

**THE KNOWLEDGE OF PROFESSIONAL NURSES ABOUT CULTURE COMPETENT  
CARE AT SELECTED MEDICAL WARDS, ONCOLOGY WARDS AND OUTPATIENT  
DEPARTMENTS IN MOPANI DISTRICT, LIMPOPO PROVINCE**

by

**THOKOZILE MANGANYI**

submitted in accordance with the requirements

for the degree

**MASTER OF ARTS**

in the subject

**HEALTH STUDIES**

at the

**UNIVERSITY OF SOUTH AFRICA**

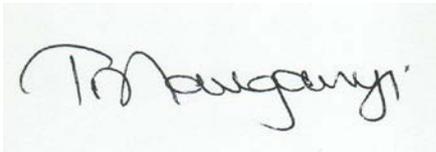
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November 2013

Student number: 4218-193-3

I declare that **THE KNOWLEDGE OF PROFESSIONAL NURSES ABOUT CULTURE COMPETENT CARE IN SELECTED MEDICAL WARDS, ONCOLOGY WARDS AND OUTPATIENT DEPARTMENTS IN MOPANI DISTRICT, LIMPOPO PROVINCE** is my own work and that all the sources that I have quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any degree at any other institution.

A handwritten signature in black ink, appearing to read 'T Manganyi', is written on a light-colored rectangular background.

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**SIGNATURE**  
(T MANGANYI)

03 October 2013

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**DATE**

# **THE KNOWLEDGE OF PROFESSIONAL NURSES ABOUT CULTURE COMPETENT CARE AT SELECTED MEDICAL WARDS, ONCOLOGY WARDS AND OUTPATIENT DEPARTMENTS IN MOPANI DISTRICT, LIMPOPO PROVINCE**

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DEGREE: MASTER OF ARTS IN HEALTH STUDIES  
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## **ABSTRACT**

The purpose of the study was to determine professional nurses' knowledge of culture-competent care at selected medical and oncology wards and outpatient departments in Mopani District, Limpopo Province. A quantitative descriptive design was used and data collected from one hundred and five professional nurses by means of a structured questionnaire. The study found that cultural knowledge needs to be nurtured through continuing education and mentoring and that culture-competent care should be included in the curriculum. Furthermore, cultural knowledge is not effective if there is no correlation of theory and practice and early clinical placement of student nurses during their basic training.

## **KEY CONCEPTS**

Transcultural nursing; professional nurse; culture; cultural awareness; cultural knowledge; cultural beliefs; cultural diversity; culture-competent care; culture-sensitive care.

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My praise and thanks to Almighty God for his grace and blessings throughout my life and this study.

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## *Dedication*

*To Mqabango Hambose Ngoma, my mother, Malesana Benford Sibuyi, my uncle and Risuna Denise, Vumboni Fortunate and Hlayisekani Vutomi Carol, my children*

*and*

*In memory of John Ngoma and Alfred Nkhensani Ngoma, my late father and brother*

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## List of abbreviations

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A	Agree
CMAC	Centre for Maternal and Child Enquiries
CNAHL	Cumulative Index to Nursing and Allied Health Literature
D	Disagree
F	Frequency
HSHD	The Higher Degrees Committee in Departments in the College of Human Sciences
N	Number of respondents
R	Regulation
SA	Strongly Agree
SD	Strongly Disagree
SANC	South African Nursing Council
SPSS	Statistical Package for Social Sciences
UNISA	University of South Africa

## List of annexures

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- Annexure A Letter for intention to submit the proposal
- Annexure B Approval from the University of South Africa
- Annexure C Letter for seeking consent to conduct research from the Limpopo province
- Annexure D Permission letter from Limpopo Department of Health to conduct the study
- Annexure E Questionnaire
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- Annexure G Letter of intent to submit the dissertation
- Annexure H Letter from the editor

# CHAPTER 1

## Orientation to the study

### 1.1 INTRODUCTION

Culture is an integral part of every society. It gives people an identity and sense of belonging. Within a cultural group people share a language, traditions and beliefs. South Africa is a multicultural society, with eleven (11) official languages, many religious denominations and diverse groups of people who immigrate into the country due to the world markets and business (Investorwords 2009).

Transcultural nursing is of concern both internationally and nationally. Professional nurses in South Africa and elsewhere nurse patients with diverse cultural backgrounds who need culturally sensitive care. Nurses are expected to render culture-competent care to all patients; consider each individual as a unique person, and refrain from imposing their own cultural beliefs on patients (Andrews & Boyle 2008:12). Serrant-Green (2001:233) emphasises the need for professional nurses to have a knowledge or understanding of the cultural background of patients in order to provide culture-competent care. Campinha-Bacote (1996:59) maintains that cultural competence is a critical factor in providing services to the growing culturally and ethnically diverse patient population.

Mopani District in the Limpopo Province is a multicultural region where Xitsonga, Northern Sotho, Tshivenda and Afrikaans are the languages spoken most commonly (Burger 2009:24). This reflects the different ethnic groups found in the region. This diversity is also found in hospitals and other healthcare institutions.

### 1.2 BACKGROUND TO THE PROBLEM

#### 1.2.1 Personal experience

The researcher is a nurse educator facilitating the education and training of the R425 programme for registration as a nurse (General, Psychiatry and Community) and

Midwife (R425, 22 February 1985, as amended). During accompaniment of nursing students in hospitals in the Mopani District, the researcher observed that professional nurses did not seem to acknowledge the cultural needs of patients when rendering nursing care. Professional nurses provided general nursing care without considering patients' language, religious differences, cultural beliefs, values, and customs. Nurses often ignored patients who spoke a different language to their own and treated them with disrespect. The challenges observed were related to communication and respect for the cultural uniqueness of patients of different cultures in the health care setting. This motivated the researcher to examine and determine professional nurses' knowledge of culture-competent care in clinical facilities in Mopani District.

### **1.2.2 Nursing care**

Health care institutions in Mopani District provide health services to patients of different cultures. During accompaniment of students, the researcher observed the following:

- Professional nurses imposed nursing care without involving patients in decisions regarding their cultural needs.
- Professional nurses gave preferential treatment to patients who spoke the same language they did.
- Husbands of female patients sometimes quarrelled with male professional nurses when they called their wives by their names.
- Professional nurses reprimanded patients' relatives who added herbs to the patients' soft porridge.

Regarding transcultural nursing, Narayanasamy and White (2005:109) found a cultural crisis in health care that requires urgent attention. They maintain that nurses claim to provide cultural care to patients of diverse cultures, but this is limited to symbolic rather than concrete aspects of culture. Marcinkiw (2003:180) points out that recognition and support of cultural differences result in health plans that look at the individual's needs, beliefs, and cultural practices.

Festini, Focardi, Bisogni, Mannini and Neri (2009:220) emphasise the need for nurses to have the required knowledge to provide cultural-competent care. According to Festini

et al (2009:220), the provision of nursing care to people of different backgrounds has the potential to create problems for nurses and to increase the level of difficulty perceived in their work. In a study in Australia, Lim, Downie and Nathan (2004:428) found that fourth-year students who were exposed to increased theoretical information and clinical experience in transcultural nursing had a more positive perception of their efficacy in providing transcultural skills than the first-year students. There is no clear evidence to indicate whether professional nurses have the required knowledge to render cultural-competent care. If professional nurses lack knowledge of culture-competent care, they might not be able to act as role models to neophyte student nurses in an environment where patients and nurses are culturally different from each other.

### **1.2.3 Training of professional nurses**

The four-year comprehensive course for registration as General, Psychiatric and Community Nurse and Midwife (R425 of 1985) and the Bridging Course (R683 of 1989) in Limpopo College of Nursing incorporate cultural principles in Fundamental Nursing Science, Ethos and Social Science. There is no specific module for transcultural nursing (Limpopo College of Nursing Curriculum 1997:30-32). No theory guides the teaching and practice of transcultural nursing in the curriculum. Fundamental Nursing Science covers the following aspects that could be applied in transcultural nursing: meeting the needs of patients; communication; interpersonal skills; illness/ill health, patient listening and observation (Limpopo College of Nursing Curriculum 1997:45). Nurse training and education are predominantly based on Eurocentric principles whereas the majority of South Africans are Afrocentric.

## **1.3 NATIONAL AND INTERNATIONAL PERSPECTIVES**

In 1994, the Royal College of Nursing in Australia established a Transcultural Nursing Society in response to growing interest in and commitment to transcultural nursing. The College promotes the principles of transcultural nursing as a discipline of study, research, practice and management (Bryant, Foley & Percival 2008:3).

Leininger (1991:14) advocates culture care, diversity and universality in nursing. In their nursing theory of cultural care diversity and universality, Leininger and McFarland (2006:189) promote transcultural nursing research, knowledge and practice. Douglas and Lipson (2008:162) maintain that culturally competent nurses can help make the transition from providing culturally incompetent nursing care to providing culturally competent nursing care by encouraging education and professional growth through mentorship, compassion, patience, and support.

In a study on pain assessment in a culturally diverse hospital in the United Arab Emirates, Ramukumba (2006:126) found that culturally competent professional nurses recognise similarities and differences in values, norms, and health practices regarding pain and pain management.

In South Africa, transcultural nursing has not developed fully as a discipline with regard to education, research and practice and its implementation has not been widely recognised (Tjallinks in Tjale & De Villiers 2004:13 2004:9).

