

**University of Natal**

**An exploratory study of the lived  
experiences of critical care nurses  
with Muslim traditional illness  
practices**

**Waheedha Emmamally**

**An exploratory study of the lived experiences of  
critical care nurses with Muslim traditional  
illness practices**

**A Dissertation Submitted**

**To**

**The School of Nursing at the University of  
Natal, Durban**

**In**

**Partial fulfilment of the requirements for the  
Masters Degree in Nursing - Critical Care  
(M N)**

**By Waheedha Emmamally**

**Supervised by Mrs. B. R. Bhengu**

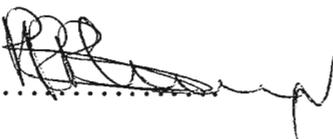
## Declaration

I declare that the research - an exploratory study of the lived experiences of critical care nurses with Muslim traditional illness practices, is my own work. It is being submitted for the Degree of: Masters in Nursing - Critical Care at The University of Natal, Durban. It has never been submitted for any other purpose. All references used and/or quoted have been acknowledged by referencing.

Signature.....

Date.....

This study has been approved for submission by the supervisor of the study, Mrs. B. R. Bhengu

Signature.....

Date.....20.11.03

## **Dedication**

This study is dedicated to my Mum and Dad - thank you  
for the gifts of life and love

## Acknowledgements

My sincere thanks go to the following people:

Mary, Fay, Olive, Kugil, Dollars and Florry, for sharing their experiences with me.

To the management and staff of the two hospitals used in the study, for granting me permission to use the premises.

To Mrs B. R. Bhengu, my research supervisor, for her insight and sage advice.

To Toni and Yasmin, for the exhausting task of editing the research study.

To my brother Afzal and sister Sajida, thank you for your support and *duas*.

To Shamshaad, without whom I would forever be lost, thank you for your optimism and for believing in me - you are the greatest.

Finally my gratitude is to The Almighty ALLAH for the strength and direction He has given me throughout my studies.

## **Abstract**

**Aim:** The aim of the study was to explore the lived experiences of critical care nurses with Muslim traditional practices.

**Methodology:** A phenomenological approach was used in the study to gain the critical care nurses' perspectives of Muslim traditional illness practices. The realised sample was six participants, from intensive care units within one provincial and one private hospital. The researcher applied the principle of theoretical saturation, which was achieved at the verifying interviews of the participants. Two semi-structured interviews were conducted with each participant an initial and a verifying interview, each of which lasted 20 – 30 minutes. All interviews were recorded and transcribed. Manual data analysis was used to identify categories and themes.

**Findings:** The participants were open-minded to the Muslim clients' belief system on healing and agreed that the clients' cultural beliefs took precedence over their own beliefs. The participants believed that Muslims relied on traditional illness practices as these provided them with hope and faith in times of despair as well as provided them with emotional and spiritual contentment. A number of methods were used by the participants to acquire knowledge about Muslim traditional illness practices. There was great support for the delivery of culturally sensitive care amongst the critical care nurses. Recommendations were suggested for nursing education, nursing practice and further research to facilitate the creation of a culturally sensitive climate in health care delivery.

# Table of contents

<b>Title Page.....</b>	<b>ii</b>
<b>Declaration.....</b>	<b>iii</b>
<b>Dedication .....</b>	<b>iv</b>
<b>Acknowledgements.....</b>	<b>v</b>
<b>Abstract .....</b>	<b>vi</b>
<b>Table of contents.....</b>	<b>vii</b>
<b>List of diagrammes .....</b>	<b>x</b>
<b>List of tables.....</b>	<b>xi</b>
<b>Chapter 1: Introduction</b>	
1.1 Background to the study.....	1
1.2 Problem statement.....	5
1.3 Purpose of the study.....	5
1.4 Objectives of the study.....	6
1.5 Significance of the study.....	6
1.6 The conceptual framework of the study.....	7
1.7 Operational concepts.....	10
1.7.1 Culture.....	10
1.7.2 Muslim cultural traditions.....	10
1.7.3 Culturally appropriate care.....	10
1.7.4 Muslim traditional illness practices.....	11
1.7.5 Critical care nurse.....	11
1.7.6 Muslim.....	12
1.7.7 Culturally Sensitive Care.....	12
<b>Chapter 2: Literature review</b>	
2.1 The impact of culture on the illness experience.....	13
2.2 A move towards culturally sensitive care at National level...	15
2.2.1 The role of the traditional healer in South Africa.....	16
2.2.1.1 Legislation concerning the traditional healer in South Africa.....	17

2.2.1.2 Proposed advantages of legalising the activities of traditional healers.....	17
2.2.2 Collaboration between the traditional and formal health systems in a bid to improve efficacy of health care in South Africa.....	18
2.3 Nursing education programmes must foster culturally sensitive care.....	22
2.4 The importance of culturally sensitive care in the intensive care unit .....	23
2.5 Traditional practices of the Muslim culture regarding the illness experience .....	24
2.5.1 The meaning of Islam .....	25
2.5.2 The concept of health and illness in the Muslim culture .....	26
2.5.3 Islamic medicine.....	28
2.5.4 Muslim traditional illness practices.....	29
2.5.5 Traditional Muslim illness practices encountered in the intensive care unit ..	30
2.5.5.1 Visiting of the sick.....	30
2.5.5.2 Death and dying issues.....	31
2.5.5.3 cleansing rituals.....	31
2.5.5.4 Healing rituals.....	32
2.5.5.5 The sanctity of the body.....	32
2.5.5.6 Euthanasia.....	32
2.5.6 The implications of Muslim traditional illness practices for health professionals.....	33
2.6 Conclusion.....	34

### **Chapter 3: Research methodology**

3.1 Research approach.....	35
3.2 Research design.....	36
3.3 The setting.....	36
3.4 Selection of participants .....	37
3.5 Data collection .....	38
3.5.1 The initial interview.....	38
3.5.2 The verifying interview .....	39
3.6 Trustworthiness .....	40
3.7 Bracketing.....	41
3.8 Data analysis.....	41
3.9 Ethical considerations.....	42

### **Chapter 4: Description and Discussion of findings**

4.1 Introduction.....	44
4.2 The setting.....	44

4.3 The participants.....	45
4.4 The interviewing process .....	47
4.5 Discussion of findings.....	48
4.5.1 Category: Cultural awareness.....	50
4.5.2 Category: Cultural knowledge .....	53
4.5.3 Category: Cultural skill .....	57
4.5.4 Category: Cultural encounters .....	60
4.5.5 Category: Cultural desire .....	64
4.5.6 Cultural Sensitivity.....	68
<b>Chapter 5: Summary of findings, recommendations and conclusion</b>	
5.1 Summary of findings.....	70
5.1.1 Cultural awareness.....	70
5.1.2 Cultural knowledge.....	71
5.1.3 Cultural skill.....	73
5.1.4 Cultural encounters .....	75
5.1.5 Cultural desire.....	77
5.1.6 Culturally sensitive care .....	78
5.2 Recommendations for the future.....	80
5.2.1 Recommendations for nursing education.....	80
5.2.2 Recommendations for nursing practice .....	81
5.2.3 Recommendations for future nursing research.....	81
5.3 Limitations of the study.....	81
5.4 Conclusion.....	82
References.....	83
Annexure A : Interview Guide.....	88
Annexure B : Ethics Clearance Form.....	89
Annexure C : Letter of Permission – KwaZulu-Natal Health Services....	90
Annexure D : Letter of Permission – Provincial institution.....	91
Annexure E : Letter of Permission – Private institution.....	92
Annexure F : Example of full interview.....	93
Annexure G: The researcher’s process of bracketing.....	94

## **List of diagrammes**

Figure 1.6.1. Diagrammatic Presentation of The Culturally Competent Model of Care .....	9
---	---

## **List of Tables**

4.1 Realised sample on data collection.....	45
4.2 Profile of participants.....	46
4.3 Categories and their themes.....	49

# CHAPTER 1

## Introduction

### 1.1 Background to the study

South Africa boasts a total population of 40.58 million. The province of KwaZulu-Natal accommodates 8.4 million of this total population, an approximate of 91 persons per square kilometer. The population within the province is diverse in its racial composition, where the Blacks total 6.9 million, Coloureds 0.12 million, Asians 0.80 million, Whites 0.56 million and others 0.07 million. Gender distinctions are also prevalent with females encompassing 53.1% of the population and males 46.9%. Further diversity is indicated in the language spoken by the people, with isiZulu spoken by 79.8% of the population, English by 15.8%, and isiXhosa and Afrikaans by 1.6% of the population. The remaining languages spoken, amount to approximately 2.8% ([www.statssa.gov.za](http://www.statssa.gov.za)). Distinctions also arise with religion, where Christianity and Hinduism dominate. Within the Durban metropolitan area, where the researcher conducted the study, Muslims, a minority religious sector, number 500 000 (Kara, 2002). The diversity of the province indicates the existence of groups of people, with each group bearing their distinctive traits that unify them as a culture.

The nurse - patient interaction occurs within a cultural context, as both are essentially cultural beings. Their behaviour and attitudes are moulded and guided by their cultural

values, norms and beliefs. Cultural barriers, as a result of conflicting beliefs, often hamper the provision of effective care to the client (Andrews & Boyle, 1995). The nurse should never underestimate the tenacity of cultural patterns on a client's health perspective. The cultural patterns shape a client's response to the causality of illnesses, their worldview of health and their expectations of treatment. Culturally incongruent treatment regimes result in the labeling of clients as being difficult, unco-operative and noncompliant (Kleinman, Eisenberg & Good, 1978). The system of healing acceptable to a client stems directly from their worldview (Andrews & Boyle, 1995). Tension is experienced when treatment regimes are incompatible with the client's worldview. The ill client often utilizes both the formal and folk healing sectors in tandem, with families and friends securing the assistance of the folk sector whilst the client is hospitalised. Folk healing comprises of various rites and rituals that provide security and stability to the client (O'Brien, 1999).

Against this backdrop it becomes the challenge of the health services of the province to provide for the health and illness needs of a pluralistic population. The nursing profession has responded to the challenge by making transcultural nursing one of the current areas of research. Transcultural nursing pioneers such as Leininger (1985), Troskie (1998), and Kleinman et al (1978) have concentrated their efforts on theory building and conceptual model development. The emerging theories and findings are geared towards providing the nursing workforce with culturally appropriate care techniques, (Giger & Davidhizar, 1995).

The core of nursing namely the nursing process, has also been extensively researched with emphasis on the assessment phase. During data collection in the assessment phase, a great deal about the cultural beliefs and idiosyncrasies of the client is elicited to provide nursing interventions that are culturally appropriate and acceptable (Brink, 1976).

Despite advances made in the field of transcultural nursing, providing culturally sensitive care to clients is a major hurdle for South African nurses. This is mainly due to nursing education programmes that have failed to include the cultural context of clients in nurse education (Abdullah, 1995). Past educational programmes have been developed according to the biomedical model, where the technical fix to illness management has been emphasized. Nurses educated according to this model have been observed to show favourable attitudes towards clients whose worldview of health and illness is consistent with the biomedical model (Abdullah, 1995). Furthermore trainee nurses received their practical experiences in hospitals that catered for clients of their own racial standing; hence they developed a unicultural stance in the provision of health care. Abdullah (1995) vetoes this form of training and education, and indicates that humanistic studies, which explore nurses' experiences with clients from different cultural backgrounds will provide nurse learners with cultural sensitivity.

In reviewing the literature, the researcher has identified a definite lack in research in the intensive care setting, where the cultural well being of the client can be severely neglected due to institutional restrictions and schedules. The intensive care setting is associated with advanced health care technology and crisis intervention. With the greater

emphasis on the physiological management of the client, the cultural dimension of holistic care may be neglected. For the critically ill client and the family, the intensive care experience is associated with stressors of social isolation, lack of autonomy and helplessness. Most important, however, is the persistent fear of death and depersonalization. This experience enhances the client's traditional beliefs, which are closely related to spiritual comfort and divine interventions. Traditional illness practices provide hope and solace in these times of perceived hopelessness. It takes a culturally sensitive nurse to bridge the gap between the technical aspects of the intensive care environment and the cultural needs of the client and his/her family (O'Brien, 1999).

A lack of research in minority cultural groups has also been identified. The researcher has identified the Muslim culture as one of these insufficiently researched groups. Past research into the Muslim culture identified the need to include Muslim traditional illness beliefs in the illness and health care of the Muslim client. In the study of the Muslim patient (Haffejee, 2000), recommendations are made to health institutions to ensure that the cultural beliefs of the Muslim client are respected in the planning of health care. Ebrahim, Hoosen & Hathout (1995) focus on death and dying and the obstacles encountered by health professionals during this period. Islamic medicine has also been an area that has been the focus of research, providing the Muslim culture with principles and guidelines to illness management (Bhikha, 2000). Most studies on the Muslim culture are from a medical perspective. This study however will concentrate on the nursing perspective regarding the Muslim culture.

## **1.2 Problem statement**

The cultural diversity of the people of KwaZulu-Natal demands that the health professionals take cognizance of the clients' traditional beliefs on illness and healing.

Wells (1983) states that cures for illness that are organic in origin following visits to shrines and faith healers indicate that faith alone can elicit therapeutic success. Muslim belief on traditional healing supports this view (Bhikha, 2000). In the intensive care setting, where the practice of tradition provides hope for the client and his family, the therapeutic regimes planned must be congruent to the client's belief system regarding illness. It is acknowledged that the critical care nurse, as the facilitator of the client's therapeutic care, is the common denominator between the delivery of culturally sensitive care and the intensive care area.

There is also the concern that the Muslim culture has not been sufficiently explored with regards to their traditional illness practices and its effect on the delivery of nursing care to the Muslim client. It is for this reason that the researcher has decided to explore the lived experiences of the critical care nurses with Muslim traditional illness practices.

## **1.3 Purpose of the study**

The study will be conducted with the purpose of exploring the critical care nurses experiences with Muslim traditional illness practices.

## **1.4 Objectives of the study**

In the study the researcher seeks to:

- Explore the critical care nurses' lived experiences with traditional illness practices of the Muslim culture
- Describe the critical care nurses' perceptions of culturally sensitive care.

## **1.5 Significance of the study**

Since culture prescribes and influences the beliefs and practices of its members regarding worldviews of health and illness, nursing attitudes that display cultural bias will present barriers to effective health care. Through cultural self-actualization nurses are able to recognize their biases and are able to approach health care planning through the client's worldview on the system of healing. By acknowledging and bringing their ethnocentricity to a conscious level, nurses are able to move from a unilateral to a multicultural perspective regarding client care. It has been identified that South African nurses due to their unicultural experiences and education according to a biomedical educational programme, are ill equipped in dealing with cultural issues (Abdullah, 1995).

