“If we sympathise with them, they’ll relax”

Fear/respect and medical care in a Kenyan hospital

Hannah Brown

In a resource-poor Kenyan hospital, relationships produced within medical encounters echoed particular kinds of caring relationships within families. Often, medical care correlated not to love or closeness but rather luoro, a Luo term meaning both fear and respect. Luoro is also the appropriate orientation for children towards parents, teachers and other adults. Within luoro relationships medical staff and patients were both understood as responsible agents in the production of care. Through luoro, nurses and clinicians imagined patients would behave ‘properly’ and thus be able to receive care. This was particularly true in the case of the labour room, where closeness, understood as ‘being relaxed’, was seen as a potential inhibitor in the successful provision and receipt of care. However, in other contexts within the hospital a more egalitarian ‘relaxed’ care was a feature of medical care. In theorising care, a common analytical device has been to divide care, for example comparing ‘emotional’ and ‘technical’ aspects of care or ‘caring-for’ with ‘caring-about’. My argument in this paper is that an alternate analytic is one of care as practice. An ethnographic focus on practices of care in this Kenyan hospital suggests that it may be helpful to think about care in health care as consisting of divergent sets of caring practices which cut across boundaries such as technical/emotional.

[care, health care, hospital, nurses, labour, fear, respect, Western Kenya, Luo]

This paper is an attempt to begin to make sense of some of the kinds of care that nurses gave to patients in a Kenyan hospital which I call Kagot District Hospital, located in a region of Kenya where the majority of the population self-identify as ethnically Luo.[1] In thinking about and describing the way nurses cared for patients, I engage with a wider discussion around whether, and if so why, nurses treat patients cruelly in African hospitals. This is a matter which has been taken up in many recent studies of nursing and healthcare more generally across a variety of African sites, with a range of authors commenting upon an absence or poor quality of care in hospitals and the abusive or stigmatising treatment of nurses towards patients (e.g. Andersen 2004; Center for Reproductive Rights & FIDA 2007; Drews 1995; Gilson

et al. 1994; Jewkes et al. 1998; Marks 1997: 28-9; Martin 2009; Mwangi et al. 2008; Wood & Jewkes 2006).

Here, I aim to add a layer of complexity to these discussions about abusive or poor treatment. Rather than concentrating on structural deficiencies of the Kenyan health system or an 'attitude problem' of medical staff, as much of this work has done, I question what can be learnt by thinking about interactions between nurses and patients as relationships of care which can be followed into other domains of social life. I do not mean to belittle patients' complaints about the quality of service they received at the hospital, nor to excuse malpractice and cruelty, but rather to underline convergences between caring relationships within and outside of this Kenyan hospital, which elucidate more complex understandings of what constitutes care within this setting.

I use ethnographic material to develop a comparison between the relationships of care found within the labour ward of Kagot District Hospital with one very specific kind of HIV care employed on the general wards, the offering of a diagnostic HIV test to people who people who showed symptoms suggestive of HIV/AIDS. In the case of the labour room, I argue that the hierarchical nature of relationships of care found in the labour room can be partly understood in reference to the Luo concept of *luoro*. The term *luoro* means both fear and respect and is a domain of social practice which also shapes many other kinds of relationships, particularly at home, for example those between children and their parents. I contrast the hierarchical care of the labour room with the more egalitarian caring practices employed towards patients who are thought to require diagnostic HIV tests, and suggest that these types of caring relationships also have parallels in kinds of relationships found outside of the hospital.

The ethnographic evidence here undermines theorisations of care which rely upon an unambiguous conceptual division between emotional and technical care or between medical and familial care. I argue that care is a useful analytic tool for anthropology specifically because as sets of practices, care often crosses such boundaries. Thinking about care as sets of mobile social practices provides a way of highlighting similarities between caring practices within different domains of social life and enriches our understanding of what might constitute care in health care.

Care in the labour room

In the labour room of Kagot District Hospital, a woman called Pamela lies naked upon a delivery bed. Lying on her back with her knees bent and legs doubled-up, she tightly grips her ankles as she is overcome by the need to push with a contraction. She is frightened, but compliant. Exhausted, she rolls onto her side and drifts into a sleep-like state as the contraction passes. Standing at some distance from her, Sister Carolyn explains to me that they are 'testing the scar' – the scar that is, of the caesarean section that ended her previous labour. But the doctor is not nearby, and it is not obvious that there is a potential back–up plan to be followed here, should the 'test' fail. So we wait. The contractions seem to be getting weaker and further apart. Carolyn is reluctant to

do an internal examination as she has only one pair of long sterile gloves which she will need later in the delivery. We keep waiting.

I think back to a day earlier in the week, where a visiting nurse from Canada held the hand of a woman in third-stage labour and exclaimed encouragingly, "Bear down Millicent!" at each contraction, showing her concern by touching the woman, holding her hand and encouraging her efforts. The Kenyan nurses in the room had joked, "Today you are lucky, you have an *mzungu* (Swahili: white person) with you!" I could not help thinking they were right, contrasting the care given by the Canadian nurse with the at times near-cruelty of the Kenyan nurses. Not that Carolyn had slapped the woman for being in the "wrong position", or "not trying", as other nurses had done as I watched women in labour. But she certainly did not use touch as a gesture of care and was distant from the woman, largely letting her get on with it, waiting on the other side of the room.

