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NURSING CARE FOR PATIENTS WITH BURNS IN TANZANIA

- An observation study

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ABSTRACT

Burns are common in low- and middle income countries such as Tanzania and fire-related deaths are numerous in Africa compared to high income countries in Europe. The nurse’s primary professional responsibility is to require nursing care to people. Nursing care for burned patients is important and demands knowledge. Nurses in Tanzania experience difficulties in their daily work in terms of heavy workload and lack of material. Transcultural nursing aims to see care, health and illness from a cultural perspective and the goal is to provide competent care to people in different cultures. The purpose of the study was to illuminate how nurses in Tanzania take care of patients with burns. The study was implemented at the hospital Kilimanjaro Christian Medical Centre in Moshi, Tanzania. A qualitative method was used; participating observations of nine nurses were carried out. The field notes were analyzed by content analysis and gradually two themes appeared; preventing infections and meeting the patient. The conclusion was that nursing care meant collaboration with the relatives, a calm and low stress atmosphere and concerns about the patients’ integrity. Difficulties experienced in the nurse’s daily work were lack of time and material, but despite this the nurses wanted to improve the care of the burned patients in order to reduce the risk of infection. An interesting finding was that normally no contact was created between the nurse and the patient. Overall the lasting impression was that nursing care must be seen and understood in the cultural context.

Key words: nursing care, burns, transcultural nursing, content analysis, Tanzania
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1 INTRODUCTION

Studying literature about burns I became interested in the subject and found that burns are a huge problem in low- and middle income countries (The World Health Organisation [WHO], 2008) and widespread in Tanzania (Mutasingwa & Aero, 2001). In Tanzania, the nurses experience their daily work as difficult in terms of lack of nurses and a heavy workload (Häggström, Mbusa & Wadesten, 2008). In Sweden nursing care is the nurse’s profession which raised questions about nursing care for patients with burns in Tanzania, where burns are common and the nurses experience difficulties in their work.

2 BACKGROUND

2.1 Tanzania

The republic of Tanzania is located on the coast of East Africa and the country has a population of approximately 39 million people. Christianity and Islam are the largest religions in Tanzania and both English and Kiswahili are official languages (Daleke, 2007). Furthermore the condition of Tanzania’s economy is typical for a country in the third world which has its base in farming and where there is great dependence on aid and loans from foreign countries. Most Tanzanians work with farming for their own household needs or in the informal sector of the economy. More than one third of the population lives under the income level for poverty, but starvation is rare (Daleke, 2007). According to WHO (2006) the total number of nurses in Tanzania is 13 292, the total number of physicians is 822 and the number of hospital beds less than 25 per 10 000 people. The vision for the Tanzanian government is free medical care for the whole population, but the healthcare system has been suffering due to the economic crisis in the country and for example there is a shortage of medicine. Mission healthcare and traditional medicine men fill the big gaps in the governmental healthcare (Daleke, 2007). The average life expectancy at birth is 47 years for men and 49 years for women. Top three cause of death, all ages, are HIV/AIDS, lower respiratory infections and malaria (WHO, 2006).
2.1.1 **Kilimanjaro Christian Medical Centre**

The hospital Kilimanjaro Christian Medical Centre (KCMC) is placed in Moshi, Tanzania (Boon, 2000) and was opened 1971 (Tumaini University, 2005). The total bed capacity of the hospital is about 450 and about 500 outpatients visit the hospital daily. KCMC is the referral hospital for over six million people in Tanzania’s northern zone (Kilimanjaro Christian Medical Centre [KCMC], 2006).

2.1.2 **The nurse at Kilimanjaro Christian Medical Centre**

Häggström, Mbasa and Wadesten (2008) describe how nurses at KCMC experience their daily work as very difficult due to a shortage of nurses, heavy workloads, lack of or defective equipment and thereby causing problems maintaining a high quality of nursing care. Lack of education and ongoing education causes unease in the nurses attributable to difficulties in keeping up with new scientific and proven methods in the care of the patients.

2.1.3 **Burns in developing countries**

According to WHO (2008) burns are a major public health problem, especially in low- and middle-income countries where more than 95 per cent of all deaths related to burns occur. Fire related burns cause more than 300 000 deaths per year. These deaths are only part of the problem, many people are left with lifelong disabilities and disfigurement. Fire related burns account for 10 million Disability Adjusted Life Years (DALYs) globally each year. The fire-related deaths are numerous in Africa (6.1 deaths per 100 000 population per year) compared to high-income countries in Europe (0.7 deaths per 100 000 population per year) (WHO, 2008). Amongst the countries in the world, burns are one of the injuries with the greatest difference in the number of people affected.

