CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The study involves an exploration of health beliefs of the urban Pare of Moshi in Tanzania.

In Chapter 1, an orientation to this study was provided by discussing the background to the problem, the problem statement, the aims and purpose of the study, the research questions and objectives, the significance of the study, terminology, an introduction to the research methodology and ethical considerations and an outline of the study. The literature review contained in this chapter focuses on health beliefs. National and international sources are cited. The literature search was directed by the terms described in paragraph 1.10, and those listed in key concepts (following the abstract at the beginning of this study). These terms include health beliefs, culture, transcultural nursing, Tanzania, Kilimanjaro Region, Pares, urban, cultural nursing assessment, and culturally congruent care.

The literature review revealed no specific transcultural studies on the health beliefs of urban Pares, but found that previous studies of Tanzanian tribes have been carried out by anthropologists, sociologists and historians. A few Tanzanian studies have been carried out from a transcultural nursing perspective.

A literature review on methodological issues revealed that a qualitative approach was appropriate for identifying health beliefs and their underlying values, as this subject requires an insider's perspective and a method which allows for exploration (see paragraphs 1.9.2 and 3.2.1.3).

2.2 PURPOSE AND SCOPE OF THE LITERATURE REVIEW

The literature review can provide information about what is already known, provide a conceptual context, and help to identify research strategies (Polit & Hungler 1995:69-

70). It can also help to determine gaps in the literature, and discover unanswered questions (LoBiondo-Wood & Haber 1994:112).

This literature review aims to briefly discuss the conceptual context of the health beliefs of the urban Pares. Since the study is located within the context of transcultural nursing, this is discussed first. Subsequently, Leininger's Sunrise Model is used as an organizing framework for this literature review, working from the top of the model moving downwards (see Figure 2.1). This involves a consideration of worldview, cultural values including health beliefs, environmental context, language and ethnohistory, care expressions, patterns and practices, and systems of health care.

In the context of urban Pares health beliefs, the worldviews include those from the magico-religious, holistic and biomedical paradigms; technological factors include the limited information technology and medical technology available; religious factors include the influence of Christianity, Islam and animism, kinship and social factors include the importance of the clan and the patriarchal social system. Cultural values include the importance of showing respect to the sick person, and providing him with support; political factors include the legacy from Nyerere's socialist policies; economic factors include the poor economic state of Tanzania and the current low coffee prices which particularly affect Kilimanjaro Region; educational factors include the universal primary education currently provided in Tanzania. The generic systems of care include home care, and care provided by traditional practitioners; these are provided within the magico-religious and holistic paradigms. Professional systems of care include clinic and hospital services which function within the biomedical paradigm. There is thus a risk of cultural imposition and conflict in the provision of nursing care. Nursing care decisions and actions require an understanding of the urban Pare culture; culture congruent nursing care is possible when cultural assessment data is used sensitively and when health care workers advocate effectively for the provision of care according to cultural needs.

The aim of the study is to provide nurses with adequate knowledge and increased sensitivity to urban Pares, so as to facilitate nursing care decisions and actions, which would promote the provision of culturally congruent nursing care (Leininger 1991:43). Nursing and anthropological sources are used, since transcultural nursing has developed as a synthesis of nursing and anthropology (Andrews & Boyle 1999:5).

2.3 TRANSCULTURAL NURSING

2.3.1 Sources of transcultural nursing literature

Transcultural nursing is a specialty within nursing that considers the cultural aspects of care. Cultural groups and subgroups are studied "*with respect to their caring behaviour, nursing care, and health-illness values, beliefs and patterns of behaviour*" (Andrews & Boyle 1999:4).

Over the last ten years there has been a growing body of material published about transcultural nursing. Textbooks include seminal works by Leininger (1991,1994), and comprehensive material has been developed by authors such as Andrews and Boyle (1999), Giger & Davidhizar (1995), Holland and Hogg (2001), Luckman (1999) and Papadopoulos, Tilki and Taylor (1998). Many standard nursing texts now have a section on transcultural nursing, including Deloughery (1998) and Stanhope and Lancaster (1992). The *Journal of Transcultural Nursing* has provided the profession with valuable material since 1989, and articles on transcultural issues appear in other nursing journals, of which a wide variety are now available via the internet.

2.3.2 Cultural assessment as a function of transcultural nursing

A transcultural knowledge base may be built up by individual nurses from experience and observation, but this knowledge may be incomplete and largely unshared. Documented research from carefully conducted cultural assessments of different groups makes useful information available to a larger audience.

Andrews and Boyle cite Leininger's definition of cultural assessment as a "*systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit nursing needs and intervention practices within the cultural context of the people being evaluated*" (Leininger 1978:85-86 in Andrews & Boyle 1999:24). Andrews and Boyle note that both the process (approach and sequence) and content (data categories) of cultural assessment are important (1999:24). They provide a comprehensive assessment tool (Andrews & Boyle 1999:539–544).

Holland and Hogg (2001:68-73) put cultural assessment within the assessment phase of the nursing process, and as a necessary prerequisite if planning, implementation and evaluation are to take place. Holland and Hogg compare different models for cultural assessment, including those of Leininger, Giger and Davidhizar, Purnell's model of cultural competence, and Littlewood's anthropological nursing model.

Tripp-Reimer et al (1984:80–82) present a comparative analysis of different cultural assessment guides, and when considering beliefs, they include health beliefs such as health maintenance, cause of illness, diagnosis and treatment, religious and other beliefs. They highlight the need to place findings in context; the client's identified values, beliefs and customs should be compared to those of the nurse and the health care facility system.

