THE NATURE OF THE PROBLEMS EXPERIENCED BY NON-ZULU STUDENT NURSES DURING THEIR ENCOUNTER WITH ZULU PATIENTS

by

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SUMMARY

THE NATURE OF THE PROBLEMS EXPERIENCED BY NON-ZULU STUDENT NURSES DURING THEIR ENCOUNTER WITH ZULU PATIENTS

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South African nurses have accepted the challenge that was brought about by the Health Reform Policy of 1990 which opened health service centres to people of all racial and cultural groups. However, recent studies on multicultural nursing have revealed that problems have occurred when delivering care across cultural barriers. Most of these studies have approached these problems from the patients point of view, where issues of dehumanized care, labelling and discrimination have been reported.

Therefore, this study was an attempt to look into these problems from the nurses point of view, by exploring the source of these problems, their effect on health care delivery and possible solutions. The researcher focussed on three critical issues, namely, lack of cultural knowledge, negative attitudes, as well as difficulty in communication.

Through focus group interviews (FGI) and responses to given scenarios, student nurses who had experienced problems with culturally different patients were given a chance to reflect on their experiences, report on these experiences and recommend possible solutions to the experienced problems.

The results revealed that:

1.The major source of the problems was lack of experience due to inadequate exposure to culturally diverse groups which in turn led to inappropriate decisions and actions at care delivery level.

2.Difficult perceptions and negative attitudes lead to the formation of stereotypes which block the delivery of culturally congruent care.

3.Inability to communicate due to differences in spoken language lead to difficulty in building the trust relationship and hence inadequate care delivery.

Student number:602-699-0

I declare that ***THE NATURE OF THE PROBLEMS EXPERIENCED BY NON-ZULU STUDENT NURSES DURING THEIR ENCOUNTER WITH ZULU PATIENTS*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

TD Khanyile ..... 20/04/98 .....

SIGNATURE **DATE**
(TD KHANYILE)

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LIST OF ABBREVIATIONS

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DIC:	**Difficulty in communication**
FGI:	**Focus group interviews**
LCK:	**Lack of cultural knowledge**
NA:	**Negative attitudes**

Categories index

Category 1:	**Lack of cultural knowledge**
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CHAPTER 1

The nature of the problems that non-Zulu student nurses experienced during their encounter with Zulu patients

1.1 INTRODUCTION

This study is about the problems that student nurses in hospitals around Durban experience when they deliver health care to patients whose culture is different from theirs. The focus of the study is on the problems experienced by nurses who, although not Zulu, are required to deliver health care to Zulu-speaking patients.

South African Nurses are faced with the challenge of having to deliver care to patients of all cultural and racial groups. The nursing profession in South Africa is required to meet this challenge because the Health Reform Policy of 1990 decreed that health services should be delivered to people of all cultural and racial groups. This requirement is a challenge to most South African trained nurses because most of them have received training in a unicultural

environment. If South African nurses are to be successful in fulfilling the Alma Ata goal of Health for All by the year 2000, their education programmes should focus on the delivery of primary health care. Primary health care issues cannot be adequately addressed without taking into consideration South Africa's cultural diversity, the problems which this diversity generates, and the influence which these problems exert on health care delivery. Problems caused by cultural differences need to be addressed first because a correct interpretation of cultural diversity is the necessary precondition for all proper caring. In order to contexualize this problem, the diversity of the South African population will be analysed in this study and the acculturation process will then be discussed. With this in mind, the researcher will highlight the impact that these two factors have had on the health delivery system of South Africa.

1.1.1 The diversity of South Africa population

One noticeable feature of the South African population is its distinctive racial-ethnic composition, a factor which makes it heterogenous. In 1995 the total population comprised an estimated forty one and a half million people (41 544 000). The four main population groups are each further subdivided into varying numbers of subgroups which further exhibit conspicuous internal cultural variations (Department of Interior, Central Statistics Department 1995).

The blacks constitute the largest component of the population. In 1995 blacks comprised 31 676 million of the total poulation. Blacks are further subdivided into a number of cultural and ethnic groups, amongst which are the Zulus, Northern and Southern Sotho, Tswana, Ndebeles, Venda, Xhosa and Swazis.

The whites constitute the second largest population group. In 1995, this group made up 5 215 million of the total South African population. This group is also subdivided on the basis of culture and language variations. More than half of the white population is Afrikaans speaking. Forty percent of the total white population is English speaking. The remainder is composed of fractions of Germans, French, Jews, Greeks, Portuguese and Italians. The

coloured population represents eight and a half percent of the total South African population (3 602 million). This group is further subdivided into Cape Coloureds, Malays and Griquas. The Asian population is the smallest of the four main populations of the total population of South Africa (1051 million). This group is also further subdivided into Hindus, Muslims, Chinese, Taiwanese and Japanese (Department of Interior, Central Statistics Department 1995).

1.1.2 Acculturation and its influence on health delivery in South Africa

The different population groups described have been in continuous contact with each other for the past two centuries. When two groups come into contact, change takes place and that change is called acculturation. According to Jonas and De Beer (1988), acculturation is a comprehensive process of cultural change resulting from direct and persistent contact between members of societies with differing cultures (Jonas & De Beer 1988:359). In the South African context, these rapidly occurring changes have made an impact on health care delivery and the training of nurses. To illustrate this, the acculturation process will be briefly outlined.

(a) The initial contact phase

In the South African context, this phase took place two centuries ago when the first immigrants from Europe arrived in South Africa as missionaries and traders. Later on, the discovery of diamonds in 1879 and of gold in 1872 led to a huge influx people into the towns, namely Kimberley and Lydenburg, where these minerals were discovered. Infectious diseases caused by overcrowding broke out and, as a consequence, more hospitals were established. This led to a need for more nurses to staff these hospitals. In 1874, nurses from an Anglican sisterhood in England, under the leadership of Sister Henrietta Stockdale, arrived in South Africa. Sister Henrietta Stockdale made a lasting impact on South African nursing because she instituted the first professional nurse training course at the Carnavon Hospital in 1877. Thereafter, nurse training spread to other towns such as Kimberley, Barberton and Queenstown in 1890 (Potgieter 1992:134).

(b) The conflict phase

The second phase of the acculturation process in South Africa was mostly experienced during the apartheid era. The essence of the apartheid system was contained in the Group Areas Act, Act 56 of 1966. This act required the separation of people according to their racial groups. By this means the government of the day hoped to effect a solution to the problems caused by the conflict phase. What happened in fact was that more problems than solutions were created. During the conflict phase, groups in contact usually experience problems because of cultural differences, and the dominant group may encounter resistance from non-dominant groups and so conflict ensues. In South Africa conflict between the white ruling group and black groups arose because of the apartheid system of government. This system had a negative impact on health delivery because health care facilities were not equitably distributed among all racial groups. There was also an uneven distribution of health services to the rural communities. The Homeland Act of 1972 further compounded this problem. This act further divided the black population in terms of ethnicity. The apartheid system also affected the training of nurses in South Africa. Because the nurse training system became uniculturally oriented, care delivery also became unicultural since black clients were cared for only by black nurses and white clients were cared for only by white nurses. This meant that nurses never received any experience of delivering care to other cultural groups (Masipa 1991:3-4).

(c) The reintegration phase

South Africa entered into the reintegration phase in 1990, when, due to the Political Reform Policy, hospitals were opened to people of all cultural and racial groups. However, since most South African nurses who were still practising in 1990 had received a unicultural form of training, they experienced problems when they were expected to deliver care to culturally different clients.

Numerous studies have revealed that problems are generated by cultural differences between nurse and patient in the nurse-client encounter. According to Uys (1989:74), psychiatric

nurses experienced problems when delivering care to culturally different clients. Uys highlighted a few problems which, according to her, were frequent when care was delivered to "pluralistic" communities of South Africa. One of the problems she highlighted was that nurses lacked cultural information about different cultural groups. When Jonas and De Beer (1988:320) described the acculturation process, they posited that a lack of cultural information may cause anxiety, suspicion, resistance and defensiveness and ultimately full-blown conflict. Uys also found that problems were caused by differences in the definitions of illness as well as the differences in treatment methods among different cultural groups in the field of psychiatric care delivery. Uys hypothesised that these problems were compounded by segregated nurse training, and that this kind of training did not equip South African nurses for the challenges of delivering care across cultural barriers (Uys 1989:74).

According to Herbst (1990:21), South African nurses require a working knowledge about other cultural groups, and cultural nursing needs to be identified as an important basis of caring. Nurses can acquire this knowledge by engaging in participant observation (Herbst 1990:21). Many nurses in South Africa today are engaged in multicultural nursing, and basic programmes for nurse training prepare students by teaching them cultural information. For example, the curriculum for the Natal College of Nursing requires that a student, during her second year of study, should analyse the human being as a social being. In the social science course, students are introduced to cultural concepts and they are expected be able to analyse the relationship of these concepts to health, disease and nursing (Natal College of Nursing 1994: Sociology Teaching Guide S43/4/1:10). It is important therefore to explore the problems that South African nurses experience during their encounter with culturally different clients.

The researcher herself has been engaged in various forms of participant observation of the problem under study. During her engagement as a clinical nurse in a number of institutions on a permanent and on a part-time basis, the researcher made some interesting discoveries about cultural differences and how they affect health care delivery. The researcher became interested in this particular problem during discussions with colleagues who had been involved in multicultural nursing situations and as a result of her own experiences. To

illustrate this, the researcher will describe some of her own experiences as examples. Two of these experiences involved a lack of cultural knowledge and one was caused by the attitudes of the people involved.

1.1.3 The researcher's own experiences

1.1.3.1 A situation involving a lack of cultural knowledge

Mrs X was admitted for an abdominal operation to one of the hospitals in which the researcher was working. When the nature of treatment was explained to the client, she refused the treatment. The reason for her refusal was that she belonged to the Zulu cultural group. This group places a high value on a peaceful death and all events according to this cultural group are interpreted in terms of good or bad luck. To be sick is a sign of bad luck and the only treatment for this kind of bad luck involves the performance of a family ritual to "cleanse" the whole family from the evil that caused the bad luck. Therefore, according to Mrs X, her illness was a family affair. The other team members could not understand the reason for her refusal of treatment since they all belonged to different cultural groups, namely Afrikaans and English. The researcher, since she also belonged to the client's cultural group, could understand the client's concerns and fears. The researcher made an arrangement to see the client's family and to discuss the issue with them. Since Mrs X's problem was not urgent, she was given a week to visit her family and to make an offering to the ancestors before she returned for surgery. After a week, the client returned for surgery.

1.1.3.2 A situation involving negative attitudes towards other cultural groups

On another engagement in one of the private hospitals in Durban, the researcher witnessed a situation that involved the issue of attitudes. The researcher was on night duty and on that particular night all the personnel on duty happened to be black nurses. One of the patients, who was a white male, reported to the Nursing Service Manager on night duty that he was afraid of the black nurses. When asked to explain what exactly was he afraid of, he reported

that he did not trust black nurses and he was afraid that they might give him the wrong medication and that he might consequently die. According to Jonas and De Beer (1988), suspicion and anxiety occur when two cultural groups meet for the first time and this often leads to resistance by the non-dominating party and defensiveness by the other party so as to protect itself from domination. This client perceived himself as vulnerable and so became defensive (Jonas & De Beer 1988:324).

1.1.3.3 A situation involving lack of cultural knowledge

Mrs Y was an Asiatic female admitted to the maternity section. The researcher was assigned to work in the neonatal high care unit to which Mrs Y's prematurely delivered baby had been admitted. On this particular day, the researcher observed that Mrs Y, usually a cheerful mother, was upset and very quiet during the breastfeeding session. She reported to the researcher that the reason for her unhappiness was due to the way the staff in the maternity unit were treating her. According to Mrs Y, no one seemed interested in helping her with her physical well-being. They insisted that she should breastfeed even when she was not feeling well enough to do so. This made the researcher realize that the issue at stake was due to a lack of understanding on the part of the staff about Mrs Y's cultural background. After further interviews to determine what the client's expectations from the nursing staff were, the client reported that, according to her culture, the delivery of a baby was a highly valued event. A mother with a new-born child was treated with respect and dignity. All the female relatives and even neighbours would take turns in helping a mother who had just given birth. This culture (Asiatic) encourages dependence on other members of the family as well as on community members. This tradition was in direct contrast to the Western culture which viewed childbirth as an achievement for the medical staff and not for the mother, since it is the obstetrician or the midwife that, according to the Biomedical Model (Boyle & Andrews 1989:80), "manages" the labour and delivers the baby. These nurses, in their attempt to promote independence and self-care by encouraging early ambulation, failed to deliver culturally relevant care. The result was stress and frustration for the patient.

1.1.4 Problems caused by acculturation process

It should be clear by now that there are numerous problems and pitfalls inherent in the acculturation process. It should also be clear that acculturation affects health care delivery. Cultural differences, communication problems, lack of cultural knowledge and attitudes towards other cultural groups are some of the sources of these problems. Cultural nursing intervention is a two-way process that involves the care giver and the recipient of care. Cultural issues as they affect care delivery need therefore to be addressed if nursing is to achieve its goals. Though a vast amount of literature exists on this issue, South African nurses need to realise that the acculturation process in the South African context was unique in the sense that it was politically oriented. The diverse nature of the South African population has been politicised since, due to the apartheid system of government, difficulties arise when attempting to differentiate between culture and racism. The available literature therefore unfortunately fails to address this problem due to cultural differences from a South African point of view. This study is an attempt to explore the nature of the problems that student nurses experience during their encounter with culturally different clients.

1.2 THE PURPOSE OF THE STUDY

The purpose of the study is to explore the nature of the problems experienced by non-Zulu student nurses during their encounter with Zulu-speaking patients in hospitals around Durban. Recent studies on multicultural nursing have revealed that problems occur when nurses render care to culturally diverse patients. However, most of these studies have approached these problems from the patient's point of view. This study, however, attempted to look at these problems from the nurses' point of view.

1.3 ASSUMPTIONS OF THE STUDY

The following assumptions are made for the purposes of this study:

(1) Different cultural practices do exist among different cultures.

(2) These differences are manifested in all social domains, including that of health care delivery.

(3) Contact with cultures unaccustomed to each other might obstruct or disrupt social communion.

(4) The qualitative research paradigm, and more specifically ethnographic research, are suitable points of departure to clarify and to describe the nature of such obstruction, the effects that these have on individuals and groups, and the reaction of individuals and groups to such obstructions and disruptions.

(5) Focus group interviews and narratives will elicit data appropriate for exploring and describing cultural differences, culturally induced problems, the effects that these have on individuals and groups, and the reaction of individuals and groups to such obstructions and disruptions.

1.4 THE NEED FOR THE STUDY

The researcher hopes to ascertain by the end of the study the effects of the following problems on the nurse-patient relationship:

- a lack of cultural knowledge
- difficulty in communication
- negative attitudes

The researcher also hopes to find out from the informants what solutions that may be appropriate for the above-mentioned problems.

- **Reasons for identifying these three problems**

From the researcher's point of view, the nurse-patient relationship involves the following: knowledge or experience about another person's cultural background, the ability to communicate, and the way in which each individual perceives the nurse-patient encounter. In other words, during the nurse-patient encounter, the nurse brings her own cultural and professional values and beliefs to the situation and the patient also brings his/her own. For primary health care to be effective, South African nurses must be willing to deliver care according to their patient's point of view. Because the nursing profession, since it is the largest health sector, needs to meet this challenge, curricula for nurse education and training should recognise the country's cultural issues and deal with these first.

However, the fact remains that most South African nurses have found themselves faced with the challenge of having to deliver health care across cultural barriers, an experience for which they are not equipped (Uys 1989:13). These nurses have accepted this challenge, but since they lack experience they often encounter problems in this area. The South African Nursing Council accepted the following policy concerning its educational task: "... to create an awareness in the registered person of the socio-cultural implications in the provision of comprehensive nursing in the South African Communities" (South African Nursing Council 1994:4). The programme objectives for the education and training of a Nurse (General, Community, Psychiatry) and Midwife leading to registration as a nurse for the Natal College of Nursing, also required the student to complete an assignment on Cultural Care. Professor Mashaba (1995:6), in her paper delivered at the National Conference for nurse educators in Natal in 1995, emphasised the fact that transcultural education practices were important since the many culturally diverse people of South Africa are in a process of being welded into one nation. Very little, however, is known or understood about the cultures of those who have been political minorities. She also said that Nursing Education was faced with the challenge of emphasising the cultural dimensions in preparation of nurses (Mashaba 1995:6).

According to the National Health Policy, nursing education programmes should be focused on primary health care. Lubanga (1995:12), the Director of Health Services of the Talbot

Perkins Children Services in New York, in her paper on Integrating Primary Health Care in Nursing Education, also stressed the fact that the new curriculum for nurses should recognize the country's cultural issues and their influence on health delivery. These issues, according to Lubanga, should be dealt with first, if primary health care is to be acceptable and effective. She further expressed her concern that nurse educators should make a conscious decision to reverse the negative impact that centuries of degradation, disrespect and downright contempt for the culture of the majority of South African's culture has had on the people. South African nurses need to view cultural issues as challenges and not as problems. (Lubanga 1995:12). More studies on the cultural issues are therefore needed so that nurses can address this challenge.

1.5 NATURE AND SCOPE OF THE PROBLEM

The majority of clients in hospitals around Durban, as was earlier indicated by the population statistics, are Zulus. The focus of the study was therefore on those nurses who are not Zulus. These nurses have delivered health care to Zulu-speaking clients and have experienced problems as a result of this encounter. The researcher has included an in-depth literature study of the Zulus so as to highlight cultural factors that influence health care delivery. For the purpose of the study, informants were drawn from one institution as it was the only one identified as having a more heterogenous population of nurses as compared to the other institutions.

1.6 DEFINITION OF TERMS

In order to facilitate communication and to ensure that the key terms are interpreted in the same way by the researcher and the reader, the researcher has defined the terms as they were used in the study.

1.6.1 Nature

For the purpose of this study, this term was used to determine the reality of the existence of the phenomena as well as the form in which the phenomena existed, the source or origin of the phenomena and the effect of the phenomena's existence during the nurse-patient relationship.

1.6.2 Problems

For this particular study, this term was used to explain those situations where the gaols were difficult to reach. Both the nurse's and the client's own goals were those perceived by informants in the study.

1.6.3 Student nurses

In this study, the student nurses were those students engaged in the programme for the education and training as a Nurse (General, Community, Psychiatry) and Midwife leading to registration as a nurse during the year 1996 (South Africa 1985. Regulation R425, as amended).

1.6.4 Culturally diverse clients

For the purpose of this study, this term was used to refer to those clients who were nursed by the student nurses but whose cultural backgrounds were different from those of the nurses, in this case specifically Zulu clients.

1.6.5 Nurse-client encounter

The term, in the sense in which it is used in the study, means the interaction between the student nurse and the culturally different client. From the researcher's viewpoint, this

encounter is associated with problems if cultures differ. For this particular study, this encounter was between a Zulu-speaking patient and a non-Zulu speaking student nurse.

1.6.6 Cultural knowledge

The researcher used this concept to encompass all basic concepts relating to culture that may have a bearing on the nurse-client encounter, namely communication, diet, life style, religious practices, family and social systems as well as beliefs about health, illness and treatment practices. From the transcultural nursing point of view, cultural knowledge is used to refer to all information about the client's beliefs, values, norms, traditions as well as their client's health beliefs, systems and attitudes towards health and health care delivery (Leininger 1978:41).

1.7 METHODOLOGY

The researcher used the qualitative approach for this study.

The purpose of qualitative research is to discover features, patterns, attributes and meanings in the phenomena under study. For this particular study, the phenomena under study were the problems which the student nurses experienced during their encounter with culturally diverse patients. The design was simply descriptive. Data collection methods, namely focus group interviews and narrative statements were used on those informants who had experienced problems during that encounter so as to explore in depth the nature of their problems. The criteria used for inclusion are discussed in chapter 4 (the chapter on methodology).

1.8 OUTLINE OF THE DISSERTATION

This dissertation is organised into six chapters. The first chapter introduces the reader to the problem under study. The purpose of the study was to explore the nature of the problems that student nurses experienced during their encounter with culturally different clients.

Chapter 2 provides some information about the culture of the Zulus since the main focus of the study was on problems experienced by non-Zulu nurses during their encounters with Zulu clients.

Chapter 3 presents the literature review of selected empirical literature pertaining to factors which may influence interactions between culturally different groups as well as a description of the theoretical framework selected for this study.

Chapter 4 explains the study design, research setting, data collection methods.

Chapter 5 explains the data analysis and interpretations.

Chapter 6 deals with the discussion of findings and recommendations.

CHAPTER 2

The culture of the Zulus and its influence on health care delivery

2.1 INTRODUCTION

This chapter focuses on some aspects of the culture of the Zulus. The diverse cultural traits of any specific group contain complex factors that influence the way individuals of the group approach and interface with other health care systems. As this study deals specifically with the interaction between non-Zulu nurses and Zulu patients in a Western health care system, it is important to review the relevant cultural dynamics of the Zulus. A brief review of the history of the Zulus will be given. This will be followed by a survey of the world view and social systems of the Zulus. The latter will be organized according to the first three levels of Leininger's Sunrise Model (Leininger 1991a:43) Leininger's Sunrise Model is regarded as an appropriate theoretical framework for this study and will be discussed in more detail in chapter 3.

2.2 THE HISTORY OF THE ZULUS

The following information was obtained from anthropological literature. Some information had to be verified and gaps had to be filled through correspondence with people living in the Empangeni district in the north of Zululand, as well as with information collected from the traditional healers from the Botha's Hill district near Pietermaritzburg, who were participants in a workshop that was organised by the Natal Institute for Community Health Education. The researcher was a participant in the same workshop.

The Zulus originated from the Nguni tribe which settled along the eastern coast of Southern Africa during the sixteenth century. The Zulus, with Malandela as their first leader, settled in the Mhlathuze valley. During that time they were a small group. Malandela had two sons, Qwabe and Zulu. Tradition from reliable sources recounts that, as a result of friction between these two sons after their father's death, Zulu, the youngest son, moved away to the North with a small group of followers. With the help of his mother, Nosinja, he founded the Zulu tribe. After his death, his own son, Jama, became the leader of the tribe. Jama was succeeded by his son Senzangakhona, who was Shaka's father. Until the time of Shaka's rule, the Zulus were a small and unimportant tribe. When Shaka succeeded to the chieftanship, he succeeded in creating a strong tribe by conquering the other tribes around him (Krige 1967:124). The whole of the KwaZulu-Natal region is therefore presently occupied mostly by Zulu-speaking people who constitute one of South Africa's major cultural groups (Van Rensburg 1995:216). Alverson (1967:139), in his study of minority group autonomy, divided the Zulus into three demographic types, namely: the fully urban type, the urban resident with mixed urban-rural involvements type, and the rural type. These demographic groupings are also ideal for this study. According to Alverson (1967:141), urban Zulus are typically European-oriented and have little or no identification with rural life, although most are rural-born. In response to Alverson, it should be said that one would be surprised to find that health practitioners were experiencing problems with regard to health care delivery to the Zulu patients if this were totally true (see figure 2.1).