Mutasingwa and Aero (2001) state that burns are widespread in Tanzania. At KCMC, the seventh most frequent cause of admission to a surgical ward during 2006 was burns. The burned patients were six per cent of the total sum of patients and made up 18 per cent of the total deaths during that year at the hospital (KCMC, 2006).
Justin Temu, Rimoy, Premji and Matemu (2008) point out that one factor contributing to the incidence of burns in developing countries is the poor architectural design of the cooking places. Other factors are the use of cooking pots at ground level, the use of open wood fires and the use of kerosene stoves (WHO, 2008). Lack of knowledge regarding safe usage techniques is also contributory (Peck, Kruger, van der Merwe, Godakumbra & Ahuja, 2008). Lack of prevention programmes, lack of adequate burn care facilities, lack of resources but also lack of trained staff are other risk factors for burns according to Ahuja and Bhattacharya (2004). Albertyn, Bicklerb and Rodea (2006) state that beliefs in traditional methods of treating burns and the lack of infrastructure also contribute to an unsatisfactory status for burn management in Tanzania.

According to Ahuja, Bhattacharya and Raj (2009) the number of burns reflects the economical development of the society and by improving the economic situation the incidence of burns could be reduced. One way to prevent burns is to develop prevention programs (Mashreky et al., 2008). Other suggested solutions are determining local health needs, conferences about burns, burn research, prevention activities and epidemiological studies (Fadaak, 2002). Delgado et al. (2002) state that to prevent burns interventions should be directed to low socioeconomic status groups and the interventions should be accordingly to local risk factors. WHO has been working together with the International Society for Burn Injuries [ISBI] and other partners to develop strategies to improve prevention of burns over the world, especially in low- and middle-income countries (WHO, 2008).

2.2 Nursing care

According to the International Council of Nurses [ICN] (2006) the nurse’s primary professional responsibility is to require nursing care to people. Socialstyrelsen [SoS] (2005), the authority which creates guidelines for Registered Nurses in Sweden, raises that the comprehensive of the nurse’s profession, nursing care, is to have a holistic and critical approach. That means for example to assume from values based on a humanistic view of human beings. Nurses have four fundamental responsibilities; to promote health, to prevent illness, to restore health and to alleviate suffering (ICN, 2006). Essential in nursing is respect for human rights, the right to life, dignity and to
be treated with respect irrespective of e.g. age, skin colour, gender, culture and illness (SoS, 2005). Other aspects of the nurse’s responsibilities is to show care and respect for the patient’s autonomy and integrity and with knowledge and care inform and take responsibility for the patient’s safety and welfare during tests and treatments.

2.2.1 Nursing care of patients with burns

The skin is the largest organ of the body (Railey, 2002) and according to Mathisen (2002) the skin is the human being’s most important organ. A serious burn might affect important functions of the skin, for example protecting it against infections. According to Mathisen (2002), an estimation of the burn on the basis of the following criteria must be done in order to assess the severity of the burn: the cause of the injury; which part of the body has been burned; how much of the body in per cent is burned, and the depth of the injury. The burn is more complicated if the patient has other injuries or diseases which complicate the situation; or if the patient is exposed to some kind of loss such as of the home. Furthermore, the most common and fastest way to assess the spread of the burn is in Total Burn Surface Area in per cent of the body (TBSA %). The burns are divided into superficial injury, part of the skin injury and full skin injury. According to Williams (2009), a superficial burn is a burn in the farthest layer of the skin, epidermis, which is also called a first degree burn. Part of the skin injury is a burn down to dermis – a second degree burn. Full skin injury is a burn which includes all parts of the skin, both epidermis and dermis, and also goes down to the fatty tissue of subcutis; it is also called a third degree burn.

According to Sjöberg and Östrup (2002), the experience of being hurt and the need for care is individual and therefore the nursing care must be adjusted to every patient, something unexpected and terrifying has happened to the person who is thereby in need of care. The spread, the depth and the location of the burn on the body are factors to take into account in the care for the patients (Railey, 2002). The nursing care of patients with burns is a multifaceted and challenging sphere of nursing practice (Fowler, 1994). Sjöberg and Östrup (2002) state that caring for the injured patient involves to take care of all aspects around the patient in a professional way; this demands both knowledge and experience. According to Mathisen (2002), professional caring means helping the patient to maintain hope, happiness and to
preserve their contact with their daily life; nursing care strives for as much well-being as possible in the patient. The nurse meets the patient in the course of their daily life and helps them carry on with their everyday activities, a determining factor for achieving a successful result is the interaction between the patient and the nurse (Mathisen, 2002). The ideal situation is one nurse caring for the patient over a long time in order to gain deeper knowledge of the patient’s individual needs.

2.2.2 Special nursing care of patients with burns

Sjöberg and Östrup (2002) state that patients with burns have an increased risk for care related infections and invasion by bacteria is not unexpected in burn victims (Sharma, Harish, Singh & Bangar, 2006). According to Lindholm (2002), infections are a relative common complication of burns and Mathisen (2002) mean that an infection can result in a delayed healing of the burn, ugly scars and an extended care time. Often the infection is caused by the patient’s own bacteria, but there is always a risk of transmission of infections between patients and between nurses and the patients. One part of the special nursing care of patients with burns is the prevention of infections (Sjöberg & Östrup, 2002). Barrier care is a useful method for reducing infections. Mathisen (2002) states that the nurse has a central role in preventing infections and is responsible for promoting an antiseptic environment around the burned patient and for observing early signs of infection.

