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**EXPLORING THE EXTENT OF CULTURAL SENSITIVITY  
AMONG THE NURSING STUDENTS  
DOING THE FOUR YEAR (4) DIPLOMA  
AT ADDINGTON HOSPITAL  
IN KWA ZULU - NATAL PROVINCE**

**BY**

**BUSISIWE BENEDICTA MAFANYA (nee Ndwandwa)**

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**BUSISIWE BENEDICTA MAFANYA (nee Ndwandwa)**

*SUBMITTED IN FULFILLMENT OF THE  
REQUIREMENT FOR THE DEGREE*

**MASTER CURATIONIS**

**DEPARTMENT OF NURSING SCIENCE  
UNIVERSITY OF NATAL, DURBAN**

**SUPERVISOR : MISS T. KHANYILE  
CO-SUPERVISOR : DR L. MOLETSANE**

## DECLARATION

I declare that this dissertation is my original work submitted as a fulfillment for the degree Master Curationis.

A handwritten signature in cursive script, appearing to read 'B. B. Mafanya', written over a horizontal dashed line.

**B. B. MAFANYA**

## **DEDICATION**

This work is dedicated to my late father, Tennyson Seymour and my mother Ellen Tetiwe Ndwandwa with love and thanks for their encouragement and motivation to learn. To my late Aunt Theodore Tamkazi Ndwandwa for being the role model and a source of inspiration and focus on working hard towards any intended goals. To my Aunt, Noreen Luhabe, who always wishes me a successful and bright future. Also to my children, especially my late Nokanyo Pozisa for their love, warmth and understanding.

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- ◆ I thank most heartily the Department of Health of Kwa Zulu - Natal for granting me permission to access my target population at Addington Nursing College.
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I could not have done a project like this without you in my life. Thank you very much. May God bless you.

## ABSTRACT

This study was undertaken to explore the extent of cultural sensitivity among the nursing students of Kwa Zulu - Natal Province. A qualitative, ethnographic, explorative design was utilized. A quantitative approach was also used. Subjects were second, third and fourth year students registered for the four year Comprehensive Diploma in Nursing leading to registration as a Nurse (General, Psychiatry, Community Health) and Midwife. To ensure measures of trustworthiness, Guba's model in (Krefting 1991) was implemented. Narrative statements in the form of scenarios and questionnaires were employed to explore, to examine and to describe the extent to which the nursing students are sensitive towards cultures of groups that are different from theirs.

The data was analyzed based on the developmental stages of cultural sensitivity by (Bennett 1986). Tesch's method was used to analyze the qualitative data and the Statistical Analysis System (SAS) was used to analyze the quantitative data. Based on the findings, the following conclusions were drawn :- Some students were unable to acknowledge variations that exist among cultures. Problems emanating from cultural differences still exist between nurses and patients due to the ethnocentric views held by some nurses. The study revealed that the students were at varying stages of levels of development of cultural sensitivity, which means that they ranged from lack of cultural sensitivity to cultural sensitivity. Nursing students, therefore, need more preparation by their program in order to provide culturally congruent nursing care to all.

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# CHAPTER 1

## INTRODUCTION AND OUTLINE OF THE STUDY

### 1.1. BACKGROUND

A lot of problems emanated from apartheid legacy and health care services were no exception. Under the apartheid and homeland government, there was fragmentation of health services along racial and ethnic lines, even care delivery was determined by racial differences (Khanyile, 1996, p.5). The policy of separate development guided people to serve their own communities but did not facilitate community development. As a result, white patients were nursed by white nurses who understood their own cultures, values and beliefs and black nurses were nursing black patients (Ntoane, 1993). In South Africa the problem of cultural differences had been viewed within the context of racial differences. Therefore, it becomes impossible to isolate problems due to racism from those due to cultural differences. Van Der Walt (1994) states that nurses socialized and educated into a specific culture have difficulty with entering into the life and history of patients from another culture. Yet people experience illness in a cultural way because of differences in view of health and illness.

Recent political changes in South Africa have provided a change from hospital to community care. This adaptation to Primary Health Care (PHC) approach is a strategy towards better health for all occupants in South Africa irrespective of colour, creed or nationality. This requires redistribution of human resources to redress the inequalities in human resource allocation. This has brought major changes in staffing levels in many hospitals and larger shifts in health workers from well off institutions to understaffed services.

The government of National Unity has realized the multicultural nature of the country and South Africa has been in the context of gross maldistribution of the country's human resources. According to the ANC National Health Plan (1994) all categories of health personnel should have experience of working in rural settings.

Also health education institutions must provide rotation of their students and staff through rural facilities for all categories of health workers to improve interdisciplinary learning activities at rural community based care facilities. People are now, not only allowed to move vertically and horizontally but are placed at the stations where there is insufficient human resources. This means that people who have no experience of working with diverse groups may suddenly find themselves doing so, for example, white nurses nursing black patients and black nurses nursing white patients et.cetera. This might create problems resulting from cultural differences.

Previous studies on the issue of cultural differences have identified the need to improve cultural sensitivity among nurses. Henderson & Primeaux (1993) contends that patients from multicultural and multi-ethnic backgrounds contributes to patient care problems. These problems center on language and cultural differences. Much of this grows out of ethnocentrism as nurses bring their ethnocentrism with them to their jobs. In a study that was conducted by Benal & Froman (cited in Bartz, Bowles, Jody & Underwood, 1993) even the experienced community nurses described themselves as not confident in working with culturally diverse clients. Nurses who are different from patients in terms of culture generally have more difficulty in communicating empathy, congruence, respect and acceptance than those who share or understand the patient's cultural perspective.

Dobson (1991) maintains that even though the understanding and appreciation of cultural diversity have been increased there has been little focus on the underlying concept of culture. Nursing has always stressed the importance of rendering culturally conscious care that respects individual differences and incorporates one's own values, beliefs and lifestyles and practices into the delivery of health care.

According to Morse (1991) cultural sensitivity implies an awareness of one's own culture of orientation as well as alertness to the variations of perception, values and beliefs of others. It is the process of becoming sensitive to other cultures. During this process individuals need to examine their own prejudices towards other cultures and become aware of how these factors can affect their perception of ethnically diverse individuals (Camphina-Bacote, 1994a). Cookfair (1996) states that the development of cultural sensitivity facilitates the communication process between the health personnel and the client. In development of cultural sensitivity :-

- Nurses first explore and affirm their own cultural identity. It then becomes easier to demonstrate acceptance, respect and interest in learning more about client's culturally based needs, particularly as they pertain to health and illness.
- Acknowledge variations in values, beliefs and norms. The development of cultural sensitivity on the part of the nurse enhances the nurse-client relationship and facilitates the caring process. In the nurse-client relationship the values of both the nurse and the patient come into play because both are members of cultural groups. When these values differ, it is important for the nurse to be able to perceive the client's values as a variation rather than a deviation from those values to which the nurse is accustomed. Nurses' values are a product of their own cultural backgrounds.

- Respect. Although the nurse may experience surprise or disagreement at the disparity between the client values and his or her own, it is important to acknowledge these feelings without challenging the client's values. The nurse must respect another person's point of view even as she or he continue to hold his or her own. The nurse develops a way of accepting, respecting and allowing the patient to subscribe to and practice such beliefs.

Knowledge and understanding of patients or clients from different cultures. Culture is a blueprint for man's living and only by understanding culture can a nurse hope to gain the fullest understanding of man as a social and cultural being. This understanding is imperative for human development and survival and for achievement of many social, political, educational, economical and health goals.

Bello in (Clark, 1984, p.295) defines cultural sensitivity as an awareness on the part of care givers of the significance of cultural factors for health and illness.

According to Bello (1976) cultural sensitivity is characterized by several identifiable components :-

- Respect for people as unique individuals and for their culture as one factor contributing to their uniqueness. The cultural sensitive nurse does not expect all persons to conform to the majority culture. Nor does she expect all members of one cultural group to behave exactly the same way.
- The awareness that ethnic groups have culturally prescribed beliefs and practices related to health. Health and illness are culturally defined as are practices that promote and prevent illness.
- The third characteristic of culturally sensitivity involves modification of nursing care to incorporate folk health practices whenever feasible.
- Finally cultural sensitivity is characterized by an ability on the part of the nurse to act as an advocate for persons of other cultural groups.

The need for cultural sensitivity in nursing is obvious particularly with the increasing probability of encountering clients from other cultures. It becomes clear, therefore, that both (Cookfair 1996) and (Bellos' views 1976) are the same regarding cultural sensitivity. Cookfair (1996) focuses on the steps that should be taken by a nurse towards cultural sensitivity, while Bello (1976) identifies the components that are inherent in cultural sensitivity. Bello extends her views and apply these in the provision of cultural congruent nursing care, that is, modification of nursing care to incorporate folk health practices whenever feasible and the nurse being expected to act as an advocate for persons of other cultural groups. In order to provide cultural congruent care, the nurse should first develop cultural sensitivity. Then he or she can appreciate and understand the components that are inherent in cultural sensitivity and therefore can incorporate these in the nursing care (Bello, 1976 : Cookfair, 1996).

## **1.2 PROBLEM STATEMENT**

Because of the diversity of the South African population, nurses need to provide care to patients from different cultural backgrounds. At the same time, the new thrust of community centered nursing which focuses upon understanding community health needs is gaining momentum. Nurses work with people in a variety of settings and frequently interact with groups and subgroups whose thinking, beliefs, values, habits, dress, language and rules of behavior are different from their own. Nurses, therefore, are faced with a challenge of providing holistic individualized nursing care to all the inhabitants of South Africa taking into consideration the cultural and ethnic trends in our society.

Previous studies have found that not all practitioners are equipped to provide appropriate care to multi-ethnic populations. The most critical issues revealed by students were lack of cultural knowledge, sensitivity and awareness and more extensive and innovative efforts are needed to overcome existing barriers (Gerrish, Grossman, Massey, Blais, Geiger, Louie, Pereira, Steward, Tayler, Filer, Nembhard, & Tally-Ross, 1998). Another study revealed that the graduate students had little self-confidence in their ability to provide culturally congruent care (Kulwicki & Bolank, 1996). Also in the literature by Bhimani, Des Gupta and Larvis, (in Tjale, 1999) suggest that nurses experience difficulty in providing care to culturally diverse clients.

The question arises as to whether the South African nurses are adequately prepared to function effectively in community based health service; whether they are sensitive and aware of the variations that exist among cultures; whether they recognize the impact of cultural values on the delivery of health care and work deliberately to address culturally based conflicts; whether they have sufficient cultural sensitivity to cope with the cultural diversity of South Africa.

### **1.3 THE PURPOSE OF THE STUDY**

This study sought to explore, examine and describe the extent to which the nursing students of Kwa Zulu-Natal Province are sensitive towards cultures of groups that are different from theirs.

### **1.4 OBJECTIVES**

1. To describe the cultural differences that exist among nursing students and patients, particularly with health and health care.

2. To determine the student's level of awareness regarding the variations that exist among cultures.
3. To determine the nursing student's level of development of cultural sensitivity.

## **1.5 THE SIGNIFICANCE OF THE STUDY**

The South African Nursing Councils' philosophy which underpins the programs of the school of nursing science recognizes that people are holistic individuals who possess bio-psycho-social, cultural, and spiritual dimensions with dignity and self-worth (South African Nursing Council, 1994). In order to fulfill this requirement, nursing students as future practitioners, need to understand the connections between culture and health in order to provide culturally congruent nursing care.

This requirement is also a challenge to all nurses in South Africa, including those who received training in a unicultural environment, of delivering care to patients of all cultural and ethnic groups. The mixing of backgrounds and experiences is increasingly a reality in the new South Africa, "a rainbow nation". It is therefore not enough to know and understand the culture of a community where one comes from.

From these findings nurses might gain insight about those cultural issues that influence health and care behaviours. It is hoped that a caring atmosphere will be fostered by the caregivers and thus contribute to the improvement of the quality of nursing care.

## **1.6 METHODOLOGY**

### **1.6.1 Research Design**

A research design is the overriding program or protocol used for answering the research question (Wilson, 1989, p.133). The ethnographic approach was used in this study. In ethnography, the researcher studies the group's views as perceived by the group (Leininger, 1985 ; Spradley, 1979). Ethnography (from anthropology) is itself a research design developed to study human society and culture.

Ethnography is a qualitative research method using naturalistic open discovery and largely derived from emic modes (from the people's point of view) and processes with diverse strategies, techniques and enabling tools to document, describe, understand and interpret the people's meanings, experiences, symbols and other skilled aspects bearing on actual or potential nursing phenomena (Leininger, 1991, p.79). Also, a quantitative approach was used in this study. This study sought to explore cultural sensitivity as perceived by the nursing students. Ethnography uses specific terms, for example, informants instead of subjects and enabler for tool or instrument.

### **1.6.2 Population**

Polit & Hungler (1991, p.254) describes the population as the aggregation of cases that meet a designated criteria. The population of this study consisted of student nurses in all levels from first to fourth year of study in the region of Kwa Zulu-Natal where a greater number of groups from different cultural backgrounds is found. Because the population is a large group there is a need for the selection of the sample. The researcher chose Kwa Zulu-Natal because of the nature of heterogeneity in this region.

### **1.6.3 Sampling**

A sample consists of a subset of the units that compose the population (Polit & Hungler, 1991, p.254). Quota sampling which uses a convenience sampling technique was used with an additional feature, a strategy to ensure the inclusion of subject types that are likely to be underrepresented in the convenience sample. The researcher identified strata, that is, levels of training and cultural groups of the population and the proportions of the elements needed from the various segments of the population. A minimum of four ethnic groups was included in the study (Burns & Grove, 1997, p.304 ; Polit & Hungler, 1991, p.258).

### **1.6.4 Data Collection Techniques**

Different methods of data collection, that is, narrative statements in the form of scenario and questionnaires were employed in order to explore the culture - ethnic experiences by the nursing students (See Annexure C and D respectively). Informants were given a paper and a pen in order to write down their responses to the given scenarios. Responses were based on the development stages of cultural sensitivity according to Bennett (1986). Questionnaires were also used. The researcher used both enablers in order to balance the weaknesses of the other.

### **1.6.5 Data Analysis Procedure**

Tesch's method of data analysis was used to analyze the qualitative data (Creswell, 1994, p.155). Data was analysed by two coders independent of each other. The first was myself as the researcher and the other one an expert in qualitative research and possesses a Doctoral Degree in nursing.

Data analysis was done immediately after the collection of data when it was still fresh in the researcher's mind. A sense of whole was obtained by reading through all the transcripts. Ideas were jotted in the margin as they came to mind. A list of topics was made and similar ones were combined and clustered together and rearranged into major topics.

Topics were abbreviated and written as codes next to appropriate segments. The researcher tried out to organise scheme and see whether new categories and codes emerged. The topics were written and turned using descriptive words into categories. The researcher reduced the total list of categories by grouping related topics and lines were drawn between categories to show interrelationships. A final decision on the abbreviation of each category was made and the codes were alphabetized. Data that belonged to each category were assembled in one place and a preliminary analysis performed. Existing data were then recorded. Arrangement was made for an expert to assist during this stage.

The researcher used the Statistical Analysis System (SAS) computer program (SAS/STAT User Guide, 1990) to analyse the quantitative data. Descriptive statistics that includes percentages, tables and graphs was utilised to organise and summarise the data.

#### **1.6.6 Academic rigour**

According to Brink (1993) the very nature of qualitative research method does not lend to statistical or empirical calculation of validity. The researcher sought basically the same end results which are better suited to a human subject matter.

Guba's model for trustworthiness was utilized to ensure the validity and reliability of this study (Lincoln & Guba, 1985, p.290). Aspects that are relevant to ensure trustworthiness will be discussed below :-

**(a) Truth value**

Truth value asks whether the researcher has established confidence in truth of the findings for the subjects and the context in which the research is undertaken. Truth value is ensured by the strategy of credibility (Krefting, 1990, p.214). Member checking was done to make sure that data is presented and interpreted according to meanings and in the context of respondents.

**(b) Triangulation**

Triangulation refers to the use of two or more data sources, methods, investigators, theoretical perspectives and/ or approaches during the study of a single phenomenon so as to enhance the quality, completeness and credibility of the research (Krefting, 1991, p.229). The researcher used two data collection methods, that is, scenarios and questionnaires to collect data. The sample of the population consisted of students from three levels of training, that is, second, third and fourth years.

**(c) Applicability**

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups. It is the ability to generalize from the findings to larger populations. Since qualitative study do not necessarily seek to generalize, applicability in qualitative research refers to whether it is fitting or transferable (Krefting, 1990, p.216). However, the researcher hoped that the questionnaire that was constructed from the subject's responses could be used in other settings.

#### **(d) Neutrality**

Guba (in Krefting 1991, p.216) asserts that neutrality refers to the degree to which findings are a function solely of the informants and conditions of the research and not of other biases, motivations and perspectives. The researcher tried to be grounded as much as possible during the study by analysing the data using direct quotes from the informants, so that data will not present as the researcher's own opinion and to control the research bias. Member checking was done to ensure the neutrality of the findings and credibility of the study. By using a second tool (questionnaire) the researcher was able to verify with the subjects or confirm if what she has documented is really what the subjects really meant.

#### **1.6.7 Ethical Considerations**

Ethical considerations are of utmost importance in research to protect human dignity and also to exercise the principle of justice (Polit & Hungler, 1993, p.445). Therefore, the ethical considerations that are inherent in research proceedings entail: Consent to conduct the study was obtained from the institution that is providing the four year Diploma and the Department of Health in Kwa Zulu-Natal province through letters. Leedy cites "the consideration of fairness, honesty, openness of interest, disclosure of methods, the ends for which the research is executed and a respect for the integrity of the individual (Leedy, 1997, p.116).

Appropriate steps to ensure that the respondent's rights are not violated were taken. The purpose of the study, and the role of the participants were explained. Subjects were told that participation is voluntary, and if for any reason the individual do not wish to continue with the research effort, he or she had a right to withdraw.

Informed consent was obtained from the students who were participation in the study. The respondents who were participating were given assurance of anonymity as their names were not required. Also the respondents were assured confidentiality as whatever information they would give in would not be divulged by anybody.

## **1.7 DEFINITION OF KEY TERMS**

### **(a) Ethnicity**

Ethnicity is a social group who shares cultural bonds and social heritage passed from generation to generation : provides a sense of “belonging” (Hunt & Zurek, 1997. p.81). Sorofman (cited in McGee, 1992) describes ethnicity as a group of people who are clearly identifiable because of their way of life, for example, religion, nationality, specific values, attitudes or behaviour.

### **(b) Culture**

Culture is defined as values, beliefs, norms and practices shared by members of the same cultural identity and guide thinking, action and being. Culture also refers to all structures and processes created by man (individuals, groups, communities and nations) to make his own world habitable and meaningful. The patterned expressions are passed from one generation to the next (Kotze, 1994).

### **(c) Transcultural nursing**

Leininger (1998a) defines transcultural nursing as the formal area of study and practice focused on a comparative analysis of different cultural care, health and illness beliefs, values and practices with the goal of using this knowledge to provide culture specific and cultural universal nursing care to people.

#### **(d) Cultural care**

Cultural care is the cognitive known beliefs, values and patterned expressions that support or enable another individual or group to maintain well-being, improve a human condition or lifeway, or face death and disabilities (Leininger, 1988a, p.156).

#### **(e) Culture care diversity**

This refers to the variations of meanings, patterns, values or symbols of care that are culturally derived by humans for their well-being to improve a human condition and lifeway or to face death (Leininger, 1988a).

#### **(f) Patient**

Patient refers to a man or a person as a unique, multidimensional unitary being, body-psyche-spirit, continuously becoming within a dynamic inseparable relationship with the world, time, fellow beings and God, of any age, sick or well, who needs help to allow or maintain optimal health (wellness). Patient also refers to individuals, families or groups, communities as the case may be, in all health care settings (Kotze, 1994).

#### **(g) Health**

Health refers to a state of well being that is culturally defined, valued, practiced and which reflects the ability of individuals (or groups) to perform their daily role activities in a culturally satisfactory manner (Leininger, 1988a, p.156). Health is also viewed from a magic-religious, biomedical or holistic perspective. From the magic-religious perspective, health which is a gift from God, is a community matter. According to biomedical perspective, health is defined by means of physical and chemical bodily processes. The holistic perspective relates health and harmony between man and nature (Herberg, 1989, p.26-35).

