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Nursing care of patients with postoperative pain

- An observation study at Kilimanjaro Christian Medical Centre, Tanzania

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ABSTRACT

Some cultures regard pain as a natural part of life compared with the Western culture which believes that pain is something unnatural and that has to be eliminated. Transcultural nursing is a way to learn about and provide culturally fitting and meaningful care to people with different cultures. Tanzania suffers from a lack of qualified health workers due to an increased burden of disease and this affects the quality and supply of effective health services. It has been seen that it is common for patients to get inadequate pain treatment and this results in many different complications. The aim of the study was to describe the nursing care of patients with postoperative pain at a rural hospital in Tanzania. The study was implemented at the Kilimanjaro Christian Medical Centre in Moshi. A qualitative participating observation study with an ethnographic approach was used to collect the data. The data was analyzed by content analysis and resulted in three themes: *1. The role of the nurse, 2. Pain management, and 3. Meeting the patient.* The conclusion was that the nursing care around patients with postoperative pain showed an extended collaboration between the nurses and other health care professionals as well as with the patients' parents. The study further showed that the atmosphere around the patients was positive and calm and that the nurses assessed pain by measuring vital signs and facial expressions.

Key words: Nursing care, postoperative pain, transcultural nursing, ethnographic approach, Tanzania.

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1 INTRODUCTION

Previous studies have shown that developing countries suffer from lack of analgesia and that pain treatment has a low priority in these countries. A recent study, in a sub-saharian country, has shown that a high percent of patients in Nigeria suffers from inadequate pain relief after surgery (Size, Soyannwo & Justins, 2007).

In the Western culture, nowadays, people seem to believe that suffering from pain is something unnatural and it should not exist. Therefore, Westerners, put a lot of value in the use of analgesia. The more people succeed in controlling the pain the more they find it unacceptable (Hawthorn & Redmond, 1999). According to Hægerstam (2008) disease, pain and death are still regarded as a natural part of everyday life in most cultures and are therefore also accepted.

We both did our somatic placement at a surgical ward at Karolinska University Hospital, Sweden, and experienced that patients with postoperative pain in general were given a large amount of analgesia. We noticed that some patients with non-Western origin had a different attitude regarding pain treatment.

As the Red Cross University College in Stockholm has a collaboration with the Kilimanjaro Christian Medical College in Tanzania we both thought that it would be interesting to do a study in Moshi. When the opportunity was given to us to write our bachelors thesis at the Kilimanjaro Christian Medical Centre [KCMC] we started to focus our attention on pain management. We read the article about pain in developing countries by Size et al. (2007) and discussed this with exchange students from KCMC. After this we decided to study the nursing care of patients with postoperative pain at KCMC.

2 BACKGROUND

2.1 Tanzania

The United Republic of Tanzania¹ is one of the world's poorest countries (Regeringskansliet 2010). Tanzania has approximately 41 million inhabitants and is located on the east coast of Africa (Central Intelligence Agency [CIA], 2010). The largest religions are Christianity and Islam, and Tanzania has more than 130 ethnic groups. Fitzpatrick (2007) writes that English and Swahili are the official languages. Forty-four percent of the population is under 15 years old and 77 percent lives in the rural areas according to The World Health Organization [WHO] (2009a), about 58 percent of the population live on less than 1 US dollar per day.

Eighty percent of the work force in Tanzania works with agriculture, e.g. coffee, sisal, tea and cotton, which provides 85 percent of the country's exports according to CIA (2010). Regeringskansliet (2007) estimates that less than 10 percent of the work force in Tanzania gets salary for their work. In the informal sector the monthly income might be as low as 7000 shillings [4,6 US dollar] and as a governmental employee the minimum salary per month is 84 000 shilling [55,6 US dollar]. Those salaries do often not even cover the most necessary expenses. Even if the maximum hours per week are 45 hours it is common that people work more than that. The highest rate of unemployed is among persons under 35 years in urban areas (Regeringskansliet, 2007).

The life expectancy for women is 53.6 years and for men 51.4 years (WHO, 2009b). The total fertility rate is 4.9 children per woman (WHO, 2006). Eight percent of these children are registered according to WHO (2009b). The most common causes of death in Tanzania are HIV/AIDS, lower respiratory infections and malaria (WHO, 2006).

There is a lack of qualified health workers at all levels due to the increasing burden of disease (WHO, 2009b). Therefore, Tanzania is facing a severe human resource crisis that is affecting both the quality and the supply for effective health services. The budget for medicine has increased with 150 percent according to WHO (2009b) but it is still insufficient and the lack of indispensable medicine continues. Another problem is that medicine is expensive and the private facilities and NGO's [Non-Governmental Organizations] force the price market up with about 60 percent (WHO, 2009b). According to WHO (2009b) the Commission for

¹The United Republic of Tanzania will be written as Tanzania through the rest of the text.

Macroeconomics and Health for low-income countries in sub-Saharan Africa recommends that 34-40 US dollar per capita per year should be spent on health, in Tanzania only 14 US dollars per capita is spent.

2.1.1 Kilimanjaro Christian Medical Centre

The Kilimanjaro Christian Medical Centre [KCMC] was established in 1971 by the Good Samaritan Foundation (Kilimanjaro Christian Medical Centre [KCMC], 2010a). Since 1997 the Kilimanjaro Christian Medical Collage has been a part of KCMC and is now a centre of medical training and teaching (KCMC, 2010b). The hospital has 450 beds but has an average daily bed occupancy of 473. The surplus patients are accommodated on mattresses on the floor. Sometimes patients do not even have a mattress and lie on blankets (Boon, 2000). Although the hospital was built to accommodate a population of 3 million, the hospital today caters for about 10 million and covers the five surrounding regions of Kilimanjaro, Arusha, Dar-es-Salaam, Tanga and Singida. The hospital is situated in Moshi town which has a population of 200 000. The hospital employs about 80 doctors and 500 nurses. Patients who are treated at the hospital have to contribute to their own care (7 percent of the costs). The rest of the money is obtained from different charities (Boon, 2000).

2.2 Pain

The definition of pain according to Boström (2003) is an unpleasant emotional and sensory experience that is associated with potential and actual tissue damage. Williams (2005) writes that the body responds with pain as a warning signal to prevent further injury and Nendick (2000) writes that the body produces its own analgesia that is 200 times more potent than morphine. Since the sensation of pain only can be felt by the person who suffers from it, she/he has the authority to define the existence and nature of his pain. The British Pain Society (2010) mean that the only way of knowing if a person is in pain is to ask them or watch them. It is therefore not possible to measure pain according to Hægerstam, (2008) but it is possible to measure expressions of suffering. The most fundamental goal is therefore to reduce suffering and restore the patients' physical and mental health (Werner & Strang, 2003).

