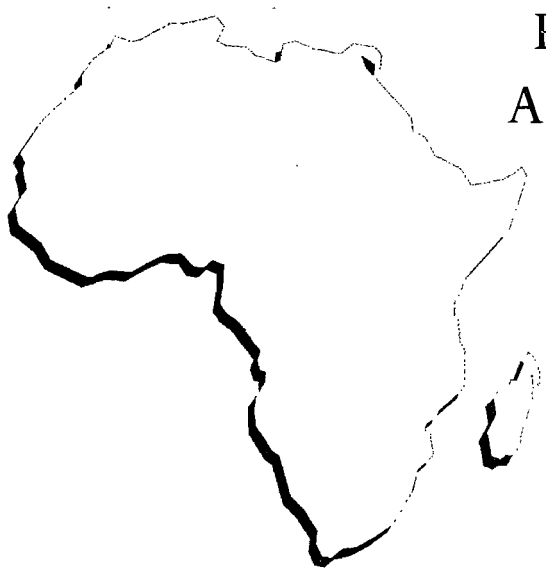

Research

Presenting Oneself as a Nurse: A Social and Professional Reality Construction

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Vue d'ensemble

Ce document examine le développement historique des soins infirmiers et leur pratique dans deux pays africains sélectionnés comme arrière plan pour l'analyse de l'image de l'infirmière et des soins.

Les recommandations faites incluent le besoin des infirmières pour diffuser le message de maturité, de responsabilité et d'expertise aux malades, à leurs proches ainsi qu'aux autres détenteurs des enjeux dans le domaine sanitaire à travers leurs apparitions, leur langage, leurs habitudes et la performance de leurs responsabilités professionnelles.

Resumo

Este estudo examinou o desenvolvimento histórico da educação e prática de enfermagem em dois países africanos específicos, como fundo para a análise da imagem do pessoal de enfermagem e da própria profissão. As recomendações efectuadas incluíram a necessidade dos enfermeiros transmitirem aos doentes e às suas famílias, bem como a todas outras partes envolvidas nos serviços de assistência médica, uma imagem de maturidade, responsabilidade e perícia profissional, através do modo como se apresentam, da forma como se expressam, como se comportam e como desempenham as suas responsabilidades profissionais.

ABSTRACT

The paper examined the historical development of nursing education and practice in two selected African countries as a background for analysing the image of nurses and nursing. Mead's (1934) Symbolic Interactionist Theory was employed to describe the basis of nurses' low social and professional image which has been perpetuated by feminization of nursing, its classification as a low status occupation, its consignment as an appendage of medicine and widespread discrimination against women in Africa. Since reality construction is a continual creation as individuals interact in any social situation and as the social status and professional roles of nurses improve the image and self presentation will be enhanced. The submissive, accepting and passive doer-oriented critical mass of practising nurses in these countries explains the need for expanding degree programmes that will facilitate collegiality in clinical relationships. It is argued that liberal university education is an important prerequisite for nurses to effectively use the concepts of assertiveness, power and influence to bring about positive change in their image and provision of quality nursing care. Recommendations made include need for nurses to convey messages of maturity, responsibility and expertise to patients, relatives and other stakeholders in health care services through their appearance, language, behaviour and performance of their professional responsibilities.

Key Words/ Concepts: Company of equals; Institutional property; Multiple cadres of nurses; Nurses' image; Presenting self; Reality construction.

BACKGROUND

Who is a nurse? This is a big question that will attract as many answers as various people perceive or experience her/him. To an average American, Wieck (2000) "the nurse is the person at my bedside taking care of me when I am in the hospital". The public perception is that of nurses as task-oriented fonts of information who always have a kind word and are never too busy to help. The nurse is a conduit to the physician, somehow the physician's extra pair of hands. To a patient's relative in an African country, who was requested to leave the ward at the expiration of visiting time, a nurse is a harsh, inconsiderate and possibly rude person. To some other people she/he may be a counsellor, educator, advocate, friend or even saviour in health or illness situations. Wieck (2000) concluded that the outlook for the nurse and nursing today appears uncertain.