**(h) Student nurse**

A student nurse is a person registered as such with S.A.N.C. and undergoing a comprehensive basic nursing education program leading to registration as a Nurse (General, Community, Psychiatry) and Midwife in terms of S.A.N.C. regulation R425 as amended. For the purposes of this study this will mean all nursing students registered with the college of nursing from first to fourth year of study.

**(i) Experiences**

Experiences refer to the accumulated set of events, and the people's reactions to them, which are common for the participants in any type of contact (Brislin, 1993).

**(j) Ethnic minority or Minority Group**

Ethnic minority is used to indicate people who do not belong to or identify with the dominant culture. It is a group of people whose culture possesses certain traits that are held in low esteem by the dominant culture (McGee, 1992).

**(k) Dominant culture**

A dominant culture is one that has, or assumes it has, the authority to act as guardian and sustainer of the controlling value system, and has a monopoly on the rewards available (McGee, 1992).

**(l) Health for All**

Health for All means that health is to be brought within reach of everyone in a given country. And by health is meant a personal state of well - being not just the availability of health services, a state of health that enables a person to lead a socially and economically productive life (World Health Organisation, 1979).

### **(m) Primary Health Care**

Primary Health Care (PHC) is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (ANC, 1994). The Oxford Reference Dictionary of Nursing describes Primary Health Care as the person's point of entry into a comprehensive health care process provided through an integrated network of services covering the treatment of common illnesses and injuries, maternal and child health problems, the care and rehabilitation of people with long and short term handicaps and disabilities and health education.

### **(n) World view**

World view refers to the way people tend to look upon the world or universe to form a picture or value stance about their life and the world about them. It consists of social structure (organisational factors of a particular culture, such as religion, economic, education and politics and how these factors give meaning and order to the culture) and environmental context (an event, situation, or experience such as interaction, emotion or physical element that gives meaning to human expressions (Leininger, 1988a, p.15).

## **1.8 OUTLINE OF DISSERTATION**

**Chapter 1** gives an introduction and overview of the study.

**Chapter 2** provides some literature review of some of the studies that were conducted with the aim of exploring cultural sensitivity of nurses towards their clients or patients. Also the three theoretical frameworks that form the bases of the study are discussed.

**Chapter 3** explains the methodology of the study, that is, research design, research setting, the target population, sampling and data collection methods.

**Chapter 4** provides the findings on the data analysis and interpretation.

**Chapter 5** draws conclusions and furnish with the recommendations in relation to nursing practice, education and research.

## **1.9 CONCLUSION**

In this chapter, the problem to be researched has been clearly stated based on the background information, research questions, purpose and objectives to undertake the study, have been stated. The research design, research methods and methods to ensure trustworthiness have been described.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter presents a review of selected empirical literature on the subject that is relevant for this study, so that it builds on knowledge that already exists and is comparable with previous research.

#### **2.2 EMPIRICAL LITERATURE**

Several studies offer supportive evidence that there is a strong need to improve cultural sensitivity among nurses in order to provide cultural congruent nursing care. From the literature, the researchers identified a lack in cultural knowledge and skills which results in a number of issues affecting the provision of sensitive or competent nursing care. These are viewed as barriers to culture sensitive care as they inhibit the formation of meaningful intercultural relations. These cultural factors have implications for the teaching and learning process, for example, ethnocentrism, stereotyping, prejudice, cultural imposition and labeling (Hunt & Zurek, 1997 : Leimmer & Squelch, 1993). However, no studies were found that attempted to explore the extent of cultural sensitivity among nursing students of Kwa Zulu - Natal province.

##### **2.2.1 Lack of cultural knowledge and skill**

Campinah-Bacote (1991) defines cultural knowledge as learning about a cultures' world view from emic perspective.

The process here is experiential, for example, when a group of students travel to a foreign land to learn about other peoples' lifeways. Cultural skill involves the process of learning how to assess one's own values, beliefs and practices in order to provide culturally competent care. Nursing students need to learn how to conduct cultural assessment as the first step in addressing multicultural health care needs for the 21st century.

Studies relating to lack of cultural knowledge were found in the literature. Blenner (1991) conducted a study on how health care providers approach treatment of culturally diverse infertile patients. Findings from in-depth providers in a major city in California revealed three types of providers :-

- culturally unaware, culturally non-tolerant and culturally sensitivity. Cultural unaware providers failed to recognize different cultural needs and treated all patients in the same way, an approach that eventually led to non-compliance.
- culturally non-tolerant providers recognized diverse needs but were unwilling to tolerate cultural conflicts in treatment or change treatment protocols. Often, this resulted in providers terminating treatment or making referrals to a more culturally tolerant provider.
- culturally sensitive providers acquired information about cultural beliefs, worked with patient limitations and adapted tests and treatment protocols to meet patient's needs.

According to this researcher the process of becoming a culturally competent practitioner must begin with a careful examination of ones' own beliefs, values and intentions. This process of self awareness must begin early in the nurses' education.

To ensure safe and effective service to the consumer of health care services, it has become necessary to provide the student and the health care professional with both the technical knowledge and cultural understanding to meet the consumers' need. Spector (1991) stated that unless the provider has a sound understanding of the consumers' values and perceptions regarding health and illness, the consumers' needs cannot be met satisfactorily.

Bucher, Klem & Adepoju (1996) professors of College of Nursing University of Delaware, Newark, conducted a study on fostering cultural competence. The findings revealed that a number of students showed very little difference between their own culture and the assigned culture and this may be due to lack of exposure to other cultural groups. According to the researchers, the lack of insight regarding cultural differences on the part of the students need to be considered when faculty plan other culture-specific learning activities.

Eliason (1998, p.27) supports the view of lack of cultural knowledge when she states that students entering the nursing profession are often not prepared for the multicultural world of the health care system. Most health care workers are socialized in the equal treatment model that all patients or clients should be treated the same. This equal treatment model emerges from an eurocentric, middle class perspective and often takes a paternalistic, patronizing view of the diverse patient or client, a child in need of protection and guidance.

Eliason & Rahein (1996) surveyed 196 nursing students and found that experiences with various cultural groups were related to level of comfort when interacting with individuals from the group. The most common response given for feeling uncomfortable with members of racial groups was lack of exposure and knowledge.

For sexual identity groups, reasons for feeling uncomfortable were evenly split between lack of knowledge or exposure and negative attitudes or feelings of disapproval. There is a real need for students to explore their own beliefs that can potentially interfere with willingness to care for some clients or clients with a particular health care problem.

A similar study that supported this view was undertaken to measure the level of comfort by graduating baccalaureate students in providing transcultural nursing care to clients of diverse cultural backgrounds (Kulwicksi & Bolank, 1996). Results suggested that graduating students did not feel confident about caring for Michigan's five major ethnic groups. The data obtained in this substantiated that nursing students are not provided with the experiences needed to give transcultural care to ethnically diverse populations.

A study by Zwane & Poggenpoel (2000) was conducted to explore and describe student nurses' experiences of interacting with culturally diverse psychiatric patients in two universities. Student nurses reported having experienced both positive and negative aspects of interacting with culturally diverse psychiatric patients. Positive aspects included optimism, racial unity, equality of facilities, enrichment and challenge, whereas negative experiences included discrimination, superiority complex, cultural ignorance and ineffectiveness of patient care, hostility and general unhappiness. Even both universities' student nurses seemed to be ignorant of each other's cultures. And as such, there is lack of knowledge concerning transcultural nursing issues that causes many problems in South Africa.

A survey of Deans and directors was conducted in Florida nursing programs to determine how nursing programs promote and integrate cultural diversity.

The majority of Deans and Directors ranked the goal of promoting cultural diversity of moderate importance. The two most critical issues perceived by the respondents were the lack of cultural knowledge, sensitivity and awareness and the academic problems and educational deficit of minority students. Data suggest that more extensive and innovative efforts are needed to overcome existing barriers (Grossman, et al, 1998).

### **2.2.2 Barriers to culture sensitive care : negative attitudes**

A study by Gerrish (1998) identified a limited understanding of cultural needs and negative attitudes among some nursing and midwifery staff while minority ethnic communities reported some positive experiences of sensitive, caring professionals. It is important for the nurses to have an understanding of negative attitudes that hinder the provision of culture congruent nursing care.

An "attitude" is when people feel a certain way towards something or someone over a period of time. When a feeling is linked to an idea or belief it becomes an opinion (Lipson & Meleis, 1985, 1992). An attitude is an outflow of a person's inner feelings and perception. It is exhibited in the person's behaviour. A person's world view as well as societal influence may both indirectly determine a person's attitudes towards phenomena (Khanyile, 1996). Attitudes and values we hold as individuals can have an impact upon our behavior towards people who are perceived to be different. The nurses' attitudes also affect the success in gathering cultural data. The client will not reveal much about himself or herself to a nurse whose communication reveals bias, condescension or lack of respect (Lipson & Meleis, 1985,1992).

### 2.2.2.1 Negative attitudes : prejudice and stereotyping

In a study by McMillan & Townsend (1994), the effects of cultural bias were investigated in the judgment of lay people about the presence of depression in the young women. Studies revealed that when making decisions, different sources of bias were shown to be influential, including professional status, education, age, amount of contact with mentally ill people, sex, religion, prestige, nationality, theoretical orientation, diagnostic trends, similarity of beliefs system, physical or psychological attractiveness and culture.

The influences of these factors on attitudes and judgments about mental illness were shown to be positive or negative in a variety of studies. This apparent inconsistency may be an artifact of poor research methodology and reflect the problem of operationalising abstract concepts such as culture. The culture of a therapist may bias judgments in favor of clients of another culture, that is, less psychopathology (Lopez & Hernandez, 1986) or bias against clients of another culture that is more disturbed (Kartz, Cole & Lowery, 1969 ; Li-Repac, 1980 ; Malgady & Rogler, 1987 ; Pope, 1979).

Louie (1990) reports in his study that there is a relationship between empathy and anxiety of nursing students and their attitudes towards patients from ethnic minority groups. In recognizing the important role that nurses and midwives play in health care delivery, the UK English National Board for Nursing, Midwifery and Health Visiting - the statutory professional body that oversees nursing and midwifery education in England commissioned a two year research project to examine the extent to which nurses and midwives were prepared to work in a multi-ethnic society. The study found that not all practitioners were equipped to provide appropriate care to multi-ethnic populations.

Martin & Belcher (1986) conducted a study aiming at determining the differences and similarities of attitudes of oncology hospital nurses towards pain, cancer treatment and the dying patients among three cultural groups, namely, Midwest American, South African English and African Zulu. The 20 - question survey was devised by the investigators and given to 36 Midwest American nurses, 31 South African English nurses and 33 African Zulu nurses. Findings revealed there were similarities as well as differences among the three groups of nurses. They shared similar opinions that : -

- all different groups of patients with cancer experience the most pain.
- the use of medication was preferred first, then relaxation to reduce pain.
- home setting was preferred by most as the place of death provided the patients who do not require skilled care.
- patients with a good positive attitude toward recovery will do better in the course of illness.

This showed some differences regarding certain views. The America and Zulu nurses differed mostly because of their cultural background. The South African English nurses were closer to the Americans because of their educational background and both groups have a basic cultural heritage of Anglo-Saxon origin. The major difference between Zulu and American nurses was that Zulu nurses' responses indicated that they feel very uncomfortable both around the dying cancer patients and also in talking about the impending death of a dying patient as compared with Midwest American nurses. This study revealed that attitudes are culturally based and that they influence individual's behavior and thus interferes with multicultural nursing.

Khanyile (1996) in her study on the nature of the problems that non-Zulu students experienced during their encounter with Zulu patients highlighted the nurses' attitude as a factor in transcultural interaction problems. In her study, she states that attitudes are culturally based, they influence an individual's behavior and therefore can interfere with a multicultural nursing intervention. Since attitudes are culturally based, nurses need to examine their cultural beliefs and values about health and illness so as to identify their own biases and prejudices.

### **(a) Stereotyping**

Stereotyping occurs when one creates a standardized mental picture based on an assumption. This mental picture is based on a characteristic or series of characteristics that come from myths or generalizations and are assigned to people based on their perceived membership in a group (Hunt & Zurek, 1997).

Stereotyping in Giger & Davidhizar (1995) is an assumption that all people in a similar cultural, social or ethnic group are alike and share the same values and beliefs. It is a tendency to ascribe the values, attributes or behaviours of a number of people to all members in the group (Cookfair, 1993, p.171).

Community based nurses are routinely in contact with individuals who are members of stereotyped groups, such as mentally ill, the poor, the homeless, the aged, and HIV-positive individuals. Aspects of a client's character that differ from the nurse can lead to negative stereotyping. Respect for the uniqueness of an individual is central to effective nursing care. Stereotypical attitudes are not based in reality. If nurses base their nursing practice on stereotypes, the result can be ineffective care (Hunt & Zurek, 1991, p.97).

## **(b) Prejudice**

Prejudice is a set of negative beliefs about a social group that leads individuals to prejudice people from that group or the group in general, regardless of individual differences among members of that group (Brislin, 1993, p.171). Prejudices are categories about people. As such they have all the features of categories especially the organization of specific bits of information and subsequent reaction to the category as a whole.

There is not only a set of beliefs about others which are captured in stereotypes, there is also a deeply felt set of feelings about what is good and bad, right or wrong, moral and immoral and so forth. Prejudice refers to the emotional component of peoples' reactions to other groups. These are negative feelings about outgroups. It is a preconceived opinion against or in favour of a person or thing and a judgment or opinion is formed beforehand or without due examination of the facts (Leimmer & Squelch, 1993).

## **(c) Ethnocentrism**

Giger & Davidhizar (1995) defines ethnocentrism as the perception that one's own way is best. Leininger in (Cookfair 1996) sees ethnocentrism as the tendency of an individual or group to believe that ones' own lifeways are most desirable, acceptable or best and act in a superior manner to the lifeway of other cultural groups. Even in the nursing profession there is a tendency to lean towards ethnocentrism. This can prompt cultural imposition, that is, the tendency of an individual or cultural group to impose their beliefs, values and patterns of behavior upon another culture for varied reasons (Leininger, 1991).

Henderson & Primeaux (1993) contends that the presence of patients from multicultural and multi-ethnic backgrounds is a source of patient care problems. These problems center on language and cultural differences. Much of this grows out of ethnocentrism as nurses bring their ethnocentrism with them to their jobs. In a study that was conducted by Benal & Froman, 1987 (in Bartz, Bowles, Jody & Underwood 1993) even the experienced community health nurses described themselves as not confident in working with culturally diverse clients. Nurses who are different from patients in terms of culture generally have more difficulty communicating empathy, congruence, respect and acceptance than those who share or understand the patient's cultural perspective.

#### **(d) Labeling**

Labeling means attaching a description to, or assigning to a category (Mavundla, 1998, p76). Labeling patients as good or bad represents another absolute, based on mistaken notions of what we would like patient's behavior to be, but what in reality, it is not (Kein, 1980, p.135).

DeSantis (1991) in her study found the nursing diagnosis of noncompliance troublesome. Client's decision not to follow biomedical oriented treatments or health education were seen as inherent in their right to decide. Patients were labeled as noncompliant and this was considered an ethnocentric judgement on the part of the nurse and based on the assumption that the tenets of biomedicine are superior to clients' health cultural values, beliefs, and practices. Viewed from a transcultural posture, the current nursing diagnosis of noncompliance violates the concept of cultural relativism and severely inhibits the ability of nurses to provide holistic and culturally congruent care.

### **(e) Cultural imposition**

Leininger (in Hunt & Zurek, 1997) describes cultural imposition as the practice in which health personnel impose their beliefs, practices and values on people of other cultures because they believe their ideas are superior to those of other groups. This is an attempt by an outsider, to impose his or her own cultural values, beliefs and mode of conduct on an individual, family or group of another culture. This phenomena has serious and ethical and professional implications, since the patient has both a human right and a cultural right to have his or her cultural values and way of life taken into consideration in nursing practice.

Nurses must recognize this right and with the patient not against him or her (George, 1984, p.43). If health professionals assume they have the right to make decisions for clients will respond as minority cultures respond to dominant cultures with passivity, resistance, anger or noncompliance (Hunt & Zurek, 1997). Nurses should be aware of the fact that their ways are not necessarily the best and that other peoples' ideas are not ignorant or inferior. Nurses must remember that the ideas of lay individuals may be valid for them and more importantly, will influence their health status (Giger & Davidhizar, 1995, p.62). Nursing has always stressed the importance of rendering culturally conscious care that respects individual differences and incorporates one's own values, beliefs and lifestyles and practices into the delivery of health care (Campinah-Bacote, 1998, p.3).

## 2.3 THEORETICAL FRAMEWORK

The researcher identified a number of theoretical frameworks that are relevant to this study, but three have been chosen, that is :-

- \* The Stages of development of cultural sensitivity by Bennett (1986), whereby responses from the participants will determine the stage in which the respondent is :
- \* The Social identity development theory whereby the nurse is seen as a social being from birth to adulthood (Adam. Bell & Griffin, 1997) ; and
- \* Chrisman`s theory, (1991) which is, Expanding nursing practice with culture – sensitive care wherein culture – sensitive care should emerge. These will be explained below.

### 2.3.1 Stages of Development

Bennett`s stages of development of cultural sensitivity has provided a frame of reference for this study. Bennett (1986) has outlined the progression from ethnocentrism to increased cultural sensitivity typically following six stages. Each stage represent a way of experiencing a difference :-

The first stage is denial whereby one`s own culture is seen as the only culture and cultural differences are not recognised. A denial of difference occurs when physical or social isolation prevent any contact at all with significant cultural differences. This represents the ultimate ethnocentrism where one`s own world view is unchallenged as central to all reality. In extreme cases of denial, cultural differences that are recognised may be explained a way by attributing sub - human status to the members of the other culture.

- In the next stage, defense, cultural differences are recognized, but are defended against by a belief that one's own culture is superior. Undesirable characteristics are attributed to every member of a culturally distinct group, for example, race, religion, age, gender or any other assumed indicator of difference.
- In the third stage, minimization, cultural differences may be recognized but the magnitude of their impact is still minimized. Cultural differences are overtly acknowledged but are experienced as unimportant compared to far more dictates of cultural similarities. An attempt is made to ignore the differences bury the weight of cultural similarities (Bennett, 1998).
- Then, in the fourth stage, there is acceptance and respect of behavioural difference and underlying cultural value differences. Differences are acknowledged and seen as part of a dynamic process that helps people set and follow social rules. Differences are seen as fundamental, necessary and preferable in human affairs. Individuals here begin to see their own culture as constructed and changeable. It is at this stage that cultural sensitive care can begin to take place.
- In the adaptive stage, an individual is able to change cultures and adapt to different cultures. The ability to change processing of reality constitutes an increase in intercultural sensitivity when it occurs in cross cultural context. Bennett (1986) states that the most common form of adaptation is empathy which involves a temporary shift in the frame of reference such that one construes events as if one were the other person. Another form is the ability to shift into two or more complete world views and the terms "biculturality" and "multiculturality" are used respectively.

- In the final stage, integration occurs when an individual is able to move comfortably among cultures. The integration of difference is the application of ethnorelativism to one's own identity. The individual is not only sensitive to many different cultures, but is always in the process of becoming a part of and apart from a given cultural context. (See Annexure A).

It is assumed in the model that intercultural sensitivity increases with movement to the right towards more relative treatment of difference. The responses from the participant determined the stage in which the respondent was. The researcher used this model to diagnose the level of sensitivity of individuals and groups.

### **2.3.2 Social Identity Development Theory**

It is also important for this study to examine the literature on racism as oppressive beliefs are internalized by victims (targets) as well as benefactors (oppressors / agents ). Practice is always shaped by theory whether formal or informal.

#### **Stage I : Naive / No Social Consciousness**

Social identity is perpetuated by the process of socialization as shown in Annexure B. The cycle of socialization illustrates how people are socialized by individuals, culture and the institutions of society to accept a system of racial dominance and racism. People are born without racist attitudes, values or beliefs.

Though people are born into social identity groups, they do not have information about themselves and about others. It is through the process of socialization process that people acquire the sets of attitudes, values, beliefs, feelings that support racism. (Adam, Bell & Griffin, 1997).

