1966:186). It appears to be higher in fluid and protein content than the normal diet, and can be managed by someone who is semi-recumbent, or having difficulty chewing or swallowing food.

As well as the suitability in promoting physical health, there are probably psychological and social benefits in receiving special foods and the attention that results from bringing it to the invalid. However, providing such a diet places some strain on family resources, in terms of time preparing the food, money for extra ingredients, and transport costs if the patient is not staying in the immediate locality.

In urban Moshi the hospital diet is largely stiff porridge and beans, apparently for economic reasons. The practice of providing this hospital diet may not have been reviewed because of the widespread practice of patients receiving food from home. Those who are hospitalised far from home or who have no family to bring them food, are restricted to the hospital diet, which means that in addition to the social deprivation they are already experiencing, they also experience the psychological discomfort of having a diet which they believe to be inappropriate to their state of health. This may affect their recovery.

4.3.2.6.2.3 Special care after childbirth

Many informants volunteered information about the kind of care, seclusion and diet that was traditionally provided for newly delivered mothers which includes rest and copious fluids for up to 4 months.

“[The newly delivered mother] is not allowed to go outside, she is on complete bed rest for two to three months. In the morning she gets milky porridge, at ten she gets soup, at twelve she gets food which is special like banana and meat soup ... in the evening around 4pm she gets soup, also at night she eats; it will be 5 times a day” (Informant B).

The results of this practice are a plentiful supply of milk for the baby, and weight increase for the mother.

“When it is time for her to come out she is so fat nearly to bursting!” (Informant G).

Traditional care of the newly delivered mother helps to promote bonding and reduce the risk of infection in the newborn. It may promote a good relationship between the newly delivered mother and her mother-in-law, who is traditionally the chief carer. The traditional practices do, however, carry the risk of development of obesity in the

mother, and theoretically there are also the risks of prolonged bed rest such as deep vein thrombosis. Urban Pares adherence to these traditional practices is reported to be declining (see paragraph 4.4.9).

4.3.2.6.3 *The sick role and role of the carers*

4.3.2.6.3.1 *Co-operation*

The care of the sick person is seen as an issue involving all the family, and neighbours and friends help with care, or with household duties, or by bringing food or contributions to help with transport.

“If the sick person is a woman and she is at home, all the women from the neighbourhood come to assist with the household activities ... If the woman is admitted to the hospital, the women also take turns in helping both at home and also caring for the patient... we Pares take it very seriously and even today it is happening ... There is a lot of co-operation when someone is sick and even when a woman has just had a baby” (Informant B).

This spirit of co-operation is similar to that described ‘among the poor in every society ... who as a result of poverty and deprivation have to survive through brotherly group care and not individual self-reliance’ (Mbigi & Maree 1997:1), known as ‘ubuntu’ in South Africa. Nyerere’s view of African socialism incorporates the concepts of mutual respect, sharing and work, which he claims are characteristic of the traditional African family (Cliffe & Saul (eds) 1972:180). Co-operation has long been a part of Pare culture; there is “ ‘*mutharagambo*’ [in Kipare]; a concept which means doing things collectively or joining hands. ...Normally such activities were related to peak seasons like during harvest, building a house, assisting a woman who had just delivered a baby ...” (Omari in Forster & Maghimbi (eds) 1992:1-2). It appears to be an important aspect of the ethos of Pare social life, which may be currently undergoing changes (see paragraph 4.4.9).

4.3.2.6.3.2 *Factors in care*

During an illness, most informants recommended rest for the patient.

“If you have a sick person at home, the first thing that’s important is that he should rest” (Informant A).

Love is another important factor identified in care.

“Most people think that good care depends on wealth, but I believe that love is the most important thing to a sick person” (Informant H).

“The patient depends a lot on love and encouragement” (Informant G).

Assuming the sick role (Cockerham 1992:140-141) through illness or being newly delivered, has major social and financial implications for a Pare.

“They know that a patient needs special care” (Informant E).

This includes special foods as discussed above, and help with bathing, and getting to the toilet. It also involves visiting, assistance with their normal duties, and financial support to help them get health care. Respect is another factor which is reported to be important in care, while the impact of family financial status is also recognised.

“We have great respect for the new mother, but then again all this depends on the financial condition. After that, when she comes out she has good health. Women come from every corner bringing foodstuffs, such as rice, bananas, chicken etc. Also they help with the work” (Informant D).

Co-operation of the patient in his management is a factor in care. It is expected that a patient or newly delivered mother will rest and follow the treatment plan decided on by the elders of the household. It is reported that major decisions about treatment are taken by the older members or parents of the household.

“Many people think that [making decisions about what to do for a sick person] is the responsibility of the father, but ... I think it’s better to involve the wife in decision making as well as anyone in the house who is capable of such responsibility” (Informant H).

Informants reported that another factor in care is respecting the privacy of a patient; they avoid exposure of the patient to members of the opposite sex.

“When a boy needs to go to the toilet or to be washed ... then father is responsible, but you find that mother is keeping an eye on everything”
(Informant C).

4.3.2.6.3.3 *Family roles*

Informants reported that they believed that women should look after sick women, and men should look after men. However, in some cases, women would help to look after men and in all cases women would be responsible for cooking. The men of the house would be responsible for procuring the food.

“[In respect to looking after the sick person at home, it is] very often the women of the house; the father will bring what is required and the women will cook. And very often it is the mother. She will look after anyone who is sick there at home – whether it is a man or a woman – but if it’s a man and he is grown up, he will be looked after by another man, who is also grown up”
(Informant A).

Traditionally social roles appear to be clearly defined. Men are not involved in cooking or collecting of firewood at all, for example. It is seen in Pares that often the menfolk of the family are involved in the care of the sick men. However the majority of nurses practising in Kilimanjaro health services are female. For example in the largest hospital in Kilimanjaro region, of 338 qualified nurses currently employed, only 6,5% are male (Kiwale 2003). Because nurse staffing levels are very low, current hospital practice relies on relatives assisting with much of the care of patients. However, patients who have no relatives or are too far from home for them to come, depend largely on female nurses to provide nursing care.

4.3.2.6.4 *Economic concerns*

As mentioned in paragraph 4.3.2.6.3, relatives and friends are concerned with the economic issues facing a sick person. Many informants expressed concern that economic problems affect urban Pares’ health in various ways, such as preventing

them from maintaining their health, and by affecting the timing and choice of health care. Several mentioned the need to have resources to maintain health.

“There are some who are very poor, they know they have to get clean drinking water, eat good food, have good housing, wear good clothes and go to hospital when they are sick, but they fail to do so because they don’t have money” (Informant C).

“So then you will notice that staying healthy depends a lot on the financial condition of that person. You cannot buy anything [particularly referring to medicines] if you don’t have money” (Informant D).

“ A lot depends on the financial condition of the individual ... we fall into two groups, the rich and the poor; the rich can buy the requirements such as proper food to maintain health, but the health of the poor is not very good” (Informant B).

The poor economic status of Tanzania (see paragraph 1.2.1) has repercussions for individual Tanzanians. The reports here support the observation that *“health problems ... are rooted in social conditions”* (Sanders 1985:157). The economic burden of illness was mentioned.

“Health is important to me, because I have children who depend on me for everything. I make sure they eat good and clean food to avoid diseases. In this way I can use my money to buy other things, not to pay hospital bills. If the patient does not have much money or someone to help then they have to work despite the fact that they are not well.” (Informant E).

“When the father is sick and he is the bread winner of the household, his dependants suffer” (Informant B).

The stress of illness is thus complicated by poverty.

“They think, ‘Here I am lying down here and I don’t know what is happening at home or work’. This worry affects their recovery. If it is a wealthy man whose absence does not affect the family income, he has more confidence” (Informant B).

One informant reported that the system of ‘cost sharing’, introduced by the Government in 1994 in which health service users contribute to the cost of health care, has reduced treatment options for some poor people who are now unable to use

the western style clinics and encouraged the use of traditional practitioners. This is congruent with research into the effects of cost-sharing (Agyemang-Gyau & Mori 1998:24-26, Moland 1998:18-20, Msoka 1998:22-24, Warioba 1998:26 – 28). One informant also noted that traditional practitioners may be prepared to accept a chicken or a piece of meat in payment, which may be more convenient for the patient. This is congruent with research in Ifakara, Tanzania (Muela et al 2000:296 – 302).

4.3.2.7 Overall impact of traditional care practices

Pares appear to consider prayer as an important factor in managing illness (see 4.3.1.1.2 above) and are concerned about economic issues affecting health and illness (see 4.3.2.6.4 above). Therefore, traditional care of the sick is holistic and includes physical, social, psychological, economic and spiritual aspects. Many of these practices appear to be beneficial to the patient, although they can be stressful for relatives and friends who feel they must care for and visit the patient frequently.

4.3.2.8 Treatment in the holistic paradigm: folk medicine

While the professional care system in Tanzania functions within the scientific paradigm, the folk care system in Tanzania functions within the holistic and magico-religious paradigm (see 4.3.1.3.5 above).

Two informants mentioned practitioners of Chinese medicine, and their value in treating dental problems, pain and abdominal problems.

“I really like Chinese doctors and you will find that I buy their medicine often. Chinese medicine is good because they do sufficient research and their remedies are taken directly from plants” (Informant H).

Other informants were not aware of this type of practice. Chinese medicine is relatively new to Moshi, and when better known, may be acceptable to many urban Pares.

All informants spoke about traditional African herbalism. Belief in the value of traditional remedies, especially herbal remedies, appears to be widespread but not universal in urban Pares. The knowledge has been built up empirically over a long

period of time. All the informants spoke of how traditionally the Pares were expert in herbal treatments, and there is some continuation of this reputation.

“Even here in Moshi the Chagga prefer traditional medicines from Pare”
(Informant E).

This is congruent with the findings of Moland (2002:37); *“Even today the waganga, traditional healers, are held in high esteem among the Pare, and provide an alternative to biomedicine that also the Chagga turn to when hospital medicine fails or is inaccessible”*.

Informants in this study also report that herbal remedies are an alternative to treatment from western style health workers.

“Those who are unable to go to hospital, they try hard to find traditional medicine to treat their illness” (Informant A).

Changes in the use of herbalism are discussed in paragraph 4.4.7.

4.3.2.8.1 *Types of treatments used in herbalism*

Herbal medicinal treatment includes the use of leaves, roots and barks, which may be chewed or dried and ground and taken as a powder added to a drink such as milk, or they may be added to hot water to inhale or used to bathe in. Informants shared information about other herbal remedies. For example one elderly lady (who is not a traditional healer herself) reported,

“There are many medicines which my children and I like a lot, one is called mvoro, it is very similar to quinine. It is boiled – the leaves – and the water is given to the patient. There is another medicine called mrumbavasi, it is a very effective medicine to treat diabetes, this is prepared in the same way as mvoro, the patient is given two spoons of the medicine in the morning only. ... Another one is ikongwe ibada for the treatment of wounds. You grind it and apply to the wound, leaving it there until the wound is healed. There is a variety of ikongwe which has a slender stem. This is used in the treatment of stomach parasites, e.g. tapeworms, roundworms. ... Honey, even if the child is burnt just now, don’t put anything else on it, take honey and put it there. Or egg, raw egg, take it, beat it, spread it on the place where the child is burnt and there won’t be a wound any more. Or the hair of a hare, if a child is burnt

take the hair of a hare and clean it, don't remove the skin (of the patient), you wash it, you take the hair of the hare and you apply it there. Then he will stay with that hair until the day the hair separates, and the wound is healed" (Informant B).

Special remedies and efforts were made traditionally for diseases that are particularly feared such as malaria and measles (see paragraph 1.2.4). This may reflect the seriousness of these conditions and the felt need to take serious measures to combat them.

"When children have measles we give them the leaves of a plant called mkwaju. They squeeze the leaves and the juice is given to the patient to drink, some of it is put in the bath water, they slaughter a young chicken and make soup and they give this to the sick child" (Informant B).