Pain is first of all a subjective experience that is unique to every patient (Hawthorn & Redmond, 1999). Every person experience pain in their own unique way and it is important to

remember that the experience of pain will differ considerably between patients. This may be one of the most important aspects of pain management and must be considered by everyone who is working with patients in pain. People have different ways and different abilities to cope with pain and they will respond differently to the pain treatment given. The most sensitive and reliable indicator for pain presence and intensity are self-reports from the patients according to Stillwell (2006). It is therefore a risk that the patient does not get adequate pain treatment if she/he is unable to communicate. Reasons why patients are unable to communicate may be because of endotracheal intubation, administration of sedatives, neuromuscular blocking agents or physiologic instability (Stillwell, 2006).

Pain can be uttered in both physiological and behavioral expressions. The physiological signs of pain can be seen as high blood pressure, high pulse, cold sweating, paleness, nausea, dilatation of the pupils and muscle tensions (Hawthorn & Redmond, 1999). Patients who may have difficulties expressing themselves verbally (due to handicap, reduced cognitive ability or language differences) can be observed crying, moaning, whining, sobbing or screaming when in pain. Facial expressions such as frowned forehead, closed eyes and closed jaws can also be a sign of pain. Hawthorn and Redmond (1999) further write that patients in pain use different body movements to try to express or cope with pain, such as limping or rubbing the aching body part. The latest are direct signs of pain while immobilization and restlessness are more subtle signs. They also write about the difficulties for some males in admitting and expressing their pain in front of a female nurse if his culture values the “macho ideal” highly (Hawthorn & Redmond, 1999). Kozier, Erb, Berman and Snyder (2004) address the problem of the patients that do not express their pain verbally unless asked about it, and that the pain assessment therefore has to be initiated by the nurse.

Hawthorn and Redmond (1999) writes that it is unfortunate but common that pain is not treated adequately in general, most of all in clinical situations as with postoperative patients. The inadequate pain treatment is a result of misunderstandings and lack of knowledge about pain measurement and pain treatment among both physicians and nurses. Pain measurement is a complicated process that is made even more difficult with the presence of different values, principles and attitudes towards pain in general. Lacking communication between the staff and the patients, as well as an unwillingness or inability to express pain, can also complicate the process. Hawthorn and Redmond write that some patients hide their pain because they do not want to bother the staff. It is of great importance that nurses who work in the frontline of

pain management understand these problems and can help the patients to express their pain in an adequate way (Hawthorn & Redmond, 1999).

2.2.1 Nursing care of patients with pain

According to Hawthorn and Redmond (1999) nurses play a significant role in pain management. Pain is a multidimensional phenomenon and it is the nurses' task to identify the factors that may influence the patients' way of experience and express pain. Williams (2005) writes that nurses have an ethical obligation to relieve pain and decrease related physiologic risks but Hughes (2004) states that both nurses and physicians underestimate the patients' pain. According to a study by Lekule (2003) at KCMC, 59 percent of the patients suffered from severe pain postoperatively despite routine analgesics. Pain management has to be prioritized and visible in the daily care of patients with pain (Williams, 2005). Hawthorn and Redmond write that it is of great importance that the patients get adequate pain treatment. This will alleviate the treatment of other symptoms. It is possible to suffer from different kinds of pain; every type of pain needs specific measures and treatments. With patients who have a high risk of getting pain, for example patients that will do an invasive procedure, adequate measurements and treatments are especially important (Hawthorn & Redmond, 1999). Evaluation about acute pain should be done frequently to be able to notice if the pain treatment is adequate (Hawthorn & Redmond, 1999).

According to Hawthorn and Redmond (1999) the patients' own description of pain is the best measure in pain treatment. But it can also be misleading and it only represents one aspect. If the nurses are able to investigate several aspects it will be possible to identify different factors that can influence the patients' way to express and experience pain. Hawthorn and Redmond further write that several different strategies are possible to use when measuring pain. The most important is good communication with the patients but the dialogue sometimes gets complicated when the patients are not able to talk because of the pain. Because of this it may be difficult for the nurses to evaluate the patients' pain and misinterpretations are easily made. When patients are not able to communicate it is of great importance that the nurses observe the patients' behaviors (Hawthorn & Redmond, 1999), e.g. verbalization of pain, agitation, crying or "fight back" tears, changes in vital signs (increased blood pressure, heart rhythm), attempting to change positions and facial expressions (Little, 1996). How the patients express pain should be documented according to Little. Pain may be the reason why patients have

problem sleeping, problem with nutrition, concentration ability, mobility and activity level according to Hawthorn and Redmond.

According to Williams (2005) the patients' experience of pain is compounded by fear, anxiety and difficulties to communicate. The nurses' role in pain treatment is to evaluate patients' pain and possible complications according to Hawthorn and Redmond (1999). It is common that patients are concerned about the future and their pain experience may therefore become even worse. To relieve that unnecessary pain; information, conversations and patient education may help.

There are about 200 instruments that measure pain and those instruments are very important for the nursing care to maintain consistent (Hawthorn & Redmond, 1999). According to Kahl and Cleland (2005) one of these instruments is Visual Analogue Scale [VAS] and the patients are asked to estimate their level of pain on a vertical or horizontal line. The line is marked from no pain to extreme pain. Hawthorne and Redmond (1999) write that instruments that can be used for patients that have difficulties with verbal communication are observation curves. These observation curves measure the patients' behavior when feeling pain, for example consumption of medicine, mobility level and non-verbal pain expressions. Instruments like this measure different behaviors e.g. breathing, sound, face expression and body language (Hawthorn & Redmond, 1999). According to Kozier et al. (2004) studies have shown that health care professionals tend to either underrate or overrate the patients' pain intensity. Therefore the use of pain intensity scales can be an easy and reliable method. Such scales could provide consistency for nurses in their communication with both the patients and other health care professionals (Kozier et al., 2004).