Figure 2.1

The rise of the Zulu Kingdom

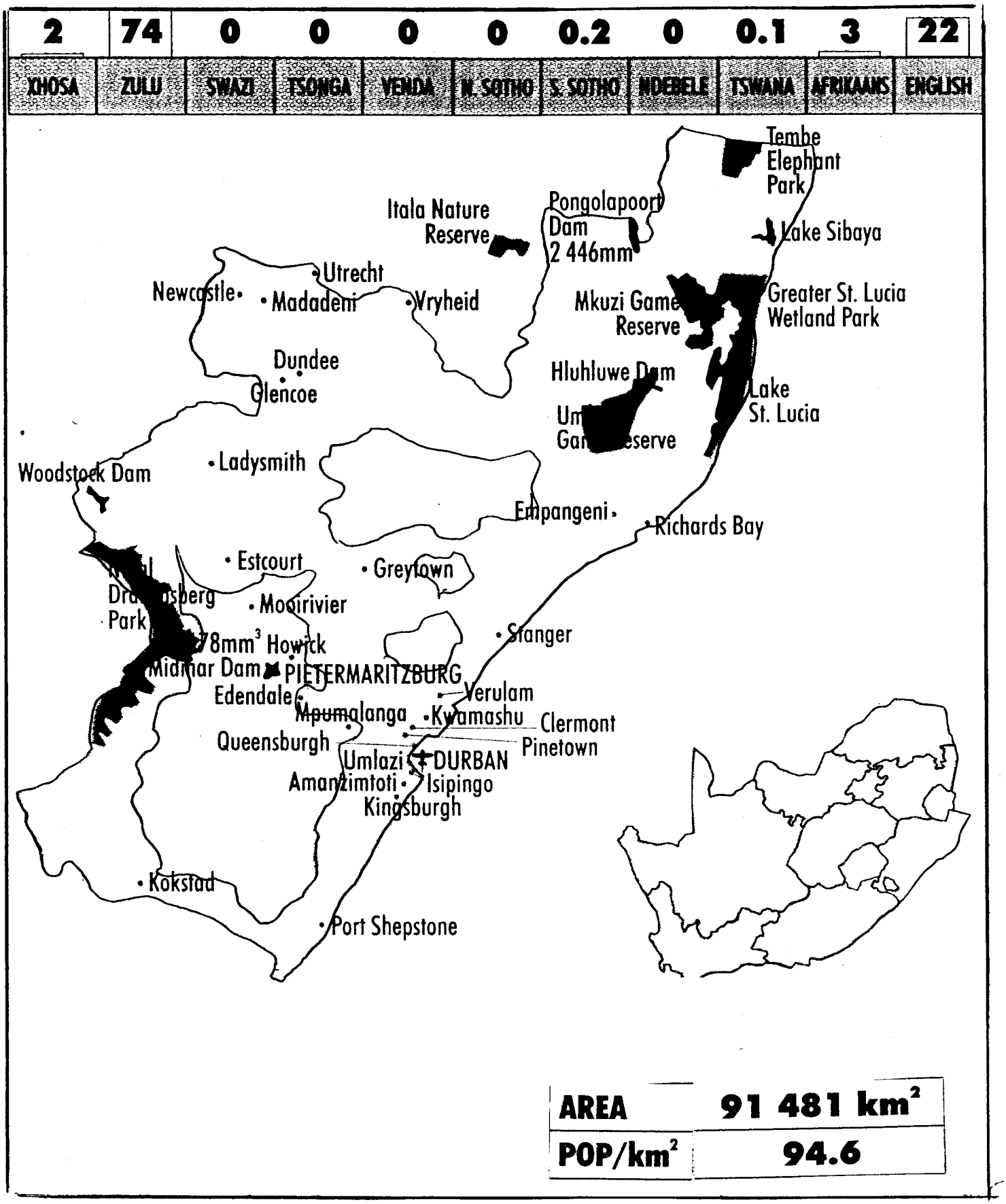

Figure 2.1

The Map of Kwa-Zulu, Natal

(Adapted from SA to Z 1996:G5)

When Jonas and De Beer (1988:106) described the second phase of the acculturation process, they described certain factors that influence cultural amalgamation, namely conservatism, patriotism, and the inferiority and superiority attitudes of the groups in contact. Urban Zulus, in attempting to adapt to the Western influences of urban life, experienced difficulties because they were expected to change their values and beliefs. What made things even more difficult was the fact that the group whose culture was being assimilated closed its ranks as they regarded them as inferior. The government of the day even introduced legislative measures, like the Group Areas Act of 1966, to prevent participation in their institutions. This gave rise to tension and resistance among urban Zulus as they struggled to maintain their continuity with their past. Urban Zulus have struggled to keep their tradition while selectively integrating them with Western influence. To say then that urban Zulus do not identify with rural traditions and residents is a myth which has been used to rationalize and to justify certain preconceived beliefs about race relations. Urban Zulus still regard themselves as culturally homogenous with those who live in rural areas. What follows is the world view and the social system of the Zulu culture and how these influence health care delivery according to Leininger's Sunrise Model.

Leininger's Sunrise Model is used to discuss some aspects of Zulu culture since it also underpins the theoretical basis for this study. According to the Sunrise Model, level 1 is the level of Cultural Care.

2.3 WORLD VIEW OF THE ZULU

O Level 1

A group's world view reflects a group's total configuration of beliefs and practices and permeates every aspect of life within the culture of that group. Members of a culture share a world view without necessarily recognizing that they do so. For the purpose of the study, only the world view as it relates to health and illness will be discussed (Boyle & Andrews 1989:23). The Zulus share the magico-religious health paradigm. A person's health is a gift from God or the Supernatural. The human individual is at the mercy of supernatural forces in the form of the ancestors who may cast spells of good or evil on the individual. In other words, when the

ancestors are neglected they respond by bestowing misfortune or illness on individuals. Health is a gift, and illness is an entity separate from the self, which is caused by an agent that is external to the body but which is capable of invading the body and causing illness or disease (Boyle & Andrews 1989:24).

2.3.1 Causes of illness

- **Sorcery - Aubuthakathi**

This form of illness is believed to be caused by human agents (sorcerers) practising sorcery. Envy, jealousy and anger are thought to motivate sorcerers to use their evil spiritual powers and other disease-causing objects to harm the people (Berglund 1976:267).

- **Pollution or ubumnyama** (intrusion by a disease-causing spirit)

This happens when an individual has been rendered weak and vulnerable during stressful times such as child-delivery, the period after the death of a family member, and menstruation. Women are therefore isolated after delivery because they are regarded as "unclean" and a source of bad luck. A woman who has lost her husband cannot attend social gatherings and mix with other people (men in paricular) because she is regarded as a source of bad luck she may pollute other people (Ngubane 1974:306).

- **Breach of taboo**

Disease can also be caused by a breach of a taboo. For instance, it is taboo to cut a child's hair before the age of one year or before the child begins to walk. It is believed that, if the taboo is broken, the result may be growth retardation and even an inability to walk. Delayed milestones may therefore be attributed to the fact that the child's hair was cut before he could walk. This may cause conflict during hospitalisation when nurses may, for example, need to administer intravenous fluids through scalp veins. If, therefore, one appreciates the Zulu perception of illness, one can appreciate why problems occur during hospitalisation. Most health professionals

adhere to a scientific or biomedical model health paradigm which states that life is controlled by a series of physical and biochemical processes that can be understood and manipulated by humans. This paradigm disavows the metaphysical (Boyle & Andrews 1989:28).

2.3.2 Treatment of illness

The Zulus mostly use the folk health system in the treatment of illness. These include the inyanga (herbalist), the sangoma (diviner), and the umthandazi (faith healer).

2.3.2.1 The inyanga

Zulus have traditionally turned to the inyanga for the treatment of practically all diseases. The inyanga uses a variety of herbs, the bark of trees, animal fat and skin, and bones to mix umuthi portions. The inyanga is a doctor who learnt his trade though apprenticeship from a senior who may have been a relative of the new trainee.

2.3.2.2 The isangoma

Zulus have always turned to diviners for information about the causes of illness and information about how to cure illnesses. Unlike the inyanga, who is usually a male, the isangoma is a woman. She is believed to be chosen for this position by the ancestral spirits. Today Zulu patients still turn to isangomas after discharges in order to "ukuzwa" (to hear) what caused the illness or even to hear who caused the illness. Sometimes Zulu patients will present themselves for hospitalisation but, because they hold a world view that attributes illness to objects outside the body, they are less concerned about treatment than about the cause of the illness. If they know the cause of the illness, they can conduct the necessary ritual to correct the situation – especially if it has been caused by the anger of the ancestors. Groups who share this world view see illness as belonging firstly to the family and even the whole community, and only lastly to the individual. That is why nurses are often faced with the problem of having to arrange a pass out for the Zulu patient who wants to visit the "isangomas".

2.3.2.3 Treatment methods

Colour symbolism plays an important role in traditional Zulu treatment and healing practices. Red-, white- and black-coloured medicines are used in various stages of treatment. These colours have the following meanings. Black signifies bad-luck or evil. Red-coloured medicines are used to strengthen the patient's body after an illness while white is associated with purity and good-luck. One interesting feature is that these medicines are given in big doses (like a litre) to be taken over five days. When patients are hospitalized, they cannot understand the doses of the hospital medicine. A patient may be expected to drink a whole bottle of cough mixture because he is traditionally used to being given larger doses. Sometimes a patient may refuse to take a white mixture during the onset of the illness since he may expect to start with a black one, followed by a red one, finally taking home a white-coloured mixture. These medicines are called "izintelezi".

2.3.2.4 The "umthandazi" or faith healer

The faith healer emerged as an adaptive strategy of the urban Zulu in an attempt to treat illness. This was done because inyangas and sangomas were not readily available in the urban areas. Faith healing, in addition, was based on Christian paradigms. Faith healing is a combination of both traditional and the religious methods of treatment. Zulu faith healers are usually Zionists. Their methods of treatment involves the use of sea water or ordinary water mixed with salt. This water is called "isiwasho"(normal saline) or purifier. It is believed to have the power to neutralize the potency of the poison used by the sorcerer. Faith healers also use laying on of hands and prayer in an attempt to physically eradicate evil spirits from the body. They also use different coloured ropes and cords with the same colour significance as do inyangas. These ropes are believed to have the power to drive off the evil spirits that caused the illness. It is important for nurses to respect this (the cord), especially when a patient is about to undergo surgery. The preparation of the patient should not interfere with the patient's beliefs and values, and the best method may be to cover the cord with a plastic bandage after explaining to the patient the reason for doing so. For urban Zulus, the rope has taken the place of a goat skin bracelet (Ngubane 1974:301).

2.4 THE SOCIAL SYSTEM OF THE ZULUS

2.4.1 Kinship system

Zulus have a strict patrilineal approach to kinship. The lineage is very important to a Zulu since behaviour patterns are defined by the lineage.

The lineage is the biggest family group and homesteads and houses within homesteads form a part of it. It provides the framework for social behaviour, obligations and privileges. The members of a lineage include all those in the patrilineal line of descent who are descendants of one ancestor. The lineage is seen as the most important factor ordering religious and ritual activities among Zulus since it encompasses both living and deceased ancestors. Members of the lineage "uzalo" tend to protect each other. This is usually evident when a person is hospitalized: he will have more than one mother or father coming to see him. Although they belong to different families within the lineage, they are all regarded as mothers and fathers. This may cause conflict especially when, during serious illness, only the next of kin is allowed to visit the patient. Nurses may have a problem identifying who the real mother of the child is.

2.4.1.1 The homestead – "umuzi"

At the middle level, one finds the homestead or "umuzi" which historically represented a cluster of the many nuclear families which are connected with one another through kinship ties - the extended family. Homesteads have always been regarded as the dominant social units in Zulu societies because, though the lineage may provide a framework for social behaviour, it is the homestead that will define the actual practices within the specified guidelines. Their dominance is also reflected in the fact that homesteads control their own economy, impose their own codes of social and marital behaviour, and exercise their own power and privileges. At the head of the homestead is the eldest male. He is regarded as "ubaba". He is the decision maker in the homestead. Appeal is made to his authority in cases of witchcraft and sorcery against any member of the homestead. Nurses in urban settings often hear patient's requesting permission to visit a farm to consult "ubaba", especially when important decisions, such as decisions about surgery, have to be made. A non-Zulu nurse may find this very confusing, especially if the patient is more than eighteen years old (Krige 1967:102) (see figure 2.2).

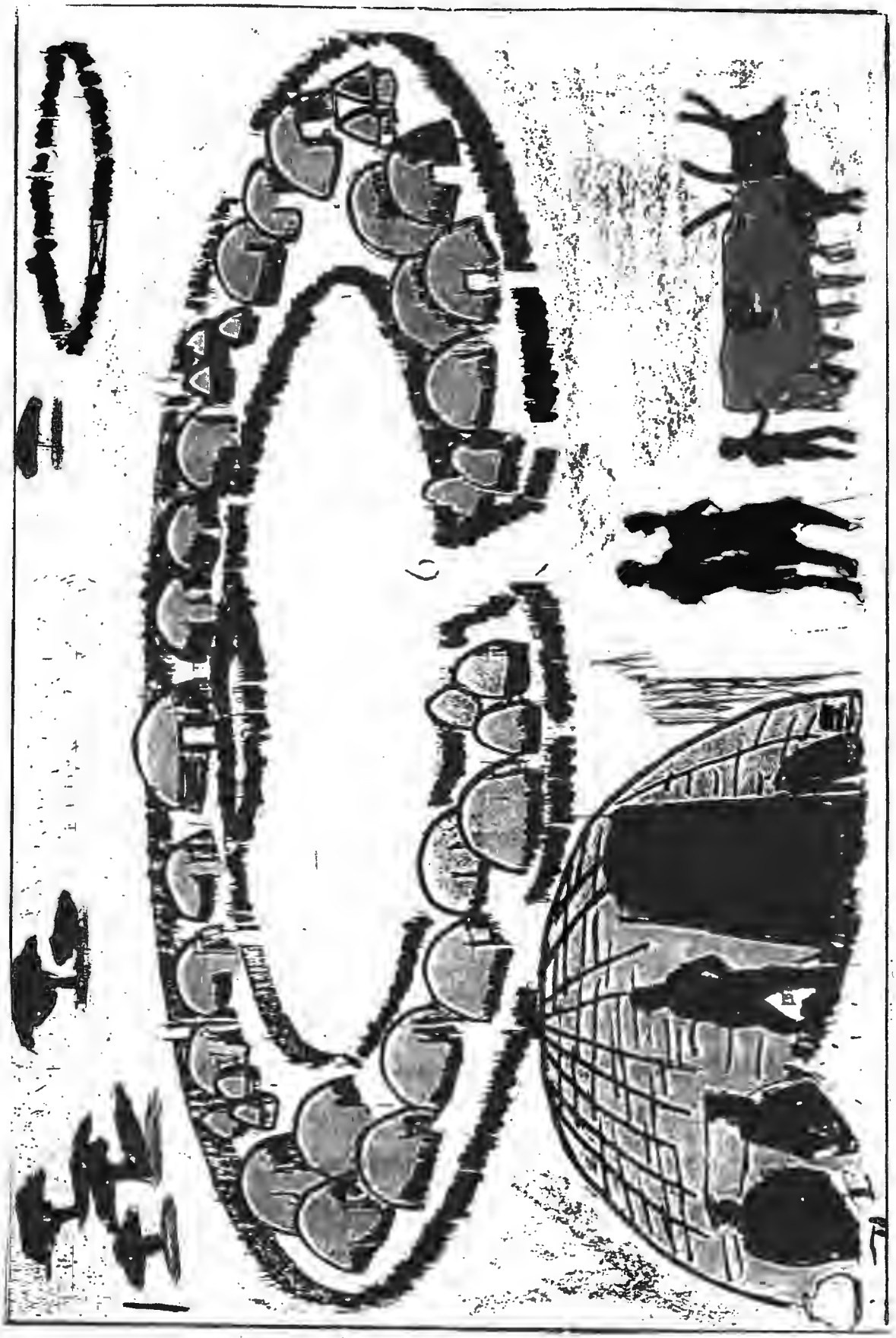

Figure 2.2

The Zulu Homestead

Umuzi

2.4.1.2 The house – "indhlu"

This is the smallest unit which comprises all the members of a nuclear family. The house, although insignificant in matters like social behaviour and obligations, is expected to take care of its own economy (Vilakazi 1962:26).

2.4.2 Cultural values and life ways

The "ukuhlonipha" concept embodies the highest value among Zulus. This literally means "to respect". For the Zulu, age and sex differentiate social behaviour. Females and young people are expected to respect older people, especially older males. According to Zulu custom, females are inferior to males and are expected to respect them. This is the reason why most Zulu nurses are perceived as being especially submissive to male doctors. A study by Martin and Bekker (1986) also revealed that Zulu nurses felt more comfortable nursing female clients and children. Conflicts may arise when a Zulu male client does not receive the respect he expects from a female nurse who belongs to a different ethnic group (Martin & Bekker 1986:306). The "ukuhlonipha" concept influences every aspect of a Zulu person's life.

- **The "ukuhlonipha" concept**

"Ukuhlonipha" simply means respect and is central to African societies in general but more especially to the Zulu-speaking communities of KwaZulu-Natal. Ukuhlonipha embraces a number of customary rules that govern relationships at different levels of society. It emphasizes respect, not only for the people one knows, but even for those one does not know. But more importantly it defines the authority of the elders over younger people, and of parents over children. It also defines the authority of men over women, and the primacy of male authority in society in general. Ukuhlonipha sometimes also attributes superiority among individuals on the basis of sex, age and social position, and defines the whole set of authority and hierachical relations found in Zulu society (Mdluli 1987:63). Ukuhlonipha is regarded as the essence of ubuntu (see figure 2.3).

Figure 2.3

Married Zulu females keep their heads covered all the time to respect their inlaws

2.5 COMMUNICATION PATTERNS IN ZULU SOCIETY

Central to the Zulu ethos is "ubuntu", humanity, a deeply felt respect and belief in the equal value of the life of human beings.

2.5.1 Principles of ubuntu

2.5.1.1 Authority and submission

Society is structured hierarchically and depends on the use of authority and submission. Authority in society is based on categories of age, social status, sex and the traditional political system.

The older a person is, the more authority he has over young people. Males are dominant in Zulu society and the father has considerable authority over his family. Indunas and chiefs exercise authority over their subordinates. Teachers, doctors, lawyers and wealthy people have more authority over ordinary people and Zulus often therefore appear to be passive and submissive about their condition and treatment procedures. Once in hospital, they submit to the authority of the doctors and nurses. They accept treatment unquestioningly since they perceive health personnel to have more authority than they do. Gender roles also play an important part in the structuring of society. People are not seen as individuals but as members of groups and they are expected to behave according to societal roles. This is confirmed by patterns of name usage, with the use of personal names being extremely limited in comparison to the use of groups names such as *mama, thisha.* Behaviour is required to conform to that expected of the group. A child refers to a nurse as *mama* or *anti* (aunt) even though they are not be related. They will consequently expect favours from *anti* – such as not giving an injection (Mdluli 1987:70).

2.5.1.2 Group membership

The emphasis on group membership results in considerable formality and prescriptiveness in Zulu society. Relationships tend to be formalized. There is little spontaneity in relationships,

and Zulus refrain from imposing themselves on others. Because of ubuntu, however, there is a general expectation of considerateness in social relations and people are always expected to offer help. Thus a Zulu patient will always say, "I am better today, doctor" but will later complain to the relatives that he is in pain.

2.5.1.3 Human dignity - "isithunzi"

Ubuntu requires a certain openness and friendliness towards people of a lower status. By behaving in a manner which does not befit his group, a person would do damage to his "isithunzi" and he may loose face in the eyes of others. "Ehliswe isithunzi" his dignity has been lowered.

2.5.1.4 Self-esteem - external to the society

When a person has done wrong, he becomes worried about what people will say and not about what an individual will do about it.

During communication with the nurse, a Zulu patient may fail to express his request clearly since direct speech is considered rude and impolite. One may hear a Zulu patient communicating about the cold weather instead of asking the nurse to close the windows.

In Zulu society, politeness is seen as a highly positive value which, in a variety of ways, contributes towards maintaining good relations within society. Politeness can be negotiated in many verbal and non-verbal ways and many of these result in what might be termed greater indirectness. The link between politeness and indirectness, which has been postulated as a linguistic universal, comes partly from a reduced understanding of the concept of politeness (De Kadt 1994:107).

2.5.2 Language

When talking to her in-laws, even if they are younger than herself, the Zulu woman is expected to keep her eyes down cast. She is not allowed to look at them nor call them by their first names. There are certain forms of speech that are taboo in Zulu culture. For example, since all Zulu first names have meanings, a married woman may not use a word if it is similar to her father-in-law's first name. (If, for example, her father-in-law's first name is Phuthu, she will have to devise another name for "pap".) During dietary history-taking, a client may therefore have difficulty in telling a nurse that she eats *phuthu*. The word she uses may not be familiar to the nurse and the nurse may think the client is merely being difficult or rude. According to Hall (1984), a Zulu woman could not tell him/ her father-in-law's name during an interview even though the woman was a trained nurse residing in an urban area. (Hall 1984:106).

Also, in Zulu, the concept "please" does not stand on its own, but it is often used subjectively as "awu-ngiboleke", meaning "please lend me". Non-Zulu speaking nurses may find it problematic when (in their view) Zulu patients never say "please".

2.5.3 Dress style

In the presence of her husband or her in-laws, a woman must cover her body from her shoulders downwards and she is expected to put on a scarf or "mnqwazo" to cover her head. When Zulu female clients are hospitalized they experience problems when admitted to those institutions which previously catered for "whites only" clients since no provision was made for them to keep their heads covered. One female Zulu client once used a bedpan cover (the linen type) for this purpose since it was visiting hours and she was expecting her in-laws (see figure 2.3 and figure 2.4).

Figure 2.4

Traditional dress for young Zulu male (on the left) and females (on the right)

Figure 2.4

Traditional dress for young Zulu male (on the left) and females (on the right)

2.5.4 Diet and eating patterns

Zulu diet is composed mostly of starch in the form of mealie-meal. Vegetables, mostly of a cheaper kind, and meat, are included in the diet. Zulus traditionally thought that to be healthy was to be fat and strong. Thinness was regarded as a form of illness and weakness. Urban Zulus have adapted to an oriental diet of curries with a lot of oil and spices. Problems arise when a Zulu client suffers from a disease for which the treatment is dietary. It may be very difficult for a Zulu person suffering from hypertension to reduce starch in his or her diet since his or her stable food is mostly starch. Newly-wed females may suffer from iron deficiency diseases since they are not allowed to eat food which is high in protein, particularly meat and milk. This becomes problematic, especially during pregnancy (Krige 1967:201).

2.6 RELIGIOUS FACTORS - THE ANCESTORS

According to Zulu society, when a male person dies, his spirit is transformed to "idlozi" or ancestor by means of a family ritual known a "ukubuyisa" (or bringing back home). For the Zulus, a man is a physical and a spiritual being. Death is regarded as the beginning of a continuation of life in the world of the ancestors and is not regarded as an end to life. Zulus' values after surgical interventions as well as death in an unfamiliar setting like the hospital are regarded as bad luck. When a person dies he therefore needs to be joined to his ancestors, who are believed to be residing in the homestead. It is important then to perform the "ukubuyisa" ritual, especially when a person dies away from home. In a hospital setting, one may encounter the family of the deceased patient who may explain that they have come to fetch the deceased person months after he has died. They usually carry a branch of a certain tree which they will drag from the area where his bed was when he died. They will speak quietly as if speaking to the deceased, and they will instruct him to return home since they have come to fetch him. An ox will be killed and beer will be brewed for this occasion since this is the occasion when they celebrate the incorporation of the deceased person among his ancestors. For the first time after his death, his name will be spoken. For the urban Zulu, religion combines dealings with the ancestors and God. The majority of Zulus are Christians but nevertheless maintain strong ties with the ancestors. The Zionists are a contemporary religious movement, and the majority of

urban Zulus are members of this African religious movement. Since the ancestors feature greatly in Zulu religious beliefs, their role will now be discussed (Ndwandwe 1996:26).