#### **1.4 RESEARCH PROBLEM**

A research problem is a situation involving an enigmatic, perplexing, or conflictful condition that can be investigated through disciplined inquiry (Polit & Beck 2008:81). During accompaniment of students the researcher observed that professional nurses did not provide culture-competent nursing care. These nurses lack knowledge of transcultural nursing principles which may guide the nurses on how to provide culture congruent health care. In addition, patients found it difficult to give the history of their illness because of distrust and language differences. Nurses come into contact with patients of different nationalities and cultural backgrounds and therefore require knowledge about patients' culture to ensure their cultural needs are met (Campinha-Bacote 1996:59; Serrant-Green 2001:233; Sidumo 2007:107).

#### **1.5 PROBLEM STATEMENT**

During student accompaniment, the researcher observed that professional nurses at the selected hospitals in Mopani District did not practise culture-competent nursing care.

The quality of care rendered depended on the cultural background of patients and of the nurses responsible for care. In some instances, patients who differ culturally from professional nurses seemed uncomfortable in expressing their cultural needs. Poor assessment and planning of nursing care for patients of diverse cultures could lead to inadequate and inferior nursing care. Knowledge of transcultural nursing is critical in a culturally diverse environment. Lack of knowledge of transcultural nursing could lead to professional nurses failing to provide culture-competent nursing care to patients. Consequently, the researcher considered it necessary to investigate whether professional nurses had the essential knowledge to provide culturally sensitive nursing care.

## **1.6 RESEARCH SETTING**

The study was conducted in hospitals in Mopani District, Limpopo Province.

### **1.6.1 Mopani District geographic location**

The Mopani District is situated in the North-eastern part of the Limpopo Province, 70 kilometres from Polokwane (the capital of Limpopo Province). It is bordered in the east by Mozambique, in the north by Vhembe District and Zimbabwe, and in the south by Mpumalanga Province through Enhlazeni District. The district covers 2 242 183 ha (22 421.83 square km). Mopani District has 15 urban areas (towns and townships), 325 villages (rural settlements) and a total of 106 municipal wards. The Mopani District, by virtue of the Kruger National Park as a District Management Area, is part of the Great Limpopo Transfrontier Park, the park that combines South Africa, Mozambique and Zimbabwe (see figure 1.1 map).



**Figure 1.1 Map of the Mopani District in Limpopo Province**

(Source: <http://www.mopani.gov.za/>)

### 1.6.2 Population

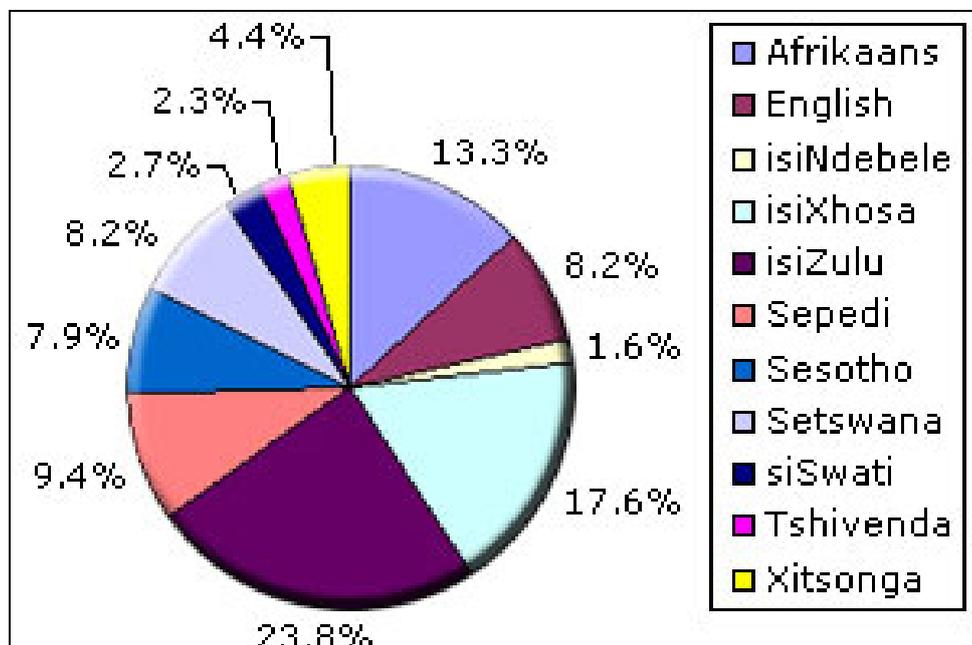
The Mopani District has an estimated population of 1 223 747. Of the population, 54,5% are females and 45,5% are males, and 51,3% of the people are younger than 35 years, with women having a longer life expectancy than men. Of the population, 81,0% reside in the rural areas, 14,2% reside in towns and townships, and 4,6% live on farms.

Table 1.1 depicts the population distribution in Mopani District.

**Table 1.1 Population for each municipality in Mopani District**

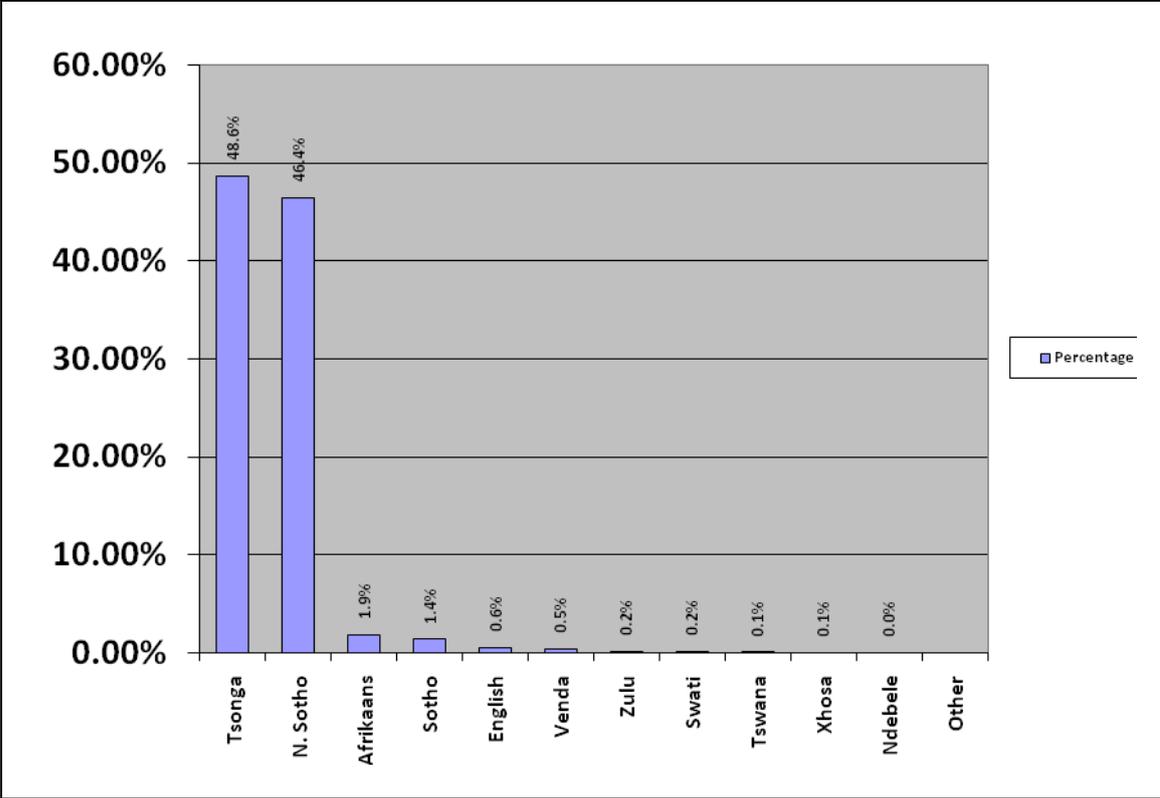
Municipality	Population	Rural	Towns/ Townships	Farm
Greater Giyani	276 668	247 585	29 083	13 729
Greater Tzaneen	442 282	362 453	45 836	33 993
Greater Letaba	260 286	245 523	14 743	27 460
Ba-Phalaborwa	137 264	49 633	69 950	17 681
Maruleng	107 247	95 162	2 494	9 591
<b>Total</b>	<b>1 223 747</b>	<b>1 000 356</b>	<b>162 126</b>	<b>102 454</b>

South Africa is a multicultural country with 11 official languages: Afrikaans (13.3%), English (8.2%), IsiNdebele (1.6%), IsiXhosa (17.6%), IsiZulu (23.8%), Sepedi (9.4%), Sesotho (7.9%), Setswana (8.2%), siSwati (2.7%), Tshivenda (2.3%) and Xitsonga (4.4%). The languages most commonly spoken in South Africa are IsiZulu (23.8%); isiXhosa (17.6%); Afrikaans (13.3%); Sepedi (9.4%), and English (8.2%) (Mopani District Municipality 2007/2008). Figure 1.2 illustrates the official languages of South Africa.



**Figure 1.2 South African population by language**  
(Source: Mopani District Municipality 2007/2008)

The main languages spoken in Mopani District are Xitsonga (48.6%) and Northern Sotho (46.4%), with Afrikaans (1.9%), Sesotho (1.4%), English (0.6%), Tshivenda (0.5%), isiZulu (0.2%), siSwati (0.2%), Setswana (0.1%), and isiXhosa (0.1%) less frequently spoken. Figure 1.3 depicts the languages spoken in Mopani District.



**Figure 1.3 Mopani District population by language**  
 (Source: Mopani District Municipality 2007/2008)

**1.7 PURPOSE OF THE STUDY**

A research purpose is “a clear, concise statement of the specific goal or aim of the study. The goal of the study might be to clearly and concisely describe, identify, or predict a solution to the problem” (Burns & Grove 2009:38).