Nurses present themselves in various aspects of their pubic, private and professional lives which critics have described as leaving much to be desired. Gordon and Grady (1995) reported that although nursing today is complex and far more autonomous but contemporary behaviour and dress tend to downplay professionalism, blur the identity of nurses and make the place of nursing in health care delivery ambiguous. Questions raised are: Who is a nurse? What do nurses do? How should nurses be treated?

In many African countries a lot of radio and television programmes depict nurses as negligent, conduit for physicians' information or impolite health care providers. Davies (1995) reported that in Canada many nurses prefer to introduce themselves to patients only with their first names. Whereas young physicians also drop

'Dr' from their names but give their first and last names but relatives and patients get to know them during interaction. Nurses identity and roles on their part, become blurred and confused with that of a cleaner or physician's handmaid. Davies (1995) also reported an experience with a nurse with masters degree in nursing working in a teaching hospital who normally behaves in an autonomous and assertive way. She calls her doctor colleagues first name privately and 'Dr' "last name" in the presence of patient. When asked why, she replied "the patients should respect their doctors". When confronted with why she does not call her colleagues nurses Mrs, Miss, Nurse or Sister 'last name' if title and last name connotes respect, she was dump founded.

These types of pictures of the nurse and nursing coming from developing and the developed parts of the world and even in the 21st century generated some irritation and challenge for an examination of theoretical basis of reality construction among nurses in some African societies. What is the social structure, status and the role of the nurse in Africa? How do nurses understand the concepts of assertiveness, power and influence, and what do nurses need to project nursing image positively? The paper is therefore aimed at examining the image of the nurse with a view to provide a framework for a better understanding of the nurse in the social context of professional practice in selected African countries. Furthermore, strategies will be recommended for the improvement of the public image of nursing in Africa.

HISTORICAL DEVELOPMENT OF NURSING IN SELECTED AFRICAN COUNTRIES

Nursing in a West and an East African country was briefly reviewed to assess historical development of its education and practice with a view to describe the social context within which nursing care is rendered and the image of nursing in the two subregions.

Nursing In Nigeria

The development of nursing education and practice in Nigeria was examined as a case study for the West African countries by Ojo (2000) and attributed its underdevelopment to the following factors:-

- Peculiarly low status of women in the West African sub-region with culture and religion perpetuating a disadvantaged gender inequality of women who constitute the large majority of nurses
- Inability of nursing, unlike other professions such as medicine, law and engineering to get and utilise early exposure to latest technological and professional developments to its advantage.
- Societal perception of nursing as a profession or rather occupation which is dependent on medicine thereby get marginalized.
- Even nurses who had early exposure to nursing education and practice in the developed countries of U.S.A and Europe returned with a feeling of superiority which created inter and intra-professional conflicts. The negative consequences hindered any development which their exposure could have brought to nursing education and practice.

The historical development of nursing in Nigeria was described in four chronological periods by Ojo (2002) as follows:-

Early past - 1850s to 1950s.
Immediate past - 1960s to 1970s.
Present - 1980s to1990s.
Immediate future - 2000 and beyond.

Early past 1950- 1960

Oyedepo (1985) while reviewing the historical development of nursing in Nigeria reported that about the time Florence Nightingale was starting health visiting in England in 1881 some christian missionary nurses and midwives from Britain were also starting health visiting in South Western Nigeria in 1886. Trained doctors and nurses were recruited from Britain as missionaries to provide health care and they started rudimentary training of local people. By 1892 - 1894 few boys and girls with elementary education were trained on simple instructions as nurse auxillaries, which started in the first government hospitals in Calabar in South Eastern Nigeria. Missions started building hospitals to supplement the efforts of the government in health care provision and training of nurses. They include:-

- Catholic Hospital, Iyienu - 1901
- St. Margaret's Hospital, Calabar - 1905
- Wesley Guild Hospital, Ilesa - 1912
- Baptist Hospital, Ogbomoso - 1925
- Seventh Day Adventist Hospital, Ile-Ife - 1944