I also thought back also to the stories Gaudentia, a Luo friend who I once lived with, had told me about giving birth. It had emerged that our neighbour, feeling the pangs of the final stages of labour, had taken herself off into the vegetable garden where she had given birth alone cutting the umbilical cord with a razor she had carried with her, an act that we had both found shocking. It was Gaudentia who first explained to me that Luo women should ideally give birth without screaming, "If you cry out people will say, 'Why are you screaming, you are not the first to feel this pain!'"

Carolyn and I are leaning on the cupboard under the window, looking out over the hospital compound, still waiting to see what Pamela's contractions might produce as she lies alone on the other side of the room. Companions are forbidden in the labour room. My mind passes over these many associations via my own terrifying experience of delivering my son by emergency Caesarean Section in a hospital in Manchester three years previously, then back to the anxious liminality of a slow and difficult delivery. I turn to Carolyn and off-hand make a joke to pass the time, "In my place we're like everyone has felt those pains so we really feel bad for the woman in labour, but here you're like everyone has felt those pains so why are you crying?!" Carolyn corrects me, "It's true we don't sympathise, although we do inside, because if we sympathise with them they'll relax (i.e. they won't push hard enough), we have to let them think it's just normal." And after the longest time, an exhausted Pamela pushes and we see the first sign of new life, a few curls of black hair pushing their way out of her gaping vagina. Carolyn puts on the gloves.

After the baby had been welcomed into the world, wrapped up in a piece of cloth known as *leso*, Pamela, close to tears, thanked us again and again, speaking of her relief and gratitude. Later, as we drank tea together in the nurses' room, Carolyn and I both voiced the doubt that we had kept silent in the delivery room, that neither of us thought it likely that that Pamela would be able to successfully deliver her baby. Carolyn also thanked me, "It was a good thing you did there, staying with that woman. You could have left because it was taking long, but it was good that you stayed."

Harsh and cruel

In Kenya, there is a wide-spread popular discourse that nurses are harsh and frequently treat patients cruelly.[2] Critical opinions of nursing behaviour can be regularly found in the popular press. For example Dr. Kimani, the director of medical services in Kenya was recently quoted as saying, "The bad attitudes of some health workers are chasing mothers from delivering in hospitals" (The Standard 9th October 2009). In another article a nurse at a mission hospital is chastised for her cruel outburst to a woman who presented at the hospital with a suspected miscarriage:

> If you want to abort your baby then do it on your own time. Don't come here. When you were getting pregnant you didn't call us. You young ladies love sex and when you get caught, you rush here. We do not procure abortions (The Standard 17th February 2010).

There is no doubt that the Kenyan labour room is often a site of abuse and malpractice. A recent (2007) report developed by the Kenyan Federation of Women Lawyers in collaboration with the American organisation Center for Reproductive Rights has compiled a collection of women's birth stories in government facilities which is a veritable litany of mal-practice and abuse. The report describes instances of verbal, physical and sexual abuse of women in labour; women being ignored by nurses and left to deliver alone. Women talk of being forced to deliver upon dirty beds, being cut with unsterilized equipment and institutional cover-ups of maternal and neo-natal deaths.

Similarly poor opinions of the labour facilities could be heard in gossip around Kagot. Cynthia Opiyo, an outpatient at Kagot District Hospital, was in no doubt about what she understood as the widespread failings of the hospital. She recounted, "There was a woman who gave birth in Kagot District Hospital who was left with the placenta undelivered and the child on the floor all night. Anywhere else the police would be called!" However, such opinions often contrasted with women's descriptions of their individual experiences of giving birth in the hospital, which tended either to describe encounters of the nurses in broadly appreciative terms, or to focus on the practical interventions of nurses. When I asked Emily Obonyo if she had been well treated by the nurses who delivered her eighth child during her first hospital delivery, she replied, "Yes, they really helped me, they gave me two bottles of water [intravenous fluids]." Judith Akinyi also outlined the nurses' help in similarly practical terms when I asked how they had supported her in hospital: "My friend knew someone who was a sister at the hospital, and she helped us arrange the bill."[3]

However, let me go back to the ethnographic vignette above, which I maintain is not a description of a relationship of abuse, but one of care. I do not wish to make a judgement about the *quality* of care that Carolyn gives Pamela during her labour – this I think is a discussion for another time and probably for a different kind of observer. Nonetheless, it is probably true to say that Carolyn's management of Pamela's delivery could have been improved, even within the constraints of this resource-poor hospital where women were required to bring with them items such as gloves, cotton wool

and cord clamps owing to shortages in the hospital. However, I maintain that it is helpful to think about the interaction between Carolyn and Pamela as a relation of care. To do so may be contentious given the potential for and reality of abuse in such kinds of relationships, but one thing that it does allow is to draw attention to divergent registers of meaning around care which are helpful for contextualising the meaning of care and abuse in this setting. If we dismiss Carolyn's behaviour as uncaring I argue that we risk misunderstanding important ways in which care is practised in this hospital.

Theorising care

In theorisations of care within and outside of health care, there has been a tendency to develop analytical positions which distinguish between aspects of care which are either technical or emotional (e.g. Kleinman & Van der Geest 2009) or to oppose care to a domain of objective rationality in order to reflect upon the overwhelming location of care within the province of the emotional/female/familial. In these analytical divisions and oppositions the external division (care – rationality) and internal division (technical – emotional) are the same conceptual division in that they draw upon similar understandings of the relationship between emotion and care.