Hence the movement to a multicultural stance and a culturally sensitive approach to nursing care will be difficult for the critical care nurse, whose training followed the biomedical health model. Nevertheless, it has been noted that the understanding of the client's traditional perspective regarding illness in an intensive care setting, is essential to

the holistic care of the client. A general understanding of various cultural groups rather than an intimate study of one group, will ensure that the critical care nurse does not become stereotypical in delivering cultural care. Exploring the lived experiences of critical care nurses with Muslim traditional illness practices will promote understanding of some of the practices.

## **1.6 The conceptual framework of the study**

The purpose of this study is to explore the lived experience of the critical care nurse with Muslim traditional illness practices. The researcher has chosen a conceptual model that depicts the lived experience of the critical care nurse as a cultural encounter.

The Culturally Competent Model of Care, designed by Campinha-Bacote (2000), was chosen as the conceptual model of the study. The model includes five constructs of a nurse - client encounter in a cultural context.

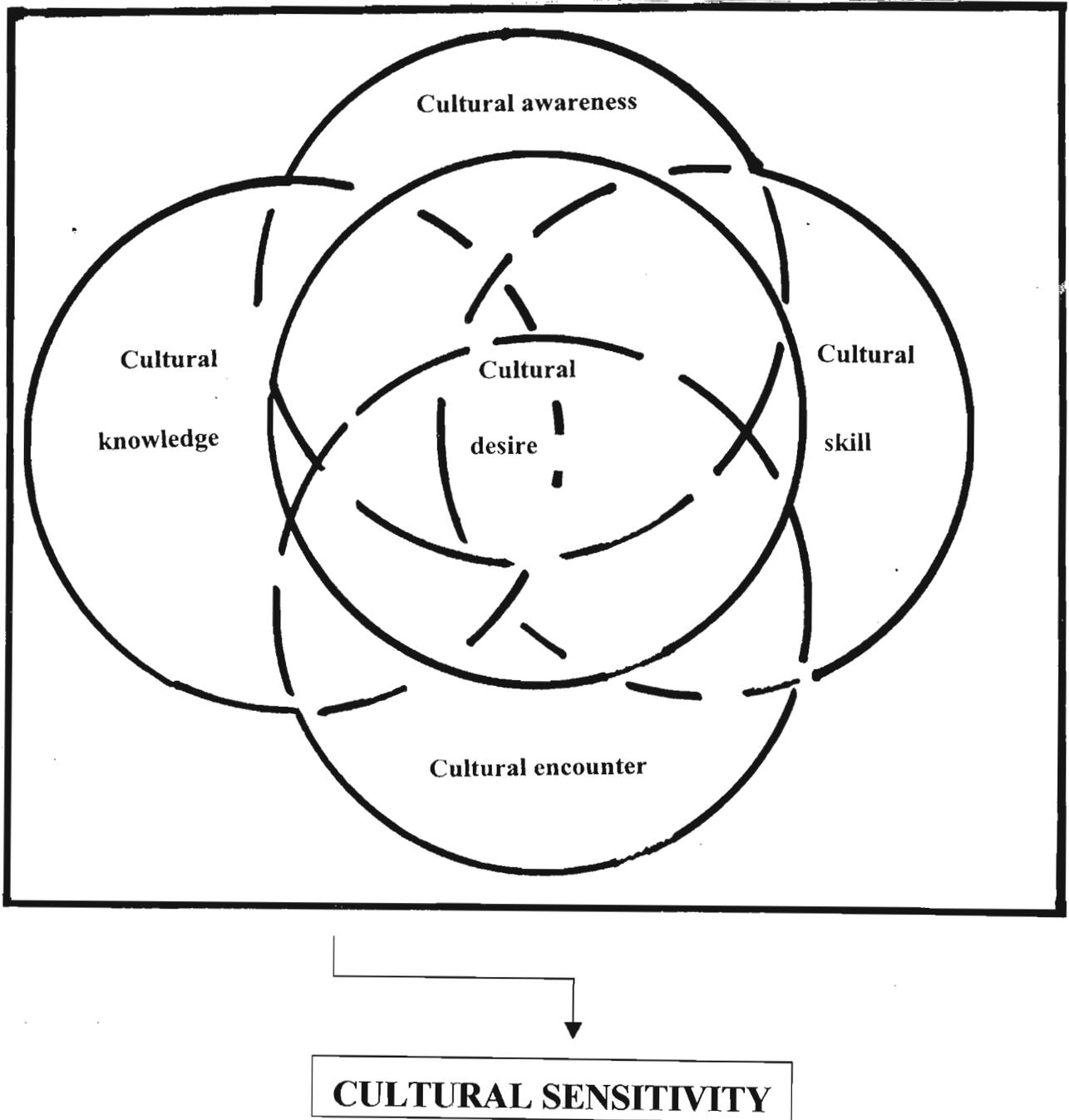
### **The five constructs are as follows:**

- **Cultural awareness:** This involves self-examination by the nurse, to identify biases and prejudices towards clients from different cultural groups.
- **Cultural knowledge:** The nurse must seek and obtain information about the worldviews of clients, and how these views impact the client's illness experience.

- **Cultural skill:** The nurse must have the skill to assess and collect information from the client regarding his/her cultural orientation to illness, to aid in planning and delivering culturally sensitive care.
- **Cultural encounters:** To develop universal cultural care guidelines and prevent stereotyping, the nurse must actively engage in face-to-face encounters with clients from different cultural groups.
- **Cultural desire:** The cultural encounter will only be possible if the nurse has the motivation to provide culturally sensitive care.

These five constructs are depicted as interlocking concentric circles (refer to Figure 1). The model is considered volcanic in nature, with the construct of cultural desire identified as the precipitate of the volcano. Without the desire for a culturally sensitive encounter with the client, the nurse will neither engage nor develop the remaining four constructs. Having the desire for cultural encounters will ensure that the four constructs continually erupt or pour forth from the nurse (Campinha-Bacote, 2000).

**Figure 1.6.1 Diagrammatic presentation of The Culturally Competent Model of Care- (Modified) (Campinha-Bacote, 2000)**



## **1.7 Operational concepts**

### **1.7.1 Culture**

Dobson (1991,45) defines the term culture, “as a way of life of a society or a group.”

It is a shared understanding as well as codes that are learnt and transmitted within a group. These codes guide the behaviour of the members of the group. In this study the researcher is concentrating on the Muslim culture. The focus of the study is on the way of life of the Muslim group, the rituals; dress code; language; values and practices that are related to health, illness, death and dying. These elements distinguish the Muslim culture from other cultural groups.

### **1.7.2 Muslim cultural traditions**

These are elements of the Muslim culture that are socially inherited. These elements are revered by the members and are perpetuated by ensuring that they are taught and handed down from generation to generation (Andrews & Boyle, 1995). Muslim traditions pertaining to illness and health include among others, mass visits to the sick; offering of prayer during the visits; as well as the client requesting the inclusion of elders of the family in the making of health care decisions.

### **1.7.3 Culturally appropriate care**

The researcher refers to this type of nursing care as being acceptable to the Muslim client within the client’s cultural framework. Care will be appropriate if the nurse is aware of the Muslim client’s view regarding his health needs and if therapeutic interventions are planned so that they are both meaningful and acceptable to the client.

### **1.7.4 Muslim traditional illness practices**

Illnesses and their cause and treatment are culturally prescribed. Muslim traditional illness practices encompass rites and rituals based on the Muslim client's belief system.

Illness practices include specific healing practices that are aimed at restoring the physical, mental and spiritual wellbeing of the individual and are among others; the use of a *Ta widh*, which is specific to the type of illness suffered by the client; fasting or the abstention from food; and personal communication with ALLAH through *Salaah* (prayer). Abiding to the Muslim dress code and ensuring that medical personnel of the same sex as the client examine the client, are also part of traditional practices adhered to during an illness experience. Contravening these traditions will result in psychological and spiritual uneasiness within the Muslim client.

### **1.7.5 Critical care nurse**

A nurse, registered with The South African Nursing Council as a professional nurse, and has worked in the intensive care department of a provincial or private hospital for more than a year. The professional nurse may or may not have an intensive care training qualification.

### **1.7.6 Muslim**

A Muslim is an individual who belongs to the religion of Islam, and submits totally to the will of ALLAH, the divine creator. A Muslim is not of any particular racial group, and is recognized by his/her following of the five Islamic principles.

### **1.7.7 Culturally Sensitive Care**

Culturally sensitive care is an approach to care that takes into account the cultural background of the patients in this case the Muslim patients' traditional illness practices.

## **CHAPTER 2**

### **Literature Review**

#### **2.1 The impact of culture on the illness experience**

Man is essentially a cultural being in that his actions, decisions and thinking are guided by cultural values and norms (Giger & Davidhizar, 1995). Culture prescribes meaning to an individual's orientation to various life experiences especially that of illness and health, in the sense that how an individual perceives, experiences and responds to illness and treatment modalities depend on their frame of reference, the social position that they occupy and the system of meaning that they employ. Germaine (1992) uses the example of facial scarring to highlight how the meaning of illness depends on what the individual considers normal within the cultural context. In the modern American culture, facial disfigurement would constitute a cosmetic emergency, due to fear of scarring, whereas in certain Black communities facial scarring is a sacred ritual. Similarly different worldviews regarding the cause of illness would affect an individual seeking help from the formal health sector or complying with treatment prescribed by this sector.

The three major worldviews that exist are the magico-religious, the biomedical and the holistic worldviews (Andrews & Boyle, 1995). In the magico-religious worldview disease is viewed as being caused by supernatural forces, either in the form of evil spirits, breaching of taboos, or sorcery. Illness is considered a communal phenomenon where the individual's illness impacts the community health and lifestyle (Andrews & Boyle, 1995). The biomedical worldview looks at illness within the individual, as physical and chemical processes that have been disrupted. The human being is made up of parts that can be studied, diagnosed and treated individually. Individual autonomy is highly regarded by health professionals (Andrews & Boyle, 1995). The holistic worldview looks at balancing of natural forces, both within the individual and between the environment and the individual. Illness results from disharmony among the forces. Cures are directed towards restoring the balance to ensure optimal individual functioning (Andrews & Boyle, 1995).

Johnson (2000) identifies the dominant worldview amongst the South African population as being the African paradigm. The African paradigm is a combination of the magico religious and holistic worldviews. Causes of illness are attributed to disharmony with natural forces, or due to witchcraft and ancestral shades. The healing process focuses on family and community involvement, involving rituals and cleansing (Johnson, 2000).

The holistic paradigm is the dominant worldview of the Muslim culture, therefore the illness treatment regimes that are incongruent to the system of healing propagated by this worldview will be unacceptable to the Muslim client. Another factor to consider in

exploring the Muslim culture and illness is the cultural consensus on who the health care decision makers are. The autonomy of individual decision - making afforded by the biomedical model is absent in the Muslim culture, where decision - making is a family or communal task (Ebrahim, 1988). Providing holistic care to clients of the Muslim culture involves acknowledging and understanding the worldview from which they operate.

## **2.2 A move towards culturally sensitive care at National level**

If culturally sensitive care were to be a theme that permeates all health services, then commitment to this would have to be at National level. Health care in South Africa has been profoundly influenced by the political shift in the country. In the past inequalities with the distribution of health care and its inaccessibility to certain groups were associated with apartheid laws and socio-economic distinctions (Dauskardt, 1994). The system of health care provision under apartheid rule was ineffective and inefficient in meeting the needs of a population that is multi-racial, multi-ethnic and multi-religious (Arthur, 1995). In its attempt at reformation, The African National Congress (ANC) prioritised on its agenda the need for health care restructuring, with the underlying theme being government commitment to health for all. This was in keeping with the Alma - Ata Conference of 1978. The Health Reform Policy (1994) cemented this national commitment by making all health care facilities accessible to all racial and cultural groups (Arthur, 1995). Another health reformation feature of national importance

became the refocusing of the health care system towards an approach in which the cultural needs of the population would be considered when planning health care policies and strategies (Arthur, 1995). Issues encountered in the distribution of health care resources when using this approach, were: What would constitute effective treatment modalities and what cultural perspectives would impede the use of available facilities (Arthur, 1995)? This principle is included in The National Health Plan formulated by the ANC (1994), where traditional healing would form part of the national health care system. The aim is total reformation of the health care sector with the emphasis on decentralization of health and illness management to provinces, districts and institutions so that people empowerment is enhanced. In the spirit of South African democratization, health reform will focus on the provision of health services that are easily accessible, in quantities and of the nature needed by the people. Of importance is that active participation of the people will be encouraged, with clarification of different worldviews regarding health being the basis of health care planning (Arthur, 1995). The core of national commitment to culturally sensitive care focuses on the acknowledgement of the traditional healer as a health care provider and on collaboration between the traditional and formal health systems of South Africa so as to improve the efficiency of health care in the country.

### **2.2.1 The role of the traditional healer in South Africa**

The traditional healer is acknowledged as the person who acts as a mediator between the visible and invisible worlds (Johnson, 2000). Within the Muslim culture the Muslim

traditional healer is revered as an individual who works within the Muslim health and illness paradigm. Types of Muslim traditional healers include, the *Hakim*, *Tabib* and the *Amil*. The Muslim client will also secure the help of traditional Muslim healers whilst in the hospital setting (Mahomed, 1997). The inclusion of research on the traditional healer in the literature review is to firstly acknowledge their role in informal health care, and secondly to enable critical care nurse to identify the different Muslim traditional healers that may be encountered in the intensive care unit.

#### **2.2.1.1 Legislation concerning the traditional healer in South Africa**

The ANC in the National Health Plan, which became policy in 1997, made an explicit statement that complementary medicine, including African traditional healing would become part of South Africa's formal health system. Accordingly consumers of health could choose whom to consult regarding provision of care (Pretorious, 1999). Legislation would also facilitate the work of the traditional healers. Regardless of the statements, currently African traditional healers are recognized in only one region, that being KwaZulu-Natal. The KwaZulu Act (6/1981) allows the licensing of traditional midwives and traditional health healers (Pretorious, 1999).

#### **2.2.1.2 Proposed advantages of legalising the activities of traditional healers**

- Through recruitment and training of traditional healers, ineffective and harmful traditional methods can be identified and eliminated. An example of a potentially

harmful traditional practice is the use of *isihlambezo* in the African culture, which when taken in the third trimester of the pregnancy been associated with premature labour and resultant rupture of the cervix (Donaldson, 1997).

- Formal training programmes for traditional healers can help them modify traditional rituals that have inherent dangers. An example is ensuring that incisional immunization, practised in certain African cultures, is carried out using sterile equipment so that the incidence of infection is reduced.
- Formal recognition and licensing would prevent bogus traditional healers practicing.
- Referral between the medical sector and the folk sector can be enhanced, allowing consumers to freely utilize both sectors, so that the treatment prescribed can complement rather than work against each other (Pretorius, 1999).