Each of these hospitals established training schools for nurses and or midwives. These hospital-based schools had varying curricular and admission requirement was primary education. Preparation was emphasizing technical and manipulative skills geared towards dexterity and humaneness in caring. Theoretical understanding as to rationale for their actions, deductive and inductive reasoning as well as making clinical judgements were ignored. Even if they had wanted to, the low level of entry qualification of students would have hindered such attempt. However, by 1930 the Midwives Board of Nigeria was established while the Nursing Council came into being in 1947. They serve as accreditation bodies for midwives and nurses in the country.

Immediate Past 1960 – 1970s

Many more hospitals got established as the need for nurses and midwives increased. More hospital-based schools of nursing were set up but with minimal improvement in the entry requirements. Advanced diploma institutions were established to train teachers for these schools. Essentially the nursing education remained inclined towards technical skill acquisition and nursing care was task-oriented with nurses functioning absolutely as fonts of information and conduit to the physicians. It can not be otherwise, since the nature of training received in the hospital-based schools is usually restrictive and non-liberal thus producing ritualistic, submissive and obedient practitioners with limited ability for equally good or better alternative ideas, actions or measures than presented to them.

When in 1965, the University of Ibadan in collaboration with World Health Organisation started the first nursing degree programme in Africa, South of the Sahara, the horizon brightened for nursing in terms of nurses being educated in similar setting as other health professions. Currently six Universities offer degree in nursing with two offering post-graduate degrees at masters and doctorial levels.

Present 1980s - 1990s

The Nursing and Midwifery Council of Nigeria which became merged in 1979, reported in its documentaries at its Golden Jubilee celebration (1997) that there are 64 schools of nursing, 66 schools of midwifery, 7 psychiatric nursing schools, 35 post-basic specialist programmes, 6 advanced diploma programmes and 5 university degree programmes. There has been tremendous improvement in the standard of nursing care rendered to the consumers. Similarly, the hospital and other health care settings where nurses participate as members of the team have witnessed significant improvement in work ethics, clear understanding of nurses' agency and defending it, ability to relate with other health care members and marked reduction in fear with dealing with doctors.

Immediate Future 2000 and Beyond

The current trend in Nigeria can be described as progressive even though the pace is very slow. Wieck (2000) after examining the implementation of the computers detailed plans for intensive care units of hospitals and the 2-year nursing programmers in the U.S.A taught by engineers, computers programmers, therapy experts and chaplains, wondered where nursing is going as we lumber towards the next millennium. What role will nurses fill? What is also the future of nursing in Nigeria?

She concluded by considering two futures for nursing. The first is the nurse as a doer with an emphasis on the skilled worker image. This represents the type of technically oriented, skillful, obedient, non-creative, uncritical and ritualistic nurses workforce that currently form the large majority of the health care sector in most African countries. The second future according to Wieck (2000) is the nurse as a thinker. These are nurses whose education at the university level is based on critical thinking and problem solving. No matter at what level computer may programme care, or the families may provide the bulk of the care as health care moves out of the hospitals, nurses will study the home setting, optimise the family caregiving potential, stay with the family briefly and provide follow-up care. Similarly, in highly computerized care hospitals, the hospital will be under the direction of critical care advanced practice nurses who practice in consultation with physicians and pharmacists and chaplains to manage care.

It is this second future that seems to represent the aspirations of nursing education and practice in Nigeria as more university-based professional education is gradually taking root and diploma doer-oriented training will eventually give way.

NURSING IN KENYA

Muiva (1998) described nursing education and practice in Kenya as "From dresser to Bachelor of Science Nurse". According to her, western medicine came to Kenya along with the Imperial British East African Company in 1895. In 1901, a group of health care providers made up of doctors and nurses with some hospital assistants created the medical department in Kenya. Some crude training in nursing for Kenyan Africans was reportedly started in 1927, which prepared them for dressing wounds. Following that effort, formal training of different cadres of nurses gradually emerged as highlighted thus: -

- Dressers in 1929.
- Kenya Registered nurses in 1952.
- Kenya Enrolled Nurses in 1959.
- Kenya Registered Midwife in 1965.
- Kenya Enrolled Community Nurse in 1966.
- Diploma in Advanced Nursing in 1968.
- Kenya Registered Community Health Nurse in 1987.

