

Hygiene, salvation and development

The constitution of nursing as a legitimate profession in Tanzania

Abstract

In this paper I examine how nursing, internationally, struggles with the problem of legitimacy, and how these struggles, historically and cross-culturally, may be seen as a tension between caring and curing. Although nursing globally has common roots and experiences similar kind of dilemmas in its quest for legitimacy, these dilemmas are shaped and expressed in relation to distinct forms of life and social organisation. This paper discusses the constitution of nursing as a profession in Tanzania, and demonstrates how it has developed as part of the modernisation project first under the colonial regime, and later in the post-colonial era. In the early phase of health care developments in the country, biomedicine interlinked with Christian teachings and morality, produced a discourse on hygiene and salvation that all health care professions derived its legitimacy from. AIDS, economic crises and health sector reform have caused a crisis of health care, and a crisis of legitimacy in the caring professions including nursing. In a crisis of legitimacy and trust, the historical bond between biomedicine and Christianity giving nursing its legitimacy as a modern and respectable profession for young women is threatened. The paper argues that a representation of nursing as risky and unclean, emanating from outside the profession itself, is gaining importance in the public at large. It shows that this representation stimulates a reaction from within the profession and produces a counter representation of nursing as self-sacrificing work for God. The representation of nursing as work for God represents an effort to re-establish or re-enforce the link between biomedicine and a cure-rationality on the one hand, and altruism, self-sacrifice and care as a basis for the nursing profession on the other. The representation of nursing as risky unclean work and the representation of nursing as work for God capture the tensions and the ambiguity in the role and the legitimacy of the nurse in contemporary Tanzania.

Introduction:

Knowledge and legitimacy have been turbulent issues in the history of nursing both as a profession and as science. The question of who should define the content of nursing as a profession is still far from settled. Nursing has gone through many stages in search for a professional identity and a domain over which it may claim jurisdiction. In this process the development of knowledge has been a major concern. Nursing draws upon knowledge from different sources and is located in the intersection between many different disciplines and traditions, the major being biomedicine, pedagogics and psychology. The relative prominence of these traditions has varied through time, but also with the social and cultural context in which nursing is constituted.

Nursing as a profession is commonly regarded as a knowledge-based practice that is internationally standardised and globally valid and applicable. There should be no doubt that nursing is a profession deeply entrenched in biomedical knowledge and practice. Its roots in western culture and society and its use of scientific knowledge, language and procedures sometimes makes it highly maladapted to the local realities in which it is practiced. The biomedical knowledge and the western norms and social structures in which biomedicine is embedded are, nevertheless, important conditions for nursing everywhere and provide a foundation on which nursing is built. It is easy, however, to overlook the fact that nursing as a profession is significantly re-created in the encounter with the social, political and cultural realities in which it is practiced.

In this paper I will demonstrate how dilemmas pertaining to knowledge and legitimacy are generated and expressed in the particular cultural context of Tanzania. The paper is developed on the basis of my mandatory trial lecture on Nursing, knowledge, legitimacy. It draws on data collected through ethnographic interviews, participant observation and archive studies, during long-term fieldwork on formal and informal systems of birth care in Kilimanjaro Region during 1997 and 1998 and subsequent yearly follow-up visits from 1999 to 2003.

A note on legitimacy

Legitimacy refers to a set of social norms that define situations or behaviours or a kind of knowledge as correct or appropriate (Abbott 1988). Drawing on Andrew Abbott's work, I see legitimacy in nursing as critically dependent on how nursing incorporates and reflects central values of the society at large. While central values in nursing originate from Judeo-Christian concepts of compassion and altruistic philanthropy on the one hand, and science on the other,

they are reshaped on the local level in the encounter with local norms and values. But values change, and these changes affect nursing as practice as well as its legitimacy. Legitimacy is not granted once and for all, but must be renegotiated on a continuous basis in the encounter with patients, but also vis-à-vis authorities and competing professions.