Alexander, Fawcett and Runciman (2007) state that basic nursing assessment of patients with pain should include observation of the patients' behaviors, asking the patients about their pain and using pain assessment tools to get a satisfactory picture of the pain the patients are suffering from. Kozier et al. (2004) write that the goal of the pain assessment is to get an objective understanding of a subjective experience. It should be remembered that a pain assessment tool is only one facet of an adequate pain assessment and should therefore always be used together with interviews and observations of the patients (Alexander et al., 2007). Kozier et al. (2004) state that because of pain being a highly subjective experience nurses

need to assess all aspects that can affect the pain experience, this means physiological, psychological, behavioral, emotional and socio-cultural factors.

Except from treating pain in a medical way there are alternative methods such as massage, vibration, physical therapy, acupuncture etc. according to Hausman (2006). However the two main ways of managing postoperative pain is pharmacologically and to use comfort measures. These two approaches work best together but it is often that the comfort measure gets minimized in clinical practice. (Mackintosh, 2007)

The essential factors of good nursing care are to identify the patients' problems, identify correct measures, write suitable nursing diagnosis and to evaluate the result of the diagnosis. When caring for people with pain one always have to remember that dialogue and interaction with the patients are crucial if the pain treatment is to be effective (Hawthorn & Redmond, 1999, p. 12).

2.2.2 Pain management in developing countries

The absence of pain is part of the basic human rights to health (WHO, 2011). Studies have shown that developing countries suffer from lack of analgesia. According to the study of Size, Soyannwo and Justins (2007) in Nigeria, a high percentage of postoperative patients suffered from inadequate pain relief; one third of the patients complained of moderate to unbearable pain up to one day after surgery. Hawthorn and Redmond (1999) suggest that inadequate pain relief may be lack of knowledge, due to myths and misconceptions regarding pain and opioid treatment and problems concerning the health care system in general. One common factor to inadequate pain relief according to Hawthorn and Redmond is the absence of an acceptable pain analysis and the absence of documentation (Hawthorn & Redmond, 1999).

According to Size et al. (2007) pain relief in developing countries have a low priority compared to other aspects of health care, therefore a large number of patients do not get effective pain treatment. It has shown that opioid analgesia is unavailable postoperatively in many places. In Uganda for example only 45 percent of the anesthetic officers had access to opioids and 21 percent never had those drugs available at all (Size et al., 2007).

2.2.3 Postoperative pain

Ministry of Health and Social Welfare (2008) defines postoperative care as the time from completion of surgery until recovery and follow up clinics. Pain after surgery, as well as after

acute injury or disease, counts as acute pain (Hausman, 2006) and the organization behind treatment of acute pain is mainly intended to postoperative pain (Werner & Strang, 2003). Acute pain is temporary and will therefore be less intense after some time according to Hawthorn and Redmond (1999). It is common that patients with postoperative pain get inadequate treatment even though acute pain is the easiest pain to diagnose and treat according to Werner and Strang (2003). Inadequate pain relief in postoperative care may result in immobility, prolonged recovery and many patients also develop increased cardiovascular, respiratory and gastro-intestinal complications as well as chronic pain conditions (Size et al., 2007). Rawal (1999) also addresses the problem of psychological effects (increased anxiety), endocrine system complications and kidney dysfunction. Postoperative pain usually originates from the surgical incision, the chest tube, mechanical ventilation, endotracheal intubation or suction although the most distressing and painful procedure for adult postoperative patients is turning and mobilization according to Stillwell (2006). However Little (1996) state that by turning, positioning and distracting the patients the nurses may reduce the pain temporarily.

2.3 Nursing care and pain management

According to the International Council of Nurses [ICN] (2006), the nurses' primary responsibility is towards people who need nursing care. The nurses shall provide nursing care with respect for the human rights and concern about people's values, customs and beliefs. According to Ministry of Health and Social Welfare (2008) in Tanzania the nurses' main focus is to use objective information, sound reasoning with measurable and observable result. The process of nursing is used to identify, diagnose and treat patients and includes assessment, nursing diagnose, planning, implementation and evaluation. Nurses' responsibility is to assess the patients' state of health by taking health history and examine the patients' behavior and physical status (Ministry of Health and Social Welfare, 2008). The nursing process is used as a tool to encourage the nurses and allows them to differentiate their work from other health care professionals, e.g. physicians. According to Ministry of Health and Social Welfare the aim of nursing is to logically and methodically assist patients to cope with problems which are a threat to their normal physical and mental functioning.

The need of care is universal and it is in the nature of care to respect the human rights, the rights of culture, the right to life, to dignity and to be treated with respect (ICN, 2006). Nurses have four fundamental responsibilities; promote health, prevent illness, restore health and relieve suffering. According to the guidelines for Registered Nurses in Sweden by Socialstyrelsen [SoS] (2005) nursing care has to have a holistic and critical approach. The nurses' responsibilities are also to show care and respect for the patients' autonomy and integrity. With knowledge and care nurses shall inform and take responsibility for the patients' safety and welfare during tests and treatments (SoS, 2005). Ministry of Health and Social Welfare (2008) state that when nurses think critically the care will have a more comprehensive and individualized approach.

2.3.1 Transcultural nursing

Transcultural nursing is a way of learning about and providing culturally fitting and meaningful care to people with different cultures (Leininger, 2002). The ambition is to educate nurses in how to give safe, beneficial and competent care to patients with diverse values, beliefs and life ways. According to Leininger this is one of the greatest challenges today - to learn how to care for people of different cultures with compassion and understanding.

The patients' needs to be respected are the base of culture-specific care (Leininger, 2002). Therefore the care has to correspond to the patients' cultural ideals, attitudes and way of life to be meaningful and therapeutic. Culturally based care leads to understanding and helping patients with diverse cultural backgrounds. The transcultural nurses must learn to identify and understand cultural expressions and patterns such as symbols, values, beliefs, rituals, expressions and more (Leininger, 2002). In that way nurses will learn about the patients' cultural way of life and modify their traditional nursing practices to provide a care that more will fit the patients' cultural needs. The nurses' thoughts and actions must be based on both humanistic and scientific knowledge, principles, theories, concepts and research about the specific culture (Leininger, 2002). Both culture and care are holistic phenomena with diverse and complex constructions and therefore focus should be on identifying and learning about diversities and commonalities both between and within cultures with the perspective of care, health, wellness and illness (Leininger, 2002).

Leininger (2002) means that nurses need to be aware of their own cultural backgrounds as well and the fact that it can influence the patients' care.