Morris (1996:35) writes about cultural assessment and she describes the use of Rosenbaum's assessment guide, modified for African-American clients. Broad cultural assessments of groups include studies such as Leininger's study of the Gadsup Akuna (Leininger (ed) 1991:231–280) and Rosenbaum's study of Greek Canadian widows (Leininger (ed) 1991:305–339). Chmielarczyk (1991:15-19) studied the Hausa of Northwest Africa with the aim of identifying culturally congruent care. Cultural assessments with a narrower focus include Purnell's (2001:40-47) transcultural nursing study of Guatamalans' practices for health promotion, and the Tanzanian study by Juntunen, Nikkonen and Janhonen (2000:174-181) to identify protective health care actions of the Bena tribe.

The sources described in this study point to the value of cultural assessment, the many tools available, the need for sensitivity in their use, and the need to adapt existing tools according to the group being assessed.

2.3.3 Transcultural nursing concepts of importance in this study

Transcultural nursing concepts were used in this study, including those of Leininger's Sunrise Model (see Figure 2.1). The concepts from the upper part of the model have been used to organise the literature review (see paragraph 2.2). The data collected in the empirical phase of the study was used to explicate the values and beliefs of urban Pares, as well as their generic care patterns which are derived from experience and transmitted within a cultural group. These are contrasted with professional care systems which are taught formally, and which are not always congruent with generic patterns of care. The recommendations arise out of analysis of the data about beliefs and patterns of care, when considered in the context of the biomedical health care system. The concepts of culture care preservation, accommodation and repatterning are utilised in these recommendations (see paragraph 5.3) (Leininger 1991: 43-49).

2.4 WORLDVIEW

Worldview is the first element of Leininger's Sunrise Model to be considered (see Figure 2.1) when using this model from the top downwards.

2.4.1 Worldview: general considerations

Kalu (1999:6) discusses the concept of worldview, and cites Kraft (1995:20) by describing it as "*the cultural lens through which human experience is viewed*". Worldviews can affect how people see themselves, other people, and nature, and allow people to make sense of their environment (Kraft 1995:21 in Kalu 1999:7). Leininger (1994:94) defines worldview as "*a way a culture tends to look out on their world and the universe*". Understanding the worldview of a culture helps the nurse to contextualise the people's views of health, illness and care. Worldviews identified by Boyle and Andrews (1989:21) include the following paradigms: naturalistic, moral, aesthetic, social, magical and cosmic. These worldviews or paradigms are "*the set of*

metaphorical explanations used by a group of people to explain life's events and offer solutions to life's mysteries".

The three dominant worldviews are identified as magico-religious, holistic and scientific. People blend together beliefs and values from different paradigms to form their personal worldview. Beliefs and values about health are derived from the individual's worldview (Boyle & Andrews 1989:22). Some studies specifically make reference to the worldview of the cultural group, for example Omeri (1997:7) describes the Iranian worldview as a combination of magic, religion, mysticism and theology.

Since the worldview and value systems espoused by a group are the context from which health beliefs are derived; they need to be understood by health care providers if culturally congruent care is to be given.

2.4.2 African worldview

The concept of African worldview has been explored by anthropologists such as Kalu (1999:3-27) and Whitelaw (1994t5:37-50). Kalu suggests that "*within a culture there could be many interlocking worldviews*" (1999:8); Kalu also suggests that time and space and the "*myth of eternal return*" are central concepts in African worldviews (1999:9). Reincarnation is for those who lived good lives and did not die from an unexplained disease or by lightning, which are considered punishment by the gods for some offence. The three dimensions of space, the sky, the earth and the ancestral worlds are a unity (Kalu 1999:10). "*In African communities, there is an emphasis on tapping spiritual forces to aid coping ability"* (Kalu 1999:14). Selepe and Thomas (2000:97) describe the influence of ancestors, and fear of evil spirits as being parts of the belief system in KwaZulu-Natal, South Africa.

A study undertaken by Price (1995:1-22) amongst two ethnically homogeneous groups of Kikuyu people, examines one group in close contact with urban influence and another group in rural Kenya. Traditionally, it was considered important to honour ancestors and appease their spirits through the bearing of children as descendants (Price 1995:3). Causes of misfortune were seen as being retribution from

ancestral spirits for lack of respect to them or for immoral conduct; sacrifice and libation were then undertaken to placate them. However, considerable variations are identified in the social institutions, cultural practices and beliefs of the two groups in different geographical locations (Price 1995:18-21). The study particularly focused on the issue of the value of children. The decline in fertility in the more urban group is thought to be related to various factors including the decline in importance of kinship relationships and ancestral influence as well as declining levels of infant mortality and near universal levels of primary education (Price 1995:5).

A study by Drew et al (1996:79–86) in Zimbabwe considers practices associated with death, and finds that it is taboo to talk of death, and illness is considered to be caused by spiritual forces. A Zimbabwean doctor reported at a conference in Moshi that traditional beliefs about the power of witchcraft and ancestral spirits are still widespread in his country (Mzezewa, 2001). Mesaki, (in Forster & Maghimbi (eds) 1995:279), writing particularly about the Sukuma tribe of Tanzania, has reported that while there is some decline in ancestral worship, *"beliefs and practices connected with the phenomenon of witchcraft (uchawi) have proved to be resilient and formidable*".