Within this ontology, nursing is understood to epitomise care, and care nursing (Leininger 1980, 1984), with all its feminine associations, except when nurses are unnecessarily drawn away from care to manage technical issues or paperwork (e.g. Penn-Kekana et al. 2004). Care is also often understood to be tightly bound up with the emotional closeness and love associated with the familial realm and often with particular kinds of relationship such as the one between mother and child (Noddings 1984: 128-131; Ruddick 1989). This is a viewpoint within which technology and care are understood as incompatible and doctoring is curative rather than caring (cf. Mol 2008; Pols: this volume). It is an ontology which looks like this:

Emotional Care	Technical Care (Cure)
Nurse	Doctor
External to the body	Internal to the body
Female	Male
Familial	Institutional
Emotional	Rational
Subjective	Objective

This is of course a crude simplification, and there are some important exceptions in theorisations of care. For example, Tronto (1993) has interrogated the production of these divisions and questioned how it is that women have become associated with care and a related realm of emotion and nurture. Others have sought to understand multiple meanings of dependency via its shifting meanings (Fraser & Gordon 1994) and its practices (Kittay 1999). Mol (2008) has used ethnography to break down such dichotomies by undoing the opposition between care and technology and broaden-

ing the concept of doctoring. Elsewhere, anthropologists of nursing in the UK have considered the way in which 'closeness' and 'care' developed as an aspect of nursing (Armstrong 1983; Savage 1995), and shown, through work with hospital support staff that nurses do not have the monopoly over therapeutic care in hospitals (Hart 1991).

This latter work is influential in how I have come to think about care, not least because it has encouraged me to question the assumptions of closeness, emotionality and intimacy often understood as central to care. However, while my argument derives much from this important work, here I want to use these insights to make a slightly different argument for care. For example, both Tronto and Mol theorise care by developing other kinds of theoretical boundaries, whether it is between an ethic of care and a justice morality, as in the case of Tronto and other feminist philosophers (e.g. Gilligan 1993; Kittay 1999), or between a logic of care and one of choice, as in Mol's case. My argument here is that it might also be profitable to stop trying to pin care down by thinking about boundaries around care or within care and instead to recognise that what is so useful about care is precisely its slippery and enigmatic character. Here, I position myself against those who have argued that because care is so very difficult to define we should do away with it as a theoretical concept. I disagree with the critical review of feminist theorisations of care which prompts Thomas to the conclusion that; "there is no such thing as 'care' in theoretical terms. It is a descriptive concept like 'housework' or 'manufacturing work' which for sociological purposes has to be placed in theoretical context" (1993: 666). Instead, I argue that precisely what is useful about care analytically is that it is difficult to pin down and define.

My argument is that one way of attending to 'mess' (Law 2004) in social life is to recognise the benefits of slightly 'messy' theoretical tools, which draw upon an understanding of theory which is closer to its etymological roots in the Greek term *theoria*, meaning contemplation, than an understanding of theory as a frame or model with which one can explain social life (cf. Latour 2005). If theory is understood as contemplation it amounts to a much more active, tentative and open undertaking than if theory is thought of as a "series of ideas and general principles which seek to explain some aspect of the world" (Chambers English Dictionary 2009). Via this contemplative theoretical mode, what I have ended up with is a purposefully minimal definition of care, which, because it is not grounded in particular real-life descriptions, does not draw upon assumptions about what care is or who does it, and is not based within or modelled on particular social relationships, like the mother-child bond, or the conjugal partnership. So it does not assume that care happens only between particular kinds of people, or indeed only between people, or only in particular places.

My definition draws heavily upon Mayeroff's (1971) essay *On Caring* in which he is also wary not to assume where and how caring might happen. From this rather wonderful philosophical essay I draw two key points; firstly, that caring is other-directed in its concern for the growth of the other. Although one can also care for oneself, Mayeroff suggests that caring for oneself and caring for the other are similar and comparable activities (Ibid.: 59-60). Secondly, Mayeroff suggests that through caring, we are 'in-place' in the world. We are in-place, he argues, because practices of caring mark out our relationships with others as we attempt to support them. He suggests that

being in-place is not a fixed position, but a dynamic state which must be continually reaffirmed and renewed as we respond to the needs of others and ourselves (Ibid.: 68-72). So practices of care are other-directed (in their concern with the development of the other) and are relationally locating. This is, I argue, a definition which is suitably vague, complex, slippery and messy to be a useful theoretical tool. It is also a definition which centres on care as practice; it is an active definition, almost an appeal for ethnography. Beginning from this focus on care as practice, care becomes useful as an analytic tool because caring practices are central to so many aspects of human life and because practices of care cut across boundaries such as familial/medical/ institutional and emotional/rational. Through its capacity for crossing boundaries, care provides a way both of illuminating such boundaries and drawing attention to similarities of practice across such boundaries. This model of care means that, as a set of practices, medical care can be thought of as extending far beyond the hospital or clinic, just as familial care can extend into medical spaces (Brown nd).