2.2.3 Transcultural nursing

Leininger (2002a) describes that transcultural nursing means discovering why cultures are alike or different from the perspective of care, health, illness and death. The goal is to provide culturally congruent and competent care to people in different culture. Transcultural nursing is based on humanistic and scientific knowledge and practises with a focus on holistic cultural care phenomena. According to Leininger (2002b) care is the essence of nursing and culturally based care is essential for well-being, health, growth and survival. Helman (1994) points out that the health care system in a country must be seen in relation to aspects of the social and the religious organization.

According to Leininger (2002a) the trend towards globalization of health care challenges nurses to learn about different cultures. Nurses who are trained in
transcultural nursing know how to provide safe and meaningful care to people from different cultures. The need for nursing is universal (ICN, 2006). Furthermore, Leininger states awareness about one’s own cultural background is of great importance for each one of the nurses and also for an understanding of how it affects the relationship with the patient.

The Sunrise Model has been developed by Madeleine Leininger (Leininger, 2002b) and the purpose is to find different culture care phenomena as seen from a holistic perspective taking in multiple factors that might potentially influence the care and well being of people. The model shows possible influences related to history, culture, social structure, worldview, environmental and other factors that can explain care phenomena.

3 THE PROBLEM AREA

Burns are a health problem in developing countries, such as Tanzania, where burns are a widespread type of injury. Caring for a burned patient is a multifaceted sphere where the care should be individualised to every patient and demands knowledge of the nurses. There are deficiencies in the Tanzanian healthcare and the nurses experience difficulties in their work such as lack of nurses and necessary knowledge. With a high number of burned patients, with a multifaceted need of care, in combination with obstacles in the healthcare and nurses who experience difficulties in their work, it is important to gain knowledge about how nursing care is given to patients with burns in Tanzania.

4 AIM OF THE STUDY

The aim of the study is to illuminate how Registered Nurses in Tanzania take care of patients with burns.
4.1 The questions asked

What kind of preventive measures against infections are used in the nursing care? What, from a nursing care perspective, can be seen in the meeting between the Registered Nurse and the patient?

5 MATERIAL AND METHOD

5.1 Design

This study is empirical and uses a qualitative approach. According to Olsson and Sørensen (2007), the purpose of qualitative methods is to acquire descriptive data through studying the subjects’ own spoken words and observable behavior. The qualitative method is a way to systematize knowledge about something that characterizes a phenomenon. The intention is to find categories, descriptions or models which describe a phenomenon or connection in the realm of human life. One way of collecting data for a qualitative study is through observation (Olsson & Sørensen, 2007).

Ethnonursing, a method in transcultural nursing, was developed in the 1960s by Madeleine Leininger for qualitative studies where the informant’s world of knowing is discovered (Leininger, 2002a). The focus is on emic and etic knowledge and practice in relation to care, health, wellbeing, illness, lifecycle experience, dying, disabilities, prevention modes, and other actual or potential areas of interest to nurses as well as transcultural nursing phenomena. According to Leininger (2002a) an emic perspective refers to the view and the values of the insider as well as the context of the studied phenomenon. In contrast, the etic perspective is the outsider’s, the researcher’s point of view and evaluation of the phenomenon. These perspectives often create different views of the same phenomenon. Ethnonursing makes it easier to acquire care and health knowledge that is related to areas such as worldwide social structure factors, ethno history, environmental factors and other additional areas belonging to the informant’s cultural lifeworld (Leininger, 2002a). The purpose with ethnonursing is to establish general concepts, theories and hypotheses, or to identify
variables, that have not been identified before. The method has been particularly
developed for cross cultural studies (Pilhammar Andersson, 1996).

5.1.1 Participant observation
The investigation is a participant study of observation. According to Polit and Beck
(2008), conducting observations means to collect data in the field. The purpose is to
see individuals in their natural environment and to have the opportunity to observe
how they act in a specific situation so as to be able to understand how individuals act
in everyday circumstances. Pilhammar Andersson (1996) states that informal
conversations can complement the data collected from the field notes.

The term nurse/s will be used continuously for Registered Nurse/s. Observations of
how nurses take care of patients with burns at the Surgical Intensive Care Unit [SICU]
and the surgical ward at KCMC were preformed. Totally nine observations of nine
nurses have been conducted, where three were at SICU and six on the surgical ward.
The observations took place over eight days. They lasted from two up to five and an
half hours. Informal conversations with the nurse in charge were added to the
observations.