Some of the traditional treatments for malaria are reported to produce severe vomiting, which is congruent with treatments for malaria when considered as a pollution illness (Green 1999:182). One informant reported that getting cold can cause malaria; others reported the belief in the involvement of mosquitoes. Other studies in Tanzania suggest that naturalistic causes are perceived as more important than supernatural causes in this disease (Gessler et al 1995a:119-130; Oberlander & Elverdan 2000:1352-1357).

Another informant, who is himself a herbalist, reported that he treats many people, and that mwarobaini is a useful remedy (see Figure 4.1).



Figure 4.1
Photograph of Mwarobaini tree
 (Savage 2003c)

“There are some medicines for example, mwarobaini, whose leaves are used for the treatment of malaria. In Pare district there is another medicine, we call it mkangala, and from my experience mkangala is more effective in the treatment of malaria than mwarobaini. And if you have moved to Moshi, like myself, it is better to use the most effective way so that your business can flourish. ... Many Pares like traditional medicine ... we take it from the plants, we prepare it by either boiling it while it is fresh, or grind it to powder, and it is taken with tea or water. ... we also use roots or barks of plants. For the treatment of peptic ulcers ... there is a tree whose bark is taken close to the ground and if the tree is not mature enough it is good to go for the roots down deep...” (Informant E).

Herbal remedies are believed to be also useful in a variety of illnesses including skin problems, chest problems, asthma, cancer, and painful legs.

“When you have pain in the stomach he looks at you and can tell what kind of stomach trouble you have. There is one problem known as ‘chango’ which is not cured by hospital medicine. He gives you herbs which you boil and drink a cup three times a day and surely enough you get cured of your problem. Yes, the Pares know how to practice traditional medicine” (Informant G).

Wounds are treated with honey or aloe vera; one informant suggested there are special herbs which must be chewed and then applied. Various informants advised that burns should be treated with honey and raw egg, oil, or the hair of a hare or rabbit. The management of wounds with honey (Ong & Ryan 1998:38), and occlusive dressings which remain undisturbed (Flanagan 1997:80-81; Hill 1998:303-305; Walsh (ed) 2002:932 -933) are current recommendations in wound care of the western paradigm.

4.3.2.8.2 Herbalists

Traditional healers in Tanzania are of two main types, those who use herbal medicines and those who deal with spiritual forces (see paragraph 4.3.4). Some informants call this latter group witches and sorcerers (*‘wachawi’*) (see paragraph 1.2.5.2), and some report that there are practitioners who deal in both types of treatment (see paragraph 4.3.1.3.5). With respect to herbalist traditional healers, informants reported that there are different groups such as the *ngetwa* and *ngoka* II, and that their treatments are often effective.

“The ngoka and ngetwa are those traditional healers who treat patients with traditional herbs from the bush, they don’t cut people ... perhaps you have rashes, perhaps you have a headache, perhaps you have high blood pressure. ... This is something which is not lost, we still have traditional doctors who are practising, and personally I reckon they are practising because they know how to treat people” (Informant B).

One informant who is himself a herbalist (informant E), said that he could treat a large variety of conditions, but not a case of dehydration if the patient was not able to take fluids orally. While the use of traditional herbalists may be declining in towns, they

are still acceptable, accessible and affordable to many. Their continued use may also suggest that they are at least sometimes efficacious, and may suggest that health services of the western paradigm are not always acceptable, accessible or affordable (Muela et al 2000:296-302).

4.3.2.9 Traditional birth attendants

Traditional birth attendants (TBA's) have been considered to belong to the holistic paradigm (Anderson & Staugard 1986:17-18). Informants reported that traditional birth attendants are still much used and are considered to provide a valuable service.

“There are those traditional birth attendants for those ladies, I know that is there. And there in the villages and even here in town I think that many ladies are still using them to deliver their babies” (Informant B).

“Even my own mother was a traditional midwife, she died in 1999, she used things like a razor blade to cut the umbilical cord, the razor blade had to be new, and each patient had to boil other things ... they do know how to deliver babies” (Informant C).

There have been training programmes for TBA's for many years in Tanzania. There appears to be some collaboration between many TBA's and the official health sector (see paragraph 2.8) (Moland 2002:219-226).

4.3.3 Scientific paradigm

4.3.3.1 Scientific paradigm: conceptualisations of health

When asked about the meaning of the word health most of the urban Pare informants made an immediate association with health services; they talked of hospital, clinics, and medicines. In Swahili conversation, it appears that the word 'health' is not much used, except in the context of 'health services'. This may perhaps explain why informants generally talked of health services initially, and the question had to be rephrased to obtain a clearer picture (see 4.3.2.1 above).

“The place where you can get help when you get sick” (Informant A).

“If you get an illness like malaria to go to hospital for a medical check and to get the necessary treatment” (Informant B).

“They have known since long ago that when they are ill, they should look for medicine ... that they should go to health centres - that is the current practice; previously they were using traditional medicine” (Informant A).

Informants also responded that health is protection from illness, and includes issues of cleanliness, safety, clean water and food.

“[Health is] the condition in which someone protects himself by eating foods which protect the body” (Informant B).

“[Health is] what they are able to do to protect themselves from illness, cleanliness, and when they become sick they run to the hospital” (Informant C).

4.3.3.2 Scientific paradigm: maintaining health

In keeping with the views of health, the Pare informants reported that to maintain health it is important to them to have health services available.

“The Pare likes to have dispensaries, so that they can get health services” (Informant C).

“They have built health centres ... when they are having meetings they discuss in detail issues related to health, such as ways of getting water ...” (Informant A).

On a personal level, they spoke of a belief in the importance of an adequate and varied diet.

“They [other Pares] understand that food is something very important and they know about illnesses caused by lack of food. ... If you see those who are badly fed, then probably it’s because of poverty” (Informant A).

“To the Pare, health has many factors, for example, you want to eat eggs, meat etc., but you don’t have the money, now how can you be healthy?”

The need for clean water was reported to be a concern to Pares.

“In the past before development came, in Pare district we used to get our water from springs but now we have tap water ... Pare people have always been cautious about drinking water” (Informant E).

A clean environment is believed to be important too.

“Because religion came to Pare district many years ago, the missionaries built hospitals and health officers would select a day ... to visit families and inspect their toilets ... they inspected many areas, for example, they would check, ‘Are the surroundings clean? Are the children clean?’ ... therefore the Pare did these things from very long ago” (Informant E).

Difficulties in implementing these beliefs are discussed in paragraph 4.4.10. These beliefs, whether they originated long ago or with the advent of western medicine would appear to be factors generally associated with disease reduction (Sanders 1985:198-204). Several informants said that they thought it would be a good idea to get a check up at the clinic, but that currently Pares only use health facilities when they are ill.

4.3.3.3 *Scientific paradigm: conceptualisations of illness*

When asked what they understand by illness, many informants referred to communicable diseases that are common in the area such as malaria and their signs and symptoms.

“The illness they always understood from the beginning is malaria” (Informant A).

“[In respect to illness] the first thing they think about is contagious diseases such as diarrhoea, measles or malaria. The next thing is mental illnesses ...” (Informant C).

This association is not surprising as malaria, gastroenteritis, measles and other infectious diseases are major causes of morbidity and mortality for the Pares (see paragraph 1.2.4). The fear of illness and its economic implications may account in part for the success of some health programmes such as the Expanded Programme of Immunisation (United Republic of Tanzania, Ministry of Health 1999:104 – 106).

4.3.3.4 *Scientific paradigm: factors causing illness*

Urban Pares appear to hold to some beliefs about disease causation which are congruent with a scientific paradigm. At least some of these ideas have been

introduced by health workers of European origin since the middle of the nineteenth century (Goergen 2001:6); some of these ideas may have come from indigenous contagion or pollution beliefs (Green 1999:55-87, 179-216). These beliefs (such as germ theory) are now promulgated and supported by the official health and educational system, which is in contact with almost all of the population. Many informants suggested a link between diet and illness.

“The illnesses and weaknesses in our bodies are a result of lacking the proper nutrition we need to keep us healthy. ... The fact is that the Pare become weak because they don’t eat well” (Informant H).

“When you have diabetes they say you have consumed too much sugar” (Informant G).

Others suggested links with other factors such as environmental hygiene, microbes, overwork and stress.

“They know that being dirty can bring diseases, they are very careful about that.”

“[Illness] is microbes of some sort that have got into the body and they have brought changes in the body....[also] many of those with a poor diet, are those who are not able to get it, they are very poor.... They know that having worries is not a good thing. But if you continue to have a lot of worries for a long time, you get heart problems or mental problems....They understand that getting wet in the rain means you must get a chest infection” (Informant A).

“Another big thing that I see is overworking themselves without resting; this is bad for the body” (Informant B).

Others blamed getting wet for producing pneumonia and fever, while another said that getting cold can produce malaria. Incomplete recovery from malaria is considered to be one cause of mental illness by some informants. Inheritance is considered to be a factor in twin pregnancy, cancer and adult epilepsy.

4.3.3.5 Scientific paradigm: management of illness

Informants reported that many urban Pares use commercially produced medicines and other treatment methods recognized by the scientific paradigm.

“The Pare whom I know here in town, they would go to the hospital straight away, they know that it is good to go to a pharmacy only after the doctor has prescribed the right drugs. Perhaps when it is just a headache and they don’t suspect malaria, that is when they would go and get paracetamol or aspirin, but most of them would run to hospital” (Informant C).

“When I came back to Moshi I went to have a medical checkup ... the doctor after checking me said I had malaria, I was given five injections. The day before yesterday I went back ... I asked them to take an x-ray ... after taking blood tests and so on, they told me I had typhoid” (Informant D).

Other treatment suggestions which could be considered to be scientific or holistic included tepid sponging for fever, application of hot water for pain and cold water for swelling. Many informants reported the use of aspirin and paracetamol from the local shop selling medicines for minor aches and pains.

“If there is a shop which has medicines which is near then they buy and use them, and you will often find it is antibiotics or pain killers” (Informant A).

4.3.3.6 Scientific paradigm: use of health facilities

Informants all reported that they would use the nearest clinic or hospital facility as a first choice in case of illness, unless it was a minor problem, when they might obtain medicine such as analgesics from a nearby shop.

“For me, I would first look for a doctor if I have any problem with my health, whether it is myself or my children. ... [as for urban Pares generally] it depends whether they live near to a health centre ... they will go to the health facility which is near where they live, first” (Informant A).

This is consistent with research into use of health facilities in Moshi which suggests that proximity rather than appropriateness of level in the referral hierarchy is a major factor in the choice of health facility (Mwanswila 2002:39).

4.3.4 The use of different paradigms

Urban Pares have been influenced by all three worldviews. Within the magico-religious worldview, there are conflicting beliefs, for example, while traditional

spiritual beliefs appear to still have an impact, the majority of Pares are associated with Christian denominations or Muslim groups. Some Pares appear to use different paradigms for causation according to the situation, which is congruent with findings of Janzen and Prins (1981:431 in Green 1999:49).

“It depends on the illness, how it starts. If it is an ordinary illness, we know where there are mosquitoes there is malaria. There are diseases which we believe come from God Almighty. But there are diseases which you look at them and say ‘mmmh! This is because the ancestors are angry’ ” (Informant H).

“Ordinary illnesses are like malaria, diarrhoea and chest infections. Believing that God causes illness – that depends on the individual. They say that the ancestors can cause epilepsy in adults, fits in children, infertility and AIDS” (Informant F).

Treatment options are available from all three worldviews.

“When you have been to hospital many times and the doctor has given you medicine for months and there is no improvement, you despair and that is when you take the problem to the traditional healers” (Informant F).

“The [traditional] healers know what medicine cures what disease, this was practised from long ago, but divination did not exist in former times. They have medicine from plants and when it is too difficult they take the patient to hospital, but they prefer herbal medicine” (Informant I).

For treating an infection, one informant said that they would choose between using antibiotics from a medicine shop, traditional remedies and going to hospital.

Beliefs in the ancestors, witchcraft and evil eye all appear to be associated with fear, and some informants made an association between these beliefs and evil or the devil.

“Witchcraft is satanic; it is to do with the devil. Now you will always be able to find cunning people who can persuade people that Satan is powerful, even more powerful than God. Yes there are those like that” (Informant C).