Drawing upon this analysis, I argue that what is going on between Pamela and Carolyn *is* care. It is other-directed and a process through which Carolyn finds her place in the world through her engagement with and support of another. Moreover, this care is both emotional (although not close or friendly), and technical (although not necessarily 'good' or 'best practice'). In saving the sterile gloves until the point when they are most needed and drawing on prior knowledge, training and experience of delivering babies, Carolyn judges when and how to intervene and support Pamela's labour process. This is a process of technical care, but it is also an emotional one, as it respects the cost of the gloves to Pamela and her family, who have purchased them prior to her admission to the labour ward and almost certainly cannot afford another pair. It also balances the risk to Pamela (of not doing a vaginal examination) against the risk of HIV infection that Carolyn faces in delivering her baby, a risk that she faces daily in her work in this hospital. Here then, emotional and technical aspects of care are not separate but intertwined – and more fundamentally, in stating the importance of not showing sympathy, Carolyn has announced that it is in fact through the development of a particular kind of emotional relationship that good technical outcomes can be achieved.

I now go on to argue that as a set of practices, the kind of caring relationship I describe between Carolyn and Pamela not only blurs boundaries between technical and emotional care but also between medical and familial care.[4] In the next section I suggest that it is by examining how such practices of care are replicated outside of the hospital that we can make sense of them; situating such hierarchical caring practices within a broader historical and cultural context.

Hierarchy and care: *Luoro* relationships in hospital and at home

If Carolyn's declaration, "if we (openly) sympathise with them, they'll relax," is a declaration of care, what kind of care is it? What can we learn about understandings of medical care in this setting when we interrogate this declaration? There is no doubt

that across Africa the nursing profession developed within a colonial hegemony which deliberately set nurses apart from those whom they served in an effort to change African subjectivities. For example, Marks argues for South Africa, that the role of nurses was "to moralise and save the sick, not simply nurse them" (1994: 208) and Vaughan (1991) claims that both secular and mission medicine in colonial East and Central Africa were based upon social pathological models of 'sickness' and aimed to influence subjectivities as much as cure illness. Hierarchical relationships between nurses and patients in contemporary Kenya owe much to this colonial inheritance, as well as to understandings of nurse identity and the role of nurses in the British models of nursing which inspired Kenyan training curricula (Rafferty 1996). These curricula drew upon a class-based hierarchy which was modelled after domestic service and upon a gendered division of labour which aligned nursing with motherhood and the care of the sick with the care of the nation (Davin 1978; Rafferty 1996). As Shula Marks has argued for South Africa, such hierarchies meshed only too well with patriarchal and racial hierarchies of colonial society (Marks 1997: 30).

As others have noted across a range of African settings, hierarchies between nurses and patients are often overlain with other kinds of hierarchies, most notably class differences between the nurses and those whom they serve (Andersen 2004; Booth 2004: 119-20; Marks 1994: 208). Nursing, along with teaching, is probably the quintessentially middle class profession in Kenya, symbolising education, wealth and upward mobility. Nurses are well off in comparison to the majority of those they serve in hospitals. These class differences are manifest in everything from the clothes nurses wear and the way they style their hair to the languages that they choose to speak. Because nursing requires post-secondary education, class differences are embodied in the profession itself. On the wards of Kagot District Hospital even those nurses who ethnically identified as Luo, like the overwhelming majority of the patients, frequently spoke about the patients as though they were cultural outsiders from their life world (cf. Booth: Ibid.).

The existence of hierarchy and authority within relations between nurses and their patients is clearly not confined to Western Kenya. However, the comparison I want to make in this paper *is* a more local one, and one which I suggest is useful because of the way it draws attention to divergent associations around care in circulation in this setting. Specifically, I suggest that as a social practice, the kind of relationship seen between Carolyn and Pamela is replicated most strikingly in relationships found between adjacent generations within the home, and other institutional settings such as the school.

As in some other African – and European – languages, the terms for 'fear' and 'respect' are combined in *Dholuo,* the Luo language, under a single term, *luoro*, making the two concepts very difficult to disentangle in the framework of the local cosmology (see also Simpson 2005: 527-3; Van der Geest 1997). *Luoro* is the basis for the relationships between children and their parents, especially fathers, who spend more time out of the home than mothers and who are often physically as well as emotionally distant from their children. Ocholla-Ayayo has described respect for elders as "the driving force" of the traditional education of Luo children (1976: 61).

During fieldwork in Kagot district, I observed that the everyday lives of Luo children and their parents are often quite separate. Frequently, as soon as a child begins to walk it will be cared for by older siblings (*jopidi* sing. *japidi*) and other female relatives as much as its own mother (cf. Ominde 1987). Children usually stay at home while their mothers go out to their gardens, to market, or to earn money. When they are at home, Luo mothers prefer their children to play outside during daylight hours with other children rather than inside the house. Although children are encouraged to greet visitors, even when very young, once greetings have finished children are kept away from adult meetings and separated from the world of adult affairs (cf. Blount 1972: 246). When children are asked to greet a visitor, they will approach in a similar way to the way they approach their father, or a respected figure such as a teacher or church leader, with eyes directed demurely towards the ground, only speaking when asked a question and standing rather than sitting in their presence. They thus show their respect by showing their fear. Children do not speak badly of people, such as their teachers, whom they are supposed to respect. My informants told me that if a man meets his mother-in-law (a situation ideally avoided) the fear/respect is so strong that he should not even shake hands with her when he greets her.