5.2 Selection
Inclusion criteria for the nurses were an ability to speak and understand English. The
inclusion criterion for the patient was being treated at the SICU or a surgical ward at
KCMC for part of the skin injury or full skin injury.

5.2.1 The nurse
The nurse who was in charge for the burned patients the day the observation took
place was selected to participate in the study. The nine nurses studied were females
and have worked from four months up to 35 years as nurses. Three of the nurses were
Post-graduated in Special Nursing: Intensive care.
5.2.2 The patient

Five female patients and three male patients have been included in the study. They were patients at SICU or at the surgical ward the days the observations took place. Three were patients at SICU and five at the surgical ward. The patients included were between one year and 58 years old. Two of the patients had untreated epilepsy and one patient had a congenital mental retardation. Two of the burns were caused by hot water, two by kerosene, one by hot porridge, one by burning clothes, one by falling into the fire and one patient was set on fire. The patients were all diagnosed as burns of the second (five patients) and third (three patients) degree. The spread of the burns were about 8 per cent up to 100 per cent of the body area.

5.3 Data collection

The data has been collected from field notes, transcribed observations, written approximately one hour after the observations took place and from complementary conversations with the nurse in charge for the burned patients on the day the observation took place. Polit and Beck (2008) claim that observations can not be memorised and therefore must be written down as soon as possible. It is helpful to use a “note structure” (Pilhammar Andersson, 1996). This is the structure which has been used for documenting the observations in the study, see Appendix 1. Conversations have taken place during the observations and background data about the nurse such as gender, time working as a nurse and possible specialist education have been collected. Because of the small number of observations the result is not possible to generalise.

5.3.1 The field

The study took place at the surgical ward and at the SICU. The surgical ward has a capacity for around 50 patients. The ward is divided into five rooms and the corridor. One room with five beds is a separate room for burned patients (personal communication, 1 October 2009). The SICU has seven beds for seriously ill surgical patients, e.g. burned patients. Visitors are usually not allowed at the ward (personal communication, 29 September 2009).
5.3.2 Access to the field

Before arriving to Tanzania and KCMC a letter for introduction was sent to the hospital management (Appendix 3). With permission from the Director and the Matron of the hospital, the study has been carried out at the SICU and the surgical ward at KCMC. To get access into the field, the first day at KCMC was an introduction day at the hospital. The gate keeper introduced me and the study to be carried out for the staff at SICU and surgical ward. Simpson and Tuson (1995) state that in order to be accepted on the field a period of introduction is necessary before doing the field studies. According to Polit and Beck (2008), it is important for the observer to be accepted as a part of the context where the observations take place. A gate keeper is an important person to contact when doing ethnographic field studies in order to get access to the field and to be introduced to the participants of the study (Pilhammar Andersson, 1996).

5.3.3 The role of the researcher

Ethnographic research means being in different worlds at the same time, the scientific and the personal and the role will affect what kind of information you will get access to (Pilhammar Andersson, 1996). The participated nurses at SIUC and surgical ward were aware of the purpose of my stay at the wards.

In this study, both an emic and an etic approach have been used. The researcher’s view of the situation through conducting observations, and the nurse’s view of the situation through informal conversations. Pilhammar Andersson (1996) states that the researcher, in practice, uses both an emic and etic approach when collecting information about the phenomena studied.

5.4 Data analysis

The transcribed data, the field notes from the observations, has been analysed by using the method content analysis. According to Polit and Beck (2008), the purpose of data analysis is to organize and structure the collected data.

The observations were extensive and written down exactly to re-create what was observed. According to Pilhammar Andersson (1996), content analysis means that the
observer identifies words or sentences in the written text (for example the field notes) which are its content. After reading the field notes meaning units were created. The part of the field notes, which covers the content of the question raised was used. Remainder text was excluded. Every meaning unit was then reduced to a code, which Pilhammar Andersson (1994) describes as a term for the phenomenon that has been observed. The last step in content analysis is to deploy the codes into categories and then into themes, including the meaning of the codes. Graneheim and Lundman (2004) emphasise that no meaning units related to the purpose of the study should be excluded due to the lack of a suitable category, therefore the categories must be exhaustive and exclusive. The data must not be placed between two categories or fit into more than one category.

Table 1.

<table>
<thead>
<tr>
<th>Field note</th>
<th>Meaning unit</th>
<th>Code</th>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the nurse came to the patient the first thing she did was to put a screen around the patient.</td>
<td>The nurse puts a screen around the patient</td>
<td>Secure for the patient's integrity</td>
<td>Closeness</td>
<td>Meeting the patient</td>
</tr>
</tbody>
</table>

The result ended up as two main themes; preventing infections and meeting the patient. The first main theme contains three categories; visions, resources and obstacles. The second theme contains five categories; collaboration, calmness, closeness, distance and difficulties (Appendix 2).