2.4.3 Worldview in Kilimanjaro

Some of the traditional beliefs of Chagga cosmology are of a naturalistic paradigm. They are described with a semicircular model with a triangle inside. This represents energy cycles including "*the snow-capped volcanic mountain environment, mother's breast and father's penis – all sources of moist energy*" (Howard & Millard 1997:110). Other features of the model are bananas (staple food), the anus, the vagina and the mouth (see Figure 2.2) (Howard & Millard 1997:109-111). Not all Chaggas appear to be aware of the details of these traditional beliefs but their impact is still apparent, for example in beliefs about breastfeeding and proper time for childbirth in the life cycle (Moland 2002:64-67; Temu 2003).

Emanatian (1996:195–236) notes some aspects of the worldview of Chaggas which underlie their health beliefs, based on Moore's writing (Moore & Puritt:1977). These include the related symbolism of feeding and reproduction; the body is seen as a container. Feeding the mouth maintains life and 'feeding' the vagina during intercourse produces new life. A child is seen as a combination of 'male milk' and female blood.

The *kihamba* (farming area surrounding the home) was central to the life and rituals of the Chaggas; initiation and circumcision being particularly important. "*The kihamba contained symbols and processes that were metaphors for fundamental principles of Chagga cosmology. These principles included the notion that properly ordered sexuality was a key to the maintenance of life, which depended upon the correct separation, combination, and sequence of vital, mystical forces*" (Moland 2002:59-84; Setel 1996:1170).

A variety of beliefs are identified amongst Chaggas. While many have espoused Christianity (the majority being Roman Catholics or Lutherans) or Islam, and the accompanying religious worldview, many still believe in the power of ancestors and witchcraft to cause disease. Syncretism is noted; for example a Roman Catholic patient requested to return home to the village in the midst of a period of hospitalisation to make a sacrifice to appease the ancestors (personal experience:2000). The felt need for social harmony and co-operation are identified; also the importance of spirituality (Savage 2002:252).

2.5 CULTURAL VALUES AND HEALTH BELIEF SYSTEMS

2.5.1 Cultural values and health belief systems: general considerations

Kleinman (1978:254) points out that interactions between clients and health workers are "*transactions between explanatory models … involving major discrepancies in cognitive content as well as therapeutic values, expectations and goals*". There is a need for health workers to understand the health beliefs of their clients, as well as their own health beliefs and values.

The World Health Organization (WHO 1996:2) acknowledges that traditional beliefs are powerful motivators and many people in the world still utilise traditional practitioners.

Luckman (1999:47-49) describes health belief systems in terms of biomedical, supernatural and holistic systems. Luckman (1999:197–203) also discusses how to elicit assessment data on health beliefs and views of illness and patterns of seeking help for use with patients presenting with an illness. Holland and Hogg (2001:15-16) define health beliefs in terms of beliefs and practices relating to health and also as "*ideas and conceptualisations about health and illness that are derived from the prevailing world-view*". They classify health belief systems as biomedical, personalistic (or magico-religious) and naturalistic (or holistic). The personalistic system encompasses three main causes of illness: supernatural, non-humans such as ancestors, and human beings such as witches.

The Andrews/Boyle transcultural nursing assessment guide asks questions relating to health beliefs and practices (Andrews & Boyle 1999:541). These include causation of illness, ideas about ideal body size and shape and which activities promote health.
Young (1976:6) argues that health beliefs are important for health care providers to understand, since "*a people's beliefs and practices about prophylaxis, diagnosis and therapy constitute the greatest part of any society's efforts to understand and deal with sickness*". Helman (2000:85-86) provides a discussion of Kleinman's Explanatory Model which considers "*the process by which illness is patterned, interpreted and treated*". An individual's explanatory model helps him to make sense of the cause of illness, its timing, pathophysiology, natural history and appropriate treatments. This model is influenced by societal views and the context in which they are used. Helman also discusses lay theories of illness causation; he classifies causative areas as being in one of four areas; the individual, the natural world, the social world and the supernatural world.

Identification of health beliefs has been a part of many transcultural nursing studies. For example, Papadopoulos (2000:182–190) uses a qualitative research approach to explore health beliefs, health needs and lifestyle behaviours of London based Greek Cypriots. Miller (2000:204–211) reports on the ethnophysiology, health beliefs and

healing practices of Haitians in a study of Haitian ethnomedicine. Haitians believe that illness is of natural origin, based on a hot/cold humoral system, or of supernatural origin.

2.5.2 African cultural values and health belief systems

Cheetham and Griffiths (1982:954-956) discuss beliefs related to health in South Africa. They suggest that the interpretation of sickness may be based on biological factors, social factors, religious factors and magical factors such as the intrusion of spirits by sorcery. Smit (1986:15–19) describes traditional beliefs in Malawi. She notes a fear of witchcraft, and the importance of violation of taboos in causing illness. Examples of taboos relate to sexual activity during pregnancy and in the puerperium, and diet for different groups within society.

The values that are prized in a particular culture are related to its worldview. Leininger (1991:357) identified priority cultural values of African-Americans as including extended family networks, religion valued, interdependence with 'blacks', and daily survival.

Pauw (1974:99–101,103) discusses the beliefs and rituals of Africans, and suggests that the ancestor cult generally grows weaker while magical beliefs persist in urban African communities; Pauw suggests that belief in witchcraft and sorcery declines in urban communities. He suggests that ancestor beliefs are adapted by urban dwellers, for example "*the* thapelo ya sephiri *groups in Soweto [South Africa] have developed a belief system in which ancestor beliefs are integrated with ideas about the Apostles of Christ, angels, Christ himself, the Holy Spirit and God*".