### **2.2.2 Collaboration between the traditional and formal health systems in a bid to improve the efficacy of health care in South Africa**

The relationship between the western and traditional healing systems has in the past been an antagonistic one. Providers of health care within the western system enjoy greater respect as their knowledge is based on science and rational thought. Since Colonial rule traditional medicine has been rejected in South Africa, as it was considered primitive and dangerous to the people. Despite this antagonism the local indigenous health system is

relied upon by many South Africans for the treatment of a wide variety of illnesses (Peltzer, 2000; Pretorious, 1999). It is believed that as many as 80% of South Africans consult with traditional healers (Hopa, Simbiya, Du Toit, 1998). Apart from being more easily accessible, various other reasons have been forwarded for the use of traditional healers as first line health providers. Traditional healing is considered more holistic in approach to western healing where reductionism dehumanizes the illness experience. Due to high costs of western medicine and competition for scarce resources it is unlikely that the health services will be available to all. The traditional healers tariffs are far cheaper and affordable to the lower socioeconomic groups. Most practices of modern medicine offer alleviation of symptoms rather than lifestyle changes. Traditional healers not only cure illnesses, but also mediate with ancestors and Gods allowing the individual to attain harmony with nature. They act as counsellors and include the family in the process of healing (Hopa et al, 1998).

Members of the Muslim culture are also known to seek the help of the traditional health system in illness management, while simultaneously utilizing the formal health sector (Mahomed, 1997). The traditional health system is relied on for spiritual well - being of the Muslim client, and also because of the Muslim belief that every illness and its cure are given by ALLAH. Acknowledging the role played by the traditional health system in the Muslim client's illness will ensure that the illness is managed holistically. Furthermore traditional rituals that need to be performed will be revealed to the health team, ensuring that any traditional illness practices that may work against the formal treatment of the client is recognized and discussed.

Freeman (1990), in the study of collaboration between the two health systems, concludes that the existence and reliance on the traditional healing system cannot be ignored as to do so would mean erosion of the African culture. In South Africa energy should be directed towards examining ways in which the two systems of health care can complement each other and coexist. Collaboration between the two systems has occurred but in a very small scale. Apart from government initiative in including traditional healing as an integral part of the care system in the country, the private sector has also made strides in recognizing the indigenous sector. Eskom has medical aid schemes that allow for tariffs from traditional healers. The Chamber of Mining and National Union of Mineworkers grant their employees three days leave of absence to visit traditional healers (Pretorius, 1999).

In Johannesburg the Child Welfare and Child Abuse Treatment and Training Services (CATTS), work together with the Traditional Healing Association (*Isifozonke*), to curb the rising incidence of sexually abused children in Soweto (Tyawa, 2001). CATTS planned formal programmes for the healers in counselling of the victims and their families. In return CATTS has been empowered by the healers, in the understanding of the client and his culture so that they have become more sensitive to the children's needs. CATTS believes that since the inclusion of the healers in the delivery of health care, families and children tend to communicate more openly with the health team. This is attributed to the fact that the traditional healer is considered to be an insider to the cultural group and therefore understands the emotions displayed by the affected families. Traditional

healers also use in their process of healing the family as a unit instead of emphasizing individual rights to the exclusion of all else (Tyawa, 2001).

Donaldson's (1997) article on The *Sangomas* in the Zola Clinic in Soweto also emphasizes the benefits of working together for the health of the nation. To capitalize on the peoples' trust in the traditional healers, the Zola Clinic in Soweto has facilitated the movement of the *sangoma* into the formal health sector through a primary health care programme. The programme trains *sangomas* in counselling and awards certificates in healing and primary health care, issued by the Department of Population and Health care. Workers at the Zola believe in mutual respect, believing that working together is the solution to the nation's health crisis (Donaldson, 1997).

The other side of the coin to traditional medicine aiding western health care is that bio – medicine has been increasingly incorporated into the traditional healing system. De Wett (1998) in the study of “*Muti Wenyoni*,” looks at how many indigenous healers incorporate into their treatment many western pharmaceutical products. Healing therapies are seen to expand over cultural boundaries and western products often take the place of traditional remedies. These products are incorporated, transformed and are used in culture specific ways by the traditional healers. This process is referred to as

*Indigenisation*. De Wett looks at how *Muti Wenyoni*, a Dutch prepared antacid given to infants for flatulence, has been misused by the folk sector to the detriment of the people. Prescribed in wrong doses by the healers it has caused many incidences of dehydration

and accompanied by lack of knowledge on rehydration has been harmful to infants (De Wett, 1998). This study brings to the fore that both the systems have in their capacity to draw from each other practices that can benefit the population, but can also be detrimental to the wellbeing of the people.

Though studies indicate that collaboration between the two systems will be beneficial, there is much controversy on how this is going to be achieved. Pretorius (1999) advocates two policy models. The first being total integration of the two systems. This however seems impossible due to divergent and irreconcilable viewpoints between various aspects of health and illness. The viable option is the existence of parallel systems that are independent with regards to legislation and organization, but will supplement each other through referrals and consultations on different health issues.

Hopa et al (1998) study on health system collaboration favours this option. Results from focus groups comprising of doctors, patients and traditional healers indicate that participants agreed that traditional healers have their own body of registration and that complete integration of the systems was not desirable or practical.

### **2.3 Nursing education programmes must foster culturally sensitive care**

The development of culture sensitive information for nurses has been limited

(McGee, 1994). The lack of education programmes on transcultural issues has encouraged nurses to meet the cultural needs of people in a simplistic way. Nursing educational programmes of the past were based on the biomedical model, where biological concerns were deemed more important than socio - cultural issues. These programmes instilled in nurses a western value orientation, as the biomedical model is culture specific to the western viewpoint. Nurses demonstrated more favourable attitudes towards clients of the western culture, as educational programmes inadvertently discriminated against certain ethnic groups (Abdullah, 1995). According to what was perceived as important to the institution and educational programme, nurses developed unicultural perspectives. To move towards a more multicultural perspective in nursing education, cultural learning experiences must form an essential part of nurse training. Nursing educational programmes need to employ models and frameworks that provide cultural universality and diversity, rather than culture specific guidelines (McGee, 1994).

## **2.4 The importance of culturally sensitive care in the intensive care unit**

The intensive care experience is associated with significant emotions of helplessness, anxiety and hopelessness. Intensifying these emotions is the ever - present feeling of impending death. During periods of critical illness, clients search for new perceptions for their life as well as to find wholeness and spirituality. Cultural beliefs and practices are closely woven with spirituality and religion (O'Brien, 1999). This is of particular significance to the nurse as it is not always possible to distinguish tradition from religion

and most often they are synonymous with each other (Mahomed, 1997). In periods of perceived hopelessness as experienced in the intensive care setting, traditional practices provide the client and the family with solace. The intensive care client and the family often express feelings of isolation and depersonalization. By employing traditional practices known to them, the intensive care client and the family experience feelings of control over the illness. The carrying out of rites and rituals associated with the illness experience facilitates coping and provides comfort to the client and family during the crisis period (O'Brien, 1999).

Mangany (1974) provides another perspective on the importance of traditional illness practices during an illness episode. The combination of Western and traditional remedies during illness and hospitalisation is viewed as a socio - cultural regression related to the degree of stress experienced by the client and the family due to competing worldviews. While stress is bearable, the client's traditional beliefs lie latent, but become activated when the stress threshold is exceeded. This is of particular relevance to the intensive care experience where coping skills no longer prove effective.

## **2.5 Traditional practices of the Muslim culture regarding the illness experience**

The Prophet Mohammad (may ALLAH'S blessing be upon him - s.a.w.), stressed the importance of Muslims seeking medical assistance without restricting His followers to

any method of healing. It follows that resorting to the modern medical system is permissible to Muslims (Ebrahim, 1988). In His teaching, The Prophet (s.a.w.) also stressed that ALLAH has created all illness and cures for the illness. Muslims may treat themselves with medicines but never with those prohibited by Islamic teaching (Ebrahim, 1988). Muslims would thus encounter problems when having to comply with treatment regimes that are regarded as *haraam*, which means prohibited. When this occurs Muslims are likely to fall back on Islamic medicine known as “*Tibb Al Nabawi*.” Most often both systems are used simultaneously, which according to Bhikha (2000) is the ideal situation where modern medicine is a part of a holistic solution of health care. The researcher considers the understanding of the religion of Islam a pre-requisite to the understanding of the traditional practices of the Muslim culture, performed during the illness experience, as many of religious factors determine the nature and practice of traditional medicine. Muslim traditional healing contains religious teachings and principles. The Muslim ideas on illness and health are an essential part of their religious system (Bhikha, 2000). “ Religion forms the fabric of tradition, being closely connected to all thoughts and activities of the people” (Arthur, 1995: 99).

### **2.5.1 The meaning of Islam**

The meaning of Islam is submission to the will of ALLAH. Muslims are followers of this teaching and way of life. The Muslim culture comprises of norms and values; dress

codes; language and traditions that are handed down from one generation of Muslims to the next. These elements provide guidelines to the Muslim individual's existence (Mahomed, 1998).

Islamic teaching is based on five pillars these being:

- Testifying that there is no God but ALLAH and that Mohamed is his beloved servant and Prophet.
- Performing the five obligatory daily prayers (*salaah*).
- Paying charity to the poor (*zakah*).
- Fasting during the ninth month of the calendar (*Ramadaan*).
- Performing pilgrimage to the holy lands of Mecca and Medina (*Haj*).

Belief in ALLAH is to believe that ALLAH alone is worthy of praise and worship, and that He has no equal in His actions, commands and attributes. ALLAH is eternal with all else being transient (Samdani, 1995).

### **2.5.2 The concept of health and illness in the Muslim culture**

Good health is viewed as a gift from ALLAH. To maintain this gift, man must follow an Islamic lifestyle, which consists of spiritual acts; eating moderately; indulging in physical labour; eliminating stress, selfishness and greed, and abstention from foods and acts forbidden by Islamic law. Adopting this lifestyle will ensure that man is capable of

overcoming any illness or disease. Health is therefore a balance between the spiritual and physical self (Mahomed, 1997).

The Muslims view illness as an event or mechanism that is aimed at cleansing the body and spirit, as well as an attempt to regain physical and spiritual harmony. Illness is also considered an experience to arrive at the knowledge of the existence of the Exalted ALLAH, as well as a punishment for a misdeed or transgression against ALLAH. Different forms of illness exist and include illness of the body; illness of the feelings (*Fikr*) and illness of the soul (*Ruh*). Muslims are assured as truly as ALLAH has created illnesses, so to did He create cures for these illnesses. The stronger an individual's belief and faith in ALLAH is, the surer is the cure (Mahomed, 1997).

Mahomed (1997) cites that Muslims identify the causes of illness as being:

- **Forbidden Acts**

Illness may be as a result of indulging in forbidden acts such as the taking of alcohol leading to liver failure, overeating resulting in obesity and its related pathologies as well as sexually deviant behavior resulting in sexually transmitted diseases.

- ***Jinns***

*Jinns* are creatures created by ALLAH from fire. They can assume human form and may be harmless or malevolent to humans causing maladies such as colic in babies.

- ***Sa`afa***

Illness due to possession by the evil eye of the Jinn is termed *Sa`afa*. Young girls are normally affected and if not treated immediately with prayer may die.

- ***Nazar***

Evil is projected through the eyes of the envious resulting in the victim becoming pale and listless.

- ***Sorcery /Jaadoo***

Bewitchment is considered the work of the devil who brings about hardship and dissension in the victim's life. Symptoms of the illness include delusions, fascination, misconceptions and imaginary visions.

### **2.5.3 Islamic medicine**

The quest for Islamic knowledge was primarily undertaken to grow closer to ALLAH (Ebrahim, 1988). The basis of Islamic medicine is *Tibb Al Nabawi* (Prophetic medicine), here - after referred to as *Tibb*. *Tibb* contains guidelines on diagnosis, treatment of conditions, and the care of the ill with the emphasis on human dignity (Kasule, Coovadia & Karim, 2000). *Tibb* also concentrates on disease prevention and health promotion as well as treatments that are acceptable to the Muslim culture. As health care teaching, it supports Muslim belief that man belongs to many systems, his environment; his family; his country and even the universe. In illness all of the systems are relevant to the

diagnosis and treatment of the condition. *Tibb* thus vetoes the western medicinal view of reducing human bodies to discrete parts to study and treat the illness (Bhikha, 2000). Islamic medicine is not limited to a single branch of healing but involves many rituals, physical exercise, wearing of talisman, ingestion of healing preparations and the drinking of holy water (Mohomed, 1998). Kasule et al (2000) conclude from their study on the relevance of *Tibb*, that it is an authentic and valid health teaching system, however there is also the recommendation that Muslims undertake more research into the field of study to ensure that the principles advocated by *Tibb* hold true to today's form of healing.

#### **2.5.4 Muslim traditional illness practices**

The holy *Qur`an* and *Hadith* provide remedies for the body and the soul that are spiritual and physical in nature. Muslim healing methods include, the use of prayer (*salaah*); reciting specific verses from the *Qur`an* and names of various attributes to ALLAH; medicines (foods and herbs used in special combinations) and abstaining from certain acts and food (fast). The use of the *Ta`widh* is a greatly respected form of healing, and is a prescription of *Qur`anic* verses that are specific cures for illnesses (Mahomed, 1997). The practice of prayer (*salaah*) as a form of healing is based on the premise that during the outpouring of one's heart to ALLAH, one gains nourishment for one's soul as well as divine guidance and blessing. Fasting is termed spiritual and physical cleansing. Through abstaining from food and water the body is allowed to eliminate superfluous matter and repair processes that were interrupted by dietary abuse. Fasting is viewed as

an act of piety, which brings the individual under the protection of ALLAH (Mahomed, 1997).

## **2.5.5 Traditional Muslim illness practices encountered in the intensive care unit**

The Muslim culture, like all other cultures have their own worldview regarding illness. This view which delineates what the causes of illness are, who the health decision makers are, the social conduct of the individual and society during the illness period, as well as the treatment modalities that are acceptable in healing the individual.

### **2.5.5.1 Visiting of the sick**

Muslim belief is that visiting the sick is a source of reward for those who enjoy good health and will therefore be worthy of further good fortune (Menk, 1994). This would account for the large numbers of Muslims that turn up regularly to visit a hospitalised friend or relative. Culture also prescribes that the visitor should talk to the patient in calm, compassionate tones without causing anxiety or remaining with the patient longer than is comfortable. During the visit the visitor must pray for the sick, reciting verses from the *Qur`an* that are especially beneficial to the sick (Ali Qadri, 1994). The visitor should also bring gifts to the sick, to increase the feelings of affection and love. These gifts must however not be harmful or interfere in the patient's treatment regime (Ali Qadri, 1994).