Firstly, this is learned from parents, then this is reinforced by media, at schools by teachers, peers; and other institutions with which people interact, for example, religious institutions, judicial system and political system. The messages that people receive from families, surrounding culture and the institutions of society combine to create social system based on the Rightness of Whiteness, the systematic oppression of People of Colour and the collusion by individuals in a cycle of racism. People receive these messages through words and silences, actions and inactions as a way to set standards for appropriate and inappropriate behaviour (Adam et al. 1997).

## **Stage II : Acceptance**

As people move to the acceptance stage, they learn to adopt an ideology or belief system about their own and other social identity groups. They learn that the world has rules, laws, institutions and authority figures that permit certain behaviours and prohibit others even if these do not make sense and violate other principles like freedom, equality. Acceptance represents some degree of internalization whether conscious or unconscious.

People have accepted the messages about the nature of their group identity, the superiority of agents and the inferiority of targets. This becomes inevitable as the learning is powerful, pervasive and consistence (Adam et al, 1997).

### **Stage III : Resistance**

There is an increased awareness of the existence of oppression and its impact on agents and targets. Agents reject earlier social positions and formulate a new world view. They are aware that oppression exists and causes disparity between agents and target groups. They redefine the problem and devise strategies to change it. They negotiate the conflict between their own values and societal definitions of appropriate behaviour for their group and move towards a new identity ( Adam et al, 1997).

### **Stage IV : Redefinition**

The focus at this stage is on creating an identity that is independent of an oppressive system based on hierarchical superiority and inferiority. They develop a positive definition of their social identity and identifying aspects of their culture and group that are affirming are necessary parts at this stage. People, now, recognise that all groups have unique and different values that enrich human life but no culture or social group is better than the other (Adam et al, 1997).

### **Stage V : Internalization**

The new social identity within one's total identity is integrated and internalized. The identity that has been developed in the redefinition stage is incorporated into all aspects of everyday life. The concern is creation of a more equal future and application and integration of the new social identity into other facets of their overall identity. This behaviour becomes spontaneous at this stage.

This theory is relevant in the nursing profession as the programs in nursing education could be redesigned to help the nurses to achieve the stages four and five (redefinition and internalization) to break the cycle of socialization.

### 2.3.3 Chrisman's Theory

This theory guides nurses in providing holistic congruent nursing care and the accompanying practice dimension culture - sensitive care. According to Chrisman (1991), an expansionist perspective, the central focus of nursing is the client and then expands to all relevant aspects of the client's context. This approach is advantageous as the culturally naive nurse is inhibited from stereotyping patients by expecting them to conform with generalizations learned about a particular culture. Expansionist approach, that is, culture - sensitive care incorporates cross cultural nursing activities into the nursing process, offering a familiar structure for practice. The socio - cultural assessment is an expanded version of the nursing assessment that would be normally carried out. The nursing interventions include the following :-

- ◇ the individual as a bio - socio - cultural being.
- ◇ the family or group within which the individual is encompassed, for example, ethnic, religious, neighbouring groups or variations in the family composition approach
- ◇ community factors, for example, ethnic composition, social class distribution, geographic region and whether the community is urban or rural.
- ◇ social and cultural factors, for example, values and beliefs, social ideology, social interaction styles.

Chrisman (1991) states the fundamentals of Cross Cultural Nursing Care as mentioned below.

#### **(a) Culture sensitive care**

The basic principles of culture sensitive care are :-

- Knowledge of the immediate cultural context of the client

- Mutual respect, a goal toward which the cross cultural nurse strive in interactions with the clients. By open valuing of self and client, the nurse can achieve this goal.
- Negotiation which signifies the nurses' willingness and ability to work actively with the patient's perspective.

### **(b) Ethnocentrism versus Cultural relativism**

Ethnocentrism, a belief that one's own cultural beliefs and behaviors are the only correct ones and those of others are wrong should be replaced by cultural relativism, an antidote to ethnocentrism. Cultural relativism promotes the view that all beliefs and behaviours must be evaluated first in their own cultural contexts. The expansionist belief is that holistic care is not possible without a reduction in ethnocentrism because accurate assessment of the patient and family perspective cannot be ensured.

### **(c) Illness - Disease Distinction**

This distinction constraints the nurse to listen for both the signs and symptoms for her bio-medical assessment and to listen to cultural beliefs of illness for socio - cultural assessment. The expansionist view supports the premise that sickness can be defined in very different ways by different players in the health care system. These fundamentals of culture - sensitive care equips the nurse to be able to adjust their practice styles in a culture - sensitive direction.

The nursing process provides structure regarding cross cultural nursing activities that should be followed in providing culture sensitive nursing care.

## **(a)Assessment**

### **(i) Assessment of Health seeking behaviour**

This is a research model that successfully provides conceptual structure to the socio cultural assessment. It focuses on the illness episode and show socio-cultural factors that have influenced the course of the illness. It contains five interrelated elements :

- system definition, which stimulates access to the client's illness perspective and show how cultural beliefs drawn from the community or ethnic subcultures are affected by the explanation and experience or sickness.
- treatment action, directs attention to the healing activities undertaken by the patient and helpers who have been used.
- adherence, refers to the degree to which one's own or other's advise has been taken.
- role shift relates to description of the everyday life alterations in the rights and obligations of role relationships.
- lay consultation and referral. This data allow insight into the ways that family and friends have participated in the illness episode.

### **(ii) Socio - cultural assessment**

The nurse begins with traditional physiological and psychological parameters listening for key cultural features of the episode. A socio - cultural assessment of three (3) interview segments each keyed to components of the health seeking process.

- The explanatory model interview whereby the nurse seeks knowledge of the patient's illness, beliefs and is related to the health seeking components of symptom definition, treatment action and adherence.

- Then follows a question about the patient's social network of family and friends who have been involved in the illness episode. These data relate to the lay consultation and referral component.
- The patient is asked about her range of daily activities and obligations and these data are related to the role shift component.

### **(b) Planning and Implementation**

After health seeking process and socio - cultural assessment, health promoting or sustaining actions by the nurse follow. The expanded assessment based on a reduction of ethnocentrism will undergrid a broader set of interventions than would otherwise be found. Expansionists suggest three (3) sets of guidelines that condition practice in cross cultural nursing and the nurse must work with and not on the patient.

The first set of guidelines is drawn from the work of Leininger (1985, 1988) theory, and these are dominant modes to guide nursing decisions referred to as culture care preservation (maintenance), cultural care accommodation (negotiation), and cultural care restructuring (or repatterning). These are drawn from the cultural caring paradigm, but are easily adapted to the client focused approach proposed here.

Another set of guidelines to culture - sensitive nursing practice is the process of negotiation which contain the following steps :

- Listen carefully to the patient's perspective concerning the contrast in care.
- Explain your perspective using terminology with which you and the patient are comfortable.
- Compare the two views emphasizing both the areas of agreement and disagreement.

- Arrive at a compromise that changes your position while encouraging the patient to do the same until a workable and safe plan can be determined. This approach depends upon nurse - client mutual respect.

The other practice suggestion is similar to Leininger's Cultural Care Preservation mode. It is important here to include beliefs and treatment practices that are part of the patient's illness perspective. Peoples' health beliefs are nearly always integrated with other aspects of culture, so maintaining such beliefs continues cultural integration. The belief here is that as long as the treatment is not biomedically contra-indicated, promoting treatment that enjoys family and community support is critical. The aim is to conceptualize the client's beliefs and practices as a whole, a linkage to cultural features of everyday life, but not to stereotypic view of an ethnic group.

### **(c) Evaluation**

This is the final step in the nursing process. In culture - sensitive care, the essential principle is to evaluate the outcomes of illness and disease. The nurse assesses the degree of success she or he has had in designing and implementing a plan of care. The culture sensitive approach is satisfying to a majority of nurses since the bond is strengthened between the two. Also as the client is culturally different, the nurse learns new and interesting ways to approach health and health care. These positive experiences are essential in promoting the growth of culture sensitive care and cross cultural nursing. This theory will guide nurses in providing nursing care in a meaningful way by treating the patient as a whole rather than looking at the patient's illness only.

Kavanagh & Kennedy, (in Hunt & Zurek, 1991) argue that the important elements for providing culturally competent care are sensitivity, knowledge, and skill. These three factors allow diversity and assist in preventing the social distancing that may occur and interfere with providing skillful communication and planning. In nursing it is common for interaction to result in decision making about health care practices.

If a nurse is culturally blind, for example, imposing the majority view on another culture, the result may be client noncompliance, which can result in high risk behaviours.

## **2.4 THE TERM 'CULTURAL SENSITIVITY'**

It is essential to explain this term as it is the core of the study. Cultural sensitivity is the response to a person(s) or situation that is considerate, compassionate, empathic, and sensible. When an individual is culturally sensitive, he or she is willing to address a person with respect and without assumptions. Sensitivity involves adopting a personal willingness to explore and have an awareness of one's own cultural beliefs. Also developing knowledge about the client's community and general history as well as an appreciation of past oppression during this history. The nurses must also suspend judgement when working with a client whose health care beliefs are different from theirs. Hunt & Zurek (1997) have provided some guidelines that will assist nurses in developing cultural sensitivity, a major step towards cultural competent care as follows :-

- look critically and continually within and be aware of one's own beliefs and attitudes (self-awareness).

- learn culture-sensitive and inclusive language. Pay attention to trends and cultural preferences.
- do not make assumptions. The only safe assumption one can make is that each person is unique, each is a human being, and that every person shares the human experiences of being born and dying.
- listen carefully to your clients. Put yourself in their shoes. Ask if unsure.
- be informed and knowledgeable about the history of the population you work with; appreciate the oppression they have experienced by the dominant culture. To appreciate means to give credit, to respect another's life struggles and their strength in coping.
- develop these traits : patience, flexibility, openness to change and a sense of humour.

## 2.5 CONCLUSION

In this chapter the researcher strived to discuss important research that is relevant to the current study. The empirical and theoretical literature have been dealt with, and also the terms that form the basis of the problem under study. From the literature, a number of issues affecting the provision of culturally sensitive care have been identified. The data that have been reviewed substantiate the need to improve cultural sensitivity among nurses in order to provide cultural congruent nursing care.

## **CHAPTER 3**

### **METHODOLOGY**

#### **3.1 INTRODUCTION**

The purpose of this study was to explore the extent of cultural sensitivity among nursing students in the four year Diploma at Addington hospital in Kwa Zulu -Natal Province. To do this, a mixed qualitative and quantitative approaches were used. This chapter gives an overview of methodology which includes the research design, the sampling procedures and the size, the study participants and criteria for inclusion in the sample, the process of data collection and analysis. Ethical considerations and measures of ensuring trustworthiness are also addressed.

#### **3.2 METHOD USED**

Both qualitative and quantitative approaches were used in the study. Quantitative approach was relevant in this study, because the aim of the researcher was to describe the cultural differences that exist among nursing students and patients particularly with health and health care (Burns, 1987).

A qualitative approach was also used because the researcher was interested in determining the level of development of cultural sensitivity as perceived by the individuals. This approach is most useful for this study as it seeks to measure the depth of knowledge, perceptions, feelings, attitudes and values. This approach has been selected because qualitative research occurs in natural settings where human behavior and events occur (Patton, 1990).

The design used is holistic in that it involves inferences, insights and creativity so that results emerge in totality (Morse, 1994). The researcher attempted to understand the phenomenon in its broader and complex perspective: How sensitive are the nursing students of Kwa Zulu - Natal province towards cultures of diverse ethnic groups?

### **3.3 RESEARCH DESIGN**

Any study needs a plan for what data will be gathered, how that data will be collected and analyzed and what comparisons will be made within it. Such a study plan is often called a research design (McGrath, 1984).

An explorative and ethnographic design was used to achieve the main purpose of this research. Each aspect of the design is fully described below.

#### **3.3.1 Ethnography**

In ethnography, the researcher studies the group's views as perceived by the group (Leininger, 1985 ; Spradley, 1979). Ethnography (from anthropology) is in itself a research design developed to study human society and culture. Ethnography is a qualitative research method using naturalistic open discovery and largely derived emic modes (from the people's point of view) and processes with diverse strategies, techniques and enabling tools to document, describe, understand and interpret the people's meanings, experiences, symbols and other skilled aspects bearing an actual or potential nursing phenomena (Leininger, 1991, p.79). This study sought to explore cultural sensitivity as perceived by nursing students. Ethnography uses specific terms, for example, informants instead of subjects and enabler for tool or instrument.

### **3.3.2 Exploratory Design**

The purpose of an exploratory study is to obtain a richer familiarity with the phenomenon and to clarify concepts as a basis for further research (Wilson, 1989). Also to explore a relatively unknown research area (Morse, 1991, p.283 ; Mouton & Marais, 1991, p.43). The aim of this study was to explore and describe the extent of cultural sensitivity among the nursing students. This design was aimed to gain insight into the perceptions of the nursing students regarding cultural differences in Kwa Zulu - Natal Province.

### **3.4 POPULATION**

A population is referred to as all constituents of any clearly described group of people, events or objects who for research purposes, are designated as being the focus of an investigation (Drew, Hardman & Hart, 1996, p.254). According to Polit & Hungler (1991), population is the aggregation of cases that meet a designated criteria. The target population for this study were the nursing students doing the 4 year comprehensive Diploma according to the South African Nursing Council (S.A.N.C.) Regulation R425 as amended. This regulation stipulates the minimum requirements for education and training for the teaching of students in the program leading to registration as a Nurse (General, Psychiatry and Community) and Midwife. The population was obtained from Addington hospital in Kwa Zulu - Natal Province where there is greater number of groups from different cultural backgrounds.

### 3.5 SAMPLE AND SAMPLING

A sample is a portion or subset of the units that compose the population (Polit & Hungler, 1991, p. 254). It consists of a selected group of units from a defined population whereas sampling involves selecting a group of people with which to conduct a study (Brink, 1996, p.133 ; Polit & Hungler, 1991, p. 254). Quota sampling is the non-random selection of subjects in which the researcher pre-specifies characteristics of the sample to increase representativeness. When using this type of sampling, the researcher, a priori, prepares a sampling frame constructed with independent variables designed to ensure heterogeneity of the sample (Morse, 1991 ; Polit & Hungler, 1991). Quota sampling which uses a convenience sampling technique was used with an additional feature, a strategy to ensure the inclusion of subject types that are likely to be underrepresented in the convenience sample. Convenience sampling is one of the non - probability sampling techniques and involves non-random sampling of subjects (Burns & Grove, 1993, p.243 ; Polit & Hungler, 1991, p.255 ; Wilson, 1989, p. 260).

The researcher identified strata, that is, levels of training and cultural groups of the population and determine the proportions of the elements needed from the various segments of the population. The proposed size of the sample was twenty, five students from each level of training making a total number of twenty (20). Because of the time and financial constraints, the researcher could not get all the groups as she planned, only the second, third and fourth years were on block during the time of data collection. There were twelve (12) students who volunteered to participate in the study, two second year students, seven third years and three fourth year students. Though this seems to be a small size, in qualitative studies, the smaller the size, the easier it is to analyze the data. The second reason for such a size is the availability of the informants in their diverse cultural groups.

A minimum of four ethnic groups were included in the study, for example, Whites, Zulu, Afrikaans, Indians (Burns & Grove, 1997 p. 304 ; Polit & Hungler, 1991, p.258). In research terms it is not enough to talk about the sample, one should clearly specify the criteria by means of which participants will qualify to participate in the research.

### *Criteria for inclusion in the sample*

- both males and females were included since both males and females are involved in nursing culturally diverse patients
- working experience of at least three months in nursing patients, that is, they should have been exposed to the clinical situation.
- voluntary participation of subjects. Participants should volunteer instead of being selected to participate in this research.
- a minimum of four ethnic groups were included in the study.

## **3.6 RESEARCH SETTING**

The researcher chose Addington College of Nursing in Durban. The reason for choosing this campus is that it is one of two campuses in Kwa Zulu - Natal province that offer the four year Diploma program leading to registration as a Nurse (General, Psychiatry, Community) and Midwife. The Kwa Zulu - Natal province has been chosen because of the nature of heterogeneity. It has high numbers of heterogeneous students as well as heterogeneous patients.

It is accessible compared with the other campus (R.K. Khan) because it is situated in the centre of Durban and, therefore, very convenient for the researcher. Both enablers were administered in the classroom during lunch time and tea time.

### 3.7 DATA COLLECTION TECHNIQUES

Narrative statements and questionnaires were used in the study to collect data. The researcher used both enablers to balance the weaknesses of the other.

#### 3.7.1 Narrative Statements

Narrative statements in the form of scenarios were employed in order to explore the nursing student' level of cultural sensitivity towards other cultures . Informants were asked to respond to given scenarios. Three scenarios were designed in such a way that the response would enable the researcher to diagnose at which level of development of cultural sensitivity the student is. The informants were given a paper and a pen in order to write down their responses to the given scenarios. The scenarios were given by their lecturers during lunch time between 13h00 and 13h15. These were based on the developmental stages of cultural sensitivity according to Bennett (1986) as shown in Annexure A. The informants wrote individually so that their responses are not influenced by others and each responded from her or his point of view. The time allocated for responding to each scenario was five minutes (5). The language that was used was English. The researcher assumed that all students were capable of speaking English since the medium of instruction at Addington Nursing College is English.

#### *Reasons for choosing the narrative statements*

These were chosen to enable the students to describe how they could handle the situation given in the scenario. The three scenarios are described below :-

### **Scenario 1**

You are allocated for a whole year in a community clinic in Mpumalanga where most of the clients are Shangaans, and you become frustrated when they speak Shangaan in your presence. You feel excluded from the conversations and uncomfortable with your role in the clinic.

- What would you do? Justify your response.

### **Scenario 2**

You are assigned a patient in the Maternity Ward, and during the visiting hours, the whole extended family come and visit the patient at the same time. They believe that every member should come to give the moral support. The policy of the hospital allows only two or three members at a time in order to prevent cross infection especially to the newborn babies. When you approach the patient's visitors to explain the situation, they become angry with you and threaten to take their relative home with them.

- How would you handle such a situation?

### **Scenario 3**

You are working in a paediatric ward. Whenever you are conducting prayers in the unit, one child (patient) would keep her eyes open. One day you heard one of your colleagues talking to this child, instructing the child to close her eyes when talking with the Almighty. After this, the nurse came and was labeling the child as "silly" and "disdainful".

- What are your views regarding this situation?
- How would you respond or react to this situation?

### 3.7.2 Questionnaires

The researcher chose the questionnaire for verification and extension of information obtained from narrative statements. The questionnaire was partly structured, consisting of three sections A, B and C and partly unstructured consisting of one section D. Section A consisted of demographic data detailing age, sex, marital status, residence by birth, ethnic group, language, level of training, previous training. Section B identified the nurses's views about health and illness. The third section determined the nurses' cultural beliefs and attitudes towards patients. The last section, D, elicited information on terminology and aimed at assessing the nurses' level of knowledge of cultural concepts.

#### *Reasons for choosing the questionnaire*

In addition to the narrative statements, a questionnaire was used. The researcher used both enablers in order to balance the weaknesses of the other. The advantage of using unstructured questions is the ability of the informant to define the situation, encouraging him or her to structure the account of the situation and introduce to a considerable extent his or her notion of what he or she regards as relevant, instead of relying upon the investigator's notion of relevance. Thus, this type of a questionnaire is concerned with unique, idiosyncratic and the wholly individual viewpoint (Lincoln & Guba, 1985, p.268). The informants were given the questionnaires to fill in at the same time by their lecturers during the tea break (15h00 - 15h30). The time allocated for filling of questionnaires was thirty (30) minutes.

Section A of the questionnaire, that is, the demographic data is described below.

## The questionnaire data

According to questionnaire, data consisted of the following variables included in the study.

### (I) Gender

Most of the participants were females n-10 as illustrated in the table below.