The theory of Culture Care and Universality is developed by Madeleine Leininger to improve the quality of health care to cultures. The focus is on human care and cultural relationships (Leininger, 2002). The purpose of the theory is to discover, document, interpret, explain and predict some of the multiple factors that influence care from inside a culture (emic) and from outside a culture (etic), to be able to give cultural based care. The goal of the theory is to give similar care to all cultures. According to Leininger the theory of Cultural Care and Universality is to be able to be holistic and care for people in different cultures. The author states that history, culture, social structure, worldview, environment etc. might influence on the care phenomenon. Leininger continues to explain the importance of understanding the relation between gender, age, class, race to social structure factors such as religion, politics and economics. By using a qualitative method the researchers' purpose is to discover patterns, symbols and attributes of informants in their natural and familiar environment. It is important that the researchers do not generalize but instead document, understand, and substantiate the meanings, attributes, patterns and symbols (Leininger, 2002).

A person's cultural heritage is presumed to have an impact on her/his thoughts about pain (Hawthorn & Redmond, 1999). Western People, for example, put a lot of value in the use of analgesia nowadays but formerly, when there was no analgesia, pain was experienced as something natural and it was therefore also accepted as a part of life (Hawthorn & Redmond, 1999). According to Hægerstam, (2008) sickness, pain and death is still regarded as a natural part of life in most cultures. In some cultures today people seek a meaning for their pain and in some religions, such as Christianity, pain is seen as God's will or a test for peoples' loyalty. In other religions people find a positive meaning with pain. It is therefore important to consider the different cultural expectations about pain when caring for patients (Hawthorn & Redmond, 1999). Hawthorn and Redmond mean that there are significant differences between how people express pain around the world and that pain is something not only physical but also an emotional, social, cultural and sometimes spiritual phenomenon. They mean that if pain is to be treated successfully all of these components have to be observed as well (1999).

3 THE PROBLEM AREA

The lack of analgesia in developing countries, such as Tanzania, is a known problem. It is necessary that patients with pain get treated both physically and mentally. Both the pain treatment and the nursing care of patients with pain should be individualised. To be able to prevent discomfort and complications of inadequate pain relief, it is of importance to highlight and further explore what nurses can do when patients suffer from postoperative pain.

4 AIM OF THE STUDY

The aim of the study is to describe the nursing care of patients with postoperative pain at a rural hospital in Tanzania.

4.1 The questions asked

- How do Tanzanian nurses care for patients with postoperative pain?
- How do Tanzanian nurses measure pain?

5 MATERIAL AND METHOD

5.1 Design

A qualitative method with an ethnographical approach was used and the data was collected through participating observations. The reason to use an ethnographic approach is, according to Willman, Stoltz and Bahtsevani (2006), to reach understanding. By doing a study about health care, the ethnographic approach gives access to beliefs and practices of health in a specific culture and therefore, the ethnographic approach provides an understanding for the behaviors who affects health and illness in different cultures (Polit & Beck, 2004). Pilhammar Andersson (1996) states that people's feelings and actions are directly or indirectly influenced by the surroundings and vice versa. By studying the phenomenon from different perspectives (emic and etic), a deep and varied understanding of the phenomenon will occur (Pilhammar Andersson, 1996).

5.1.1 Participating observation

According to Polit and Beck (2004) participating observation is a method where collection of data is made in a group where the researchers participate as members. The aim is to understand the behaviors and experiences of people in their usual surroundings (Polit & Beck, 2004). During the collection of data we participated as nursing students and assisted the nurses when needed, for example when turning the patient. It is claimed that researchers should be passive during the overall procedures in clinical practice and participate only in minor procedures such as making the bed or helping the patients to the toilet (Pilhammar Andersson, 1996). Observations were done throughout the shifts. According to Pilhammar Andersson (1996) the main idea in the participating observation is being there and doing continuous observations of the occurrences taking place.

5.2 Selection

The participants in this study were nurses working at the SICU [Surgical Intensive Care Unit] at KCMC. The inclusion criteria for the participating nurses were their ability to speak and understand English so that we were able to get a deeper understanding for the situation. The inclusion criteria for the patients was their status as postoperative patients at the SICU.

5.2.1 The nurses

On every day shift, three nurses were scheduled to work at the ward. The two day shifts were six hours each and the night shift was twelve hours. One nurse cared for five beds and the other two nurses cared for one bed each, because two beds were for patients who needed ventilators. There were all together eight nurses who were asked and who gave their consent to participate in the study, all of them were female.

5.2.2 The patients

Six female and nine male patients were part of the study. Four of the males were children under the age of six. The patients were all postoperative patients and between 6 months and 71 years old. All of the patients were treated at the SICU after different invasive procedures and were prescribed various analgesics.

5.3 Data collection

The study took place at the SICU in November 2010 and consisted of 59 observations during ten days. The observations lasted between five to 15 minutes depending on how long the procedures lasted. We did the observations separate from each other, but sometime they came to concern the same situation. Every observation became one field note. Conversations with the nurses were added to the field notes to clarify incomprehensive situations. The observations were done either from nurses' desk or standing beside the patients' beds during the procedure. In order not to miss any details, the field notes were written down in note structure (Appendix 1) at the nurses' desk immediately after the observations or the conversations. It was possible to do that because all patients were in the same room and the desk was in the middle of the room. From this location it was possible to observe what was happening at the ward and in the same time write down the field notes. Field notes can, according to Pilhammar Andersson (1996), be made simultaneous with the observation or be chosen to be done retrospectively. To some participants it can be disturbing if writing the notes in front of them and therefore it is suitable to record them in privacy afterwards. Field notes do not follow any specific pattern but some information should be recovered according to Pilhammar Andersson, such as where the observations has taken place, when it took place, what kind of activity was observed, what was said and done (by whom, to whom and in which way) and the atmosphere around the procedure.

According to Polit and Beck (2004) it is not possible to memorize the observed data and Hammersley (2007) also states that is not enough to rely on memory when the recorded data later will be analyzed. Therefore the data must be recorded as soon as possible after the observations. It is common to use field notes in ethnographical studies to record observations and interviews (Hammersley, 2007) and they work as narrative descriptions of what happened in the field (Polit and Beck, 2004).

The field notes were written in Swedish, instead of English, to minimize the risk of losing important information. The conversations with the nurses were written down in English and not translated into Swedish, they were included in the field notes. All data except the conversations were analyzed in Swedish and then translated to English when writing the result.