### **2.5.5.2 Death and dying issues**

When in the vicinity of the dying patient, Muslims recite various verses (*Kalima and Sura Yaseen*). Special positioning of the body is also advocated where the patient is placed on the back, the face is slightly raised, while the body faces a specific direction (Ebrahim, Hoosen & Hathout, 1995). *Loe-sticks* or fankinscence are also lit around the dying patient. All pictures depicting any form of life are removed and individuals considered unclean do not have contact with the dying person. An example of an individual considered unclean is a female who is menstruating at the time. All these practices are said to decrease the pangs of death for the dying Muslim (Ebrahim et al, 1995). With regards to death itself, the Muslim patient is placed on the back; a piece of cloth is tied around the chin to the top of the head to prevent the mouth from opening. The big toes are tied together with a cloth to prevent the legs from adducting and the hands are straightened to the side. At this stage the family and friends take over the last rites from the medical and nursing personnel. The body of the deceased is not removed by hospital personnel, but by the Muslim burial services (Ebrahim et al, 1995).

### **2.5.5.3 Cleansing rituals**

After urinating or defecating, Muslim clients often request water or a dampened cloth to cleanse their genitals. This ritual termed *istinja* is a purification practice to ensure bodily cleanliness at all times (Ali Qadri, 1994).

#### **2.5.5.4 Healing rituals**

Muslim patients often have on their person talisman (*ta`widh*) to protect them from the work of evil and effect cures. Holy water may also be drunk by the ill and sprinkled around the cubicle or the bed of the ill client. The client and his family may request that permission for *salaah* is granted to them. These prayers involve spiritual and physical worship and relieve burdens of stress and worry associated with the illness experience (Mahomed, 1997). Holy water is also given to the ill, after being blessed by relatives. This is said to facilitate the healing process (Ali Qadri, 1994).

#### **2.5.5.5 The sanctity of the body**

Muslim clients may refuse for a member of the opposite sex to examine them, or may request that a third person of the same sex as the client be present during the examination. The client may also refuse the gowns provided by hospitals and choose their traditional garb (Ebrahim et al, 1995). Personal privacy and respect for the human body forms the foundation of this value.

#### **2.5.5.6 Euthanasia**

The Muslim belief is that the sanctity of human life is a basic value. The concept of a life not worth living does not exist for the Muslim culture. Thus euthanasia or mercy killing is considered unlawful. "For the Muslim client seeking medical treatment from illness is mandatory, but when the treatment holds no promise it ceases to be mandatory"

(Ebrahim et al, 1995: 17). In this instance ordinary life must be sustained, through the provision of food, water and nursing care (Ebrahim et al, 1995).

### **2.5.6 The implications of Muslim traditional illness practices for health professionals**

Haffejee (2000) has made recommendations to health institutions to facilitate culture sensitive care to a Muslim client. He advocates that washing facilities be made available in toilets to aid with *istinja*. With bedridden clients, a container of water should be offered to them post elimination. When handling body secretion care must be taken not to soil the patient. Muslim clients must be served only *halaal* foods and care must be taken that these foods are not contaminated by foods that are prohibited. Muslim clients should be allowed to dress traditionally if it does not interfere with planned procedures. Female Muslim clients should always be examined in the presence of another female. To avoid embarrassment and breach of privacy, screens must be used during vaginal and rectal examinations to separate the examiner from the female being examined. Where possible females must bathe female clients. Prayer facilities must be made available so that clients and family members may conduct routine prayers. All treatment regimes must be discussed fully with the client and the relatives, and the use of substances eg. The use of medicinal alcohol must be made known to them. When dealing with social problems, it is preferred to involve a Muslim social worker in counselling issues, as the principles of the culture will then form the basis of therapy (Haffejee, 2000).

## **2.6 Conclusion**

With government focus on providing South Africans with culturally sensitive health care, nurse educators must now take a step towards creating educational programmes that will equip nurses with the skills necessary to deal with cultural issues of the client. This will also foster an attitude of positivity towards traditional issues and practices. More especially, nurses working in the intensive care area need to be committed towards acknowledging and facilitating traditional illness practices as these traditions provide solace to the intensive care client and the family in an area that is distressing and emotionally charged.

The Muslim client as a believer in Muslim traditional illness practices brings to the fore the importance of spiritual upliftment in holistic health care.

# CHAPTER 3

## Research Methodology

### 3.1 Research approach

The research was conducted using the qualitative research approach. Although there is a need for objectivity and technical proficiency in nursing, the humane aspects of a nurse - client relationship cannot be ignored. Nursing is the science and art of human caring. This caring can only be realized if it focuses on the uniqueness and holism of human phenomena. Qualitative research lends itself to describing phenomena in all its richness (Lo Biondo-Wood & Haber, 1990). Qualitative research also brings to the fore the innate complexities and idiosyncrasies that form the client's illness experience (Streubert & Carpenter, 1995). The researcher thus found the approach ideal for a research study that focuses on human phenomena.

For years quantitative research has provided us with health statistics that fail to identify environmental and social influences that impact on health and illness outcomes. However, most significant to this research study is that qualitative research acknowledges the traditional and social factors that shape health and illness beliefs (Streubert & Carpenter, 1995).

## **3.2 Research design**

The phenomenological design to qualitative research was used in this study. This design was selected as it highlights the critical care nurses lived experiences with Muslim traditional illness practices. According to Lo Biondo-Wood & Haber (1990: 22), “Phenomenology regards human reality as contingent on the individual’s perspective in the world; this perspective is of an array of possible points of view.” The phenomenology design concerns itself with an individual’s perspective that forms diverse realities. This type of research design also highlights how the experiences of the critical care nurse with the Muslim culture may affect the critical care nurses perception of the Muslim client and his traditional illness practices.

## **3.3 The setting**

Both private and government franchised hospitals, provide health care to the multi cultural population within the province of KwaZulu-Natal. The study was carried out in two recognized intensive care units (irrespective of the type of intensive care unit), in hospitals within the Durban metropolitan area. One private hospital and one provincial hospital was chosen. Inclusion criteria for the hospitals were, firstly that the intensive care unit admitted more than three Muslim clients in a month; that the stay of the client in the unit was more than two days; and that the critical care nurses within the unit worked

with clients on a rotational basis. These criteria ensured that the critical care nurses within the selected hospitals had adequate exposure to Muslim clients and their traditional illness practices. From the private and provincial hospitals that met the inclusion criteria, one private and one provincial was chosen according to convenience for the researcher with regards to distance in travelling to the hospitals, the time factor and personal funds available for travelling expenses.

### **3.4 Selection of participants**

The participants were critical care nurses currently employed in the intensive care units of the selected hospitals. Purposive sampling was used to select the participants. Since the aim of the phenomenological approach to research was to generate rich descriptions of participants' experiences, the researcher chose to include as the sample, the first line critical care providers (critical care nurses providing care directly to the client). They were considered by the researcher to have had first hand experience with clients of different cultures and were faced with more cultural issues than nurses in administrative positions. A further inclusion criterion was that the critical care nurse be employed in the unit of the selected hospital for more than a year, also ensuring that participants had sufficient experience with nursing of Muslim clients. Although theoretical saturation was used, the study began with six participants, three from each of the selected hospitals. On gaining permission from hospital authorities for use of the facilities, the charge sisters of

the intensive care units were approached. A meeting was held with the critical care nurses of the unit during which the researcher discussed the purpose and process of the study, including ethical considerations. Critical care nurses were asked to volunteer as participants for the study.

### **3.5 Data collection**

The actual method of data collection comprised of two semi - structured interviews. The researcher chose this method of collection as it allowed for the participants to share free flowing in-depth information to the researcher while the researcher still maintained the focus of the study with the use of probes. All interviews were audio taped with permission from the participants. The interviews were conducted during working hours as this was considered more convenient by the participants. The sisters in charge of the unit arranged that their offices be used for the interviews, allowing the researcher to maintain privacy. The sisters in charge also arranged for each participant to be relieved of her duties by a colleague, allowing her time for the interviews. The interviews were conducted individually with each of the six participants.

#### **3.5.1 The initial interview**

During this interview the researcher established rapport with the participant, which assisted the participant to share her experiences with much ease. The researcher again

highlighted the purpose and ethical considerations, following which the participant was asked to choose a pseudonym. Biographic data was requested which included the number of years the participant was employed in the unit as well as his/her job title. This was to confirm that the participant met the criteria for selection. The researcher then used the interview guide (see annexure A for interview guide) to allow the participant to share her experiences of traditional illness practices firstly with a patient from a different culture to her own, and then with a patient of the Muslim culture. The interviews were approximately thirty minutes long.

### **3.5.2 The verifying interview**

These interviews were approximately fifteen to twenty minutes long and were held a week after the initial interview. The experiences and thoughts of each participant from the initial interview was summarized by the researcher and repeated to the participant. The purpose of this was to allow the participants to confirm the validity of the information, as well to clarify any areas that appeared unclear to the researcher. The participants also had the opportunity to share more experiences that they may have recalled in the interim. The researcher used this opportunity to thank the participants for their enthusiasm and to reaffirm that the findings of the study would be made known to them.

### 3.6 Trustworthiness

Like any other qualitative researcher, the researcher rigorously attempted to capture and present the essence of the participants' experiences and thoughts as accurately as possible. The researcher accomplished this through the use of four techniques, namely, credibility, dependability, conformability and transferability (Streubert & Carpenter, 1995: 25).

**Credibility** was achieved through successive interviews with the participants namely the initial and verifying interviews. Data analysed by the researcher from the initial interview was presented to each participant for validation that the findings presented were their own experiences and thoughts. At this stage misconceptions were also clarified and participants provided greater clarity to shared information. The researcher attempted to accomplish the processes of **conformability and dependability** through the use of the audit trail. The researcher engaged the assistance of an experienced Masters qualified nurse to carry out an independent data analysis. The research supervisor also assisted in checking the data analysis. This was possible as all interviews were transcribed verbatim from the audiotape. (A full interview is included in the study as annexure F). Although the generalization of findings was not the aim of the study, the researcher achieved **transferability** through the provision of information that was rich in detail and clarity.

### **3.7 Bracketing**

To attempt objectivity of findings the researcher used the process of bracketing. Bracketing is a process whereby researchers purposefully discount their own ideas and preconceptions about the phenomenon under study, so that the focus of the study is on the participants' experience. The literature review also assisted the researcher in illuminating preconceived ideas on the area of study. The process of bracketing carried out by the researcher is attached as annexure G.

### **3.8 Data analysis**

Data analysis began simultaneously with data collection. The researcher herself transcribed the interviews verbatim. The researcher reviewed the transcriptions continuously. Each participant's ideas and experiences were summarized by the researcher and confirmed by each participant in the verifying interview. On conclusion of the data collection the researcher spent time examining the transcripts. This period of protracted immersion in data enabled the researcher to identify significant statements. Transcripts were analysed sentence by sentence to aid in identification of these statements. The researcher did this manually. The statements were then extracted and relationships among statements were sought. Similar statements were grouped together to form categories and sub categories until a time that all data was grouped into

meaningful units. The categories were drawn from the conceptual framework of the study (Streubert & Carpenter, 1995).

### **3.9 Ethical considerations**

Approval of the proposal by the University of Natal Ethics Committee was granted

(see Annexure B). The relevant hospital authorities were then approached for access to the hospital premises and their employees. Copies of these letters granting permission to the researcher are included as Annexures C, D and E in the study.

The researcher adhered throughout the study to two ethical principles identified by Brink (1996: 39 & 40) as being respect for persons and the principle of beneficence.

**Respect for persons** - to ensure the autonomy of the participants, the researcher stressed that the participants voluntarily participated in the study and were not coerced in any way. The participants were also informed that they were free to leave the study at any stage without repercussions, and could refuse to divulge information they were not willing to share. The purpose of the study was clearly delineated. The researcher adhered to this principle through the obtaining of informed consents from the participants on their willingness to participate in the study. Consent for audio taping the interviews were also obtained from participants. All participants were assured confidentiality of all

divulged information. Participants were given the option of choosing a pseudonym at the outset, and all identifying information, e.g. addresses and telephone numbers were not included in the publication of results. The researcher also agreed that no information would be shared between participants. The subjects were treated courteously at all times.

**The principle of beneficence** - was adhered to, by ensuring that the participants' physical and emotional safety was at no time overlooked. The researcher achieved this through conforming to the above-mentioned ethical considerations. Furthermore the participants were also informed as to how the results of the research were to be processed and published.

# **CHAPTER 4**

## **Description and discussion of findings**

### **4.1 Introduction**

The researcher interviewed six critical care nurses. Three of the participants were from a provincial hospital and three were from a private hospital. The principle of theoretical saturation was applied, where the researcher collected data until no new information was revealed. On achieving theoretical saturation, a total of twelve interviews were conducted over a time frame of three weeks, with the participants being involved in two interviews each.

### **4.2 The setting**

As proposed, the research was carried out in the intensive care units of two hospitals within the Durban Metropolitan area of KwaZulu-Natal. The researcher chose one provincial hospital and one private hospital to ensure depth and diversity of data collected. These hospitals also met the criteria of having admitted more than three Muslim clients in a month whose stays in the unit had exceeded three days, and the critical care nurses having worked on a rotational basis with patients. This ensured that all participants had sufficient exposure to nursing Muslim clients. A realized sample of the setting and participants is presented in Table 4.1

**Table 4.1 Realised sample on data collection**

<b>Hospital</b>	<b>Unit</b>	<b>Participants</b>
<b>Private institution</b>	Medical intensive care unit	3 female participants
<b>Provincial (Government) institution</b>	Cardiac intensive care unit	1 female
	Surgical intensive care unit	2 Females
		<b>Total: 6 participants</b>

### **4.3 The participants**

All six participants involved in the research were first line critical care providers who had clinical experience of more than a year in the intensive care unit. The sample of participants was realized irrespective of gender, race, cultural background or the type of intensive care unit that they worked in. The participants were initially hesitant to volunteer, but became willing once the ethical considerations were explained to them. They were very enthusiastic when asked to choose pseudonyms and these pseudonyms were used throughout the research study. All participants displayed a great interest in the field of transcultural nursing and were eager to discover the outcome of the research. A profile of the participants is presented in Table 4.2

**Table 4.2 Profile of participants**

<b>Pseudonym</b>	<b>Position in unit</b>	<b>Years in the unit</b>	<b>Description of participants</b>
<b>Mary</b>	Registered nurse in surgical intensive care unit (ICU)	2 years	Asian female, Christian, 20's, married with one child, has attended in-service programmes on intensive care topics, not ICU trained.
<b>Fay</b>	Registered nurse in surgical ICU	15 years	Asian female, Muslim, 40's, married with three children, has intensive care certificate.
<b>Olive</b>	Registered nurse, medical ICU	3 years	Asian female, Hindu, 30's, single, has ICU certificate.
<b>Kugil</b>	Registered nurse, medical ICU	2.5 years	Asian female, Hindu, 30's, married with two children, has ICU certificate
<b>Dollars</b>	Registered nurse, Medical ICU	3 years	Asian female, Christian, 30's, married with no children, has the high care course.
<b>Florry</b>	Registered nurse, Medical ICU	3 years	Coloured female, Christian, single mother, one child, has done a cardiac course.