5.5 Pre understanding

According to Olsson and Sörensen (2007), pre understanding is understanding in terms of experience and concepts derived from the context. In describing the pre understanding, the basis of the interpretation is made known. The objectivity of the observations and the interpretation of the results should not be affected by the pre understanding. The pre understanding of the researcher affects which data is registered in the field and how the collected data is analysed (Pilhammar Andersson, 1996).
I am a Swedish nursing student in my last year of training. My experiences of hospital- and nursing care are based on Swedish circumstances.

6 ETHICAL CONSIDERATIONS

Information about this study was given verbally, both to the Nurses in Charge at the SICU and the surgical ward, and to the nurses who participated. According to Polit and Beck (2008), giving information and introducing the study to the people who will be part of it, is necessary to eliminate doubts about the study. Pilhammar Andersson (1996) states that one ethical dilemma for the observer in the field is the conflict between being both nursing staff and observer. Therefore data has solely been used from observation situations. All the persons included in the study have been treated anonymously and the data maintains confidentiality. The concept “confidential” means that the information is neither available for, nor can be recognised by unauthorized authors. Anonymity means that the data can not be identified (Olsson & Sörensen, 2007).

7 RESULTS

The themes and the categories are explained in the written text. The text which appears in italics and with quotation marks represents extracts from the field notes.

7.1 Preventing infections

7.1.1 Visions

The nurses expressed a wish for more resources to be able to improve the care of the patients with burns. Because of the risk for spreading infections they want one nurse in charge of the burned patients during every working shift. In order to reduce the risk of infection the nurses also wanted to have one special ward for burns. Because of a lack of adequate material, the nurses were critical of the current nursing care and treatment of the burns. The nurses also experienced a need for more knowledge about burned patients if they are to improve the care given. One favorable scenario would be special training for nurses in burn care and treatment in order to provide updated
information. Thereafter the specially trained nurses can share the knowledge with the others who are involved in the care of burned patients;

"...they (the nurses) want to have a nurse who is specially trained in burns, so that he or she can get the latest information about the treatment and care of burns and then share it with the rest of the nurses."

7.1.2 Resources

The nurses focus on the importance of preventing infection. Sterile material is accessible for dressing burns. When a patient tried to take sterile material from the tray the nurse protected the material from becoming unsterile, by preventing the patient from touching it.

"...the patient is not allowed to take sterile things with her own hands."

During one observation the nurse controlled the blood pressure and the saturation of all the patients, except for the one with burns. The burned patient needs his own equipment due to the risk of infection but, because of lack of equipment, it was not possible to make these controls of the burned patients. Preventing infections seemed to be a more important measure than controlling the vital parameters of the burned patients, except for the body temperature which was possible to control as this patient had his own thermometer.

"...the burned patient must have their own blood pressure and saturation machine because of the risk of infection..."

On the surgical ward the burned patients had their own room; they did not have to share a room with other patients. This reduced the risk of the burned patients getting infections. The room has only five beds, compared to other rooms at the ward, which room more than twenty patients.

"...the surgical ward has one room of its own for burned patients."
7.1.3 Obstacles

Due to a shortage of nurses it was not possible to have one nurse per working shift who was just caring for the burned patients. Lack of space and a great number of patients with burns meant that burned patients on the surgical ward sometimes had to be mixed with other patients. In the SICU the burned patients had to be placed with other injured patients, because there is only one intensive care unit for surgical patients with severe problems.

"...the burned patients are mixed with other injured patients."

7.2 Meeting the patient

7.2.1 Collaboration

The nurse often had many patients to take care of at the same time, but their nursing efforts were supported by persons nearby. Relatives often collaborated with the nurses; this was shown in eight of nine observations. Soaking and dressing of the burns was a procedure where the relatives often helped the nurse. Another observed scenario was when the patient himself prepared to remove the bandage with a bucket of water. The nurse explained that the relatives and the patient facilitated matters and helped to speed up the work for the nurses.

"The relative is next to the patient the whole time, helping the nurse in many ways, for example holding the compresses."

"...the fourth patient, without relatives, is removing the bandage by herself."

One situation was observed when relatives went to the pharmacy to collect medicine for the patient. Another situation arose with a sister of a patient spending the whole morning lying in the bed next to the patient, handling most of the caring issues without help from the nurse.

Sometimes the nurse, the patient and the relatives were working together helping each other. Education for the relatives was given if the patient was about to be discharged,
but still was in need of support, for example with bathing or taking care of the burn. If the patient did not have relatives who could help, the patient had to stay in the hospital until the burns were healed and the patient had no more need of nursing care or treatment.

“When the patients are going to be discharged we (the nurses) teach the relatives to take care of the soaking and dressing…”

The different professional groups, at the hospital, had distinct working areas and usually they did not work in teams. But, if the nurse thought there was a need of help from other professionals, such as physicians, physiotherapists and priests, she consulted them for help. For example, a nurse contacted a priest because she felt that the patient probably could be helped by talking to a priest and after that a priest came into the room and sat down next to the patient. In that situation the nurse found the priest to be a better resource for the patient. The nurse told me;

“...the patient is feeling depressed and does not want to eat anymore, I think the priest can help her.”