There are different kinds of knowledge and different ways of knowing. Knowledge may have different sources. One of them is science, another one is tradition, yet another is general learning through experience. Finally we may distinguish knowledge gained through bodily experience. All these ways of knowing are relevant *in* and *to* nursing, but they do not enjoy the same level of legitimacy. The fact that power and legitimacy are conferred on some kinds of knowledge, and not others, has represented a constant problem in nursing and its claim to legitimacy (Jordan 1997). Formal education in modern society has gained recognition as legitimate knowledge and know-how at the expense of other kinds of knowledge (Bourdieu 1977). In the hierarchical knowledge structure that results, other ways of knowing are devalued and subordinated. The constitution of nursing as a particular kind of knowledge and practice that integrates different ways of knowing, is an ongoing process that reflects power relationships within a community of practice in which the position of biomedicine, though challenged, remains authoritative.

Abbott (Abbott 1988) holds that legitimacy of knowledge and practice is connected to *what* professions do and *how* they do it. It is useful to distinguish between legitimacy that is obtained *directly* on the basis of results and method, and legitimacy that is obtained *indirectly*. Since health itself has often been conceived as the absence of disease, the results of medical work are perceived as *directly* legitimate. But an interesting aspect is that it can also have other *instrumental* aspects, for instance where medical services offered in medical institutions like hospitals also serve as instruments in realising values that are external to strict health concerns. Biomedical discourse and structures have often been criticised as being dis-empowering and an increasing body of literature inspired by Foucault discusses how individual bodies as well as populations become subjects of discipline and control in medical institutions. Recent contributions to the discussion of women's experiences of the power/knowledge regime of biomedicine have brought yet another and complimentary perspective to the forefront. Lock and Kaufert (Lock and Kaufert 1998) discuss how access to biomedicine may be experienced as empowering and may be seen as an opportunity to escape from other forms of power, residing for instance in traditional structures and institutions. The legitimacy of nursing, no doubt, is closely connected to what nurses do and how they do it,

but it also depends on the structures and the institutions in which nursing is embedded and what these institutions represent and symbolise in a particular cultural context.

The tension between caring and curing

The tension between the different knowledge traditions in nursing is often described as a tension between *caring* and *curing*. Whereas caring represents a kind of knowledge, and an approach to the suffering person that focuses on human experience, curing is associated with the more technical tasks of nursing.

Care and cure have also been described as different kinds of ethical approaches to clinical situations (Kottow 2001). Female concerns of nursing care have been contrasted with masculine, cure-oriented attitudes. In 1982 Carol Gilligan introduced her ideas of an alternative 'ethics of care' (Gilligan 1982). She argued that women are inclined to construct a moral problem as one of care and responsibility rather than as one of justice and reciprocity. Although her claim to an alternative ethic based on care and responsibility has been heavily criticised within moral philosophy as well as in post-structuralist feminism, it revitalised the debate on rationality and the concept of care in general (Benhabib 1992), and its place in the development of knowledge in nursing in particular.

Nursing internationally may be defined as a profession working in the intersection between caring and curing. The *emphasis* of nursing practice, however, varies between different countries and depends on factors associated with history and culture on the one hand, and health care policies, infrastructure and professional strategies on the other. The practical realities within which nursing is practiced as well as the ideologies that have informed nursing as a modern profession, pull nursing in Tanzania, I shall argue, towards *curing* rather than *caring*. I will discuss what I see as the major sources of legitimacy to nursing practice in the development of nursing in Tanzania. I will emphasise how biomedicine, allied first with Christianity and later with the development ideology, has attained a position of cultural authority (Starr 1982), meaning broad public acceptance of its knowledge and practice. I will also discuss how this position is threatened in the contemporary situation of economic crises.

Locating nursing in the history of biomedicine in Kilimanjaro Region

The medical doctor has generally been regarded as a powerful door-opener for Christianity in Africa (Rekdal 1999). In the process of colonial expansion, Western concepts of health and health care were actively promoted through churches and missions (Zwi and Mills 1995).

Missionaries often saw the provision of health services as “part and parcel of civilising” the locals and introducing Christianity (Zwi and Mills 1995). In Kilimanjaro it was no different.