The purpose of the study was to determine professional nurses’ knowledge of culture-competent care in medical and oncology wards and outpatient departments at selected hospitals in Mopani District, Limpopo Province.

The objectives of the study were to

- examine and determine professional nurses' knowledge of culture-competent care in medical and oncology wards and outpatient departments at selected hospitals in Mopani District, Limpopo Province
- make recommendations for an in-service training programme on culture-competent care for professional nurses working in Mopani District hospitals

## **1.8 SIGNIFICANCE OF THE STUDY**

The study should contribute new scientific knowledge which can be utilised in nursing education and practice. The findings could be incorporated to develop an in-service training programme for professional nurses. If professional nurses provide culture-competent care, it may be possible to improve patient care and enhance the well-being of patients, irrespective of their cultural background, in hospitals in Mopani District. The universals for culture-competent care could lead to the revision of the curriculum of R425.

## **1.9 THEORETICAL FRAMEWORK OF THE STUDY**

A framework is "an abstract, logical structure of meaning that guides development of the study and enables the researcher to link the findings to nurses' body of knowledge" (Burns & Grove 2009:701).

This study was guided by Campinha-Bacote's (1999) model of cultural competence in the delivery of healthcare service. Campinha-Bacote (2002:181) regards cultural competence as an ongoing process in which the health care professional continuously strives to achieve the ability to work effectively within the cultural context of the patients (individual, family, community). Campinha-Bacote's (2002:181) model comprises five constructs, namely cultural awareness; cultural knowledge; cultural skill; cultural encounters, and cultural desire. According to Campinha-Bacote (1996:59), cultural competence is a critical factor in providing relevant services to culturally diverse patient populations. This model was chosen because the researcher perceived nurses to lack

cultural competence when providing nursing care. Chapter 2 discusses the theoretical framework in detail.

### **1.10 RESEARCH DESIGN**

A research design is “a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings” (Burns & Grove 2009:218). In this study, a quantitative, descriptive design was adopted to determine professional nurses’ knowledge of culture-competent care.

Quantitative research is “a formal, objective, systematic process in which numerical data are used to obtain information about the world” (Burns & Grove 2009:22). Polit and Beck (2008:18) describe quantitative research as “the investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design”. The researcher chose a positivist paradigm because it is systematic (Polit & Beck 2008:16).

The purpose of descriptive studies is to provide an accurate portrayal or account of characteristics of a particular individual, situation, or group. Descriptive studies are a way of discovering new meanings, describing what exists, determining the frequency with which something occurs and categorise information. Descriptive studies are conducted when little is known about a phenomenon (Burns & Grove 2005:26). This study wished to examine the knowledge of professional nurses about culture-competent care.

### **1.11 RESEARCH METHODOLOGY**

Research methodology refers to the techniques used to structure a study and gather and analyse information in a systematic way (Polit & Beck 2008:765). The research methodology includes the population, sample and sampling, data collection and analysis, trustworthiness and ethical considerations.

### **1.11.1 Study population**

A population is all the elements, individuals, objects or substances that meet certain criteria for inclusion in a study (Burns & Grove 2005:40). The population in the study comprised all the professional nurses working in the medical and oncology wards and outpatient departments in the five selected hospitals in Mopani District, Limpopo Province. To be included in the study, the respondents had to be professional nurses:

- Involved with direct nursing care of patients from diverse cultures.
- Working in medical and oncology wards and the outpatient departments in the five hospitals.

### **1.11.2 Sample and sampling**

In this study, hospitals included by Limpopo College of Nursing for clinical exposure for their students were selected:

- One Provincial Hospital: Letaba Hospital.
- Four District Hospitals: Nkhensani Hospital; Maphuta-Malatji Hospital; Kgapane Hospital, and Van Velden Hospital.

A sample consists of “elements of the population considered for actual inclusion in the study or a subset of measurements drawn from a population in which the researcher is interested” (De Vos, Strydom, Fouche & Delport 2005:194).

Probability sampling was used to select the desired number of professional nurses working in medical and oncology wards and the outpatients departments in the five hospitals. In probability sampling, all elements in the population have an equal chance of being included in the sample (Brink 2009:126; Polit & Beck 2008:762). Probability sampling was used because every member of the population “has a probability of higher than zero of being selected for the sample” (Burns & Grove 2009:349). Systematic random sampling was used, which involves “selecting every *k*th individual on the list using a starting point selected randomly” (Polit & Beck 2008:762). Staff lists of every institution were obtained for this purpose. The research population was listed and every

second person selected as explained by De Vos et al (2005:196) (see chapter 3 for discussion). Table 1.2 lists the population and sample size for the selected hospitals.

**Table 1.2 Sample size of professional nurses in the selected hospitals**

<b>Name of hospital</b>	<b>Female</b>	<b>Male</b>	<b>Total population</b>	<b>Sample size</b>	<b>% of the total sample</b>
Nkhensani Hospital	39	9	48	24	9,6
Letaba Hospital	59	5	64	32	12,8
Kgapane Hospital	44	4	48	24	9,6
Van Velden Hospital	42	6	48	24	9,6
Maphuta-Malatji Hospital	39	3	42	21	8,4
<b>Total</b>	<b>229</b>	<b>21</b>	<b>250</b>	<b>125</b>	<b>50.0</b>

### 1.11.3 Data collection

Data collection refers to the “precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypothesis of a study” (Burns & Grove 2005:73). A structured questionnaire was used to determine the respondents’ knowledge of culturally competent care. Polit and Beck (2008:766) state that a structured approach often takes considerable effort to develop and refine, but yields data that are relatively easy to analyse. Structured methods are appropriate for in-depth examination of a phenomenon. Data was collected by means of a self-report questionnaire.

### 1.11.4 Data-collection instrument

The study used a structured questionnaire as data-collection instrument for the following reasons (Brink 2009:147):

- Respondents feel a sense of anonymity and are more likely to provide honest answers.
- The format is standard for all respondents and is not dependent on the mood of the interviewer.
- Questionnaires provide a quick way of obtaining data from a large group of people.
- Questionnaires are less expensive in terms of time and money.

### **1.11.5 Validity and reliability**

The quality of a research instrument is determined by its validity and reliability.

Validity refers to the extent to which an empirical measure accurately reflects the concept it is intended to measure (De Vos et al 2005:160). Validity of a measurement instrument measures accuracy. This study considered content, face, criterion and construct validity (De Vos et al 2005:161):

- Content validity is concerned with the representativeness or sampling adequacy of the content of an instrument.
- Face validity concerns the superficial appearance or face value of a measurement procedure.
- Criterion validity involves multiple measurement and is established by comparing scores on an instrument with an external criterion known or believed to measure the concept, trait or behaviour being studied.
- Construct validity involves determining the degree to which an instrument successfully measures a theoretical construct.

The validity of the questionnaire was enhanced by submitting it to the researcher's supervisors and a statistician for evaluation and approval.

Reliability refers to the consistency of the measurement result. Reliability of instruments refers to a measuring instrument's ability to yield consistent numerical results each time it is applied; it does not fluctuate unless there are variations in the variable being measured (De Vos et al 2005:162). The quality and adequacy of an instrument determine its reliability.

The questionnaire contained questions relevant to culturally competent care, based on the literature review and Campinha-Bacote's (1999) model of cultural competence in the delivery of healthcare service.

### **1.11.6 Data analysis**

Data analysis is conducted to reduce, organise, and give meaning to the data (Burns & Grove 2005:43). Descriptive statistics were used to analyse the data. Descriptive statistics allow the organisation of data in ways that give meaning, and facilitate insight into and examination of a phenomenon from various angles (Burns & Grove 2005:461). A statistician analysed the data using the Statistical Package for Social Sciences (SPSS) Programme version 21. The results were presented in tables and charts.

### **1.12 SCOPE AND LIMITATIONS OF THE STUDY**

The study was conducted in Mopani district, Limpopo Province. Professional nurses working in the medical and oncology wards and outpatient departments at five selected hospitals participated in the study.

Limitations of a study include sample deficiencies, design problems and weaknesses in data collection, among other things (Polit & Beck 2008:73). This study was limited to one district in Limpopo Province and to professional nurses. Enrolled nurses and enrolled auxiliary nurses and student nurses were not involved although they also nurse patients of diverse cultures. Accordingly, the findings cannot be generalised to the whole province or other parts of the country.

### **1.13 ETHICAL CONSIDERATIONS**

Ethics is concerned with matters of right and wrong. *Collins English Dictionary* (1991:533) defines ethics as “a social, religious, or civil code of behaviour considered correct, esp. that of a particular group, profession, or individual”. Ethical considerations mean that the respondents’ rights and the rights of others in the setting are protected (Pera & van Tonder 2005:4). The following ethical considerations were adhered to:

- **Protecting the rights of the institution**

The proposal of the study was presented to the Higher Degrees Committee in the Department of Health Studies (HSHDC), College of Human Sciences, UNISA for

approval (see annexure B). A letter requesting permission was written to the Limpopo Department of Health Ethics Committee for permission to conduct the study (see annexure C). Permission to conduct the study was granted (see annexure D). The research committee had the right to terminate the study if the safety, ethics and confidentiality of the respondents were not protected.

- **Protecting the rights of the respondents**

Respondents' rights have to be protected. If the purpose of the study appears to infringe on respondents' rights, the researcher should re-examine the purpose of the study and the study may have to be revised or abandoned (Burns & Grove 2005:81). The following respondents' rights were protected: self-determination and autonomy; anonymity and confidentiality; fair treatment; protection from discomfort and harm, and informed consent.