## 4.4 The interviewing process

All of the twelve interviews were conducted whilst the participants were on duty. This appeared to be more convenient to them. The sisters in charge of the units graciously offered the researcher the use of their offices for the duration of the interviews. In both the private and provincial hospitals, the offices were situated away from the intensive care area and were quiet and private. From the onset all participants appeared at ease with the researcher and were unperturbed that the interviews were recorded. The participants were friendly and often shared a good laugh with the researcher as they relayed experiences.

The one hitch experienced by the researcher was during the verifying interviews in the private hospital. The researcher, participants and sisters in charge decided upon a convenient time for the interviews, however whilst interviewing the second participant the unit experienced two emergencies and an influx of admissions. The researcher suggested postponing the interviews but the participants verbalized that they wanted to continue. The researcher observed that thereafter, they appeared distracted and hurried in their responses.

## **4.5 Discussion of findings**

The purpose of the study was to explore the lived experiences of critical care nurses with Muslim traditional illness practices. Accordingly the twelve interviews of the six participant critical care nurses, which were transcribed verbatim, formed the data for analysis. The researcher immersed herself in the data and in doing so identified commonly occurring ideas and feelings amongst the participants' shared experiences with Muslim traditional illness practices as well as their perception of culturally sensitive care in general. These common and consistently occurring feelings and ideas were then discussed as themes under five categories. The categories consisted of the five constructs of the conceptual framework, namely cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire. The researcher has identified these five constructs as essential characteristics in culturally sensitive encounters between a nurse and her client (Campinha-Bacote, 2000). The categories and themes derived from data analysis are displayed in Table 4.3

**Table 4.3 Categories and their themes**

Category	Theme
<b>Cultural awareness</b>	<ul style="list-style-type: none"> <li>• ‘This is not about me’</li> <li>• Open-minded to patient’s perspective</li> <li>• Nurses personal belief system regarding traditional illness practices</li> </ul>
<b>Cultural knowledge</b>	<ul style="list-style-type: none"> <li>• ‘Emotional and spiritual upliftment’</li> <li>• Patients achieve peace</li> <li>• Traditional illness practices provide hope and faith</li> <li>• ‘Worked for them’</li> </ul>
<b>Cultural skill</b>	<ul style="list-style-type: none"> <li>• ‘Asked a lot of questions’</li> <li>• Learning from cultural experiences</li> <li>• ‘Learn from each other’</li> <li>• Consulting literature on Muslim cultural practices</li> </ul>
<b>Cultural encounters</b>	<ul style="list-style-type: none"> <li>• Muslim’s are close to their traditions</li> <li>• Muslim traditional illness practices can be disruptive</li> <li>• Muslim traditional illness practices sometimes upsets other patients</li> <li>• Muslims support each other</li> <li>• Muslim patients can differ in cultural beliefs</li> </ul>
<b>Cultural desire</b>	<ul style="list-style-type: none"> <li>• Insensitive to patient’s cultural needs</li> <li>• Families, patients and health team work together</li> <li>• Respecting each other’s beliefs is important</li> <li>• ‘Nurses should be more accommodating’</li> <li>• ‘Holistic care’</li> <li>• Cultural needs are important</li> </ul>

In keeping with the ethical principle of maintaining the confidentiality of the participants their chosen pseudonyms are used throughout the discussion of the findings.

#### **4.5.1 Category: Cultural awareness**

This category deals with the participants identifying their feelings, biases or prejudices towards traditional illness practices in general and specifically towards Muslim culture.

##### **Theme 1: 'This is not about me'**

All participants shared the feeling that the importance of the traditional illness practice to the recovery of the patient whether spiritually or physically took precedence over their own beliefs regarding the practices, *I feel negatively, which is not fair as well, as you are imposing your belief and feeling on them, so if it is for their peace of mind its okay with me, even though I may not feel like being there* (DOLLARS). She went further to describe how she once listened to Muslim songs being played for an unconscious Muslim patient for three days and although she had found it annoying, she stated, *I kept thinking this is not doing any good for me,* DOLLARS let the tape play simply because the family told her that it would allow the patient to die peacefully, *I thought how can I feel like this, so I said catch a wakeup this is not about you, this is for the patient.* FLORRY expanded on this with the thought that the Muslim patient or any other patient should never be robbed of the chance to carry out traditional illness practices because they may conflict with the nurse's personal belief system and expressed *I would never be condescending to anyone's faith, or prevent them from showing this faith. I will say God*

*Bless them, though this may not be what I practice.* There was agreement among the participants that they would never impose their traditional beliefs on patients, FLORRY expressed this by saying, *Who am I to stand in anyone's way, my beliefs are my beliefs ...cause I never want to stand in their way.* From these responses it was clear that the participants believed that they had to put aside their personal beliefs regarding traditional illness practices when nursing patients from different cultural backgrounds including Muslim patients.

## **Theme 2: Open-minded to patient's perspective**

The participants declared themselves as open-minded regarding Muslim traditional illness practices stating that patients were entitled to their own beliefs regarding illness. There was a feeling of acceptance of the traditional illness beliefs and practices of the Muslim culture with OLIVE expressing her feelings as *I would say I am very open- minded and I do show a willingness to accommodate requests made by Muslim patients and families.* FLORRY stated that she was not biased towards the practices of Muslim patients even though they sometimes clashed with her belief system. DOLLARS open- minded attitude was highlighted in her description of an experience with a Muslim relative, who had requested a private room to pray. Although her belief was that a person could pray anywhere she organized a place for the lady and stated, *Muslims have their own ideas and traditions of praying.* KUGIL interestingly pointed out that at times a patient's traditional needs were not met if the nurse was not of the same traditional standing by saying *especially when the patient is from a different cultural group to the nurse ... is*

*ignored so to speak.* These shared experiences indicated that participants appeared unbiased towards Muslim beliefs on traditional illness practices.

### **Theme 3: Nurses' personal belief system regarding traditional illness practices**

Throughout the interviews it was clear that all the participants had at some stage in their careers examined their beliefs regarding tradition and identified themselves as being traditional or as being non traditional. OLIVE confessed to not being traditional and described herself as *I'm not religious or traditional or anything but I understand most Hindu traditions and sometimes why things are done*, but she went on to clarify that although she was not traditional she was accepting of her patient's traditional practices and stated, *even though I don't emphasize traditional practices in my life, I realize how important it is to some patients.* FLORRY also described herself as not being traditional *I'm not really into my own tradition and other cultural issues.* She expanded that this was perhaps why she found Muslim patients to be fascinating as they were so into traditional practices. FAY and KUGIL believed that nurses who were not very traditional themselves were found to be not very accepting of Muslim traditional illness. FAY explained, *but some nurses themselves don't carry out their traditions, so I don't expect them to understand mine. They mock things that don't count to them.* She said that non-traditional nurses viewed the requests of Muslim patients to carry out traditional illness practices as requests for being *treated as special.* KUGIL agreed, and stated that if nurses did not think strongly about their tradition they would not understand the Muslim patient's strongly traditional outlook to the treatment of illness. The remaining four

participants identified themselves as being very traditional in their beliefs. FAY stated that because she herself was so deeply traditional she encouraged the Muslim patients to carry out traditional illness practices where possible. Throughout the two interviews she continually repeated the fact that she felt that tradition was very important thus emphasizing her strength of belief in Muslim traditional illness practices. KUGIL used her tone of voice to convey how important she personally felt tradition to be. She appeared dismayed at the fact that traditional issues were ignored and used the words *It's very upsetting, it's a sad thing*, to convey this. In her description of her experiences with Muslim traditional illness practices it was apparent that she went the extra mile to ensure that the patient's traditional needs were respected. This was evident in her experience with the female Muslim patient where KUGIL also garbed herself fully and stood outside the cubicle during visiting hours to show her respect for the Muslim traditional need of privacy. These responses indicated that the participants had been involved in introspection regarding their feelings on Muslim traditional illness practices and their personal reliance on tradition.

#### **4.5.2 Category: Cultural knowledge**

This category incorporates the participants' knowledge of the significance of traditional illness practices to the Muslim patient and the family, gained through their encounters with the Muslim culture.

## **Theme 1: 'emotional and spiritual upliftment'**

The participants felt that Muslim patients were deeply religious and that Muslim tradition was interwoven in this. They mentioned that the Muslim patient, even whilst in hospital, abided by religious codes of which *tradition was part and parcel* (MARY). Due to the strong religious significance of traditional illness practices, Muslim patients and their relatives achieved spiritual and emotional contentment from performing these practices. FAY highlighted this by stating *when a Muslim patient is very ill spiritual upliftment is important, hmm ...visits to the Imam strengthens them spiritually*. MARY described experiences where the traditional practices of the Muslim patient was encouraged as she said, *we (NURSES) felt that spiritual comfort was all we could offer*. She went on to say that when the Muslim patient gained spiritual fulfillment they achieved inner peace. DOLLARS spoke of placing the prayer beads in the hands of a Muslim patient because he seemed happier when he clutched the beads. The shared experiences on Muslim traditional illness practices indicated that the participants felt that these practices provided the Muslim patient with emotional and spiritual contentment.

## **Theme 2: Patients achieve peace**

Closely tied with spiritual and emotional upliftment, was that traditional illness practices provided inner peace to Muslim patients and to patients from all cultural groups, *its amazing how peaceful patients become or how peacefully they die when the traditional rites are carried out* (KUGIL). DOLLARS described her experience of having had to listen to Muslim music for three days whilst nursing an unconscious Muslim patient. The wife explained that the music would help the patient to die peacefully. When the patient

died DOLLARS went on to say, *I'm was happy I played my part in helping him go peacefully.* FAY spoke of the importance of allowing the families in to pray when Muslim patients were on their deathbed. She mentioned a special prayer that had to be recited to allow the patient to die peacefully. KUGIL related that when a Muslim patient was ill, she mentioned *the Word of ALLAH* as she believed that the Muslim last rites was a traditional practice that allowed the Muslim patient to achieve peace before death. From the above responses provided, the researcher concluded that the participants felt that Muslim traditional practices were essential in creating a feeling of peace within the Muslim patient during the period of critical illnesses or in death.

### **Theme 3: Traditional illness practices provide hope and faith**

The participants expressed that the Muslim traditional illness practices played an integral role in providing the Muslim patient and the family with hope of recovery. Their unwavering faith in their traditional practices provided them with miracles of recovery. MARY highlighted this with her experience with a Muslim man who had chanted healing verses everyday for his seriously ill wife. The wife recovered and MARY described this as, *I saw the very mans faith in his tradition provide him with his miracle.* She continued, *to him tradition was faith as in faith that the prayer will work and it did work, the faith allowed him hope.* DOLLARS mentioned that Muslim patients had always requested to carry out traditional acts and she could not say if those practices had helped them recover, however she concluded *one can't really say what makes them recover, but they have faith and hope and to them that is important.* All participants viewed the hope and faith

provided by these traditional illness practices to the Muslim patient as especially significant to the intensive care experience which was associated with hopelessness and despair. OLIVE summed this up with *their faith is strong and well in the ICU, when nothing seems to work it is their faith that gives them hope*. These responses indicated that the participants believed that that Muslim patient's hope of recovering lay in his/her unwavering faith in the success of their traditional illness practices.

#### **Theme 4: 'worked for them'**

It was also evident that the participants viewed traditional illness practices as a type of support system that Muslim patients had relied upon in the past. OLIVE believed that Muslim patients clung to traditional practices as *something to make them strong. In their times of hardship it worked for them*. KUGIL agreed that in general patients looked to tradition and culture as a system that had never failed them. She explained *at the end tradition is what we (Muslims) know and what has worked for us from the time we (Muslims) were born it's the comfort at the end*. FAY added that traditional practices provided Muslims with direction in times of difficulty. The researcher concluded that the participants agreed that the Muslim patients' faith in the success of healing associated with traditional illness stemmed from their previous reliance on traditional illness practices.

### 4.5.3 Category: Cultural skill

This category deals with the methods used by the participants to gain information about the cultural orientation of patients with focus on Muslim patients.

#### Theme 1: 'Ask a lot of questions'

At some time during interviewing each participant described an experience where there had been the need to ask the purpose of a traditional illness practice. All participants agreed that the reason behind the question had been to understand the significance of the traditional act to the patient as well as the family. MARY added that by asking the purpose behind the traditional illness practice nurses had often been able to assist in ensuring that the practice was adhered to. She gave an example of where the nurses having understood the importance of the *taw'idh* to a Muslim patient made sure that it was always on her even after a bed bath. OLIVE declared that Muslim traditional practices were sometimes *odd*, and by asking the reason for the practices nurses have saved themselves from misunderstanding or embarrassment. She related how she had been angry with a male Muslim patient who refused to look at her or shake her hand. Later she discovered that this was a sign of respect for a female. She concluded, *sometimes their traditions can seem strange, but if you know why its done then it helps you accept it*. According to DOLLARS it was good to ask about traditional practices, as they then made sense. She stated that patients felt the nurses were interested in their

wellbeing and a trusting relationship developed. FLORRY described Muslim traditional practices as *difficult to follow* and added *so to make my working with them easier I ask a lot of questions*. The researcher concluded that all participants favoured asking the purpose behind traditional illness practices as a method to achieve a greater understanding of the cultural orientation of the Muslim patient.

## **Theme 2: Learning from cultural experiences**

MARY related that her experiences with Muslim patients had equipped her in dealing with traditional requests, as she now understood why Muslim patients had behaved in a certain manner or had made particular requests. DOLLARS described an experience where she had been inconvenienced by a Muslim relative who had requested that she provide a private room for her prayer. DOLLARS went on to say that the incident had motivated her to arrange with the charge sister, a room to allow Muslim patients and families to pray in. She said that her experiences with the Muslim culture *had taught her little things, for the bank you know*. DOLLARS clarified *the bank* as being her personal store of information on the Muslim culture. FLORRY mentioned that she had worked predominantly with Muslim patients and working with them had made it easier for her to understand their traditional illness practices. She continued *this has helped me nurse Muslim patients in this hospital as well*. Participants thus viewed their multiple experiences with nursing Muslim patients as their main source of having gained knowledge of the Muslim culture.