5.3.1 Access to the field

Before starting the study a meeting with the dean of the Kilimanjaro Christian Medical College took place. She gave permission for the study to take place at the Surgical Intensive Care Unit [SICU] at KCMC. The dean also contacted the SICU to inform them about the study.

Pilhammar Andersson (1996) claims that it is important to have a gate keeper before starting a study in an unfamiliar field. She/he will help the researchers to access the field by introducing the researchers to the participants of the study. We made contact with our gate keeper several weeks before starting the study. She was the student coordinator at the KCMC and in charge of our previous clinical practice at the hospital.

5.3.2 The field

The SICU at the KCMC is divided in two different wards, A and B. Ward A is for postoperative patients with a low risk of infections and B for patients with a high risk of infection. The study took place at the SICU A, where there are seven beds for critically ill surgical patients. All beds had removable curtains to be able to create privacy for the patients. Two of the beds were for patients that needed ventilators and those beds had one responsible nurse each. The ward did not allow any visitors, other than in some special cases as when the patients were children, because of the risk of infections.

5.3.3. The role of the researcher

According to Pilhammar Andersson (1996) there are two main focuses in ethnographic participating observations: “emic” and “etic” – being there as an observer and at the same time sharing the participants view upon existence and reality.

The “emic” approach in this study was achieved by objective observations. To reach the “etic” approach some of the observations were completed with conversations with the nurses. By us choosing to be participating observers the nurses had to be aware of our role and not rely on us assisting them in their work. Therefore the nurses were informed about the purpose of the study before the start.

5.4 Data analysis

The transcribed data from the observations and the conversations, the field notes, were analyzed by using a qualitative content analysis method. A content analysis is a way of analyzing text, communication and observation according to Elo and Kyngäs (2007).

The field notes were reduced into meaning units. A meaning unit is words or sentences that relate to each other through their content and context (Graneheim & Lundman, 2004). By identifying patterns in the meaning units they were grouped into sub-categories and by grouping the sub-categories that were similar main categories were recognized. The main categories were then summarized in themes (Table 1).

Table 1. Example of the process of the data analysis

Field note	Meaning unit	Subcategory	Category	Theme
The nurse says that they don't use VAS when measuring pain but she thinks that it would work on this ward if it was implemented	They do not use VAS on the ward	Do not use pain assessment scales	Measurements	Pain management
	The nurse thinks that VAS would work on the ward	Positive towards pain assessment scales	Measurements	Pain management

6 ETHICAL CONSIDERATIONS

In studies where human beings are used as participants one must ensure that the rights of these people are protected (Polit & Beck, 2004). As researchers it is of importance to consider the ethical requirements and continually ask your selves if the study is safe for and protects the participants (Polit & Beck, 2004). The main rule in ethnographic studies is to avoid hurting or giving out sensitive data about the participants. This means that data should be made as anonymous as possible and that information that has been given in confidence will not be published. The participants should receive information about the study, understand the information, remember it and they should feel free to participate (Pilhammar Andersson, 1996).

Information about the study was given to both the dean of the Faculty of Nursing, the Kilimanjaro Christian Medical College, the Nurse in Charge at the SICU and to the nurses participating in the study. The nurses were informed that they were free to participate and that they could interrupt their participation at any time. We were aware of the possibility that the nurses could feel unable to refuse participation because of the dean's permission to perform the study at the ward and that they somehow would feel forced to take part in the study.

The patients were not informed about our study because the focus was on the nurses and how they performed the nursing care, although we were introduced as exchange students from Sweden.

The field notes did not contain any personal information about the participants that could expose their identity and the data was kept confidential throughout the study.

7 RESULTS

The collected field notes were reduced into meaning units and were the base for the sub-categories. The sub-categories were grouped into ten categories that in their turn were summarized to three themes as follows; 1. *The role of the nurse (Caring, Administration, Collaboration)*; 2. *Pain management (Environment, Measurements, Prevention, Obstacles)*; 3. *Meeting the patient (Relatives, Concern, Supporting the patient)* (Appendix 2).

The themes and categories are presented in the text below. The quotations in italics are extracts from the field notes.

7.1 The role of the nurse

7.1.1 Caring

The nurses at the SICU had many different responsibilities. For example they did a lot of the medical checkups and examinations of the patients. They seemed very concerned about preventing infections and taking care of the patients' hygiene. Some of the nurses' tasks were to dress and clean the surgical wounds. Before every procedure the nurses prepared a tray with all the supplies that they needed. If the patients were tied to the bed or could not move because of other reasons the nurses tried to prevent pressure wounds by positioning the patient in a suitable way or by shifting the ties so that they would not chafe.

"...tightening the patient (to the bed) again but this time she taped the middle finger to the ring finger and put gauze bandage through so that it wouldn't chafe against the skin."

7.1.2 Administration

Every day the nurses used a report book to document all the patients' diagnoses, statuses and pain treatments; e.g. analgesics. During the nurses shift they wrote nursing diagnoses and did follow ups of the diagnoses.

"The nurses write in the report book that the patient is on anti-pain medication. I haven't seen one patient that's not on anti-pain medication."

7.1.3 Collaboration

At the ward the nurses worked together with each other in many different procedures. It was common that two nurses worked together when dressing a wound or moving a patient. Collaboration between different health care professionals and students was also common and that helped the staff to better assess the patient. The different health care professionals reported the patients to each other several times a day.

“Physiotherapists, physicians, assisting nurses and nurses work parallel on the ward and they help each other.”

7.2 Pain management

7.2.1 Environment

The atmosphere at the SICU was always very calm and positive. The nurses did not express any stress and they worked in their own tempo. If there was a critical situation the nurses continued to act in a calm and relaxed way. The staff often laughed and joked with both each other and the patients. This contributed to the positive atmosphere surrounding the patients and although many of the patients were severely ill the SICU came across as an encouraging and optimistic place.

“The atmosphere on the ward is still calm despite that the machine is still beeping...”

“The staff laughed a lot, both with each other and with the patients.”

During more intimate procedures, e.g. wound care, dressing the patients etc., the nurses were very concerned in creating a private sphere for the patients by closing the curtains around the patients' beds. At most of the observations the nurses had the curtains closed during the whole procedure.

“The curtains were closed during the whole procedure.”