All these programmes were at Medical Training Centres except the Diploma in Advanced Nursing that started in University of Nairobi.

- Bachelor of Science in Nursing in 1988 at Baraton, Eastern African University owned by Seventh Day Adventist Mission.
- Bachelor of Science in Nursing in 1992 at University of Nairobi .
- Bachelor of Science in Nursing in 1998 at Moi University, Eldoret.

To date (2002), there is no post-graduate nursing degree programme in Kenya.

Musandu (1998) while writing on the nurse in the 21st century argued that thousands of nurses in Kenya who managed to go through the basic training programme have had to practice for many years without any opportunity to have further education. She contended that with opportunities now offered at university level they should be willing to have some extra training to enable them cope effectively with the demands for better nursing services in the 21st century Kenya. Epaalat (2001) described the trends in nursing in Kenya from various perspectives including the low pubic image of nurses and nursing. The major concerns also raised by Buresh and Gordon (2000) concerning the low public image and self worth of nurses include:

- Lack of public voice in favour of nursing.
- Great momentum of voice against nurses from the public, press and other health workers.
- Agency of nurses is unknown to public.
- In most situations, nurses portray themselves as extension of the doctors' agency.
- Nurses are unable to deal with the fear of making doctors angry.
- Most nurses are unable to describe the complexity of the care they give and the clinical judgements they use.
- Nurses inability to deal directly with doctors by discussing aspects of their behaviours related to gender, patient care, collegiality and etiquette in clinical relationships.

With about six decades of nursing education in Kenya, first at apprenticeship level in 1927, to different cadres of diploma, sub-degree and practical oriented manipulative skill-focused training, the low rating of nursing currently in Kenya and many other African countries can easily be understood and appreciated. However, as the numbers of university trained, critical thinkers and problem solving, liberally educated nurses increase in Kenya, the status and image of nurses is bound to improve.

Similarities and Differences

The scenario that has emerged from the review of the historical development of nursing in these selected African countries can be described as similar under the variable of:

- Nursing as a by product of colonialism.
- It was closely linked with christianity.
- Entrants initially were of very low education.
- Training was mainly technical oriented with products becoming doers rather than thinkers.
- According to Bullough and Bullough (1979) hospital-based nursing education was dominated by the very group that employed nurses, the hospitals. As long as it was possible to use student nurses in key nursing roles, any potential long term struggle for higher status and wages could be frustrated simply by increasing the number the of student nurses.
- The educational entry requirements have significantly improved with nursing education moving into universities for producing liberally educated and critically thinking professional nurses.

The differences between the two countries' nursing development are:

- That nursing started earlier in Nigeria than in Kenya.
- The political and socio-economic terrain of both countries differ.
- There are only two cadres of nurses in Nigeria (diploma and graduate) Kenya has a third lower cadre of enrolled nurses.
- While the critical mass of practising nurses in Nigeria are registered diploma nurses, in Kenya that critical mass is the enrolled certificate nurses.
- Finally, the age of nursing in Nigeria gave it the advantage of more human and material resources for higher nursing education opportunities in the country than in Kenya.

THEORETICAL ANALYSIS AND PROFESSIONAL REALITY CONSTRUCTION

There are two main categories of nurses that have emerged from the assessment of nursing education and practice in Nigeria and Kenya. These are enrolled and diploma nurses who constitute task-oriented, technically trained and doer nurses and secondly the graduate and post graduate nurses who had liberal, comprehensive education for problem solving, critical thinking and who are nurse thinker. This nurse as doer and nurse as thinker concepts by Wieck (2000) will be used as application of Meads (1934) analysis of symbol interactionism.