### **Theme 3: ‘Learn from each other’**

The participants mentioned that they frequently asked their colleagues about the significance of traditional requests made by Muslim patients. FAY explained that, *most of us like to learn about each other’s culture cause patients are of the same culture*. She emphasized this point by repeating it in her second interview. KUGIL said that in her quest to provide traditional last rites to Muslim patients she had asked her Muslim colleagues for their suggestions. She also expressed that she had often imparted her knowledge regarding Muslim traditional practices to the other nurses so that they understood the relevance of the practices. FLORRY said that she shared her insight of Muslim traditional practices gained from having worked mainly with them with her peers and described this method of learning about patients cultural preferences as a *good way to learn what Muslim beliefs encompassed*. She said that she had often passed on tips on how to accommodate Muslim traditional illness practices in the intensive care unit, and went further to give the examples of having left jugs in toilets so that Muslim patients could wash themselves after elimination and of having washed bedridden patients after they had urinated. She concluded, *word gets carried around and we share cultural experiences, that’s one way of learning about how to accommodate patients’ cultural beliefs*. These responses indicated that participants relied on each other’s knowledge about Muslim traditional practices to increase their own knowledge base.

### **Theme 4: Consulting literature on Muslim cultural practices**

Another method that participants had favoured when collecting information on Muslim clients as well as clients from other cultural groups, was having read literature on

different cultural beliefs as well as having written notes on cultural knowledge gained from their own experiences and their colleagues experiences. KUGIL expressed that she had *written notes on most of the cultural groups that I nurse, things that are of overall importance*. DOLLARS agreed that information that she had read or points that she had written down from her experiences with Muslim patients had served as a basis of reference for future encounters with similar traditional practices. FLORRY was emphatic that she now worked comfortably with Muslim patients and understood their traditional illness practices through having read extensively on their cultural heritage on first encountering them. KUGIL and DOLLARS mentioned having read notes on the social history taken on admission and had thus identified taboos of the Muslim culture. DOLLARS said that she had always read notes on Muslim support system so that she could prepare herself for the *mass visits*. Reading and making notes on Muslim traditional illness practices appeared to be another method used by participants to gain information to assist them in nursing Muslim patients.

#### **4.5.4 Category: Cultural encounters**

This category deals with the participants' thoughts on their experiences with the traditional illness practices of the Muslim culture.

##### **Theme 1: Muslims are close to their tradition**

OLIVE mentioned that through her experiences with Muslim patients she had discovered that nothing gave them more satisfaction than practicing their tradition. She described

this as *Muslim patients always request that they be close to their tradition, they are unhappy otherwise*. DOLLARS spoke of the experience where she was puzzled by a Muslim relative need to have privacy to pray. In the next breath, she said *but you know Muslims they've so very traditional*, her tone appeared as one of resignation or acceptance of a well-known fact. FLORRY used the word *staunch* when she described her experiences with Muslim patients. FAY summed up her thoughts on the Muslim culture and traditional illness practices as, *people believe in tradition, but Muslims depend on tradition to heal them*. There was a tangible feeling that the participants respected the Muslim culture from being so traditional in their approach to life and illness in particular.

## **Theme 2: Muslim traditional illness practices can be disruptive**

Participants feelings ranged from being amused to being disgruntled with the effects of Muslim traditional illness practices on the ill patient and on the routine of the unit. All participants mentioned *mass visits* (FLORRY) as being the most disruptive of all Muslim traditional illness practices. KUGIL was the most lenient in her assessment of the ill effects of this practice and said that she had also encountered other cultures that also visited in large numbers. KUGIL said that the Muslim community practiced togetherness and nurses should not be unduly harsh. The remaining participants verbalized that they understood the need for togetherness, but the visits were unruly and they had on numerous occasions chastised relatives. MARY, DOLLARS and FAY appeared upset by their experiences, and MARY described the incidents as a *take over or invasion*. FAY said that relatives crowded corridors and DOLLARS recalled an experience of the

relatives distressing her patient to the point where there had been an increase in the heart rate and blood pressure. FLORRY appeared amused and giggled as she described *army visitations*. All participants agreed that rules of two visitors per patient in the unit had to be adhered to despite traditional requests. MARY concluded, *I feel as much as people have a right to their traditions, I feel that they should take note of the different environment...we are not being difficult if we ask them not to interfere in our helping the patient*. All participants agreed that although they understood the importance of the illness practices to the Muslim patient some of these practices did disrupt the care of the patient and other patients.

### **Theme 3: Muslim traditional illness practices sometimes upsets other patients**

Again participants mentioned that certain Muslim traditional illness practices had upset and annoyed the other patients in the unit. KUGIL mentioned that other patients were also curious at the incident where she had to continually screen a Muslim female so that her privacy was ensured. KUGIL went on to say that she had explained to the other patients the reason behind the request and that they had been satisfied. FLORRY agreed, that even when other patients had become irritated with the demands made by Muslim patients and their families, explanations of the Muslims need to fulfill their traditional practices had pacified other patients. All participants agreed that the crowds of visitors for Muslim patients had been by far the most distressful practice of all. FLORRY made an interesting observation that although she understood that Muslims visited the sick to indicate fellowship and love, this traditional belief could be in contrast to other patients

beliefs for the need of solitude during an illness and said that *it was not always feasible to accommodate all patients traditional ideas*. FAY explained that traditional illness practices were indeed important to the Muslim community, *but no less important than other patients beliefs, they should therefore make an effort not to infringe on other patients need for medical care as well as their own personal beliefs*. All participants thus conveyed the concern that Muslim traditional illness practices could and had disturbed other patients in the unit.

#### **Theme 4: Muslims support each other**

There was an overwhelming acknowledgement that the Muslim community was very supportive to each other. The participants agreed that it was this that made most staff tolerable to the practice of *army visitations* (FLORRY). KUGIL described Muslims as being *a full community* and continued that this was the reason behind the mass visits and said that, *if you know this, then rather than becoming annoyed you will say why two are to visit and will not be harsh*. OLIVE reasoned that Muslim patients had many visitors, as this was a tradition that showed love and support of each other in crisis. FLORRY described the Muslim people as being *close and always showing goodwill to each other*. Shared responses indicated that participants felt that the Muslim community was close-knit and demonstrated this by visiting the ill, thus Muslim patients would always have crowds of visitors.

## **Theme 5: Muslim patients can differ in cultural beliefs**

FLORRY, MARY and KUGIL expressed that their experiences with patients from the Muslim culture had taught them that one could not assume that all Muslims had the same beliefs. MARY explained that her experiences had made her aware that not all Muslims were staunchly traditional and assuming this could lead to embarrassment. FLORRY shared that her extensive experiences with nursing Muslim patients had impressed upon her *not to take them for granted as it doesn't mean that once you've nursed one Muslim you've concurred the culture, they are very different in their beliefs of things like showing their face and their dressing.* KUGIL concluded that this was a general rule when nursing people of the same culture, *people can belong to a cultural group but they may not practice everything...so you treat every one as a person too.* KUGIL'S response indicated that participants believed that it was important that Muslim patients be treated as individuals who have their own beliefs that may differ to the beliefs shared by the rest of the Muslim culture.

### **4.5.5 Category: Cultural desire**

This category deals with the participants expressing their enthusiasm towards delivering culturally sensitive care to patients and their recognition that this is an important part of holistic health care. This was gleaned from their shared experiences with traditional illness practices in general and with patients from the Muslim culture.

## **Theme 1: Insensitive to patients' cultural beliefs**

Ignoring patient's cultural requests or failing to accommodate them was identified by the participants as being insensitive to the beliefs and rights of people. KUGIL described this insensitivity as being a *terrible trait*. DOLLARS declared vehemently that she would *hate to be called insensitive* and FAY said *it was important to be considerate about patients' personal beliefs*. FLORRY described her thoughts on insensitivity as, *my conscience would not allow for me to disregard patients' beliefs, I just couldn't mock them*. Participants' responses indicated strong dismay at being insensitive to a client's cultural belief system.

## **Theme 2: Families, patient and health team work together**

Participants believed that the obstacles encountered in meeting the cultural needs of patients could be overcome if all parties involved worked together. DOLLARS admitted that she found the Muslim traditional illness requests *bewildering* and went further to add that only when these traditions had been explained to her had she understood them. MARY described an experience of a Muslim spouse who had carried out his chanting in the corridor so that the nursing staff was able to give his wife the care that she had required. She explained that his consideration had prompted the staff to aid the man in everyway to carry out the traditional rituals. OLIVE believed that working together created a climate of trust for healing and that nursing personnel should always enquire how they could help facilitate traditional illness practices. FAY described an incident where the nursing staff and the relatives had failed to work together which had resulted in the family giving a ventilated patient holy water and causing the patient to aspirate.

MARY described that working together was *the only way for the patient to recover, which is the goal of everyone*. Participants therefore favoured working with patients and their families to achieve the goal of rendering culturally sensitive care.

### **Theme 3: Respecting each other's beliefs is important**

The participants desire to provide culturally sensitive care was evident in their declaration of having respected the various traditional illness practices that they had experienced, irrespective of personal feelings. FLORRY mentioned that Muslim traditional illness practices were sometimes difficult to understand but she said *No- one is asking you to absorb their beliefs, respecting each other is what counts*. KUGIL spoke of how she accommodated Muslim traditional practices of being fully garbed and continued to say that traditions should be respected and honored. FAY identified respect for traditional practices as a hospital policy and indicated her support of the policy by stating that she felt that it was a *splendid policy*. On pursuing this response regarding the policy on culturally sensitive care the policy was identified as a norm within the hospital rather than a written policy. From the responses it was evident that participants valued feelings of mutual respect between nurses and patients regarding cultural beliefs.

### **Theme 4: Nurses should be more accommodating**

Throughout the interviews the participants displayed their support for culturally sensitive care by describing incidents where they had made allowances in their routine and care of the patient so that traditional illness rituals could be practiced. MARY described an experience where family had requested daily morning prayers to be done for a dying

relative, a time that MARY identified as being the most hectic time in the unit. Although this did cause major disruptions MARY went on to say that they accommodated the family as the nurses felt that spiritual healing would also benefit the patient. OLIVE mentioned that Muslim traditional illness practices did sometimes interfere with patient management, but she understood that a Muslim's entire existence was governed by tradition and therefore she said, *you have to find a way to modify your treatment to fit in traditional practices*. KUGIL touched on the point that understanding that Muslims were a very traditional culture enabled nurses to become more accommodating to their requests as she emphasized that Muslim patients and relatives did not practise their tradition *simply to get the staffs' backs up*. DOLLARS spoke again about the Muslim visitors that were disruptive saying that *families and nurses had to reach an agreement on what was the best for the patient*. KUGIL described the nurses need to make allowances for traditional illness practices as *an obligation to allow them to help each other I feel that we have an obligation to allow for the Muslims to practice their traditional needs*. The participants clearly supported an attitude of accommodation amongst nursing personnel towards traditional illness practices.

### **Theme 5: 'holistic care'**

The participants equated the rendering of culturally sensitive care with holistic care. *I feel that cultural needs are important at the end of the day we are providing health care which is taking the patient as a total whole and health care is improved if we have this focus* (FLORRY). KUGIL mentioned that nurses were under the misconception that they did provide holistic care as they frequently ignored traditional illness practices of

patients. She went on to say that it was *a sad thing, as holistic care which included cultural beliefs of patients was stressed from initial training*. KUGIL clarified that the sadness was because nurses failed to adhere to the basis of all education and teaching. Participants' responses indicated an agreement that incorporating traditional beliefs of the patient was an essential part in providing holistic care.

### **Theme 6: 'cultural needs are important'**

The researcher felt that the participants aptly verbalized their desire for rendering of culturally sensitive care with the words *I feel that cultural needs are important*. In the verifying interviews all participants mentioned these words to summarize their feelings on Muslim traditional illness practices in the intensive care unit. OLIVE felt that the practices were *essential*, MARY described them as being *vital*, KUGIL said that *they played a big part* and the remaining three participants said they were *very important to the wellbeing of the patient*. Despite the difference in their wording the researcher felt that the participants conveyed their beliefs that the cultural needs of the patients are important in holistic health care management with clarity.

### **4.5.6 Cultural Sensitivity**

Culture sensitivity encompasses care that takes into account the cultural background of patients in terms of the interest in the patients' culture, its respect and negotiation of a safe plan of care that accommodates both western and traditional paradigms.

The participants demonstrated their sensitivity to their patients' culture in the above constructs repeatedly in their expression of the desire to know the culture of the Muslim patients and develop the skill to assess and collect information on their patients' culture. OLIVE suggests knowing more about a culture to be able to understand it: *sometimes their traditions can seem strange, but if you know why it's done then it helps you accept it*. FLORRY mentioned that Muslim traditional illness practices were sometimes difficult to understand but she said: *No one is asking you to absorb their beliefs, respecting each other is what counts*. FAY on the other hand expresses sensitivity to patients' cultural beliefs as follows: *it is important to be considerate about patients' personal beliefs*.

In conclusion the participants expressed culture sensitivity in most of their accounts in different ways. However, there is no indication of any formal policies to accommodate such cultural desires.

## **Chapter 5**

### **Summary of findings, recommendations and conclusion.**

#### **5.1 Summary of findings**

The findings will be discussed bearing in mind the purpose of the study, which was to explore the lived experiences of the critical care nurses with Muslim traditional illness practices.

##### **5.1.1 Cultural awareness**

This category addressed the participants' feelings, prejudices and biases towards Muslim traditional illness practices.

It was evident that the participants had at sometime been involved in introspection during their experiences with Muslim traditional illness practices. This was undertaken to identify their personal feelings and/or biases towards the traditional illness practices that they had encountered. A careful review of personal beliefs to determine unconscious attitudes towards clients from diverse cultural backgrounds, is supported by Giger and Davidhizar (1995). Giger and Davidhizar (1995) explain that it is vital for a nurse working with clients from multicultural backgrounds to identify his/her personal beliefs regarding tradition and culture, as this creates an awareness of ethnocentrism and

prejudices that may affect the nurse's behaviour and care of the client. Participants agreed that the patient's beliefs took precedence over their own beliefs regarding the system of healing and that they were open-minded towards the Muslim traditional illness practices that they had encountered. Giger and Davidhizar (1995) recommend that nurses should cast aside personal beliefs and attitudes regarding illness and its care as these beliefs maybe considered judgemental and may therefore negatively affect patient care. Lynam (1992) states that exploring one's values on illness and health care enables one to clarify values that may inhibit one from adopting an open-minded approach to the provision of care. The author goes further to explain that a prerequisite to the provision of culturally sensitive care is the knowledge that the client's perspective of health and illness is the focus of health care.