An example of a transcultural nursing study exploring African beliefs and values is Holt's study of Eritrean immigrants (Holt 2001:146–154). The purpose of this study was to identify end of life customs among Eritrean immigrants in the United States, so as to understand the expectations and resources that these people have in dealing with the challenges of illness and death. The study involved interviewing two women informants using open-ended questions. The values uncovered included respect, the centrality of faith and of family, use of herbs, and the importance of visiting. Holt

notes that Eritreans should not be simply grouped together with Ethiopians, and makes recommendations for culture care preservation, accommodation and repatterning. Leuning, Small and Van Dyk (2000:71-80) identified respect for elders and spirituality as important values in urban Namibian families.

Haegert (1996:83) compiled the findings of a group of student nurses in Cape Town, South Africa, and reported that respondents gave many different replies to the question "what do you think causes you to be sick?" including bacteria, lack of exercise, eating badly, God punishing, stress, curses/spells, the devil. When asked "what do you do when you are sick?" responses included go to a pharmacist, use mother's remedy, go to homeopath, go to traditional healer, use herbal medicine.

Selepe and Thomas (2000:96–101) explored beliefs and practices of traditional birth attendants in KwaZulu-Natal, South Africa. They identified health practices, such as a taboo for newlyweds to eat milk and eggs, the administration of herbal mixtures with oxytocic properties in labour, and the administration of enemas to neonates.

In Uganda, people caring for AIDS patients have been found to use both generic and professional health systems, and some believe AIDS to be produced by supernatural causes such as witchcraft (MacNeil 1996:16).

When exploring the possibility of developing an African ethic for nursing, Haegert (2000:492-502) suggests it might evolve from the proverb "A person is a person through other persons"; this concept is referred to as *ubuntu* in South Africa and speaks of the interdependence of people and the need for compassion and justice.

2.5.3 Tanzanian cultural values and health belief systems

Swantz (1970:305-309) describes the Zaramo tribe whose traditional home is 25 miles north of Dar es Salaam. She notes that their beliefs included fear of pollution from female blood, danger from the 'heat' of childbirth and following male circumcision and that breaking of taboos would lead to illness. She notes that in case of illness or calamity, all relatives and neighbours are expected to be involved, and the medicine man and the diviner are visited. Also, offerings are made at the graves of the ancestors

(Swantz 1970:110). However, Swantz notes throughout her book that rituals are changing and that the major changes in societal behaviour that are taking place produces a sense of insecurity (Swantz 1970:317).

A study on lay health beliefs concerning HIV and AIDS in Tanzania found factually incorrect beliefs that were undermining AIDS control programmes. These included the belief that HIV is transmitted by mosquitoes, an HIV-infected person can be recognized, and that bar-girls and prostitutes are resistant to HIV/AIDS (Nicoll, Laukamm-Josten, Mwizarubi, Mayala, Mkuye, Nyembela & Grosskurth 1993:231-241).

Traditional healers in four areas of Tanzania have been found to recognise adult forms of malaria in similar groupings to western practitioners, but differences were found for concepts of causation, and severe malaria in children may not be perceived as being malaria, which may contribute to delayed treatment. While 19 of 31 traditional healers interviewed attributed malaria to mosquito bites, others blamed dirty water, tick bites and staying in the sun as causes. Severe malaria of children, *'ndegedege'* may be managed as a disease with a spiritual cause (Gessler, Msuya, Nkunya, Schar, Heinrich, & Tanne 1995a:119-130). Oberlander and Elverdan (2000:1352-7) have supported the findings of Gessler et al (1995a:119-130) in a study of health beliefs relating to the causation of malaria and their effect on health seeking behaviour in Tanzania. Three of the disease identities relating to malaria which are differentiated in traditional practice are *degedege*, *mchango* and *kibwengo*. *Degedege* is considered to be caused by bad luck; *mchango* may develop into epilepsy, and *kibwengo* are spirits of the devil. The traditional treatment for these disease entities is not antimalarials. "*Bondei nosology is … a system in which malaria is seen as part of a scheme of things that go beyond the usual biomedical explanation*" (Oberlander & Elverdan 2000:1354).

The practice of traditional healing in Tanzania is extensive, even in cities where western medical services are available. Traditional healers often take over the practice from relatives or by initiation through ancestral spirits. They use different practices including divination (Gessler et al 1995b:145-160).

There appears to be widespread fear of epilepsy in Tanzania: Chagga informants report that many Tanzanians are afraid of touching a person who is convulsing, and think that epilepsy is contagious (Minja 2003; Temu 2003). There is "*the general belief that epilepsy is of supernatural causation and therefore not treatable by Western medicine*" (Jilek-Aall, Jilek, Kaaya, Mkombachepa & Hillary 1997:783). The main causes are considered to be angry spirits and witchcraft (Jilek-Aall et al 1997:789).

In southern Tanzania, it has been found that people distinguish between 'normal illnesses' or 'out of order' illnesses. 'Normal illnesses' occur accidentally, from such agents as germs, heat or cold; they are considered amenable to treatment by biomedical means, although herbalists may be consulted. 'Out of order' illnesses include problems like barrenness, impotence, mental disturbance, and chronic disorders. These require divination to identify whether the cause is witchcraft, ancestral spirits or other spirits (Muela, Mushi & Ribera 2000:296 – 302).