2.6.1 The role of the ancestors

The ancestors, who were the male heads of their families, are expected to continue their role of protecting the family even after their deaths. They will, for example, protect them against illness. The ancestors, however, cannot take care of themselves and they rely on their living descendants to look after them and feed them (Ndwandwe 1996:25).

2.6.2 Communication with the ancestors

The living are expected to communicate from time to time with their ancestors through the performance of certain rituals such as slaughtering a goat or cow. For the urban Zulu, pressed by financial constraints and the unavailability of goats and cows in urban areas, the use of a chicken has become an accepted ritual substitute. Illness is to a Zulu man a form of communication from his ancestors, indicating anger and a threat to break off any future communication. A hospitalized patient may therefore ask for a pass out for a few days to go home and communicate with his ancestors through the performance of a ritual. Before any major decision, such as consent for major surgery like amputation, is taken it is necessary for the patient or his family to slaughter a goat so as to ask for "good luck" from the ancestors. The ancestors sometimes communicate with the living descendants through dreams. They either make demands or warn them against impending danger or they give them instructions about how to protect themselves. The contents of a dream are therefore taken very seriously by a Zulu, especially if the dream involves deceased people. Health practitioners need to treat their patients feelings about the contents of their dreams seriously and with respect if a good nurse-patient relationship is to be maintained. This is especially the case if the contents of the dream have been communicated to a health professional, as is usually the case. Nurses should also respect a patient's customs such as the wearing of a goat skin bracelet during hospitalization, because, for a Zulu, this is a form of protection (Krige 1967:195).

2.6.3 Zulu traditions and Christian beliefs

Long before the advent of missionaries from Europe and America, Zulu people were aware of, and acknowledged, the existence of God whom they called "Umvelinqangi". They acknowledged Him as the Almighty God and the Creator of all things. For urban Zulu therefore, religion combines ancestors and God. The majority are Christians who still maintain strong ties with their ancestors. The Zionist is a contemporary religious movement and the majority of urban Zulus are members of this African religious movement. An example of this movement is the Shembe church which has been in existence since 1893. According to Ndwandwe (1996), the Shembe church is the largest African religious movement, with a membership of more than two million in the Durban region only. The Shembe church was founded by Mdliwamafa Shembe who settled in Natal from Orange Free State. In 1906 he was ordained as minister in the African Baptist Church but, due to differences in his interpretation of the Bible, he decided to leave and form his own Church of Nazareth. Having acquired a large piece of land near Inanda, they called it Ekuphakameni, and this is the Mecca of the Nazarites. People come to Ekuphakameni from all parts of the country to be healed of diseases or exorcised of demons. Many women come to be prayed for by Shembe, so that they might have children. The present leader of the church is Mbusi Shembe, son of the late Amos Kula Shembe who was the second to blend Christian beliefs with Zulu traditions and practices by his strict adherence to Zulu-sociocultural thought patterns and his adaption of the Bible to fit the Zulu way of living. Traditional modes of dress are encouraged, especially on ceremonial occasions (Ndwandwe 1996:24) (see figure 2.4).

2.7 ECONOMIC FACTORS

Farming, especially cattle and crop farming, were the only means of subsistence in the past. A Zulu male's financial status would be measured by the number of cattle in his kraal as well as by the number of wives, since more wives meant more children, and, if those children were female, it would mean that he would gain more cattle (because of the lobola system). Even today, among urban Zulus, a man's priority in saving money is to buy more cattle. Family planning may be difficult among Zulu rural people since they believe in the importance and financial value of big families. With industrialisation, people have moved from the rural areas to urban areas, and this

has resulted in informal settlements around big cities like Durban. Men leave their families to come and seek employment in urban areas, and they end up with two families, one in the rural area and one in the city. This has serious implications in that it may cause the proliferation of poverty and poverty-related diseases like pulmonary tuberculosis and malnutrition and these may lead to the overcrowding of health care institutions.

2.8 EDUCATIONAL FACTORS

Until recently, education was not valued among the Zulus. Male children had to look after the cattle and females had to assist with crop farming and other house chores. As a result, the illiteracy rate is high among Zulus and illiteracy causes problems during hospitalization. Communication problems may arise, especially if a nurse cannot communicate in Zulu. Today the trend has slightly changed. The illiteracy rate is still high among Zulus but there are marked improvements due to industrialization which has influenced people to move to urban areas. The education system has however also been influenced by politics. The ubuntu-botho syllabus was drawn up by the Natal African Teachers Union. Ubuntu means being human and this embraces values like universal brotherhood for Africans, sharing, and treating and respecting other people as human beings. This concept has a positive connotation. Its aim is to teach pupils good citizenship. Zulu patients, even those from urban areas, may be perceived as passive and not taking an interest in their health since when hospitalized they view health practitioners as having authority. Hence a Zulu patient may be heard saying, "udokotela owaziwayo" (meaning "Doctor knows everything about my health"). They unquestioningly accept any form of treatment (Mdluli 1987:69).

2.9 POLITICAL FACTORS

For prevailing political system among Zulus has been a form of traditional leadership in which the Zulu king has been the highest decision making authority. The amakhosi or chiefs were and still are subservient to the Zulu king. Chieftainship is still determined by blood lineage. What happened in KwaZulu-Natal was that there was a "marriage" between traditional leadership and politics and, as a result, ethnicity has become a strong political influence in KwaZulu-Natal since

1970. Since KwaZulu-Natal is an ethnically homogenous region, ethnic identity is highly valued, especially by those in rural areas. Problems may occur when a patient of royal blood is hospitalized because nurses, unaware of this fact, may call such a patient by his name and this will be regarded as insulting and dehumanizing. Traditionally all people with Zulu surnames, even though not directly related to the Zulu royal house, are referred to as "abantwana" (Nzimande 1994:11).

2.10 SUMMARY

This chapter discusses the history and customs of the Zulu, and Leininger's Sunrise Model (level 1) was used to organize information so that it related to the phenomena under study. Information from this chapter will be referred to throughout the study. The next chapter will present a review of the literature related to the problem under study.

CHAPTER 3

Literature review

3.1 INTRODUCTION

This chapter presents a review of selected empirical literature which describes problems which students encounter while nursing culturally diverse patients, as well as a description of the theoretical framework that was selected for this study. The review of literature served three specific purposes for this study. Firstly it helped to illuminate the significance of the study since the empirical literature did not clarify the nature or origin of problems encountered in multicultural nursing interaction. This indicated a need for further studies. Secondly, the literature reviewed served to provide a general understanding of the variables to be examined, namely cultural knowledge, attitudes and communication. These variables were chosen for the study since in the researcher's opinion they formed the basis of the nurse-client encounter. Thirdly, theoretical literature provided a framework within which to examine the problems under study. With the help of the librarians from the main campus

in Pretoria and from the Durban regional centre, the researcher was successful in locating some relevant literature on the phenomena under study. The main concepts used as key words for the computer search were: transcultural nursing, culture and health, cultural diversity in, and problems in multicultural nursing.

3.2 EMPIRICAL LITERATURE

3.2.1 Lack of cultural knowledge as a factor in transcultural interaction problems

This concept was used in this study in the sense of meaning information that nurses possess about another person's cultural background, that would influence the interaction. In other words this information or the lack thereof influences the nurse-patient relationship. This information encompasses all the patients values, beliefs, norms, perceptions about of health and illness, and the treatment of illness. Cultural knowledge as a concept was explained under the heading "definition of terms" (see page 11).

Several studies relating to factors such as the lack of cultural knowledge affecting care delivery were found in the literature. The focus of these studies and the research methods used were different. All of them nevertheless identified the lack of cultural knowledge as a factor. Bernal and Froman (1987:200), both professors in the department of nursing at Hartford University in 1987, conducted a study into the confidence levels of community health nurses in caring for ethnically diverse populations. They were concerned about the fact that the majority of community health nurses had not been academically prepared to render care to culturally diverse patients. According to these two researchers, experience increased the nurses' confidence whereas a lack of experience gave rise to a lack of confidence and therefore problems. Major variables in their study were self-efficacy or confidence, experience, anxiety, role models, verbal praise and comfort. The results revealed that the community health nurses in the study did not have the confidence to deliver care to the three defined cultural groups because of a lack of cultural knowledge. One interesting feature that the study revealed was the fact that all subjects welcomed the use of an interpreter as a solution to the problem. It showed that these nurses viewed diversity as

a problem and not a challenge that they had to address (Bernal & Froman 1987:202).

Another similar study was conducted by Murphy and Clark in 1993. They explored the issues, problems and experiences of student nurses during their encounter with culturally diverse clients. Questions were focused on five different areas, namely communication, the nature of the nurse-client encounter, the presence or absence of information, the clients family's contribution to care, and issues of frustration. The results revealed that all respondents highlighted difficulty in communication and lack of cultural knowledge as major problem areas. They all expressed feelings of frustration caused by their failure to develop a trust relationship with their clients. The respondents also only felt comfortable with their clients while an interpreter was present. Some of the respondents revealed that the care they delivered was, according to them, below standard and incomplete since they lacked cultural information about their clients. Like the respondents in the previous study, they felt that the introduction of interpreters during nursing interventions would provide a solution (Murphy & Clark 1993:61). Numerous researchers like Conway (1989), Dobson (1993) and Kanitsaki (1983), have emphasized the importance of cultural knowledge. They have highlighted the need for nurses to be equipped with cultural assessment skills so as to be able to deliver care to cultural groups (Conway 1989:69-71; Dobson 1993:106-111; Kanistaki 1983:42-53).

3.2.2 Nurses attitude as a factor in transcultural interaction problems

An "attitude" is a feeling for or against something and it is more or less long lasting (Baron & Byrne 1991:70). A person's world view as well as societal influence may both indirectly determine a person's attitude towards phenomena. From the researcher's point of view, an attitude is an outflow of a person's inner feelings and perception. It is exhibited in the person's behaviour. Attitudes are culturally determined, but may not be culturally bound since there are variations between and within cultures.

According to Gagne (1985:63), an attitude is an internal state that influences the choice of personal action made by the individual. Attitudes are learnt as individuals develop from childhood to adult life. They serve to predispose the individual to act towards things in a

particular manner. Gagne goes further in his description of the components of an attitude. Firstly, an attitude has a cognitive component which consists of beliefs which an individual holds about the object. Secondly, an attitude has an affective component which expresses the feelings that the individual has about the beliefs which he holds about the object. Thirdly, an attitude has a behavioural component which is a predisposition to act in some or other way towards the object. Attitudes may therefore influence the nurse-client interaction in a multicultural nursing situation because attitudes influence behaviour and behaviour is culturally determined (Gagne 1985:63).

Other researchers have expressed views that qualify the influence of attitudes. According to Felder (1990:276), factors like nurses' beliefs and values that are different from those of the client may lead to the development of attitudes towards the client. Beliefs and values are the building blocks for attitude formation (Felder 1990:276). Other studies similar to these, which highlight the importance of attitudes, have been conducted. Louie (1990), who was an assistant professor at Lehman College in New York in 1990, published a study on the relationship of attitudes and behaviour. The purpose of her study was to examine student nurses' attitudes towards ethically and culturally diverse clients. Major variables in the study were empathy, anxiety and attitude. The results of the study revealed that non-United States citizen students showed more favourable responses to ethnic minority clients than did students who were United States citizens. Apart from this, the hypothesis about the relationship between the level of empathy and attitude and the hypothesis about the relationship between anxiety and attitudes, were not supported. The reason why this hypothesis was not supported may have been due to the fact that the majority of the informants were white United States citizens. Perhaps a more random selection of informants would have taken care of this factor (Louie 1990:36)

A similar study was conducted by Martin and Belcher in 1986. Martin was an Executive Director of the Dayton clinical oncology programme in Ohio, and Belcher was an assistant professor of Nursing at Wright State University in Ohio. These authors were interested in investigating whether it was cultural knowledge or attitudes that influenced the care that nurses delivered to oncology patients. The purpose of the study was to investigate the cultural differences and similarities of the nurses attitudes towards their patients' treatment of pain and

dying. Through a survey, questionnaires were distributed to South African English-speaking and Zulu-speaking nurses who practised in the area of hospital clinical oncology, and also to nurses from the Midwest America working in similar clinical settings. Results revealed the following: there were similarities among the three cultural groups of nurses on issues like pain - they all agreed that patients with cancer experienced pain. They also agreed that the patient should make a major decision about where to die – either in hospital or at home. All subjects felt that dying at home was more favourable. There were clear differences between South African Zulu-speaking nurses and American nurses. The South African English-speaking nurses fell between the two groups, and findings were as follows. The Midwest American nurses and the South African Zulu-speaking nurses were all on extreme ends of the spectrum because of their cultural origins, and had never been in contact with each other. The differences between the two groups were especially evident in their attitudes towards a dying patient, as well as in the question of gender preferences when nursing patients. Zulu-speaking nurses felt more comfortable nursing female patients than male patients since, in accordance with their cultural background, females feel more comfortable around other females since they respect ("hlonipa") males. On the other hand, for the American nurses, male patients were preferred to female patients. The Zulu-speaking nurses felt that death should be followed by the cleansing ritual to remove "bad luck" or *ubumnyama* and so they did not feel comfortable around a dying patient in a hospital setting. It was interesting to note that Zulu respondents in the study were all urban people who had supposedly been acculturated and who had all been trained in a Western-oriented training system. In spite of this, their values and beliefs still influenced their attitudes towards their patients, even though they practised in an Anglo-Saxon cultural setting. This study revealed that attitudes are culturally based and that they influence an individual's behaviour. Since attitudes are culturally based, nurses need to review their own cultural beliefs and values about health and illness so as to identify their own apprehensions and prejudices.

Sands and Hale (1983:49) published an article which described strategies to resolve the problem of attitudes. They were both professors at the universities of Alabama and Maryland respectively. They were approached by nurse managers of surrounding hospitals to address the issue of cultural conflicts between personnel and patients. A group of professional nurses was taken for a course to address the problem. A strategy used in the course was to provide

participants with cultural information about specific communities.

After that the group was sent on participant observation to work with communities who were culturally diverse. They would thereafter be required to report on their experiences. Some of the informants possessed information about their clients which was later proved to be false (based on stereotypes). One informant, whose father had worked with a specific cultural group to which a patient belonged, believed the myth that the group performed very poorly in time-keeping activities, but she later discovered that the group placed a much higher value on people than on tasks. They were a people-oriented group who would spend some time everyday just chatting to staff members and patients.

In another strategy the group were shown videotaped vignettes which depicted conflict situations between personnel and patients. Group members were then required to answer questions. Their responses revealed that most of them identified themselves with the nurse in each scenario even when the nursing intervention was dehumanizing. This may be explained by the fact that both the group of nurses in the study and the vignettes belonged to the same cultural group whereas the patients in the scenario belonged to a different cultural group. This case study reveals that attitudes are culturally based and that attitudes can interfere with a multicultural nursing intervention (Sands & Hale 1983:49-54).

Felder (1990:276) shared a similar view about the effect of attitudes in the treatment of culturally diverse patients. She was an associate professor at the University of Wisconsin-Milwaukee School of Nursing in 1990 and her study investigated the effect of cultural diversity education in nursing on students' cultural knowledge of and attitudes towards black American clients. The problem stated that, although students received information about cultural diversity in nursing, their attitudes towards culturally diverse clients remained unchanged. The findings revealed that the majority of informants had only an average cultural knowledge of black American clients. They also revealed that cultural knowledge increased as students progressed from freshman to senior. However, the study also revealed that the informants' attitudes towards black American clients were neutral, with no significant difference or improvement between the two different programmes and between the levels within each programme. These findings revealed that

cultural knowledge does not affect the a person's attitude towards culturally diverse patients (Felder 1990:276-282).

Bornaparte and Ruiz (1979:166) held different views about the issue of attitudes and how they influence interaction in a multicultural situation. According to them, attitudes are intrinsic in the sense that different people have different attitudes to the same phenomena even though they may belong to the same cultural group. They investigated the nurses' attitudes towards culturally diverse clients. Using a measure of open- and close-mindedness, they discovered that nurses who were close-minded or highly dogmatic were likely to have negative attitudes towards culturally diverse clients while nurses who were open-minded had positive attitudes to culturally diverse clients. The nurses who were close-minded perceived culturally diverse clients as anxiety provoking and threatening. This study revealed that attitudes can change as a person changes his perspective on phenomena (Bornaparte & Ruiz 1979:166-171).

3.2.3 Presence of cultural knowledge as a factor in a multicultural nurse-patient encounter

Researchers like Bartz, Bowles and Underwood (1993:233) hold the view that the very presence of cultural knowledge can be a factor in transcultural interaction problems. According to them, once a nurse possesses cultural knowledge, she develops certain expectations of the client in accordance with the client's cultural background. Such problems may even be worse in community settings where the client is seen in his natural state without the influence of an alien hospital environment. To confirm this point of view, Bartz, Bowles and Underwood in 1993 published an article in which they described their own experiences and their students experiences with culturally diverse clients in a community setting.

The researchers and the students described their experiences of frustration and success during their encounter with culturally diverse clients. The students had been taught cultural assessment skills but they had not been exposed to a situation of interacting with culturally diverse clients. Both researchers had some cultural knowledge about the clients but they lacked experience in dealing with these clients. In describing their frustrations, both the researchers and the students highlighted the delay they met in trying to build a trust-relationship with their clients. All were

perceived as strangers and they were viewed with suspicion by the clients. They had not expected this kind of reaction as they had some knowledge of the clients' cultural background. But what they did not know was that the clients did not know anything about their (the researchers' and students') cultural background. This frustration led one student informant to realize that textbooks fail to explain that the nurse needs time to establish a trusting relationship before she applies whatever cultural information she may possess about the client. She then described her experiences with the cultural assessment tool without any exposure as being similar to being taught physical assessment without any opportunity to listen to heart or lung sounds (Barz, Bowles & Underwood 1993:233).

3.2.4 Communication as a factor in a multicultural nurse-patient encounter

Communication is a process of transmitting information or ideas from one person (the sender) to the other person or group of people (the receiver). Communication has two dimensions, and they are the content of communication and the way people communicate. Effective communication occurs when the message received matches the message the sender intended to send. There are, however, barriers to communication and differences in cultural background between the sender and the receiver is one of them. Using a common language when communicating with members of a different cultural group does not therefore mean that effective communication will automatically occur (Lemmer & Squelch 1996:30).

In chapter 2, some important communication patterns in Zulu society were explained. If one compares the communication patterns of the Zulu people with those in, for example, Western societies, differences readily spring to mind. Major differences may be noted in self-disclosure styles, or the willingness or unwillingness to convey emotions. Similarly, the non-verbal communication in some cultural groups differs from those in other groups. For instance, eye contact is valued in the Western cultures while in other cultures like the Zulu culture, it is considered rude, immodest or even dangerous. Body language and posture are other forms of non-verbal communication that vary according to culture. In some Hispanic groups, young girls and women are expected to keep their heads slightly bowed to maintain a modest demeanor. Language differences can also hamper the therapeutic relationship between nurses of one cultural

group and patients of another cultural group, even if they speak the same language (Mitchell 1978:142). Gagnon (1983), published an article in which she wrote about her own experiences as a community health nurse. She was assigned to a low socio-economic community where she experienced problems and frustrations due to differences in style of communication since language is not conveyed solely by voice but also by means of the entire body (Gagnon 1983:127-131). Other articles have been published which reveal that patients may be taken for granted if they are fluent in the nurse's language (Cohen 1982:26; Kanitsaki 1985:50; Kunhi 1980:24). The study by Murphy and Clark (1993:61) also revealed that problems may be encountered due to communication difficulties. In this study questions were asked about communication. All respondents highlighted difficulties in communication as constituting a major problem which hindered the development of trust relationships between them and patients. (This study has already been referred to on page 37.)

3.3 SUMMARY

This chapter dealt with both the empirical and theoretical reviews. The next chapter will describe the methodology of the present study.

CHAPTER 4

Methodology

4.1 INTRODUCTION

In this chapter, the researcher describes the methodology used for the study. It deals with the approach used, the theoretical frameworks, sampling procedures, data collection methods and a full description of the instruments that were used. Issues of validity and reliability are also looked at, as well as the ethical issues in the present study.

4.2 APPROACH USED

For this particular study a qualitative approach was used. Qualitative methods are used where there is little that is known about the phenomena. Qualitative methods are also useful when describing phenomena from the emic perspective, that is the "native's" point of view. For this study, the emic perspective was the perspective of the student nurses since they were

informants in the study. Qualitative approaches proceed inductively since analytic induction is an essential mode of inquiry directed towards bringing knowledge into view. The researcher also proceeded inductively by first identifying the three variables and thereafter exploring in depth through focused group interview and narrative statements, the source, the effects, and the solutions to the problems that the informants experienced during their encounter with culturally diverse clients (Morse & Field 1996:8).

4.3 THE RESEARCH DESIGN

Ethno-nursing was used since the study was based on a transcultural nursing theory. According to Leininger, ethno-nursing is a qualitative research method using naturalistic open discovery and largely inductively derived emic modes (from the people's point of view) and processes with diverse strategies, techniques and enabling tools to document, describe, understand and interpret the people's meanings, experiences, symbols and other skilled aspects bearing on actual or potential nursing phenomena (Leininger 1991a:79). This study sought to explore the nature of the problems that student nurses experience during their encounter with culturally diverse patients. Ethno-nursing was therefore an appropriate technique since it was only from the student nurses' point of view (emic) that the nature of the problems they experience could be understood. Ethno-nursing was chosen since it seemed the only research method uniquely developed for nursing research by nurses. For this reason specific research terminology was used like *informants* for subjects and *enablers* for instrument. Data collection techniques were also in line with the ethno-nursing methods and this will be discussed later in the chapter. The purpose of ethno-nursing research is to discover the nature, essence, attributes, meanings and understandings of a particular phenomena under study.

4.4 THEORETICAL FRAMEWORK

For the purpose of this study, Leininger's Sunrise Model was selected to be used as a framework. Leininger is an internationally renowned transcultural nurse who developed a theory about cultural care universality and diversity. She used the Sunrise Model to illustrate the major components of the theory. She developed her theory from a combination of anthropology and

her clinical experiences as a clinical nurse specialist in child mental health (Leininger 1988:16-25). Leininger's theory provided a unique and important basis for this particular study since the study dealt with the influence of culture on people's behaviour during multicultural encounters. Leininger recommended an inductive approach to data collection for studies using her theory. This study also proceeded inductively since the researcher used the informants' own experiences as a basis for tentative explanation (Leininger 1988:157).