These patterns of avoidance and distance do not apply in the same way to grandparents, with whom children are in general more relaxed, and with whom they often have much more intimate, joking relationships (Geissler & Prince 2004; Prince & Geissler 2001). Nor do they the same way to siblings and age mates, although age and birth order also stratify relationships in hierarchical ways. However, in Luo cosmology, the sexuality of adults is thought to present a particular danger to children. Luo children should not see their parents naked, they should not enter their parents' sleeping area once they have reached the age of seven or eight, and they should not be held upon the lap of a grandmother who is still sexually active. It has been argued that these sexual taboos are at the root of the relationship of avoidance between adjacent generations, and the closeness and intimacy that exists between alternate generations (Geissler & Prince 2004: 97; Prince & Geissler 2001: 451). Breeching these taboos is thought to bring a serious and fatal illness of *chira* to the family.

While sexual taboo may lie at the heart of avoidance practiced in the parent-child relationship, it is interesting to note how the practices that exist in these kinds of relationships occur in other hierarchical relationships where there are no such concerns. It seems to me that what is at issue are not simply issues of taboo and avoidance but also more broadly the kind of person which such interactions help to produce. Children in the home are trained in skills which they will need to survive and to become proper people. These include how to relate to others, care for younger siblings and carry out particular tasks around the home which especially for girls include a range of domestic tasks. In the case of boys, they may include responsibility for animals that need grazing (cf. Ominde 1987). Children and parents expect children to carry out tasks around the home efficiently and without complaint. Comparably, in the labour wards of the hospital, women need to be taught to give birth, that it is 'just normal', so that they can get on with this difficult task. Indeed, Carolyn does not cultivate distance from Pamela in order to protect herself from the emotional intensity of such a relation-

ship, as was the case in the advice given to British nurses before nursing models began to reflect upon the benefits of relational 'closeness' in patient care (Savage 1997). On the contrary, the cultivation of distance is assumed to create the possibility for a successful relationship of care between the two women.

Care, abuse and the proper management of pain

During fieldwork, I found that physical reprimands were often seen as acceptable within *luoro* relationships if such discipline taught people to 'behave properly'. Hearing a child screaming in our compound one afternoon, I came outside to find that Winston, in his early 20's, had slapped John, 8. John was crying with his head in his hands and whimpering.

> Hannah: Why is he crying?
> Winston: You see this boy was checking me [i.e. mocking or back chatting] like he is my age mate.
> Hannah: You beat him?
> Winston: Of course! But it was not hard, just a light slap on the face.

Just as children might be beaten at home in order to remind them to enact the child role properly, and some men talked openly about beating their wives if they did not perform domestic tasks adequately, 'disobedient' patients, and especially women in labour, were sometimes slapped by the doctor or nurses. It is unfortunate that I do not have up-to-date ethnographic observations of women's experiences of giving birth at home in this part of Kenya. However, Ominde (1987: 61) noted that birth assistants at home may also slap women if they do not follow their instructions. Certainly, the women whom I knew in Kagot district who had a reputation of being able to assist other women deliver at home (*nyamreche* sing. *nyamrerwa*) were all older women, suggesting that by virtue of age alone they may have had similarly hierarchical relationships with the women whom they assisted to deliver.[5] Meanwhile, in the hospital, my informants seemed to be broadly of agreement that physical abuse and restraint, such as tying non-compliant patients to their beds so they would be still for examinations, were a necessary recourse on some occasions. However, there were certain parameters within which such treatment could occur, and limits to the way this kind of discipline could be carried out. Physical discipline was gendered. Only women were slapped. Usually they were women who were in labour or were refusing examination. Men might be held down, but they were never slapped. Women were not slapped to deliberately hurt or punish them (which would have been regarded as cruel) but to get them to perform the patient role properly. For example if women in labour were slapped it was usually on the legs, or perhaps the arms, in an effort to make them hold their legs in the manner which nurses required. It would have been inconceivable to slap a woman on the face, or to hit her so hard that she was bruised, or bleeding. Thinking about some medical encounters as based on *luoro* relationships is helpful,

I suggest, in part because it contextualises a range of practices which from outside might be classed as abuse, but in this context are not.

Moreover, there was broad consensus that women in labour should behave in particular ways, in particular by managing pain properly, which meshed with the obligation for the woman in labour to fear/respect the nurses within these hierarchical relationships. Emily Obonyo described to me her many labours at home, proudly emphasising her exemplary comportment. "When I give birth I just carry on as normal, I go to my gardens and when the baby is coming I go home. I just call somebody to hold my legs and the baby comes." In rural areas, most women, even when heavily pregnant, continue with work such as gardening and lifting and carrying water. It is only in the period after delivery that women rest and send others to carry out chores for them. A good labour and pregnancy are managed by making them "just normal", to borrow Carolyn's phrase. Many women I spoke to also reiterated what Gaudencia had told me, that screaming in labour is looked down upon. A number of nurses on the wards recounted the story of how their colleague Sister Christina came and gave birth in hospital, with Sister Hilda confiding, "I would never give birth here, you know, staff were coming to watch her, they were wondering how she will give birth, whether she will scream."

Other kinds of care

In the labour room *luoro* was the standard kind of interaction. Nurses did not touch women in labour, certainly not when women were in first stage labour, when they were told simply to walk around to ease the pain. In third stage nurses touched women only to encourage them to move their bodies into the right position. Words such as stubborn, difficult, un-cooperative were frequently heard about labouring women:

> A woman has been admitted with prolonged labour. The doctor performs a vaginal examination in the labour room. He tells her to lie properly and hold her legs in. She's lying naked on the left hand bed. The assisting nurse, Onyango, goes over and holds her head. "Lie straight!" he says, and grabs her leg. "Move the other one too!" he orders (field notes September 4th 2006).