The sources cited here strongly suggest the need for exploration of different aspects of health beliefs, and the need to elicit information about health beliefs other than those of biomedicine during a cultural assessment.

2.5.4 Cultural values and health belief systems in Kilimanjaro region

The Chaggas of Kilimanjaro are close to the Pares geographically, and many of the rural Chaggas and Pares share a similar mountain terrain and pattern of cultivation. However, it cannot be assumed that health beliefs are identical between these groups. Howard (1994:246) notes various cultural health beliefs, such as that the signs of malnutrition "*tend to be taken as evidence of violations of Chagga cultural precepts regarding cosmological balance, particularly those which deal with marriage and reproduction*". Howard (1994:247) reports that it was considered important for health to avoid sexual intercourse post-partum, to breast feed for 1 to 3 years, and to stop breast-feeding as soon as a woman finds that she is pregnant. Female circumcision (more correctly called genital mutilation) was also considered important in the prevention of *'kuvimba'* (the swelling often seen in malnutrition). Howard has written more expansively in her book co-authored with Millard (Howard & Millard 1997:73–

118), entitled "*Hunger and shame: Child malnutrition and poverty on Mount Kilimanjaro*". Health beliefs of the Chaggas described include the belief that sorcery can be responsible for injury or death, the need for ancestral offerings, illness being considered to be the result of immorality, the danger of breast feeding when pregnant, the danger of continuing to have children after one's first child is circumcised, and ill health resulting from ancestral displeasure if bridewealth is not paid.

Savage (2002:248-253) has explored aspects of the Chagga culture important for the provision of culturally congruent care using a case study presentation. A convenience sample of Chagga informants was used until data saturation was reached; semi-structured interviews were conducted. Cultural values identified in Chaggas were congruent with the findings of Leininger (1991:357) in African-American culture; showing respect, social support, and valuing religion were identified.

Moland (2002) has described beliefs and patterns of behaviour related to childbirth in Kilimanjaro region. She describes related issues including the traditional *'kihamba'* regime (see paragraph 2.4.3), family functioning, Chagga cosmology, and practices around the time of childbirth. She describes changes that are taking place in beliefs and patterns of behaviour, but notes that "*while biomedicine is increasingly important in pregnancy care among the Chagga, ancestor and witchcraft beliefs, taboos and fear of the unknown are still important concerns for the pregnant woman and her kin*" (Moland 2002:76).

2.5.5 Cultural values and health belief systems in the urban Pares

Studies relating to other cultural groups in Africa, and especially in Tanzania, provide some pointers for a study on the urban Pare of Moshi. Moland (2002:37-38;123-127) makes some reference to Pares in respect to childbirth practices and beliefs, although her work mainly refers to Chaggas. There appears to be no published transcultural nursing studies specifically relating to the Pare tribe, and no published material specifically on their cultural values and health beliefs.

2.6 ENVIRONMENTAL CONTEXT, LANGUAGE AND ETHNOHISTORY

2.6.1 Environmental context, language and ethnohistory: Tanzania

Many of the anthropological texts relating to Tanzania are about the nomadic Masai tribe, such as that by Spear and Waller (1993). The history and culture of the Wangoni, a Tanzanian group of Songea district, has been described by Ebner (1987). Forster and Maghimbe (eds.1995:xx–xxvi) discuss economic and social issues. They note that 80% of the Tanzanian population are peasants depending on their agricultural activities. "*No sober scholar can dispute the fact that mass absolute poverty is widespread in all districts and villages in Tanzania, although actual land shortage is restricted to some areas only (notably Kilimanjaro, Pare …)*" (Forster & Maghimbi (eds) 1995:xxi). There seems to be a consensus that socialist policies under Nyerere were unsuccessful in promoting economic development; social services are very limited.

While the Arusha declaration of 1967 "*strongly rejects the colonial division of people according to skin colour or their national or tribal origin*" (Jerman 1993:33), tribal identity still appears to be an important part of life in Tanzania (see paragraphs 1.2.3 and 4.4.1).

2.6.2 Environmental context, language and ethnohistory: Kilimanjaro region

Moshi is a town of about 200,000 persons situated on the foothills of Mount Kilimanjaro (see Figures 2.3 and 2.4). The surrounding mountainous area, fertile soil and rainfall allow for cultivation of different crops including coffee, bananas, maize and beans. In town, many people have small living areas, and subsist with employment in 'small businesses' such as selling foodstuffs, second hand clothes, or are employed in various ways including in shops, bars, health care, and education. The informal sector, which "*thrives on poverty – and structural adjustment policies*", burgeoned in the 1990's (Schulz 1995:4).

Figure 2.3

Photograph of part of urban Moshi including referral hospital

(Savage 2002)

Figure 2.4

Photograph of Moshi town with Mount Kilimanjaro

(Savage 2003a)

Swahili is the language mainly used in town, although when members of a particular tribe meet they may use their tribal language, such as *kichagga* (for Chaggas) or *kipare* (for Pares) by preference. The historical background of the Pare tribe is described in Chapter 1. A significant number of Pares have migrated from their traditional homes in the Pare Mountains to towns such as Moshi. In Kilimanjaro

region, it has been noted that men commonly leave the village in search of work in the town, leaving their wives behind in charge of their children, their land and their aged parents (Moland 2002:41).