### **5.1.2 Cultural knowledge**

The participants revealed that the Muslim patient and the Muslim family relied on traditional illness practices for a sense of inner peace as well as for spiritual and emotional upliftment. The participants identified many Muslim traditional illness practices that they had witnessed which had provided the patient with peace as well as emotional and spiritual contentment. Mahomed (1998) supports the participants' beliefs in the importance of traditional illness practices to the Muslim patient, explaining that Muslim traditional illness beliefs go beyond the individual and his/her illness experience

where the focus is on ALLAH, The Creator. By focusing on ALLAH, the patient demonstrates his/her faith in The Creator, thereby fulfilling the purpose of his/her creation and this creates the feeling of inner peace as well as spiritual and emotional contentment. Ebrahim (1988) states that the strongest of men is he who places complete trust in ALLAH, as it is this trust that will enable the individual to accept the illness with dignity and will eliminate the turbulence of feeling that prevents the achievement of peace.

The participants acknowledged that Muslims relied on traditional illness practices as it appeared that these practices had in the past provided them with solutions to hopeless situations. The participants agreed that the Muslim patient exhibited an unwavering faith in the belief that these traditional illness practices would be successful in healing them. Islamic teaching encourages Muslims to have faith in times of adversity. Having faith in the fact that ALLAH has provided a cure for every illness creates a positive feeling within the ill individual enabling him/her to persevere with treatment even in the midst of pain (Ebrahim et al, 1995). Ebrahim et al (1995) goes further to explain that ALLAH will test a person with adversities but glad tidings will follow if the person's faith never falters and his /her perseverance never dwindles. These are the teachings that provide the Muslim culture with the ever certain faith that their traditional illness practices will lead them to recovery as well as provide them with the strength to persevere (Mahomed, 1998).

### 5.1.3 Cultural skill

It was evident that the participants had used a number of methods to gather information on the Muslim and the traditional illness practices. The participants favoured the method of asking the Muslim patient the purpose of a traditional illness practice. Participants explained that knowing the purpose of a traditional practice enabled them to understand the significance of the practice to the patient's illness experience. Giger and Davidhizar (1995) also favour this method of discovering the beliefs of different cultures, suggesting that wherever possible, the client should be the nurse's primary source of information as others, even those close to the client may have different ideas and beliefs regarding the traditional practice. McGee (1994) agrees that working within the cultural framework of the client will be enhanced if the caregiver understands the significance of the client's perspective on healing.

Other methods of gaining information on the Muslim culture used by the participants included, learning from previous experiences with Muslim patients, learning from the experiences of their colleagues as well as reading up and making notes from literature on the Muslim culture and their practices.

Previous experiences with Muslim traditional illness practices had equipped the participants to anticipate possible requests that Muslim patients made. This allowed the

participants to make provision in advance to accommodate these requests. Previous encounters with the Muslim culture also provided the participants with a greater understanding of the Muslim culture. Lynam (1992) documents that working with patients from diverse cultural groups equips the nurse with the skills and sensitivity needed to communicate with patients regarding health related behaviours. A valuable means of acquiring information on the multiple views on illness, which are prevalent within a culture, is by interviewing and working with patients from that cultural group (Lynam, 1992). The author suggests that this method also be used to sensitize learner nurses with cultural experiences, where the learners are shown videos of nurses interacting with patients of different cultures.

The participants saw learning from each other as another useful manner of learning about the idiosyncrasies of the Muslim culture. The participants relayed instances where they had shared their knowledge regarding a certain Muslim traditional illness practice with their colleagues in an attempt to aid the colleagues in acquiring a deeper understanding of the Muslim culture. There were also instances during which the participants requested the advice of their colleagues regarding Muslim traditional illness practices to enable them to work with greater sensitivity with the Muslim patient. Learning from nursing colleagues of different cultural groups is advocated by Tilki, Papadopoulos & Alleyne (1994). Tilki et al (1994) describe the hospital as a “melting pot ” of cultures where nurses from different cultural groups must interact fruitfully. They believe that nurses

from diverse cultural groups can be relied upon for their ideas, creativity and problem solving in nursing patients from similar backgrounds to their own.

#### **5.1.4 Cultural encounters**

The participants used their experiences with the Muslim traditional illness practices as the knowledge base for their beliefs and thoughts about the Muslim culture. The participants identified the Muslim culture as being deeply ingrained in their traditional practices and way of life. Muslim relatives and patients were seen to be dependant on tradition and religion in every sphere of their existence. This was tied with the participants' belief that traditional illness practices brought to the Muslim patient feelings of peace and spiritual contentment. The participants voiced that they respected the Muslim culture for their traditional outlook to life and life's experiences. Mahomed (1997) supports the participants' views of the Muslim patient being dependant on tradition for healing. The author explains that Muslims believe that the healing methods are derived firstly from the *Qur'an* and then from tradition, which is part and parcel of religion.

All participants conceded that although they respected the Muslim patients need for the traditional illness practices, these practices had sometimes been disruptive to the hospital routine and sometimes also had a negative effect on the wellbeing of the Muslim patient as well as other patients. Participants focused on the crowds of people that visited the Muslim patient. Menk (1994) describes the purpose behind visiting the sick as an act of

goodwill that allows the visitor, firstly to pray for the sick individual's recovery and secondly to accrue blessings for the one's self. The participants acknowledged this purpose but emphasised that the crowding of visitors had impeded the movement of nurses as well as infringed on other patients' rights for privacy.

The participants also described the Muslim culture as being very supportive of each other and as being close knit. The Muslim community was seen as being a stronghold in times of adversities, where the Muslim people rallied around the individuals needing help and support. Ali Qadri (1994) is of the opinion that Muslims provide support to each other in order to increase feelings of affection and to create a stronger brotherhood. The author goes further to explain that the spiritual strength of the ill person is increased when friends and family congregate in his/her presence to offer prayer and gifts of love.

The participants mentioned stereotyping as an obstacle in delivering culturally sensitive care to the Muslim patient. The participants explained that through their encounters with Muslim patients they had discovered that not all Muslims subscribed to a certain belief and that the individual's personal belief system had to be considered to prevent misinterpretation of the patient's definition of culturally sensitive care. Giger & Davidhizar (1995) support the participants' beliefs that stereotyping as a result of past associations and experiences with a culture can lead to faulty interpretation of the individual's needs and beliefs. McGee (1994) suggests that to prevent superficial

generalisations, culture specific information must exist within a framework that creates an awareness of the individual's differences and preferences regarding cultural traditions.

### **5.1.5 Cultural desire**

The participants displayed their enthusiasm for the delivery of culturally sensitive care to Muslim patients as well as to patients from different cultural backgrounds by verbalizing that they would hate to be insensitive to patients' cultural beliefs. Leininger (1984) states that the essence of working within the client's perspective of the illness experience is sensitivity to the cultural needs and practices of the client.

The participants' support of culturally sensitive care was displayed by their desire to work with the patient and the family so as to include traditional illness beliefs in the treatment regimes. Germaine (1992) comments that the patient's distress that his/her cultural beliefs and needs will be ignored is lessened when the health team and the patient work together. Andrews & Boyle (1995) conclude that when there is participative decision making regarding illness treatment, potential conflicts that hamper progress of the patient are avoided and divergent assumptions between the patient and health team are revealed.

Participants also spoke of respecting the traditions of the Muslim culture and other cultural groups. This respect was evident as they described their feelings and actions

during their experiences with the Muslim culture and the traditional illness practices. Troskie (1998) indicates support of mutual respect for cultural values that should exist between the nurse and her client. The author explains that each culture is worthy of esteem and cultural practices must not be modified unless they were seen to be detrimental to the well being of the client. Giger & Davidhizar (1995) state that respect for the client's traditional beliefs overcomes cultural barriers that may exist, communication is enhanced and the interpersonal distance between the nurse and client is reduced. A participant revealed that respect for the patient's traditional beliefs was an institutional norm. McGee (1994) suggests that for culturally sensitive care to prevail, organisational processes must be geared towards creating a climate that promotes respect for cultural diversity.

#### **5.1.6. Culturally Sensitive Care**

While all the five aforementioned constructs indicate observance of culture sensitivity among the participants, these participants further indicated their motivation towards providing culturally sensitive care by describing how they had accommodated the requests of Muslim patients to carry out traditional illness practices. Leininger (1985) defines this culturally sensitive approach to nursing care as cultural accommodation, whereby the client's treatment and care is adapted to a manner that is culturally acceptable to him/her.

Central to the participants' needs to provide culturally sensitive care was their desire to provide holistic care. The participants mentioned the importance of caring for the patient in totality, thereby ensuring harmony of the body, mind and spirit.

Kasule et al (2000) have documented that the total recovery from an illness includes treatment prescriptions that heal the physical and psychological maladies, creating within the individual spiritual contentment.

All participants displayed their commitment towards providing culturally sensitive care by stating that they considered the cultural belief system of patients regarding health and illness as essential in illness management. Abdullah (1995) states that commitment to providing culturally sensitive care begins with the acknowledgement that the client's identity is tied up in a cultural process that defines the illness experience and its care. McGee (1994) explains that incorporating the client's traditional beliefs in illness management reduces recidivism and promotes compliance to treatment. Andrews & Boyle (1995) conclude that it is exclusion of the client's cultural beliefs regarding illness that results in insensitive handling of cultural variations in illness causes and treatment.

## **5.2 Recommendations for the future**

### **5.2.1 Recommendations for nursing education**

Findings revealed that cultural knowledge is gained primarily through informal encounters and through the interest of the individual nurses, but not from formal education. The nursing profession therefore has an obligation to develop nursing practitioners who are able to respond to the unique cultural needs of the members of a

multicultural society. To fulfill this obligation nurse educators must develop education programmes that provide the learners with cross cultural learning experiences. These experiences must create within the learner awareness of the value of multiculturalism. The opportunity to explore human experiences must provide the learner with insight into their own biases. Education programmes must include the teaching of culturally appropriate assessment tools that will enable the learner to identify the cultural needs of the client so that effective individualised care can be planned. It was realised during the study that a major obstacle to culturally sensitive care is stereotyping that results from acquiring culturally specific knowledge. The implication of this finding is that nurse educators should not focus on teaching culture specific information but rather the focus on a general cultural framework that would enable nurses to provide culturally sensitive care to individuals from a variety of cultural backgrounds. An example is a cultural data collection instrument for history taking and discharge planning.

### **5.2.2 Recommendations for nursing practice**

The realisation of an organisational climate of culturally sensitive care cannot be an individual undertaking. There has to be commitment from management to facilitate the rendering of this type of health care. Top level and line managers must ensure that all organisational processes including the hospital philosophy and mission statement reflect organisational support of culturally sensitive care. Management must liaise with nurse educators to provide inservice programmes to staff on issues in culturally sensitive care.

### **5.2.3 Recommendations for future nursing research**

The study highlighted that while some ethnic groups have received much attention from transcultural researchers, many minority ethnic groups have been ignored. The lack of available literature on the Muslim culture indicates a need for further research into the idiosyncrasies of the culture to prevent a superficial approach to the rendering of culturally sensitive care to Muslim clients. Research should also be carried out to identify ways in which nurses from different cultural groups can aid South African nurses overcome the many obstacles that impede the rendering of culturally sensitive care.

## **5.3 Limitations of the study**

The most significant limitation was the shortage of available academic literature on the study itself. The researcher was unable to rely on the literature review to guide data

collection. Another limitation occurred during the verifying interviews in the private hospital, where the participants were distracted as the unit was busy. Their responses were vague and hurried and thus the reliability of the verifying interviews can be questionable. The fact that the researcher was a Muslim could have also influenced the participants, in that they may have responded in a way that they thought the researcher would like to hear. Another limitation was the small sample of six participants, which prevents the researcher from generalising the findings beyond the context of the study. The sample consisted of participants from the Asian race group and the Coloured racial group. Thus it can be argued that the findings may be biased as the participant nurses were not representative of all race groups within the country.

## **5.4 Conclusion**

The study focused on exploring the lived experiences of critical care nurses with Muslim traditional illness practices. It was evident that the participants supported the inclusion of the client's belief system on illness in health care delivery, despite having witnessed some ill effects of Muslim traditional illness practices. A deep commitment to delivering care consistent to the Muslim client's definition of the illness experience was evident among the participants. It is hoped that these sentiments are echoed by all South African nurses who are faced daily with the challenge of providing health care to a multicultural society.

## References

Abdullah, SN. 1995. Towards an individualized clients care: implications for education. The transcultural approach. *Journal of Advanced Nursing* 22: 715-720.

Ali Qadri, MSS. 1994. *From illness to death*. Halqa-E-Qaderiyah Razzaqiyah: Durban.

Andrews, MM & Boyle, JS. 1995. *Transcultural concepts in nursing care*. 2<sup>nd</sup> edition. Philadelphia: JB Lippincott.

Arthur, ML. 1995. *Health education in cross cultural encounters- An agogical perspective*: UNISA.

Bhikha, R. 2000. *Tibb - Traditional roots of medicine in modern routes to health*. Ibn Sina Institute of Tibb: Pakistan.

Brink, P. 1976. *Transcultural nursing*. Prentice- Hall, Inc: New Jersey.

Brink, HI. 1996. *Fundamentals of research methodology for health care professionals*. Juta & Company LTD: Cape Town.

Campinha-Bacote, J. 2000. *The Process of Cultural Competence in the Delivery of Health Care Services: A Culturally Competent model of Care*. Available at: <http://www.transculturalcare.net>.

Census 2000. *National census – 1996*. Available at : [http:// www.statssa.gov.za](http://www.statssa.gov.za)

Dauskardt, RPA. 1994. *The evolution of health systems in a developing world metropolis. Urban herbalism on the Witwatersrand.* University of Witwatersrand: Johannesburg.

De Wet, T. 1998. Muti Wenyoni: commodification of an African folk medicine. *South African Journal of Ethnology* 21(4): 165-172.

Dobson, SM. 1991. *Transcultural nursing.* Scutari Press: Oxford.

Donaldson, E. 1997. Nurses and sangomas team up to our nation. *Pace.* Nov: 80-87.

Ebrahim, AFM. 1988. *Biomedical issues - Islamic perspective.* Islamic Medical Association of S.A: Durban.

Ebrahim, AFM, Hoosen, GM, Hathout, H. 1995. *Death and dying - advising patient and family.* Islamic Medical Association of S.A: Qualbert.

Freeman, M. 1990. Integration and collaboration between allopathic and traditional medicine: Problems and challenges. *The South African Journal of Epidemiology and Infection* 5(3): 42-43.

Germaine, CP. 1992. Culture care: A bridge between sickness, illness and disease. *Holistic Nursing Practice* 6(3): 1-9.

Giger, JN & Davidhizar, RE. 1995. *Transcultural nursing and assessment.* 2<sup>nd</sup> edition. Mosby: New York.

Haffejee, F. 2000. *The Muslim Patient.* Alba Printers: Durban.

Hopa, M. Simbiya, LC, Du Toit, CD. 1998. Perceptions on the integration of western and traditional healing in the new South Africa. *South African of Psychology* 28(1): 53-61.

Johnson, AB. 2000. *Social change and shifting paradigms: The choice of healer among Black South Africans in psychological counseling*: Rhodes University.