“Witches were considered very bad people, evil people who do not know God” (Informant I).

These beliefs have been condemned by local and national religious leaders. While fear of ancestral displeasure may discourage certain behaviour (such as sexual

immorality) which is harmful for individuals and society, generally, there appear to be many negative consequences of these traditional beliefs.

Howard and Millard (1997:155) suggest that “*sometimes a supernatural explanation relieves anxiety over uncontrollable conditions; at other times it provokes anxiety*”. Informants’ reports suggest that the supernatural explanation for illness is more commonly a stress factor that can contribute to physical, psychological, social and spiritual illness in those directly or indirectly affected by it. This view corresponds with the views of Smit (1986:16) and personal observation. The stigma attached to conditions such as mental illness and infertility causes additional suffering to those afflicted, as well as the stress and fear associated with the illness and possible delay in the use of effective treatment, as shown in research on epilepsy (Rwiza, Matuja, Kilonzo, Haule, Mbeni, Mwang’ombola and Jilek-Aall 1993:1017-1023). The interaction between health care providers of the different paradigms has not always been one of co-operation, but since 1989 the Ministry of Health has had a section of traditional medicine, and the organisation CHAWATIATA, made up of traditional healers and TBAs, is recognised (Goergen 2001:4).

In terms of culturally congruent care it would appear that home care practices largely based on the holistic paradigm differ from care in hospitals, based on the scientific paradigm and imported from a Western cultural background (see paragraph 4.4.9). There is continuous change within each paradigm; this is perhaps most obvious in the holistic (Green 1999:33) and scientific paradigms. There is also continuous change in people’s use of different paradigms

4.4 CHANGE AND CONTINUITY

It may be surprising to some non-African readers that there are still many people who continue to hold traditional beliefs although they are affected in some measure by science and technology. While some beliefs patterns are changing, many urban Pares appear to hold onto traditional beliefs. These include beliefs such as the danger of ‘contaminated’ breast milk or eating solid foods during illness. There are also widely held general beliefs such as in the power of witchcraft.

Change can be perceived as a challenge, which can be positive or negative. Some changes may be associated with benefits and be perceived as progress; others may produce conflict and contradiction. Culture is not static; cultural change is inevitable (Boyle & Andrews 1995:12). Whenever there is contact with other cultures some assimilation takes place. World changes, political policies and economic factors are also factors that produce cultural change. Within the last 150 years, the Pare tribe (and their forebears) with its rural communities and traditional lifestyle and beliefs have met with new religious beliefs, and a new paradigm for health. This new health paradigm has become accepted as the official health system. In the case of urban Pares, they are also encountering a new lifestyle and contact with different cultures.

While belief changes may take place more slowly than behavioural and technological changes there must be some cognitive conflict and confusion produced by the inherent contradictions (Boyle & Andrews 1995:20). There must also be social conflict when different family members have different views about disease causation and appropriate treatment. There is potential for spiritual distress if, for example, treatments offered do not concur with beliefs about spiritual causes of illness. There are economic implications to the changes in worldview, for example in differing payment methods such as cash payments on presentation compared to farm produce paid on recovery, for different practitioners. Physical well-being may be affected by the impact of these stresses, or more directly, for example, when there is an adverse reaction between therapies used in different paradigms. Thus the changes occurring in the belief systems of urban Pares affect their physical psychological, social, spiritual and economic well-being.

4.4.1 Continuity in sense of identity in urban Pares

Many of the urban informants when asked about Pare beliefs, spoke of the lifestyle and beliefs of the rural Pare farmers on the mountain slopes of the Pare Mountains (see Chapter 1). The interviewer often had to return the informant to discussion of the urban Pares of Moshi, this being the focus of the study. All the informants interviewed had lived in the Pare mountains at some time, (this was not a criterion for selection of informants,) and considered this their home. Almost all still had relatives, homes and / or land in the mountains, and would go and visit there, especially at

Christmas time. An urban Moshi dweller is in no doubt about which tribe he belongs to, such as being a Chagga or a Pare, and a Pare is often heard saying “*nakwenda Upareni*”, meaning, “I’m going to Pare district”, and is less likely to say, “I’m going to Same district” or “I’m going to Mwangi district” which would be the terminology of the district reorganisation (see paragraph 1.2.3. and Figure 1.2). While urban Pares have had other influences on their lives, some spoke of their ‘roots’ as being very influential.

“[As for remembering Pare customs] I must remember since I grew up there, how can I not know the customs of my people while all my people are there? Both my parents are buried there; I can not follow the customs of other people. That is impossible. Even I can dance the Pare dance, I also speak the Pare language very well” (Informant D).

“A Pare is a Pare. Whenever we get problems we go [back to Pare district], for example the mvoro, even my sister-in-law whom you saw just now is going home and I have asked her to bring back some mvoro ...Any Pare living in town has links with his people in Usangi, Same, Ugweno, etc. Very few have completely moved out, those who have moved out but still have relatives there have strong connections with them” (Informant B).

“Home is home, and even in December I will go there for ten days” (Informant E).

One informant suggested that Pares are not the same as other tribal groups.

“You know we Pares are very different. Our families are very close. The father and his wife share in everything, and love each other very much. Another thing is that Pare husbands don’t beat their wives ...” (Informant I).

However, the Pare tribe is relatively new, ‘created’ in 1928 by the British colonial administration and then subsequently the district was split into the Same and Mwangi districts (see paragraph 1.2.3). The term Pare district, is no longer officially used although it is well understood by Tanzanians. Moreover, Nyerere’s detribalisation policies have had some impact on tribal identities (see paragraph 1.2.2).

While Pares seem to have kept a sense of identity, several informants suggested that the Chaggas and Pares do not differ markedly in their cultural patterns and beliefs.

This is not surprising as they are geographically neighbours, traditionally farmed in similar mountain terrain and have interacted for many centuries.

“We and the Chaggas are quite close to each other” (Informant F).

“The Pares and Chaggas don’t differ a lot in the care of mothers” (Informant B).

The urban wage-earning lifestyle differs markedly from the rural subsistence farming Pare lifestyle, and would be expected to reduce the sense of identity of urban Pares.

“Personally, I think that those who live in town, really they get more income and even if he is short of money, but at least he is able to have strength and help from his friends who are their neighbours ... But those who live in the mountains far from town [especially] ... those who live in the far South [of Same District] I really think that their living conditions are different from those friends of ours in the north. They still need services ...” (Informant C).

The urban lifestyle also differs in that urban Pares cannot so easily continue with some traditional practices such as making sacrifices at ancestors’ graves, and also that they are living in communities with other tribal groups. The social organization includes, for example a ‘ten cell system’ in which a local grouping of ten households are responsible for each other, under the supervision of a ten cell leader. This is not arranged along tribal lines, so an urban ten cell group is likely to have several tribal groups represented.

4.4.2 Changing worldviews

All informants described traditional beliefs and practices which relate to the magico-religious and holistic worldviews (see sections 4.3.1 and 4.3.2). This means that health beliefs fall into two major categories, and treatment options usually follow the appropriate route for the believed cause. All informants also described beliefs and practices associated with the scientific paradigm. Currently there are three different paradigms being used by urban Pares, and the scientific one appears to conflict with the views of reality offered by the other two. It appears that beliefs from the different paradigms may be used at different times by the same person, and sometimes apparently simultaneously.

4.4.3 Change in spiritual beliefs and practices

Traditional spiritual beliefs include belief in ancestral spirits, and the power of the evil eye and witchcraft (see sections 4.3.1.2 and 4.3.1.3). Some informants suggested that they didn't know anything about the subject of traditional beliefs early in the interview, but later were more forthcoming. This initial reticence suggests that there may be some cognitive conflict about the subject, particularly perhaps, as the interviewer was European. Europeans are probably considered likely to be unfamiliar with traditional beliefs, and are not expected to hold them.

There were conflicting reports about the extent of urban Pares beliefs in ancestral spirits. These reports included that all Pares believe in this, many Pares still believe in this, it is not much practised, it depends on the clan, it depends on the religion of the family (it is alleged by some to be more common in non-Christians), it is less common in town dwellers, it is more common in Chaggas than Pares. None admitted to personally believing in it or being involved in associated practices. These very varied reports suggest that the current time is a period of transition in respect to these beliefs, although traditional beliefs and practises are still well known.

“[With respect to past traditional beliefs] if there has been a drought, people checked to see if there was a girl who was pregnant outside wedlock, and whoever was held responsible for this drought was killed. ... So I think this was just belief, they also say that if you upset your grandfather you will be cursed and your life will be bad. ... People have moved from this belief to other beliefs ... Now we go to church where they tell you that people who practice sorcery will be the first to burn in the fire of hell” (Informant E).

The Christian and Muslim religions have been introduced relatively recently (see paragraph 1.2.1). *“Islam grew rapidly [in Tanzania] between 1880 and 1960”* (Johnstone 1993:528); and *“the first serious [Christian] missionary activity in the Kilimanjaro region began in 1885”* (Howard & Millard 1997: 84). In 1900 more than 80% of the population were following traditional religions such as animism; by 1990 this proportion was estimated to be 13% (Johnstone 1993:527). The Christian and Muslim religions differ in their practices and beliefs, but they join in condemning beliefs in ancestral spirits and witchcraft.

When asked about belief in witchcraft, several informants denied continuing beliefs amongst urban Pares early in the interview. By the end of the interview, however, almost all informants concurred that many other urban Pares believe in the power of witchcraft.

Some informants spoke of changing patterns of spiritual beliefs.

“[With respect to Pares’ beliefs in witchcraft] personally, I think they have advanced. Those from the area where I come from, which are Same and Mwanga districts, these practices have now gone. ... The Christian religion has helped, because it is widespread” (Informant C).

“This kind of thing [witchcraft] has disappeared unless it’s going on in a few places. And it has disappeared because of religion, however in the past many people believed in witchcraft” (Informant A).

“Witchcraft is still practised, but those who are religious don’t practise these things. People have become up-to-date. This depends on the individual” (Informant D).

Several informants reported that some people adhere to Christianity or Islam and also practise witchcraft. One informant suggested that formal religion is practised in the day, the latter at night.

“This thing of ancestors becoming angry, nowadays it is not much believed in, but witchcraft is very common” (Informant B).

It appears that witchcraft is still believed in, and different authors have argued that it is declining, static or increasing in urban Africa. If witchcraft and sorcery are related to interpersonal tensions *“shouldn’t the urban “modernization” processes ... result in the increase of witchcraft accusations in urban society?”* (Swantz:1990 in Green 1999:53).

In Tanzania as elsewhere in the world, it has been observed that urban religious practice has declined faster than rural religious practice. Informants reported that the use of prayer by Pares in town is less than the use of prayer traditionally in the villages.

“In town we use medicines but in the villages they use prayers, even when the patients are in the hospital they pray so that God will help them” (Informant H).

4.4.4 Conflicting perspectives on health maintenance

Some reported Pare perspectives on health and health maintenance are congruent with scientific ones, such as those relating to environmental and personal hygiene.

“They try hard to build good houses, with corrugated iron roofing, to have good ventilation and good air condition so that they get fresh air when they are asleep. Then another thing that I understand is that these days they like water, they like to get clean drinking water in order to avoid illnesses. Body hygiene is also important to them ... they like to eat well ...” (Informant C).

The western perspective about the importance of maintaining health by exercise and weight control is held by some urban Pares, but not by all. For example, some informants reported that exercise in addition to that undertaken in normal daily activities is not necessary to maintain health, based on rural experiences (see paragraph 4.3.2.2).

“They wake up in the morning and walk for about six kilometres to fetch animal feed, when they get back they pick up a hoe and go to the field and work for hours” (Informant B).

One informant suggested that both underweight and overweight are unhealthy, and another condemned obesity; this is congruent with scientific thinking.

“Obesity is bad. People think that being fat is healthy, but no, not so” (Informant G).

However, several informants reported the belief that being fat is a sign of being healthy and is associated with social prestige. This belief has arisen in an agricultural subsistence economy where poor crops could be disastrous for a community, and having some body fat reserves may have been a prudent measure.