Growth in population, urbanisation, migration and economic changes, have altered the age and sex composition of mountain dwellers in Kilimanjaro, and similar changes have affected the former Pare region. By 1972, 62% of households in one part of Kilimanjaro had two or more sons with no access to land; 25% of these young men were working in Moshi or Arusha. By 1988, there were 10 –15% fewer men than women aged between 15 and 45 years in the mountain villages (Setel 1996:1171-2).

Spear (1997) has studied the history and social changes of the Meru and Arusha tribes who inhabit the area of Mount Meru. The 'mountain farmers' of Mount Meru live in similar geographical and climatic conditions to those who inhabit Mount Kilimanjaro and the Pare Mountains. The Arusha region borders on the Kilimanjaro region (see Figure 1.1). An early Christian missionary to the area wrote "*I suggested to them how stupid it is to think every sickness to be a spell and how even more foolish it is to want to call help by making sacrifices to the spirits*" (Krause 1903:40 cited in Spear 1997:100). Spear notes that in the 1890's, the reputation of a successful Meru or Arusha elder depended on his having a large *kihamba* (area of land for farming around his home), a large family, and some cattle. By the 1960's his reputation would be "*more likely to rest on his education and job; his roles in the Lutheran Church, Co-operative, and Citizen's Union; and his income from raising coffee on a small kihamba / engisaka surrounding his cement house and his production of annual food crops on the plains*" (Spear 1997:236). Spear shows that while members of the Meru and Arusha tribes share a geographical terrain, their cultural values differ, and their response to changes such as increasing population also differ (Spear 1997:240).

There are some published works about cultural groups other than the Pare in the Kilimanjaro region. Some is older anecdotal material, such as that by Ntiro (1972) written in Swahili about Chagga customs, and by Moore and Puritt (1977) about the Chagga and Meru peoples. Grove (1993:431–448) discusses water use by the Chagga on Kilimanjaro. Grove notes that traditionally springs and streams were considered sacred; there are still many farmers who rely on the water channels which are supplied

from rain and melting snow from the higher altitudes. Grove discusses the intensive farming and geography of the area in detail.

The anthropologist Howard lived in Tanzania for several years and obtained information by interviewing and participant observation of local Chaggas with whom she lived and worked. Howard's analysis of socio-economic causes and cultural explanations of childhood malnutrition among the Chagga of Tanzania suggests that the high rates of infant malnutrition are not so much due to parental ignorance or laziness, but to factors such as fluctuations in the world economy and demographic pressures (Howard 1994:248-250). The effect of grinding poverty and the uncertainties of agricultural production and international markets are indeed visible everywhere in Tanzania (personal observations).

The Chaggas and Pares have been proud of their educational achievements; schooling is a major consideration in family life, with families struggling to find money for school fees. The negative effects of schooling include lack of labour for cultivation, and production of conflicting values (Stambach 1996:545–567).

The impact of colonialism, and that of the introduction of Christianity, has been enormous. Hasu (1999:29), when considering historical factors that have impacted on Chagga culture, notes that "*to be Chagga is to be Christian … the contemporary rural Chagga communities also face the consequences of the expansive global markets and the devastating consequences of the AIDS epidemic. The material and moral crises are addressed both in terms of ritual practice and moral discourse about gender relations, witchcraft and alien spirits*".

Moland notes that there are major tensions in contemporary Kilimanjaro related to changing values, such as "*issues of bridewealth and choice of marriage partners*" (Moland 2002:41).

2.6.3 Environmental context, language and ethnohistory: Pare tribe

The historian Kimambo (1991) provides information about the social and economic history of the Pare tribe (see paragraph 1.2.3). The negative effect of external traders

seeking ivory and slaves, and subsequent exploitation by German and British colonial powers is documented. The various tribal groups that existed in the nineteenth century; the creation of the Pare district in 1928, and changes in the administration of the district up to 1960 are described.

Aspects of the social and economic life of the Pare are discussed by the sociologist, Omari, in texts edited by Forster and Maghimbi (1992, 1995). Omari notes that the Pare are traditionally patrilineal, and organize their work in family groups (Omari in Forster & Maghimbi (eds) 1992:2). Land inheritance has traditionally been only to men, but there is slow change with some women inheriting from their parents and others buying land (Omari in Forster & Maghimbi (eds) 1995:130-141). The Pare tribe was commended by Nyerere (the first President of Tanzania) for being particularly active and successful in self-help programmes such as road building in the 1960's (Omari in Forster & Maghimbi (eds) 1992:4-6). The former Pare district was split to form the Mwanga and Same districts in 1978 (see Figure 1.2) (Omari in Forster & Maghimbi (eds) 1992:15). In spite of this, local people still talk of the Pare district, for example, if a Pare is going 'home' from Moshi, she will say '*Nakwenda upareni*' (I am going to Pare district) (Omari in Forster & Maghimbi (eds) 1992:16; personal observations). There has been a rapid growth in population of the Pares, as indicated in Table 2.1.

Table 2.1: Estimated population of Pares

Year of census	Total population of Pares
1928	55,648
1931	57,911
1948	85,599
1957	108,436
1967	149,635
1978	208,000
1988	269,313
2000 (projected)	365,729

(Omari in Forster & Maghimbi (eds) 1992:16)

The average number of children per household in Mwanga district was between 6 and 7 in 1992, which corresponds to national figures (Omari in Forster & Maghimbi (eds)

1992:15). It is speculated that the population growth seen in the Pare may have been accelerated by improvements in education and health (Omari in Forster & Maghimbi (eds) 1992:16–18). Maghimbi considers rural poverty to be the main contributor to high population growth rates, as poor people have more children in order to help them with the work and support them in old age (Maghimbi in Forster & Maghimbi (eds) 1992:230).