- **Self-determination and autonomy**

The right to self-determination is based on the principle of respect for persons as autonomous agents, who have the freedom to conduct their lives as they choose without external control (Burns & Grove 2005:181). The principle of autonomy holds that individuals are capable of controlling their destiny; they should be treated as autonomous agents, who have the freedom to conduct their lives as they choose without external control (Burns & Grove 2005:180). The researcher explained the nature and scope of the study and informed the respondents that participation was voluntary and that they had the right to refuse to participate.

- **Anonymity and confidentiality**

Anonymity exists if the respondents' identity cannot be linked, even by the researcher, with their individual responses (Burns & Grove 2009:196). After being informed of the purpose of the study and their rights, the respondents signed informed consent (see annexure F). The researcher kept the informed consent forms and the questionnaires separate to ensure anonymity. Numbers were used instead of names.

- **Fair treatment**

The right to fair treatment is based on the principle of justice (Burns & Grove 2005:189). The researcher ensured that all the respondents were selected and treated equally and fairly. The respondents received no remuneration.

- **Protection from discomfort and harm**

The right to protection from discomfort and harm is based on the principle of beneficence, which holds that one should do good and above all, do no harm (Burns & Grove 2005:190). The possibility that respondents might experience exhaustion and psychological discomfort when completing the questionnaire was taken into account. The researcher developed a questionnaire that was simple and easy to answer and not too long.

- **Informed consent**

Informed consent is an agreement to voluntary participation in a study, which is reached after the respondents have assimilated essential information about the study (Burns & Grove 2009:201). The respondents had the opportunity to choose whether or not to participate in the study. The respondents were reassured that the information would not be shared with other respondents. The final report containing anonymous information would be available to all at the end of the study.

The researcher provided the respondents with an information leaflet about the study, including her contact details (see annexure F).

- **Scientific integrity of the research**

The researcher ensured that the findings of the study were not falsified or fabricated. The research report is a true representation of the findings of the study. All the information was acknowledged to prevent plagiarism.

## **1.14 DEFINITION OF KEY TERMS**

For the purpose of the study, the following terms are used as defined below.

- **Transcultural nursing**

Transcultural nursing is a formal area of study and practice focused on comparative holistic culture, care, health and illness patterns of people with respect to differences and similarities in their cultural values, beliefs and ways of life, with the goal of providing culture-congruent, competent and compassionate care (Leininger 1991:29; Tjallinks in Tjale & De Villiers 2004:8). In this study, transcultural nursing means nursing in which professional nurses render nursing care of patients considering differences in their cultural background in relation to language, religion, beliefs and values related to illness.

- **Culture**

Culture refers to the learned, shared, and transmitted values, beliefs, norms and life ways of a particular group that guide their thinking, decisions, and actions in patterned ways (Leininger 1991:47; Giger & Davidhizar 2004:3). In this study, culture refers to the inherited beliefs and customs of different cultural groups in Mopani District. Different cultural groups have different beliefs and customs regarding health care.

- **Cultural beliefs**

Cultural beliefs develop from the shared experiences of a group in a society and are expressed symbolically (Andrews & Boyle 2008:66). In this study, cultural beliefs refer to what people in Mopani District believe to be acceptable and unacceptable according to their inherited culture.

- **Cultural competent care**

Cultural competent care is a process through which healthcare professionals integrate knowledge, attitudes and skills that enhance effective interactions with others to continually strive to effectively work in culturally diverse contexts (Andrews & Boyle

2008:40; Campinha-Bacote 2002:131). In this study, cultural competence refers to a professional nurse's ability to be competent to provide culturally sensitive nursing care.

- **Culturally sensitive care**

Culturally sensitive care is a deliberate cognitive activity in which healthcare professionals become appreciative of and sensitive to the values and beliefs of their patients (Giger & Davidhizar 2004:9). In this study, cultural sensitivity refers to the situation where professional nurses are sensitive to the cultural beliefs of patients and treat them with respect, irrespective of their cultural differences.

- **Cultural diversity**

Cultural diversity means that different people retain their individuality while contributing to a collective larger picture (Tjallinks in Tjale & De Villiers 2004:202). Purden (2005:226) defines cultural diversity in the context of health care as "the unique patterns and attributes of health and care among different societies". In this study, cultural diversity refers to situations where people in a hospital ward (patients and nurses) are from different culture groups or cultural backgrounds and require unique patterns of health and nursing care.

- **Professional nurse**

A professional nurse is a person who has been trained to provide comprehensive nursing care. In this study, a professional nurse is a person who is registered with the South African Nursing Council (SANC) as a nurse or as a midwife in terms of the *Nursing Act, 33 of 2005*.

- **Knowledge**

Knowledge refers to all that a person knows; all that is known; an organised body of information (*Shooter Oxford English Dictionary* 2002:1510). In this study, knowledge refers to professional nurses' knowledge about culture competent care and culturally diverse practices.

- **Nursing**

Nursing refers to a caring profession practised by a person registered under section 32 of the Nursing Act, 33 of 2005 (South Africa 2005:5) which supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he or she lives in comfort and with dignity until death.

### **1.15 LAYOUT OF THE STUDY**

The study is divided into five chapters.

Chapter 1 introduces the study, briefly describing the purpose, significance, research design and methodology, and ethical considerations.

Chapter 2 discusses the literature review conducted for the study.

Chapter 3 covers the research design and methodology.

Chapter 4 discusses the data analysis and interpretation.

Chapter 5 briefly presents the findings and makes recommendations for practice and further research.

### **1.16 CONCLUSION**

This chapter discussed the purpose, objectives and significance of the study; described the research design and methodology; defined key terms, and briefly discussed the ethical considerations of the study. Professional nurses provide nursing care to a culturally diverse patient population. The researcher wished to examine and determine the knowledge of professional nurses working in the selected wards of hospitals in Mopani District about culture-competent care.

Chapter 2 discusses the literature review undertaken for the study.

## CHAPTER 2

### Literature review

#### 2.1 INTRODUCTION

This chapter discusses the literature review conducted for the study. The literature review covered transcultural nursing; culture; cultural awareness; cultural knowledge; cultural beliefs; cultural diversity; culture-competent care, and culture-sensitive care. The theoretical framework for the study and the literature review was Campinha-Bacote's (2002) model. The model comprises five major constructs, namely cultural encounters; cultural knowledge; cultural skill; cultural awareness, and cultural desire.

A literature review is an organised, written presentation of what has been published on a topic. The purpose of the review is to convey to the reader what is currently known about the topic of interest (Burns & Grove 2009:92). Stommel and Wills (2004:339) define a literature review as "the formal process of locating existing information about a topic, with the goal of being able to summarise the state of knowledge". The literature review helps the researcher to develop a theoretical or conceptual framework for the study as well as relevant study methods and instruments or tools with which to measure the study variables (Brink 2006:52). The review should be comprehensive and cover relevant journal articles, books, reports, dissertations and theses.

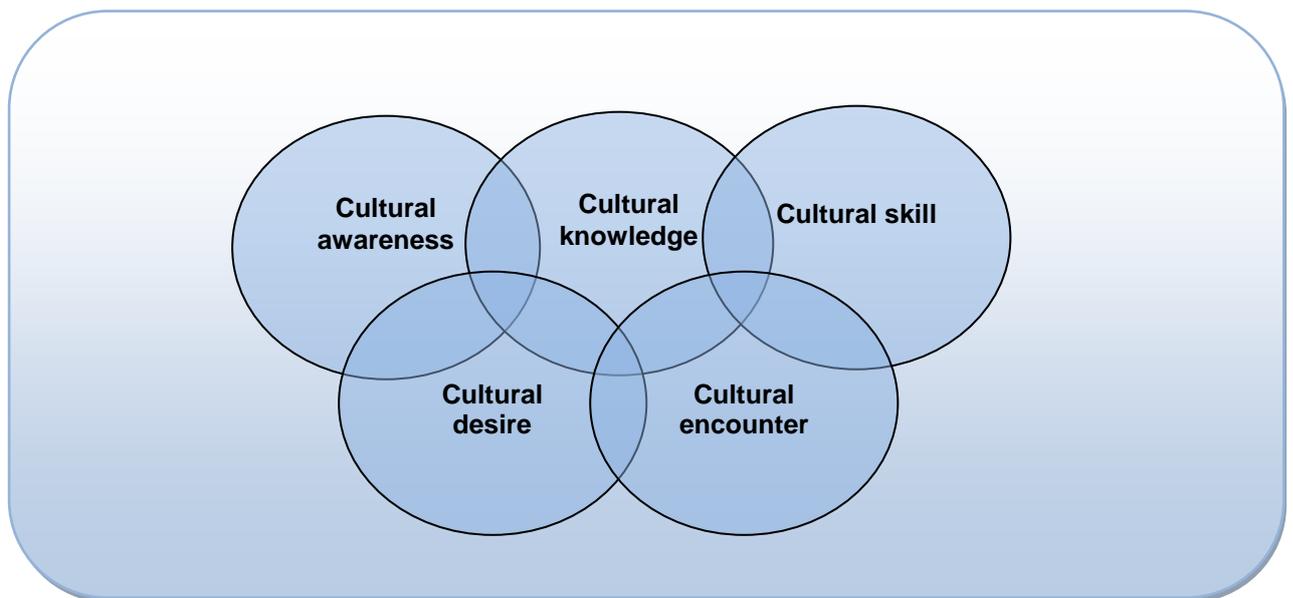
Polit and Beck (2008:10) state that a literature review:

- Helps to orientate the researcher about what is known and not known about an area of inquiry and then to compare the information with the research findings.
- Enables the researcher to ascertain how the research can best make a contribution to the existing base of evidence.
- Assists the researcher to determine any gaps or inconsistencies in the body of research.
- Lays the foundation and provides context for a new study.