7.2.2 Calmness
All the nine nurses in the study radiated calmness; there was no stress and no hurry. Even if they had many patients to care for, they gave time for performing the nursing measures and worked in their own tempo. From the nurse’s own description of their stress level it became clear that the atmosphere around them was the true view of how they actually felt.

“The nurse acts calmly and is not stressed. I ask her if she is stressed and she says no.”

“...the nurses are doing everything in their own tempo, without stressing.”

The atmosphere around the patient was friendly, calm, open, happy, warm and easy. The atmosphere can be described by using the expressions above throughout all the
nine observations. On the ward the nurses talked Swahili and laughed together, which created a positive atmosphere on the ward.

"...the nurses are talking to each other and laughing, 
the atmosphere feels warm and open between the nurses."

7.2.3 Closeness
Out of concern for the patient’s integrity the nurse often used a screen or curtains around the patient. In all care moments the nurses used the screen. It happened that the screen was not big enough to hide the patient, but still the nurse tried to secure the patient’s integrity.

"When the nurse came to the patient the first thing  
she did was to pull a screen around the patient."

In the care situations with the patients the nurses used the Swahili word “pole” which, according to Awde (2000), means “I sympathize with you” or “My sympathies are with you”. The word was frequently used, as much as in eight out of nine observations. Sometimes the nurse and the patient talked to each other in Swahili. In one observed situation the patient was lying under the blanket, crying. The responsible nurse told me that the patient did not want to live anymore. With regard to medication against anxiety, the nurse said that instead of medication they talk to the patient.

"Both the nurses say pole to the patient..."

"The nurse lifts the blanket, under which the patient is lying and  
talks to her in Swahili...their faces are close to each other."

One situation was when the nurse refrained from using a special treatment after a conversation with the patient. The nurse listened to the patient’s own opinion about what could be the best treatment to use, but the nurse did not try to explain why the bandage chosen might have been good to use.
"...the patient does not want to have that kind of bandage."

The nurses protected the patient in different ways; by using a lamp above the patient’s body the nurse stopped the patient from feeling chilly. It was notable that the nurses tied the hands of the patient onto the edge of the bed. Questioning why the nurse was doing that to the patient, she explained;

"...that is to protect the patient from hurting himself."

7.2.4 Distance

It has been observed; when the nurse came into the room of the patients or to the individual patient, she did not say anything to the patient and did not give information about what was going to happen, for example that the soaking and dressing part was going to take place. Most of the time during the procedures, the nurse did not talk to the patients, and the patients did not talk to the nurse.

"The nurse and the patient do not talk to each other..."

During the night report, in the morning, the nurses from both the night shift and the coming day shift are going around at the ward, to every patient. The nurse from the night shift gives a short report about the patient’s current status. No one of the nurses asked directly the patients about how he/she feels. One nurse told me;

"...it is only the nurse who talks about the patient."

The nurses often had a blank facial expression during their interaction with the patient. It was not possible, from looking at their faces, to understand how they felt about the situation and how they were affected by a specific situation. This feeling about the nurses’ lack of facial expression has been the same throughout all the observations. The nurse and the patient did not seem to set up any contact at all.

"The nurse’s facial expression looks the same when she is spending time with the patients."
“... can not feel that there is a contact between the nurse and the patient.”

7.2.5 Difficulties

One of the problems in the nurses’ daily work was a lack of time, which resulted in a feeling of not having enough time to care for the patients in various ways. One example was that the nurse was dependent upon help from the relatives and the patient himself in the caring efforts, especially with the dressing and soaking of the burns.

“I ask why they (the nurse and the patient) are doing the soaking and dressing together and the nurse explains that doing it together goes faster.”

Due to the lack of time the patients were expected to remove the bandages before the soaking and dressing of the burns. All patients started with the removal themselves as the nurse could not help all the patients at the same time with the soaking and dressing. This meant that the patients had to wait for their turn sitting naked in their beds until the nurse was able to help each one at a time.

“... in the room the three patients have taken away their bandages, and are sitting naked in their beds.”

It happened that the nurse had to leave out the pain relief that was to be given before a procedure because there was no time to wait for the effect. Another situation was when the nurse giving pain relief and due to the lack of time, did not wait for the pharmacological effect before doing the soaking and dressing.

“...it takes too long waiting for the effect (of the pain relief).”

Lack of material also was one of the difficulties that the nurses experienced in their daily work and this meant problems in providing optimal care for the patient. Once a burned patient with low body temperature needed blankets and the nurse noted that:

“...the patient can only have one blanket... because of lack of supplies.”