MEAD AND SYMBOLIC INTERACTION

Mead (1934) proposed the relationship that exists between mind, self and society as the unique ability of humans to symbolize. According to Mead (1934) our ability to communicate by symbols means that we can contemplate possible actions, guess about their outcomes, and compare the qualities of different objects, in effect, we can think. Mead (1934) referred to this ability as mind.

Just as we are able to evaluate our own potential actions we can also evaluate the action of others. Mead (1934) called this "taking the role of a particular other". He concluded that by accumulating such evaluation we develop a self. This is a cumulative idea of who we are that is constructed from the actions of others towards us. He argued that there is no inborn or unvarying human character or self because since each person experiences a unique set of interactions with people and the environment each necessarily develops a unique self. Ultimately, human beings develop the ability to evaluate and internalise the expectations of a group of people simultaneously. He called this "taking the role of the generalized other. Therefore, the society is the sum total of the ways in which people agree to act in given situations, which are internalised by its members. Mead (1934) concluded that there is nothing in social order that is real unless the participants in society agree that it is real. Thomas and Thomas (1928) gave the famous words "if people define situations as real, they are real in their consequences". See Figure 1.

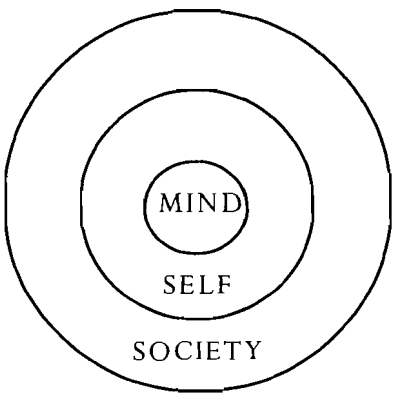
SOCIAL STATUS AND SOCIAL ROLES OF NURSES

Any health care setting where nurses and other health care providers interact is a social institution that has its structure. Relationships in such a setting are specific sets which can be depicted and are always patterned and stable. Each person in a social structure occupies a social status with rights and obligations that apply to the position. Emerging from social structure and social status is social roles which are sets of expectations for the behaviour of a person in a given social status (Levin, 1984).

From this perspective, the social status of nurses of various cadres and their social roles are bound to differ. Unfortunately, while improvements in the educational preparation of nurses have been occurring in African countries, their social status and social roles failed to show corresponding positive changes. While the more educated nurses have been exposed to liberal education that provides them with mental tools for critical thinking and problem solving, the society which determines ways people agree to act (Mead, 1934) seems to hold on to the usual social status and role of the doer-oriented nurses it used to know. Ojo, (2001) observed this scenario in Nigeria where there are limited job opportunities for graduate nurses and parents still have preference for diploma schools of nursing for their wards.

As nursing scholars are revisiting the future of nursing and charting a vision that can effectively meet the challenges of the 21st century, many societies in the developed and developing countries will have to be reorientated to accept an enhanced social status and roles for nurses.

Health Care Delivery Situation and Social and Professional Reality Construction among Nurses



MIND
Has the ability to:
- Contemplate possible actions
- Guess their outcvomes
- Compare quality of objects
(THINKING)

SELF
Has the ability to:
- Evaluate action of others
- Cumulate such evaluation
- Use the cumulative idea of other's action to one to construct self

SOCIETY
Has the ability to:
- Provide each person unique interactions with people and environment
- Determine how each person should evaluate and internalise group expectations
- Determine ways people agree to act in society

Figure 1: Diagramatic Representation Summarising Mead's (1934) Symbolic Interactionism

Having an agreed rules for behaviour makes things predictable and relatively stable in everyday interaction. Since different health care providers that make up health care team have been taught the rules of daily clinical behaviour under different circumstances and each group lives a unique life, there is a great deal of room for individual evaluation of the meaning of the social situation where they practice. Therefore, the agreements that are internalised in the process of socialization are only guidelines for social behaviour and not unchanging, narrow commands. Blumer (1969) described social order as a process of continual creation. Every time we interact we create a new version of social reality. Whenever we find ourselves in a specific situation, we evaluate the stimulus and decide what it means before we act.