> Peter, who is the mortuary assistant, walks into the labour room and says "tut-tut" when he sees the woman in labour. Carolyn complains that she's very stubborn and not cooperating. The woman pushes many times. Carolyn tells her to hold onto her legs and each time the woman refuses and holds on all over the place, rolling around the bed screaming. When she refuses to hold her legs Carolyn slaps her arms and legs (field notes 22nd August 2006).

Yet even in the labour room there were occasional moments where there were other kinds of care. Sister Rachel kindly delivered tea into the labour room prepared by family members for a woman in long labour. On another occasion when Carolyn was

delivering a woman who was "not cooperative", another nurse came into room and took hold of her hand, telling her gently, "The baby is getting tired you need to push hard."

However, caring practices in the labour room stood in marked contrast to other kinds of medical care provided in the hospital. To give one particular example, they contrasted with the way in which nurses and doctors dealt with the need to request patients' permission to test for HIV. At the time of fieldwork, the HIV prevalence among men and women aged between 13 and 34 years was approximated as 11% and 21% respectively (Adazu et al. 2005).[6] Many of those patients who were admitted to the hospital were HIV positive, and some were dying of AIDS. Patients who were suffering from diseases common in HIV and who did not know their HIV status were usually referred for HIV testing on the wards. However, despite the ubiquitous nature of HIV/AIDS on the wards, everyone who worked there took immense care to avoid talking directly of HIV and AIDS and of the need for HIV tests. HIV tests were referred to as 'DTCs', which stood for Diagnostic Counselling and Testing, or 'serology'. HIV+ patients were described as being 'reactive'. "Is this condition common in ISS (Immuno-Suppression Syndrome)?", I learnt to say when following the doctors on their rounds. Or, "Has he tested reactive?"

> Sister Amanda comes in and takes William, one of the patients, for his DTC test. When she asks him to come she just asks him, "Can you walk? I want to go with you outside to discuss something" (field notes 9th September 2006).

> The doctor asks the patient if he attends the PSC (the Patient Support Centre, where HIV care is provided). The patient shakes his head and after listening to his chest the doctor says in Swahili "Sister will come here and talk to you and test your blood" (field notes 4th Sept 2006).

> The doctor comes to the last man in the ward who is sitting up in bed. He asks him, "Are you sick?" He replies in the affirmative. He tells doctor that he came yesterday because he was coughing a lot and he had a terrible pain in his chest. The doctor looks at his x-ray and then says to him in Swahili, "You have TB." He continues, "You will go down there to the chest clinic [points to the other side of the hospital compound]. They can also test [pause] your blood. It's not a must, only if you want" (field notes 25th August 2006).

When I asked the doctor why they used this guarded euphemistic language about HIV in the hospital he replied to me, "people don't like it [if you talk about their HIV status]. They will say, 'you were discussing me with a foreigner.'" While this coded language certainly owes something to issues of stigma around HIV/AIDS, this cannot wholly explain the marked difference in types of care within the same context. After all nurses could have cruelly revealed people's HIV status, had they wished. Susan R. Whyte (1997: 217-9) has characterised similar kinds of talk in Eastern Uganda as 'care-ful' talk, underlining how family members and loved ones underline sympathy for their sick by avoiding the harshness of a definitive diagnosis.

I suggest that the difference in caring practices noted here lies in the fact that unlike in the labour room, where outcomes are uncertain and nurses claim that a particular kind of emotional relationship can facilitate the labour process, in the case of HIV testing, the outcome (a HIV+ test result) is generally known prior to the giving of the test. Medical staff in Kagot District Hospital had become experts in recognising the signs of suppressed immunity. Those patients who were referred for HIV testing rarely tested negative. The interaction between medical staff and patients in the case of diagnostic HIV testing does not have the urgency of creating a particular kind of person which will enable a potentially difficult outcome to be achieved. For this reason medical staff can respect people's feelings and desire for privacy and behave in a more 'relaxed' way with these patients. My point here is that, in an interesting parallel with care in the domestic domain, medical care seemed to consist of both *luoro* interactions and more egalitarian ones. While it was true that egalitarian relationships were less often found between patients and doctors or clinicians[7] than with lower level medical staff, it is also true to say that certain kinds of medical interaction were much more likely to be *luoro* than others. Medical care did not consist of a single type of care, but changed according both to existing hierarchies between patients and medical staff but also according to the kind of care deemed appropriate for a particular situation.

Concluding remarks

The idea which I tried to sketch in this article is that these practices of care point to two dominate models of care in Luo society which might be glossed as *luoro* and egalitarian care. In the context of Kagot District Hospital, '*luoro* care' and 'egalitarian care' did not map upon a simple division between medical care and familial/emotional care and nor could they be easily labelled as either emotional or technical, but on the contrary cut across these domains. *Luoro* care, for example, is based upon a particular kind of relationship of emotional distance. Good care outcomes were thought to be possible through the correct application of these two types of care, which each seemed to properly belong within particular spaces and relationships and to the proper enactment of particular roles. In this understanding of care created through relationship and practice, closeness and intimacy were not always the right kind of care needed to produce particular outcomes and were in fact in some situations understood as detrimental to the provision of good care.