- **The Sunrise Model**

This model was mentioned in chapter one. It will be discussed at length in this chapter (see figure 4.1 on page 48). This model describes how a theory's components influence the health and care delivery to individuals in various cultures. The basic concepts of the theory are: world view, culture, care, folk health or a well-being system (Wesley 1995:115). The Sunrise Model has four levels.

- **Level 1**

This level represents the world view and the social systems. Information from this level provides knowledge about the cultural groups attributes of care. This level was utilized in chapter 2 for organization of the cultural aspects relating to the Zulus. This information will help the nurse involved with a culturally different client to appreciate the differences in meanings about health and illness as well as differences in treatment as influenced by all the social factors as well as the patient's world view.

- **Level 2**

This level of the Sunrise Model provides information about individuals, families, groups, and institutions in different health systems. It also provides information about specific meanings and expressions as they relate to health and health care. This information is valuable to a nurse who is interacting with culturally diverse patients since she/he will know the systems used for the particular cultural group.

- **Level 3**

This level provides information about folk and professional health systems that operate within a culture, including nursing. It also allows for cultural diversity and universality. The nurse in possession of this information may be able to emphasize the cultural universalities and understand and respect the diversities to avoid conflicts at care delivery level. The present study is conducted at this level, with the eventual purpose of applying findings to level 4.

- **Level 4**

This is the care delivery level. Actions and decisions on this level are based on the information obtained from the first two levels. This is the level where problems may be experienced if the information from the first two levels has been undermined or ignored. The focus of this study originated from this level (Wesley 1995:114). Leininger also predicted that the differences in health delivery systems were a source of problems during the nurse-client encounter (Leininger 1991b:102). According to the present study, the variability between the Zulu patients and non-Zulu student nurses gave rise to problems during the nurse-client encounter. In this study, non-Zulu student nurses were involved as informants to explore their problems during a multicultural nursing situation. In other words, level 4 of the Sunrise Model was explored since it was assumed that it is at this level that most problems occur – though problems may also occur at level 3 (see figure 4.1).

4.5 RESEARCH SETTING

One nursing college campus in Durban was chosen as the most suitable setting for this particular study. It was discovered that, when compared to other campuses, it had a higher than average heterogenous population of students, namely whites, Coloureds, Asiatics and Africans. It was also discovered that the institution that offered clinical practice opportunities for these students had a higher than average heterogenous patient population. The reason for this was the fact that this health institution is centrally situated and therefore more accessible in terms of transport when compared to the other institutions around Durban.

Leininger's theory of culture care diversity and universality

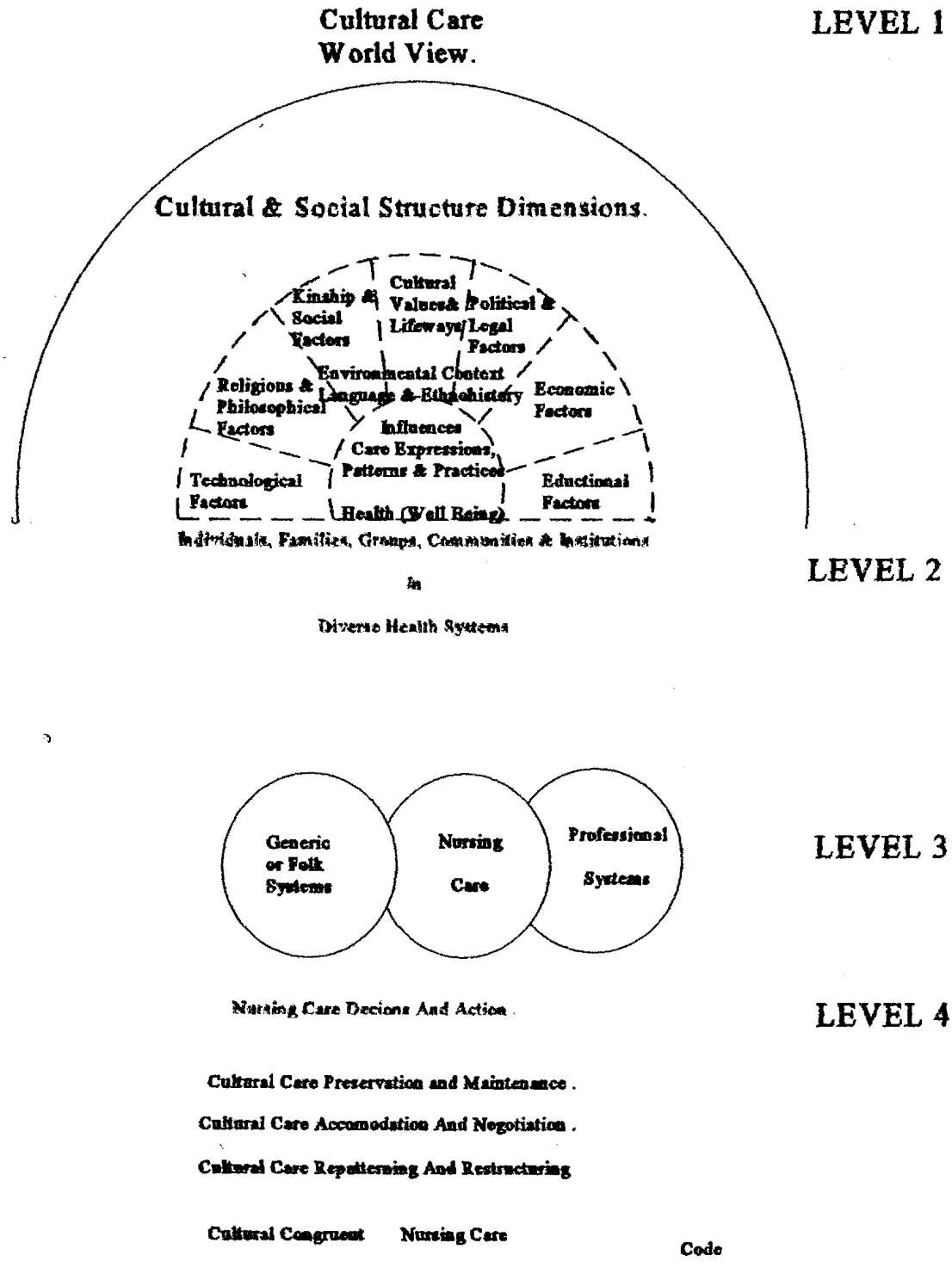

Figure 4.1

Sunrise Model

(Adapted from Leininger 1991b:106)

4.6 THE POPULATION

The student population in this particular campus for the year 1996 was three hundred and two. All these students were following the four-year diploma course in nursing according to the South African Nursing Council Regulation R425, 1985 as amended. This regulation stipulated the minimum requirements for education and training for the teaching of students in the programme leading to registration as a Nurse (General, Psychiatry and Community) and Midwife. This regulation further emphasized the importance of content. It stipulated that a fundamental nursing science includes definitions for health and illness, including cultural determinants relevant to the community served, and cultural differences in regard to health and illness including health practices and the nature of the sick-role and their implications for nursing relevant to the community served (South African Nursing Council Guide 1992:4). When one therefore studies the South African Nursing Council's policy on the education and training of nurses, it becomes clear that programmes for nurse training do cater for cultural information. What is not clear is the source or origin of problems that these student nurses encounter when they deliver care to culturally diverse patients.

4.6.1 Target population

- **Midwifery**

Due to the nature and extent of this study, the target population comprised only those students who have already completed their first two years of training and who were in their third and fourth year, since the focus of the study was on students who had done the Midwifery module. The first and second year students were excluded since they had not been exposed to the Midwifery module.

- **Reasons for focussing on the Midwifery discipline only**

  - The researcher aimed at targeting only those student nurses who had more than two years experience in nursing. The researcher believed that, after two years, the

student would have had adequate experience in care delivery to be able to differentiate between problems due to cultural differences and other health-related problems.

- To put the study into context, the researcher decided to focus on only one discipline and therefore the Midwifery was chosen as an appropriate area of focus.

- The students following the Midwifery module and those that had already done it were available during the time of data collection.

4.7 SAMPLING

4.7.1 Principles of sampling

○ Appropriateness

This principle ensures proper identification and utilization of informants who can best inform the researcher according to the theoretical requirements of the study. In order to fulfil this principle, careful sampling is important because of the awkwardness in handling bulky, qualitative data. It was also important to sample carefully since data collection was costly.

4.7.2 Sampling method

Purposive sampling was used since the researcher was interested in only those non-Zulu students that had nursed Zulu patients and had experienced problems. Informants were sampled according to the following criteria:

○ Levels of training

- The third and fourth year students had had more than two years experience in general, medical, surgical and outpatients clinics.

- The third and fourth year students had had theoretical lectures in midwifery.
- The third and fourth year students had had clinical exposure to Community Midwifery.
- The third and fourth year students had had clinical exposure to gynaecology and obstetric nursing.

○ **Availability**

The third and fourth year group was readily available since they were in block during the data collection period.

○ **Those that experienced problems**

Only non-Zulu student nurses who had experienced problems during their involvement with Zulu patients were selected. In this particular study, problems were explained as being *those situations where the goal of nursing care was difficult to achieve*. This included both the nurses and the patient's goals of care and the reasons for failure were attributed to cultural differences. For this particular study, problems that were highlighted were those associated with communication, lack of cultural knowledge, and attitudes towards culturally different people. The reasons for highlighting only these problems was the fact that the researcher herself had experienced similar problems during her engagement with culturally different patients, and also the fact that, after discussions with numerous colleagues who had been involved in similar situation, similar problems under similar circumstances had been noted by those colleagues. Because this was an assumption, informants were given a chance to discuss other problems that they had perceived as being the source of problems during their multicultural nurse-patient encounters.

4.7.3 Sample size

Out of 58 students who were in their third and fourth year of training, only twelve students met the criteria for inclusion in the sample. After discussions with the students concerned and the college principal, all twelve of them agreed to participate in the study.

4.7.4 Adequacy of the method chosen

Adequacy means that there is enough data to develop a full and rich description of the phenomena under study. Adequacy also means that the stage of saturation has been reached and that there is no more data that might emerge from further interviews. For this particular study, the researcher included other tools to collect data so that in-depth information could be retrieved. The researcher had to return a second time to the informants to verify with the informant, data that had been collected.

4.8 ENABLERS USED

4.8.1 Focus group

The focus group interview was used for this study. This is a carefully planned session which is audio-taped and designed to obtain perceptions about the problems which informants experience in a non-threatening environment (Kruger 1988:18). The duration of the sessions was less than two hours. The researcher herself acted as a moderator and a facilitator.

- **Reasons for choosing the focus group**

The strengths of focus groups come from a compromise between the strengths found in other qualitative methods such as participant observations and interviews. In focus groups the researcher observes, asks questions to facilitate the discussion, and, as a result, she/he has access to the experiences and feelings of the informants as she observes their non-verbal cues. This enabler was also an appropriate tool to generate more information that was used in subsequent data collection procedures. A questionnaire was later developed using the information obtained from the focus group discussions.

4.8.1.1 The design of focus group

- **The structure**

The problem under study was considered to be a topic of low intensity since very few studies had been undertaken in this area. Questions were also less structured so as to ensure that the researcher was getting the participant's own responses to questions at hand. A tightly structured design was considered to be less appropriate since the goal was to encounter new perspectives on the problems experienced. Because of this, imposing structures would have confined information to the predetermined question alone.

- **Group size**

Each group consisted of four participants. Smaller groups were preferred to maximize the group dynamics in each group. Smaller groups allowed each participant the chance to participate. They also tended to generate more intense discussions with more information being made available about the point of view of each participant. Smaller groups also allowed the researcher to observe non-verbal cues during the discussion sessions. Since the study required the informants to delve deeply into their experiences and feelings, smaller groups were appropriate.

- **Group composition**

Homogenous groups were used because informants were all third and fourth year students. Though it would have been advantageous to have heterogenous groups, homogenous groups were used because of the unavailability of other levels of students on block during data collection. Because the purpose of FGI (focus group interviews) is to produce self-disclosure, homogeneity of the group reduced the perceived risk for informants.

- **Number of groups**

The number of group sessions was determined by the saturation point, as has been mentioned

earlier. A pilot group was used to generate more ideas, language and vocabulary that could be used by informants. This pilot group was obtained from another setting which was representative of the research setting. This gave the researcher access to the informants common sense conceptions. This also ensured that informants' own thoughts and theories received consideration. The total number of focus groups was three.

- **The environment**

A comfortable, non-threatening setting was provided for the group session. Arrangements we made at the Unisa regional centre in Durban for that purpose. An audio-tape recorder was hired. Informants were seated on comfortable chairs around a table with refreshments.

- **The moderator**

The researcher herself acted as moderator by developing questions and by channelling the discussion towards the topic under study.

4.8.1.2 An example of a focus group

- **Introduction**

The researcher introduced herself to the informants by telling them her name, address, place of employment as well as her academic qualifications. Informants were also given a chance to introduce themselves.

- **Briefing session**

The researcher welcomed the informants and explained to them what information was sought from them. Ethical issues involved in the study were emphasized. The fact that information was going to be tape-recorded was explained, as was the approximate duration of the discussion session. An explanation of the concept "problems" was given in the sense in which it was used

in the study. After the informants were seated according to the criteria, correct forms were issued for them to sign.

- **Discussion session**

See Annexure 6 for a model of the focus group interview session.

- **Debriefing session**

At the end of the discussion each informant was given a chance to explore his/her feelings during and after the group discussion. The researcher helped to allay anxious feelings or guilt feelings. Thereafter the informants were thanked for their participation. See Annexure 6 for a model of the focus group interview session.

4.8.2 Narrative responses

In addition to the focus group interviews, informants were asked to write down their responses to a given scenario. The scenario was formulated in such a way that it included all three problems as mentioned earlier, namely lack of cultural knowledge, nurses attitudes and communication difficulties. Reasons for choosing the narrative response was that students were able to describe how they would have handled the situation. See Annexure 7 for a model of the scenario.

4.9 ETHICAL CONSIDERATIONS

4.9.1 Permission

Permission to do the study was obtained from the Director of Nursing for the KwaZulu-Natal region, the Principal of the Natal College of Nursing, as well as from the Medical Superintendent of Addington Hospital, which had offered clinical learning for the students in the study. Permission from the hospital was considered important since the study involved their experiences

during their clinical practice. For letters of permission and approval, see Annexures 2 and 3.

4.9.2 Respect for human dignity

This principle included the right to self-determination which meant that prospective informants should have the right to decide voluntarily whether or not to participate in the study. It also meant that the informants had the right to terminate their participation or to refuse to give information or to ask for clarification about the purpose or any aspect of the study.

4.9.3 Informed consent

To address this principle, informants were given full information about the purpose of the study, its significance, and data collection procedures before data was collected. This principle received priority consideration since informants in the study were students and they might have perceived the researcher as having authority over them or alternatively students might have perceived themselves as being a captive audience. They were informed that participation was strictly voluntary and a consent form was signed by each informant.

4.9.4 Risk/benefit ratio

This principle means that the degree of risk to be taken by those participating should never exceed the potential humanitarian benefits of the knowledge to be gained. Qualitative research is considered non-invasive, depending on the topic under study. This study focused on a significant topic that had a potential to improve care by improving the nurse-patient relationship. The informants might have felt nevertheless that their personal space and psyche were invaded during the interviews. For this reason, a focus group interview was chosen as a tool for data collection since it allowed informants to "ventilate" their feelings in a non-threatening and non-interrogative way (by means of discussion). The researcher, who assumed the role of a facilitator during the discussion sessions, helped by providing intervention in those cases where the discussion triggered emotional responses.

4.9.5 Confidentiality

Confidentiality in this study was not easy since precise quotations from transcripts had to be included in the collection of data. Informants were reassured that information gained would not be disclosed to authorities.

4.9.6 Principle of beneficence

This principle involves the protection of informants from harm. Although this study was not considered to be potentially harmful in terms of physical harm, it did contain an element of potential psychological harm in that it it focused on cultural problems which, in most cases, are confused with problems of racism. An explanation of the concept *culture* was therefore given during the briefing session. A debriefing session was undertaken after the collection of data since there might have been feelings of guilt about self-disclosure and self-reflection.

4.9.7 Rewards

The purpose of the study was reinforced so that informants appreciated the importance of their contribution. They were assured that the findings of the study would be reported back to them. The fact that the results may contribute towards the improvement of the nurse-client relationship also served as an indirect reward.

4.10 DATA ANALYSIS

Data was analysed using Leininger's phases of ethno-nursing data analysis for qualitative studies. (Leininger 1995:95). Chapter 4 reports the description of data analysis fully.

4.10.1 First phase

Collecting and documenting raw data took place by means of

- reading and re-reading notes made during the group sessions, listening to the tape-recorded information and transcribing this word for word

- recalling observations made, especially non-verbal cues during the focus group session
- listening to the tapes. This gave the researcher more than just words: it also involved feelings, emphasis, long pauses, sighs and exclamations

According to Morse and Field (1996:568), pauses are denoted by dashes, and gaps are denoted by a series of dots. Different information is denoted by new paragraphs. All pages were numbered sequentially and each page was coded with the informant's number.

4.10.2 Second phase

- **Identification of description and components**

- Tapes were played over and over again to study and to identify similar or dissimilar statements that could be coded or classified to understand the domains or questions under study.
- Codes were used as means of categorizing and organizing data.
- Categories were broad and were kept to a minimum and an index was kept in order to enhance consistency in the application of codes for subsequent data collection.

4.10.3 Third phase

- **Pattern and contextual analysis**

- Data was organized to discover patterns of behaviour, structural meanings and contextual analysis.
- Specific elements in the data were selected according to the components of the Sunrise Model and the components of the culture care theory was used to organize data.
- Data extracted from phases 1 and 2 was scrutinized for recurrent patterns of similarities and/or differences, and findings were considered in relation to the purpose of the study and the research assumptions.
- Data was examined in relation to the criteria for qualitative research namely: confirma-

bility, credibility and meaning-in-context and recurrence (more information about this will be given later in this chapter).

- The saturation criteria were also examined.

4.10.4 Fourth phase

- **Themes, major research findings**

- This is the highest phase of data analysis and synthesis.
- Major themes were explicated and developed from the findings abstracted and verified from the previous three phases.
- Data was thereafter synthesized and interpreted into meaningful themes.

4.11 ISSUES OF VALIDITY

Qualitative studies, as has been said, are not for generalization to larger populations. Issues of validity of the instrument are, however, a determination whereby the instrument actually reflects the abstract construct being examined (Burns & Grove 1993:346). For this particular study, the following aspects of validity were addressed.

4.11.1 Credibility

This refers to the truth, accuracy or believability of findings that have been mutually established between the researcher and the informants as accurate, believable and credible with regard to their experiences and their knowledge of phenomena. Through focus groups, interviews and narrative statements, informants were given an opportunity to describe their experiences while the researcher listened, took down notes and thereafter validated information recorded with the informants themselves.

4.11.2 Confirmability

Confirmability means the repeated direct and documented evidence from a thoroughly observed source of data, with repeated explanations or interpretative data from informants about certain phenomena. This means confirming what the researcher has heard and observed with respect to the phenomena under study. For this study the researcher continuously checked (confirmed) what she had heard with the informants data from notes and audio-taped information before data was analysed. During the second phase of data analysis, the researcher confirmed with the informants the data that had been collected at an earlier stage.

4.11.3 Recurrent patterning

This meant repeated instances, sequence of events, and experiences that tended to recur over a period of time in designated ways and contexts. For this study, patterns were drawn from the informants' audio-taped responses, their written responses to the given scenario, and their responses during the second phase of data collection.

4.11.4 Transferability

This refers to whether the findings from the study could be transferred to another similar context or situations and still preserve the particularized meanings, interpretations and inferences of the completed study. As mentioned before, the purpose of qualitative study is not for generalization, but to obtain in-depth knowledge. The researcher, however, hoped that the findings could be used in similar research contexts because literature has revealed that this is possible (as in, for example, Zulu nurses experiences with nursing non-Zulu patients or any other non-Zulu cultural group). In the pilot study, the researcher used another cultural group other than Zulus. Though the idea was to test the instrument, the results revealed that it is possible to transfer findings to another similar setting.

4.11.5 Saturation

Saturation occurs when the same information is obtained over and over again. The researcher was satisfied that this point had been reached when the last focus group interview session yielded similar responses to the first and second group sessions. By using more than one data collection instrument, the researcher hoped to satisfy this criterion.

4.11.6 Other aspects of validity

4.11.6.1 Internal or content validity

As far as this study was concerned, the only possible threat was in the selection of informants. A selection threat is more likely to occur in studies where randomization did not occur, and since this study used purposive sampling, one might have been tempted to include all the informants that met the selection criteria, namely those that had experienced problems. However, it was felt that the sample was already too small to be randomly selected and, for qualitative studies, a small study is more suitable. The number of variables included in the tool were carefully selected since the variables needed to be essential to the research questions. In this study, variables like cultural knowledge, communication difficulties and attitudes were carefully selected.

4.11.6.2 Construct validity

This would have been threatened if there had been an inadequate pre-operational explication of construct. In this study, most concepts were taken from Leininger's Sunrise Model. Level 1 of the Sunrise Model, which explains the person's world view and social system, provides information that forms the basis for the nurse-patient relationship during a multicultural nurse-patient encounter (see figure 4.1).

4.12 ISSUES OF RELIABILITY

The reliability of qualitative research refers to the truth value or the believability of the findings.

The descriptions developed through data analysis confirmed that the enabler was reliable. Aspects covered for this study included the following:

4.12.1 Stability

This is concerned with the consistency of repeated measures. For this particular study, the researcher used more than one enabler to collect data and, if the same information was yielded, this meant that the information received was reliable.

4.12.2 Equivalence

The focus of equivalence is on comparing two versions of the instrument. For this particular study, there was one rater, the researcher, but she observed, took notes and tape recorded information. Thereafter, the researcher reflected back and compared all the information gathered to ensure equivalence of data. The researcher also consulted another experienced qualitative researcher to discuss the enablers used as well as the data collected. The researcher was fortunate to have had an opportunity to consult a panel of research experts whom she met during a workshop on data analysis that she attended. The contribution that these people made was greatly acknowledged.

4.13 SUMMARY

This chapter discuss the methodology used for this study. The next chapter will look at the actual data collection procedures as well as data analysis.

CHAPTER 5

Data analysis

5.1 INTRODUCTION

In this chapter, the data collection and analysis procedures will be discussed. For the purpose of the study, the researcher used a combined method of data collection, namely, the focus group interview and the narrative statements and then, a month later, to meet the credibility and confirmability criteria, the researcher returned to the informants in order to verify the data collected.

Data was analysed using Leininger's phases of ethno-nursing data analysis for qualitative studies. In all, therefore, there were two sets of data, each of which was analysed separately first, before all the results were compared and interpreted.

5.2 REALISATION OF THE STUDY

During the time when the study was conducted, there were three groups of students on block, namely, the first, third and the fourth years. The first years were excluded because, as was mentioned earlier, they did not meet the criteria for inclusion.

5.2.1 Sampling

Purposive sampling, as was mentioned in the previous chapter, was the most appropriate method for this particular study.

5.2.2 Sample size

Out of fifty eight students, only twelve students met the criteria. All twelve students gave their verbal consent to participate in the study. The college principal kept a record of all those who agreed to participate, and this was available for the researcher's examination. Arrangements to transport the informants to the venue were made by the researcher together with the informants.