7.2.2 Measurements

The nurses' estimated the patients' experience of pain by interpreting the patients' facial expressions and by measuring vital signs. To know if a patient was in pain the nurses asked the patients if they felt pain. When asked about pain assessment scales some of the nurses

stated that they never had seen either a VAS-scale or any other assessment tools. At the observations the nurses were never seen using assessment scales to measure pain. Talking about the pain assessment scales some of the nurses thought that it would be difficult to implement but most of them were positive to the thought of using assessment tools.

”We depend a lot on vital perimeters; if the heart rate goes up you can suspect that the patient is in pain.”

“- Do you have scales for measuring pain?”

- Here? No we don't have.

- You think it would work?

- Yes, but it would be hard to implement.”

7.2.3 Prevention

All patients that were observed had been through surgery. After asking the nurses how they know if the patients were in pain they answered that everyone who ever been through surgery experiences pain. To prevent pain the nurses measured the patients' vital signs and observed the patients frequently. In some cases the nurses helped each other changing the patients' body position to make it more comfortable and to prevent pressure wounds. According to the nurses they read about pain and pain management during their nursing education. They were taught about alternative pain treatment but they remembered most about how to relieve pain with analgesia. They had also read about the causes of pain and one of the nurses said that she remembered the importance of conversing with patients who are in pain and the importance of talking in a supportive way to these patients.

“- All patients who have been through surgery are in pain.”

7.2.4 Obstacles

Even if the nurses' goal was to measure all the patients' vital signs it was not possible due to lack of equipment. The nurses expressed a wish for more resources and supplies, such as more nursing staff and more monitoring devices. Because of the shortage of nursing staff the ward

sometimes was left unattended. When time was lacking (due to the shortage of staff) the nurses would check the patients' vital signs without communicating with them.

“The nurse says that there is a shortage of staff at the ward and that there isn't enough equipment. She would like to have more monitoring devices.”

It was only at one of the observed procedures that the curtains were not closed. During this observation the ward was full and four patients used ventilators. All of the ventilators were beeping and the environment was very disturbing.

“Disturbance at the ward. The ward is full with patients; four BIPAP machines are beeping plus one pulse oximeter. It is just two nurses here but a lot of other health care professionals”.

“All the machines on the ward are beeping and no one is turning the sound of.”

One of the nurses was given the question if they usually ask the patients if they suffer from pain. According to her it was not possible to ask the patients because then they would say that they were in pain and therefore the nurses would have to administrate a lot of analgesia. She stated that the nurses relied on the patients telling them when they suffered from pain and she said that the patients are not able to know how much pain she/he has.

”- They (the patients) will tell us if they are in pain.”

Some of the patients at the ward were intubated and because of the lack of monitoring equipment these patients had to be awake. The patients were therefore tied to the bed in their arms so that they could not pull the tubes out. The patients who were tied to the beds did sometimes get blisters on their wrists due to not changing the position of the tie. Sometimes those patients did not get any mobilization for many hours.

”... all the patients are laying in the same position as when we came this morning, those who are tied (to their beds) still have the tie around their wrists.”

7.3 Meeting the patient

7.3.1 Relatives

Relatives were not allowed at the ward because of the risk of infection. Only in special situations, like with children, one parent was allowed to stay with the patient during the whole stay. When a parent was at the patient's bedside she/he was often engaged in the care around the patient. For example the parents helped the nurse when giving medication and they took care of the basic nursing care of the child. The nurse instructed the parents how to perform the procedures.

"The nurse... instructs the mother in Swahili how to give the suppository. The mother performs the procedure."

During the patients' stay at the SICU the nurses supported the parents both mentally and physically during the procedures, and the parents supported the patients.

"The boy's mother looks worried; the nurse talks to her for a while in Swahili."

7.3.2 Concern

The nurses were always very concerned about caring for the patients integrity by closing the curtains and assisting the patient when putting on clothes. When patients were transferred to another ward the nurse kept the patient warm by putting a blanket on them.

"The nurse closes the curtains. The patient is lying in bed without any clothes. The nurse gets a blouse and dresses the patient."

When handling the patients the nurses always were very careful and used the Swahili word "pole" frequently to show their concern and worries for the patient. The word "pole" is used as a word for feeling sorry for another and for comfort (Lodhi & Otterbrandt, 1987).

"The patient's wound is hurting and he twists and turns during the procedure. The word "pole" is being frequently used."

7.3.3 Supporting the patient

The nurses did almost always communicate with the patients and informed the patients during the procedures. The nurses supported the patients by talking to them. It was a constant collaboration between the nurses and the patients. The nurses helped the patients with their

personal hygiene if needed and when the patients needed to stand up or move around in bed the nurses assisted the patients.

”...helping the patient with the catheter bag and the drip, helping the patient from the bed by supporting the patient on her way to the wheelchair.”

8 DISCUSSIONS

8.1 Method discussion

The aim of the study was to describe the nursing care of patients with postoperative pain at a rural hospital in Tanzania. The study was chosen to be done at KCMC because of the long term collaboration between the Kilimanjaro Christian Medical College and the Red Cross University College. To be able to observe the nursing care and the nurses in their own context an ethnographic approach with participating observations was used. According to Polit and Beck (2004) it is possible to get a deeper and richer understanding of behaviors and social situations by using participating observations.

Hammersley (2007) accentuates that the observers always want to observe everything and that they have a fear of missing vital incidents while being away from the field. By being two observers at the same field we reduced the risk of missing vital incidents. The fact that all patients stayed in the same room helped us to detect observations immediately.

Polit and Beck (2004) state that it will influence what the observers will see by collecting unstructured or loosely structured data when doing a qualitative study. We were somehow consistent in what we observed because we used note structure when transcribing the observations. This could mean that we may have excluded data that might have been significant for the study but it also helped us in focusing on the aim. Hammersley (2007) states that the field notes always are selective and that the recorded data will depend on the observers' opinion of what is relevant and as well on background expectations. Graneheim and Lundman (2004) mean that the content analysis method depends on the subjective interpretation of the researchers and therefore the result can be understood in various ways. The data collected in qualitative studies have numerous meanings and therefore there is always some degree of interpretation when analyzing the qualitative text. By using this method the result in this study is completely based upon what we thought was relevant to observe and transcribe related to the aim of the study. The result is therefore a description of how the nursing care around postoperative patients was performed during these specific days.

White and Marsh (2006) state that the overall process of the content analysis can propose new questions that was not predictable at the start of the study. Because we transferred the field notes to an electronic document after every shift we detected questions that we wanted to be answered to give clarity to the observations. These questions were raised in conversations with the nurses at the following shift and were then added to the field notes.