The researcher used Campinha-Bacote's model; the Cumulative Index to Nursing and Allied Health Literature (CINAHL) data base, Medical Literature On-Line (Medline), and the Institute for Scientific Information (ISI) to search for appropriate literature (Polit & Beck 2008:110).

## 2.2 THEORETICAL FRAMEWORK

The theoretical framework guided the literature review. Campinha-Bacote's (2002:182) model of cultural competency is regarded as a process rather than an end point in which professional nurses continuously strive to achieve the ability to effectively work within the cultural context of an individual or community from a diverse or ethnic background. Figure 2.1 depicts the five major constructs in Campinha-Bacote's model (2002:183).



**Figure 2.1 The process of cultural competence in the delivery of health care services: a model of care**

(Adapted from Campinha-Bacote 1999:205)

Competence refers to the ability to have the skill to do something (*Oxford South African School Dictionary* 2010:122). According to Mays, De Leon Siantz and Viehweg (2002:139), cultural competency is constituted by practice through which knowledge is institutionally organised, certified, and transmitted. Furthermore, when nursing students are not taught about cultural differences in the curriculum, they only know the

institutional culture without knowing the cultural differences between different cultural groups. By including cultural competence in assessments of quality and implementing culturally competent systems of care, organisations can make serious progress towards successfully meeting the health care needs of a diverse patient population (Narayanasamy & White 2005:107).

Cultural competency is an ongoing process and must continually be monitored, reviewed and adapted to meet the specific cultural needs of clients. Professional nurses should always strive to achieve competency in nursing patients of diverse cultures by referring to individual knowledge, skills, values and behaviours and organisational management and operational frameworks and practices (Munoz et al 2009:499).

In order to render culture-competent care, health care professionals must take cognisance of Campinha-Bacote's five constructs: cultural awareness; cultural knowledge; cultural encounters; cultural skill, and cultural desire.

### **2.2.1 Cultural awareness**

Awareness refers to the knowledge of something (*Oxford South African School Dictionary* 2010:52). Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background. According to Campinha-Bacote (2002:182), increasing cultural awareness means to see both the positive and negative aspects of cultural differences. Culturally aware people realise that people are not the same, but that similarities and differences are important. Professional nurses should seek out experiences and opportunities to learn about cultures that are different to their own. Learning about cultural commonalities and differences can assist and enable professional nurses to communicate effectively with people, especially during challenging times. Cultural awareness requires professional nurses to listen carefully, identify information being conveyed, and avoid being biased.

Rew, Becker, Cookston, Khosropour and Martinez (2003:250) cite Clinton (1996) who maintains that people are culturally aware when they are conscious that people are different from one another, partly because of their cultural backgrounds. Furthermore, the task of delivering culturally competent education begins with nurse educators'

awareness of how their own cultures affect different aspects of their lives (Rew et al 2003:250).

Quappe and Cantatore (2005:1) maintain that increasing cultural awareness means seeing both the positive and negative aspects of cultural differences and recognising that what is considered appropriate behaviour in one culture is frequently inappropriate in another one. Culture can influence the manner in which individuals express their emotions (Campinha-Bacote 2002:182). To render culture-competent care, being aware is not sufficient. The professional nurse should have cultural knowledge.

### **2.2.2 Cultural knowledge**

Knowledge refers to what you know and understand about something (*Oxford South African School Dictionary* 2010:582). Cultural knowledge refers to knowledge of the beliefs, values and behaviours of a cultural group. Cultural knowledge could enhance the relationships and nursing care between people of diverse cultures. According to Marcinkiw (2003:175), cultural knowledge is obtained by actively seeking information on how others view the world. Worldview refers to the way individuals or cultures grow, perceive and know their world. A worldview should be an integral part of all nursing practice, teaching and research. Nurses should constantly seek for insight about many diverse aspects of human living and look at the unifying values of individuals (Leininger & McFarland 2006 2).

According to Campinha-Bacote (2002:182), cultural knowledge is the process in which a professional nurse seeks and obtains sound educational information about the worldviews of different cultural and ethnic groups as well as biological variations, disease and health conditions, and variations in drug metabolism found among ethnic groups. Moreover, obtaining cultural knowledge about clients' health-related beliefs and cultural values involves understanding their worldviews. According to Tjallinks (in Tjale & De Villiers 2004:13), a worldview concerns a system of values that underlies and shapes people's behaviour. A worldview refers to how people relate to circumstances of their lives by positioning or adapting themselves in time and space in relation to the environment in which they live. Clients' worldviews explain how they interpret their illness and how this guides their thinking, doing, and being.

Cultural competence is the sound educational foundation that nurses establish as they gather cultural information in a formal and/or informal manner (Munoz, DoBroka & Mohammad 2009:498). According to Sargent, Sedlack and Martsof (2005:215), cultural competence amongst nursing students and faculty involves obtaining information pertaining to specific biological variations, beliefs related to illness causality, culture-bound illness, and forms of interaction among ethnic groups.

### 2.2.2.1 *Culture*

Giger and Davidhizar (2004:3) define culture as a “behavioural response that develops over time as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations”. Giger and Davidhizar (2004:3) add that culture is shaped by values, beliefs, norms, and practices that are shared by members of the same cultural group. Culture also guides people’s thinking, doing, and being and becomes patterned expressions of who they are. Culture-determined factors include language spoken at home, religious observances, customs, acceptable gender roles and occupations, dietary practices, intellectual, artistic and other types of behaviour, and transmitted values, beliefs, norms and life ways of a particular group that guides their thinking, decisions, and actions in patterned ways (Leininger 1991:47).

Culture influences a person’s concept of disease and illness. It is the variable known to determine health beliefs and behaviours. According to Campinha-Bacote (1994:4), culture

- Is learned.
- Is acquired by one’s experience and the process by which culture is transmitted from one generation to another is referred to as enculturation.
- Is shared.
- Defines patterns of values, attitudes, beliefs and behaviours that are learned throughout socialisation.
- Gives an individual a sense of direction as well as meaning to life.
- Guides an individual internally to do what ought to be done in certain situations.

Campinha-Bacote (1994:4) emphasises that the cultural aspect of health care is an important and influential variable to consider when providing health care services to individuals from diverse cultural backgrounds. Giger and Davidhizar (2004:5) maintain that culture influences the way people think, feel and behave and that cultural groups have unique verbal and non-verbal patterns of communication. Culture is described in many ways and includes an integrated combination of constructs that go beyond ethnicity and race (Gallagher 2010:155). Moreover, culture is an integrated pattern of human behaviours including thoughts, communication, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups (Gallagher 2010:155).

#### *2.2.2.2 Transcultural nursing*

There is no consensus on a definition of transcultural nursing. Culturally diverse nursing care refers to the variability in nursing approaches needed to provide culturally appropriate and competent care (Giger & Davidhizar 2004:7). Cultural beliefs develop from the shared experiences of a group in a society and are expressed symbolically (Andrews & Boyle 2008:66). Culturally competent care is a process by which health care professionals integrate knowledge, attitudes and skills that enhance effective interaction with others to continually strive to work effectively in culturally diverse contexts (Andrews & Boyle 2008:40). Culturally sensitive care is a deliberate cognitive activity by which health care professionals become appreciative of and sensitive to the values and beliefs of their patients (Giger & Davidhizar 2004:9).

In the mid 1950's Leininger (cited in Andrews & Boyle 2008:4) envisioned transcultural nursing as a formal area of study and practice and coined the term "transcultural nursing". Transcultural nursing focuses on comparative holistic culture, care, health and illness patterns of people with respect to differences and similarities in their cultural values, beliefs and ways of life, with the goal of providing culture-congruent, competent, and compassionate care (Giger & Davidhizar 2004:6). Giger and Davidhizar (2004:6) define transcultural nursing as a culturally competent practice field that is client centred. The authors maintain that every nurse, regardless of academic or experiential background, must use transcultural knowledge to facilitate culture specific appropriate care.

Andrews and Boyle (2008:4) describe transcultural nursing as a specialty in nursing focused on the comparative study and analysis of different cultures and subcultures, with the goal of developing a scientific and humanistic body of knowledge in order to provide culture-specific and culture-universal nursing care. Transcultural nursing is grounded in caring and culture care. It is also viewed as culture competent and client centred. Patients and nurses with different cultural backgrounds meet during nursing care. According to Price and Cortis (2000:238), the goal of transcultural nursing is to achieve a body of knowledge that will underpin the skills needed to provide holistic health care to people who may be of a different cultural persuasion to that based on the Western system of medicine.

Much research has been done on transcultural nursing. Transcultural nursing encompasses environment, health, people and nursing.

- *Environment* can be defined as all tangible and symbolic phenomena that impinge on and influence development, beliefs, and behaviour. The physical environment includes climate, geography, housing and sanitation, and air quality. The physical environment is a factor in the development of any culture and influences how houses are built and the economy developed, and the clothing worn. The social environment includes all those structures associated with socialisation of a person into a group in a society. The symbolic environment refers to music, art, history, language, and other symbols that provide a common means of communication and identification with a group's values and norms (Andrews & Boyle 2008:10).
- Andrews and Boyle (2008:10) cite the WHO's definition of *health* as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Health includes meeting one's needs for fulfilment or realisation of one's potential. According to Bereda (2002:22), health as a category of culture includes a wide variety of practices, attitudes, and beliefs held by different people. Professional nurses are expected to provide quality nursing care to all patients and should therefore have knowledge of nursing patients from diverse cultures.