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8 DISCUSSION

8.1 Method discussion

It seemed appropriate to carry out the study at KCMC because of the extensive and long collaboration with Red Cross University College. The aim of the study was to illuminate how nurses in Tanzania take care of patients with burns. An ethnographic approach using participating observations was chosen, the method gave the opportunity to observe the nurses in their own context and at their daily work. The nurses in charge were informed about the purpose of my visit to the ward. Because of the ethical aspects information had to be given about the study. But as knowledge about my study might have influenced their behavior, the research questions were not presented. I was welcomed to take part in the nurses’ daily work, and my presence at the ward was not questioned. A few times the nurses asked me to assist them in their daily work. I was dependent on being at the ward and observing the nurses and therefore I had to come to an agreement with them and I decided to assist them a few times. According to Pilhammar Andersson (1996), the researcher is not allowed to participate or act like a nurse at the time of observation. The occasions when I was acting as a nurse are not part of the field notes.

The field notes were not written down during the observations, which might have resulted in missed details. This was a choice made to help the nurses feel comfortable about the situation and for me to melt into the context. About one hour after the observations the field notes were written down and I did not talk to anybody about the observations in advance.

According to Pilhammar Andersson (1996), wearing working clothes can be a negative factor and should be avoided, but because of the hygienic aspects and my ambition to be part of the context I used working clothes.

Aspects of the ethical perspective are based on literature and experiences from Swedish hospital- and nursing circumstances. The study provided an opportunity to reflect on the emic perspective, that is coming closer to the nurses’ perspective by observing their daily work taking care of patients with burns at the hospital in
Tanzania. The pre understanding of the researcher affects what is to be observed or not (Pilhammar Andersson, 1996). In a transcultural study it is understandable that the researcher’s own cultural background and view of nursing care will affect the data collection and the analysis. By reflecting on and acknowledging the risk, the intention was to give as objective a view of the subject as possible.

8.2 Result discussion

The aim of the study was to illuminate how nurses in Tanzania cared for patients with burns. The aim was achieved and striking findings from the study were the low stress-level of the nurses and the distance between the nurse and the patient. In general the most notable discovery was the cultural differences that appeared and how nursing care differs between countries.

According to Leininger (1999) cultural care means providing care that is meaningful and adjusted to the patient’s beliefs and way of life. Culture consists of the total or holistic life patterns of human beings. The theory of cultural care diversity and universality focuses on diverse and common dimensions of human care world wide. It is based on the supposition that care is the essence that is the central and dominating part of nursing and transcultural nursing. The Sunrise Model shows possible factors, for example religion, education, language and environment, which might affect the care and well being of people (Leininger, 2002b). Tortumluoglu (2006) shows that people from different cultures may have different kinds of demands in terms of health. It is necessary take this into account when discussion the result of the study. However everyone, irrespective of cultural background, ought to be respected from their cultural values and the health care provider must consider this fact.

The nurses had visions about how to improve the care of the burned patients and their working efforts to change an unsatisfactory situation were impressive. According to Mathisen (2002), correct treatment from the beginning is important in order to achieve a successful result for patients with burns. Therefore it is vital that the nurses should want to gain deeper knowledge about how to take care of the burned patients. It is an advantage that the nurses focus on preventing infection, despite the lack of relevant methods. Knowledge about how to prevent infection can be seen as basic knowledge
for nurses. Therefore it has to be asked if the knowledge that the nurses in Tanzania had about the importance of preventing infection can be seen as a resource, or if it is just basic knowledge for any nurse. Still, it is a positive aspect that the nurses found this important.

Shortage of nurses and lack of space were obstacles in the nurses' daily work for preventing infections, but difficult for an individual nurse to have an impact on. Because of the current circumstances it therefore seems more important to determine how to handle the available resources and how to decrease the negative effects generated by the obstacles.

Initially the collaboration with the patients and their relatives in the nursing care seemed to be built on an ambition to involve the family and the patient in the care. However, it gradually became obvious that the nurses needed help due to lack of time and not primarily from a wish to collaborate. Caring for 50 patients, it was understandable that they included the relatives as a resource in order to reduce the workload and be able to complete the care of the patient in time. According to Sjöberg and Östrup (2002), nursing care of patients with burns must be based on knowledge and experience. Therefore assistance from the relatives and the patients meant that caring for the patients was not based on these important factors. Personal experience is that in Sweden, irrespective of lack of time, the collaboration with the relatives and the patient does not seem to be a vital part of the nursing care as such, but is fundamentally based on a desire to involve the family.

On the one hand, it was a positive experience that the nurses were careful about the patients' integrity, but on the other hand this ought to be a fundamental aspect of the care of all patients. A warm and positive atmosphere around the patient was created by the nurse through her cooperation with the other nurses. This feeling did not exist between the nurse and the patient. The friendly atmosphere among the nurses had vital positive effects on the patients, but could not replace the important relation between the nurse and the patient. My feeling is, that on a Swedish ward the climate often is characterized by high speed but also by a close contact between the nurse and the patient; this was quite the opposite in Tanzania. Burned patients have a unique
need for nursing care, but little information has been found to indicate a theory-based approach to the care of burn patient (Wilson & Gramling, 2009). This is important to remember when discussing the findings in the study.