The observations were recorded in Swedish, both because it was possible to write them down faster and because they became more varied than in English. The content analysis was also done in Swedish and the result was later translated to English. We both experienced that it was easier to write in Swedish and that we captured more data than if we would have written in English. To maintain the nurses' own words we transcribed the conversations in English and this made it possible to quote them in the result. Quoting the nurses in the result gave the text a more substantial meaning.

The official languages of Tanzania are Swahili and English. On the SICU the nurses spoke Swahili to the patients and to each other, but they spoke English to us and to other health care professionals. However, all charts were written in English. The language barrier could be a bias; in situations where the participants were talking in Swahili the non-verbal communication between them and the patients had to be relied on. By not being able to understand Swahili we felt distanced from the interaction between the nurses and the patients, but this may have helped us to keep an "etic" perspective. English could also be a bias because it is not our mother tongue and because of the different accents that made it hard to understand each other sometimes.

Polit and Beck (2004) and Pilhammar Andersson (1996) write that it is easy to lose objectivity when using participating observations because the relations you establish with the participants may end in you becoming "one of them". Being students from a Western country this may have helped us being objective as observers and enhancing the "etic" perspective because neither the nurses nor patients confused us with being a part of the context. However this can also have resulted in barring us from the "emic" perspective when never feeling as a natural part of the context at the ward.

8.2 Result discussion

The aim of the study was to describe the nursing care of patients with postoperative pain at a rural hospital in Tanzania. The study resulted in three main themes; *1. The role of the nurse*, *2. Pain management* and *3. Meeting the patient*. From the sub-categories ten categories were extracted that comprised the result of the field notes.

The nurses at the SICU at the KCMC as well as the nurses in Sweden have different responsibilities; along with the nursing care of the patients there were also administrative work and collaboration with other health care professionals. The nursing care around these postoperative patients was often advanced and had a medical approach. Due to the lack of equipment and the shortage of staff the care in some ways was even more advanced than expected. This because some patients were so severely ill that they should have been monitored by machines instead of manually observed by the nurses at the ward. This put great responsibility on the nurses who constantly had to assess the patients' conditions and act on their subjective opinions.

One of the main concerns for the nurses was to prevent infections and therefore it was of great importance to look after the patients' hygiene. This was sometimes a problem due to the lack of supplies. Sometimes there were no clean sheets to put in the patients' beds or clean clothes to dress the patients in. It was hard for us to see the nurses struggling to keep the patients clean without enough material available. Sometimes patients had to lay on dirty sheets and sometimes there was not enough bandaging to cover the surgical wounds completely.

Compared with previous experiences from intensive care units in Sweden and because of preconceptions, we were surprised how peaceful and positive the atmosphere at the ward was. The nurses and the other health care professionals at the ward worked in their own tempo and even in a critical situation the nurses acted calmly and focused. It was sometimes difficult to see beyond our own personal opinions and pre-understandings about nursing care and how nurses should act in critical situations which led to the opinion that in some situations the nurses maybe should have acted faster than they did. However it could have been a conscious choice by the nurses to act that way to not stress the patients. The communication between the staff and the patients was very easygoing even though some of the patients were severely ill. It seemed like the staff focused on the person behind the disease more than the disease itself.

Although this was a ward where severely ill patients were being treated the easygoing atmosphere helped patients, staff and us to maintain a positive spirit.

The ward was crowded, seven beds in a small room, and therefore we were happy to see that the nurses prioritized creating private space for the patients when needed. According to Hawthorn and Redmond (1999) it is important that the environment surrounding the patients is suitable; the patients must be able to rest. If the environment is not secluded this could increase the patients' anxiety and pain experience and lack of privacy may also lead to less pain expressions from the patients and interfere on the communication (Hawthorn & Redmond, 1999). Although the atmosphere at the ward was calm and relaxed most of the time there was some situations where there were a lot of other health care professionals and students at the ward. This made the small ward come across as crowded and stressed. Sometimes the vital signs machines were beeping at four beds at a time without anyone turning of the sound or controlling why they were beeping. Then the atmosphere was everything but calm and relaxed but neither the nurses nor the patients seemed to mind.

When it came to measuring pain the nurses often relied on the patients' facial expressions and vital signs. The nurses did not always ask the patients if they were in pain and they did not use any assessment scales to estimate the patients' pain experiences. Somehow they did not seem to trust that the patients were capable of assessing their own pain and if being asked they would assess their pain higher than necessary and that the nurses therefore would give them too much analgesia. Some of the nurses were positive towards using assessment scales, however some thought it would be difficult to implement. According to Kahl and Cleland (2005) assessment scales, e.g. VAS could be difficult to use when treating a patient with visual or cognitive deficits. This may be one of the reasons why it would be difficult to implement at the SICU, because the patients may be intubated or unconscious. We think that another reason could be that where pain assessment scales usually are used analgesics are more common as well because the assessments often are followed by analgesic interventions.

We often got the feeling that the nurses were careful with giving analgesics because they had limited resources of drugs. Hawthorn and Redmond (1999) and Little (1996) write that it is important to observe the patients' behaviors since pain can be uttered in facial expressions such as frowned forehead and closed jaws and that physiological signs such as high blood pressure and high pulse can be a sign of pain as well (Little, 1996). The nurses relied on that

the behavioral and psychological signs would be enough to assess the patients' pain. The nurses that participated in the study had education about pain and pain management from nursing school. According to them they were taught about alternative pain treatment, e.g. massage and acupuncture, but they remembered most about relieving pain with analgesics. If they were taught about alternative pain treatment they could have used this knowledge and put it into practice on the patients that expressed pain and then they maybe not have felt as pressured to use analgesics.

The shortage of staff resulted in that the nurses could not observe the patients regularly. It also resulted in that the ward was left unattended a few times, although it was just for a few minutes. To leave an intensive care unit unattended seems unethical to us. Some of the patients were severely ill and seemed to be in need of constant monitoring. When there was a lot to do at the ward the nurses tended to save time by not communicating with the patients when performing the procedures. However we do believe that shortage of staff and lack of time is a common problem not only in Tanzania but also in Sweden and that this is an issue that the nurses have little impact on.