The future of nurse-doctor, nurse-patient, nurse-other health care providers and nurse-society relationships can be viewed from this perspective of process of continual creation. In effect, as the impact of university education gets reflected in these relationships, both within the care setting and in the society, a new order of evaluations of others action towards nurses will emerge and nurses themselves will cumulate such evaluation and use the ideas to construct a new self. Such a new self will be coming from nurses' unique interactions with others and the environment. It is therefore most likely to satisfy group/societal expectations.

From this theoretical viewpoint, the future of the image of nursing can be predicted as capable of appreciating and being able to compete favourably with other professions in the health care industry in no distant future in Africa.

However Okunade (2001) observed that the development of university education in Nigeria is unacceptably low compared with trend in general and professional education. Among fac-

tors extensively discussed as contributing to the underdevelopment of nursing globally are:

- Feminization.
- Classification of nursing as a low status occupation and
- Its consignment as an appendage of medicine (Bullough and Bullough, 1977b).

In addition, discrimination against women which is broad based particularly in Africa where gender is constructed as a psychosocial, economic and cultural imposition on the biological sexual identity in order to protect and perpetuate patriarch (Okunade, 1999) constitutes another major factor. Of significance too is Florence Nightingale's image which considered nursing as a special calling and nurses were regarded as specially committed to the needy which seemed to blur any early desire for higher education for enhanced status and image of nursing.

Nevertheless, global awakening for gender equalities and the trends, though slow in African countries, of females getting equal opportunity and equal pay for equal work will soon get nurses the much needed equality. Feminists must however realise that writing to papers, forming committees and getting into parliament only will not get things done. That is just self indulgence. As women, nurses should no more be expected to be submissive, accepting and passive but present constructive, convincing and active positions in all matters relating to health care services and the entire society.

HOW NURSES CAN USE THE CONCEPTS OF ASSERTIVENESS, POWER AND INFLUENCE

The theoretical analysis presented in this paper appear to establish a strong basis for a positive change of the image of nurses and nursing in future despite all constraining factors. It therefore becomes imperative to explore the strategies for the expected change so that nurses may start coming into grips with such strategies since no other people will do it for them. Benton (1999) provided a leading propositions on how nurses can use the concepts of assertiveness, power and influence to bring about positive change in the image of nurses and maximize their effectiveness in nursing care delivery.

Some nurses are reported to be uncomfortable discussing these topics because they are more preoccupied with the job at hand while others believe such matters do not affect them. Such nurses do not realise that these concepts are indispensable at all levels and in all roles of their professional practice (Benton, 1999).

According to Egan (1977) an assertive person is one who is able to get his/her own needs and wants met while still ensuring that the rights of others are respected. In other words being assertive is being a good and effective communicator. Bond (1986) presented four styles of communicating:

1. Assertive.
2. Aggressive.
3. Manipulative.
4. Submissive.

The style of nurses' communication in their clinical practice setting can be described as submissive considering references to their relationships as physicians' spare hand and conduit of information. Becoming assertive is therefore an outcome of better preparation and attitudinal reorientation to recognise and decide to defend their needs and wants for providing quality care, be respected in their own rights as professionals as well as listened to by other health care providers in making clinical decisions.

Power is the fuel of change which provides an opportunity to influence and get things done. Leininger (1978) described power as a latent resource that must be unleashed. French and Raven (1959) described seven types of power:- Resource, Information, Expertise, Connections, Coercive, position and personal power. Nurses will be expected to posses information, expertise, connection, position and personal powers to effect change in their current image. Being well equipped with technical information about the organisation, the clients and the society provides a leverage for the nurse. Similarly, having specialist knowledge and skill in a particular field of nursing will add a degree overlap with information power. Furthermore, to have a wide network of influence both personal and professional contacts outside as well as inside the work setting facilitates getting work done. The most obvious source of power is the formal position one occupies which allows you to get people do what you want. As nurses assume top management positions in health care delivery system in many parts of the world, including African countries, they should demonstrate public trust, accountability and ethical professional practice in the use of position power. Nurses in positions of authority ought to realise that they have opportunities to advance public knowledge about nursing. Educating other professionals at every opportunity on the agency of nursing, describing the complexity of the care nurses give and the clinical judgements they make should be their priorities to bring about change. Personal power is the last considered relevant for nurses to possess and use. This type of power can be described as magnetic force that makes others to respect one and follow his/her directions. It is charisma. Not all people possess it but any nurse leader who has earned and won this power by his/her actions, deeds and abilities should use it to improve the image of nursing.