5.2.3 The venue

The study was conducted at the University of South Africa's Durban regional centre. This centre was ideal for the study since facilities like an audio room, which was noise-proof, and functional tape-recording equipment, were readily available. The venue was perceived by all informants to be non-threatening.

5.2.4 The composition of the sample

The sample consisted of twelve informants. Eight informants were doing their third year and the last four informants were in their fourth year. For the focus group interviews, three groups of four each were formed, and the groups possessed the following characteristics:

5.2.4.1 The level of training

The first two groups were formed from the third year students and the third group was made up of all fourth year students.

5.2.4.2 The ethnicity

The first group was more heterogenous in terms of ethnicity. This group consisted of one coloured, one Tswana, one Asiatic and one Swazi student. The second group was more or less homogenous in ethnicity since it was made up of three white students and one coloured student. The third group was also made up of three whites and one coloured student.

5.2.4.3 Experience

All informants had experience in Midwifery since all of them had done the module and had all been exposed to obstetrics for clinical experience.

5.2.5 Data collection

5.2.5.1 Stages of data collection

- **First stage**

Informants were exposed to focus group interviews and these discussions were tape recorded. This enabler was discussed at length in chapter four (see Annexure 6).

- **Second stage**

After the focus group interviews (FGI), informants were given narrative statements to which they had to respond. These scenarios were formulated and based on the assumptions of the study (see Annexure 5).

- **Third stage**

One month after the initial data collection stage, the researcher returned to the informants for the purpose of confirming with the informants the data that had been collected earlier. During this stage, tapes were played back to the informants for them to verify the tapes recorded.

5.2.5.2 Dates and time of data collection

5.2.5.2.1 First group

The first group was interviewed on Wednesday afternoon between 15:00 and 15:30 on 5 March 1997.

- **Introduction and briefing**

On arrival at the venue, after all the informants were comfortably seated, the researcher introduced the research topic. All the informants understood the purpose of the study as it was explained to them and they all seemed comfortable with the fact that the discussion was going to be tape-recorded. They all signed the consent forms. All the informants were familiar with each other since they belonged to the same group (third year) and no one expressed any discomfort about disclosing their experiences.

- **Discussion**

The researcher opened the session by asking each informant to tell about his/her experience with a Zulu patient, an experience which resulted in a problematic situation as perceived by the informant. The tape recorder was switched on. All the informants took turns in talking about their experiences. The researcher took down some notes and observed non-verbal communication as the discussion carried on. Key points and words used during the discussion were also documented by the researcher. Questions that were asked by the

researcher focused on the three variables identified in the assumptions, namely communication, attitudes and lack of cultural knowledge. This lasted for thirty minutes. Thereafter a fifteen minute break was taken by the group and during this time refreshments were served. After that the group session resumed. Thereafter the informants were given an opportunity to explore other possible sources of cultural problems. They were also asked to express, in their own opinions, possible solutions to these problems. Informants were each given three narrative statements to respond to. The second session lasted for one hour.

- **Debriefing**

The researcher switched off the tape recorder and thanked the informants for their time. Questions were invited from the informants and they were answered by the researcher. All the informants felt quite comfortable at completion of the discussion. After the discussion ended at 4.30 pm, the informants were taken back to the residence.

5.2.5.2.2 Second group

The second day session was held earlier since it was a Friday and the college closes at 13:00 on Fridays. It started at 11:00.

- **Introduction and briefing**

This was done as with the first group. This group was homogenous both culturally and because they were all third year students. During the introduction phase, most members seemed shy, but they started opening up when the purpose of the study and the reason for the choice of the data collection method was explained. One informant asked if they were going to be informed about the results of the study, and she was assured that this was going to be done. They were also assured that their names were not going to be disclosed. They all consented to the use of a tape-recorder. They all signed the consent forms provided.

- **Discussion**

Discussion was invited, just as it had been on the previous day, except that, since time was limited, the informants asked if they could start with the narrative statements before the actual discussion. This was accepted by the researcher.

- **Debriefing**

All informants felt quite comfortable at the end of the discussion. Questions were invited from the informants but none were posed. The researcher thanked the informants for their time and the discussion ended at 13:10.

5.2.5.2.3 Third group

The third day session took place on a Monday afternoon between 15:00 and 15:30.

- **Introduction and briefing**

Informants of this group seemed reluctant to talk at first. They asked questions about the purpose of the study, which were comfortably addressed by the researcher. They were also not clear about the concepts of culture and racism but, after a discussion, the researcher cleared the misconceptions. They all signed the consent forms.

- **Discussion**

This carried on in the same way as it had in previous discussion. Informants seemed to be at ease with the discussion .

- **Debriefing**

No major difficulties were experienced. The researcher thanked the informants for their

participation.

5.3 DATA ANALYSIS

As it was said earlier, data was analysed in two stages as it was collected in two stages.

5.3.1 Data analysis of the focus group interviews

○ Documenting raw data

Data was documented or transcribed verbatim from the tapes. Key words used by the informants during their discussion were also documented. Observations of non-verbal cues that were made by the informants during the focus group interviews were also documented. Emphatic phrases and exclamations made were also highlighted. All pages were numbered sequentially. All this data was put together in a master file with all the informants' responses numbered (see Annexure 9). Enough space was left between each speaker and a generous margin was left on both sides for coding on the left and for making comments on the right. Data was then checked against the tape recorded data for accuracy. A code index was provided (see list of abbreviations).

❒ Formulation of categories

Tapes were played over and over again to study and to identify similar or dissimilar statements that could be classified to understand the questions under study. Statements were classified according to each assumption namely:

- lack of cultural knowledge
- negative attitudes
- difficulty in communication

These were then analysed separately. Under each classification, categories were formed according to the purpose of the study as follows:

- a category for the source of the problem
- a category for the effect of the problem on the nurse-patient relationship
- a category for the solution of the problem as perceived by the informants in the study

❑ **Formulation of patterns**

Data was scrutinised from the above categories to discover patterns and this was done in relation to the purpose of the study and also in relation to the first assumption. Data was therefore organised according to the sources of LCK, the effects of LCK on care delivery, as well as solutions to this problem.

5.3.1.1 Category 1: Lack of cultural knowledge

○ **Sources of LCK**

From the informants own experiences and from their responses to the question focused on the sources of LCK, the following patterns emerged:

▲ **Pattern 1: Unicultural system of training**

Senior nurse personnel were perceived by some informants as the ones who, due to their unicultural system of training, had lack of cultural knowledge about patients. This system, according to the informants, restricted them from interacting with patients from different cultural backgrounds.

> *"I think this LCK is especially with the seniors. They trained during those years when cultures were like protected."* *(Informant 1)*

"I was worried because I know the meaning of the string, that the matron instructed the patient to remove, but how could I tell her! I was afraid of her."

(Informant 2)

(In this scenario, the informant was afraid to tell the matron about the meaning of the black string around the patient's neck)

▲ **Pattern 2: Inadequate exposure to different cultural groups**

According to two informants, their training does not afford them enough exposure to different cultural groups. According to them, when a person is sick, his or her ability to cope with stressful situations is functioning poorly.

"You see, we meet them for the first time when they are sick."

(Informant 2)

"There is too little contact with the community. We see them for the first time when they are sick, and they easily become irritated." *(Informant 12)*

○ **Effects of LCK on care delivery**

From the informants' discussions of their own experiences, as well from responses to the question that focused on LCK, the following patterns emerged.

▲ **Pattern 1: Feelings of shock**

According to three informants, they experienced a feeling of surprise or shock when they experienced problems due to LCK.

"I was shocked to learn that the Zulu patient expects females to bow down."

(Informant 3)

"I was surprised because in my culture I am not supposed to kneel or bow down." *(Informant 2)*

(In both the above scenarios, the patients had refused to eat because, according to them the nurses did not give food "properly", since they did not bow down. Bowing down by Zulu females is a sign of showing respect, especially towards males.)

"I was shocked to see what she has done. It was a learning experience for me because I did not know that Zulu females are supposed to keep their heads covered." *(Informant 4)*

(In this scenario the female patient had removed the sterile dressing that covered the wound on her head in an attempt to cover her head. It was during the visiting hour and her mother-in-law was approaching her. According to the Zulu custom, married women are supposed to cover their heads with a scarf all the time as a sign of respect. This was discussed in chapter 2 under the heading of "ukuhlonipha" among the Zulus.)

"I was so shocked and scared by what she had done, I was amazed." *(Informant 9)*

(In this scenario, the Zulu patient had come out of bed and delivered the baby on the floor. This was in accord with the Zulu custom where a woman is expected to kneel down when giving birth.)

▲ **Pattern 2: Conflict situations**

According to four informants, conflict situations occur because of LCK.

"The patient demanded that I bring it (sac) back and she threatened to tell her husband." *(Informant 10)*

(In this scenario the conflict situation was a result of a clash between Western culture and Zulu culture. According to Zulu culture, the placenta should be buried and not incinerated.)

"The patient refused to give me his hand, so I went to the sister and told her."
(Informant 3)

(The patient's refusal was a sign of anger towards the nurse who earlier did not treat him properly since she did not bow down when giving him food.)

"The patient was very upset, and she totally refused. The patient said, she would rather be discharged than to have her string cut." *(Informant 2)*

(The matron had instructed the nurse to cut the patient's goat skin "bracelet" as a measure to prevent cross infection.)

"I was angry with the patient. We were both angry." *(Informant 4)*

(The patient expected the nurse to bow down when giving him his food, and the nurse did not understand why. The result was conflict.)

▲ **Pattern 3: Difficulty in rendering care**

According to three informants, LCK results in difficulty in rendering care to culturally diverse patients. According to these informants, it becomes difficult to satisfy the patient's needs because of a lack of understanding of some health-related customs and traditions.

"Because there are Zulu customs and traditions that I do not understand, I sometimes find it difficult to nurse a Zulu patient." *(Informant 6)*

"Sometimes as a nurse you think you have done all that is good for your patient and you become surprised that the patient does not look satisfied.". (Informant 9)

"You see, sometimes you may offer the patient foods that are taboo according to his culture --- and you just wonder why the patient has not eaten." (Informant 12)

- **Solutions to the problem**

Responses to the questions that required informants to give solutions to their identified problems were scrutinized for solutions that were specific to the problem of LCK. From these responses the following patterns emerged.

▲ **Pattern 1: More interaction**

According to three informants, nurses need more interaction with culturally different communities and should not only meet them for the first time when they are sick. According to these informants, they need to interact with them in their community (natural) settings.

"May be during the community health module, we need to visit people of different cultural groups in their homes." (Informant 12)

"We need more exposure to the families and community settings. Yes, more home visits." (Informant 2)

"We need to interact more." (Informant 1)

▲ **Pattern 2: Patients need to understand cultural diversity**

According to four informants, patients need to understand the fact that cultures differ, and

they need to appreciate the fact that, during the nurse-patient encounter, perceptions and expectations may be different.

"Public need some cultural education." *(Informant 10)*
"Patients need to be educated about cultural diversity." *(Informant 1)*
"Both nurses and patients need to compromise." *(Informant 2)*

"Nurses need to educate communities about cultural differences."
(Informant 9)

- **Pattern 3: More cultural information**

According to four informants the solution would be to include more cultural information in the curriculum.

"Training should include information about other cultures." *(Informant 2)*
"More cultural information to be included in the curriculum." *(Informant 4)*

"This cultural information needs to be included in our curriculum."
(Informant 12)

"Ignorance plays a big role, so solutions will be more cultural information included in the curriculum." *(Informant 5)*

- **Formulation of themes**

- **Theme 1: Inadequate interaction leads to lack of experience when dealing with culturally different patients**

According to informants in the study, this was the greatest source of problems. This pattern emerged when discussion revealed how problematic it is to have a unicultural training system

for older colleagues and how inadequate is the exposure afforded by the existing curriculum. Most informants from the study felt that there was less than adequate exposure to different cultures. According to them, they meet the patients for the first time when they are sick.

According to Leininger's Sunrise Model, nurses need to acquire more information about the patient's world view, and cultural and social structure dimensions, and they also need to know how patients perceive health and well-being within their own communities and in their families since all this information could help nurses when they make decisions and action about care delivery. In other words, as was mentioned in chapter three, without the information from the first two levels of the Sunrise Model, problems are bound to happen at the fourth level. Informants in the study therefore confirmed the first assumption, namely that culture influences care delivery and LCK will therefore lead to problems. The next theme describes these problems (Leininger 1991:104).

- **Theme 2: Due to lack of experience, nursing decisions and actions become inappropriate when delivering care to culturally different clients**

From the following pattern, namely feelings of shock, conflict and difficulties in rendering care, the above theme emerged. The goal of Leininger's theory of cultural care, (whose model formed the framework of the study), is to provide culturally congruent care which, according to her, will provide satisfying, beneficial and meaningful nursing care to clients because it is grounded in people's life styles, values and beliefs (Leininger 1991b:104). It therefore becomes clear that, due to lack of experience, the goal of providing culturally congruent care will not be possible because nurses will be unable to deliver satisfying, beneficial and meaningful care. In other words nursing decisions and actions will be inappropriate.

- **Theme 3: A positive approach will enhance appropriate decisions and actions at care delivery**

This theme emerged from the following patterns: a need to interact more, a need to educate

patients about cultural diversity, and a need for more cultural information for nurses. A nurse using a transcultural nursing approach will involve the client in planning care and setting client-centred goals. The more nurses are therefore exposed to culturally different clients, the more they will gain experience and accumulate knowledge about their clients. When they therefore meet clients during illness, they will be better equipped to render culturally relevant care.

Transcultural knowledge is used to augment, clarify, explain or assist in attaining client-centred goals. Collecting cultural information will help nurses to modify or alter planned nursing interventions so as to meet their needs.

During their involvement with diverse communities, nurses can also encourage their clients to accept and recognize the fact that cultures differ. As a result, patients during hospitalization may be more easily disposed to accept culturally different nurses.

These themes are in line with Leininger's Sunrise Model (level 4), which describes the culture care accommodation or negotiation that a nurse is expected to apply so as to deliver culturally congruent care.

- **Plausible hypothesis**

Plausible hypothesis offers other researchers who may be interested in replicating this study a point of departure. The researcher therefore, after analysing this part of data, came up with the following plausible hypothesis:

- Cultural knowledge influences health care delivery. A lack of cultural knowledge will therefore give rise to problems during a multicultural nurse-patient-encounter.

- Cultural knowledge will empower the nurse with more information to render culturally congruent care.

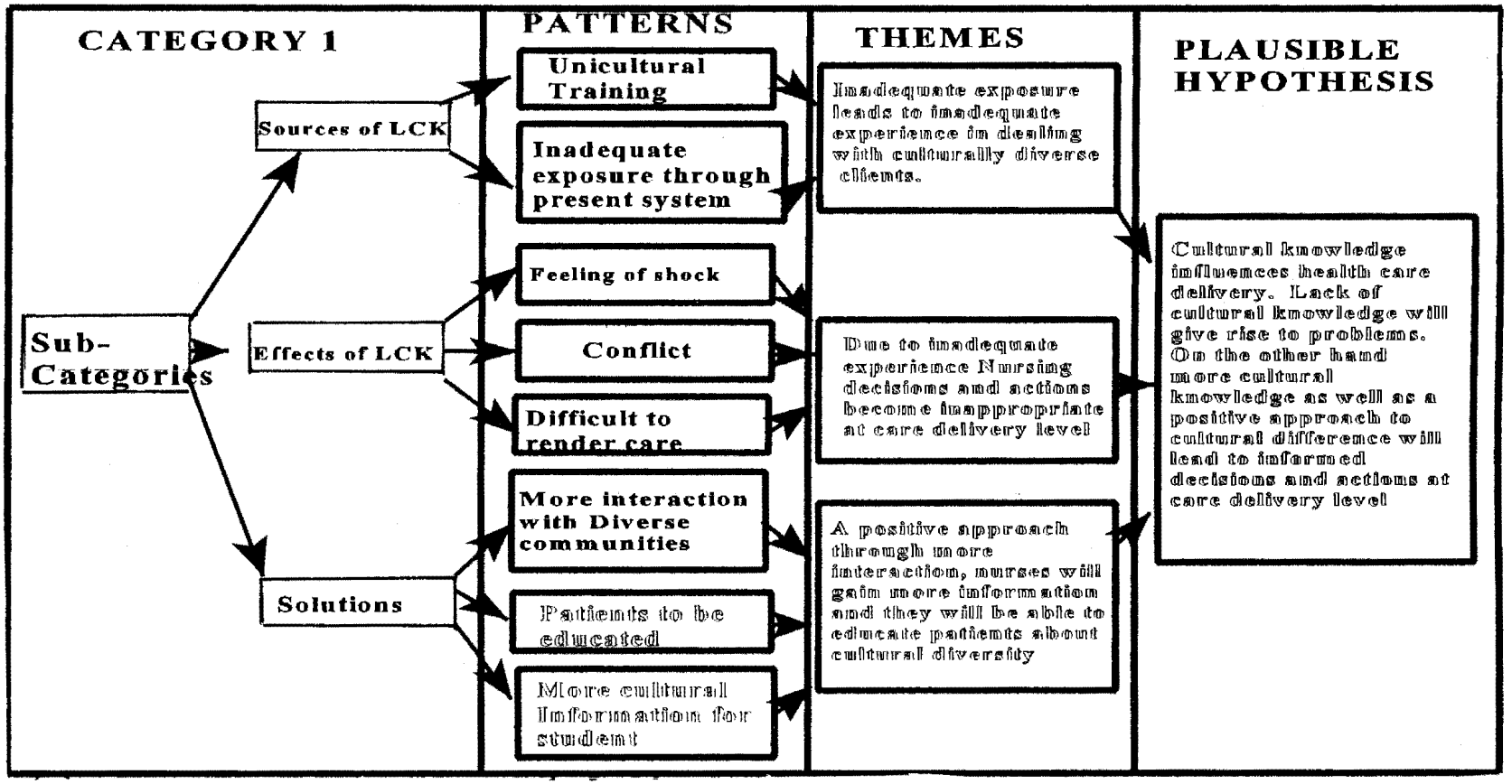

Figure 5.1

FGI analysis of category 1: lack of cultural knowledge

5.3.1.2 Category 2: Attitudes influence care delivery

○ **Categorisation of data**

Sub-category 1: Sources of negative attitudes

Responses to the question that focused specifically on the issue of negative attitudes were carefully scrutinised. From these responses, those that revealed the source of negative attitudes were grouped together under the above category.

Sub-category 2: Effect of negative attitudes

Responses that were organised into this category were extracted from the responses to the question that focused specifically on the issue of negative attitude.

Sub-category 3: Solutions to the problem of negative attitudes

Responses that were organised into this category were extracted from responses to the questions that focused specifically on the issue of negative attitudes.

❑ **Formulation of patterns**

▲ **Pattern 1: Difference in perceptions and expectations**

This pattern emerged from the first category, namely sources of negative attitudes. According to three informants, patients are the one's who display negative attitudes towards nurses because of factors such as a contradiction between the patient's expectations and hospital policies, and this may lead to feelings of defensiveness. In such a situation, if neither of the parties is unable to compromise their differences, negative attitudes may develop.

"Yes I agree, but to me it is the patients, especially the Zulu male who have negative attitudes." *(Informant 1)*

"Patients need to understand that they won't always get what they want, sometimes patients are so demanding." *(Informant 6)*

"You see this thing is a circle, the patient reacts negatively if treated negatively and so does the nurse." *(Informant 10)*

▲ **Pattern 2: Other problems**

This pattern was also extracted from category one. According to two informants, the nurse may become frustrated because of other problems such as a difficulty in communication and an increased work load. She would therefore be frustrated by the patient and not by the problem, but the result may be that they would be perceived by patients as having negative feelings towards them. The other problem identified was conflicting values.

"Due to frustration as a result of lack of communication, both the nurse and the patient may develop negative attitudes towards each other."

(Informant 5)

"I think the problem of communication really leads to the development of attitudes." *(Informant 8)*

"Sometimes the nurse becomes frustrated not by the patient but by the increased work load." *(Informant 11)*

○ **Effects of negative attitudes on the nurse-patient relationship**

▲ **Pattern 1: Stereotypes formation**

This pattern emerged from the second category (effect of negative attitudes). Informants did not directly address the effect of negative attitudes towards care delivery. Instead they generalised the effect into "problems". Under this heading, individual responses were grouped together and the above pattern emerged.

"Zulu males are aggressive." *(Informants 1 and 7)*

"Zulus are forward." *(Informant 10)*

"Sometimes Zulu patients are demanding, especially males." *(Informant 6)*

"Sometimes patients have bad ideas about nurses, even before they come to the hospital." *(Informant 9)*

People actively draw conclusions or make generalisations based on their previous experience. It would appear that the above informants also, in an attempt to make sense of a threatening situation, resorted to stereotypes as they tried to understand Zulu patients.

○ **Solutions to the problem of negative attitudes**

▲ **Pattern 1: More understanding of own cultural values and beliefs**

Data from category three was extracted to formulate this pattern. Three informants, according to their responses, expressed the view that nurses need to first understand their own cultural values and beliefs so that they can be able to accept and appreciate the differences that exist between different cultural groups. In other words, understanding their values and beliefs will help them to identify their own biases and refrain from making value judgements about the personal and social problems of others who may be culturally different from them.

> *"We cannot change the fact that we differ, can we? So, for me, tolerance, finding out more, and understanding is all that is important." (Informant 6)*

> *"We need to first understand our own cultural beliefs and values. We also need to understand that people are not the same, they differ." (Informant 11)*

> *"We need to understand more about patient value system and stuff like that." (Informant 10)*

▲ **Pattern 2: Tolerance from both patients and nurses**

Three informants felt that, in addition to understanding differences, people need to tolerate those differences. According to these informants both nurses and patients need to tolerate each other.

"It's no use educating patients only: people need to tolerate each other."

(Informant 9)

"Tolerance is important, we cannot change the fact that we differ."

(Informant 6)

"Patients must learn to compromise as well as nurses too." *(Informant 12)*

- **Formulation of themes**

- **Theme 1: Different perception and previous experience will lead to the formation of stereotypes**

This theme emerged from three patterns that were formulated under the first category (sources of negative attitudes). These patterns showed differences in perception and expectations as well as other problems, namely communication difficulties and conflicting values. It would appear that all these problems can lead to the formation of stereotypes. According to Boyle and Andrews (1987:102), the behavioural stereotypes are "hasty generalisations about people, based on limited information, and also generalisation from subgroups that are not representative of the whole group". Stereotypes also occur when one overlooks the fact that there is a possibility of cultural change and variability within groups. Stereotyping leads to a further lack of understanding and a lack of appreciation of the wide range of differences among people. *(Informants 1, 6, 7, 9 and 10)*

"Zulu males are forward." *(Informant 1)*

(This informant explained that, after watching Shaka Zulu (a film), she formulated this impression about the Zulu males.)

- **Theme 2: Stereotypal information, if used during a multicultural nurse-patient encounter, leads to inadequate care delivery**

Stereotyping is generally derogatory and occurs because a lack of exposure to a sufficient number of people in a particular cultural group leads to unrealistic expectations. On this basis, informants reported problems such as a loss of trust and a lack of understanding. These may lead patients to be defensive and react in a hostile way. In the presence of negative attitudes, nursing care cannot be rendered. Negative attitudes, according to these informants, adversely affect care delivery. It would appear then that, at level 4 of the Sunrise Model, the nurse may consider the patient's cultural group to be weird or superstitious and she may base her actions and decisions on that impression.