Table 3.1 : Table showing Gender distribution of informants

Gender	Number	Percent %
Males	2	16,7
Females	10	83,3
Total	12	100

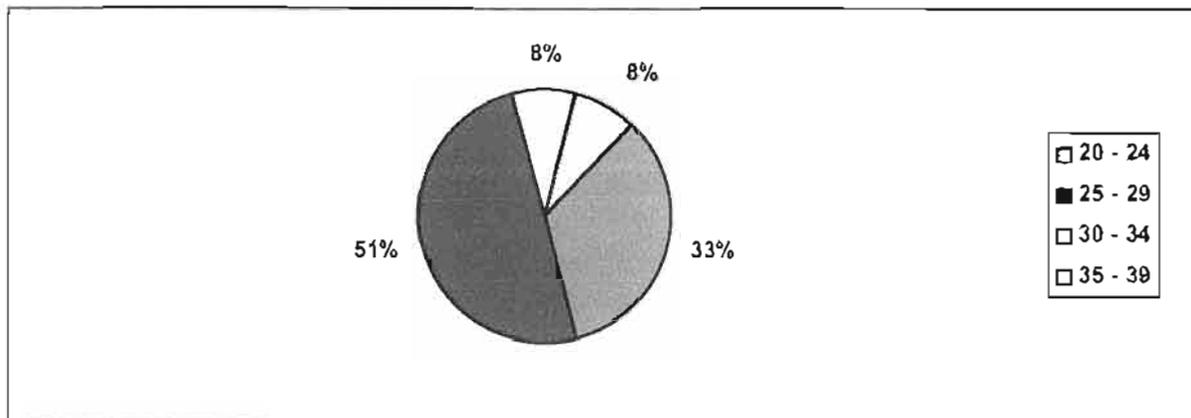
### (ii) Marital Status

All the informants (n-12) were single.

### (iii) Age

Half of the informants (n-6) ranged from 25 to 29 years, while four (n-4) ranged between 20 and 24 and one informant was between 30 and 34, and one between 35 and 39 years of age.

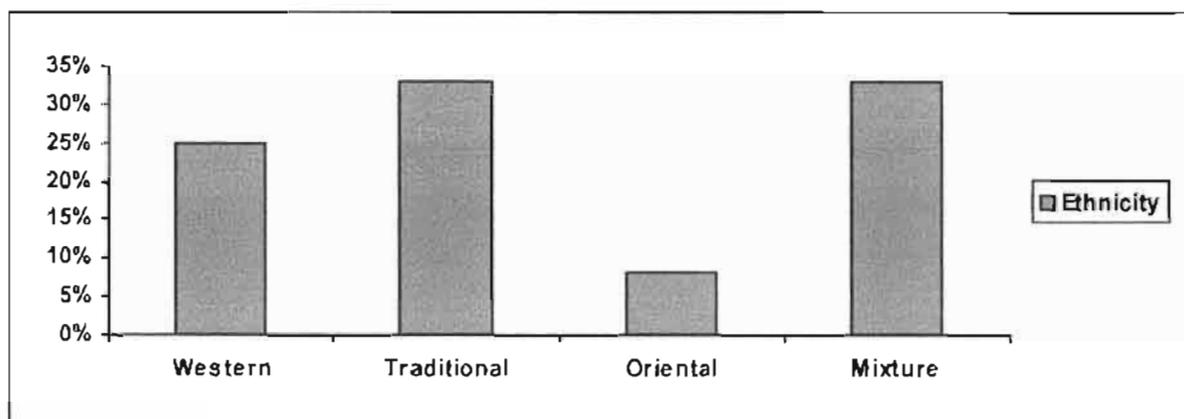
**Figure 3.1 : Pie Diagram showing age groups that were participating in the study**



**(iv) Ethnicity**

Though the researcher aimed at getting a sample which consisted of more than five ethnic groups, there were four ethnic groups that were represented in the study.

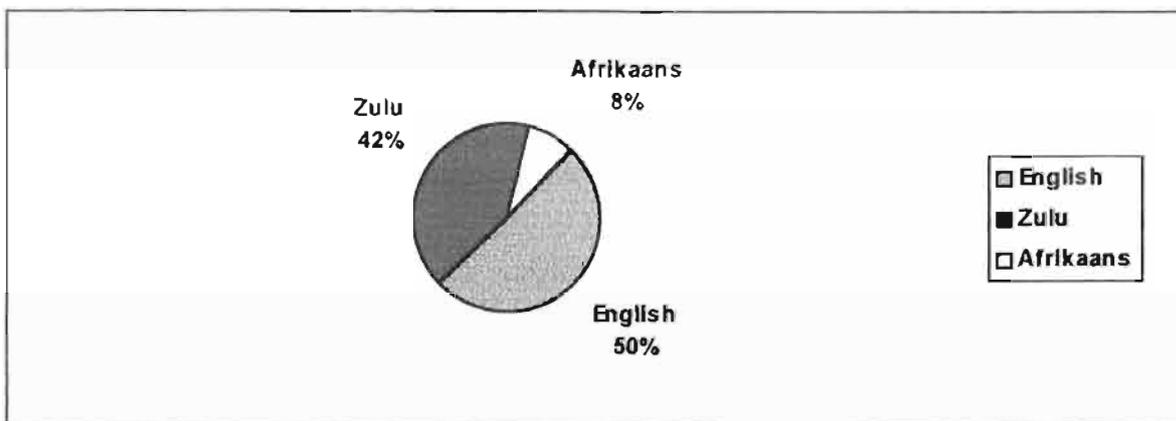
**Figure 3.2 : Graph showing different ethnic groups that were represented.**



**(v) Language**

Six (n-6) informants were English speaking, five (n-5), were Zulu speaking and one (n-1) Afrikaans speaking.

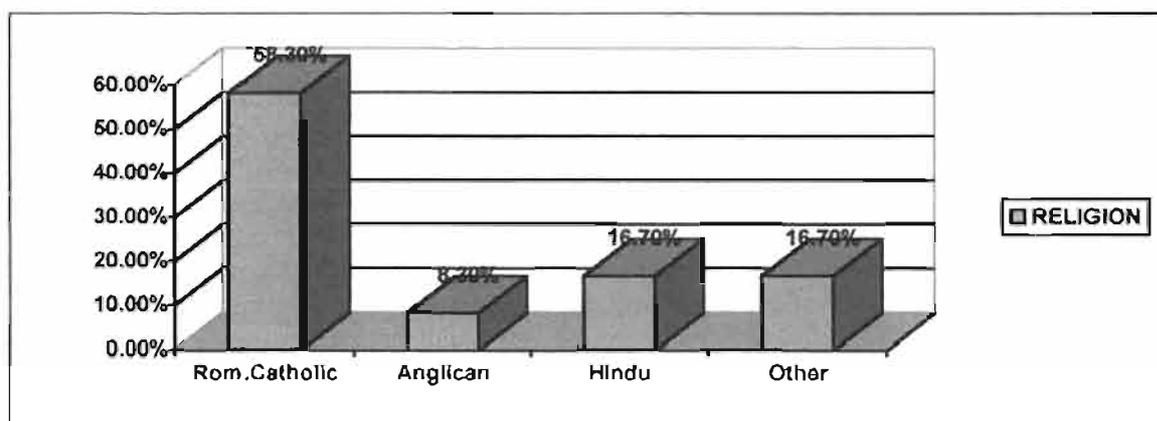
**Figure 3.3 : Pie Diagram showing different languages**



**(vi) Religious background**

Though there were few informants from other Christian denominations like Jehovah's Witness (n-1), Anglican (n-1) and Assemblies of God (n-1), the majority of the participants belonged to Roman Catholic Church (n-7) followed by those who belonged to Hindu religion (n-2).

**Figure 3.4: Bar Graph showing different religious denominations**



**(vii) Residence by birth**

Most participants (n-9) were coming from the urban areas. Only three participants were from rural areas.

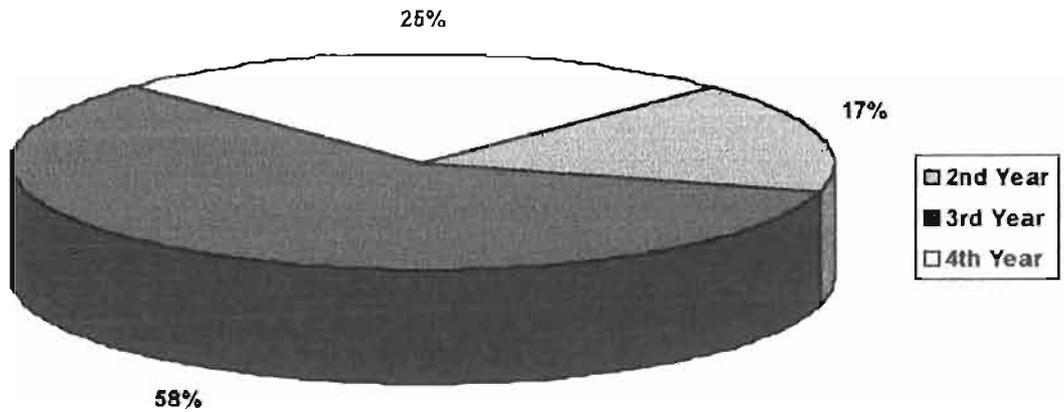
**Table 3.2 : Table showing residence by birth**

Residence by birth	Frequency	Percent %
Urban	9	75
Rural	3	25
Total	12	100

**(viii) Level of Training**

From the total sample of 12, two participants were doing their second year of study, seven were doing 3rd year and three were doing their final year of study.

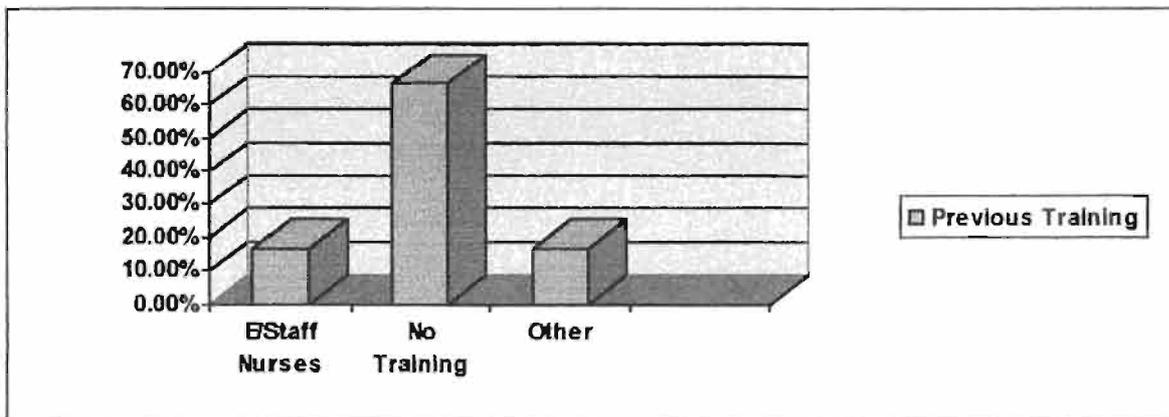
**Figure 3.5 : 3D Pie Graph showing different levels of training**



**(ix) Previous training**

Only four participants (n-4) had previous training, two have had nursing experience as they were enrolled staff nurses (n-2), one had an experience of sociology and psychology (n-1) and the other one (n-1) was computer literate.

**Figure 3.6 : Bar Diagram showing previous training of informants**



### 3.8 QUESTIONNAIRE DATA

In qualitative research, data analysis occurs simultaneously with data collection and continues until the results of the study are communicated. Qualitative analysis is non - numerical and it is the interpretation of data in order to discover patterns, themes, forms and interview transcripts, field notes, diaries, documents and other text (Wilson, 1989, p.454). The researcher in her study was guided by Tesch's method of content analysis presented in eight steps (Cresswell, 1994, p.155) when analysing the scenarios as follows :-

1. getting a sense of whole by reading through all the responses time and again and jotting down some ideas as they come to mind.
2. going through each response and thinking about the underlying meanings and jotting down thoughts in the margin.
3. making a list of all topics that emerge, clustering together similar topics and finally arranging them as major topics, unique topics and leftovers.
4. assigning codes to the topics by abbreviating them, then comparing the list of topics with appropriate segments of the text, and writing the codes next to the relevant segment. Then seeing if no new categories and codes emerge.
5. grouping of related topics to reduce the total list, then assign the most descriptive wording to the topics.
6. making a final decision on the abbreviation to each category and alphabetizing these codes.
7. assembling data material belonging to each category in one place and doing preliminary analysis.
8. recording of existing data.

Data was analysed by two coders independent of each other. The first was myself as a researcher and the other one an expert in qualitative research and possesses a Doctoral Degree in nursing. The researcher used the Statistical Analysis System (SAS) computer programme (SAS/STAT User Guide, 1990) to analyse data obtained by means of a questionnaire. Descriptive statistics that includes percentages, tables and graphs was utilised to organise and summarise the data.

### **3.9 ETHICAL CONSIDERATIONS**

Ethics aim at protecting the rights of human subjects whilst ensuring scientific research. Appropriate steps were followed to ensure that the rights of the research informants are not violated in any way and to adhere to the ethics of the research (Wilson, 1989, p.69).

#### **3.9.1 Permission**

Permission to conduct the study was obtained from the Department of Health for Kwa Zulu - Natal province and the principal of Addington Campus. For letters of permission (see Annexures E and F respectively). Furthermore, the researcher obtained permission from the participants before collecting the data. (See Annexure I).

#### **3.9.2 Informed consent**

Secondly, informed consent was obtained from the informants. Leedy (1997) cites the consideration of fairness, honesty, openness of intent, disclosure of methods, the ends for which the research is executed and respect for the integrity of the individual.

The researcher held the value of honesty and openness during the research so that participants would feel relaxed and unthreatened by the presence of the researcher. Informants were given full information about the purpose of the study. They were informed that participation was voluntary and that they had the right to withdraw or terminate their participation if they so wish. They had the right to refuse to give information or ask for clarification about any aspect pertaining the study.

### **3.9.3 Anonymity and confidentiality**

Participants were assured of anonymity in that their identity during and after the study would not be revealed. No names had been linked to the data collected. Instead the letters of the alphabet were used. Confidentiality was maintained by not sharing information with anyone other than those involved in the study. During the course of the study all the material that were used to collect data had been kept at a secret place, and were destroyed after completion of the study.

### **3.10 ACADEMIC RIGOR**

According to Brink (1993) the very nature of qualitative research does not lend to statistical or empirical calculation of validity. The researcher seeks basically the same end results which are better suited to a human subject matter. Guba's model for trustworthiness was utilized to ensure the validity and reliability of this study (Lincon and Guba, 1985, p.290). Aspects that were relevant to ensure trustworthiness are discussed below :-

### **3.10.1 Truth value**

Truth value asks whether the researcher has established confidence in the truth of the findings for the subjects and the context in which the research is undertaken. Truth value is ensured by the strategy of credibility (Krefting, 1990, p.214). The researcher tried to maintain truthfulness of the findings by focusing on the lived experiences of students. The researcher used two methods of data collection in order to validate or confirm one's own results or conclusions.

Member checking was done to make sure that data were presented and interpreted according to meanings and in the context of respondents. The researcher discussed the study continually with a colleague who is an expert in research to validate data gathered.

### **3.10.2 Applicability**

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups. It is the ability to generalize from the findings to larger populations. Since qualitative studies do not necessarily seek to generalize, applicability in qualitative research refers to whether it is fitting or transferable (Krefting, 1990, p.216). However, the researcher's aim was not to focus on the similarities that can be developed into generalizations, but to detail the many specifics that give the context its unique flavor (Lincoln & Guba, 1985). The researcher hopes that the questionnaire and the scenarios that was constructed for the subjects could be used in other settings.

### **3.10.3 Neutrality**

Guba (in Krefting 1991, p.216) asserts that neutrality refers to the degree to which the findings are a function solely of the informants and conditions of the research and not of other biases, motivations and perspectives. The researcher tried to be grounded as much as possible during the study by analyzing the data using direct quotes from the informants, so that data would not be presented as the researcher's own opinion and to control the research bias. By using a second tool (questionnaire), the researcher was able to verify with the subjects or confirm if what she had documented was really what the subjects meant.

### **3.10.4 Triangulation**

Triangulation of methods involves using a variety of data collection techniques which have been selected because each taps a different aspect or dimension of the problem being studied. Triangulation can be something other than scaling, reliability and convergent validation. It can capture a more complete, holistic and portrayal of the units under study (Morse, 1991, p.234). Besides the completeness, it enhances the quality, as well as the credibility of the study (Krefting, 1991, p.229).

In the sample of the nursing students population, students were from different levels of training, for example, 2nd, 3rd and 4th year students because the researcher believes that student's level of cultural sensitivity thus developed might vary according to each level. The researcher used two data collection methods that is, scenarios and questionnaires to collect data. Informants were given an opportunity to describe their experiences by responding to given scenarios. Also the questionnaire was given to validate or confirm ones' own results.

### **3.11 LIMITATIONS**

This research was conducted in one campus only, therefore, the results are contextualised within the campus where work was conducted. The other limitation is that the study or research that was conducted focused on one single nursing program. Thus the results are not generalisable to students following other nursing programs. Lastly, the researcher had planned to include all levels in the training of the four year Diploma from first to fourth year of study. Because of the time and financial constraints, the researcher could not get all the groups, only the second, third and fourth years who were on block during the time of data gathering were included in the study.

### **3.12 CONCLUSION**

This chapter dealt with the research methodology and the limitations of the study. The next chapter deals with the research findings, conclusions and recommendations.

## CHAPTER 4

### DATA ANALYSIS AND FINDINGS

#### 4.1 FINDINGS

The purpose of this study was to explore the extent of cultural sensitivity among nursing students in the four year Diploma at Addington hospital in Kwa Zulu - Natal Province. From the responses to the three scenarios, the following themes emerged:

##### 4.1.1 ABILITY OF NURSES TO OVERCOME COMMUNICATION BARRIERS.

Scenario 1 read :

You are allocated for a whole year in a community clinic in Mpumalanga where most of the clients are Shangaans, and you become frustrated when they speak Shangaan in your presence. You feel excluded from the conversations and uncomfortable with your role in the clinic.

- What would you do? Justify your response.

From this scenario, the informants suggested that in order to effectively provide nursing care to patients from diverse cultures, there is a need for all nurses to overcome communication barriers. Specific strategies suggested included learning the language, finding an interpreter, using non-verbal cues to facilitate communication, using a common language and transfer to another clinic.

Firstly, in the new South Africa which allows for easy immigration and emigration, learning to work with people of varied cultures is essential. According to St. Clair & McKenry (1999) traveling to other countries to experience the daily life of other people can be beneficial in increasing individual's cultural awareness and possibly move the individual towards achieving cultural sensitivity. Responses from the informants indicated that learning the main language of patients would be ideal to attempt to communicate with the community. For example, the following responses emerged :

*" I am willing to learn their language if they could teach me"*  
(Informant A, B & G)

*" I will attempt to learn the language so as to be able to communicate with them in their mother tongue"* (Informant C )

*" I would try to learn the language as I would then be able to communicate with them in their own language"* (Informant D & F)

According to Bennett's stages of development of cultural sensitivity, the individual progresses from ethnocentrism to increased cultural sensitivity following six stages as outlined in Annexure A. As highlighted by Bennett (1986), there are very few individuals that reach the last two final stages that is, adaptation and integration. Even though almost all the students indicated the need to learn the language, the extent to which the language will be learnt has been explained. This has led to two sub - categories.

The first is to learn a few words. Responses from some informants have not reached the final stage “integration” as they can learn the language to a certain extent. Therefore, they only accept that they need to learn (stage 4).

Communication for subtle affect and signals for key relationships guideposts such as respect, defense or attention are subject to a wide range of cultural expression. Therefore interpretation process must convey not only words but also information to establish relationships among nurse, patient and interpreter (Ewalt, Freeman, Stuart & Pooler). The examples of responses are highlighted below :

*“... if they could teach me phrases most often used” (Informant B, G & H)*

*“ I would ask him or her to help me learn simple words or phrases that are useful in medical understanding” (Informant E)*

*“ ... but to learn simple sentences like 'Good morning', 'How are you?', to maintain a simple conversation” (Informant L)*

The second is to make efforts to learn the language. This is one of the qualities of individuals who become successful in their intercultural interactions (Brislin, 1993, p. 210). Some informants expressed the view that they could devise means to learn the language. This shows that they have moved to a higher level of cultural sensitivity than those informants who would just learn few words, that is, adaptation stage (Bennett, 1998). Adaptation is the ability to change or adapt to another culture. One informant indicated that the aim is to become part of the clinic and avoid being uncomfortable. The ability to move comfortably across cultures reflects the highest level according to the stages of Bennett’s level of cultural sensitivity, that is, integration.