Hygiene and salvation

Biomedicine was introduced with the missionaries who were posted to Kilimanjaro Region in the 1880s during the German colonial rule and was, in part, adopted with a remarkable speed. In his ethnography of health and illness among the Chagga, Philip Setel (Setel 1995; Setel 1999) argues that biomedicine was not only any system of knowledge. It was a power/knowledge regime with its own set of social relations and its own institutional arrangements that came to attain an important position in Chagga society. But the development of biomedicine in Kilimanjaro cannot be seen in isolation from the introduction of Christianity and modern education. Traditional medicine depended strongly on beliefs and customs that the Church regarded as heathen. According to Setel (Setel 1995) the practice of traditional medicine was abhorrent to the Church, not primarily because it was medically harmful or lacked efficacy, but because it was morally wrong. The church and the medical clinics became mutually reinforcing institutions that had a fundamental impact on Chagga life and ideology.

Under the colonial rule of the Germans and later the British, nutrition and sanitation were areas of great concern to the authorities (Turshen 1977). Epidemics of various kinds gave rise to an emphasis on hygiene. Setel (Setel 1995) reports how hygiene merged with medical, moral and educational ideologies in social criticism of Chagga life. Customary ways of distributing and cooking meat, of rearing children, of sanitation and personal hygiene, of burial customs, of dress and of material and methods of house building were all attacked as unhygienic and unhealthy.

Biomedicine, interlinked with Christian teachings and morality, produced a discourse on hygiene and salvation that was persuasive in Chagga community. This was not only related to the fact that people got access to medical assistance and religious preaching. The clinic and the church also represented opportunities for Chagga to get involved in non-farm work in a situation where population growth had made access to farmland scarce and where economic differentiation increased accordingly.

An emerging occupation for young modern women

It was in such a climate that nursing became an attractive career path for young women in Kilimanjaro. Nurses were trained in missionary hospitals from the 1930s onwards (Juntunen

and Nikkonen 1996). At the same time as nursing represented access to education and modern life, it was a kind of work that did not compromise young women's respectability. As deeply anchored in the Christian philosophy of humanity and self-sacrifice, nursing as a profession combined the characteristics necessary for young girls with aspirations for a modern life. Hence, during this phase there is no doubt that the close coupling between the church and biomedicine worked to legitimise nursing as a profession for women.

Non-tolerance for traditional medicine

As part of a general tendency, the curriculum of the nursing schools was to a large extent copied from English schools and was basically poorly adapted to the specific needs and the cultural context of Tanzania. Although most of the people using medical facilities had different concepts of disease and disease causation, and used various kinds of indigenous medicine, this was rarely recognised in other terms than as obstacles.

In the development of nursing as a profession in Tanzania its identification with biomedicine as a system of knowledge and as a basic condition for the organisation of modern health care has been strongly emphasised. Likewise, a corresponding rejection of traditional medicine has been forcefully stressed. Nurses who did not recognise the moral distinction between allopathic and indigenous medicine, -the distinction between Christian and heathen values-, and who did not respect the borders of the hospital as a line between scientific medicine and superstition, or as a demarcation between the civilised and the primitive, would risk losing their job. The following case illustrates:

In 1948 the District Commissioner and the Chief in a district in Kilimanjaro Region had to handle a delicate case. A respected senior midwife had been caught giving her patients indigenous medicine during hospitalisation. The midwife first denied, but later explained the value of the medicine in assisting conception, delivery and post-natal recovery. In view of the seriousness of the matter she could not retain her position in the hospital, but because of her long and faithful service she was not dismissed, but was asked to retire. The drug was later sent for analysis.

The condemnation of the midwife was based not on scientific facts about the effect of the medicine in question, but rather on its status as indigenous and, as such, improper as opposed to "proper" in the sense of efficient and scientifically tested. It was based in a dichotomy of rationality and superstition, - of knowledge and belief. According to Meredith Turshen

(Turshen 1977; Turshen 1984), who has written extensively on the introduction of biomedicine during the colonial period in Tanzania, the rejection of indigenous medicine by the colonial regime reached the level at which traditional practitioners were un-discriminately labelled as witchdoctors, and in the 1920s, a witchcraft ordinance allowed for the prosecution of practitioners identified as witchdoctors and sorcerers .