> *"I think Zulu females have given their men too much supremacy. Even in Shaka Zulu females were so submissive."* *(Informant 1)*

It is not surprising then that this informant had earlier on, expressed this view.

> *"I did not know whether it was just a Zulu culture that they (females) want to be addressed properly."* *(Informant 1)*

- **Theme 3: A positive approach comprising self-understanding, respect of cultural differences, tolerance and compromise will result in adequate care delivery**

Patterns that were grouped into these themes were the following: more understanding, more

tolerance and a need to compromise. According to Boyle and Andrews (1987:101), the more nurses can recognise their own biases and blind spots, the better they can overcome them when dealing with others. It would appear then that, through increased self-understanding, the nurse will be able to respect the cultural differences that exist between her and the patient and to be ready to compromise. Compromise, in other words, means that the nurse is ready to contextualise information she has about her patient according to the patient's cultural background. It would also mean that the nurses are willing to assess the patient's behaviour within its context and to avoid misinterpreting such behaviour. In other words, a positive approach would mean that the nurse displays cultural sensitivity towards her patient by attempting to modify her professional care to include folk health care.

"We need to understand more about our patient's value systems."

(Informant 10)

For example, through "compromise" the nurse would be repatterning or restructuring care delivery according to the patient's point of view. The above themes are in accordance with level 4 of Leininger's Sunrise Model where the nurse uses cultural care repatterning or restructuring according to the patient's point of view. Level 4 is the application level where the nurse will apply all the information gathered from the first three levels. At this level her actions and decisions will be based on that information.

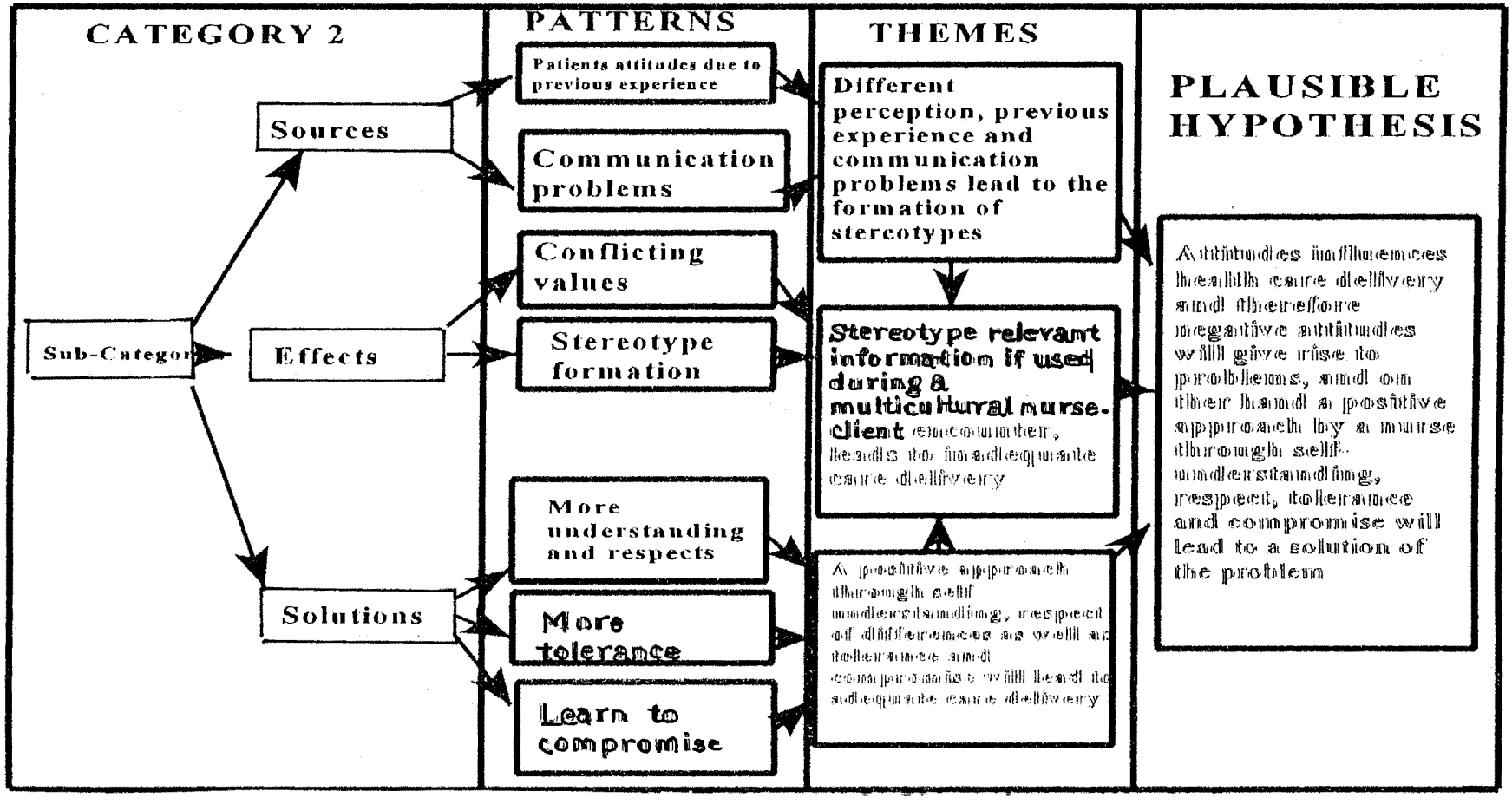

Figure 5.2

FGI analysis of category 2: negative attitudes

5.3.1.3 Category 3: Communication influences on health care delivery

○ **Categorisation of data**

- **Sub-category 1: Sources of the problem**

- **Sub-category 2: Effects of the problem**

Responses that formed this category were extracted from responses to questions that focused on difficulty in communication as an issue during care delivery as well as from responses from informants' own experiences.

- **Sub-category 3: Solutions to the problems**

Responses in this category were extracted from the responses to the question that focused on solutions to the identified problems. Only those solutions that dealt with the problem of communication were extracted.

❑ **Formulation of patterns**

■ **Sources of the problem**

▲ **Pattern 1: Difficulty in spoken language leads to difficulty in explanation**

Their responses were extracted from their own experiences and discussions as well as from responses to the question that focused on difficulty in communication. According to responses from five informants, the source of the problem was due to language differences in situations where the nurse could not understand the patients' language or vice verse. This difference in spoken language, according to these informants, led to a lack of understanding. From these responses, the above pattern emerged.

"I could not do anything for her, and I did not know how to tell her that I did not understand her because she also did not understand English."

(Informant 5)

"It was in labour ward and the patient was Zulu-speaking. Unfortunately there was nobody in labour ward who could speak Zulu." *(Informant 7)*

(According to this informant, the patient in the scenario looked uncomfortable, but she did not understand English and the informant did not understand Zulu.)

"She did not understand English. I wanted to console her, but I could not express myself in Zulu." *(Informant 8)*

(In this scenario the patient had just delivered a stillborn infant).

"I wanted to console her, but because she did not understand English it became very difficult.". *(Informant 12)*

(In this scenario the patient had just been told by the ward sister that her baby had passed away).

"I said this in English and I thought she understand --- to my surprise when I tried to assist her, she refused." *(Informant 5)*

(The informant in this scenario wanted to help the patient to ambulate.)

- **Sub-category: Effects of difficulty in communication**

From the questions that focused on difficulties in communication, responses that attributed causes to the problem of communication were extracted. Informants experienced the following feelings because of language problems, and they were grouped into the following

patterns:

▲ **Pattern 1: There are feelings of guilt and helplessness**

"I felt uncomfortable because I could not understand whether she wanted to feed the baby or what." *(Informant 5)*

"I felt guilty because the patient looked worried all the time." *(Informant 7)*

"I felt like I had really messed up because I could not communicate with her." *(Informant 8)*

"I felt guilty. I felt as though I had failed on my part as a nurse." *(Informant 12)*

(In all the above scenarios, the informants experienced problems because, though they observed that something was wrong with their patients, there was nothing they felt they could do because of difficulties in communication.)

▲ **Pattern 2: Feelings of suspicion and frustration**

According to three informants, difficulty in communication (DIC) leads to feelings of anger and frustration. This pattern emerged from responses to the questions that focused on difficulty in communication.

"I was angry at her first, but later on I realised that if we could understand each other. I think its more frustrating to the patient to find a nurse not knowing her language." *(Informant 4)*

"You know, I felt like, aw what's wrong with me now? I got cross with her. She put me off." *(Informant 5)*

(The patient in this scenario had earlier refused to get out of bed when the informant asked her, but later on, after she had been asked by a Zulu-speaking nurse, she agreed.)

> *"At last the patient was frustrated, and she pushed my hand away and turned her back from me."* *(Informant 8)*

> *"The first thing that strikes you is that they are saying something nasty about you. You are so frustrated you want to die."* *(Informant 6)*

(In this scenario, the informant was explaining the frustration of seeing two Zulu-speaking patients talking and laughing in front of her [a non-Zulu].)

Bonaparte and Ruiz (1979:166), in their study of nurses' attitudes towards culturally diverse clients, used a measure of open and close mindedness to assess the nurses' attitudes. According to them, close minded nurses viewed culturally different patients with suspicion.

▲ **Pattern 3: Difficulty in rendering care and difficulty in building the trust relationship**

According to four informants, if there are communication problems, it becomes difficult to render care and build the nurse-patient relationship because of a loss of confidence and a lack of trust. To formulate this pattern, responses were taken from questions that focused on DIC as an issue.

> *"I agree, you see, if we can't communicate, the care we give is only on clinical basis. You just do things you can't even explain."* *(Informant 9)*

> *"Even when you understand a bit of the patients language sometimes it is difficult to explain especially medical terms and the patient looses trust in you."* *(Informant 10)*

"You see, if you cannot communicate with your patient you feel like strangers to each other. There is no relationship that is built. (Informant 12)

"But again it is frustrating because what happens is that Zulu patients become more confident in the interpreter than you." (Informant 8)

Sub-category 3: Solutions to the problem of DIC

Responses were extracted from responses to the problem of DIC as an issue in care delivery and from responses to questions that focused on solutions to these problems in general. In this section, only those solutions that specifically addressed DIC were extracted. From this category of responses, the following patterns emerged:

▲ **Pattern 1: Need to learn the language**

"Yes, if nurses could understand their (patients) language, it could help a lot." (Informant 7)

"Perhaps if some health related language can be taught throughout the training, because you see interpreters do not always solve the problem." (Informant 5)

"If we start with the basic in first year and carry on, by the time we are in fourth year, I mean we will have learnt a lot." (Informant 7)

"So we need to learn Zulu language." (Informant 8)

▲ **Pattern 2: Role of interpreters problematised**

According to these informants, they problematised the role of interpreters. In other words they did not see it as a major solution. They based this on their experiences they had had.

> *"Interpreters are definitely not the answer. They themselves end up being frustrated."* *(Informant 8)*

> *"Interpreters are not always available."* *(Informant 7)*

> *"In fact, interpreters draw the two (nurse and patient) further apart."* *(Informant 5)*

> *"The Zulu patient becomes more confident in the interpreter than you."* *(Informant 8)*

○ **Formulation of themes**

- **Theme 1: Differences in spoken language between the nurse and the patient will lead to a lack of understanding**

According to most informants in the study, the problem of difficulty in communication really interfered with the nurse-patient relationships because, when the spoken languages differ, it becomes difficult for nurse and patient to understand one another and once there is lack of understanding, the nurse-patient relationship is adversely affected.

All four of the informants who expressed a view that language differences were the major source of communication problems, said that they found it difficult to understand the patient and as a result difficulty in helping the patient. *(Informants 5, 7, 8, 9 and 12)*

> *"I agree, you see, if we cannot communicate the care we give is only on clinical basis. You just do things you cannot even explain." (Informant 9)*

- **Theme 2: Due to lack of understanding, there are difficulties in building a trust relationship between the nurse and the patient and this leads to inadequate care delivery**

According to most informants, the nurse experiences a feeling of guilt and helplessness because of a failure to help the patient because of language difficulties. They also express their frustration in explaining actions and this leads to a loss of trust and confidence because the nurse cannot explain the procedure to the patient. Other informants also felt that, due to this lack of understanding of the spoken language, it sometimes becomes natural to become suspicious when people are talking and one cannot understand the conversation. All this leads to frustration and anger.

It is clear then that once all these feelings are present, the nurse-patient relationship will be affected and the result will be inadequate care delivery.

(Informants 4, 5, 6, 7, 8, 9 and 12)

> *"You see if you cannot communicate with your patient, you feel like strangers to each other, there is no relationship that is built." (Informant 12)*

- **Theme 3: More understanding between the nurse and the patient will enhance the trust relationship and that will lead to adequate care delivery**

This theme emerged from patterns such as the need to learn the language and the fact that informants realised that the role of interpreters was sometimes problematic since it also interfered with the nurse-patient-relationship. From these patterns, it becomes clear that, according to these informants, a positive approach to the problem of communication was more important than ready-made solutions such as using interpreters. It was interesting to realize that, according to these informants, they viewed the issue as more of a challenge than of a problem.

This theme too is in line with level 4 of Leininger's Sunrise Model. It seemed that informants in this study realised their shortcomings and they expressed a willingness for cultural repatterning/restructuring so that culturally congruent care could be rendered.

- **Plausible hypothesis**

From the above themes, the researcher was able to postulate the following plausible hypotheses:

- Communication influences health care delivery and difficulty in communication will give rise to problems during a multicultural nurse-patient encounter.

- Cultural repatterning through more understanding and an effort to learn the language will solve communication problems.

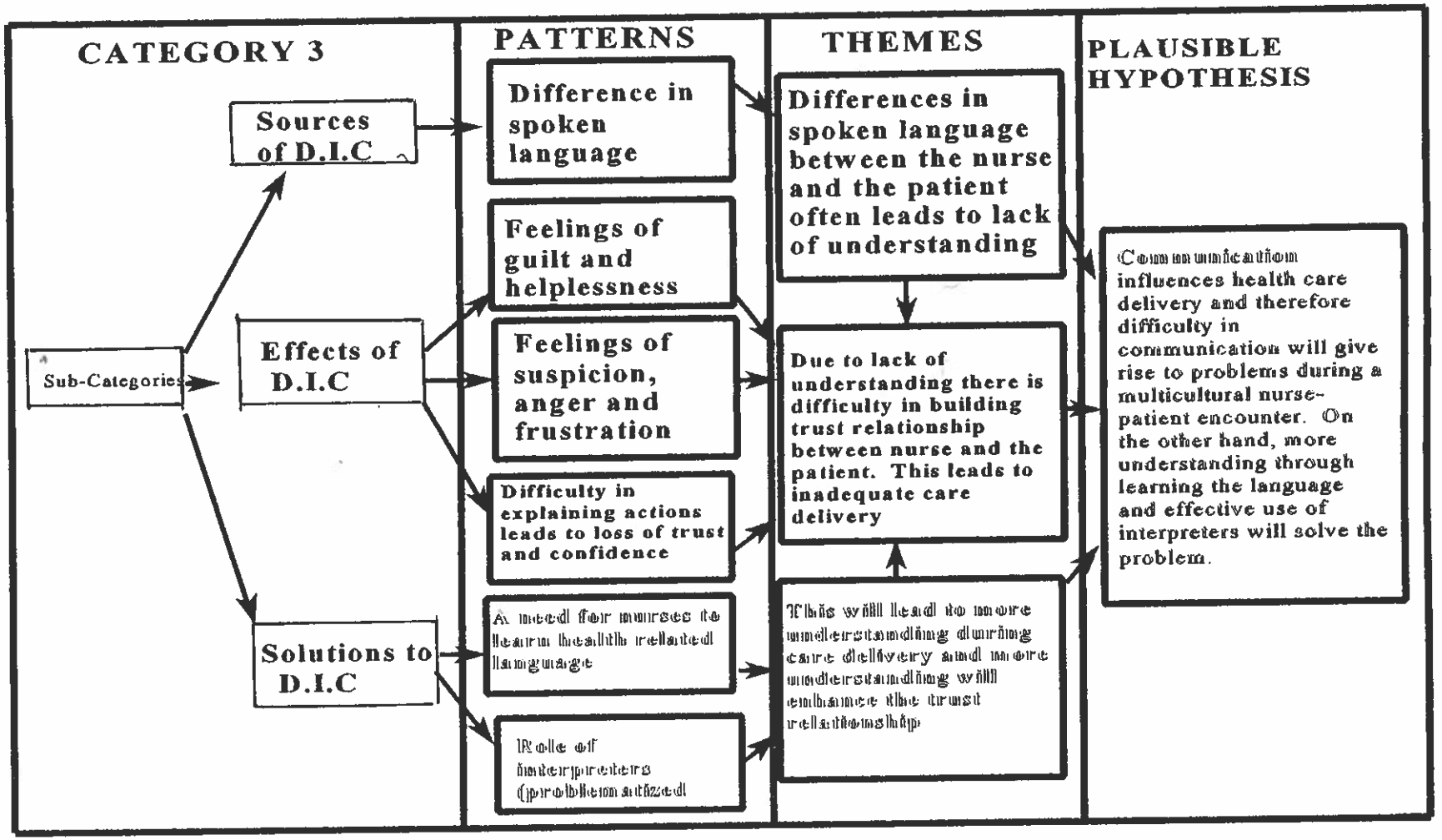

Figure 5.3

FGI analysis of category 3: difficulty in communication

5.3.2 Analysis of data from narrative statements

This set of data was analysed separately.

➤ **Phase 1: Documentation of raw data**

Data from each scenario was carefully read and transcribed into one file. All pages were numbered sequentially. A separate number was given for each informant's set of data (see Annexure 10).

➤ **Phase 2: Categorisation of data**

Categories were opened according to each scenario. Only direct statements were first underlined and then extracted as follows:

5.3.2.1 Responses to the scenario that involved lack of cultural knowledge

○ **Category 1: The narrative scenario**

You are a senior nurse in ward two where Mrs Xulu has been admitted for amputation of her left leg. The patient is refusing surgery and the doctor has asked you to explain the reason for surgery to this patient. During your discussion the patient reveals to you that, according to her cultural belief, illness is a sign of bad luck and the only treatment is by performance of a ritual to cleanse her of this evil. How would you respond to this situation? Only direct statements were extracted from their responses.

❑ **Formulation of patterns**

From the above statements the following patterns emerged.

▲ **Pattern 1: Educate the patient (Informants 1, 2, 3, 4, 5, 6, 7, 8, 10 and 11)**

All these informants expressed the view that they would educate the patient in an attempt to enlighten the patient about the importance of the proposed treatment.

"Educate the patient about the importance of surgery." *(Informant 1)*

"I will try and make the patient understand the importance of surgery." *(Informant 2)*

"I would educate the patient." *(Informants 3 and 4)*

"Explain the importance of surgery to the patient." *(Informant 5)*

▲ **Pattern 2: Involve the patient's family (Informants 2, 3, 4 and 8)**

According to their responses, involving the patient's family would also be an attempt to get more cultural information about the patient as well as an attempt to get more information to them so that they could support the patient in her decision about the proposed treatment.

"Perhaps family members need to be involved." *(Informant 2)*

"I would involve the patient's family." *(Informant 3)*

"Involve family members." *(Informant 4)*

According to Bartz, Bowles and Underwood (1993), their study highlighted the importance of building a trust relationship with the culturally different client. Involving the patients family would therefore enhance the relationship of trust between the nurse and the patient. This is especially true for Zulu patients for whom taking a major decision is a family matter (the head of the homestead "ubaba" is the decision maker). Involving family members would

be in line with the social system of the Zulus.

▲ **Pattern 3: Respect patient's beliefs (Informants 2, 4, 10 and 11)**

Four informants expressed the view that they would respect the patient's beliefs about illness. These informants, according to their responses, demonstrated a positive approach to the problem since respect of differences is an important aspect of cultural sensitivity.

" I will tell the patient that I respect her beliefs." *(Informant 2)*

"Tell the patient that I respect her beliefs." *(Informant 4)*

"I would respect the patient's beliefs." *(Informants 10 and 11)*

▲ **Pattern 4: Patient has a right to decide (Informants 1, 2, 5, 6, 7, 8, 9, 10 and 12)**

According to these informants, the patient's right to decide would be respected. They would avoid dictating to the patient and they would also give the patient enough time to decide. These informants also demonstrated a positive approach to the problem since they respected the patient's right.

"I would not dictate to the patient." *(Informant 1)*

"I would avoid dictating to the patient." *(Informant 5)*

"I would let the patient decide." *(Informant 6)*

"The patient has a right to decide." *(Informants 7 and 8)*

- **Themes that emerged from the above patterns**

- **Theme 1: A positive approach, which involves patient education, family involvement and more cultural information, will lead to appropriate decisions and actions in care delivery**

Patterns such as educating the patient, involving the family, respecting patients' beliefs and respecting the patient's right to decision, were all combined and the above theme emerged. Patient involvement as well as family involvement is important in attaining client-centred goals because it can be assumed that, through this involvement, more cultural knowledge can be obtained, which will help the nurse during care delivery.

Though these informants did not specifically identify the problem in this scenario (since they mainly viewed the problem from the patients lack of knowledge about the proposed treatment), their approach was more positive than negative.

Failure to identify the existence of problems from their perspective (their lack of cultural knowledge), is a clear indication that their training does not afford them enough experience to deal with culturally different patients.

This was in line with level 4 of Leininger's Sunrise Model where the nurse is expected to base her decisions and actions on more cultural information about the patient. In other words these nurses would find it difficult to render culturally congruent care according to level 4 of Leininger's Sunrise Model since they would not be ready to restructure their care delivery to accommodate the patient's cultural perspective because they would have been ignorant of this necessity.

5.3.2.2 Data from the second scenario

○ **Category 2: Negative attitudes**

You are on night duty in ward six where a patient, whose cultural background is different from yours, is admitted and is on blood transfusion. During your hourly rounds you noticed that the patient is awake though it is 02:00. When you inquire from the patient why he is awake he tells you that he is afraid to sleep because he does not trust the nurses and that he will therefore stay awake until the blood transfusion is complete. How would you deal with the situation?

Under this category only direct statements were extracted.

❒ **Formulation of pattern**

Patterns that emerged from informants responses to the first scenario

▲ **Pattern 1: Equal training (Informants 1, 6 and 11)**

In their attempt to regain the patients' confidence in them, these informants felt that they would explain that nurses, regardless of their cultural backgrounds, received equal training.

> *"I will explain to him that both black and white nurses received the same training."* *(Informant 6)*

> *"I would tell the patient that both Black and White nurses received the same training."* *(Informant 1)*

> *"I will explain that all nurses received equal training."* *(Informant 11)*

▲ **Pattern 2: Equal treatment (Informants 2, 4, 7, 8, 9 and 12)**

In another attempt to build the patients' confidence in nurses, informants expressed the view that they would tell the patients that, regardless of their cultural backgrounds, nurses render equal treatment to all.

"I will explain to the patient that nurses do not see colour, they treat everyone similarly." *(Informant 9)*

"I will tell him that nurses are not racists." *(Informant 2)*

"Nurses are taught to treat patients equally." *(Informant 4)*

"Nurses render holistic care." *(Informants 7 and 8)*

"Explain that nurses do not discriminate." *(Informant 12)*

▲ **Pattern 3: Reassure the patient (Informants 2, 3, 5, 7, 8, 9, 10 and 11)**

According to these informants, the patient was experiencing anxiety and fear. They realised then that it was necessary to allay the patient's fears in an attempt to enhance the trust relationship.