Kara, S. 2002. *Islam in Southern Africa*. Alba Printers: Durban.

Kasule, OH, Coovadia, M & Karim, G. 2000. *Prophetic medicine – Al Tibb Al Nabawi*. Islamic medical association of S.A: Qualbert.

Kleinman, A. Eisenberg, L. Good, B. 1978. Culture illness and care. *Annals of Internal Medicine* 88(2): 251-258.

Leininger, M. 1984. Transcultural nursing: An overview. *News Outlook* 32(2): 72-73.

Leininger, M. 1985. Transcultural care diversity and universality. *Nurse health care* 6(4): 209-212.

Lo Biondo-Wood, G & Haber, J. 1990. *Nursing research methods, critical appraisal and utilization*. 2<sup>nd</sup> edition. Mosby: USA.

Lynam, MJ. 1992. Towards the goal of providing culturally sensitive care: principles upon which to build nursing curricula. *Journal of Advanced Nursing* 17(2): 149- 157.

Mahomed, IBB. 1997. *A comparative study of Zulu and Muslim Traditional Healers: A sociological perspective*: University of Durban - Westville.

Mahomed, S. 1998. *Modern and Islamic Medicine: Some implications for training health care professionals in Kuwait*: UNISA.

McGee, P. 1994. Culturally sensitive and culturally comprehensive care. *British Journal of Nursing* 3(15): 789-793.

Menk, SMI. 1994. *Social conduct of a Muslim*. African Muslim Agency: Cape Town.

Mangany, NC. 1974. Health and disease-Some tropical problems of socio cultural transition. *S.A. Medical Journal*, 48: 922-924.

O'Brien, ME. 1999. *Spirituality in nursing. Standing on holy ground*. Jones & Bartlett Publications: Massachusetts.

Peltzer, K. 2000. The perceived efficacy of western and traditional health care in an urban population in the Northern Province, South Africa. *Acta Academica* 32(2): 87-103.

Pretorius, E. 1999. In the home stretch: the legislation of African traditional healing in South Africa. *Acta Academica* 31(2): 1-17.

Samdani, RA. 1995. *The essence of Islamic Faith*. Sunni Ulama council: Cape Town.

Streubert, HJ & Carpenter, DR. 1995. *Qualitative research in nursing- Advancing the human perspective*. JB Lippincott Company: Philadelphia.

Tilki, M, Papadopoulos, I & Alleyne, J. 1994. Learning from colleagues of different cultures. *British journal of Nursing* 3(21): 1118- 1119, 1122- 1124.

Troskie, R. 1998. Ethical decision- making in a transcultural context. *Health SA Gesondheid* 3(1): 3- 8.

Tyawa, M. 2001. Success through a western- African partnership. *Children First* 4: 3-4.

Wells, A. 1983. *Health and Healing*. Houghton Mifflin Company: Boston.

**Annexure A**

**Interview guide**

# **Interview Guide**

## **Biographic data**

Number of years employed in the unit?

Religious standing?

## **Perception / awareness of culturally sensitive care**

Describe an experience of nursing a client of a different cultural group to your own.

## **Experiences with Muslim traditional illness practices**

Describe an experience of your encounter with nursing of a Muslim client.

What did you think about this experience?

What traditional illness practices did you observe?

What was the outcome of these practices?

How did these practices impact on your nursing care and treatment of the client?

## **Annexure B**

### **Letter of permission – Ethics committee of Natal University**

**RESEARCH ETHICS COMMITTEE**

Student: WAHEEDHA EMMAMALLY

Research Title: AN EXPLORATORY STUDY OF THE LIVED EXPERIENCES OF CRITICAL CARE NURSES WITH MUSLIM TRADITIONAL HEALING PRACTICES

A. The proposal meets the professional code of ethics of the Researcher:

YES       NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: *Emmamally*      Date: 14-04-03

Signature of Supervisor: *[Signature]*      Date: 14.04.03

Signature of Head of School: *[Signature]*      Date: 14/4/03

Signature of Chairperson of the Committee: *Fresco*      Date: 15AP'03  
 (Professor F Frescura)

## **Annexure C**

### **Letter of permission – KwaZulu Natal Health Services**

NATALIA  
330 LONGMARKETSTREET  
PIETERMARITZBURG

TEL. 033-3952111  
FAX 033-3426744

Private Bag : N9051  
Isikhwama Seposi : Pietermaritzburg  
Privaatsak : 3200

---

REFERENCE : 9/2/3/R – Vol.11  
ENQUIRIES : Mr G. Tromp  
EXTENSION : 2761

MAY 2003

University of Natal  
School of Nursing  
Faculty of Community and  
Development Discipline  
**DURBAN**  
4041

**For Attention:** W. Emmamally

Dear Sir/Madam

### REQUEST TO CONDUCT A NURSING RESEARCH

Your letter dated 24 April 2003 refers.

Please be advised that authority is granted for you to conduct a research at R.K.Khan Hospital for an Exploratory study of the Lived Experiences of Critical Care Nurses with Muslim Traditional Healing Practices provided that:-

- (a) Prior approval is obtained from Heads of relevant Institutions.
- (b) Confidentiality is maintained;
- (c) The Department is acknowledged; and
- (d) The Department receives a copy of the report on completion.

Yours sincerely



**SUPERINTENDENT-GENERAL  
HEAD: DEPARTMENT OF HEALTH**

FM/research.emmamally

## **Annexure D**

### **Letter of permission –Provincial institution**



HOSPITAL MANAGER  
PRIVATE BAG X004  
CHATSWORTH  
4030

4033223 EXT. : 2030 FAX 031-4010505

E.MAIL: H001894(a)dohho.kzntl.gov.za

OUR REFERENCE :

ENQUIRIES: MRS F J NGIDI

DATE : 12 JUNE 2003

MISS W EMMANALLY  
145 ROAD 729  
MONTFORD  
CHATSWORTH  
4092

**RE : RESEARCH – MUSLIM TRADITIONAL PRACTICE**

Your letter dated 11 May 2003 has reference.

Permission is hereby granted to you to conduct the above research at this institution.

  
NURSE MANAGER  
For HOSPITAL MANAGER

JN/KP

## **Annexure E**

### **Letter of permission- Private institution**



# St Augustine's Hospital

107 Chelmsford Road, Durban • PO Box 30105 Mayville, 40

Tel +27(0)31 288-5000 • Fax +27(0)31 201-4606

Web address: [www.netcare.co.za](http://www.netcare.co.za)

P.R. No. 5802562

9<sup>th</sup> June 2003

Waheedha Emmamally  
C/o B.R. BHengu (Research Supervisor)  
University Of Natal (Durban Campus)  
School of Nursing  
Faculty of Community and Development Disciplines  
DURBAN  
4001

**Fax No: 031 – 4049020**

Dear Waheedha

**RE: RESEARCH PROJECT – CRITICAL CARE NURSES – MUSLIM TRADITIONAL HEALING**

Thank you for your interest in utilising St. Augustine's Hospital as a research facility.

Permission is hereby granted for you to publish your case presentation with the proviso that anonymity is maintained.

Yours sincerely

**MISS B HUDDLE**

Nursing Manager



Netcare Hospitals

Directors: J. Sheveti, R.H Friedland.

St Augustine's Hospital (Pty) Ltd: Company Registration No. 630452/01

## **Annexure F**

### **The full interview as transcribed**

PARTICIPANT: KUGIL  
HOSPITAL: ST. A  
DATE: 10 JUNE 2003  
FIRST INTERVIEW.

GOOD AFTERNOON, ANYTHING YOU NEED CLARIFIED BEFORE YOU CHOOSE A PSEUDONYM?

Nothing for now.

SO WHAT AM I GOING TO CALL YOU?

(laughter) I'm thinking. Hmm Kugil.

HOW LONG HAVE YOU BEEN IN THIS UNIT?

2.5 Years

WHAT RELIGIOUS OR CULTURAL STANDING ARE YOU?

I am a Hindu.

KUGIL CAN YOU RELATE AN EXPERIENCE OF NURSING A CLIENT FROM A DIFFERENT CULTURAL GROUP AND WERE SOME TRADITIONAL PRACTICES HAS HAD AN IMPACT ON YOU?

With my experience of nursing people from different cultural groups there is one thing that stands out in my mind, and that is traditional practices at the time of dying and though it is most important it always gets brushed under the carpet. For example we had this one patient who for the whole night had a not recordable bloodpressure and a heart rate of below 40, but he hung on. The next morning I took over and I asked the wife when she arrived if there were any last minute traditional rituals that they carried out. She said yes and I gave her the opportunity to them. An hour later the man died. I know that some people call me the Angel of death, but I come from a strongly traditional background so I feel that if my family were going to die this what I would want for them, at the end tradition is what we know and what has worked for us from the time we were born it's the comfort at the end. Especially when the patient is from a different cultural group to the nurse who is looking after him, this is ignored so to speak. I've seen it many times. When a patient comes in under religion preferences and taboos are listed, but not many look at this, and mostly tradition and religion go hand in hand. Personally for myself I can safely say that I have taken it upon myself to look that up or ask the relatives especially if the patient is very ill. When it came to a Muslim I asked a colleague and she said that its best to inform the family and they will do their practices but saying the word of Allah that means everything to a Muslim. I think it is critical for us to find out what patients and families expect especially in ICUs where death rates are high, its amazing how peaceful patients become or how peacefully they die when the traditional rites are carried out.

YOU SPEAK OF TRADITIONAL PRACTICES AND BELIEFS BEING IGNORED, HOW DOES THIS MAKE YOU FEEL?

Its very upsetting, and the cultural issue in nursing is something that is addressed very scantily. Nurses think that they give holistic care, but how can we call it holistic if we don't bother to find out from the patient or their relatives what are the beliefs regarding health and illness and death and incorporate this in our care for the patient. Time and time again I reach out to the girls because I feel so strongly about this, I do but I try my best to encourage the others. But it doesn't always work. It's a sad thing actually because right from our initial training cultural beliefs are stressed. But its an individual thing nurses need to look deep inside themselves like I did and realize their beliefs. If you feel strongly about your tradition maybe then you will realize why this is so important to the patient as well.

YOU MENTIONED ASKING A PATIENT OR THEIR FAMILY FOR INFORMATION ABOUT THE TRADITIOANAL PRACTICES THAT THEY MAY NEED TO CARRY OUT WHILE IN HOSPITAL CAN YOU PERHAPS ELABORATE ON THIS?

Yes, in this way you know what the patient expects and what is permissible in his faith and you don't make the mistake of assuming that all Hindus like ash on their foreheads or that all Jehovahs witnesses wont accept blood transfusions. People can belong to one cultural group but they may not practise everything, so you treat everyone as a person too, and be cautious about there traditional practices, that's why I say that from admission you encourage them to share with you what traditional practices they think is important. Admittedly when the patient comes in things are so hectic cultural issues are ignored but a nurse who believes in holistic care will go back to it and leave information for her colleagues or just share stuff so that everyone is aware. I have written down notes on most of cultural groups that I nurse, things that are of overall importance and I remember and abide by them when I nurse patients of that cultural group. It works for me.

IS THERE ANYTHING YOU WOULD LIKE TO SHARE REGARDING THE MUSLIM CULTURE?

Hmm , hmm specifically I know most Muslims believe in being fully garbed, and that it embarrasses them to see naked parts of other people, I nursed this one Muslim female who covered her face and asked to be screened during visiting hours. Well when I nursed her I put on a t serve so that my arms were covered and theatre cap to cover my head and during visits were the males came and seemed uncomfortable with me being around I stood mainly outside the screened cubicle. I feel in any case you have to respect and honor their traditions.

DID THIS CAUSE ANY PROBLEMS WITH THE CARRYING OUT OF CARE AND WARD ROUTINE?

Other patients were curious but again explaining the reason behind the action often satisfies other patients. And sometimes it was not always possible to screen her and I

explained this to her, so during this time she kept her veil on. Even if routine gets upset we must try and meet each other halfway. Eh and I think if you able to at least allow for some traditional practices to be carried out it uplifts you as a person and removes the barrier between you and the patient. It allows for trust. It brings about holistic care which is definitely paramount.

**WHAT OTHER MUSLIM TRADITIONAL PRACTICE ASSOCIATED WITH ILLNESS DO YOU FEEL IMPACTS COMMONLY IN THE HOSPITAL?**

(laughter) well everyone speaks about the entire Muslim population being there, but this is not only among Muslims so we cant put only Muslims in that apple cart. But yes they do visit in numbers and can disrupt the patient and annoy other patients and staff, but again if you get to know about the Muslim Culture the stick together family or no family. If you know this then rather than becoming annoyed you'll understand the reasoning and your approach when telling them why two are to visit will not be harsh, cause they are really not doing this to get the staffs backs up. In fact it will make you more accommodating.

That's about it, I'm personally very for tradition in any culture, I find nursing patients with different cultural needs challenging, and I feel that traditional practices uplifts patients emotionally and spiritually. I don't understand everything about culture but that's not from the lack of trying, I think we should make it our duty to learn about patients cultural beliefs to be better care givers.

**THANK YOU, THAT WAS REFRESHING.**

## **Annexure G**

### **The researcher's process of bracketing**

## **The researcher at the outset acknowledged and then put aside feelings on the subject of study**

### **Experiences with the Muslim culture**

As a Muslim, I am able to understand and empathise with Muslim clients and families regarding the inclusion of certain practices of healing that seem strange or disruptive to nurses from different cultural backgrounds. I sometimes become angry and want to defend the actions and requests of the clients or their families when colleagues make comments such as, “the whole of Mecca is here.”

I also accept that Muslim clients can be forceful in making demands regarding practicing of their customs without explaining the rationale behind this, which often frustrates nurses.

### **Experience as a critical care nurse**

As a critical care nurse I have encountered feelings of helplessness and despair among clients where their only solace is to participate in traditional rituals and to turn to traditional beliefs of healing. Western medicine seems to fail in restoring them to health and they often turn to practices that have worked for them in the past. I have also encountered clients who through faith in traditional methods of healing renew their fight against illnesses. Working in the critical care environment has made me realize that in

the quest for health, optimal recovery is the only goal to all involved participants and the means to achieving this goal is often arbitrary.

### **The impact of transcultural studies on the researcher's perspective on culturally sensitive care**

Whilst involved in this study I have become aware of my ethnocentrism and effectively bracketed it. In all works of life I have become more sensitive to peoples' way of life, their views, whether culturally born or otherwise. In the working arena I am often frustrated by the inability of the medical and nursing staff to see the importance of including the client's cultural beliefs in the treatment regime. I become angry when clients are labeled un-cooperative, simply because their lack of compliance stems from treatment being incompatible to their belief systems.

Always is there, the fervent wish that more staff would discover the need for a culturally sensitive stance to health care.