“[In respect to the three months resting period for the newly delivered mother] it’s very important that the mother is well fed, and when she comes out the father is happy if his wife has become very fat” (Informant A).

The belief in the importance of avoiding unnecessary worry and accepting life's problems is antithetical to the proactive problem solving method used by some as a scientific approach.

4.4.5 Changing and conflicting beliefs on disease causation

Urban Pares are living in a society where many different ideas about disease causation are held. Informants reported that the views about the problems of infertility and mental illness, traditionally seen as caused by witchcraft, appear to be changing.

"[If a woman cannot have children], sometimes it is illness and sometimes it is due to bad luck" (Informant H).

There was some conflict of ideas between causation and treatment, however.

"They see her as a barren woman, she cannot have children, they think it is God's will. ... [When asked "what do they do to help her?" the reply was] They take her to the traditional healer, and if even that does not work, they keep trying" (Informant D).

While understanding the cause of illness appears to be important in indigenous practice, *"this doesn't mean that verbalized statements about aetiology are always good predictors of behaviour"* (Green 1999:32).

Views about mental illness appear to be changing; there was not only the traditional belief in causation by witchcraft expressed by informants but also some concern for those who are sufferers, as well as the realisation that mental problems can affect anyone.

"Of all illness, the worst in the lives of human beings is mental illness ... people will run away from you, you are not able to get food and they will withdraw from you, because they are afraid of you. ...They say probably that it is a curse, but these days a lot of the time, the young people who become mentally ill, they say it's because of marijuana" (Informant A).

"[Depression] is not illness but only a problem of the mind, this depends on the way you think" (Informant H).

“When I’m worried I don’t feel well, I believe this and even the Pare believe this, this state of unhappiness brings illness, you get headaches and hypertension” (Informant C).

While the conceptualisation of inheritance as a causative factor in illness is congruent with scientific beliefs, it is applied in a non-scientific manner in respect to adult epilepsy. All informants concurred that epilepsy in adults known as *‘kifafa’* is generally believed to be inherited. This produces added stress to those affected, because when a marriage is proposed, careful enquiries are made about the occurrence of epilepsy in the family, so as to avoid marrying into a family with epilepsy.

“If you suffer from epilepsy it is hard to get a husband. You will only get a husband if you hide the problem” (Informant F).

“[In respect to the most feared disease for Pares] to tell the truth, they fear epilepsy. For instance, if I live in town and I want to marry from home, my parents will make sure that I marry from a family that is free from this disease, because the disease is passed from parent to child” (Informant E).

Some informants suggested that an urban diet can be disease producing.

“They claim that the cooking oil we use nowadays causes high blood pressure. They also claim that the foods sold in shops have things that cause illnesses” (Informant B).

Excessive working hours without rest were also blamed as a cause of stress and illness (see paragraph 4.3.3.4). Micro-organisms and poor environmental hygiene were considered to be causes of ill health.

“They know about contagious diseases and diseases which can result from mental confusion. They understand various diseases such as pulmonary TB, TB, pneumonia, malaria. They know that diseases can be brought about by germs ... Illness is something you can get from the environment. But I cannot go along with the belief that illnesses can come from witchcraft. ... there are those who instead of going to hospital they go to the traditional healer. There will always be people like that, and they won’t come to an end. But they are few, most people believe in hospitals, and most people believe that illnesses

can only be treated in hospital, and that diseases are caused by a dirty environment” (Informant C).

While informants report that many people associate AIDS with witchcraft (see paragraph 4.3.1.3.3), there are other views.

“Ordinary people think that this disease is caused by fornication, and it originated from the people, through immorality and lust; it was brought like that. Religious people think it is because of our increasing sinfulness and that is why the cure has been impossible to find ... So there are two beliefs; one, it was brought about by immorality and Bukoba and Uganda are mentioned a lot; two, others believe that God punishes us for disobeying Him” (Informant C).

One informant referred to AIDS as a fulfilment of Biblical prophesy about incurable diseases occurring in the last days of the world.

4.4.6 Change in meaning of traditional rituals

There may be some change in the meaning ascribed to traditional rituals such as sacrificing a goat to the ancestors. One informant described the rituals in a different way to other informants (see paragraph 4.3.1.2.3).

“When misfortunes happen and many people die in a short period of time they say “maybe our grandfather is angry”. But this is done in a good way, not like praying to the dead, but coming together, the people of the clan, and ask yourselves why you have been neglecting each other. They cook some food and make some liquor, such as dengelua, (locally brewed rum) and share it. They believe that when they do this and pray to God the misfortune will go away. It’s all about praying to God” (Informant C).

Another informant suggested that these rituals may be used as a kind of celebration.

“I think these rituals are a form of thanksgiving or offering. For example, when I have been blessed with a good life, have had children, I would go home and tell my father about it. He will say, ‘We have to slaughter a goat in honour of our ancestors and we will share it with our relatives’ ” (Informant E).

The same informant reported the continuing use of rituals as a kind of preventive measure, alongside the use of Christian prayer.

“They say, “let us give [grandfather] Sereki the offering so that he will bless his grandson before circumcision.” I do these things because my parents do them. We don’t consider them as part of treatment, but rather as prayers. If my child is going to Europe, I go to church to pray, and at home I perform some rituals, saying “and you, my ancestors, please watch over your son, wherever he is.” When we are performing the rituals we start by saying, ‘God in heaven and ancestors underneath’ ” (Informant E).

The annual family reunion appears to be much practised by Pares. It was at such a time that a sacrifice would normally have been made, and for many this may now be a time of celebration, where a goat may be slaughtered, with the primary aim of feasting together.

“These days, they do not practice sacrifices. Only a few people do that. But they meet together at Christmas and slaughter a goat, and have a feast together, all the family” (Informant F).

4.4.7 Change in patterns of treatment

The traditional practices of sacrificing to the ancestors appear to be less common these days.

“So these things are still there, they say that the ancestor is angry, they take the child right to the grave of his ancestor ... but I’m personally not sure that they work, that if the child is sick with pneumonia and is not taken to hospital, that he will get better by taking those things to the ancestral grave” (Informant B).

Hospitals and clinics are reported to be much used.

“In our times, when they see someone is sick they are taken to hospital because there are many hospitals around. In the past when someone was sick they were treated with the traditional medicine available” (Informant E).

“When they become sick they run to the hospitals” (Informant G).

First aid measures and use of medicines from a shop are alternatives available to urban Pares.

“In the past they used to take some bark from certain trees. The bark was boiled and it was used to cure constipation. Some leaves were ground and given to a patient to smell as a cure for headache, but this was happening a long time ago when we were young and now I don’t remember the type of trees any more. Personally, I don’t believe in herbal medicine. ...As first aid, the Pare know that if there is a person who is ill with a headache and when they are not having a nosebleed, firstly they can take water and bathe the patient to lower the fever if it’s a high temperature, they heat up the water to be luke warm, and they find tablets. Now people have advanced, they will find him aspirin or paracetamol to help him” (Informant C).

Some reported that in towns the expertise in traditional medicines is being lost, but in the rural areas herbal remedies are widely used.

“[The modern Pares] have forgotten, because I think the old men who were experts have died without leaving the expertise to the next generation” (Informant G).

While many informants suggested that clinics are now preferred by urban Pares, several informants made some contradictory statements within the same interview.

“They understand they should go to the health centre these days. In former times many of them were using traditional medicine ... [as for using home remedies] they do use them; many of them use home remedies or traditional medicines they call them. This may be things like roots and leaves” (Informant A).

Another informant, early in the interview reported that Pares do not use herbal treatments but later reported that they do.

“In Mwanza [in the Lake zone of Northern Tanzania] when someone gets sick they don’t take them to hospital at first, they give them herbal medicines without even knowing whether the medicine is appropriate for the illness. For us in Pare district there is no such thing, maybe in the past but not now ... [about 15 minutes later in the interview] A Pare is a Pare. Whenever we get problems we go (back to Pare district), for example the mvoro, even my sister-

in-law whom you saw just now is going home and I have asked her to bring back some mvororo because I have noticed some malaria signs in the house. Many people use ikongwe, mrumbavasi and mvororo a lot, even today” (Informant B).

One informant remembered traditional remedies being used when he was a child but thinks that they are now forgotten:

“[For malaria] if you ask the old Pares they will tell you that a goat must be slaughtered and its liver squeezed to extract juice. If a child has measles they slaughter a chicken, burn the feathers and mix it with the soup to be given to the patient, and they were getting cured – you never know. Maybe it was God’s hand helping all along, because there was no way out, no hospital. ... [The modern Pares] have forgotten, because I think the old men who were experts have died without leaving the expertise to the next generation” (Informant G).

The informants gave a picture of a fairly flexible approach to treating illness, which involves trying different treatment options according to the type of illness and its likely cause, but with consideration for accessibility and affordability of treatment options. This is congruent with the pattern of using low cost and home remedies first and moving to more expensive solutions later, noted in other countries (Green 1999:33).

There is also change within treatment paradigms, for example the traditional healer informant talked about his practice having been affected by scientific knowledge.

“But now because of advancements in the medical field, when someone comes to me I take their medical history. If they have liver problems, then I give them the appropriate treatment, only if they have proved to me that at the hospital they were told that they are suffering from liver problems” (Informant E).

This is congruent with the notion that “indigenous African healing systems are dynamic, adaptive, ever-changing systems, open to the accommodation of therapeutic pluralism” (Janzen 1981:189 discussed by Green 1999:33).

There is also interaction between different paradigms, as the traditional healer reported.

“Some fevers are very high, they dry up the blood from the body, my medicine can cure these. But we get stuck when people are dehydrated and they cannot eat or drink because we cannot replace the water in the body and therefore the patient dies ... we depend on hospitals to help them” (Informant E).

4.4.8 Change and continuity in care patterns

There is continuity in the recurring theme of respect for the sick person demonstrated in care by family and friends, and the practice of visiting and providing special foods. The degree of co-operation traditionally practised during illness may be changing.

“Co-operation in the family is very common but nowadays it is becoming a bit less common because of changes in lifestyle” (Informant I).

This is thought to be due to changes in values away from a traditional extended family orientation to a more individualistic orientation, which may be related to economic factors and contact with other cultural groups.

Traditional breastfeeding practices are well known and respected, but it is reported that they may not be always practised as in the past.

“You find that he has not reached two years and the child is weaned. This is the result of the environment in which they go around, and it is in this impoverished state that they are going around, but their intention is to breast feed for a long time” (Informant C).

Informants reported that adherence to the traditional care practices for newly delivered mothers, while still strong in the mountain Pare communities, is not so strong in the town.

“These days, if a mother delivers in the village, many are doing just like that [traditional seclusion and feeding], but the majority of those in town, like our children, they don’t want things like this” (Informant B).

“Normally in Pare district new mothers rest for three months, but this was practised mostly long ago, nowadays they can only rest for one and a half months; life has become more hectic” (Informant G).

Home care continues to be individualised and includes a lot of attention and time given to the sick person (see section 4.3.2.6 above). Taking responsibility for a sick patient at home or in hospital is normal practice. A commonly heard phrase is “*nina mgonjwa (hospitalini)*” meaning, “I have a sick person [that I am nursing] (in hospital)”. The large numbers of visitors who arrive at hospitals bearing flasks of drinks and hotpots of special food, as well as relatives who stay with their patient – sometimes day and night - to help with nursing care in hospital, demonstrate this sense of responsibility. Family members provide most of the home care, and it is reported to be provided in an atmosphere of love and concern. Illness is a crisis which is dealt with by co-operation (see paragraph 4.3.2.6.3.1).

Traditional practices relating to special foods for sick people may also be changing.

“[With respect to sick people] we give them soft food, they say that the body can’t digest hard foods, but now things are changing, you know the old people are dying off and in our generation we eat anything” (Informant G).

Resting is considered by many to be important, but there may be some change in this.

“When I was young the Pare used to believe it was good for the patient to just rest. But now they have realised that a patient must have some rest and also have some exercises. They have already got this idea” (Informant C).