This situation of rejection is not unique to Tanzania nor to the colonial period. It is a result of the way in which biomedicine claims and is granted status as authoritative in a context of medical pluralism (Whyte 1982)

The development ideology

An empirical observation that has puzzled me is that local nurses working in remote rural settings in Tanzania where the national language, Swahili, is poorly understood, continue to give their health education talks in Swahili, even when they do command the *local* language and they know that the majority of the listeners do not understand what is being said. I will discuss this issue in view of the development ideology characterising the period following independence in 1961.

The authority of biomedicine that developed under the colonial period was re-emphasised in the post-colonial era, though in a totally different ideological framework which promoted health as a right of all people (Hartmann 1990; Nyerere 1968). At the same time health care became a central part of the nation building project. The mobilisation of Tanzanian values that was used in this endeavour did, however, not entail a promotion of indigenous medicine. The Swahili term *maendeleo*, often translated as development, took on an ideological meaning as progress in terms of education, economic development and health. The distinction between development and under-development was made from the outset. Health in this context was defined as public hygiene and the absence of disease and grew out of biomedical reasoning.

The Tanzanian government, after the 1967 Arusha Declaration, promoted a strategy emphasising mass health education, primary health care, education and rural development activity (Zwi and Mills 1995). The mass campaigns of public health and nutrition in the 1960s

and 70s¹ established the connection between disease, ignorance and poverty as obstacles to development, and mobilised the population to take part in the effort to meet these challenges. Ignorance as the opposite of knowledge was often equalled with traditional beliefs. Through radio broadcasts and local field workers these campaigns reached even the most peripheral rural areas and development became a concern not only of the urban elite, but also of ordinary people (Hall 1985). Development has since that time been a constant theme and a preoccupation in the public discourse in Tanzania.

In the nation-building atmosphere following independence all citizens were expected to make sacrifices for the good of the nation. Nursing was a key profession in this context of *maendeleo* and nation building. Nurses were trained to promote *maendeleo* through better health and were assigned the role as important *agents of change* on the community level.

In Western countries care has played an important role historically in the struggle to develop nursing as a profession different from, and not subordinate to, medical doctors (Martinsen 1989). Nurses in Tanzania work in a very different reality, not only in terms of the cultural and social context in which nursing is practiced, but also in terms of the organisation and the resources of the health care system. This has a bearing on the kind of role that nurses play, the definition of nursing tasks and hence on the construction of nursing as a profession. The legitimacy of nursing in Tanzania has historically derived primarily from biomedical *curing* and *health education* and from its close association with Christianity and, later, development (*maendeleo*). Only to a less extent has nursing derived its legitimacy from nursing *care*. In a situation where there is only one medical doctor per 30.000 patients, the technical and medical aspects of nursing have been promoted while care has remained the responsibility of relatives also during hospitalisation (Moland 2002). The nurse is often the one dispensing drugs in rural primary health care, and it may be hard for patients to distinguish the nurse from the doctor on the basis of what they *do*.

The contemporary situation of health care crises

“Hospitals are just empty buildings”

Recently the policy environment of nursing in Tanzania has changed. Today, the public health services in Tanzania are in deep crises. The health sector reform driven by the implementation

¹ *Mtu ni Afya* (Man is health) addressing issues of public health was one of the most important campaigns. Others were *Uchaguzi ni wako* (The choice is yours) which sought to raise political consciousness and participation; *Wakati wa furaha* (Time for rejoicing), which sought to deepen the Tanzanian sense of nationhood; and *Chakula ni uhai* (Food is life) which sought to improve nutrition and food production (Hall, Budd L. 1985).

of structural adjustment programmes aimed to bring down public spending has had an unfavourable effect on health services. The principle of government responsibility for health care that was established after independence and the policy of low cost accessible primary health care for all, has been replaced by a policy promoting shared ownership and shared responsibility (Benson 2001). Salaries of government employees were frozen for many years and did not match the increased cost of living. Government employed nurses depend on additional income. Patient fees have been introduced with the aim to improve services, but these initiatives have not had the expected effect. Patients complain that the quality of services has dropped and that hospitals have become “just empty buildings”. Many nurses do petty trade on the side, and sometimes also within the hospital during working hours. Charges of bribing have been raised (Moland 2002). In this process the trust in medical services has been seriously set back, and the authority of public health services is threatened.