- All societies are made up of *people*, a collection of individuals, who reflect the shared cultural heritage of the group to one degree or another. According to Andrews and Boyle (2008:11), individuals share some part of the cultural heritage of their group but never all of it. Moreover, the nature and extent of people's participation in the cultural traditions valued by society are influenced by personal forces, both internal and external, such as temperament, education, motivation, maturity, and past experience (Andrews & Boyle 2008:11).
- *Nursing* represents both the nurse and nursing care. According to Andrews and Boyle (2008:13), nurses enter the health care profession with their own unique concepts of health but are socialised during their training to shed their old values and thoughts, adapt to new scientific concepts, learn new attitudes, and develop behaviour patterns in line with their new culture.

Transcultural nursing is a strategy of caring that takes into account, with sensitivity, the individual's culture, involving specific values, beliefs and practices. Transcultural nursing is holistic in nature, embracing a range of cultural factors, such as spirituality, economics, politics and kinship in diverse cultures (Tjallinks in Tjale & De Villiers 2004:8). Every individual is culturally unique and it is important for nurses to remember that culture can and does influence how clients are viewed and the care that is rendered (Tjallinks in Tjale & De Villiers 2004:8).

In terms of transcultural assessment and intervention, a patient is a culturally unique individual, who should be assessed on communication, space, social orientation, time, environmental control and biological variations in order to formulate nursing diagnosis for the planning of nursing care (Giger & Davidhizar 1999). Individual patients must be assessed holistically and the planned nursing care should cover all their needs.

Leininger's (1991:3) culture care, diversity and universality theory was the first theory in nursing to focus systematically on human care from a transcultural perspective as the essence of nursing and a central, dominant and unifying domain of nursing knowledge and practice. The purpose of the theory was to discover human care diversities and universalities in relation to social views and structures. Leininger's theory challenges nurses to discover transcultural human care knowledge that guides the provision of culture-competent care (Leininger 1991:39).

Caring refers to actions and activities directed towards assisting, supporting, or enabling others with evident or anticipated needs to ameliorate or improve a human condition or life ways (Leininger 1991:46). Leininger argues that caring is essential for curing and healing, for there can be no curing without caring. Leininger and McFarland (2006) later expanded the theory to a worldwide nursing theory of cultural care, diversity and universality.

Omeri (2008:207) stresses that advancing transcultural nursing requires collaboration, particularly due to globalisation of health care and contemporary demands on health care. Nurses need to recognise that they live in a multicultural world and all professional nurses must be culturally competent to serve people appropriately (Omeri 2008:209). The world is becoming more multicultural, which means that all health workers should be able to provide culture-competent nursing care to meet the needs of patients from diverse cultures (Wikberg & Erikson 2008:485). Professional nurses should understand patients' cultural background and needs when providing nursing care because a lack thereof could result in interpreting the patients as uncooperative, difficult or stubborn. In Italy, Festini, Forcadi, Bisogni, Mannini and Neri (2009:220) found that Italian nurses experienced communication problems when nursing foreign children and their families.

#### *2.2.2.3 Necessity for and process of rendering transcultural nursing*

Nurses need to recognise and respect patients' cultural values in order to render culturally competent care and to prevent cultural imposition, cultural care negligence, and cultural care conflicts. Cultural care re-patterning (or restructuring) also helps clients to change their ways to improve their health and well-being (Leininger 1991:42). Cultural care differences and similarities exist universally between professional caregivers and patients. Health care providers care for patients from different cultural groups. In a study of Saudi Arabian cultural knowledge among Non-Muslim nurses working in obstetric units, Sidumo (2007:19) found that nursing should aim at professional commitment in building a global community that is inclusive, respectful and dedicated to health care for all.

#### *2.2.2.4 International perspectives on transcultural nursing*

Globalisation and increasing interconnectedness further emphasise the need for nurses to have knowledge of nursing patients from diverse cultures. According to Maier-Lorentz (2008:37), transcultural nursing has become a key component in health care and a requirement for today's practising nurse because of escalating multiculturalism in societies. This requires nurses to recognise and appreciate cultural differences in health care values, beliefs and customs. Douglas and Lipson (2008:162) emphasise that transcultural nursing mandates that the principles of social justice, human rights and cultural competence extend as much to nurses' professional colleagues as to their patients. All health care professionals' training should incorporate principles of culture diversity. Greer, Park, Green, Betancourt and Weissman (2006:1107) found that physicians' preparedness to deliver cultural care was influenced by the degree of instruction they received during their graduate medical training. The American Medical Association and the Accreditation Council for Graduate Medical Education have called for the inclusion of transcultural nursing training curricula to improve cultural competence amongst the physicians (Greer et al 2006:1109).

Ghana is a developing country with many different cultures and religions. The population uses both modern and traditional health care systems. In Ghana, individuals' interaction with the health care system depends on how the health problem is perceived by the sick individuals, their relatives and their friends (Tabi, Powell & Hodnicki 2006:52). Tabi et al (2006:54) found a need for professional nurses in Ghana to receive formal education about culture-competent care because of the diversity of the population and health care systems used.

#### *2.2.2.5 Transcultural nursing in South Africa*

In South Africa, transcultural nursing has not developed fully as a discipline with respect to education, research and practice and its implementation is not yet widely recognised (Tjallinks in Tjale & De Villiers 2004:9). In the nursing curriculum implemented by the Nursing College in Limpopo, the principles of transcultural nursing are integrated in modules but not presented as a separate module. Students are taught the principles of transcultural nursing in the modules Fundamental Nursing Science and General Nursing Science (Limpopo College of Nursing curriculum 1997:680). In a study on traditional

healing as a health care delivery system in a transcultural society, Bereda (2002:100) found that in South Africa many patients were ready to use the three health care systems, namely modern health care, traditional healing, and holistic health care. Modern health care explains disease on the basis of science. Knowledge is shared; information on disease can be tested, measured and verified, and research is conducted. Traditional health care or healing regards disease and its cause from a magico-religious perspective. Holistic health care explains disease from the environment and supernatural world. Bereda (2002:100) maintains that educating health professionals about traditional health care is necessary because they are generally prejudiced against traditional practitioners. Cultural knowledge is important in a changing society.

When providing nursing care, professional nurses should understand patients' beliefs regarding their health care needs. For example, some patients may require their priests to come and pray for them while they are still receiving care while others may require a "pass out" to go home and see their traditional healers and come back to hospital to receive medical treatment.

In a study in Mopani District on the culture care beliefs, values and attitudes of Shangaans in relation to hypertension, Risenga (2002:85) found that knowledge of traditional healing is important for providing culture-competent care. Ignorance of this knowledge may lead to failure to adjust and cope with the chronic disease of hypertension.

Transcultural nursing is not well developed in basic training programmes. In higher education, such as at the University of South Africa, transcultural nursing is offered as a module.

#### *2.2.2.6 Cultural education in nursing*

Duffy (2001:487-495) maintains that cultural education in nursing has not evolved to meet the demands of the multicultural global society. Leuning, Swiggum, Wiegert and McCullough-Zander (2002:45) state that cultural knowledge needs to be nurtured through continuing education and mentoring. According to Esegbona-Adeigbe (2011:489), cultural knowledge is the most important construct of cultural competency

for health professionals. Esegbona-Adeigbe (2011:489) refers to a report that the increased mortality rate in black African mothers may be attributed to cultural factors. Midwives should use culture as the first point of assessment for women when devising care plans or patterns of care and this will allow consideration and acknowledgement of cultural norms and respect for taboos. Student midwives in the United Kingdom are now being educated about specific cultures and cultural practices relevant to pregnancy and childbirth. Nurse educators need to make opportunities available for areas of teaching transcultural nursing. Moreover, cultural knowledge is the foundation of cultural competency in health care hence there is a need for nurse educators to be engaged in activities to improve cultural knowledge (Esegbona-Adeigbe 2011:489). In the USA, Mancuso (2011:65) maintains that many health disparities can be overcome by overcoming health literacy barriers. Mancuso (2011:65) stresses that efforts to overcome health literacy must be bidirectional: building on and attending to community needs while also adding to provider knowledge and understanding.

Marcinkiw (2003:178) states that students can be given lessons on culturally competent care through formal education in classrooms and clinical areas to gain cultural knowledge. Regarding intercultural education of nurses and health professionals in Europe (IENE), Taylor, Papadopoulos, Maerten and Ziegler (2011:194) point out that practical experiences are fundamental to developing cultural competence. Practical experiences refer to skills gained following clinical exposure in nursing patients of diverse cultures. Furthermore, health care practitioners need to be adequately prepared for these experiences as an intercultural experience does not automatically lead to learning.

Purden (2005:232) argues that classroom teaching of cultural content does not adequately address the provision of culturally sensitive care and may, in fact, oversimplify the cultural needs of patients. Omeri (2008:208) concurs, indicating that the challenge is to provide research-based transcultural knowledge to guide practice and to be effective in helping others for the development of transcultural education of clinicians and faculty. However, Sealey, Burnett and Johnson (2006:138) found that very few respondents in their study had formal preparation to teach transcultural nursing.

In their outcome analysis of a research-based didactic model for education to promote culturally competent nursing care in Sweden, Gebru, Khalaf and Willman (2008:348)

found that the respondents appeared to be well prepared for the multicultural society in which they were to be active as professionals.