The person is not only sensitive to many cultures but is always in the process of becoming a part of a given cultural context (Bennett, 1998). Integration is believed to occur very rarely as individuals move comfortably among cultures while recognizing variations in cultural practices (Cookfair, 1996, 47). The informants in this study indicated the need for this in their responses. For example.

*"... and become part of a member of the clinic and avoid being uncomfortable"* (Informant A)

*" I will participate in conversations to facilitate my learning of the language"* (Informant C & D)

*"I would also attend a course for Shangaan lessons"* (Informant I)

*" I can even organize someone to teach me the language"* (Informant K)

Secondly, the respondents suggested that one way of overcoming communication barriers is to find an interpreter. According to Hunt & Zurek (1997) though the use of interpreters is one way to bridge language barriers, interpreters have the power to relay all or only part of the information and may put their own biases or perspectives into the interpretation of information. Therefore, it is not always appropriate to use an interpreter. It is important for the nurse to know the interpreter is competent. Roles should be clarified and materials and situations reviewed before each session.

Cheetham & Rzakowolski (cited in Shezi & Uys, 1997) contends that when translators interpret they often say that the patient is talking nonsense not understanding that it may be that very nonsense which may shed the light to a correct diagnosis. However, agencies who used interpreters for non - English speaking clients demonstrated success (Kline, Acosta & Johnson, 1980), although in contrast to the client's high satisfaction ratings, the workers reported feeling ineffective and concerned that they did not accurately convey an understanding of the clients and that clients would not return for future services.

Statements to find an interpreter were mentioned as one of the alternatives to the problem of inability to communicate with the Shangaan community.

*" I would ask for an interpreter, that is, one of the members or employees from the clinic" (Informant A & G)*

*"I will try to get an interpreter to translate if I am having difficulty with the language" (Informant F & G)*

*" I would ask for someone to interpret especially where important information is given to patients" (Informant I)*

A third strategy of overcoming communication barriers is to use non - verbal cues to facilitate communication. However, only one informant highlighted that different types of gestures and non-verbal communication can be established to facilitate communication. Body language despite the popular belief in its universality, may in fact convey quite different meanings in various cultures and thus contribute to confusion in the interpretation process.

*“ Different types of gestures and non-verbal communication can be established to facilitate easy communication Posters made of different languages should be displayed to gain co-operation” (Informant F)*

A fourth strategy is to use a common language. A few responses indicated negative attitudes showing some resistance to change as there is lack of cultural flexibility. Cultural flexibility involves changes in one’s behaviour to meet the demands of situations found in other cultures (Brislin, 1993). These responses also indicated the use of English, a common language, would be a solution to this problem of breakdown in communication.

Ewalt, Freeman, Kirk & Poole (1996) contends that even when English is the native language of both the worker and the client there may be subtle or clear confusion due to regional origins, age or racial differences. The examples of responses given by the informants were stated as follows :

*“ But if they are talking with me we must speak the common language that we both understand” (Informant G)*

*“ ...ask them to explain what they are speaking about in English” (Informant H).*

*“I would ask them also to try and communicate in English” (Informant J)*

A fifth strategy suggested by the informants involved transferring to another clinic by nurses who can’t speak the local language.

Transfer to another clinic could be an option, although this could show some rigidity on the part on the people involved in such a situation. These statements can have adverse influence on the patients thereby inhibiting the helping intent of interaction (Hein, 1980).

*“ If all fails, a request to transfer to another clinic where a language that I can speak is spoken” ( Informant D)*

*“ ... if there is no progress should ask my community sister to relocate me to an area convenient for me” (Informant H)*

**Table 4.1.**

**4.1.1 ABILITY OF NURSES TO OVERCOME COMMUNICATION BARRIERS**

- (i) Learn the language
  - Learn few words
  - Effort to learn the language
- (ii) Find an interpreter
- (iii) Non - verbal cues can facilitate communication
- (iv) Use of a common language (English)
- (v) Transfer to another clinic

#### 4.1.2 ACCOMMODATING AND TOLERATING DIVERSE CULTURES WHEN RENDERING PATIENT CARE.

Scenario 2 read as follows :

You are assigned a patient in a Maternity ward, and during the visiting hours, the whole family would come and visit the patient at the same time. They believe that every member of the family should come to give the moral support. The policy of the hospital allows only two or three members at a time in order to prevent cross infection especially to the newborn babies. When you approach the patient's visitors to explain the situation, they become angry and threaten to take their relatives home with them.

- How would you handle this situation?

In response to this, the informants indicated a recognition of the need to accommodate and tolerate diverse cultures. Strategies to achieve this included allowing relatives to come in groups, allowing patients to see relatives in the visiting or waiting room, explanation of reasons or consequences of limiting visitors, adhering to hospital rules or policies and advising the relatives to see the baby at home after discharge.

Chrisman (1986) states that negotiation is one of the basic principles of culture sensitive care. Negotiation signifies the willingness and ability to work actively with the patients perspectives. Negotiation involves three (3) steps

- ◇ Listen carefully to the patient's perspective concerning the contrast in care.
- ◇ Explain your perspective using terminology with which you (nurse) and the patient are comfortable.

- ◊ Compare the two views emphasizing both the areas of agreement and disagreement.
- ◊ Arrive at a compromise that changes your position while encouraging the patient to do the same until a workable and safe plan can be determined. This approach depends upon nurse - client mutual respect.

According to Leininger (1998) cultural care accommodation or negotiation refers to those assertive, supporting or enabling professional actions and decisions that help clients of a particular culture to adapt to or negotiate for a beneficial or satisfying health status. The first three categories form the basis of negotiation which is a set of guidelines to culture - sensitive care.

The first category involved, allowing relatives to come into patient's ward in groups. Some informants expressed the view that they would reach a compromise. While they would adhere to the policy of the hospital, they would allow patients to come in groups of two or three. The following examples illustrate :

*" If there is more than three visitors, there is a visitor's lounge in which they can sit and each can have a chance of visiting three at a time while the others wait" (Informant B, C, F, G & J).*

*" Ask her (patient) to request from the family that they only come in 2 at a time. Try to reach a compromise - all the relatives may come to hospital but only 2 at a time should be allowed entrance for 5 - 10 minutes at a time" (Informant D).*

*“ They should alternate three members at a time and eventually everyone can give their support 15 - 20 min. apart.” (Informant H)*

The second category involved, allowing the patient to see relatives in the visiting or waiting room and only one response chose this option.

*“ If the entire family wish to see the patient then I would advise the patient to sit with the relatives in the visiting or waiting area away from the other patients” (Informant L)*

The third category involved explaining the reasons for limiting visitors. An attempt to negotiate has been shown by most responses. This include explaining to the patients or relatives the reasons or the consequences for not allowing only few numbers to visit the patient. Some informants stated that they would tell them the reason but did not mention them, while other informants explained the reasons. The following were some of the strategies suggested :

*“ Explain importance of patient and baby staying in hospital and that this is not for your benefit but for the benefit of the patient and her baby. Explain the dangers, complications of actions etc. to the patient and try make her understand importance of compliance” (Informant D)*

*“ ... I would also explain to her about the importance of remaining in hospital with baby until they are discharged by their duty doctor. I would also explain about cross infection to newborn babies and tell the relatives that baby could pick up something from them and get sick” (Informant A, J & H)*

*"I would explain that newborns are prone to infection because they are still young and immunity is low"* (Informant B & C)

The fourth category involved adhering to hospital rules or policy. This group of responses from some informants demonstrated lack of cultural sensitivity when they put into consideration only the rules and policies of the hospital. To illustrate some of the responses stated :

*" ... They must try and understand hospital policy and the treatment of patients in equality. I would stress the importance of patient's need for medical care and compliance"* (Informant E)

*" I will be assertive but not aggressive to calm them down and to see that I am only being fair"* (Informant A)

*" I would explain the reasons for restricting visitors and I would give written pamphlets for them to read"* (Informant I)

*"I will set limits. I will tell them it is not for them to decide if the patient can stay in hospital or not the patient can decide. I will tell them hospital has rules only to protect patients not to relatives"* (Informant K)

The fifth category involved advising the family to wait to see the baby at home after discharge. A few informants felt that the relatives could wait and provide support at home after discharge. Their responses were :

*" ... or other relatives they can visit the child at home more especially the extended family"* (Informant G)

*“ Also make them aware that the mother will return home with the baby and then they will have enough time to visit” (Informant J)*

**Table 4.2**

**4.1.2 ACCOMMODATING AND TOLERATING DIVERSE CULTURES WHEN RENDERING CARE**

- (i) Allow relatives to come in groups
- (ii) Allow patient to see relatives in the visiting or waiting room
- (iii) Explanation of reasons or consequences of limiting visitors
- (iv) Adhere to hospital rules or policies
- (v) Advise to see baby at home after discharge

The responses to this scenario revealed differences in how the informants perceive health and health care practices. For instance, category 1 was chosen mostly by Indians and few Africans, while categories 4 and 5 were chosen by Whites and Africans. According to their demographic data the informants that demonstrated some flexibility in accommodating the patients also chose the holistic health belief system. The responses to this scenario provide evidence that cultural practices can create discrepancies between the patients and nurses' concept of what constitute good health practice. While nurses believe in adhering to hospital rules this can result in lack of effective care and abandonment of the system by the patients. Middle ground is achieved when the nurse practices sensitivity, obtains knowledge and practice skillful implementation of culturally sensitive care (Hunt & Zurek, 1997, p.95).

### 4.2.3 ATTITUDES OF NURSES TOWARDS PATIENTS OF DIVERSE CULTURES

Scenario 3 read :

You are working in a pediatric ward. Whenever you are conducting prayers in the unit, one child (patient) would keep her eyes open. One day you heard one of your colleagues talking to this child, instructing the child to close her eyes when talking with the Almighty. After this, the nurse came and was labeling the child as "silly" and "disdainful".

- What are your views regarding this situation and why?
- How would you respond or react to this situation?

Responses to this suggest that the nurses' attitudes towards patients of diverse cultures are important elements of providing adequate care to all patients. Strategies they suggested include rejection of ethnocentric attitudes, recognition of cultural differences, respect of other cultures, collection of more data, interpretations of child's behaviour.

Firstly, the responses to this scenario indicated strong sympathy with the child and rejection of the nurses' ethnocentric response. The following responses illustrate :

*" I would not be judgmental and ridicule her (the child). Talk to the nurse who refers to the child as "silly" and explain to the nurse that it is a child who might not understand that what is being done is not correct according to dictations of society. Ask the nurse to have an open mind and not to label the child or show any prejudice actions towards the child" (informant D)*

*“ I would speak to the nurse not to label the child as ‘silly’ as this is being judgmental” (Informant E)*

*“We must not force our religion, beliefs and values onto others. I would approach the nurse and tell her that is not ethical to label patients or to force our religion, beliefs and values onto others” (Informant I & L)*

*“The nurse is ethnocentric because she thinks that because she is a Christian everyone must be a Christian. So I will remind my colleague that it is not for her to decide if the child is silly or not” (Informant K)*

The second strategy suggested involved recognition of cultural differences. Informants expressed the view that the child's behaviour may have been due to differences in religious beliefs. Some even expressed the view that the child may not be a Christian. For example, the following three examples illustrate :

*“ The child may not even be a Christian” (Informant C)*

*“ I believe that every person has a right to freedom of religion or believe what they want e.g. atheists, agnostics etc.” (Informant E)*

*“ Each child has his different ways of praying” (Informant F)*

*“ I feel that may be this child was not socialized into prayers and may come from a different cultural background where they do not pray or have different religious practices” (Informant H)*

However, one informant wrote *“ children are God's children”*.

According to Bennett (1986) this assumption falls in stage three, that is, minimization and is referred to as "transcendent universalism". Here cultural differences are recognized and tolerated to some degree. Transcendent universalism suggest that all human beings, whether they know it or not are the products of some transcendent, principle, law or imperative, for example, all people are creations of a particular entity of force.

A third strategy suggested is to respect other cultures. The majority of informants expressed the view that even though there are some differences in cultures, they respect other people's cultures. Chrisman (1986), mutual respect is a goal toward which the cross cultural nurse strive in interactions with the clients. By open valuing of self and client, the nurse can achieve this goal.

Respecting other person's views, opinion, culture, Bennett (1986), determines that the individual has reached stage 4 (acceptance) level of cultural sensitivity. The following responses illustrate :

*" I would respect the child's view and honor it by allowing her to carry on doing so "* (Informant B)

*" The child has a right to be respected "* (Informant E, G & J)

*" I would tell her the importance of respecting other people's beliefs "*  
(Informant I)

A fourth strategy is to collect more data regarding the patient's behaviour. According to Chrisman's' theory, the nurse should do socio - cultural assessment. A socio - cultural assessment consist of three interview segments each keyed to components of the health seeking process.

- ◇ The explanatory model which seek knowledge of the patient's illness, beliefs when is relating to the health seeking components of system's definitions, treatment action and adherence.
- ◇ Then follows a question about the patient's social network of family and friends who have been involved in the illness episode. These data relate to the lay consultation and referral component.
- ◇ The patient is asked about her or his range of daily activities and obligations and these data are related to the role shift component.

The following responses to the scenario illustrate :

*" I would take the child aside and ask questions. Ensure that the child is used to me and trust me and encourage her to talk "* (Informant A)

*"She should have waited and find out from the child the reason why the child open eyes during prayer "* (Informant G)

*" I would investigate why the child refuses to close her eyes during prayer. would find out what faith she belongs to in order to meet her needs. I would also find out what pattern of prayer she follows, if at all any "*  
(Informant L.)

Other than differences in cultural backgrounds, the informants felt that there might be other reasons that contribute to the child's behavior. Therefore, from this category, sub - categories emerged.

First, the child could have a short attention span :

*" This is a child who at the best of times could have a low attention span"*  
(Informant D)

*" The child could also have a short attention span"* (Informant H)

Secondly, the child's behaviour could result from lack of knowledge :

*" Maybe is unfamiliar to the child as at home , prayers are conducted differently and the whole procedure is strange to the child and is trying to see what is going on around her"* (Informant D)

*"I feel that maybe the child was not socialized into prayers"*  
(Informant B, E & H.)

*" We as nurses should accept that maybe the child (patient) does not understand the concept of God and prayer and we should not label him or her due to this"* (Informant J)

**Table 4.3**

**4.1.3 ATTITUDES OF NURSES TOWARDS PATIENTS OF DIVERSE CULTURES**

- (I) Rejection of ethnocentric attitudes
- (ii) Recognition of cultural differences
- (iii) Respect other cultures
- (iv ) Collect more data
- (v) Interpretations of child's behavior
  - Short attention span
  - Lack of knowledge or understanding

## **4.2 ANALYSIS OF QUESTIONNAIRE DATA**

The researcher chose to use a questionnaire in order to determine facts about subject's beliefs, attitudes, opinions and level of knowledge. The questionnaire consisted of four sections. The first section dealt with the demographic data detailing sex, age, marital status, residence by birth, ethnic group, language, level of training, previous training as shown in chapter 3. The second section identified the nurses' views about health and illness. The third section determined the nurses' cultural beliefs. The last section consisted of terminology and aimed at assessing the nurses' level of knowledge of cultural concepts.

### **4.2.1 INFORMANT'S VIEWS ABOUT HEALTH AND ILLNESS**

A little more than half (n-7) of the responses regarding their health belief system showed that informants believe in holistic approach whereas (n-5) believed in scientific approach. Illness according to the majority of the informants (n-8) is due to multiple environment interaction, while three (n-3) indicated that illness is due to a breakdown in the human machine and one informant was uncertain about the cause of illness (n-1).

### **4.2.2 INFORMANT'S CULTURAL BELIEFS**

This section used 5 point Likert scale which reflected the informant's responses from strongly agree to strongly disagree. Scores ranged from 1 - 5 and indicated the extent to which nurses are culturally sensitive by exploring their beliefs and attitudes about nursing patients from different cultural backgrounds.

Informants answered each item by choosing one out of 5 alternatives, a format proposed by Likert (1932) as part of his attitude scaling method. The five alternatives were : - 1) strongly agree, 2) agree, 3) uncertain, 4) disagree and 5) strongly disagree. Twelve statements were provided in which the informant were asked to respond to.

⇒ **Statement 1**

*"In nursing, it is not worthwhile to focus on one's own cultural values and social norms because only the client matters"*

Results :

More than half (n-7) the number of the responses did not agree with the statements. n-4 strongly disagreed and n-3 disagreed.

This means that there is quite a number of responses that did not support this statement because focusing on one's own cultural values and social norms instead of those of the patient would contribute to the nurse imposing these onto the patient (cultural imposition).

⇒ **Statement 2**

*"Being of diverse culture in our society takes strength. I am aware of my own bias and prejudice and that I need to work on my understanding and attitude"*

Results

Most responses were supported with n-4 strongly agreeing and n-6 agreeing statements.

⇒ **Statement 3**

*"Treating people differently because of religious, ethnic, cultural or other characteristics implies prejudice and discrimination"*

## Results

Responses did not support this statement. Patients have the right to be treated as unique human beings and treating all patients equally would imply treating some poorly (Troskie, 1998). The rights of patients to be treated as unique beings are often hampered by a commonly accepted belief in medicine and nursing that patients should be treated equally. Even teachers by treating pupils all the same and by ignoring cultural and racial differences, teachers run the risk of perpetuating ethnocentrism, prejudices and stereotypes in the education (Leimner & Squelch, 1993). Most of the informants (n- 8) agreed strongly and one agreed.

### ⇒ Statement 4

*“ Minorities must adapt to the dominant culture's institution rather than the institution adapting to the needs of the minority group or individuals”.*

## Results

Most responses were supporting this statement as the majority disagreed strongly (n-7) and n-3 agreed. Very few informants (n-3) showed a bit of resistance to change or lack of cultural flexibility.

Lemmer & Squelch (1993) refers to this as the assimilation theory whereby a monocultural policy in terms of which minority groups are absorbed into the mainstream of the dominant culture. People are expected to adopt the language, values and cultural modes of the dominant group. During the apartheid era, in 1950s, the policy of assimilation prevailed despite the cultural diverse nature of societies due to racism (Le Roux, 1997).

### ⇒ Statement 5

*“ One can 'sense' another culture's needs without having to learn about its social organization and social processes”*

## Results

Six informants showed supporting responses towards this statement. Only one who agreed strongly, three agreed, one disagreed strongly, and five disagreed, and two were uncertain.

One has to adapt and learn another persons' culture, rather than "sensing" or assuming.

### ⇒ Statement 6

*" Different ethnic and cultural groups deserve to have their civil rights protected even though I may be uncomfortable about their culture and lifestyle "*

## Results

Informants supported the statement about the rights of patients. Five(5) strongly agreed and six (n-6) agreed.

The civil rights movement emerged in the 1960`s with the aim of eliminating discrimination in all spheres of society (Lemmer & Squelch, 1993, p.3).

### ⇒ Statement 7

*"The diversity of people is the valuable thing (all groups e.g. Africans, Coloreds etc.) are a valid part of that diversity. Therefore I am involved in combating cultural discrimination and bias in workplace "*

## Results

Most of the informants responded by supporting this statement as they showed acknowledgment of differences in cultures. (n-5) strongly agreed and (n-6) agreed.

### ⇒ Statement 8

*"Individuals from different ethnic or cultural groups should be accepted as they are (e.g. You are not a Black person to me, you are just like all of us) "*

## Results

Almost all the informants supported this view (n-10) agreed strongly, (n-1) one agreed. Only one (n-1) who disagreed strongly. Accepting patients as they are, also means respecting them as unique individuals and as such nurses put into consideration the fact that ethnic groups have their own culturally prescribed beliefs and practices related to health.

### ⇒ **Statement 9**

*“Altering care or treatment procedures to accommodate cultural variables is unnecessary because any person can adapt”.*

## Results

Responses from this statement supported the idea of altering care and treatment procedures with five (n-5) of them strongly disagreeing and n-5 disagreeing. One response (n-1) agreed and one (n-1) strongly agreed.