The principle of respect for the sick person, while a recurrent cultural pattern in traditional care, is reported to be neglected in health care institutions.

“Some nurses when you go to see your relative at the hospital, they wear gloomy faces, which make you think you are bothering them. Some, though, have happy faces and even greet you. They tell you how your patient is doing, some are good and others even when you greet them they don’t answer you.... These days the language they use to the patients is bad ... when the patient arrives and meets with bad language that makes him feel uncomfortable. He won’t recover because he’s already been shown that here is no-one to serve him or comfort him” (Informant B).

4.4.9 Potential for change towards provision of culturally congruent care

For urban Pares, culturally congruent care would appear to include attention to issues of respect and love for individuals, social, psychological and spiritual care, including relief of distress, physical care including hygiene, special foods and herbal remedies and adequate rest (see section 4.3.2.6). Informants reported that nurses currently provide care with no consideration for any cultural difference. One informant considered that this may be due to a lack of motivation.

“Nurses provide service to people without consideration of the tribe. It’s that nursing has deteriorated, many of them have become discouraged because of the very low wages ... there is no differentiation” (Informant A).

They mentioned the importance of avoiding discrimination. One informant suggested that

“Personally, I won’t lie to you, in [two particular hospitals] I have seen that the nurses make no difference between tribes, they treat them equally, they don’t discriminate and treat the Masai in a particular way because he lives in the bush and a Chagga in another way because he wears a suit” (Informant C).

The idea of culturally congruent care appeared to be a new idea to the informants, who appear to be more familiar with the notion of avoiding discrimination, in the sense of treating everyone the same.

“[As far as respecting people’s culture is concerned] it’s possible to do more, like the Masai are people who like food such as meat and blood, and now are unable to get these things when they are in hospital ... but anything that is available for everyone like the hospital food should be shared out for everyone” (Informant A).

Others suggested that cultural requirements such as special foods, can be provided by relatives. They acknowledged that current hospital food is not culturally congruent.

“No, patients do not eat stiff maize porridge and beans in Pare district, and when he is sick he is never given beans” (Informant I).

Informants did not see the need for other special provision; they suggested that it would be economically impractical, for example, for hospitals to cater for different dietary preferences.

“[As for providing different food for different tribes] this is not possible, it will be very costly; nowadays even the Masai eat beans and rice ... those who can eat meat all the time have money - meat is expensive - and if a Masai has many cows he can eat meat. It does not depend on the tribe but rather the financial position” (Informant C).

There are some moves towards addressing the issue of total quality management in health services in Tanzania. A few nurses are involved in degree level studies and have been exposed to the ideas of transcultural nursing. It is possible that change will be forthcoming (see Chapter 5).

4.4.10 Conflict between stated health beliefs and their implementation

As discussed in paragraph 4.4.9, there is a conflict between the traditional belief in respect for sick people and the lack of respect and individualised care available in hospitals.

Beliefs about environmental hygiene and health promoting behaviour are not always put into practice.

“[In respect to access to clean water] to tell the truth it’s not all of them [that have it]. Yes, there are some who are very poor, they know they have to get clean drinking water, eat good food, have good housing, wear good clothes and go to hospital when they are sick, but they fail to do so because they don’t have money” (Informant C).

Economic problems (see paragraph 4.3.2.6.4), lack of infrastructure and expertise are major obstacles to implementing stated health beliefs about water, food, and suitable housing.

“To the Pare, health has many factors, for example, you want to eat eggs, meat etc, but you don’t have the money, now how can you be healthy?” (Informant I).

For many urban Pares, it is a struggle to obtain enough money to have the varied diet that they have learnt about in school and from health workers. Clean water is not always available even to all urban Pares, with water cuts from time to time in some areas. While they appear to believe that environmental hygiene is important, uncontrolled littering, for example, is found all over Moshi. Regular refuse collection is not a service that is generally available. Health services are not easily accessible to all urban Pares, in spite of being prized by them. They report that although the very poor are entitled to free treatment at government institutions, this is not always easy to obtain. Private clinics charge prices that are not affordable to all, with a minority of the population being wage earners, and the minimum wage being below a living wage.

“... after taking blood tests etc they told me I had typhoid. Just taking the tests it costs 2,500/= and the medicine 6,000/=” (Informant D).

1,000/=, that is one thousand Tanzanian shillings, has a current value of about one United States dollar. 8,500/= is about 80% of a week's wages for many people.

One informant was also concerned about the lack of equipment in hospital, particularly when compared to provision in the 1970's:

“These days even if a lady is going to hospital to deliver there is no service except for that of the theatre or labour ward for delivery. There is not even a pad, there are no blankets to wrap the baby in ... as a pregnant mother you are told to go with all of your requirements” (Informant B).

So there is a conflict between what individuals believe is necessary to maintain health and what for economic, social or political reasons is actually available.

4.5 SUMMARY

Urban Pares interviewed reported that the three major worldviews are all important influencers of health beliefs. A wide variety of health beliefs and practices are therefore found in urban Pares. The beliefs and practices identified here are largely congruent with findings discussed in Chapter 2, especially the findings in Chaggas. Differences between Chagga and Pare beliefs and practices include more widespread use of herbalism in Pares, and some minor differences in invalid foods. While some traditional Pare beliefs and practices continue relatively unchanged in Moshi town,

others are starting to change and still others appear to have changed dramatically. This is a period where changes are occurring not only in health beliefs but in many spheres of life. These changes may result in improvements in health, they may also bring stress and conflict. Nurses have been a part of the changes that have taken place; they have been part of the positive change in health care provision, but have also been part of the system which is generally not providing culturally congruent care.

4.6 CONCLUSION

In order to achieve maximum clarity and understanding of the data, as well as attainment of the objectives of the study, the data was read carefully to identify important concepts and recurring themes. Irrelevant data was omitted. The themes identified were then grouped into two major themes with categories, and then the categories presented by using verbatim quotations and descriptions in the account provided in this chapter. By correlating data with specific literature references, better understanding is achieved. In the final chapter, the conclusions and recommendations of the study will be discussed.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The following conclusions and recommendations arise from the analysis of data in Chapter 4 and of the literature. Some of the recommendations were made by informants themselves. This chapter utilises the data presented in Chapters 2 and 4 to identify health beliefs and practices that are important in the provision of culturally congruent care for urban Pares (see purpose and objectives of the study in paragraphs 1.4 and 1.5, 3.3.2 and 5.2). Recommendations may be involve changes in health care practice, education or advocacy. The provision of culturally congruent care would be facilitated by the improvement of nursing care standards in general.

5.2 SUMMARY OF THE STUDY

The first chapter of this study included background information, assumptions and terminology. The research question identified was:

- What are the health beliefs of the urban Pares living in Moshi, Tanzania?

The purpose of the study was to explore the health beliefs and practices of the urban Pares of Moshi. It aimed to determine what are normal care patterns, expressions and practices, and how nurses can improve their care so as to provide culturally congruent care for this group.

The researcher aimed to achieve the following research objectives:

- to gain an understanding of the health beliefs and practices of the urban Pares of Moshi, Tanzania
- to describe the health beliefs and practices of the urban Pares of Moshi, Tanzania
- to recommend how nurses may modify their current practices to provide culturally congruent care for this group.

The research question is reflected in the guided interview schedule. The issue of health beliefs is reflected in questions 7.1, 7.2, 8.1, 8.2, 8.3, 8.5, 8.6, 8.7, and 9.2. The issue of practices is reflected in questions 7.3, 8.4, 9.1 and 9.3. The issue of improving nursing care to become culturally congruent is reflected in questions 10.1 and 10.2 (see Annexure A).

The literature review in Chapter 2 was structured according to Leininger's Sunrise Model and examined literature related to worldview, cultural values and health belief systems, environmental context, language and ethnohistory, care expressions, patterns and practices and systems of health care. The literature examined revealed a lack of transcultural information relating to the urban Pares of Moshi, and a low standard of nursing care in Tanzania generally.

The description of the methodology in Chapter 3 addressed how the research questions should be approached, using a purposive sample and semistructured interviews as part of a qualitative approach. A thematic analysis of the data was undertaken in which important recurring concepts were derived. This process continued during data collection. Related concepts were grouped into themes and within the themes were grouped into categories. When no new themes or concepts were forthcoming from new informants data saturation had occurred, and the sample size was considered to be sufficient.

Chapter 4 described the findings from the data analysis in terms of two main themes, multiple worldviews and change and continuity. It was found that health beliefs and care practices arise from the magico-religious, holistic and scientific paradigms, and while some aspects of these beliefs and practices continue, others are changing. Informants reported that urban Pares lack culturally congruent care from the biomedical health care providers, but it appears that there is potential for improvement.

5.3 BACKGROUND TO CHAPTER FIVE

According to Campinha-Bacote, (in Andrews & Boyle 1999:8) the process of building cultural competence involves cultural awareness, cultural knowledge, cultural skill and cultural encounter. While an individual health worker can acquire cultural knowledge from personal experience, and while planned sharing of cultural knowledge in a health care institution may be valuable, documented cultural assessments allow for wider dissemination of knowledge. It is recommended that cultural assessment tools be modified or developed to include issues identified in this study, such as beliefs in the magico-religious paradigm. The need for health workers to undertake cultural assessments to build on the knowledge base of nursing practice underlies many of the conclusions and recommendations of this section. There is also the need for health workers to understand and apply the principals of transcultural nursing. A revision of curricula for preservice and inservice educational programmes to include transcultural content is recommended. The concepts of the Sunrise Model (see Figure 2.1) (Leininger 1991:43), especially the concepts of generic systems, nursing care and professional systems, culture care preservation, accommodation and repatterning are important for nurses to understand. Generic care systems are derived from experience and transmitted within a cultural group. Professional care systems are taught formally. Nursing care systems refer to learned patterns of care related to health needs.

Culture care preservation refers to actions or decisions that a professional takes that involve supporting values and beliefs held in a particular cultural group. Culture care accommodation refers to actions or decisions that a professional takes that require some adaptation of behaviour for a particular cultural group. Culture care repatterning involves the professional helping clients to change patterns of care which are judged to be harmful (Leininger 1991:47-49). These three approaches to planning care are referred to in the recommendations which follow. Health workers need to consider not only when they should recommend change but also to consider when they need to change their practices.

Health workers need to be aware of the ethical issues involved in the nursing care actions of culture care preservation, accommodation and repatterning. There is a risk

that health workers may adopt a paternalistic approach which may affect the autonomy of the client. Health workers need to be keenly aware of the issues of beneficence and non-maleficence, giving careful attention to respecting their clients' autonomy. Ethical dilemmas are bound to arise in transcultural nursing practice, for example when a client believes that a particular practice is important and the health worker perceives it as being detrimental to health (Bandman & Bandman 1990:43-44; Rumbold 2002:217-230; Seedhouse 2001:192-193).

5.4 CONCLUSIONS AND RECOMMENDATIONS FROM THE DATA ANALYSIS

The conclusions and recommendations are structured according to the themes and categories identified in Chapter 4.

5.4.1 Conclusions and recommendations on multiple worldviews

5.4.1.1 General conclusions on multiple worldviews

Urban Pares in Moshi appear to be influenced by the magico-religious paradigm, the holistic paradigm and the scientific paradigm. They use beliefs and practices from these paradigms when managing different health problems, and the stated beliefs do not always appear to be congruent with the practice. (See paragraph 4.3.4). The urban Pare view of health could be stated as “physical and mental well-being that provide security by allowing an individual to work” (see paragraphs 4.3.2.1.1 and 4.3.2.1.2), which relates to the holistic paradigm.

5.4.1.2 General recommendations on multiple worldviews

Health workers who are aware of the cultural practices and beliefs of those they are caring for, and the possible impact on health care provision will be able to provide care that is more satisfying to clients and providers of care. It is recommended that health workers be made aware of the multiple world views that Pares hold. This could involve inclusion of appropriate material in the curricula of pre-service courses, as well as in-service education for qualified staff and orientation programmes for new

staff, whether they are local or expatriate. Transcultural nurses and anthropologists could help to provide this education, based on research findings. Health workers would then be sensitive to the fact that a Pare may have a perspective of his disease causation other than a biomedical one, and may have already tried different treatment options. It is recommended that health workers adopt a realistic and non-judgmental attitude to urban Pares who may try the treatment offered by a health facility for a limited time period and move on to another option.