Lim, Downie and Nathan (2004:433) emphasise that it is critical for nurse educators to correlate theory and practice for the students to ensure that the future generations of nurses are better able to provide effective and efficient care to meet the health care demands of a multicultural society.

Regarding a goal for nursing education, Marcinkiw (2003:175) examined internet usage for acquiring cultural information. The feedback from the students in an initial exchange opportunity indicated that 76% of the respondents who participated in the study increased their cultural knowledge through internet communication.

#### *2.2.2.7 Integration of transcultural nursing in nursing education*

There is a need for the inclusion of information on transcultural nursing in the nursing curriculum (Maier-Lorentz 2008:37; Purden 2005:232). This could enhance the quality of nursing care and enrich the experiences of nurses who have immigrated to foreign countries. Transcultural nursing can be integrated and facilitated by means of mentorship and effective interaction.

- *Mentorship*

Mentorship is a system of support provided to pre- and post-registration students by more experienced colleagues to facilitate their professional and personal development (*Blackwell's Nursing Dictionary* 2005:365). The Transcultural Nursing Society developed standards based on Leininger's culture theory and Campinha-Bacote's model of cultural competence (Leuning et al 2002:40). The standards are intended to foster excellence in transcultural nursing practice, to evaluate nursing care, to be a tool for teaching and learning, to increase the public's confidence in the nursing profession, and to advance the field of transcultural nursing. The standards serve as a guideline on how people should function within the organisation. When applied in nursing practice, the standards can serve to mentor professional nurses as well as guide them to practise transcultural nursing. Leuning et al (2002:41) identify seven transcultural nursing standards:

*Standard I: Theory* emphasises that transcultural nurse generalists should utilise nursing theory and theoretical concepts as a basis for practice.

*Standard II: Cultural information* emphasises knowing one's own culture and that the nurse should approach an individual, family or community with the intent to gain understanding of the insider meaning, expressions, patterns of health, care and caring as lived and experienced by persons or the group.

*Standard III: Caring and health system* emphasises that the information on the caring, and healing systems and modalities used by an individual, family or community are essential for holistic assessment.

*Standard IV: Cultural health patterns and caring practices* emphasises that identification of caring and healing values, beliefs and practices used by individuals, families or communities is essential to guide health promotion, illness reduction, or optimal living with disability or death.

*Standard V: Health care planning* emphasises that health care planning is done in collaboration with persons seeking care. The standard is based on Leininger's cultural care theory, which indicates that nursing care planning encompasses the following three processes or caring actions: culture care preservation (assistive, supportive, facilitative or enabling professional actions and decisions that help people of a particular culture to retain and/or preserve relevant values and practices), cultural accommodation (professional actions and decisions that foster mutual adaptation to beneficial or satisfying health outcomes), and cultural care re-patterning (professional actions and decisions made in collaboration with the clients or patients seeking care that assist in modifying cultural patterns).

*Standard VI: Evaluation* emphasises that evaluation is critical to reflective and informed practice. It emphasises that the nurse actively seeks feedback from individual, family, or community about the quality of care they have received.

*Standard VII: Research* emphasises that the foundation of a discipline is its body of knowledge, core values and contributions to the greater good of society and community.

In addition, transcultural nurse generalists participate in the advancement of transcultural nursing theory and practice.

- *Effective interaction*

Cultural knowledge may lead to effective interaction and appropriate responses to patients' needs. According to Leininger and McFarland (2006:276), cultural knowledge may reduce stress, conflict and practices that prevent cultural problems and offensive acts. Sidumo (2007:19) and Leininger and McFarland (2006:276) stress that cultural knowledge may influence the quality of nursing care provided to patients of diverse cultures.

Cultural knowledge assists professional nurses to understand patients' needs and to plan the nursing care considering the cultural differences of patients. Cultural care universality refers to the common, similar, or dominant uniform care meanings, patterns, values, life ways, or symbols of care that manifest among many cultures and reflect assistive, supportive, facilitative or enabling ways to help people (Leininger 1991:47). Healthcare professionals need cultural knowledge to render culture-competent care. This knowledge is unique and not specific to one ethnic group.

#### *2.2.2.8 Pharmacogenetic research*

Campinha-Bacote (2002:61) points out that the provision of culturally relevant services regarding drug therapy is neglected. Since the late 1990s pharmacogenetic research has uncovered significant differences among racial and ethnic populations regarding metabolism rates. Pharmacogenetic research is dedicated to understanding the genetics of patients' response to and experience of side effects of medication. It facilitates precise, personalised prescription based on patients' individual genetic composition (Pharmacogenetics Research Clinic 2012). Cultural knowledge is important for nurse educators to include variant responses to drugs in ethnic or racially distinct groups when they prepare and present lectures on pharmacology such as drug actions in the body.

### 2.2.2.9 Importance of cultural knowledge

In a study on cultural care beliefs, values and attitudes of Shangaans in Mopani District, Risenga (2002:96) found that delivery of culturally sensitive health care requires that nurses develop a positive attitude towards people from different cultural backgrounds. Gaining cultural knowledge means familiarising oneself with cultural variations in families and health beliefs. Mays, De Leon Siantz and Viehweg (2002:140) indicate that organisations that serve persons from diverse backgrounds must incorporate cultural knowledge into their model of service delivery.

### 2.2.2.10 Principles of cultural knowledge

Australian nursing curricula emphasise the importance of nurses having a sound knowledge of cultural values, beliefs, practices and attitudes in order to respond effectively to the needs of patients (Pinikahana, Manias & Happel 2003:150).

- *Values.* Values relate to the principles and beliefs that people hold about what is right and what is wrong (*Oxford South African School Dictionary* 2010:656). Values relate to norms of a culture and identify what should be judged as good or evil. Individual cultures develop values which their members broadly share. Different cultures reflect different values. According to Tjallinks (in Tjale & De Villiers 2004:50), values are sets of personal beliefs and attitudes about the truth, beauty and worth of any thought, object or behaviour. Values also provide a frame of reference and a basic comprehension of reality through which people integrate, explain and appraise new ideas, events and personal relationships. Values are learned through moralising, modelling, reward and punishment, explanation, manipulation, enculturation and exposure to life experiences (Tjallinks in Tjale & De Villiers 2004:50). Examples of values are respect for the elders, good morals and sense of humour for a specific group of people which are learned.
- *Beliefs.* Belief refers to people's belief especially as part of their religion (*Oxford South African School Dictionary* 2010:54). Patients of diverse cultures have different religious beliefs related to their health, and they should be respected by

professional nurses while rendering nursing care (e.g., Christianity and ancestral beliefs).

- *Practices.* Practices refer to actual application or use of an idea, belief, or method as opposed to theories about such application or use (*Oxford South African School Dictionary* 2010:468). Cultural practices apply to any person manifesting any aspect of culture at any time. They also refer to the traditional practices developed within specific ethnic cultures, especially those aspects of culture that have been practised since ancient times (Cultural Practice 2012).

#### 2.2.2.11 *Stereotyping and discrimination*

Stereotyping refers to judging a group of people who are different from you based on your own or others' opinion. It also refers to a fixed set of ideas or an impression about a particular type of person or thing (*Oxford South African School Dictionary* 2010:54).

Discrimination refers to distinguishing treatment of an individual based on their actual or perceived membership in a group or category (*Oxford South African School Dictionary* 2010:168). Carson, Bond and Jones (2004:283) found that cultural knowledge and educational preparation of health care professionals may influence cultural skill. Professional nurses who are culturally aware and have acquired cultural knowledge need skills to execute the information obtained in order to render culturally competent care.

### **2.2.3 Cultural skill**

A skill refers to something that you can do well (*Oxford South African School Dictionary* 2010:555). Cultural skill is the ability to collect relevant cultural data regarding the client's presenting problem as well as accurately perform a cultural assessment (Campinha-Bacote 2002:182). Munoz, DoBroka and Mohammad (2009:498) describe cultural skill as "the ability to collect relevant objective and subjective cultural data from culturally diverse clients during a cultural assessment". A cultural assessment is a major skill which includes many aspects. Professional nurses have to listen and ask questions in order to collect relevant data from the client. An individual cultural assessment is needed because every client has values, beliefs and practices that must be considered

when rendering health care services (Campinha-Bacote 1996:61; Sargent et al 2005:215; Marcinkiw 2003:179). Campinha-Bacote (1996:61) emphasises that cultural assessment should not be limited to a specific ethnic group, but rather conducted with each individual. Every individual is unique with his/her own cultural need. Practical experiences are fundamental to developing cultural competence. Practical experiences refer to skills gained following clinical exposure to nursing patients of diverse cultures. Furthermore, health care practitioners need to be adequately prepared for these experiences as an intercultural experience does not automatically lead to learning.

Cultural skill includes communication, space, social organisation, time, environment control, and biological variation.

- *Communication.* Communication is a continuous process through which one person may affect another through written or oral language, gestures, facial expressions, body language, space or other symbols (Blackwell's Nursing Dictionary 2005:140). Communication is the means by which culture is transmitted and preserved (Giger & Davidhizar 2004:8, 22)

Culturally informed communication requires thinking beyond race ethnicity; thinking outside one's own box; experiencing culture; using language that evokes images of people actively engaged in life; listening carefully; learning by asking; avoiding insensitive comments; expanding one's comfort zone; making local connections; exchanging stories, and respecting language preferences; honouring flexibility in others' self-identification. Suarez-Balcazar, Balcazar, Taylor-Ritzler, Portillo, Rodakowsk, Garcia-Ramirez and Willis (2011:12) state that becoming culturally competent is an on-going process that results in professional understanding and improved ability to adequately serve individuals who look and behave differently from the health workers. To best communicate with people in any community, it is important to be open to differences in how people express their feelings.