The Pare are traditionally cultivating the slopes of the Pare Mountains (see Figure 2.5); they mostly hold small plots; the plot nearest to their home is planted with bananas and coffee, and they keep stall-fed animals here. On other plots beans and maize, and some sweet potatoes and sugar are grown. From the early 1960's a land shortage was noted in the area which is now Mwanga district. Some Pare resettled away from traditional holdings as part of a government resettlement scheme; more have moved spontaneously. Some have resettled successfully in other districts such as Morogoro and Monduli. The migrant generally keeps his inherited land, and does not sell it; this land may not be well cared for by other relatives (Omari in Forster & Maghimbi (eds) 1992:18-20). "*The migrant has one foot in his new settlement and the other one in the mountain zone. He is more likely to leave behind his old parents and school-going children … he has created an absolute labour shortage in the economy of his place of origin*" (Omari in Forster & Maghimbi (eds) 1992:20).

Migration is not only to find new farming land, but also for paid jobs, especially to urban areas. In towns, there is a high rate of inflation and low wages, so a small amount of funds returns to the traditional homes (Omari in Forster & Maghimbi (eds) 1992:26-27). Grandparents whose grandchildren had been returned for care to traditional homes from towns have complained that these children were not helpful in farming and housework as they had become lazy. It seems that "*the mountain zone will continue to produce active and skilled labour for the towns*" with its secondary schools and teacher training college (Omari in Forster & Maghimbi (eds) 1992:27). Maghimbi notes that migration is an important feature of life in Tanzania; "*because of poverty and harsh farming conditions rural people migrate to urban areas and to other rural areas to look for jobs or seek help from relatives and friends. My own estimation based on first hand observations in three districts (Mwanga, Same and*

Moshi) is that at any moment in Tanzania about 500,000 people are on the move …" (Maghimbi in Forster & Maghimbi (eds) 1992:217).

Figure 2.5

Photograph of Pare mountains from Moshi town

(Savage 2003b)

Cultural aspects noted recently amongst the Pares are the continuing practice of female genital mutilation, the inheritance of widows by the brother of the deceased, and the usual practice of women not owning land (Ketang'enyi 2001:4).

While many Pare still live in their traditional geographical location, migration has occurred and urban Pares in towns such as Moshi are a significant part of the population.

2.7 CARE EXPRESSIONS, PATTERNS AND PRACTICES IN TANZANIA

Lugina (1994:63,65) has noted that men are generally responsible for decision making in Tanzania. This is the case in the Bondei tribe, with its patriarchal orientation (Oberlander & Elverdan 2000:1354). Practices in the Bondei tribe include the functioning of a 'therapy management group' which makes decisions relating to treatment with traditional practitioners, home remedies or western medicine. "*The importance of a strong therapy management group in a society with a pluralistic and poorly functioning health care system cannot be overestimated*" (Oberlander & Elverdan 2000:1355).

Three Finnish nurses, Juntunen, Nikkonen and Janhonen (2000:174–181) have undertaken an ethnographic study of the protective health care actions of the Bena

tribe of Tanzania. This tribe lives in and around Ilembula in the South of Tanzania. Forty nine villagers were interviewed. It was found that the Bena tribe implement protective actions for breastfed children, against the new moon, during menstruation, in pregnancy, in the puerperium and in the menopause. These actions were related to various health beliefs including the power of blood, the umbilical cord, breast milk and semen; the risk of being bewitched by someone who is jealous and the new moon as a cause of convulsions.

The need for improvement of institutional care provision in Tanzania has been noted repeatedly (Green 2000:403-430; Juntunen & Nikkonen 1996:536-544; Kohi & Horrocks 1994:77-86; Moland 2002:167-8; Msoka 1996:252-3). Caring constructs of professional nursing identified in Ilembula included protection, encouragement (including appropriate greetings), and comfort. Non-caring aspects of professional nursing included the superior attitude of the nurses, attachment to ward routines, thinking of some things as taboos and focusing on ward maintenance (Juntunen & Nikkonen 1996:7–11).

When studying Chagga culture, the need to improve institutional nursing care by showing respect and improving nurse-client communication has been identified, also that adequate time for visiting and spiritual care be allowed for hospitalised patients. Major efforts to improve health in the community are also needed including provision of clean water and sanitation, as well as improved health facilities and addressing the issue of poverty (Savage 2002:248-253).

Health workers have been found to be the major group responsible for performing female genital mutilation in Moshi rural district (Chugulu & Dixey 2000:108).

2.8 SYSTEMS OF HEALTH CARE IN TANZANIA

2.8.1 Provision of health services

Some aspects of health and health care have been discussed in paragraphs 1.2.4 and 1.2.5. Lyimo (2001:108-110) has described a historical view of health care under German colonial rule and subsequently under British colonial rule. He has discussed

the late introduction of primary health care into Kilimanjaro in 1987, and reasons for the failure of primary health services, including an overemphasis on curative services (Lyimo 2001:140–142; 183–191).