5.4.2 Magico-religious paradigm

5.4.2.1 Conclusions and recommendations on belief in God

5.4.2.1.1 Conclusions on belief in God

All the informants reported that God is important to them, and many reported the belief that God is able to protect from illness or to cause illness. They reported that their ancestors believed in an all-powerful creator God. Their view of the nature of God is now informed by the Christian and Muslim religions. The informants all reported the belief that prayer is valuable in health and illness (see paragraph 4.3.1.1).

5.4.2.1.2 Recommendations on belief in God

It is recommended that the orientation of new health workers in urban Moshi should include education about the importance of the urban Pares' belief in God. Those involved in orientation of new staff need to be aware that the area of spiritual care may be considered less important in other cultures than in the culture of urban Pares (Leininger 1991:355-368). Nurses should encourage individuals and communities to take issues related to spiritual health seriously. They should facilitate patients' religious observance and attendance by religious advisors. For example, the need to respect prayer times, visits by religious leaders, and the need to demonstrate solidarity with local colleagues during religious ceremonies may not be immediately obvious to someone from another culture.

Cultural care preservation is appropriate in respect to prayer, as it appears to have only positive outcomes. Indeed, nurses could be strong advocates for more attention to be given to the spiritual needs of the sick, including prayer. This might involve having more hospital chaplains, religious leaders and carefully selected workers or volunteers available in community and institutional settings.

5.4.2.2 Conclusions and recommendations on belief in ancestral spirits

5.4.2.2.1 Conclusions on belief in ancestral spirits

Some urban Pares believe in the power of ancestral spirits to cause illness and thus feel the need to make an offering or sacrifice in a special location to appease them. The traditional practices of making offerings to the ancestral spirits appears to be a family concern, rather than an individual practice (see paragraph 4.3.1.2).

5.4.2.2.2 Recommendations on belief in ancestral spirits

It is recommended that health workers be sensitised about beliefs in ancestral spirits, through preservice and inservice education so that they can identify, advise and manage patients appropriately. It is recommended that health workers communicate more openly with individuals and families in relation to beliefs in ancestral spirits, using a non-judgmental approach. If a patient wishes to be discharged to visit his ancestral home and return, it is recommended that this be negotiated, as it may be in the interests of the patient's psychological health to be temporarily absent. A short period away from hospital may be preferable to discharging the patient against medical advice, as this latter option may create unnecessary stress and conflict, especially if readmission is required. Cultural care negotiation is appropriate in this context.

5.4.2.3 *Conclusions and recommendations on belief in evil forces*

5.4.2.3.1 Conclusions on belief in evil forces

It appears that belief in evil forces such as the evil eye and witchcraft are fairly common in urban Pares. Such beliefs appear to have harmful effects, including social and psychological distress, for example, in the case of the social stigma experienced by a patient suffering from an illness believed to be caused by evil forces. If midwives trained in the western paradigm do not take special precautions with the placenta or umbilical cord there is potential for creating psychological distress, although relatively few babies are still admitted in health facilities at the time of separation of the cord. Some traditional practices such as stopping breastfeeding during pregnancy and abstaining from intercourse when breastfeeding appear to have originated in pollution beliefs. Informants reported that some urban Pares continue these traditional practices (see paragraph 4.3.1.3).

5.4.2.3.2 Recommendations on belief in evil forces

Nurses need to be able to identify patients who are affected by belief in evil forces; appropriate cultural assessment tools are needed in this context (see paragraph 5.3). Cultural care repatterning is appropriate when countering spiritual beliefs which are damaging to individuals, families and society. Nurses need to be able to recognise signs of spiritual distress, diagnose accurately and plan appropriate care, using guidelines such as those proposed by Govier (2000:32-36). This includes identifying resource persons who can assist in implementing care. Recommendations relating to education for health workers in paragraph 5.4.5.6 are important in this context. Kyomo (1997:132) and Mbowe (2003) suggest that conditions such as possession by evil spirits or illnesses believed to be produced by witchcraft require expert handling by a mature spiritual worker.

It is recommended that midwives receive appropriate education in preservice and continuing education programmes in order to develop cultural sensitivity in respect to the care of the placenta and umbilical cord. Health workers caring for newly delivered mothers should discuss with their clients whether they require any special practices

regarding the newborn, the umbilical cord and the placenta, and negotiate practices which are not likely to produce harm.

Education to sensitise health workers about beliefs in evil eye is recommended, to avoid expressions and behaviour which could be perceived as being admiration of a child. Nurses need to discuss issues related to pollution beliefs with individuals, families and communities, such as discontinuation of breastfeeding as soon as a woman realises she is pregnant. Cultural care negotiation would be appropriate.

Illness believed to be caused by evil forces are stigmatising. Cultural care repatterning is recommended to improve the quality of life for those suffering from mental illness, epilepsy, infertility and AIDS, as well as improved services for these groups. This could be undertaken in a similar way to the project undertaken in Southern Tanzania which improved the attitudes of the community to those suffering from epilepsy (Jilek-Aall et al 1997:783-795).

5.4.3 Conclusions and recommendations on the holistic paradigm

5.4.3.1 General conclusions and recommendations on the holistic paradigm

5.4.3.1.1 General conclusions drawn from the data on the holistic paradigm

Much of the home care provided by urban Pares appears to be both holistic and individualised, with respect and love being shown for the sick person or newly delivered mother. Attention is given to physical, social, psychological, spiritual, and economic needs. Special foods and visiting are particularly important. Maintaining health is seen to be important for survival. Breastfeeding is traditionally encouraged. Pares knowledge of herbal remedies is extensive. Family roles are defined and social co-operation in times of illness is reported. Traditional birth attendants are assisting many women (see paragraph 4.3.2.9).

5.4.3.1.2 General recommendations on the holistic paradigm

Culture care preservation of holistic practises should be implemented by health workers; the respect, concern, love and individualised planning appear to be beneficial to patients. The current practice in health care institutions is often

fragmented and task oriented. It is recommended that primary nursing with patient allocation and the use of the nursing process with written care plans be encouraged, along with increased staffing levels and improved nurse education. The current practice of co-operation and support from family and friends can be encouraged and utilised. However, relatives' willingness to help with care should not be abused when professional nursing care is indicated.

There is a need to use research findings and resource persons to provide sensitive and creative responses to cultural requirements including such aspects as diet, visiting, communication patterns, dress, and orientation to time, spiritual care and biological variations (Giger & Davidhizar 1995:11-13). This care needs to take into account findings from this study such as the multiple world views, holistic care practices with respect for the sick and newly delivered, use of traditional remedies and prayer. Care needs to take into account the economic realities of the Pares, and the changing beliefs and lifestyle that is their current experience.

5.4.3.2 Conclusions and recommendations on visiting practices

5.4.3.2.1 Conclusions on visiting practices

Visiting appears to be an important aspect of care during illness to urban Pares. The value of avoiding loneliness and providing social and psychological support is recognised by urban Pares. Visitors may also help by bringing special food and offering financial assistance (see paragraph 4.3.2.6.1).

5.4.3.2.2 Recommendations on visiting practices

Health workers should consider culture care preservation in respect to visiting practices. The issue of hospital policies related to visiting should be reviewed for the Pares, with community representatives. Pares might welcome provision of chairs for relatives to sit on, special visiting areas for ambulant patients, and perhaps some sort of accommodation for visitors, in or near the hospital. It may be appropriate to make special provision for those who have no relatives visiting; perhaps volunteers could be recruited to visit to help meet social and psychological needs. Culture care negotiation

may be appropriate for those who have many visitors; they could be asked to organise a rota system of visiting which would allow perhaps four visitors at one visiting time session in hospital. This culture care negotiation once agreed by health service staff and the community that they serve, would need to be communicated, perhaps by posters displayed continuously in different facilities and in special open days, through hospital broadcasting systems, and the radio as well as by individual teaching of users of health services.

The recommendation of implementing primary nursing in paragraph 5.4.3.1.2 would enable nurses who were caring for urban Pare patients to assess the patient's need for visitors, and limit or encourage visitors accordingly. Considerations of risk of infection from or to visitors needs to be considered, and also visitors may be unnecessarily overburdened with visiting if good communication and negotiation is neglected. One informant suggested that there should be special visiting hours for long stay patients.

One informant suggested that the gate guards at a particular hospital were very harsh in preventing entry of visitors. A system of special gate passes issued by nursing staff for relatives of seriously ill patients needing constant attendance might help the situation.

It is recommended that other cultural groups might learn from the Pares in respect to the value of visiting. This is not only the value of social contact at the time, but there is also the long-term psychological impact of the reassurance of being loved, and later memories of the visit. Visitors may even impact on spiritual health, for example by praying with the sick person.

5.4.3.3 Conclusions and recommendations on diet during illness

5.4.3.3.1 Conclusions on diet during illness

Urban Pare informants reported that traditionally, special foods are prepared according to the wishes of the sick person. These foods are generally soft or semi-fluid, and higher in protein content than the normal diet. There was a belief reported that the stomach cannot 'grind' food in illness, and therefore that food such as stiff

maize porridge is inappropriate for those who are ill. There appear to be some urban Pares who no longer hold these traditional beliefs. The hospital diet provided in government and mission hospitals is largely stiff maize porridge and beans (see paragraph 4.3.2.6.2.2).

5.4.3.3.2 *Recommendations on diet during illness*

Cultural care preservation in respect to traditional diet for the sick and newly delivered should be encouraged in home care and attempted by health workers in institutions, for those urban Pares who prefer it.

“[In most hospitals] they give them stiff maize porridge every day. Now a patient who is admitted for months finds this difficult; it would be good to ask our patients what they like to eat” (Informant B).

Informants recommended that some improvements could be made in increasing the variety of food, for example, by using local green vegetables more. Some improvements appear to be a question of organisation, and minor additional resources. This would require nurses to be patient advocates to hospital management. It is recommended that special provision be made for those who have no one to bring them traditional foods. The relative importance of diet to the sick needs to be reassessed, in the light of other priority areas for spending of the health budget. In terms of patient satisfaction, which may influence recovery times, it may be a worthwhile investment to provide foods which are traditionally believed suitable for sick people and newly delivered mothers.

While the beliefs and practices associated with invalid food are generally appropriate for nurses to encourage, some cultural care negotiation may be appropriate in view of the costs incurred. The belief that the stomach cannot grind food in illness may require some education to avoid unnecessary anxiety and expense. Nurses need to be alert to the possibility that in the absence of proper information unscrupulous business people may promote expensive drinks, tonics and food for invalids.

5.4.3.4 Conclusions and recommendations on demonstration of respect

5.4.3.4.1 Conclusions on demonstration of respect

Urban Pares reported that traditional care for the sick involves respect, which is evidenced in various ways. For example, the sick person is visited and provided with individualised care; he is shown love and concern. His food preferences are followed, and his dignity respected by having a carer of the same sex (see paragraph 4.3.2.6.3.3).

5.4.3.4.2 Recommendations on demonstration of respect

Communication patterns which demonstrate respect and concern for the sick are culturally congruent, and deserve cultural care preservation from health workers. It is recommended that all health workers are fully instructed and supervised in this aspect of practice. Informants identified the need to give appropriate care, and to behave ethically.

“As for the nurses, it’s important that they recognize what the patient needs, and to provide services according to his requirements and not to put him aside or accuse him of anything, or to do anything to him which is not right”
(Informant A).

Respectful behaviour should extend to relatives and others caring for patients. Nurses need to remember that the family is usually the main support for a sick person; relatives need psychological support and adequate information to help them to cope with the situation. Relatives may be the ones to make major decisions about care in some families, and should be involved in care planning. They also need adequate supplies of equipment such as protective gloves where appropriate.