Now, how does this situation affect the legitimacy of the nurses as employees in government hospitals? The idea of the nurse as a central actor in building the nation, has been challenged by the experience that nurses like other professionals, work to enhance their own income, sometimes even at the expense of general professional ethical values.

The structural adjustment programmes have involved large cuts in staff in public hospitals (Benson 2001). In a retrenchment plan, many nurses accepted to retire with a lump sum compensation. Some tried to set up private maternity clinics in their local communities. But without a formal institution and a social structure supporting their legitimacy, the nurses lost their advantage vis-à-vis traditional practitioners. As private practitioners in a local community, nurses experience that their legitimacy have to be renegotiated and that to a large extent it has to be gained on the basis of *character* rather than on *technique and science*. In this situation *traditional birth attendants* have become real competitors and without a formal structure supporting them, the trained nurses tend to lose out.

The HIV epidemic and negotiations on legitimacy

Alongside with economic crises, the HIV/AIDS epidemic has developed and has made nursing a less attractive career path in as much as it is *associated* with a high risk of infection. Positive HIV status among nurses is commonly explained in terms of patient contact. AIDS patients have become a major patient group occupying beds in hospital wards and nurses are preoccupied with protective measures. Gloves have become indispensable barriers between the patient and the nurse (Moland 2002). In this process, distance is created, and the caring

dimensions of nursing may get even less attention. This situation is reflected in recruitment of nurse students as well as in the number of nurses leaving the profession.

In these circumstances, which may be described as a *crises* of legitimacy, it is interesting to observe how nurses in Tanzania re-emphasise the roots of nursing in Christian philanthropy in negotiations of legitimacy. In the occupational rhetoric of nurses, the idiom of nursing as a vocation is pronounced. With low pay and heavy work, nurses describe their work as *work for God*. This rhetoric may be seen as an effort to re-establish nursing as an occupation with a humanitarian motivation. Although nursing involves contact with other people's bodies, which are viewed as potential sources of contagion, nursing has been spoken of as a clean or self-sacrificing occupation. Clean in this context, refers to the humanitarian basis of nursing rather than to its practice. It refers to nursing as goodness, rather than as a means of earning a living.

Nursing as perceived high risk, on the one hand, and nursing as *work for God* on the other, captures the tensions and the ambiguity in the role and the legitimacy of the nurse in contemporary Tanzania.

Medicalisation as empowerment

In the introduction I mentioned that legitimacy may also be granted to nurses not only because of what they do and how they do it, but in an indirect manner, related to the role that health care may play in the realisation of other values. This view does *not preclude* a *critical* view of the role of biomedicine in generating dependency and in disqualifying other ways of knowing about the body. Knowledge, based for instance in indigenous medicine or expressions of body experience usually enjoy limited legitimacy in the biomedical regime where objective signs maintain a high status in diagnostic work and in prescribing therapy.

The concept of medicalisation usually has negative connotations. Researchers, starting with Ivan Illich (Illich 1976) have often described the medicalisation of society as a process that undermines the knowledge and the self-confidence of ordinary people. Medical rationality is seen to colonise the consciousness of the people and entails unnecessary dependency on expert help and professional support. The medicalisation of birth is one example that has received substantial attention in the West. Scholars like Emily Martin (Martin 1987) who wrote the path-breaking: "The woman in the body" has been important in demonstrating how biomedical knowledge and discourse works to undermine women's experiences and control of the birthing process.