One of the characteristics of cultural sensitivity according to Bello (in Clark, 1984, p.265) involves modification of nursing care to incorporate folk health practices whenever feasible.

### ⇒ **Statement 10**

*“Cultural diversity is indispensable to our society. Diversity is a gift to all of us. I have deep affection for particular culturally diverse individuals and I delight in their individuality and their gifts. I work as their advocate”.*

## Results

Five informants (n-6) strongly agreed, four (n-4) agreed showing higher support for this statement.

Cultural differences exist in the health care setting because of ethnocentrism as nurses have a tendency of bringing their ethnocentrism into their jobs, thereby imposing their values beliefs and patterns of behaviour upon their patients and clients (Leininger, 1991).

⇒ **Statement 11**

*“ Ethnocentrism and separatism is a mature way of life. Segregation of cultures should be encouraged and reinforced”*

Results

Most of the informants (n-7) strongly disagreed and one (n-1) disagreed to the given statement. The responses did not support as they were opposing ethnocentrism.

⇒ **Statement 12**

*“Folk systems need to be incorporated into professional approaches to nursing care”.*

Results

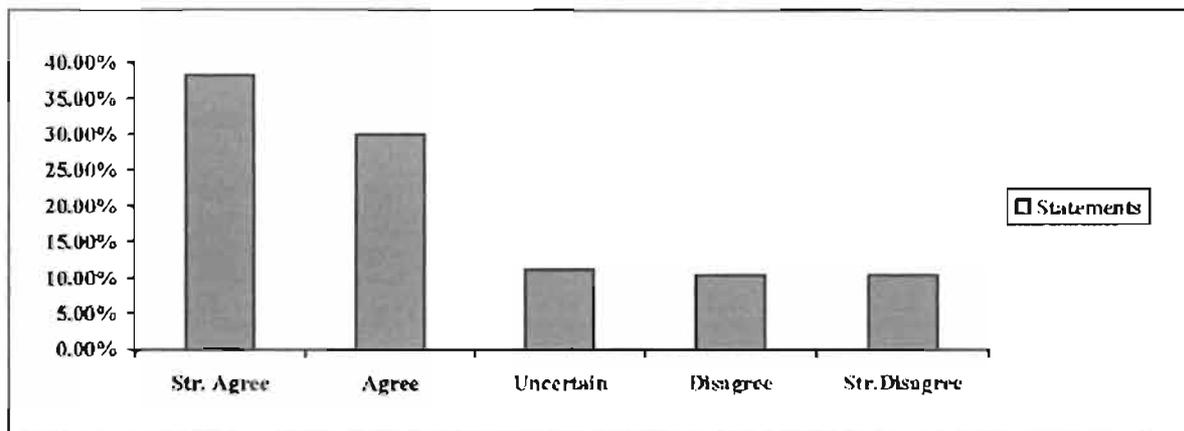
Only two (n-2) agreed or accepted the view that folk systems need to be incorporated in professional approaches. The majority of the informants were uncertain with (n-7) and only three disagreeing.

Cheetham & Griffiths (cited in Shezi & Uys, 1997) states that the African concept of illness embraces biological, social, religious and magical factors. Symptoms from disorders are generally shaped by local beliefs, norms and general patterns of living. Dobson (1991) maintains that nursing has always stressed the importance of rendering culturally conscious care that respects individual's differences and incorporates one's own values, beliefs and lifestyles and practices into the delivery of health care.

### Results of the twelve statements

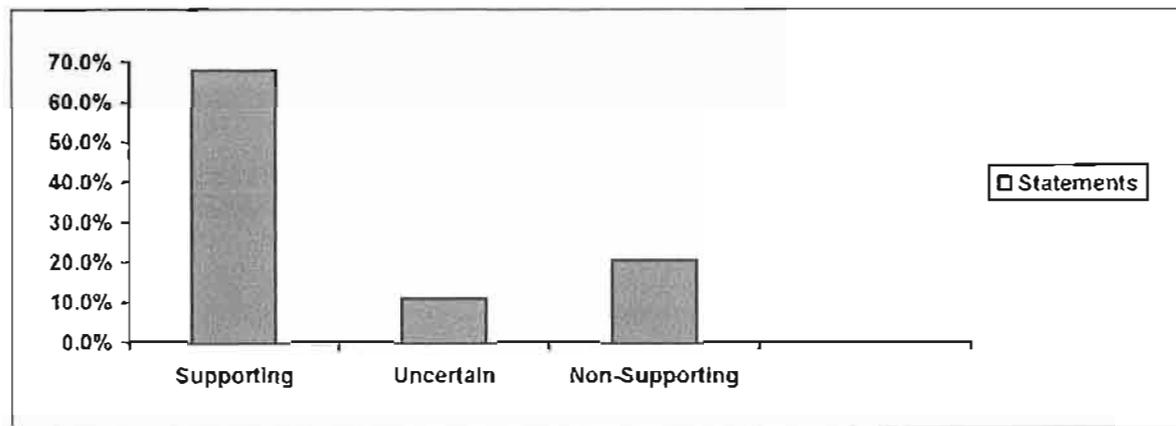
Generally, there were a lot of statements that were supported than those that were not supported. Only three (25%) statement were not supported, one was neutral as the results indicated uncertainty ( 8,3%) and eight (66,6%) of the responses were supporting the statements. Figure 4.1 illustrates the results, supporting statements include both agreeing and strongly agreeing responses, whereas non-supporting statements include disagreeing and strongly disagreeing statements.

**Figure 4.1 Attitudes and beliefs of nurses towards patients of diverse cultures.**



Generally there were responses that supported the statements on attitudes and beliefs of nurses towards patients of diverse cultures than those that were not supported. (68,1%) of the responses were positive, (20,8 %) were negative and (11,1 %) of responses indicated that the informants were uncertain as shown in the Figure 4.2.

**Figure 4.2 Supporting versus non-supporting statements**



### **4.2.3 : INFORMANT'S UNDERSTANDING OF CULTURAL CONCEPTS**

The informants were asked to show their understanding of the cultural concepts that are commonly used. Five concepts were asked, for example, stereotype, cultural imposition, ethnocentrism, prejudice and labeling.

#### **4.2.3.1 Stereotyping**

##### **Results**

Responses to this concept indicated that all the informants (n-12) had the understanding of this concept. The responses included :-

*“ my own opinion and understanding of another person's culture or towards an individual” (Informant A)*

*“ when you place a group within a certain category according to past experiences and involvement with others in the group” (Informant B)*

*“people are judged before knowing them and are not given a chance to prove themselves” (Informant C)*

*“people are judged before knowing them and are not given a chance to prove themselves” (Informant C)*

*“This is when one generalize about a certain issue e.g. All Whites are racists” (Informant K)*

#### **4.2.3.2 Cultural Imposition**

##### **Results**

Results show that few students had the understanding of this term. Three (n-3) did not know the concept, while four (n-4) did not provide any answer. Only five (n-5) showed some understanding of this concept. The following are some of the examples given by the five (n-5) respondents who showed some understanding of the concept.

*“ this is enforcing my culture on to the next persons” (Informant A)*

*“imposing your culture onto another to either sway them onto your views”  
( Informant B)*

*“ trying to force your own culture on that of another person) (Informant D)*

The following are examples of the respondents who did not know the term cultural imposition.

*“your cultural values and beliefs” (Informant F:)*

*“ this is when one ' culture is not considered” (Informant I)*

#### 4.2.3.3 Ethnocentrism

##### Results

Most responses (n = 10) understood the concept ethnocentrism. Two informants did not provide answers. The following examples illustrate the informant's understanding of this concept.

*" my belief that my culture is better than any other"* (Informant A)

*" a feeling of superiority to other cultures and people"* (Informant D)

*" when one believes his or her culture is the best and look down on other cultures"* (Informant I)

*" the belief that one's own culture is better than all the rest. Have a way of looking down on other cultures, feelings of superiority"* (Informant H)

#### 4.2.3.4 Prejudice

##### Results

All the students (n=12) had an understanding of the concept prejudice. The following are some of the examples that illustrate the informant's understanding.

*" a dislike for other age groups, other sex or culture for no reason"*  
(Informant C)

*“ to discriminate according to culture, age or race e.g. not showing interest in old patients” (Informant F)*

*“ dislike or negative reaction towards another race, age, sex (Ageism, racism, sexism shown in the way patients are treated.) (Informant G)*

#### **4.2.3.5 Labeling**

##### Results

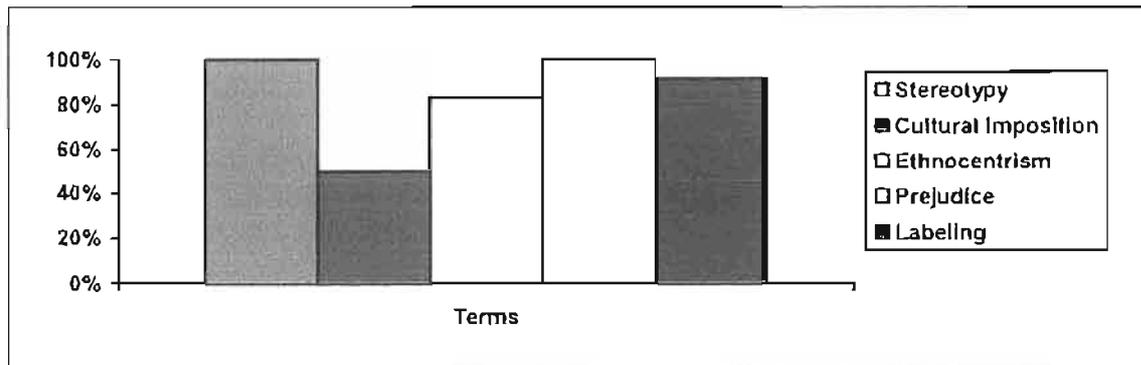
Eleven (n=11) informants showed understanding of the concept. only one (n=1) who did not know this concept. The responses included the following :

*“ to judge a person or a group and analyze them and assign certain labels to them” (Informant E)*

*“ means calling a person by names e.g. prostitute if she suffers from sexually transmitted disease” (Informant I)*

*“this is a form of adopting another name to a person, such as labeling someone as a miser because he is wise with his money. (Informant L)*

**Figure 4.3 Knowledge of cultural concepts**



#### **4.2.4 CULTURAL FACTORS THAT PLAY A ROLE IN HEALTH - ILLNESS CONTINUUM**

Informants were asked to show their knowledge and understanding of cultural factors that play a role in the health - illness continuum. One informant did not have any understanding of these cultural factors. However, some had an understanding with answers ranging from two to eight. Factors that were provided by the informants include language difference, customs, norms, beliefs, values, religion, food and eating habits, dress code, reaction to pain and death, folkways, cultural sanctions or restrictions, ancestor worship, belief in God, use of magic, sorcery and witchcraft, rituals, scientific base.

## 4.3 INTERPRETATION OF THE FINDINGS

### 4.3.1 Findings from the scenarios

#### \* Scenario 1

Scenario 1 simulated difficulty in communication. Informants demonstrated positive responses as they stated that learning the language will be ideal. All the informants expressed this as the first option. Other responses were given as alternatives including finding an interpreter, non-verbal means of communication, using a common language and transfer to another clinic.

The use of a common language and transfer to another clinic were viewed as negative alternatives by the researcher as these options show some resistance to change. Almost all the informants reached level 5 (adaptation) of Bennett's stages of development as learning the language was the first option. However one informant reached the highest level. (integration).

#### \* Scenario 2

The informants were expected to demonstrate their cultural understanding as applied to nursing. This scenario focused on the ability of nurses to accommodate and tolerate other cultures. Most of the informants responded positively by reaching a compromise of allowing two or three visitors at a time. One informant indicated that the patient could go and see relatives in the visiting or waiting room. Very few informants showed some lack of cultural knowledge by stating that they would adhere to the hospital policy or rules.

According to Bennett (1986), most informants' responses tallied with stage 5 (adaptation) as they indicated that they would respect and adapt to accommodate the visitors. Very few (n=4) responses tallied with stage 3 (minimization) as they ignored the patient's values and did not acknowledge as important. Their failure to compromise and put into consideration only the hospital rules or policies indicated some rigidity and therefore lack of sensitivity to other cultures.

Another option according to the researcher could have been putting the patient in the side ward as the state of the condition is not stated in the scenario, but none of the informants made mention of this option. All the informants assumed that the patient is already up and about during the stage of ambulating.

#### \* **Scenario 3**

Informants were asked to respond to the negative attitude emanating from the perception of a nurse towards a child (patient). This resulted in the nurse imposing her or his cultural values onto the patient. Responses to this scenario were very positive as most of the informants disapproved of this behavior, rejecting the ethnocentric attitudes. They recognized differences in cultures as they stated that the child may belong to other religious organization or may be atheistic.

Responses tallied with the highest level (integration) as they never indicated any discomfort in the child's behaviour.

### **4.3.2 Findings from the questionnaires**

#### **4.3.2.1 Views about health belief system and illness**

Many informants believe in holistic approach whereas a few believe in science only. This is supported by their responses about how they view illness.

A majority of informants believe that illness is due to multiple environment interaction, a few believe that illness is due to a breakdown in human machine. One informant was uncertain about the cause of illness.

#### **4.3.2.2 Cultural beliefs**

This section explored the attitudes and beliefs of nurses about nursing patients from different cultural backgrounds. Results revealed that there were more responses that supported most of the statements. Out of twelve statements, only three statements were not supported adequately, on the average Statements 1, 3 and 12).

Statement 1 reads : *"In nursing, it is not worthwhile to focus on one's own cultural values and social norms because only the client matters"*

Focusing on one's own cultural values and social norms, not on the patient would imply that nurses might be ethnocentric, prejudiced, stereotyping, labeling and impose their values onto the patient. 58% of the informant's responses are still on stages one (denial) and two (defense) whereby one's own view is unchallenged and seen as central to all reality.

Statement 3 reads : *"Treating people differently because of religious, ethnic, cultural or other characteristics implies prejudice and discrimination"*

Literature reveals that people have a right to be treated as unique beings as treating all patients the equally would imply treating some poorly (Troskie, 1998).

Responses indicated lack of appreciation of people as unique beings. They believe in treating the same irrespective of their cultural backgrounds. According to Bennett (1986), this belief might perpetuate non- acceptance and respect of behavioral differences and underlying value differences as a result cultural differences will never be accommodated even if they might be recognized.

Most of the responses tallied with Bennett's level 1, 2 and 3 (denial, defense and minimization) respectively.

Statement 12 reads: *Folk systems need to be incorporated into professional approaches to nursing care "*

Only two responses accepted this view as the majority were uncertain and a few disagreed strongly. Literature revealed that people experience health and illness in a cultural way. Therefore, ignoring their belief systems could lead to the patients not reaching their optimum level of health. the majority of responses tallied with level one (denial) as this signifies that there is no insight into the existence of differences in culture.

#### **4.3.2.3 Knowledge and understanding of cultural concepts**

The informants were expected to demonstrate their knowledge and understanding of cultural concepts. Five cultural concepts were asked. Responses were positive ranging from 50% to 100% as shown in figure 4.3.

#### **4.3.2.4 Factors that play a role in health - illness continuum**

Informants were asked to identify the factors that play a role in health - illness continuum. Generally the response was positive, informants identified the concepts ranging from two to eight factors. Only one informant who had no idea about the cultural concepts.

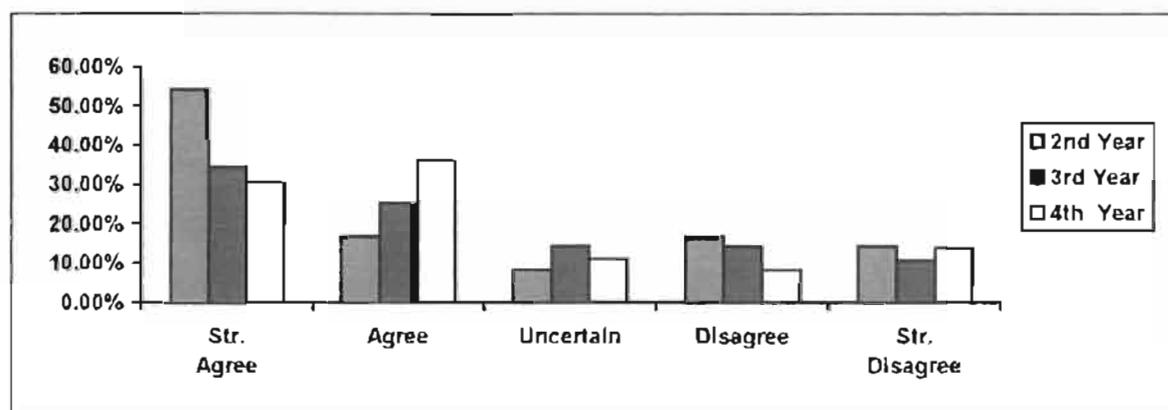
### 4.3.3 Findings related to level of training

Results revealed by this study shows that there is no relationship between the extent of cultural sensitivity and the level of training as illustrated by figures below. There were two nursing students who were doing second year (Informants A and B); seven were on their third year of training (Informants C,D,E,F,G,H and I); three students were on their fourth year of study ( Informants J,K and L).

#### 4.3.3.1 Cultural beliefs

Regarding the cultural attitudes and beliefs, figure 4.4 shows that more supporting statements were expressed by the second years instead of the fourth years as expected. Supporting statements include strongly agree and agree statements. Non-supporting statements include strongly disagree and disagree statements.

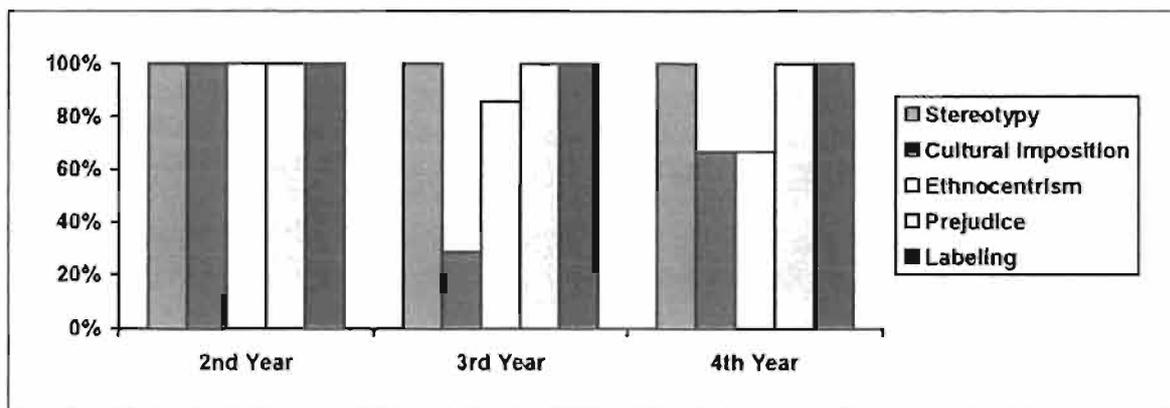
**Figure 4. 4 Cultural attitudes and beliefs of various levels of students**



#### 4.3.3.2 Understanding of cultural concepts

More knowledge and understanding of cultural concepts was demonstrated by the second years. Second years scored highest of all these groups with 100% of all the five concepts asked.

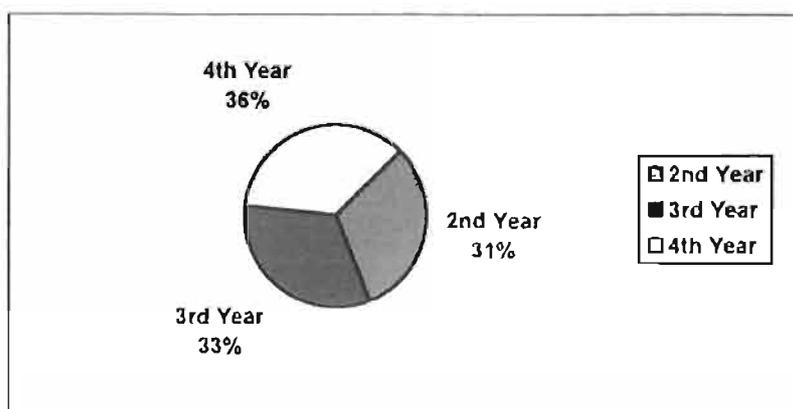
**Figure 4.5 Understanding of cultural concepts among various levels**



### 4.3.3.3 Factors that play a role in health - illness continuum

Informants were asked to identify cultural factors that play a role in health - illness continuum. Results revealed that Informant C who did not know anything about these factors belonged to third year. On the average the second years identified 4 (31%) factors, third years 4,2 (33%) and fourth years identified 4,6 (36%) factors. Figure 4.6 illustrates the findings.