5.4.3.5 Conclusions and recommendations on herbalism and traditional practitioners

5.4.3.5.1 Conclusions on herbalism and traditional practitioners

Urban Pares reported that Pares have the reputation of being knowledgeable about herbal remedies. Informants reported that this expertise is to some extent being lost, but there are still many urban Pares who use herbal remedies in the treatment of illness. Sometimes this involves obtaining the herbs from the rural areas, and sometimes it involves visiting a herbalist in town. Traditional practitioners still play a significant role in health care for urban Pares. There are traditional birth attendants, herbalists and other traditional practitioners who are practising (see paragraphs 4.3.2.8, 4.3.2.8.1, 4.3.2.8.2 and 4.3.2.9).

5.4.3.5.2 Recommendations on herbalism and traditional practitioners

Some research into local herbs is currently being undertaken in Kilimanjaro; the Pare tribe's wealth of knowledge could be utilised in this context. It is recommended that extensive research be undertaken before local expertise is lost. Culture care negotiation may be appropriate, and dialogue between traditional practitioners and biomedical practitioners would appear to be valuable.

It is recommended that health workers are educated in preservice and continuing education programmes about traditional medicines that are being used by urban Pares. Teaching sessions using Pare resource persons, including experienced traditional healers, would be useful. The indications, effectiveness, side effects, methods of administration and possible interactions of traditional medicines with other treatments should be known. If health care providers are unaware of these beliefs and practices, they may provide care which is unacceptable or even dangerous.

Improved communication between herbalists and health workers in the western paradigm would appear to be in the patient's interest. Information days, workshops and open days may be a suitable setting. This is not an easy recommendation to

implement, as herbalists are not all registered and do not all advertise their practice. Moreover, some also practice witchcraft. Control of herbalists' practice is probably impractical at the present time as there are not enough officials to monitor or control even the use of drugs from the biomedical paradigm. This is clear because a wide variety of drugs including a range of antibiotics and analgesics are freely available in shops selling medicines, few of which have a qualified pharmacist.

The programmes already in place for collaboration with traditional birth attendants such as TBA training programmes could be strengthened and expanded; this involves culture care negotiation. Continuing recognition of the work of TBAs could be enhanced by sensitising health workers to the contribution TBAs make to health services. This could be done through educational programmes and cultural days. Collaboration with traditional healers whose livelihood involves witchcraft, is problematic. These practices appear to be dangerous, but correct identification of those involved is difficult. While informants complained that some traditional healers cheat patients and delay treatment, their practice is difficult to control. Those who claim to be able to cure AIDS could be a priority to identify, especially since drug therapy for HIV infection is becoming available. Nurses fighting against female genital mutilation (still common in many parts of Tanzania) are still having a difficult task to reduce its prevalence, although it is possible to identify those involved in the practice, some of whom are traditional practitioners (Chugulu & Dixey 2000:108).

5.4.3.6 Conclusions and recommendations on male health workers and home care

5.4.3.6.1 Conclusions on male health workers and home care

Informants reported that traditionally males are generally cared for by males, and that home care by family members was practised (see paragraphs 4.3.2.6.3.2 and 4.3.2.6.3.3).

5.4.3.6.2 Recommendations on male health workers and home care

Cultural care preservation of roles could be attempted by health workers in respect to recruiting and training more male staff, in view of the Pares' preference for males to care for males. However, as this is unlikely to meet the need for male assistants in institutional settings, the assistance of male relatives and friends could be continued, with allocation of male health workers to male patients who have no outside carer. Some degree of cultural care accommodation on the part of male clients to help them accept care from female health care workers is probably realistic.

Cultural care preservation of home care with support from health care workers is appropriate for many conditions and is probably cost-effective. This was specifically recommended by one informant; there is currently little provision for this.

5.4.3.7 Conclusions and recommendations on breastfeeding, family spacing and care of the newly delivered mother

5.4.3.7.1 Conclusions on breastfeeding, family spacing and care of the newly delivered mother

Urban Pare informants reported traditional practices of prolonged breastfeeding, family spacing by postpartum abstinence, and a prolonged resting period following delivery with special foods and attention being given to the new mother. Informants reported that there are some changes taking place in respect to these practices (see paragraphs 4.3.2.3, 4.3.2.6.2 and 4.3.2.6.2.3).

5.4.3.7.2 Recommendations on breastfeeding, family spacing and care of the newly delivered mother

It is recommended that positive attitudes to prolonged breastfeeding can be encouraged by nurses. Culture care preservation of this practice would help to reduce child under-nutrition and gastroenteritis.

Education is needed to counter the fear of continuing breastfeeding during pregnancy, as this causes premature interruption of breastfeeding. This education is needed by all members of the community, and may be carried out through health services, schools and public broadcasts on radio. Student health workers could be sensitised during their educational programmes. The traditional practice of avoiding sexual intercourse during breastfeeding may encourage infidelity and the spread of sexually transmitted diseases. Culture care negotiation appears to be appropriate and may include the encouragement of contraception. However, there is currently limited use of contraception, in spite of its widespread availability, which may be related to religious beliefs and the lack of social security system.

Cultural care accommodation may be recommended for some traditional practices associated with care of the newly delivered mother to reduce the risks of obesity and complications of prolonged bed rest. Perhaps reducing from five to three main meals daily, with additional fluids in between as desired, may be sufficient for the new mother. The addition of fats and butter to her porridge may not be necessary all the time. The progressive introduction of exercises and activities could be recommended.

5.4.3.8 Conclusion and recommendations on passive acceptance of problems

5.4.3.8.1 Conclusion on passive acceptance of problems

Some urban Pares reported that psychological health depends on accepting life's problems and difficulties passively (see paragraph 4.3.2.2).

5.4.3.8.2 Recommendations about passive acceptance of problems

Cultural care preservation of passive acceptance of life's problems may be appropriate when it is seen to promote psychological health. This philosophical approach to life may be judged in different ways in different contexts. In some contexts preserving this approach and indeed encouraging its adoption by other cultural groups would appear to be health promoting, especially at the individual level. In the broader political context, however, it may delay developments which

could be health promoting, especially at a community level. There is a need to critically evaluate methods of problem solving in different situations.

5.4.3.9 *Conclusions and recommendations on economic concerns*

5.4.3.9.1 *Conclusions on economic concerns*

Many urban Pares reported that economic concerns have a major impact on health and the management of illness (see paragraphs 4.3.2.1.2 and 4.3.2.6.4). For example, health care practices have been affected by the introduction of ‘cost sharing’ by health facilities funded by the government; this has led to the increased use of traditional practitioners.

5.4.3.9.2 *Recommendations on economic concerns*

It is recommended that accessibility to health care facilities for poor urban Pares be improved. A system for identification of the very poor and waiving of ‘cost sharing’ fees is in place but appears to be difficult to implement efficiently. It is recommended that greater efforts be made so that poverty does not hinder or delay needed care and treatment. It is also recommended that people’s basic rights to clean water, sanitation and food should not be compromised by economic considerations.

5.4.4 *Conclusions and recommendations on the scientific paradigm*

5.4.4.1 *Conclusions on the scientific paradigm*

The urban Pare informants reported widespread use of the services of clinics and hospitals functioning in the biomedical paradigm. Health education programmes appear to have been effective in disseminating information about diet and environmental hygiene, and causation of disease in biomedical terms. However, putting the information into practice appears to have been more difficult for urban Pares, especially the poor (see paragraph 4.3.3).

5.4.4.2 Recommendations on the scientific paradigm

It is recommended that health workers be educated about the historical perspective of the introduction of the biomedical system of care in Tanzania in preservice and continuing education programmes. Nurses need encouragement to move beyond their traditional roles such as care provider and teacher, to practise reflectively and identify cultural imposition. Nurses also need to develop their role of advocate for change, which may involve more political activity and intersectoral collaboration. While clean water, sanitation, and environmental hygiene are not available to all, nurses need to speak out for those who do not have them. Nurses themselves need to ‘repattern’ their behaviour and practice to meet the needs of the communities they serve. This requires that the profession of nursing in Tanzania actively recruit candidates who can function in these roles and upgrade existing staff. This in turn requires giving higher budgetary priority to nursing education and to allow improved wage scales, in order to attract candidates of the required calibre.

Education programmes are needed to provide appropriate information to reduce the risk of developing obesity and its complications. (Education programmes related to prevention of under-nutrition are in place.) This might take place in schools and community groups as well as through health facilities. Different media could be utilised including radio and television. One factor would be recommending adequate exercise and reducing intake of starch and fats. This may need culture care repatterning for those who feel that obesity is healthy and that exercise is not necessary. This is a challenge in a country where the prevalence of non-communicable diseases such as hypertension and diabetes mellitus appear to be rising. This fear of illness could be a powerful motivator for other programmes, such as perhaps a national tetanus vaccination programme, screening for diabetes mellitus or cancer, and lifestyle changes for reducing hypertension. Regular health checks which could screen for common illnesses such as hypertension and allow for earlier management, could help to reduce morbidity and mortality. There is a need to identify serious diseases such as tuberculosis and cancer early, and encourage Pares to take notice of warning signs.

Widespread campaigns to provide the community with information about first aid and recognition of common conditions and safe management could be initiated. This could include safe traditional practices, which would involve cultural care preservation and introduction of safe locally available treatments of the scientific paradigm, which would involve cultural care repatterning. Programmes such as a recent programme in the United Kingdom which guides consumers about appropriate care (Banks 2001) could be used as a basis, but would require considerable adaptation.

5.4.5 Conclusions and recommendations on change and continuity

5.4.5.1 General conclusions and recommendations on change and continuity

5.4.5.1.1 General conclusions on change and continuity

While some aspects of urban Pare life appear to be continuing unchanged, other aspects are changing gradually and others are changing rapidly. For example urban Pares appear to continue to see themselves as having a tribal identity. Contact with other cultures, education, changes in lifestyle and technological changes are among the factors that have brought changes in worldview, care patterns, meaning of traditional rituals, and treatment patterns. Urbanisation and migration has changed lifestyles (see paragraph 2.6.2). There appear to be areas of conflicting perspectives, such as on health maintenance, and belief causation. There is also conflict between stated health beliefs and their implementation. There is potential for change towards provision of culturally congruent care (see paragraph 4.4).

5.4.5.1.2 General recommendations on change and continuity

It is recommended that cultural assessments include not only traditional practices, but also changes and their impact. It is recommended that health workers keep in touch with the changing beliefs of the communities that they serve. Resources need to be allocated to transcultural research and transcultural education. Health workers need up to date information to be able to adapt their programmes and educational material accordingly. They need to be aware of the cognitive and interpersonal conflict that

may arise when changes in beliefs and practices occur, and be able to counsel and support their clients effectively. As noted in paragraph 2.5.3, “*the disintegration of the traditional society which is in progress produces situations which give the people a new sense of insecurity*” (Swantz 1970:317).

5.4.5.2 Conclusions and recommendations on continuity in sense of identity in urban Pares

5.4.5.2.1 Conclusions on continuity in sense of identity in urban Pares

Urban Pares appear to value their tribal identity, although there has been a district reorganisation so that ‘Pare district’ no longer exists in geographical terms (see paragraph 1.2.3).

5.4.5.2.2 Recommendations on continuity in sense of identity in urban Pares

Since the Pare identity appears to remain strong, further cultural assessments on the Pares as a cultural group would appear to be justified. There is a need for comprehensive cultural assessments of the rural and urban Pares, and of the other cultural groups that are resident in urban Moshi. This recommendation could be extended to Kilimanjaro region, Tanzania and beyond. Since culture is not static, these assessments need to be reviewed regularly. There is a need to develop transcultural nursing expertise in Tanzania; this requires assistance from experts from other countries.

5.4.5.3 Conclusions and recommendations on changing worldviews and spiritual beliefs

5.4.5.3.1 Conclusions on changing worldviews and spiritual beliefs

The urban Pares use the three main worldviews; beliefs and practices from these three paradigms are reported. While some of these beliefs appear to conflict with each

other, one individual may use different paradigms interchangeably. Christian religious practice is probably declining overall in towns. Beliefs and practices related to ancestral spirits appear to be declining, while beliefs and practices related to witchcraft are reported to be fairly common (see paragraphs 4.3.4 and 4.4.3).