"I would reassure the patient that nothing would happen." *(Informant 4)*

"I would reassure the patient to build her confidence in nurses." *(Informant 2)*

"Reassure the patient." *(Informants 7, 8, 9, 10 and 11)*

▲ **Pattern 4: Find out reasons first (Informants 3, 6, 9, 10 and 12)**

According to these informants, it was important to first establish from the patient the reason for this lack of trust. These informants displayed a positive approach to the existence of negative attitudes.

> *"I would first find out from the patient his reasons for not trusting black nurses."* *(Informant 3)*

▲ **Pattern 5: Would be offended (Informants 1, 2 and 7)**

Three informants expressed the view that they would be offended by this patient's statement. According to their responses, they were being defensive in the situation. In other words they adopted a negative approach to the situation.

> *"I would really feel offended by this patient's attitude."* *(Informant 2)*

> *"I would be offended and ask the patient why he came to this hospital because he was going to be treated by both black and white nurses."* *(Informant 7)*

○ **Themes developed from the above patterns**

Patterns 1, 2, 3 and 4 were combined together and the following theme emerged.

• **Theme 1: Rebuilding the trust relationship**

One common impression about these patterns was that they were all attempts to restructure the relationship of trust between the nurse and the patient. These informants, according to their responses, realized that the patient was having a negative attitude towards them. They realized too that the presence of negative attitudes would interfere with the trust relationship. They were therefore concerned with rebuilding the trust relationship. According to their

responses, nursing care action and decisions would be based on this trust relationship. Patterns such as finding out more reasons and reassuring the patient all displayed an attempt to establish a common ground on which to base the actions and decisions so that culturally congruent care would be possible.

"I would find out more from the patient his reasons for not trusting nurses."
(Informant 3)

This theme was in line with level 4 of Leininger's Sunrise Model, where nurses are expected to use culture care repatterning actions.

- **Theme 2: Feeling of insensitivity**

When pattern 5 was scrutinized, it became clear that these informants viewed the problem negatively. According to their responses, these individuals were insensitive to the problem. The patient in the given scenario expressed a negative feeling towards culturally different nurses. These informants therefore, by responding as they did, failed to rebuild the trust relationship.

"I would really be offended by this patient's attitude." *(Informant 1)*

5.3.2.3 Data from the third scenario

- **Category 3: Difficulty in communication**

You are on night duty in a female surgical unit where Mrs Duma is admitted. You are assigned to nurse her. She does not speak your language. She has just come back from theatre and she is awake. You have a problem since you cannot communicate with this patient and neither can all the staff who are present. How would you deal with this problem?

Only direct statements were extracted and analysed under this category.

❑ **Formulation of patterns**

Patterns that emerged from the above responses:

▲ **Pattern 1: Non-verbal communication (Informants 2, 3, 5, 7, 9, 10 and 11)**

All seven informants expressed a view that in such a situation, they would resort to using non-verbal communication. Some of them felt that they would encourage the patient also to use signs.

"I would use hands to communicate with this patient." *(Informant 2)*

"I would try and use sign language." *(Informant 3)*

"I would try non-verbal communication." *(Informants 5 and 7)*

"I would try and use hands." *(Informant 9)*

"I think non-verbal communication would be appropriate." *(Informant 10)*

"I think non-verbal communication would be the only form of communicating." *(Informant 11)*

▲ **Pattern 2: Find an interpreter (Informants 2, 3 and 6)**

Three informants also expressed the view that an interpreter would solve such a situation if the other attempts failed.

"If I could find someone to interpret, that would be better." *(Informant 2)*

"I would try and arrange for an interpreter." *(Informant 3)*

"I would find someone to interpret." *(Informant 6)*

▲ **Pattern 3: Stick to own language (Informants 6 and 10)**

According to these informants, there might be similarities in the patient's and the nurse's language. But both these informants had other solutions in case this one did not work.

"I will try and speak my own language, there maybe similarities." *(Informant 6)*

"I would use my own language, some words may be similar in both languages." *(Informant 10)*

▲ **Pattern 4: Remain with the patient (Informants 6, 7, 8, 11 and 12)**

Five informants expressed their view that they would be present with the patient so as to reassure him that he would not be alone. One felt that this patient would be her number one patient. All these were strategies to allay the patient's anxieties that might have been caused by the difficulty of communication.

"I think I will remain with the patient." *(Informant 6)*

"I will try and be positive." *(Informant 5)*

"I would reassure the patient that he is not alone." *(Informant 7)*

"I would reassure the patient." *(Informant 8)*

"The patient will receive priority treatment." *(Informant 11)*

"Remain with the patient." *(Informant 12)*

- **Formulation of themes from the above patterns**

- **Theme 1: A positive approach to the communication problem will enhance adequate care delivery**

The communication difficulty, as it appeared in the study, is a problem whose solution is not possible, especially if one considers the amount of contact time between the nurse and the patient. However, this problem has the greatest impact on the nurse-patient relationship. Informants in the study adopted a positive approach to this problem. They realised, according to their responses, that care had to be delivered across communication barriers.

The following responses qualified a positive approach:

"If I can find someone to interpret that would be much better." *(Informant 2)*

"Non-verbal communication does help." *(Informant 10)*

"Being there, --- I think it will help to allay the patients anxieties." *(Informant 6)*

"I think I would try and be positive about the situation. Non-verbal communication usually helps." *(Informant 5)*

5.4 INTERPRETATION OF FINDINGS

5.4.1 Interpretation of findings from the first enabler (FGI)

5.4.1.1 Category 1: Lack of cultural knowledge

- **Source of the problem**

Results revealed the following:

- The lack of cultural knowledge is the result of inadequate interaction with culturally diverse communities and, as a result, nurses meet these culturally different clients for the first time when they are sick.

  "You see we meet them for the first time when they are sick."

  (Informant 4)

- This inadequate exposure is due to the unicultural system of training which most South African nurses received and whose influence is still evident in today's nursing. It is still experienced by the younger generation like the informants in the study. According to Uys (1989:74), nurses experienced problems when delivering care to culturally different patients. One of the causes of these problems that Uys (1989) highlighted was the segregated form of training which most South African nurses received.

- The present system of nurse training, according to the informants in the study, also does not afford students with enough opportunities to interact with different cultural groups in their natural settings.

- Mashaba (1995:1-5) and Lubanga (1995:1-8) also stressed the importance of making nursing education programmes focus on Primary Health Care.

- **Effects of the problem**

- This lack of cultural knowledge leads to inadequate care delivery due to conflict situations (Murphy & Clark 1993:104). According to Murphy and Clark (1993), respondents felt that the care they rendered was below standard and incomplete since there was lack of cultural information.

- Conflict situations occur due to cultural differences which influence the perceptions and expectations of the nurse-patient encounter.

According to Leininger (1989:46), at this level, the nurse's actions and decisions are based on information obtained from the first three levels. For example, according to one informant a conflict situation occurred between herself and the Zulu patient due to differences in customs about what to do with the placenta after delivery. In this scenario, it would be assumed that cultural care preservation was impossible due to lack of cultural knowledge.

- **Solutions to the problem**

According to the result of the study, the following solutions were given:

- **More interaction with culturally diverse communities**

This solution was in line with Bernal and Froman's findings (Bernal & Froman 1987:200). According to them, the more experience nurses accumulated in nursing culturally different clients, the more confidence they gained in dealing with them. Informants in this study also felt that more opportunities, perhaps in the form of community projects, would enhance their cultural knowledge.

- **More cultural information should be included in the curriculum**

Informants in this study also felt that another solution would be for more information about the different cultural groups to be included in the curriculum. What these informants did not suggest was that only theoretical information about the different cultural groups be given. In other words, this would suggest that more opportunities for interaction with culturally different clients should be given.

Murphy and Clark (1993) also emphasized the importance of cultural knowledge in the curricula for nurse training. Other researchers like Kanitsaki (1993), Dobson (1993) and Conway (1989) highlighted a need for nurses to be equipped with cultural assessment skills. The use of cultural assessment skills was problematised by researcher like Batz, Bowles and Underwood (1993), who viewed the very presence of theoretical knowledge as leading to the formation of stereotypes. Their solution to the problem of cultural differences seems to correspond with the following solution.

- **Greater community enlightenment about the issue of cultural diversity**

According to informants in this study, this would lead to more tolerance and more understanding of the cultural differences during a multicultural nurse-patient encounter. According to Bartz, Bowles and Underwood (1993:233-234), clients also needed background so that they could accept nurses and so that a relationship of trust between the nurse and the patient might develop.

5.4.1.2 Category 2: Negative attitude

- **Source of the problem**

The results revealed that negative attitudes originate from different perceptions and expectations about the nurse-patient encounter. These are often based on previous experience.

The results also revealed that both nurses and patients develop negative feelings towards each other.

- The results also revealed that communication problems between the nurse and the patient may influence their perception of the encounter.

- Conflicting values and beliefs were also cited as a source of problems since they influence peoples' perceptions and expectations.

○ **Effects of the problem**

Negative attitudes lead to the formation of stereotypes, and this often leads to problems during care delivery.

Sometimes the very presence of cultural knowledge may lead to problems which may in turn lead to the development of negative attitudes. This was confirmed by the informants in this study since, according to them, negative attitudes are based on previous experience.

Felder (1990:100) shared a similar view about the effect of attitudes towards culturally different patients. The problem stated in her study was that, although some students received information on cultural diversity in nursing, their attitudes towards culturally different patients remained unchanged. In the present study too, as was indicated earlier, although some informants did receive information about cultural diversity (according to their programme objectives), some informants displayed stereotypical responses (as in statements like "*Zulus are forward*").

- **Solutions to the problem**

According to informants in the study, nurses need first to have more self-understanding. They also need to interact more with culturally different patients so that they will learn more about their patients' cultural backgrounds and will therefore understand them better when

they meet them in the health care settings. This was in line with the findings by Bornaparte and Ruiz (1979:63) on their study about nurses' attitudes towards culturally different patients. Their findings revealed that nurses who were more open minded had positive attitudes towards their patients and those who were closed minded and highly dogmatic had negative attitudes towards culturally different patients. In the present study, it became clear that informants who had revealed stereotypical behaviour towards Zulu patients would be regarded as closed minded since they expressed a dogmatic view on the issue of the source of negative attitudes. According to these informants, seniors had negative attitudes. Later, the same informants expressed the view that they were afraid of the seniors. In short, the results revealed the following as solutions to the problem of negative attitudes:

- Self-understanding of one's own cultural values and beliefs before one can appreciate the differences between cultural groups.

- More tolerance and understanding of cultural differences.

- More interaction to enhance this understanding.

5.4.1.3 Category 3: Difficulty in communication

Results revealed the following:

○ **Source of the problem**

- It became clear that communication problems are often due to differences in patterns of communication as well as differences in the spoken language.

○ **Effect of the problem**

Due to difficulty in communication, there was a lack of understanding and this resulted in the following feelings:

- Feelings of guilt and helplessness.
- A loss of trust and confidence.
- Feelings of suspicion and anger.
- This in turn led to less than adequate care rendered since it was only on a clinical basis.
- The result confirmed the fact that level 4 of the Sunrise Model would be affected should there be a communication problem because nursing patterns of accommodation, preservation and restructuring cannot be possible.
- The results therefore confirmed the fact that difficulty in communication will give rise to problems during a multicultural nurse-patient encounter.

According to Leininger's Sunrise Model at level 4, the nurse makes use of the information collected at the first three levels. If there is difficulty in communication, the amount of information about the patient's cultural background becomes inadequate. This will be especially true with Zulu patients where self-disclosure especially to strangers is not accepted. Due to language differences the patient may regard the nurses as strangers. Also, among Zulus direct speech is considered to be rude and impolite. Because of this, the nurse may find it difficult to collect the necessary information about the patient's illness (De Kadt 1994:107). What is termed "indirectness" in Western society may be viewed as politeness by Zulu society.

This may all lead to difficulties for the nurse who has to make decisions and take action and hence patterns of accommodation may be impossible. That is why informants in the study also felt that, without communication, the care they rendered was only on a clinical basis. There was no relationship that was built and hence they felt guilty and helpless. In the study by Murphy and Clark (1993), respondents also felt that, without adequate communication with their patients, the care they rendered was below standard.

- **Solutions to the problem**

In Bernal and Froman's (1983:200) study, all subjects welcomed the use of interpreters as

a solution to the problem of difficulty in communication. In contrast to that, informants in the present study problematised the role of interpreters. It may therefore be assumed that informants in the present study viewed difficulty in communication as a challenge and not a problem. It also became clear that informants in the study showed concern about the relationship between themselves and their patients. The following statements qualify this:

> *"You see if we can't communicate, the care we give is only on clinical basis, you just do things you can't even explain."*

These informants, according to their responses, value "caring" as a relationship between the nurse and the patient and not just a nursing action.

- Informants regarded non-verbal communication as the most important solution.
- The use of interpreters was also cited but with great concern because of its negative effects on the nurse-patient relationship of trust.

5.4.2 Interpretation of data from the second enabler

5.4.2.1 Category 1: Lack of cultural knowledge

Informants were required to provide solutions to the problem of lack of cultural knowledge. Findings revealed that:

- Most informants failed to identify (according to their statements) that they were experiencing a problem due to lack of cultural knowledge. Instead, most of the informants viewed the problem from the patient's point of view and regarded the patient as the one who was experiencing a problem of lack of knowledge.

- Though they failed to identify the existing problem, they did approach the problem positively since they did express views about education of the patient about the proposed treatment, involvement of the patient's family, and respect of the patient's

right and beliefs about illness.

- It would be assumed therefore that their failure to identify the problem was due to the fact that their present programmes do not afford them with adequate cultural information.

- This failure may also be attributed to the influence of the biomedical model on which most nurse training programmes are based. This model views the nurse as the one with more knowledge and a solution to the patient's problem, and the patient as the one who always has the problem (Boyle & Andrews 1989:54).

5.4.2.2 Category 2: Lack of trust

In this scenario, informants were expected to provide solutions to the problem of negative attitudes during a multicultural nurse-client encounter.

- Findings revealed the fact that negative attitudes, should they exist, will interfere with the nurse-patient relationship.

- Results also revealed that the trust relationship was the most important basis for nursing decisions and actions.

- Results also revealed attempts by the informants at restoring or rebuilding the trust relationship.

The above findings were in line with the results study by Bonaparte and Ruiz (1979:166). In their study they discovered that close mindedness led to the formation of negative attitudes and that negative attitudes in turn interfered with the nurse-patient relationship. The findings also revealed that open mindedness led to the formation of positive attitudes. In the present study, more than 50,0% of the informants displayed a positive attitude or what Bonaparte and Ruiz term "open mindedness" since they would:

- Find out more from the patient.
- Reassure the patient so as to rebuild confidence.
- Require more information about the quality of training as well as the quality of care which nurses render to rebuild confidence.
- Only three informants displayed a negative approach since expressed the feeling that they would be offended by the patients statement.

5.4.2.3 Category 3: Communication difficulty

In this scenario, informants were expected to provide solutions to the problem of difficulty in communication.

All informants except one expressed a positive attitude were they to be faced with this problem. The majority of the informants felt that non-verbal communication would be considered as a solution. Some felt that the use of an interpreter would also be considered. Other solutions mentioned were reassuring the patient to allay his fears and anxieties, remaining with the patient in an attempt to allay his anxieties. One informant felt that she would refuse to nurse the patient because of communication difficulties. This was regarded as a negative view on the issue. This informant did however express the view that she would swop units in an attempt to find someone to assist the patient.

It would appear from these findings that most informants viewed this as a challenge and not a problem. It would be assumed therefore that a positive approach would be the best solution.

5.5 COMPARISON OF FINDINGS FROM BOTH ENABLERS

- The first enabler explored the existence of the problem by examining its sources, its effects on health care delivery as well as solutions to the problem.

- The second enabler was administered to assess the informants' responses when faced with the problem. Findings will be compared under the heading of each assumption.

5.5.1 Category 1: Cultural knowledge influences on health care delivery

Lack of cultural knowledge will give rise to problems during a multicultural nurse-patient encounter.

5.5.1.1 Findings from the first enabler

The sources of lack of cultural knowledge were the following:

- unicultural system of nurse training
- inadequate exposure to other cultures afforded by the present system of nurse training

The effects of this on health care delivery

- inadequate nursing care delivery

The solutions identified were

- more interaction with culturally diverse clients
- more cultural information in the curriculum
- more patient education about cultural diversity

5.5.1.2 Findings from the second enabler

- All but one informant failed to identify the problem of the nurses' lack of cultural knowledge from the scenario given.

Instead, they identified the patients' lack of cultural knowledge about the proposed treatment.

As a result their approach to the problem was focussd mainly on helping the patient to acquire more knowledge and understanding.

When the two enablers were compared, it appeared that this failure to identify the problem was due to the very lack of cultural knowledge in delivering culturally congruent care.

It would also appear that this is due to inadequate exposure in dealing with culturally diverse clients.

There was no difference between the two enablers.

5.5.2 Category 2: Attitudes influence on health care delivery

- Negative attitudes will give rise to problems during a multicultural nurse-patient encounter.

5.5.2.1 Findings from the first enabler

The responses revealed a positive approach to the problem since most of them aimed at restructuring the relationship of trust between the nurse and the patient. In other words, these informants managed to identify the problem, namely a loss of trust. When these findings were compared with those from the first enabler, it became clear that, on both enablers, informants were sensitive to restructuring the nurse-patient relationship which was affected by the existence of negative attitudes.

5.5.2.2 Findings from the second enabler

It revealed that the source of negative attitudes was different perceptions and expectations

and also previous experience, other existing problems like communication difficulties, and conflicting values and beliefs.

The effects of negative attitudes were:

- the formation of stereotypes which hinder effective care delivery.

Solutions to the problem identified were:

- self-understanding of one's own cultural values and beliefs
- more tolerance and understanding
- more interaction to enhance this understanding

5.5.3 Category 3: Communication influences on health care delivery

5.5.3.1 Results from the first enabler

It was revealed that the source of the problem was:

- differences in patterns of communication
- differences in spoken language

The effect of this on health care delivery:

- inadequate care delivery

The solution:

- non-verbal communication

- use of interpreters cited with great concern
- need to learn the language.

5.5.3.2 Results from the second enabler

It was revealed that:

- non-verbal communication was cited by the majority of informants (66,06%)
- use of interpreters was cited as the second option
- others solutions cited were: reassuring the patient (through non-verbal communication, remaining with the patient - also a form of non-verbal communication of presence)

When a comparison of the above results is made, it becomes clear that the informants on both enablers displayed a positive approach to the problem. The fact that the role of interpreter was problematised in the first enabler was confirmed by the fact that, during their response to the second scenario, it was also not chosen as number one solution. This too displayed a positive approach to the problem of language differences.

5.6 CONCLUSION

In this chapter data was analysed and interpreted. Data from the two enablers was analysed and interpreted separately and thereafter the findings from both enablers were compared. In conclusion, it may be said that results revealed that the three variables, namely cultural knowledge, communication and attitudes, do influence the nurse-patient encounter.

In the next chapter, the researcher will reveal her own impressions gathered during the discussions of the findings and thereafter she will make recommendations about possible solutions to the problems that nurses are faced with in a multicultural nurse-patient encounters. The study limitations will also be discussed in the next chapter.

CHAPTER 6

Summary of findings, conclusions, implications and recommendations

6.1 INTRODUCTION

In the previous chapter, the findings of the study were described and discussed in detail after data was analysed. These findings centred around the sources, effects and solutions to the three problems identified by informants in the study.

In this chapter, the study and its findings will be summarised. Conclusions will be drawn and recommendations will be made on the basis of those conclusions.

6.2 SUMMARY OF THE STUDY

The purpose of the study was to explore the nature of the problems experienced by non-Zulu

student nurses during their encounter with Zulu patients. When the acculturation process was discussed in chapter one, problems that were thought to be inherent to the acculturation process were highlighted. These guided the researcher to identify three variables, namely lack of cultural knowledge, difficulty in communication, and negative attitudes. From the researcher's point of view, the nurse-patient encounter includes the following: information about the patient including cultural information, the ability to communicate with the patient, and the nurse and patient's perceptions about the encounter. In other words, this study examined problems which arose as a result of the nurse-patient encounter in a multicultural setting.

To achieve this, the researcher first conducted a literature review in order first to identify a theoretical framework for the study. Leininger's Theory of Cultural Care Universality and Diversity was identified as the most relevant theory. Leininger's Sunrise model was used as a framework for organising information. The Sunrise model has four levels: the first is the world view and the cultural and the social structure dimension; the second level is the level of information about individuals, families, groups and institutions in diverse health systems; the third level is the level of information about health care delivery and practices; and the last level is the level of the nursing care decisions and actions.

According to the researcher, the focus of the study was based on the last phase because this is the level of care delivery. This is the level where problems are bound to occur if the nurse has not collected relevant information on the first three levels. To achieve the objectives of the study, the researcher carried out purposive sampling. Informants were drawn from those who were experts on the problem under study, namely those student nurses in one specific setting who had had an encounter with culturally different patients and who had experienced problems because of that encounter.

Through focus group interviews, informants were required to reflect on their previous experiences with a Zulu patient. Later informants were also expected to explore from their points of view the sources and results of their problems and then to identify solutions to the problems that they identified. The next enabler that was used was one which enabled

narrative responses. In this setting informants were invited to make responses to given scenarios. These scenarios were carefully constructed to address the three variables identified, namely a lack of cultural knowledge, difficulty in communication, and negative attitudes.

Three groups were used, which in turn were made up of the following cultural groups: whites, Asiatics, coloureds, Tswana and Swazi. Before data analysis, the researcher returned to the informants to verify the data collected.

Then data was analysed using Morse and Field's stages of qualitative research analysis. Data was first transcribed and categorised according to the three variables. Thereafter data was organised in such a way that patterns emerged and, after that, themes were developed. Data from the two enablers was analysed separately first and then compared. This was done in an effort to enhance the trustworthiness of data obtained (Morse & Field 1996:301).

6.3 SUMMARY OF FINDINGS

Findings were summarised according to the sources of the problems identified, their effect on the nurse-patient relationship, and the solutions that the informants identified as the most appropriate to each problem.

These findings were:

6.3.1 Lack of cultural knowledge

According to informants in the study, the source of the lack of cultural knowledge was the unicultural system of training that most South African nurses were exposed to. The effect that this had on care delivery was that inadequate care was being rendered. The solution, according to informants, was more interaction with culturally different patients as well as more cultural information in the curriculum.

6.3.2 Difficulty in communication

According to informants in the study, language difference was a source of communication problems. These communication problems led to an incomplete care that was only actually only care on a clinical basis. The solution, according to informants, was a positive approach involving (for example) the use of non-verbal communication and sign language.

6.3.3 Negative attitudes

According to informants in the study, a lack of contact with culturally different patients, as well as previous experience, influence the nurse's perception about the encounter. This leads to labelling and hence conflict and, as a result, inadequate care is rendered. The solution, according to most informants, required a more positive approach towards cultural diversity.