Influence is the means by which power is brought to bear. Leninger (1978) said that influence is the process by which change is brought about. Some of the principles underlying effective use of influence include:

- Social proof - people are more attracted to those similar to themselves. As more nurses become better educated in African countries they will be able to function as company of equals with other health care providers.
- Linking and integrating - It is important to take time to explain to others how listening to nurses and taking their views into consideration in decision making is a change that is linked and integrated with development process which supports the organisational mission and will improve services.
- Emotion - the nurse should make effort to be pleasant, polite and respectful in discussion always if he/she wants to exert influence on others. With an understanding of how to modify submissive communicating style to an assertive one, understand and be willing to use the levers of power as well as the principles of influence, it is believed that the image of nurses and nursing will positively change.

EXPECTED AREAS FOR CHANGE IN SELF PRESENTATION OF NURSES

In both developed and African countries, there are multiples of ways in which nurses are negatively presenting themselves which nurses themselves must be aware of and encouraged and guided to change. These include:

1. There is the need for nurses to over come the fear that nobody cares to listen to them.
2. Nurses must also outgrow the fear of making doctors angry so will prefer to remain submissive instead they should become good and effective communicators.
3. Nurses ought to desist from trivialising their contribution to patients' recovery.
4. They must stop being afraid of making mistakes about their works or being misinterpreted so will keep quiet.

Afterall, to err is human.

5. They ought to feel in control of their role in clinical settings so as to enjoy the respect of their colleagues in clinical practice.
6. More often they do not present themselves as mature adults but infantilize themselves and their colleagues. This phenomenon should cease in professional relationships of nurses.
7. Finally, nurses should affirm their professional individuality and stop appearing as institutional properties.

All these are situations and events of the mind, self and society which with proper reordering and social engineering can be achieved and a relationship of mutual respect will develop among nurses, between nurses and doctors and nurses and other stakeholders in health care delivery system.

RECOMMENDATIONS AND CONCLUSION

Buresh and Gordon (2000) presented a satisfactory approach for dealing with nurses fear of making doctors angry by urging nurses to deal directly with physicians who might respond defensively, aggressively or abusively to nurses in an attempt to silence them by discussing the aspects of their behaviour related to gender, patient care, collegiality and etiquette. Abuse from physician must never be tolerated.

In addition to those areas needing change in the professional practise and self presentation of nurses as they interact with the larger society, it is recommended that nurses should always be prepared to take advantage of every opportunity to make the agency of nursing/nurses known at all public fora, family levels social gatherings or at personal levels.

Nurses should come to terms with the reality of life in making errors but always endeavour to be knowledgeable and current in their chosen field. Individuals nurses should convey a message of maturity, responsibility and expertise to patients, relatives, physicians, other health care provides and society through their appearances, language, behaviour and performances in their professional responsibilities.

More universities in African countries have to be encouraged and assisted to start nursing degree programmes to increase this category of nurses. Even those universities offering nursing need to develop more nursing speciality programmes at postgraduate level and grow to faculties and colleges of nursing. The agency of nursing should become more articulated in curative, preventive and health promotive services to the community in order to chart a clear vision for its future. Wieck (2000) warned that failure to have a vision is a slow trip to irrelevance.

A historical, theoretical and contemporary view of nursing image, with particular reference to two African countries, has been explored and appropriate recommendations for improvement were made. Knowing the past of nursing provides basis for comparison with the present and the future which all nurses should build ought to be a visionary one.

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