Leininger (2002b) states that the need for nursing care is universal, but it must be taken into consideration that nursing is also culturally related and dependent upon varieties between countries. The word “pole” seemed to have a more extended and deeper meaning than the English correlate “I am sorry”; this single word seemed to include a deeper feeling from the nurse. However, the nurse and patient did not have much conversation and the impression was that closer contact never was established. The large number of patients that the nurses care for might affect the possibility to create a contact with the patient. Energy might be lacking, but on an individual basis it is still possible to create an occasional relation, lasting only for the moment.

According to Osborn (2003), pain management remains an important aspect of burn care for both wound healing and patient comfort. This raises questions about the absence of pain relief before the soaking and dressing. The nurses explained that it was due to lack of time they did not wait for the effect of the pain relief. It is very unsatisfactory that the patients are caused suffering from aspects of care beyond the nurses’ control. According to Hampton (2001), nursing staff from developed countries must understand that poor countries are lacking in necessary material. Nevertheless, in the situations observed pain relief was available, but the patient was still not sufficiently provided for. The lack of time also meant that the patients had to sit naked and wait until the nurse had time to take care of the burn. This seems very unethical and offensive to the patient, and it is therefore important to find another solution to the time problem. Nonetheless, considering cultural aspects is necessary in any discussion of ethics, due to there are differing opinions about that between various countries.

On one hand it is, by taking the ICN code of ethics for nurses (ICN, 2006) in mind, possible to reasoning about the quality of the general nursing care in Tanzania. On the other hand, as Helman (1994) states, the health care system in a country must be considered in combination with other aspects of the society, such as social and
religious matters. This must be taking into considering before measure the quality of the nursing care for patients with burns in Tanzania. Finally, there is a conviction that what is seen as good nursing care in Tanzania is different from the view of good nursing care in Sweden.

8.3 Conclusion

The nursing care of patients with burns in Tanzania involved collaboration with the relatives and a very calm and low stressed atmosphere. Integrity, protection and visions about how to reduce the risk for infections were the main concerns for the nurses. However, verbal communication, the important tool for the caring nurse did not exist significantly and the nurses experienced difficulties in the work as nurses. Overall, nursing care must be related to and seen in the cultural context.

8.4 Clinical applications

The culture has a great influence on the nursing care in every country. Nowadays, with the world and health care systems becoming more international, it is important to realize that people from other countries and cultures have different opinions and expectations regarding nursing care. An open mind with regard to nursing care and culture is central when caring for patients.

8.5 Suggestion for further research

A qualitative study consisting of interviews with burned patients in Tanzania in order to get a view of the burned patients’ own opinions and expectations regarding how nursing care should be given to burned patients.

9 ACKNOWLEDGEMENTS

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10 REFERENCES


Appendix 1 STRUCTURE FOR FIELD NOTES

Where took the observation place:

Date and time:

Backgrounds data:
  • Gender
  • Age
  • Possibly diseases
  • Reason for the burn
  • Type of burn

Which were the activities?

What happened?

My own reflections:
## Appendix 2 SCHEDULE RESULTS

<table>
<thead>
<tr>
<th>Theme Category</th>
<th>Preventing Infections</th>
<th>Meeting the Patient</th>
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<tbody>
<tr>
<td></td>
<td>Visions</td>
<td>Resources</td>
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<tr>
<td><strong>Code</strong></td>
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<tr>
<td>Want better treatment</td>
<td>Personal equipment</td>
<td>Shortage of nurses</td>
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<tr>
<td>Want one responsible Registered Nurse</td>
<td>Secure for sterile material</td>
<td>Lack of space</td>
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<tr>
<td>Want special education about burns</td>
<td>Keep burn patients together</td>
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<tr>
<td>Want knowledge</td>
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<td>Want special ward</td>
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Appendix 3 INTRODUCTORY LETTER

Red Cross University College
- education and research in the healthcare sector

To whom it may concern

Stockholm April 2009

My name is Klara Ekvall and I’m a nurse student at Red Cross University College (RCUC) in Stockholm, Sweden. This autumn, when I start my third and last year at RCUC, I will have the opportunity being a part of the collaboration between RCUC and Kilimanjaro Christian Medical Centre (KCMC). I’m very grateful that I have got the possibility to collect data for my bachelor’s thesis at KCMC.

My research project is, by doing observations, study how nurses at KCMC take care of patients with burns. I’m hoping to get Your permission for collecting the data. I have planned to do approximately eight observations of the nurses’ and of course the observations will be done in view of considering for anonymous, for both the nurses and the patients.

It’s an honour getting the opportunity to visit KCMC and I’m looking forward to a collaboration and to meet You.

Best regards,
Klara Ekvall

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