**Figure 4.6 Cultural factors that play a role in health - illness continuum**



#### **4.3.4 Findings related to previous training**

Out of 12 informants, 4 informants had previous training. Three were in their third year of study (Informants C, F, and I), two were enrolled staff nurses and the other one had computer literacy. One informant (B) had previous knowledge of sociology and psychology. Therefore, more informants with experience belonged to third year and according to the findings, this did not show or did not have any influence on the results.

### **4.4 RELATIONSHIP OF THE STUDY WITH THE THEORETICAL FRAMEWORKS USED IN THE STUDY**

#### **4.4.1 Social Identity Development Theory**

Social identity development theory describes the attributes that are common to the identity development process for members of all groups. This theory shows that people move neatly from one stage to another though at times people experience several stages simultaneously. This model is helpful to understand the students as they move from one stage to another in the profession of nursing. It helps the nurse educators to select instructional strategies for nursing (Adams et al. 1997).

- **Stage I - Naive /No Social Consciousness**

Socialization is a life -long process starting from birth to death. As a child is born into a particular socio-cultural context, he or she learns who he or she is, who other people are. By the time a person is admitted as a nurse, he or she comes with the messages he or she has been taught or acquired consciously or unconsciously from mainly parents, teachers, peers, religious organizations.

Of - course nurses have no **knowledge** about the profession, its values, norms and expectations when they join nursing. They bring their prejudices, stereotypes, and racial attitudes which they have acquired from those who have been around them. They depend on the nurse educators and other role models for them to learn the values and norms of the profession and unlearn those that they have brought in (Adams et al, 1997).

- **Stage II : Acceptance**

Nurses at this stage are expected to learn to adopt an ideology or belief system of the nursing profession. They learn that the profession of nursing is guided by Acts, rules and regulations that approve or disapprove and even prohibit certain behaviors. As they have accepted the messages about the nature of their group identity, it becomes difficult to unlearn their dominant world views. However, if learning during the socialization process is powerful, pervasive and consistent, it becomes inevitable (Adam et al. 1997).

- **Stage III : Resistance**

Nurses experience difficult emotions during this time as their accepted identity comes to scrutiny and are afraid of and uncertain what the implications of self - examination will be. Nurses reject earlier social positions and formulate a new world view. They develop an awareness of their social identity but one which is not necessarily positive. They negotiate the conflict between their own values and profession`s definitions of appropriate behavior so that they move towards a new identity (Adams et al, 1997).

- **Stage IV : Redefinition**

At this stage nurses develop a positive definition of their social identity and identifying aspects of their culture and groups that are affirming as necessary parts.

They begin to acknowledge that all groups are unique and have different values that enrich human life and as such there is no better culture or social group than the other. They learn to see a patient as a unique being whose health care needs are different from the other patients. They respect the patients and do not see themselves as superior to them (Adams et al, 1997).

- **Stage V : Internalization**

The norms and values of the profession are internalized and integrated within ones' total identity. The new identity that has been developed is incorporated into all aspects of everyday life and become spontaneous (Adams et. al, 1997).

Annexure B illustrates the Stages of Social Identity Development by (Hardiman & Jackson, 1992).

#### **4.4.2 Stages of development of cultural sensitivity**

Bennett (1986) has provided a frame of reference for this study. Bennett has outlined the progression from ethnocentrism to increased cultural sensitivity typically following six stages ( See Annexure A). As the nurse develops or increases her or his level of cultural sensitivity, he or she progresses from stage 1 to stage 6.

- **Stage 1 : Denial**

At this stage cultural differences are not recognized. The nurse represents the ultimate ethnocentrism whereby ones' own world view is unchallenged as central to all reality. This has been demonstrated in scenario 3. The nurse has no insight at all of the existence of differences in cultures. Almost all the informants were against the labeling of patients as such they seemed to have past this stage.

Although some of the responses in the questionnaire showed that there are students who are still at this stage, for example, their responses in statements 1,3 and 12 reflect that they have negative attitude and prejudice against other cultures.

- **Stage 2 : Defense**

At this stage the nurses recognize different cultures but they see their culture as superior to that of patients as a result they tend to impose their own values onto the their patients (cultural imposition). From both tools, responses reveal that a few informants are still at this level.

- **Stage 3 : Minimization**

Culture may be recognized at this stage but the magnitude of their impact is still minimized. Although cultural differences are overtly recognized, nurses at this stage, tends to ignore the patient' cultures as they do not acknowledge their importance or value. A few responses from all levels of training tallied with this stage.

- **Stage 4 : Acceptance**

Nurses accept and respect behavioral difference and underlying cultural value differences. They view culture as a dynamic process that help people set and follow social rules. The majority of the informant's responses demonstrated that they are in the process of becoming culturally sensitive towards other cultures.

- **Stage 5 : Adaptation**

Nurses are able to change and adapt to different cultures. Bennett (1986) states that the most common form of adaptation is empathy which involves a temporary shift in the frame of reference such as one construes events if one were the other person.

The ability to change processing of reality constitute an increase in intercultural sensitivity when it occurs in cross cultural context. This was demonstrated in scenario 1 and most of the responses were positive except very few statements which were mentioned as alternatives to the problem.

Most of the responses in the questionnaire tallied with this stage and a few are still far from reaching this stage.

- **Stage 6 : Integration**

Nurse apart from being able to adapt and change, they move comfortable among cultures. According to Bennett (1986) the integration of difference is the application of ethnorclativism to one's own identity. The nurse at this stage is not only sensitive to many different cultures, but is always in the process of becoming a part of and apart from a given cultural context. From this study, only one response indicated that the aim of learning the Shangaan language and culture is to become part of them ( Scenario 1).

#### **4.4.3 Chrisman Theory**

Chrisman's theory " Expanding nursing practice with culture - sensitive care : A new approach to Transcultural Nursing" has also provided theoretical framework for this study. This theory guides the nurses in providing holistic congruent nursing care and the accompanying practice dimension culture - sensitive care. This approach is advantageous as the culturally naive nurse is inhibited from stereotyping patients by expecting them to conform with generalizations learned about a particular culture. This has been described thoroughly in Chapter 1.

## 4.5 CONCLUSION

In conclusion, this chapter discussed the findings and interpretation of the study with reference to Bennett (1986) stages of cultural development. The next chapter will summarize the findings and provide the recommendations of the study.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 CONCLUSIONS

This study sought to explore the extent of cultural sensitivity among the nursing students doing the four year Diploma at Addington Hospital in Kwa Zulu-Natal Province. Firstly narrative statements in the form of scenarios were employed in order to explore the nurse's extent of sensitivity to other cultures. Three scenarios were designed to simulate the following :-

- ◇ difficulty in communication
- ◇ lack of cultural knowledge demonstrated by inability to accommodate and tolerate diverse cultures when rendering patient care
- ◇ negative attitudes of nurses towards patients of diverse cultures.

In the first scenario, the informants were asked to demonstrate their ability to overcome the communication barriers. Informants demonstrated positive responses as they stated that learning the language would be an ideal. All the informants expressed this as the first option. Other responses were given as alternatives including finding the interpreter, non-verbal means of communication, using a common language and transfer to another clinic. The use of a common language and transfer to another clinic were viewed as negatives by the researcher as these options show some resistance to change. Communication is a major barrier to the provision of culturally relevant care. In such situations, nurses experience difficulty in providing care to culturally diverse clients and patients.

Van Der Walt (1994) contends that cultural sensitivity involves far more than just language proficiency. it requires adaptability, flexibility and empathy.

The second scenario, the informants were expected to demonstrate their cultural understanding as applied to nursing. This scenario focused on the ability of nurses to accommodate and tolerate other cultures. Most of the informants responded positively by reaching a compromise of allowing two or three visitors at a time. One informant indicated that the patient could go and see relatives in the visiting or waiting room. 33.3% of the informant's responses could neither tolerate nor accommodate as they indicated that they would adhere to hospital rules or policy. This supports the researcher's findings in her study that some nursing students failed to recognize the variations among cultures and obviously, cultural differences exist between nurses and patients. This could be attributed to lack of cultural knowledge (Blenner, 1991). Lack of cultural knowledge about other cultures and generalizations based on experiences affect the quality of care provided to patients of different cultures.

In a study that was conducted by Blenner (1991), on how health care providers approach treatment of culturally diverse infertile patients, findings revealed three types of providers. The culturally unaware, culturally non-tolerant and culturally sensitive providers. Cultural unaware providers failed to recognize different cultural needs and treated all patients in the same way, an approach that eventually led to non-compliance. Culturally non-tolerant providers recognized diverse needs but were unwilling to tolerate cultural conflicts in treatment of change treatment protocols. Often, this resulted in providers terminating treatment or making referrals to a more tolerant provider.

Culturally sensitive providers acquired information about cultural beliefs, worked with patient limitations and adapted tests and treatment protocols to meet patient's needs.

The third scenario, expected the informants to respond to the negative attitude emanating from the perception of a nurse towards a child (patient). This resulted in the nurse imposing her or his cultural values onto the patient. Responses to this scenario were very positive as most of the informants disapproved of this behaviour, rejecting the ethnocentric attitudes. They recognized differences in cultures as they stated that the child may belong to other religious organization or may be atheistic.

Secondly, the informants were given a questionnaire to fill in where they were asked to indicate their views about health belief system and illness, their cultural beliefs, knowledge and understanding of cultural concepts, factors that play a role in health - illness continuum. The majority of the responses tallied with the stage 4 and 5 which means that they are sensitive to other cultures. Some responses that are few indicated lack of cultural sensitivity. From both enablers, all levels of cultural sensitivity manifested : For example, denial of difference by failing to acknowledge differences in cultures. Defense against differences shown by negative stereotypes and cultural superiority as shown by beliefs held in the statements 1, 3, and 12 and by responses in scenario 2 indicated adhering to rules. Minimisation of difference shown by acknowledging differences but buried differences under the weight of cultural similarities as they strive to treat every patient equally. All the stages explained are referred to as ethnocentric as they indicate lack of cultural sensitivity.

However, ethnorelative stages were reached. Acceptance of cultural differences as the informant's responses moved beyond acknowledging cultures and indicated the importance of respecting other cultures. In this stage cultural differences exist and difference is perceived as fundamental, necessary and preferable in human affairs ( Bennett, 1986 ). Adaptation to cultural differences allows for the higher levels as shown by the informant's responses indicating willingness to change and adapt behaviour and thinking to cultural differences occurring more specifically in cross cultural contexts. Integration of difference was shown by a few as they not only indicated appreciation, respecting and valuing cultural differences, but commitment in promoting social equality and change. Responses supported this stage by stating that they would strive to become part of another culture apart from a given context. At this stage people have the ability to integrate new experiences with old ones and are fluid in their view of difference (Ewalt et al. 1990).

The results of the study revealed that the nursing students were at varying stages of levels of development of cultural sensitivity. Each stage represent a way of experiencing difference, from denial, defense, minimization, acceptance, adaptation and integration. According to Bennett (1986) the higher the level, the more the individual is sensitive to cultures of diverse groups. This means that nursing students ranged from ultimate ethnocentrism to ethnorelativism, that is, lack of cultural sensitivity to cultural sensitivity.

Based on the findings, the following conclusions were drawn by the researcher :-

1. Some nursing students are unable to acknowledge variations that exist among cultures.

2. Problems emanating from differences in cultures still exist between the nurses and the patients particularly with health and health care due to ethnocentric views still held by some nurses.
3. Nursing students are at varying stages of levels of development of cultural sensitivity.

Oosthuizen (in Troskie 1998) found that nurses were not sufficiently prepared to deliver real culturally sensitive care to patients as they could not identify diverse cultural needs of patients.

## **5.2 RECOMMENDATIONS**

The recommendations of this research are dealt with in three sub - headings : recommendations for nursing practice, for nursing education and for research.

McKenna (1997) uses the metaphor that theory, practice and research are like three dancers. They need to be competent and confident or else the dance will be ruined. Weak relations between theory, practice and research will be detrimental to the development of the nursing discipline, and that research without the consideration of theory would be a fruitless exercise.

### **5.2.1 For the nursing practice**

The researcher through her own experience as a nurse and nurse educator observed some forms of cultural issues which triggered her to undertake this study as reflected in scenario 2 and 3. Apart from the researcher's experiences, the results of the study revealed that problems emanating from differences in culture still exist.

It is important, therefore, that the management should develop a system of capacity building for all nurses from the top hierarchy to the least junior nurse in the form of workshops, seminars and conferences. The majority of nurses could benefit, as some received training during the time of separate development whereby people were trained and guided to serve their own communities whose cultures, values and beliefs were similar to theirs.

South African nurses (Eliason, 1998 ; Kanyile, 1998) practiced before 1990 Health Reform policy which decreed that health services be open to all cultural and racial groups received a unicultural form of training. The managers should take the lead in promoting a healthy cultural diverse environment. They should role model behaviour and attitudes they desire from their staff. Top management can affirm cultural diversity with a public declaration expressed in their mission statement (Bhimani & Acorn, 1998).

The structure of the country has changed, the new South Africa comprises of nine provinces with eleven (11) languages. According to Act No. 200 of 1993, one of the fundamental human rights that needs to be protected is the right to own language and culture (Human Services Research Council, 1994). Nurse practitioners need extensive cultural knowledge to guide them in their decisions and actions to prevent cultural backlash, conflicts, legal problems and unfavorable nursing outcomes. The new National Health Plan for South Africa (ANC, 1994) focuses on PHC at grassroots level, health for all and community partnership within the health delivery system (Poggenpoel, 1996). To be relevant as a health profession, nurses need to provide culturally sensitive care to all people irrespective of patient's cultural background.

### 5.2.2 For the Education of nurses

Some nursing students have demonstrated the presence of ethnocentric views in the findings of the study. To face the challenge of a multi - ethnic society, nursing schools in South Africa must become more culturally diverse in their students and faculty composition. As nurse educators convey the messages consciously and unconsciously to the students, they are the key figures in providing appropriate education. Besides having an understanding and knowledge of their own cultures, they should be aware of the cultures of their students and know which cultural factors influence the learning - learning process. They should use appropriate instructional material that reflects the culturally diverse nature of the school and society. Nurse educators, too, need to lead by example and be free from prejudice and ethnocentrism themselves.

An important aspect of multicultural education is the inclusion of culturally relevant and appropriate content into the curriculum. This could be achieved by providing a separate program presented in the form of a module, subject or course. Alternatively, in the curricula for basic nurse training programs, the cultural content should be built in to enable nurse practitioners to provide a more holistic and effective service to culturally diverse communities. The existing nursing curriculum of all the universities and colleges needs to be examined, so that alterations and innovations could be done where necessary until the whole multicultural curriculum is developed. This could address the problem of insufficient preparation of nursing students as revealed by the findings of this study.

In the light of inability by some students to acknowledge variations among cultures, students should be placed in a variety of settings during their placement in the communities so that they have an understanding of the particular needs of people of different cultures and subcultural backgrounds. It is also recommended that there should be a link between the South African universities and colleges and the other countries. By so doing, students will be exposed to multicultural groups abroad with the aim of overcoming their ethnocentrism, experience a transformative and sensitive as well as understand and integrate the patient's cultural practices into the student's health practices.

### **5.2.3 For Research**

Apart from the recommendations for practice and nursing education, there is a need for more research to investigate the extent of cultural sensitivity among nurses. It could be interesting to compare the different groups of nurses in different settings, that is, nurses who interact frequently with patients from different cultural backgrounds and those who are not often interacting with patients of diverse cultures. The reason is that in small towns there is less degree of contact with differences as the populations are generally homogenous than in larger, cosmopolitan cities. Lack of exposure to a variety of cultures, could, therefore, contribute to denial of difference, that is, complete insensitivity to other cultures (Bennett, 1986).

The focus could be on different nursing programs in different areas of South Africa. A comparison of results between different programs could yield meaningful information. Cross cultural comparative research and ethnographic research also have to be supported to explore cultural attitudes and values and their impact on the educational process.

Gaps or extreme difference in culture relevant knowledge could be identified and if there are any, a review could be done. It is recommended that a study whereby two data sources are included should be undertaken. The researcher believes that patients could provide a valuable source of information in the assessment of how sensitive are the nursing students in nursing patients of diverse cultures. This could validate the findings of the study as well.

In conclusion, the biggest challenge that faces the providers of health in South Africa is to become culturally sensitive. South Africa is increasingly multicultural and people live in a world of rights and charter, as stated in the new Health Reform Policy (1990) and in Act 200 of 1993 (Human Services Research Council, 1994). The new paradigm shift from hospital to community based approach (PHC), and the new strategies for learning, (CBE and PBL) all demand a new look on how to prepare nurses to become culturally sensitive in order to provide culturally congruent nursing care to all.

Although Adams et al (1997) contends that at times people experience several stages of cultural development at the same and also revealed by some informants in the study, it is imperative to shift from the ethnocentric stages to more culturally relative stages of sensitivity. The purpose of the study was to explore the extent of cultural sensitivity among the nursing students in Kwa Zulu - Natal. In the new South Africa, understanding cultural diversity is the important tool in order to reach the goal of Health for All.