In Kagot District Hospital, care in healthcare cannot be thought of as a singular set of practices within which it is easy to identify certain aspects as 'good'; 'good care' is relationally and contextually contingent. In this sense care in health care is very much like care outside of health care. I suggest that further exploration of how the intersection of how different types of care can work to produce outcomes which both patients and care-givers experience as good or successful, within similar medical contexts, may do more than allow us to develop new insights into practices of care within health care. It may ultimately provide us with observations which we can use to improve

care outcomes by engaging with, and perhaps supporting, such divergent registers of meaning around care, even as we search for ways to improve patients' experience of health care and fight against cruel and abusive treatment.

Notes

Hannah Brown is a Ph.D. candidate in Social Anthropology at the University of Manchester. She carried out ethnographic fieldwork in Western Kenya between 2005 and 2007. Her research focuses on practices of care across different sites including a hospital, a community-based organisation and people's homes. Other than care, her research interests include: HIV/AIDS, home-based care, gender, development, Community Health Workers, health administration and hospital ethnography. E-mail: hannah.brown@gmail.com

A thousand 'thank yous' to everyone in 'Kagot' who helped me during fieldwork; erokamano ahinya. I am grateful to the participants of the symposium "Care and Health Care" and of the University of Manchester Social Anthropology 2010 Postgraduate Showcase as well as the two anonymous reviewers who all provided very useful comments on earlier drafts of this paper. Maia Green also provided many helpful suggestions. I am grateful to the Kenyan Ministry of Education for granting me permission to carry out fieldwork in Kenya. The Population Studies Research Institute of the University of Nairobi kindly allowed me to affiliate with them during my time in Kenya and I am particularly grateful to Prof. Lawrence Ikamari and Prof. A.B.C. Ocholla Ayayo who acted as my local supervisor until he sadly passed away. Fieldwork was carried out as part of an ESRC Ph.D. studentship and I would like to thank the ESRC for their support.

1 The hospital is referred to by a pseudonym, as are all personal names in this paper. This hospital is located in the central area of Nyanza Province, in the West of Kenya, a few kilometres from Lake Victoria. The hospital is small compared to other district hospitals in Kenya and relatively poorly resourced. Inpatient facilities existed for 50 patients (although many more were often admitted, with patients often sharing beds), housed within eight wards. The hospital also had outpatient services and acted as first line treatment for people who lived locally. There was a small theatre where doctors could perform minor surgery including caesarean sections. However, shortages of staff and irregular supplies of equipment such as gas for anaesthesia meant that patients who required such interventions were more often sent to the provincial hospital in Kisumu via the hospital ambulance.
2 Although (perhaps somewhat paradoxically) nursing remains a relatively prestigious and well-regarded profession.
3 These comments are suggestive of the existence of an additional understanding of care which I unfortunately do not have the space to consider in depth here, where an important aspect of the role of nurses is understood to be to distribute the resources of the hospital to patients (cf. Whyte 1992: 6 on nurses as gatekeepers).
4 I should emphasise that I am not arguing that boundaries between technical and emotional care or medical and familial care do not exist or are not important. On the contrary, the wide body of literature on care which employs and develops such distinctions can be read as a sign of how relevant and pervasive such boundaries are. My argument is that these boundaries do not form a map which defines where or how social practice happens, but are produced through social practices, and that ethnographic analysis can reveal how such boundaries are made (powerful), maintained and traversed (cf. Luedke & West 2006). As I

have argued elsewhere (Brown nd), there were other occasions within this hospital where nurses sought to make an emphatic distinction between the responsibilities and practices of 'medical care' against 'familial care'.

5 This is a matter which would benefit greatly from further investigation in order to examine in more detail similarities and divergences between births at home and at hospital (cf. Drews 1995 for such a comparison in Zambia).

6 This data is taken from a region which includes approximately half of 'Kagot' district and another district, but which I consider to be broadly accurate for the whole district. Such figures should of course only be taken as approximate and I have included them to give a sense of relatively high levels of infection.

7 In Kenya, doctors are distinguished from clinicians. Both are allowed to prescribe medication but doctors are more senior than clinicians and have received more training at medical school.

References

Adazu, K. et al.
2005 Health and demographic surveillance in rural western kenya: A platform for evaluating interventions to reduce morbidity and mortality from infectious diseases. *American Journal of Tropical Medicine & Hygiene* 73: 1151-58.

Andersen, H.M.
2004 "Villagers": Differential treatment in a Ghanaian hosptial. *Social Science & Medicine* 59: 2003-12.

Armstrong, D.
1983 The fabrication of nurse-patient relationships. *Social Science & Medicine* 17: 457-60.

Blount, B.G.
1972 Aspects of Luo socialization. *Language in Society* 1: 235-48.

Booth, K.
2004 *Local women, global science: Fighting AIDS in Kenya*. Bloomington & Indianapolis: Indiana University Press.

Brown, H.
n.d. Hospital domestics: Care work in a Kenyan hospital. *Space & Culture* (under review).

Center for Reproductive Rights & FIDA
2007 *Failure to deliver: Violations of women's human rights in Kenyan health facilities*. Center for Reproductive Rights, Federation of Women Lawyers-Kenya.

Davin, A.
1978 Imperialism and motherhood. *History Workshop Journal* 5: 9-66.