5.4.5.3.2 Recommendations on changing worldviews and spiritual beliefs

It is recommended that regular cultural assessments of urban Pares and other cultural groups should include changing worldviews and spiritual beliefs, and their impact on the physical, psychological, social, spiritual and economic well-being of the group. The findings of such studies should be used to educate nurses so that they can be aware of possible stresses and conflicts that may be occurring as a result of these changes (see also paragraphs 5.4.5.1.2 and 5.4.5.2.2).

5.4.5.4 Conclusions and recommendations on conflicting perspectives on health maintenance and disease causation

5.4.5.4.1 Conclusions on conflicting perspectives on health maintenance and disease causation

Some urban Pares reported that they value exercise and that being overweight is unhealthy, while others reported the belief that exercise in addition to the normal daily activities is not necessary, and that obesity is a sign of good health. Informants reported that different views are held about the causation of diseases including mental illness and AIDS (see paragraphs 4.4.5 and 4.4.6).

5.4.5.4.2 Recommendations on conflicting perspectives on health maintenance and disease causation

It is recommended that the underlying values and philosophy of urban Pares need to be considered carefully by health workers and health care planners. For example, health beliefs about breastfeeding, healthy body weight, exercise and disease causation are amongst the issues to be considered when planning care and health

promotion activities. The changing beliefs about obesity, mental illness, infertility, epilepsy and AIDS need to be monitored and cultural care repatterning planned where needed to promote health and reduce the stigmatisation of those suffering from diseases traditionally believed to have a supernatural cause. Underlying these recommendations are the need for transcultural nursing research and the development of transcultural nursing expertise.

5.4.5.5 Conclusion and recommendation on change in meaning of traditional rituals

5.4.5.5.1 Conclusion on change in meaning of traditional rituals

Informants reported that family gatherings and sharing of a roasted goat may now be an annual social event with positive results in terms of social contact and support, although its origin may have been connected with sacrifices to the ancestors (see paragraph 4.4.7).

5.4.5.5.2 Recommendation on change in meaning of traditional rituals

It is recommended that health workers are constantly updated on patterns of behaviour and their current meaning. This would help to avoid inappropriate attempts at cultural repatterning.

5.4.5.6 Conclusions and recommendations on change in patterns of treatment and change and continuity in care patterns.

5.4.5.6.1 Conclusions on change in patterns of treatment and change and continuity in care patterns.

Informants reported that sacrificing to ancestors is declining as a method of treating the sick, while use of medicines from shops and clinics and hospitals are increasingly

used. Traditional herbalism, while still much used, is affected by the scientific paradigm and expertise may be diminishing.

It was reported that demonstration of respect for the sick person, while important in home care, is not always a feature of care from professional health workers. Traditional visiting practices appear to continue unchanged. Some changes are reported in the use of traditional foods for the sick, in co-operation between community members, in length of breast feeding, and in care practices for the newly delivered mother (see paragraphs 4.4.8 and 4.4.9).

5.4.5.6.2 Recommendations on change in patterns of treatment and change and continuity in care patterns.

It is recommended that health workers monitor changes in patterns of treatment and care, so as to be able to plan and evaluate the effectiveness and acceptability of current health care provision. Health workers need to investigate why changes are taking place, and advocate on behalf of their clients when necessary. For example, the increased number of private clinics and shops selling medicine may reflect dissatisfaction with government funded facilities. The quality of service and the overall impact of the practices of these new services need to be evaluated. Total quality management programmes examining the health services as a whole as well as the services provided by institutions need to be developed and implemented.

It is recommended that health workers are educated about changing care patterns of their clients. The reasons for and the impact of changes in patterns should also be sought. For example, if there is reduced co-operation from community members in times of sickness, other mechanisms such as a social security system may be needed. The lack of respect shown by some professional health workers needs to be corrected by education focusing on ethical practice and supervision to ensure that ethical issues are addressed at the point of care provision.

It is recommended that more literature be made available to health workers to help them to improve standards of nursing education and care. There appears to be a paucity of East African nursing textbooks. Current textbooks from the developed

countries need creative application in view of the many differences encountered, including differences in resources, disease patterns and culture.

5.4.5.7 Conclusions and recommendations on potential for change towards provision of culturally congruent care

5.4.5.7.1 Conclusions on potential for change towards provision of culturally congruent care

Informants reported that professional care is currently provided with no consideration of cultural differences, and without discrimination. The concept of culturally congruent care appeared to be a new one for many of the informants, and the economic implications of implementing a measure such as choice of food for patients admitted to hospital was seen to be an obstacle.

The valuing of cultural differences is an element of quality nursing care, which appears to be seen to be relatively unimportant to the informants at the present time. This view may be affected by the emphasis given politically to unity within Tanzania and the policy of detribalisation. It may reflect an ignorance of the possibility of culturally congruent care, or a belief that other aspects of quality care may be seen as having a higher priority at the present time (see paragraph 4.4.10).

5.4.5.7.2 Recommendations on potential for change towards provision of culturally congruent care

There is a need to educate nurses in transcultural nursing; this could begin with the inclusion of transcultural nursing in curricula at all levels of training. There is also the need to encourage the development of transcultural nurse specialists. The education of health service users as well as providers is important. If users develop an expectation of quality care and an understanding of their right to quality care which is culturally congruent, this may help to exert pressure to bring about improvements.

Barriers to transcultural communication need to be identified, such as lack of linguistic skills. There is a need to promote proficiency in local languages in all health

workers; employers or nursing organisations could organise language education programmes.

It is recommended that appropriate cultural assessment and health assessment tools be developed (Tuck 1984:261-262; van Ede 1996:153-159), and a more substantial base of transcultural nursing knowledge in Tanzania be built up. Documented cultural assessments could assist all health workers to improve their care and would also help them to collaborate with each other. Appropriate tools need to be refined. Tools such as that developed by Giger and Davidhizar (1995:11-13) require not only translation but adaptation, for example, with greater attention required in respect to religion and religious practices, traditional practices related to childbirth and death, and different languages spoken. Semantic problems, such as was encountered relating to defining health, need to be overcome. It is recommended that 'practical' questions be asked as well as theoretical definitions, for example, when asked about being healthy, informants reported that this included physical and psychological factors. When different aspects of care were explored, social, psychological and spiritual aspects of care were described. This would suggest that the latter gives a more accurate picture of how people perceive care, and even perhaps health. Informants may not have had the opportunity to consider what they really mean by the word health, and the answer may be inaccurate just because it is not thoroughly thought out.

Research is also needed to explicate the extent to which urban Pares would value culturally congruent care. If the apparent lack of concern for cultural differentiation is a true reflection of current urban Pare's beliefs, it should be respected, but considered open to change in the future.

The development of transcultural nursing is enhanced if cultural care preservation, accommodation and repatterning recommendations are acceptable, practical and 'two-way', in the sense that nurses working in western style facilities would modify their practices as would communities modify their traditional practices. Nurses need to be willing to learn from other cultures, and should expect to be changed themselves. *"The nurse who carries out a cultural nursing assessment is not simply gathering information; she will be changed by the experience and can become a transformative agent for her clients"* (Savage 2002: 253).

The development of transcultural nursing in Tanzania would be assisted by the development of local research expertise. This would help to reduce bias and facilitate communication.

There is a need to identify resource persons within health institutions, and even in the community, who can assist with the provision of culturally congruent care. A data base could be assembled so that cultural and linguistic skills are known, to be able to assist in clinical situations, education and research.

It is recommended that budgetary priorities be re-evaluated, for example in respect to provision of acceptable diet for patients of different cultures.

5.4.5.8 Conclusions and recommendations on conflict between stated health beliefs and their implementation

5.4.5.8.1 Conclusions on conflict between stated health beliefs and their implementation

Informants reported that although they believed in the importance of environmental hygiene, good food and medical treatment these were not always available to all urban Pares, for economic, social and political reasons (see paragraph 4.4.10).

5.4.5.8.2 Recommendations on conflict between stated health beliefs and their implementation

It is recommended that problems which arise as a result of conflict between stated health beliefs and their implementation need careful evaluation. Where the problem is largely economic, such as may be the case with delayed attendance at health facilities, poor water supply, lack of environmental hygiene or inadequate diet, creative solutions and political action may be needed.

Improving health services is a major political issue; *“the promotion of health is intimately related to the process of ending underdevelopment ...it is most importantly a political relationship”* (Sanders 1985: 171).

5.5 PERSONAL EXPERIENCES DURING THE STUDY

The researcher found this study personally, professionally and academically enriching. It has allowed the researcher to gain a better understanding of the society in which she is living and working, and has helped her in social, clinical and teaching settings. It has raised the challenge that there remains a wealth of cultural knowledge to be explored and described. It has motivated her to be constantly enquiring from the people around her, and to respect and enjoy the differences in cultures.

5.6 STRENGTHS OF THE STUDY

The qualitative approach was well suited to the research questions, and allowed for exploration of the theme. It was possible to interview informants in their own homes, which allowed them to feel ‘in control’ of the situation, and also allowed the researcher to observe their home environment.

The study was undertaken in a setting where the researcher is living and working with Chaggas and Pares. She was able to informally verify findings with friends and colleagues, and observe the behaviour of Pares to see if it was congruent with stated beliefs.

Tanzanians are generally friendly and co-operative, and proud of their culture. The informants were willing to share information, and although they were reticent in answering some questions early in the interview, as they saw that the researcher was interested and not judgmental, they proceeded to share more openly. The urban Pare reviewer of the interview data agreed with all the findings, and emphasised that practices reported in this study such as witchcraft are common, and are largely related to jealousy.

The findings are immediately useful to the researcher in clinical practice and teaching, and when disseminated, will be useful to many others who are working with Pares in Kilimanjaro and throughout Tanzania.

5.7 LIMITATIONS OF THE STUDY

This study is not transferable to another group, and will require repeating from time to time if it is to be useful for application to clinical practice. Only issues directly related to health beliefs were addressed. The small sample may not be representative of urban Pares, and the interview schedule was newly constructed and may lack credibility (see paragraph 1.11).

The researcher may have gained more detailed and subtle information if her Swahili had been of a higher standard. There may have been some bias in information provided because the researcher is from a different cultural background, and was known to be a nurse tutor. This may have been perceived as a power differential with the risk of producing skewed data. A broader spectrum of ages in the informants might have yielded a broader range of data. The researcher had expected to interview a more varied group of informants in terms of age and religious affiliation. The choice of informants was largely made by friends of the researcher, who, although they understood that the objectives of the study were to explore a range of urban Pares' health beliefs, felt that it would be more valuable to the researcher to interview informants with more knowledge of traditional cultural beliefs.

If time and scope of the dissertation had allowed, it would have been interesting to have undertaken a full cultural assessment of urban Pares, and also to compare urban and rural Pare culture. Time did not allow the researcher to visit the traditional home of the Pare tribe, or to observe any of their traditional rituals at first hand.

5.8 CONCLUSION

Some of the recommendations made here are small scale and relatively easy to implement. Others are large scale and will require major changes in resource commitments. Transcultural nursing is part of comprehensive, holistic care. It cannot

be provided in isolation. Previous research in Tanzania (see paragraph 2.7) and informants in this study suggest the need for improvement in health services generally including the quality of nursing care. Nurses have a moral duty to change their practice so that the best care is provided within the limitations of the situation, and to advocate for changes on a large scale. A nursing priority in Tanzania may need to be to establish basic standards so that comprehensive care might follow. An element of comprehensive care would be culturally congruent care, based on knowledge about health beliefs and care practices.

The researcher re-examined the research objectives stated at the beginning of the study, which were to:

- gain an understanding of the health beliefs and practices of the urban Pares of Moshi, Tanzania through the literature and semistructured interviews
- describe the health beliefs and practices of the urban Pares of Moshi, Tanzania through the data presented in Chapter 4
- recommend how nurses may modify their current practices to provide culturally congruent care for this group through the data presented in Chapter 5.

After reviewing the data presented in Chapter 4, and the conclusions and recommendations of Chapter 5, evaluation showed that these research objectives had been achieved.