6.4 CONCLUSIONS

Based on the findings, the following conclusions have been drawn:

6.4.1 Cultural practice differences exist amongst people of different cultural groups

People of different cultural groups have different world views, different value orientations, and different social structure dimensions.

These cultural differences, if not understood by the nurse who comes into contact with a culturally different patient, lead to problems. In other words, contact with cultures unaccustomed with each other might disrupt social communion because of a lack of cultural knowledge.

6.4.2 Problems highlighted in this study cannot be changed but the nurse's approach to these problems can change

In other words, the fact that people differ cannot be changed. Communication barriers also cannot be changed but they can be resolved if the approach to this is reviewed.

6.5 IMPLICATIONS

How can nurse educators help students to be constructive about addressing problems brought about by cultural differences?

Informants in the study all expressed the view that a positive approach to the problems brought about by cultural differences was the best solution. This was interesting since this was different from responses in other related studies. This led the researcher to realise that South African nurses have accepted the challenge with which the country's cultural diversity has confronted them. A more positive approach will therefore mean that South African nurses are prepared to deliver care across cultural barriers. This leads directly to the next implication.

A move away from the biomedical to the holistic health paradigm model will adequately equip students to be able to cope with problems brought about by cultural differences.

The ethnocentric bias of the biomedical model should be discouraged. Under the influence of the biomedical model, nurses view themselves as being more knowledgeable than patients. According to this model, nurses know what is best for their patients.

The influence of the biomedical model was also revealed by the results of the study. When the informants in the study were required to respond to a scenario which involved a lack of cultural knowledge, all but one of the informants failed to identify that they lacked cultural knowledge about their patients. According to these informants, it was the patient who lacked

knowledge about the indications for amputations. This was informed by their responses that they would all "educate the patient". Only one informant expressed the view that she would "find out more about the patient's beliefs".

The influence of the biomedical model is also seen in the unilateral approach often used by nurses during history taking. During history taking, nurses will often overlook culturally based knowledge and practices. Information about the patient's cultural values, beliefs and practices can make all the difference in patient care.

The present shift of emphasis from hospital-based programmes to community-based programmes is an attempt to focus more on primary health care. Comprehensive nursing care "ideally" is holistic, serving clients with unique problems and needs. But how holistic is care delivery without cognizance of the patient's cultural background? According to Boyle and Andrews (1985), the holistic paradigm seeks to maintain a sense of balance or harmony between humans and the larger universe. In the holistic paradigm, health is viewed as a positive process that encompasses more than the absence of signs and symptoms of disease.

Health is not restricted to biological or somatic wellness but rather involves broader environmental, socio-cultural and behavioural determinants (Boyle & Andrews 1995:65).

The move away from the influence of the biomedical model will therefore help nurses to understand their patients' illnesses in a broader context.

6.6 RECOMMENDATIONS

Based on the conclusions, the implications, and the findings of this research, the following recommendations are made:

6.6.1 Move towards transcultural nursing

According to Leininger (1981:336), transcultural nursing is a formal area of study and practice that focuses on a comparative analysis of cultures and subcultures with respect to diverse health-illness caring beliefs, values and practices, which has the goal of generating scientific and humanistic culture-specific or culture-universal therapeutic nursing care practices. The focus of transcultural nursing is health care delivery to the consumer within his own cultural context (Leininger 1981:366).

The nursing profession has a responsibility towards the community to deliver holistic and individualistic care, and nurses should therefore take into account the cultural differences of people. During history taking, for example, a nurse using the transcultural approach will not undermine the patient's subjective history which may include, among other things, his perception about health and illness, what he views as an appropriate form of treatment, and what he understands to be the cause or causes of his illness. All this information will equip the nurse with cultural information to enable her to deliver care according to the patient's cultural point of view. In other words, a nurse using the transcultural approach will be sensitive to the patient's values and beliefs in order to meet the patient's needs. This nurse will not impose her values and beliefs or those of her profession upon the patient. Having said this, one question remains. How can nurses acquire the knowledge and skill to render transcultural care? This question will be answered by the second recommendation.

6.6.2 Inclusion of transcultural nursing in the nursing curricula

It is imperative that nurse educators prepare students to look at culture as an integral component of professional nursing practice. This is accomplished by the deliberate intergration of cultural content into nursing curricula.

- **Factors related to the inclusion of cultural content**

- The manner in which cultural diversity is handled within any given curriculum

depends on the values and beliefs of the nursing philosophy and the conceptual framework. Nurse educators must therefore examine their institutional philosophy to determine whether they reflect a commitment to providing a safe, effective care to clients from diverse cultural groups. In other words, the philosophical base will determine the institutions commitment to teaching cultural content.

- The other factor related to the inclusion of cultural content is the way in which the curriculum is organized and whether it is integrated or non-integrated.

An integrated curriculum usually organizes content in a broad and conceptual manner. If culture is viewed as a broad construct, cultural content can be integrated with ease into nursing courses. The South African Nursing Council supports this approach.

- **Horizontal and vertical threads**

The vertical strands of the conceptual framework support the concept of progressive learning and are content oriented. The horizontal strands are process oriented and more consistently reinforced throughout the programme. Thus, the identification of culture as a horizontal and/or vertical thread will influence how the content is developed in the curriculum.

- **Curriculum orientations**

Approaches to learning following the medical model severely limit the amount of content on cultural diversity. Epidemiology can be addressed but the human experiences of culture is not the focus of the curriculum. Instead, the germ theory, disease and health care management pervade the curriculum. On the other hand, a holistic model provides direction for the inclusion of diverse content.

6.6.3 Curricula approaches for teaching cultural content

The specific cultural content will depend on all the above-mentioned factors. There are

various approaches for including culturally diverse content, namely concept, unit, course and multidisciplinary approaches. The concept approach requires the identification of major concepts that are taught at the basic level and then reinforced throughout the various semesters. As such, cultural concepts become vertical and horizontal threads for curriculum building. One disadvantage is that there will be a fragmented presentation and, as a result, key content will not be covered.

- **The unit approach**

- In this approach the faculty is responsible for teaching a unit or several units related to culture. The unit approach has these advantages: It does not require major curriculum revisions; students can explicitly identify the cultural content; guest speakers can be invited to offer specific content, and the content can be monitored with ease.

- **The course approach**

- This is the offering of a required or elective course pertaining to culture and health care. The course is usually one semester in duration. The distinctive advantage of this approach is that the cultural content can be explored in depth. The pitfall is that, if it is designed as an elective, it may not reach all students.

6.6.4 Teaching strategies for cultural content

Numerous strategies can be employed to foster student learning about culture and health care. These include lectures, seminars, role playing, role modelling and clinical conferences. Other teaching methods include the following:

- **Resources**

Articles pertaining to culture and health care are common in nursing and non-nursing journals

and textbooks. Reference lists should be distributed to students. There are specific exercises in the literature that can be used by students to make them more culturally sensitive.

- **Lectures versus discussions**

More lecture time may be necessary for undergraduate students than for graduate students. Graduate students have more life experience, which, coupled with professional experience, enable them to contribute to group learning.

- **Reports, field studies, projects**

It is recommended that all students complete a report, field study or project associated with culture and health care. Topics could include folk health practices, specific health care beliefs, and selected health care problems of a particular cultural group. This will help a student to learn a specific topic in depth and also how to communicate and share with peers.

- **Guest speakers**

The use of experts in the delivery of culturally sensitive care is an effective teaching strategy. Nurses with experience in delivering care to various cultural groups can share their experience with students.

6.7 STRATEGIES FOR CLINICAL TEACHING

6.7.1 Assigning students to culturally different community settings

This would help students to learn more about different cultural backgrounds in their natural settings and not just in the classroom. During these assignments, preceptors who are preferably from the same cultural background as the community, could be used as resource persons who might offer support and guidance to students. Village health workers, if available, can be useful. Other peers who belong to the community's cultural background can also be used

(Kanitsaki 1988: 5-10).

6.7.2 Joint projects

Joint projects can be organized with other community organizations and groups in order to focus more on competent cultural care. During this involvement, students can acquire more cultural knowledge and they can be accepted by the community.

6.7.3 Information centres and health line service

These should be established for various ethnic groups in their own languages. These centres can provide information about available resources, and where and how to obtain translation. These services can also identify hospitals or clinics and community centres that provide intepretational services.

6.7.4 Volunteers from ethnic-specific organizations

These could be trained so that they provide a link between service and the community. These volunteers may be involved in establishing self-help groups for rural communities.

6.7.5 Cultural sensitivity

To overcome barriers to cultural diversity, nurses must to identify their own cultural values and beliefs by comparing their own beliefs with those of their patients. By doing this, nurses may discover ways to provide more culturally sensitive care. The main goal is to develop beneficial care plans and goals.

6.8 OTHER RECOMMENDATIONS

- Taking positive steps to include cultural anthropology and linguistics as core subjects in curricula.

- Offering nursing students a second/third language.
- Considering the humanities as being of equal value and worth to the physical science subjects when selecting candidates for nursing courses.
- Modifying criteria to ensure that students who have a different cultural background and who speak a second language are selected and setting up support programmes which ensure the students academic success.

6.9 FURTHER RESEARCH

6.9.1 Future research

More research to increase health professionals' knowledge about transcultural nursing should be undertaken. This should focus on identifying the needs and gaps in the system and the skills of the service care providers/nurse educators.

6.9.2 Replication of the study

During data analysis, the researcher made some plausible hypotheses which were based on the study findings. They are the following:

- Cultural knowledge influences health care delivery and a lack of cultural knowledge will therefore give rise to problems during a multicultural nurse patient encounter.
- Attitudes influence health care delivery, and negative attitudes will therefore give rise to problems during a multicultural nurse patient encounter.
- Communication influences health care delivery and difficulty in communication will therefore give rise to problems during a multicultural nurse patient encounter.

The researcher hopes that other researchers will be able to can replicate this study or conduct other similar studies with the above hypotheses.

6.10 LIMITATIONS OF THE STUDY

The first enabler used in this particular study required informants to express their views and share their experience on issues of cultural differences. The researcher experienced a problem in trying to differentiate between culture and racism, especially in the South African context. At first, some informants viewed the researcher with suspicion.

When the researcher had to go back to the informants for the second time to verify the data with them, it became very difficult to get all of them together at one time since they were out in the clinical setting. The researcher had to spend more time than she had earlier to get all of them together.

Initially the researcher had planned to include all levels from the second through to the fourth level, but, due to delays in obtaining permission to do the study, she could only get two levels, namely third and fourth year students. It would have been interesting to see how junior students, namely second years, would have responded.

6.11 CONCLUSION

Delivery of culturally appropriate health care in our society demands that nurses develop proper attitudes, knowledge, communication and interpersonal skills. It would appear therefore that experiential learning is an appropriate approach in addressing this problem. Nurse educators should therefore help students to explore their personal values as an essential step in developing cultural awareness. Informants in the study displayed a readiness to move beyond their ethnocentrism into understanding and acceptance as well as appreciation of the challenges that this cultural diversity of the South African population confronts them with. What is left therefore is for nurse educators to adopt a truly transcultural approach based on principles of adult learning and their facilitation of learning. Only when the curricula for nurse training is relevant to the specific cultural needs of this country will South African nurses be confident in delivering care across cultural barriers, and only then will the goal for health for all by the year 2000 be fully realised.

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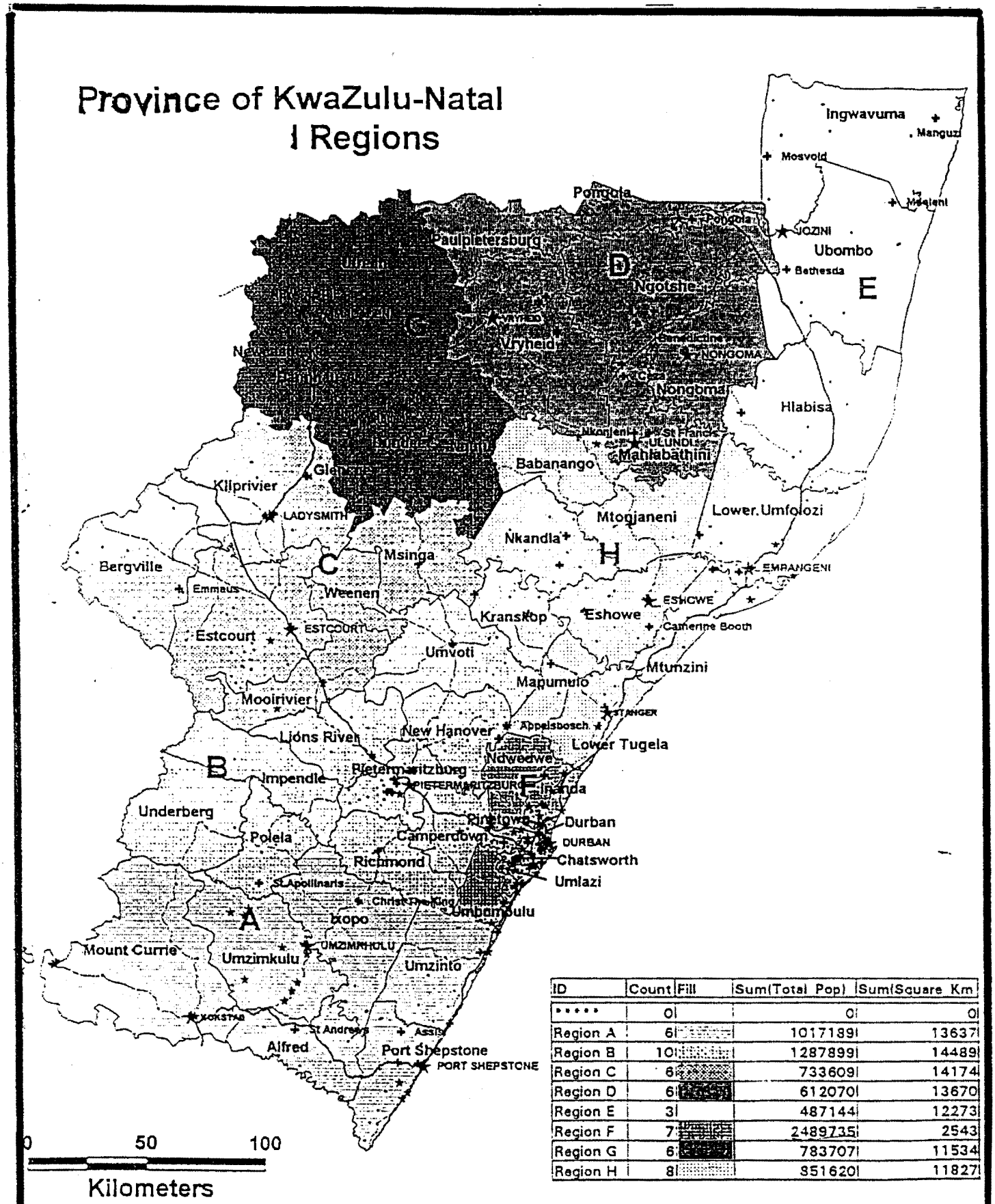
Annexure 1

Map of KwaZulu, Natal

ANNEXURE 1



ID	Count	Fill	Sum(Total Pop)	Sum(Square Km
.....	0		0	0
Region A	6		1017189	13637
Region B	10		1287899	14489
Region C	6		733609	14174
Region D	6		612070	13670
Region E	3		487144	12273
Region F	7		2489735	2543
Region G	6		783707	11534
Region H	8		351620	11827

Prepared: KNEHIS January 1995 - NGCF
Population Data - Development Bank 1993

Annexure 2

Application for permission letter

ANNEXURE 2

FAXED
-7 JAN 1997

Department of Nursing Science
P O Box 12099
Amalinda
5252

31 July 1996

The Principal's Office
Natal College of Nursing
Private Bag 9089
Pietermaritzburg
32000

Dear Sir / Madam

RE : PERMISSION TO CONDUCT A STUDY AT ADDINGTON COLLEGE OF NURSING

I hereby request your permission to conduct a study at the above mentioned institution during the year 1996. I am registered with UNISA for a Mater's degree programme. The topic of my research is "Problems experienced by student nurses in a multicultural nursing situation". What triggered my interest in the study is the fact that before 1990, hospitals were not open to people of all racial and cultural groups, and as a result nurses were not adequately equipped to render culturally congruent care to people of other cultural groups. Previous studies have revealed that cultural knowledge or lack thereof is a major determining factor in rendering care across cultural barriers. Nurses have accepted this challenge but studies have also revealed that nurses experiences problems since the care they deliver is sometimes perceived inadequate by the recipients.

The reason for choosing Addington as my research setting was the fact that out of all the other hospitals and colleges around Durban, Addington was found to have a higher than average heterogenous population, since it is centrally situated. My target population will be those students involved with the Midwifery modules and from them I will sample only those that admit to have experienced problems during their engagement with culturally different clients. I will interview these students.

The results of my study will be published and I will send a copy to the Addington to share the information with them. Presently I am with the Nursing Science Department at the University of Fort Hare, unfortunately I had to change employment before I finished my study. I plan to come to Durban during the month of September to collect the data.

Hoping that my request will be considered.

Thank you

TD KANYILE

PRINCIPAL
DATE 7.1.97
ADDINGTON COLLEGE
OF NURSING

Annexure 3

Letter of approval

PROVINCE OF KWAZULU-NATAL
DEPARTMENT OF HEALTH

ISIFUNDAZWE SAKWAZULU-NATALI
UMYANGO WEZEMPILO

PROVINSIE KWAZULU-NATAL
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REFERENCE: 66/3
ENQUIRIES: Dr L.L. Nkonzo-Mtembu
TELEPHONE: 95-2275

Miss T.D. Kanyile
Nursing Sciences
P.O. Box 12099
AMALINDA
5252

Dear Miss Kanyile

RE: RESEARCH PROJECT "PROBLEMS EXPERIENCED BY STUDENT NURSES IN A MULTI-CULTURAL NURSING SITUATION"

Dr P. Emerson, Director, has supported your request to undertake the above research provided that:-

(1) You approach the Hospital Management Team for permission.

(2) The Department is acknowledged on completion of the research.

(3) A copy is forwarded to the Department.

(4) That you maintain the confidentiality of the interviewees.

Yours faithfully

L L Nkonzo

for SECRETARY : DEPARTMENT OF HEALTH
KWAZULU-NATAL

JM/rcb/s.r17 30/1/97

Annexure 4

Informed consent form

ANNEXURE 4

INFORMED CONSENT FORM

6026990

UNIVERSITY OF SOUTH AFRICA

INFORMED CONSENT FORM

RESEARCH TITLE: ***PROBLEMS EXPERIENCED BY STUDENT NURSING DURING THEIR ENCOUNTER WITH CULTURALLY DIVERSE CLIENTS***

COURSE: **MASTER'S DEGREE NURSING EDUCATION**

RESEARCHER: **TD KANYILE (PHONE 0403-612184 613954**

The purpose of this study is to explore the nature of origin of those problems that non-Zulu student nurses experience during their encounter with Zulu patients. Focus group discussions will be conducted. Each session will last approximately two hours. During these sessions each informant will be required to describe a situation that he/she was involved in with a Zulu patient, in which the informant experienced a problem or problems. These discussions will be tape-recorded, and the cassette will be destroyed immediately after data has been analyzed. There may be no direct benefits to you as a participant of this study, but there may be changes in the nurse-patient relationship following the completion of the study.

6026990

THIS IS TO CERTIFY THAT I, ... (print name) hereby agree to participate as an informant in the abovementioned study. I understand that there will be no health risks to me resulting from my participation in research.

I hereby give permission to engage in focus group discussion and for those discussions to be tape-recorded. I understand that, at the completion of the research, the tapes will be erased. I understand that the information may be published, but my name will not be associated with the research.

I understand that I am free to deny any answer to specific questions during the discussion session. I also understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I desire and all such questions have been answered to my satisfaction.

. . . . .	. . . . .	. . . . .	. . . . .
PARTICIPANT	**WITNESS**	**RESEARCHER**	**DATE**

Annexure 5

Narrative statements schedule

ANNEXURE 5

SECOND DATA COLLECTION TOOL

NARRATIVE SCENARIOS

FIRST SCENARIO

You are a senior nurse in ward 2 where Mrs Xulu has been admitted for amputation left leg. The patient is refusing surgery and the doctor has asked you to explain the reason for surgery to this patient. During your discussion, the patient reveals to you that according to her cultural beliefs, illness is a sign of bad-luck and the only treatment is by performance of a ritual to cleanse her of this evil.

How would you respond to this situation?

SECOND SCENARIO

You are on night duty in ward 6 where a patient whose cultural background is different from yours is admitted and is on blood transfusion. During your hourly rounds you notice that the patient is awake though it is 02:00. When you enquire from the patient why he is not sleeping he tells you that he is afraid to sleep because he does not trust the nurses, therefore he will stay awake until the blood transfusion is complete.

How would you deal with this situation?

THIRD SCENARIO

You are on night duty in a female surgical unit where Mrs X is admitted and you are assigned to nurse her. She does not speak your language as she belongs to a different cultural group than you. She has just come back from theatre as she is awake.

You have a problem since you cannot communicate with this patient. Neither can all other staff on duty communicate with this patient.

How would you deal with this problem?

Annexure 6

Focus group interview schedule

ANNEXURE 6

DATA COLLECTION TOOL

FOCUS GROUP QUESTIONS

These will be used for general discussion.

FIRST SESSION

Researcher: *"I would like each one of you, to describe a situation that she/he was involved in, with a Zulu patient/client and during which she/he experienced a problem or problems".*

Informants: *Each take turns discussing their experiences.*

Researcher: *Takes down notes together with the tape recorder turned on. Thereafter the researcher will proceed from general to specific questions, namely:*

Researcher: *"Numerous studies have revealed that the cause of problems during a multicultural nursing encounter is* ***due to lack of cultural knowledge".*** *What examples can each one of you give to qualify or disqualify this statement?*

Informants: *Engage in discussion.*

Researcher: *Takes down notes, observe nonverbal cues, makes summaries.*

Duration: *30 Minutes.*

Break: *15 Minutes (refreshments served).*

SECOND SESSION

Researcher: *Now each one of you is going to describe a situation that she was involved in with a Zulu patient where she experienced a problem or problems due to communication problems.*

Informants : *Each take turns discussing their experiences.*

Researcher : *Takes down notes together with the tape recorder turned on.*

Researcher : *I would like each one of you to reflect back on one encounter with a Zulu patient after which you felt the cause was due to negative attitudes.*

Informants: *Engage in discussion*

Researcher : *Listens, takes down notes, observe non- verbal cues, and makes summaries*

Duration : *30 minutes*

Debriefing session: researcher thanks the informants for their participation after turning the tape recorder off.

Annexure 7

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ANNEXURE 7

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A INFORMANTS CHARACTERISTICS

Group	Informant number	Age	Sex	Ethnicity/Race	Year of study	Cultural group
1	1	18	F	Coloured	2	Western
1	2	19	F	Tswana	2	Mixture/Western/ Traditional
1	3	18	F	Indian	2	Mixture/Oriental/ Western
1	4	19	F	Swazi	2	Mixture/Western/ Traditional
2	5	19	F	White	2	Western
2	6	19	F	Coloured	2	Western
2	7	20	F	White	2	Western
2	8	19	F	White	2	Western
3	9	18	F	White	3	Western
3	10	19	F	White	3	Western
3	11	20	F	White	3	Western
3	12	20	F	White	3	Western