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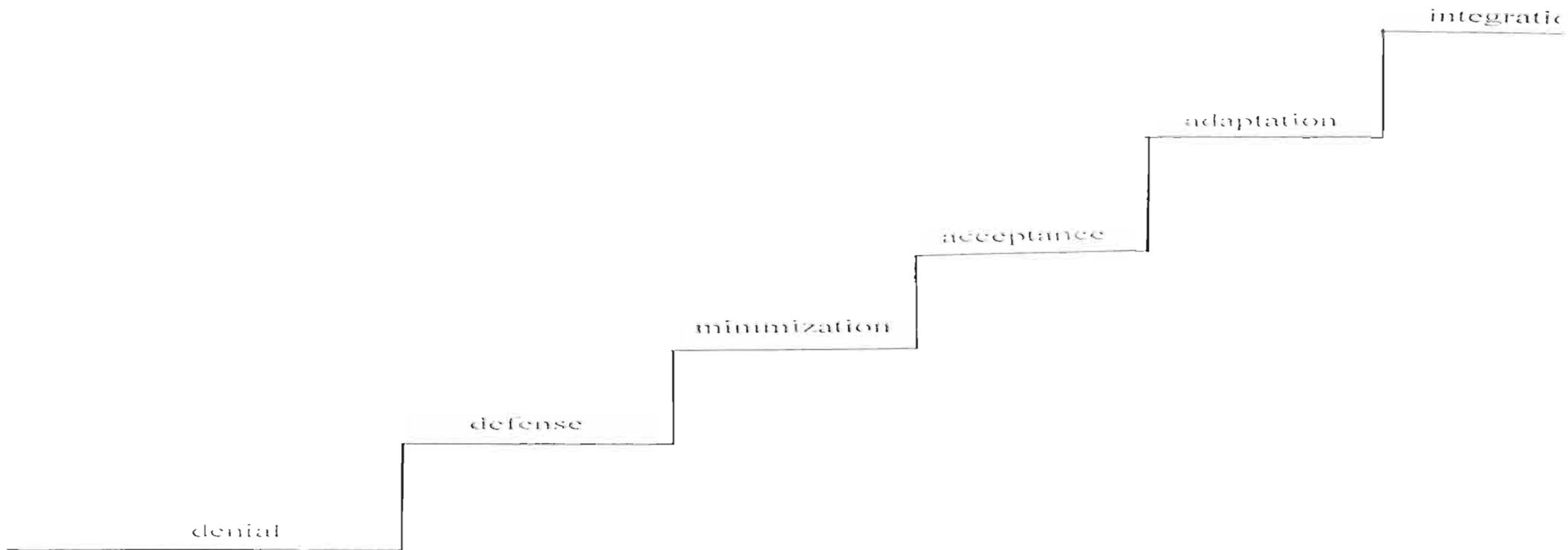
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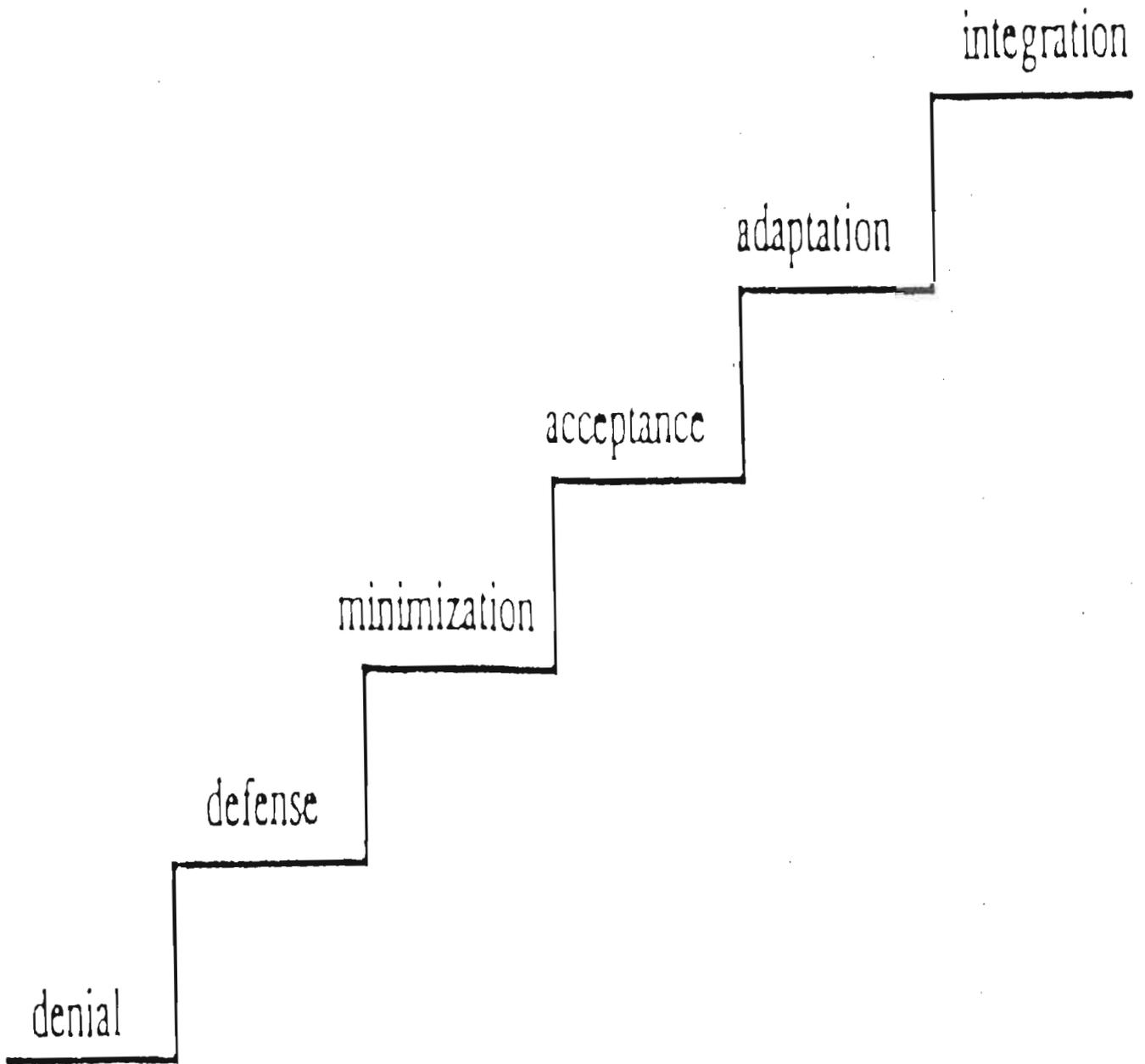
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**ANNEXURE A**

**Bennett's Stages of Development  
of  
Cultural Sensitivity**



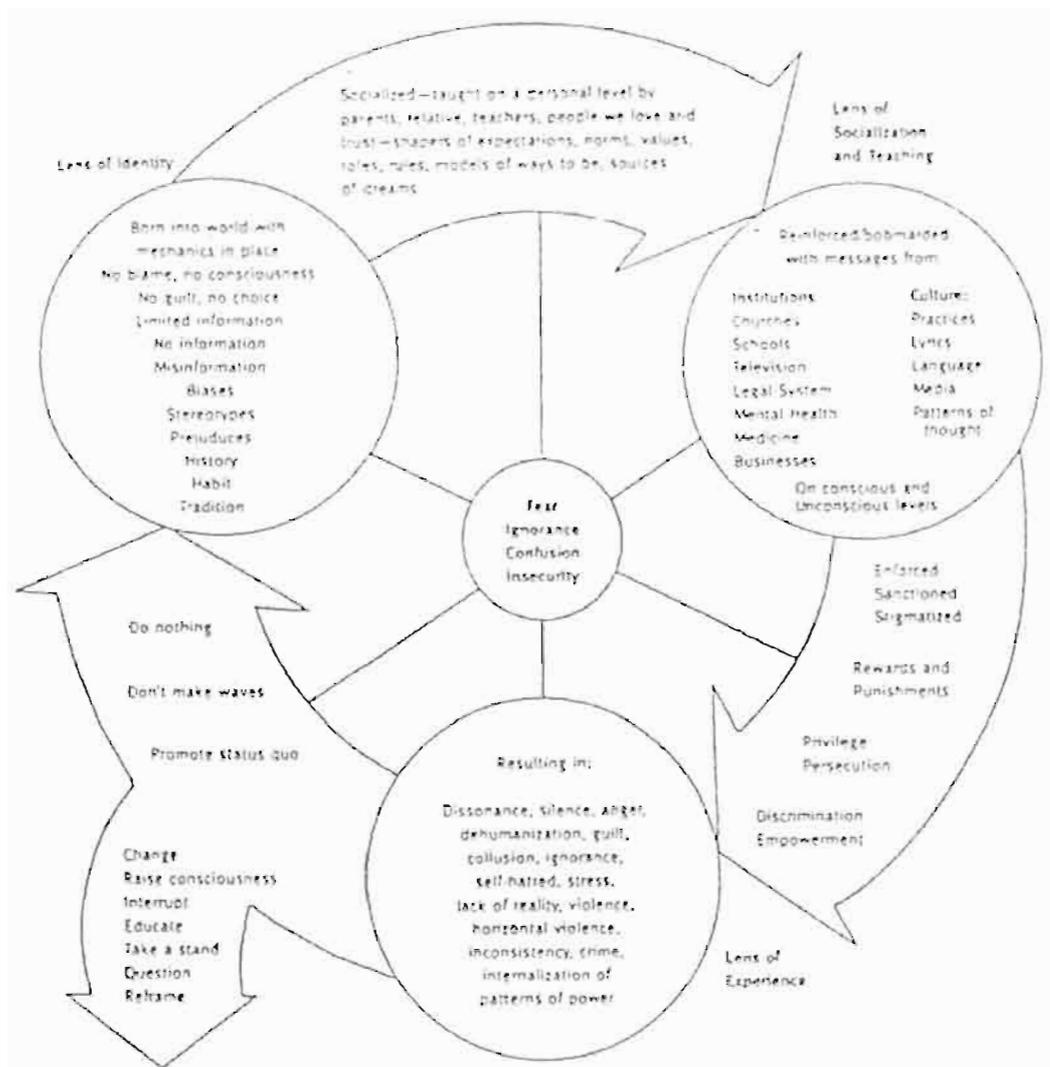
Bennett's stages of development of cultural sensitivity (*From A developmental approach to training for intercultural sensitivity by M.J. Bennett, 1986, International Journal of Intercultural Relations, 10, 179-196.*)



Bennett's (1986) stages of development of cultural sensitivity.

## **ANNEXURE B**

### **Cycle of Socialisation by Harro**



Cycle of Socialization by B. Harro

## **ANNEXURE C**

**Narrative statements in the form of scenarios**

## **FIRST DATA COLLECTION TOOL : NARRATIVE STATEMENTS**

### **SCENARIO 1.**

You are allocated for a whole year in a community clinic in Mpumalanga where most of the clients are Shangaans, and you become frustrated when they speak Shangaan in your presence. You feel excluded from the conversations and uncomfortable with your role in the clinic.

What would you do? justify your response.

### **SCENARIO 2 .**

You are assigned a patient in a Maternity ward, and during the visiting hours. the whole extended family would come and visit the patient at the same time. They believe that every member should come to give the moral support. The policy of the hospital allows only two or three members at a time in order to prevent cross infection especially to the newborn babies. When you approach the patient's visitors to explain the situation, they become angry with you and threaten to take their relative home with them.

How would you handle such a situation?

### **SCENARIO 3.**

You are working in a paediatric ward. Whenever you are conducting prayers in the unit, one child (patient) would keep her eyes open. One day you heard one of your colleagues talking to this child, instructing the child to close her eyes when talking with the Almighty. After this, the nurse came and was labeling the child as “silly” and “disdainful”.

What are your views regarding this situation and why?

How would you respond or react to this situation?

## **ANNEXURE D**

**Questionnaire used as second data collection tool**

## SECOND DATA COLLECTION TOOL : QUESTIONNAIRE

### A. SOCIO - DEMOGRAPHIC DATA

#### 1. Gender

Male		1
Female		2

#### 2. Marital Status

Single		1
Marricd		2
Separated		3
Divorced		4
Widowed		5

#### 3. Age

15 - 19 years		1
20 - 24 years		2
25 - 29 years		3
30 - 34 years		4
35 - 39 years		5
40 - 44 years		6
45 - 49 years		7
50 - 55 years		8

#### 4. Religion

Christian		1
Muslim		2
Hindu		3
African		4
Aesthist		5
Other (specify)		6

## 5. Language

Zulu		1
Xhosa		2
Swazi		3
English		4
Afrikaans		5
Indian		6
Sotho		7
Other (specify)		8

## 6. Ethnic Group

White		2
Indian		3
Mixture of any two		4
Other (specify)		5
African		6

## 7. Residence by birth

Urban		1
Rural		2

## 8. Level of Training

1st year		1
2nd year		2
3rd year		3
4th year		4

## 9. Previous training

Enrolled nurse		1
Enrolled staff nurse		2
Health educator		3
None of the above		4
Other (Specify)		5

## B. YOUR VIEWS ABOUT HEALTH AND ILLNESS

1. What are your health belief system?

Science		1
Holistic		2
Magico-religion		3
Other (specify)		4
Uncertain		5

2. According to your own point of view, ILLNESS is due to

Supernatural forces		1
A breakdown of the "human machine"		2
Multiple environment-host-interaction		3
Uncertain		4
None of the above		5
Other (specify)		6

## C. YOUR CULTURAL BELIEFS

### Instructions :

Respond by making a cross (x) next to the most appropriate response for this section.

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
	5	4	3	2	1
1. In nursing it is not worthwhile to focus on one's own cultural values and social norms because only the client matters					
2. Being of diverse culture in our society takes strength. I am aware of my own bias and prejudice and that I need to work on my understanding and attitude					
3. Treating people differently because of religious, ethnic, cultural or other characteristics implies prejudice and discrimination					
4. Minorities must adapt to the dominant culture's institution rather than the institutions adapting to the needs of the minority group or individuals					
5. One can "sense" another culture's needs without having to learn about its social organization and social processes					
6. Different ethnic and cultural groups deserve to have their civil rights protected even though I may be uncomfortable about their culture and lifestyle					
7. The diversity of people is a valuable thing (all groups e.g. Africans, Coloreds etc.) Therefore, I am involved in combating cultural discrimination and bias in workplace.					

8. Individuals from different ethnic or cultural groups should be accepted as they are (e.g. You are not a Black person to me, you are just a person like all of us)					
9. Altering care or treatment procedures to accommodate cultural variables is unnecessary because any person can adapt					
10. Cultural diversity is indispensable to our society. Diversity is a gift to all of us. I have deep affection for particular culturally diverse individuals and I delight in their individuality and their gifts. I work as their advocate					
11. Ethnocentrism and separatism is a mature way of life. Segregation of cultures should be encouraged and reinforced					
12. Folk systems need to be incorporated into professional approaches to nursing care					

**D. YOUR UNDERSTANDING OF CULTURAL CONCEPTS**

1. Stereotyping -----  
-----  
-----

2. Cultural imposition -----  
-----  
-----

3. Ethnocentrism -----  
-----  
-----

4. Prejudice -----  
-----  
-----

5. Labeling -----  
-----  
-----

6. In your opinion, what cultural factors play a role in the health - illness continuum?

- -----
- -----
- -----
- -----
- -----
- -----
- -----
- -----
- -----
- -----

**ANNEXURE E**

**A letter requesting permission to conduct a study  
from the  
Department of Health**

University of Transkei  
Dept. of Nursing  
P/B X1  
Unitra  
5117  
1 September, 2000

The Department of Health  
P/B X9051  
Pietermaritzburg  
3200

**ATTENTION : DR Nkonzo-Mtembu**

Dear Madam,

**RE : PERMISSION TO CONDUCT A RESEARCH STUDY**

I hereby request your permission to undertake a research study at Addington Campus. I am currently registered for a Master's Degree with the University of Natal. My expectations are to conduct a research study in nursing education. The title of my research project is "*Exploring cultural sensitivity as perceived by the nursing students in Kwa Zulu-Natal Province*".

My area of interest is the Diploma in nursing (General, Psychiatry, Community) and Midwifery, and that is why I have chosen the Campus stated above. Also I have chosen this province because of its heterogeneity. After completion of the study I will share the information with both the campus and the Department of Health and the results will be published.

Verbal consent will be obtained from the participants. The respondents will be given assurance of anonymity as their names will not be required, instead the letters of alphabet will be used. Confidentiality will be maintained throughout as the information that will be given in will not be divulged by anybody. Also there will be no financial implications for Kwa Zulu - Natal Province.

As a researcher, I will acknowledge the Department of Health and a copy will be supplied to the Department. The following documents are hereby attached :-

1. Research Proposal.
2. Copy of scenarios and a questionnaire that will be used to collect data.
3. A letter of clearance from the ethical committee of the University of Natal.
4. A letter from my supervisor confirming my status as a student and research project.
5. Informed consent for the students of Addington Campus who will be participating in the study.

Your co-operation in this regard will be highly appreciated.

Yours sincerely,



B. B. Mafanya (Mrs. )

**ANNEXURE F**

**A letter requesting permission to conduct a study  
at  
Addington College of Nursing**

University of Transkei  
Dept. of Nursing  
P/B XI  
Unifra  
5117  
1 September, 2000

Addington Campus  
P.O. Box 977  
Durban  
4000

**ATTENTION : Mrs. Sissing**

Dear Madam,

**RE : PERMISSION TO CONDUCT A RESEARCH STUDY**

I hereby request your permission to undertake a research study at Addington Campus. I am currently registered for a Master's Degree with the University of Natal. My expectations are to conduct a research study in nursing education. The title of my research project is "*Exploring cultural sensitivity as perceived by the nursing students in Kwa Zulu-Natal Province*".

My area of interest is the Diploma in nursing (General, Psychiatry, Community) and Midwifery, and that is why I have chosen this Campus. Also I have chosen this province because of its heterogeneity. After completion of the study I will share the information with you the results will be published.

Your co-operation in this regard will be highly appreciated.

Yours sincerely,



-----  
B. R. Mafanya (Mrs )

**ANNEXURE G**

**A letter of permission to conduct a study  
granted by  
Addington College of Nursing**

PROVINCE OF  
KWAZULU-NATAL  
HEALTH SERVICES

ISIFUNDAZWE  
SAKWAZULU-NATALI  
EZEMPILO

PROVINSIE  
KWAZULU-NATAL  
GESONDHEIDSDIENSTE

TEL: 031 - 3272999  
FAX: 031 - 3272756

☒ ADDINGTON CAMPUS  
COLLEGE OF NURSING  
P.O. BOX 977  
DURBAN, 4000

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Enquiries :	Date :	Reference :
Imibuzo :	Usuku : 23 October 2000	Inkomba :
Navra :	Datum :	Verwysing :

---

MRS B.B. MAFANYA  
UNIVERSITY OF TRANSKEI  
DEPARTMENT OF NURSING  
P.O. BOX 1  
UNITRA  
5117

RE: PERMISSION TO CONDUCT RESEARCH – "EXPLORING CULTURAL SENSITIVITY AS PERCEIVED BY THE NURSING STUDENTS IN KZN PROVINCE".

The above request is granted and research study will involve students in their 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> years of the four year integrated course.  
Period for this study to be in the week 30 October to 3<sup>rd</sup> November 2000.

Good luck.



M.A. SISSING (MRS)  
CAMPUS PRINCIPAL  
MAS/mvl

**ANNEXURE H**

**A letter of permission to conduct a study  
granted by  
Department of Health**

PROVINCE OF  
KWAZULU-NATAL

ISIFUNDAZWE  
SAKWAZULU-NATALI

PROVINSIE  
KWAZULU-NATAL

DEPARTMENT OF HEALTH

UMNYANGO WE ZEMPILO

DEPARTEMENT VAN GESONDHEID

NATALIA  
330 LONGMARKET STREET  
PIETERMARITZBURG

Telephone : 033-3952111

Ucingo :

Telefoon :

Fax : 033-3945868

Feksi :

Faks :

Private Bag : X 9051

Isikhwama Sepost : Pietermaritzburg

Privaatsak : 3200

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Reference: 66/3

Date: 26 October 2000

Mrs B.B. Mafanya  
University of Transkei  
Department of Nursing Science  
Private Bag X1  
JNITRA  
5117

## RESEARCH APPLICATION

**TITLE: EXPLORING CULTURAL SENSITIVITY AS PERCEIVED BY NURSING STUDENTS DOING  
B.CUR. IN KWAZULU-NATAL PROVINCE**

Thank you for taking interest to conduct research on the above subject.

Permission to conduct the research is granted. It is to be noted that the Addington institutional management also have to be approached for permission to access the facility.

A copy of the research report will be appreciated and it should be directed to the Superintendent-General, Department of Health.

  
DIRECTOR : HRD

## **ANNEXURE I**

**A letter of consent for the participants**

University of Transkei  
Dept. of Nursing Science  
P/B XI  
Unitra  
30 October, 2000

Addington Campus  
Durban

Dear Participant.

### RE : INFORMED CONSENT

I am a lecturer at the University of Transkei. I am studying with the University of Natal doing M.Cur Degree (Master's degree in nursing). In order to fulfill the requirements for this degree. I will have to conduct a research study. *"Exploring Cultural Sensitivity as perceived by the nursing students doing B.Cur in Kwa Zulu - Natal Province"*. I have chosen Kwa Zulu - Natal Province because there is a greater number of groups from different cultural backgrounds.

The purpose of this study is to explore, examine and describe how the nursing students of Kwa Zulu - Natal Province are sensitive towards cultures of groups that are different from theirs. The information from the participants will be obtained through the use of unstructured questionnaires, and by responding to three scenarios that will be given. The filling of a questionnaire will last for about 45 - minutes and responding to scenarios will take about 30 minutes. I will assist you in filling the questionnaire.

It would be my pleasure if you agree to participate in this study. You were selected in this study because you are involved in nursing patients from different cultural backgrounds. You have, therefore, experiences of nursing patients with diverse ethnic groups. Participation in the study is voluntary and that you have the right to terminate or withdraw before the end of the study if you so wish.

I undertake to ensure anonymity by not using names instead the letters of the alphabet will be used. Confidentiality will be maintained in that all the information thus given will not be divulged in anyway. The transcription of the materials used will be shared by the researcher and the expert that will assist in analyzing data. On completion of the study the material will be destroyed. You have the right to access the information on request. The results will be made available at the end of the study if you wish to know the outcome.

You will not be paid for participating. However, it is hoped that the information you give will contribute to knowledge base. This will help the nurse educators to provide guidelines in the nursing programs to promote and integrate cultural diversity. Nurses will then be better equipped with strategies to improve cultural sensitivity in nursing education. A caring atmosphere will then be fostered thus contributing to the improvement of the quality of nursing care.

Thank you.

By signing this document you are giving consents to participate in the study.

----- (Print Name)

----- (Signature)

Researcher

Participant

Witness