In Kilimanjaro Region many women, in spite of bad experiences with hospital birth nevertheless prefer hospital birth to home birth (Moland 2002). The explanation for this preference may obviously be sought on different levels. It could be associated with lack of any alternative, it could be associated with trust in the nurses' knowledge or it could be associated with trust in the technology available in hospital. All three explanations can be seen as a result of an extensive medicalisation process in which birth has been moved from the lay to the professional domain. The medicalisation explanation is thus all-encompassing, and maybe at the same time, one-dimensional and deterministic. It may also be possible that women, using the health care system, do not experience the biomedical regime as dis-empowering. In her study of Sudanese Muslim women's interaction with the health care system, Ellen Gruenbaum (Gruenbaum 1998) writes that contrary to the situation in the West, where women at times experience the interaction with doctors and health personnel as dis-empowering, disadvantaged people in poor countries often see it differently. She argues that to women in Sudan it is often the obstacles to *access* medical services that seem to constitute disempowerment.

Indeed the indirect legitimacy of the health system in general or of nursing in particular may also be constructed *in spite* of the dis-empowering mechanisms of biomedicine. To many women, the experience of dis-empowerment may be a matter of degree. Young Chagga women for instance often express a preference for birth in hospital because they feel that it is the safest place to give birth even if the process of birthing may be dehumanising and dis-empowering. But in addition, women often express two other concerns. One is related to traditional power structures and the other one is related to status enhancement. The nurse and the clinic represent an opportunity to make a legitimate escape from the traditional authority of mother-in-law in childbirth. The intimacy between the birthing woman and the mother-in-law during childbirth is by many young women experienced as threatening. Not only may the birthing women's body be subject to evaluation and moral judgement. Her behaviour during childbirth may be interpreted as a sign of either strong or weak character. Her future status in the family may thus be affected. In this perspective a woman may experience hospital birth as liberating and even empowering.

A different, but maybe not less important issue is the way in which the use of modern institutions may play a role in identity management. In Chagga, hospital birth does not only represent a possible escape from traditional authority structures, but also an escape from the status as uneducated and backward. Nurses as representatives of these modern institutions

come to gain legitimacy and authority as symbols of modernity and progress and as an embodied critique of traditional power structures.

Conclusion: The nurse as an agent of change

To conclude I will return to why the Tanzanian nurses working in their home communities give health education talks in Swahili when they do know that only very few of the people listening will be able to understand.

The answer to the question has to be sought in how nursing is constituted as a modern profession deeply entrenched in the project of development and nation building in postcolonial Tanzania. The use of a common language was an important tool in building a common identity as Tanzanians. Nurses were supposed to speak Swahili. As educated persons, nurses are assigned the role as *agents of change*. Health care, as an important aspect of nation building, was constructed to address not only disease, but also ignorance, seen as a moral vice and an underlying cause of bad health. Local knowledge and local language in this context was constructed as an impediment of development both during the colonial and in the postcolonial era. The use of Swahili language is part of the symbolic repertoire employed by nurses to underline their belonging to the modern Tanzanian nation.

A nurse was not only a health care worker, but also an agent affecting change from bad to good habits and customs, and from primitive belief to rational knowledge. The juxtaposition between *knowledge* and *belief* has been persuasive in the history of medicine (Good 1994). The representation of other ways of knowing as *belief*, has authorised the position of biomedical knowledge. It also lends authority to nursing. The nurse in this context is the embodiment of a kind of knowledge that enjoys authoritative status and which is associated with modern life.

In this paper I have examined how nursing, internationally, struggles with the problem of legitimacy, and how these struggles, historically and cross-culturally, may be seen as a tension between caring and curing. I have tried to show that although nursing globally has common roots and experiences similar kind of dilemmas in its quest for legitimacy, these dilemmas are shaped and expressed in relation to distinct forms of life and social organisation. I have made an attempt here to illustrate how nursing in Tanzania has been constructed as part of the modernisation project, and how its current precarious legitimacy is connected to changes in the social and political environment of health care.

The situation of health care crises in the wake of economic reform is not unique to Tanzania. According to WHO, many countries report that nurses and midwives leave the health services due to poor working conditions and low pay and that, as a result, an increasing number of patients receive inadequate care or no treatment at all. The world health assembly of 2001 brought up the crucial role of nurses in reducing excess mortality and morbidity. Hence, the legitimacy of nursing is now on the agenda of international health politics and it remains to be seen how this strategy will affect nursing in the future.

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