Drews, A.
1995 *Words and silence: Communication about pregnancy and birth among the Kunda of Zambia.* PhD Dissertation, University of Amsterdam.

Fraser, N. & L. Gordon
1994 A genealogy of dependency. *Signs* 19: 309-36.

Geissler, P.W. & R.J. Prince
2004 Shared lives: Exploring practices of amity between grandmothers and grandchildren. *Africa* 74: 95-120.

Gilligan, C.
1993 *In a different voice: Psychological theory and women's development*. Cambridge, Mas. & London: Harvard University Press [1982].
Gilson, L., M. Alilio & K. Heggenhougen
1994 Community satisfaction with primary health care services: An evaluation undertaken in the Morogoro region of Tanzania. *Social Science & Medicine* 39: 767-80.
Hart, L.
1991 "A ward of my own": Social organization and identity among hospital domestics. In: P. Holden & J. Littlewood (eds.), *Anthropology and nursing*. London & New York: Routledge, pp. 84-109.
Jewkes, R., N. Abrahams & Z. Mvo
1998 Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine* 47: 1781-95.
Kittay, E.F.
1999 *Love's labor: Essays on women, equality, and dependency*. New York & London: Routledge.
Kleinman, A. & S. van der Geest
2009 'Care' in health care: Remaking the moral world of medicine. *Medische Antropologie* 21 (1): 159-68.
Latour, B.
2005 *Reassembling the social: An introduction to actor-network-theory*. Oxford: Oxford University Press.
Law, J.
2004 *After method: Mess in social science research*. London & New York: Routledge.
Leininger, M.
1980 Caring: A central focus for nursing and health care services. *Nursing & Health Care* 1: 135-43.
1984 Care: The essence of nursing and health. In: M. Leininger (ed.), *Care: The essence of nursing and health*. Detroit: Wayne State University Press, pp. 3-15.
Luedke, T.J. & H.G. West (eds.)
2006 *Borders and healers: Brokering therapeutic resources in Southeast Africa*. Bloomington: Indiana University Press.
Marks, S.
1994 *Divided sisterhood: Race, class and gender in the South African nursing profession*. New York: St. Martin's Press.
1997 The legacy of the history of nursing for post-apartheid South Africa. In: A.M. Rafferty, J. Robinson & R. Elkan (eds.), *Nursing and the politics of welfare*. London & New York: Routledge, pp. 28-44.
Martin, H.M.
2009 *Nursing contradictions: Ideals and improvisation in Uganda*. Diemen: AMB Publishers.
Mayeroff, M.
1971 *On caring*. New York: Harper Perennial.
Mol, A.
2008 *The logic of care: Health and the problem of patient choice*. Oxford & New York: Routledge.

Mwangi, R. et al.
2008 Perceptions of mothers and hospital staff of paediatric care in 13 public hospitals in northern Tanzania. *Transactions of the Royal Society of Tropical Medicine and Hygiene* 102: 805-10.
Noddings, N.
1984 *Caring: A feminine approach to ethics and moral education*. Berkeley, Los Angeles & London: University of California Press.
Ocholla-Ayayo, A.B.C.
1976 *Traditional ideology and ethics among the southern Luo*. Uppsala: The Scandinavian Institute of African Studies.
Ominde, S.H.
1987 *The Luo girl from infancy to marriage*. Nairobi: Kenya Literature Bureau [1952].
Penn-Kekana, L., D. Blaauw & H. Schneider
2004 "It makes me want to run away to Saudi Arabia": Management and implementation challenges for public financing reforms from a maternity ward perspective. *Health Policy & Planning* 19: i71-77.
Prince, R.J. & P.W. Geissler
2001 Becoming 'one who treats': A case study of a Luo healer and her grandson in Western Kenya. *Anthropology & Education Quarterly* 32: 447-71.
Rafferty, A.M.
1996 *The politics of nursing knowledge*. New York & London: Routledge.
Ruddick, S.
1989 *Maternal thinking: Towards a politics of peace*. Boston: The Women's Press.
Savage, J.
1995 *Nursing intimacy: An ethnographic approach to nurse-patient interaction*. London: Scutari.
Simpson, A.
2005 Sons and fathers/boys to men in the time of AIDS: Learning masculinity in Zambia. *Journal of Southern African Studies* 31: 569-86.
The Standard
2009 Ministry to hire 5,000 nurses. 9th October 2009. Nairobi: The Standard Group.
2010 Let us not use 'abortion' to victimise innocent women. 17th February 2010. Nairobi: The Standard Group.
Thomas, C.
1993 De-constructing concepts of care. *Sociology* 27: 649-69.
Tronto, J.C.
1993 *Moral boundaries: A political argument for an ethic of care*. New York & London: Routledge.
Van der Geest, S.
1997 Money and respect: The changing value of old age in rural Ghana. *Africa* 67: 534-59.
Vaughan, M.
1991 *Curing their ills: Colonial power and African illness*. Cambridge: Polity Press.

Whyte, S.R.
1992 Pharmaceuticals as folk medicine: Transformations in the social relations of health care in Uganda. *Culture, Medicine & Psychiatry* 16: 163-86.
1997 *Questioning misfortune: The pragmatics of uncertainty in Eastern Uganda*. Cambridge: Cambridge University Press.
Wood, K. & R. Jewkes
2006 Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters* 14: 109-18.