The intubated patients were not sedated because of lack of equipment. If all patients that were intubated had been sedated the two monitoring devices at the ward would not have been enough. Because of this, the intubated patients were tied to their beds, either in one hand or in both. These patients were often anxious and were sometimes pulling their vein catheters and tubes. Tying the patients resulted in blisters and edemas on their wrists. It also resulted in immobilization because the patient had to lie in the same position for a long period of time. According to Alexander et al. (2007) immobilization after surgery increases the risk of chest infections, deep vein thrombosis and pressure ulcers. We think that tying the patients to their beds is wrong. However we discussed if sedating a restless patient would be more correct but found both ways unethical. Whether the patients are tied to their beds or sedated without their consent it is a violation against the patients' autonomy. By looking at the problem from the KCMC nurses' point of view we found that sedating the patients and not being able to monitor them is not the solution either. This is a very difficult issue that needs to be discussed further.

Relatives were not allowed at the ward other than in special cases and when the patient was a child. The parents who were at the ward during the observations were seen doing the basic

nursing care of the patient. The parents were used as a resource in the care of the patient and that unburdened the nurses. The nurses instructed and supported the parents during the procedures. Callery (1997) means that to provide good quality care for children, it is necessary to involve their parents. By involving the parents in the care it can help them to develop skills and confidence to care for the child at home and that may reduce the length of stay at the hospital. By having the parents at the ward the patient/child was able to receive comfort and support throughout the whole day (Callery, 1997). The parents were a resource both for the nurses and for the patients; they helped the nurses with the procedures and at the same time the patients felt safe and calm with their parents being there with them. We found it kind of sad that the adult patients were not allowed to meet their relatives. Once a day the relatives were let into a room that was connected to the ward. This room had windows so that the relatives could see the patients but not meet nor talk to them. Although it may seem harsh we understood that this was a necessary measure to be able to reduce the risk of severe wound infections and that it therefore would benefit the patients' recovery in the long term.

The nurses were always careful when handling the patients and expressed their concerns by saying "pole" several times during the procedures or when just passing a patient's bed. When it came to performing the procedures the nurses closed the curtains to secure the patients' private area and as respect for the patients integrity. We were happy to see that they placed great importance on creating privacy for the patients and that they always were very concerned about respecting the patients' integrity. The word "pole" was very useful, and expressing concern about the patient was always very appreciated by the patients.

According to A. Savage, nurse and nurse tutor at the Kilimanjaro Christian Medical College, (personal communication, 11 November 2010) the view upon pain in Tanzania is not the same as it is in, for example, England. Her experience is that people in Tanzania look upon pain as a natural part of life. During the observations the patients rarely or never complained about pain. If this was because the patients were adequately pain relieved or if it was a cultural phenomenon is to be unknown.

8.3 Conclusion

Nursing care has to be seen and related to the cultural context. Our result showed that the nurses rely on the patients' vital signs and their facial expressions when assessing pain. Even

though many of the patients were critically ill the atmosphere at the ward was very positive and calm. The nursing care around the patients was structured and different health care professionals worked together in many procedures and situations. For children the parents had a significant role in the basic nursing care. The nurses expressed a wish to have more monitoring devices which would make their work easier and especially help them with patients in critical conditions.

8.4 Clinical impact

To improve the knowledge of different cultures actual impact on health care and the attitudes towards health in general there should be a bigger focus on culture during the nursing education. It is of great importance for health care professionals today to be able to understand and reflect over the differences in opinions and expectations on health care between different cultures. Culture has a great influence on how people think about health, sickness, pain and death and therefore people who works with health care must be open minded about people's opinion on what is right or wrong.

8.5 Suggestion for further research

To compare the difference in pain assessment at the Kilimanjaro Christian Medical Centre, by using a pain assessment scale of patient experience versus the current way of estimating the patient's pain.

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Appendix 1 STRUCTURE FOR FIELD NOTES

Where the observation took place:

Date and time:

Background data:

- Gender
- Age
- Reason for surgery
- Possible disease

Which activities were observed?

What happened?

- What was said and by whom?
- What was done and by whom?
- In which way was it done and to whom?
- How was the atmosphere around the procedure?

Own reflections:

Appendix 2 SCHEDULE RESULT

THEME	THE ROLE OF THE NURSE		
CATEGORY	Caring	Administration	Collaboration
SUB-CATEGORY	Caring about the patient's hygiene Preventing infection Cleaning wounds Wound dressing Preparing nursing procedure Medical check up Advanced nursing care Preventive nursing care to prevent pressure wounds Examination of the patient	Careful report about pain treatment Check up Writing nursing diagnoses	Collaboration between nurses Collaboration between nurses and student Collaboration between different health care professionals Reporting between nurses and other health care professionals

THEME	PAIN MANAGEMENT			
CATEGORY	Environment	Measurements	Prevention	Obstacles
SUB-CATEGORY	Privacy Providing privacy Positive atmosphere Calm atmosphere	Do not use any pain assessment scales Asking the patient about pain The nurse believe that it would be difficult to implement pain assessment scales Depends on vital signs when assessing pain The nurse interprets pain by facial expressions The nurse do not know of any pain assessment scales	Observation Vital sign control Mobilization The patient assume to have pain after surgery Is assumed to have pain The nurses have education about pain The nurses have education about analgesia The nurse have education about the importance of conversation with patients with pain The nurses have education about the causes of pain	Lack of privacy Lack of equipment Shortage of staff Unattended ward Disturbing environment Wish for more resources Doubts the patient's own pain assessment Do not ask the patient about pain Believes that the patient wants too much pain relief The nurse do not talk to the patient The patient is tied to the bed No mobilization

		<p>The nurse is hesitant to VAS scale</p> <p>The nurse have never seen a VAS- scale</p> <p>Positive towards pain assessment scales</p>		<p>The patient gets tied to the bed</p>
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THEME	MEETING THE PATIENT		
CATEGORY	Relatives	Concern	Supporting the patient
SUB-CATEGORY	<p>Relative present</p> <p>The relative gives nursing care</p> <p>The relative gives care</p> <p>Communication between the nurse and the relative</p> <p>Education of relative</p> <p>The nurse supports the relative</p> <p>The relative supports the patient</p>	<p>Concerned for the patient</p> <p>Care about the patient's integrity</p> <p>Keeping the patient warm</p> <p>"Pole"</p> <p>Handling the patient carefully</p>	<p>Helping the patient with personal hygiene</p> <p>Helping the patient</p> <p>Supporting the patient</p> <p>Informing the patient</p> <p>Collaboration between the nurse and the patient</p> <p>Communication between the nurse and the patient</p>