The observations in a village close to Muheza, inland from the coastal port of Tanga, are congruent with those noted throughout Tanzania. The village has "*a pluralistic health care system comprising the hospital and two pharmacies in Muheza, a semi-public clinic at a nearby sisal estate, three shops in the village that sell some medicine, 13 traditional healers, and numerous shops in Muheza that sell both local medicine and Western pharmaceuticals*" (Oberlander & Elverdan 2000:1352). As well as Western practitioners, Ifakara (in southern Tanzania) has a folk sector including 63 registered healers, and many more are not registered. They include a diverse group of herbalists, diviners and 'knowledgeable women' (Muela et al 2000:298). In Ifakara, it was found that "*people may indeed be willing, but may nevertheless not be able, to pay for biomedical health care – even when they can afford costly traditional medicine*" (Muela et al 2000:296). This paradox appears to arise because there are different acceptable methods of payment for traditional healers, such as payment with a chicken or some beans. The activation of social networks for financial help from relatives and friends works differently in the two sectors (Muela et al 2000:296–302).

In Moshi town there is the district government hospital, a private referral hospital, government clinics and a large number of private dispensaries, numerous *'duka la dawa'* (shops selling medicines) many of which have no qualified pharmacist, a recently opened private hospital with limited facilities, and street vendors selling herbal treatments for a variety of disease entities such as *'kifafa'* which is epilepsy (personal observations).

The World Health Organization (1996:2) reports that "*a large proportion of the population in a number of developing countries still relies on traditional practitioners*". This is clearly the case in Tanzania. Traditional practitioners may not all be 'visible' to a visitor, but Chagga informants report that there are many of them practising; some use spiritual methods such as divination and some use herbal treatments. Many families use home herbal remedies too (Savage 2002:249).

Moland (1998:1-3) has studied the role of traditional birth attendants (TBA's) in the system of maternity care in Kilimanjaro. This study not only examined the practice of TBA's, but also noted that the 'cost-sharing' scheme whereby clients pay for hospital health services at the time of service provision, makes it more difficult for the very poor in Kilimanjaro to obtain these services. The very poor include obstetric high risk groups such as young unmarried girls and grandmultipara; if they cannot afford hospital services they are likely to deliver at home with the help of a TBA.

The quality and availability of public health services has declined since the early 1980's because of reduced social sector allocations and the introduction of 'cost-sharing'. "*Despite recent increases in health spending amid substantial donor support, almost two decades of systematic under-investment in the social sectors has drastically curtailed the capacity of the public health system to meet even the most basic needs of the country's population*" (Green 2000:404-405). The dissatisfaction with state medical provision has produced an increased use of private medical services. Since these private facilities are often of poor quality, there is concern that this trend has negative consequences for health (Green 2000:403-430).

2.8.2 Training of health care workers

Traditional birth attendants (TBAs) learn their skills by observing and working with another TBA, or by trial and error. The Ministry of Health of Tanzania has been using materials produced by the World Health Organisation to train TBAs in various aspects of maternity care in a course lasting a month. (WHO 1992:1-13.) Table 2.2 shows the numbers of TBAs in three regions of Tanzania in 2001.

Traditional practitioners learn their skills by working with another practitioner as an apprentice. It has been commented that *"traditional healers may be more likely than laypersons to remain traditionalists in illness interpretation, faithful to the elders – the spiritual advisers – who taught them about herbs and healing"* (Green 1999:199).

Table 2.2: Number of traditional birth attendants in three regions of Tanzania, 2001

Region	Untrained TBAs practising in 2001	TBAs trained in 2001	TBAs previously trained and practising in 2001
Arusha	1100	388	1266
Kilimanjaro	1039	24	825
Tanga	1854	0	1799
Total	3993	412	3890

(Memba 2003)

The first group of nurses to be trained by the Tanzanian government were enrolled in 1947 (Sanga 1994:34-41). Mission hospitals, private hospitals and government institutions are currently involved in nurse education programmes. A one year health attendant training programme was discontinued in 2002. Tanzania trains nurses in 13 institutions at diploma level and 18 institutions at certificate level. The annual output of nurses is about 400 diploma level nurses and about 700 certificate level nurses. There are advanced diploma level programmes in seven specialties producing less than 120 specialist nurses annually between them. There are three bachelor's degree courses in nursing producing less than 20 graduates annually. There are no master's programmes for nurses in Tanzania yet established. Apart from nurses and doctors, Tanzania also trains 27 other cadres of health worker including assistant medical officers, clinical officers and laboratory assistants (United Republic of Tanzania, Ministry of Health 2002:11-18).

2.9 NEED FOR CLARIFICATION OF HEALTH BELIEFS OF THE URBAN PARES

The studies discussed here suggest that there is some documented information related to health beliefs in East Africa, and even in the Kilimanjaro region of Tanzania. This can provide pointers for a study of health beliefs in the urban Pares. The traditional health beliefs of the Chaggas have been discussed in the context of other studies such as the study of malnutrition. The studies surveyed suggest that even neighbouring

tribes may have different cultural patterns and that urban and rural groups of the same tribe may differ in their beliefs and behaviour over a period of time. Published work specifically on the Pares is concerned with historical, social and economic considerations. These findings appear to justify a study of urban dwellers of the Pare tribe, with respect to their health beliefs and practices.

2.10 CONCLUSION

In this chapter literature sources were used to examine the issues of transcultural nursing source material, worldviews, cultural values and health belief systems, environmental context, language and ethnohistory, care expressions, patterns and practices in Tanzania, and systems of health care in Tanzania. In the next chapter the research design of this study will be discussed.