According to Dogan, Tshudin, Hot and Özkan (2009:684), effective communication between patients and health care providers is a critical element in quality health care and ethical practice. Dogan et al (2009) investigated Turkish people who immigrated to Germany between 1955 and 1975. Turkish patients

expressed the need to be able to communicate well with nurses, and a need for physical contact and understanding of their culture-based expressions of illness. The German nurses expressed the need for language barriers to be minimised and for education in the specific culture of Turkish patients. Labun (2001:874) found that North American nurses working with Vietnamese refugees regarded them as a community of refugees without considering their cultural needs. This changed when the nurses came to realise that the Vietnamese were individuals with different cultural needs. They followed Camphinha-Bacote's model to become culturally competent. Patients expect their cultural beliefs, values, and life ways to be understood and respected by nurses and other health care providers (Andrews & Boyle 2008:5). The increased use of health care technology sometimes conflicts with patients' cultural values. In Saudi Arabia, Sidumo (2007:46) found that nurses encountered difficulty in having many family members present and asking questions related to illness because a family is a support system.

- *Space.* Space is the area around a person's body that includes the individual body, surrounding environment, and objects within that environment. A person's space can be used to meet the needs of security, privacy, autonomy, and self-identity. For example, the intimate space that is reserved for comforting, protecting and counselling (Tjallinks in Tjale & De Villiers 2004:164).
- *Social organisation.* Social organisation refers to family structure and organisation, religious beliefs, and the group's participation in social activities.
- *Time.* A person focuses on the past, present or future. Most cultures include all three time orientations but one is more likely to dominate the cultural perspective. Time may be related to work. There is also social time, which is the time after work. Measures are taken to ensure that time is utilised properly. Time is stated in minutes and hours of a day. Time is important in nursing because all the routine work is done according to the stated time. Professional nurses need to consider time when rendering culture-competent nursing care because each routine is done according to the rules and policy of the institution.

- *Environmental control* refers to the perceived ability of individuals from particular cultural groups to plan activities that control nature, such as illness causation and illness. For example, individuals may wear bracelets or cords around their waists believing that these will stop illness from attacking their body.
- *Biological variation*. Biological differences among racial and ethnic groups may include physical characteristics such as skin colour, and physiological variations such as lactose intolerance (Giger & Davidhizar 2004:8).

Cultural skill assists health care professionals to be able to mentor other nurses (Leuning et al 2002:45). Furthermore, transcultural nursing standards were developed to assist nurses in providing culturally competent care. Professional nurses should be able to listen and ask open-ended questions after identifying the language of a patient in order to collect relevant cultural data. The data gathered from each patient on admission will be used by the professional nurse to plan an individualistic nursing care plan.

#### **2.2.4 Cultural encounter**

An encounter means to experience something (*Oxford South African School Dictionary* (2010:54). Cultural encounter encourages professional nurses to directly engage in cross-cultural interactions with patients from culturally diverse backgrounds (Campinha-Bacote 2002:182). According to Munoz et al (2009:498), cultural encounter is the process in which nurses seek opportunities to engage in cross-cultural interactions directly or indirectly. A direct encounter is when the professional nurse gives direct care to an individual from a different cultural background using cultural knowledge and implementing cultural skill in the care provided. An indirect encounter is when the professional nurse obtains cultural information based on the experiences of another professional nurse in a direct encounter.

The value of cultural encounters can be influenced by communication barriers. Diamond and Jacobs (2009:191) found that migration led to increasing language barriers in the United States of America. Many immigrants had limited English proficiency and language courses implemented to teach clinicians proved beneficial. The language

courses improved health professionals' knowledge, attitudes and skills and decreased the need for interpreters for help in cultural issues.

Jirwe, Gerrish and Emami (2010:443) examined Swedish student nurses experiences of communication in cross-cultural care encounters, especially when they did not speak the patients' language. Although the student nurses used a range of strategies to facilitate communication, they found themselves unable to communicate effectively and this led to dissatisfaction with the caring experience. Jirwe et al (2010:444) maintain that nursing programmes should enable students to become competent in communicating in cross-cultural care encounters and the clinical learning environment provides the opportunity to put their learning into practice. Cultural encounters between students from different cultural backgrounds is a fruitful way of teaching nurses because it enables them to share information on experiences in nursing patients of diverse cultures and also teaches them different languages.

#### *2.2.4.1 Process of communication during a cultural encounter*

Communication refers to sharing or exchanging information, feelings, or ideas with somebody (*Oxford South African School Dictionary* 2010:120). Giger and Davidhizar (2004:22) describe the components of the communication process as the communicator, encoding, message, channel, noise, recipient, decoding, interpretation, feedback and context.

The *communicator* is the starting point of communication with others such as face-to-face communication. *Encoding* means that the communicator is the encoder of the message. Encoders turn their thoughts into a form that can be understood by others. The *message* identifies the encoded thought and ideas and links the communicator and the recipient. The *channel* refers to how the encoded message is transmitted. The channel can be a telephone, printed material such as pamphlets, and booklets, or mass media such as newspapers, radio or television. *Noise* refers to anything that distorts the message that the communicator encodes. For example, external noise can be sounds and internal noise can be thoughts and ideas that can interfere with the message. The *recipient* is the person who receives the communication or message. *Decoding* is the process of giving meaning to and interpreting. The recipient must be willing to decode the message; that is give meaning to and interpret the message from the communicator.

*Interpretation* refers to the active meaning the recipient assigns to the message. *Feedback* refers to the recipient's response to the communicator, who in turn assigns meaning to the recipients' feedback. *Context* is the environment where communication takes place. The context is influenced by time, place, physical surroundings and the roles of people involved (Giger & Davidhizar 2004:24).

### **2.2.5 Cultural desire**

Professional nurses may be culturally aware, knowledgeable, have cultural skills and communicate through encounters, but should demonstrate a desire to execute the construct. Without the desire (will), culturally competent care may be compromised. Desire is a feeling of wanting something very much (*Oxford South African School Dictionary* 2010:168). Cultural desire is health care providers' motivation to want rather than have to engage in the process of becoming culturally knowledgeable, culturally skilful, and familiar with cultural encounters (Campinha-Bacote 2002:182). Cultural desire is the commitment and motivation of human service professionals to provide cultural competent care (Munoz et al 2009:498). *Commitment* is an agreement to perform a particular activity at a certain time in the future under certain circumstances (*Oxford South African School Dictionary* 2010:120), *motivation* refers to the internal and external factors that stimulate desire and energy in people to be continually interested and committed to a job (*Oxford South African School Dictionary* 2010:396).

Professional nurses' desire can influence their ability to work well with patients of diverse cultures. Marcinkiw (2003:180) indicates that if health care professionals have a true aspiration to work with culturally diverse patients, the patients will feel greater support and understanding if cultural aspects are included in the creation of health plans. *Aspiration* is a desire or ambition for which someone is motivated to work very hard (*Oxford South African School Dictionary* 2010:35).

Professional nurses want to be actively involved in and seek greater understanding about cultural competence. Cultural desire makes health professionals to want to become culturally competent. Lack of desire can result in professionals not being interested in providing culture-competent care.

Professional nurses must have an interest in learning and acknowledging cultural differences to become cultural competent. Cultural differences refer to differences in relation to religious beliefs, ethical beliefs, values and norms, and practices, while similarities may be related to respect amongst elders and authorities and sharing and clothing (Tjallinks in Tjale and De Villiers 2004:72). Professional nurses should have desire or ambition to learn about culture competent care, to obtain knowledge about differences in patients and to respect patients when providing nursing care (Tjallinks in Tjale & De Villiers 2004:72).

### **2.3 CULTURALLY COMPETENT CARE AND NURSING EDUCATION**

Nursing education aims to develop nurses through theoretical and practical training to prepare them for their nursing care as professionals. According to Price and Cortis (2000:240), curricula that address components of human difference, whatever their source, need to advance professional understanding and acceptance of people as individuals each with their own rights and personal esteem. Moreover, teachers of health care professionals need to equip their students with the requisite knowledge and skills to prepare them for practical experience.

According to Woods (2010:721), nurses are frequently regarded as caring, compassionate, skilful, knowledgeable and resourceful professionals who aim to provide appropriate or effective care when meeting health-related needs. Woods (2010:721) adds that nurses are expected to offer holistic care and must appreciate the influence of culture on individuals' biophysical, psychological, social and environmental dimensions. The cultural dimension of nursing care is frequently ignored or marginalised.

Narayanasamy and White (2005:109) state that the Transcultural Health Care Forum for nurses, lecturers and other professionals has been established in the UK to promote greater awareness of culture and ethnicity in nursing practice and education. Most theoretically driven models of transcultural care make slow progress in terms of application and practice. Narayanasamy and White (2005:109) point out that much of the current understanding of transcultural nursing is derived from educational research and literature reviews. Narayanasamy (2006:840) indicates that the relationship between spirituality and culture needs to be communicated in nursing education and

clinical practice. Moreover, nurses are ill-equipped to meet patients' spiritual and cultural needs due to inadequate education and training. All professional nurses require further education in transcultural nursing to provide quality nursing care to patients of diverse cultures.

## **2.4 CONCLUSION**

This chapter described Campinha-Bacote's (2002) model of care, which formed the theoretical framework for the study and the literature review undertaken for the study. Chapter 3 discusses the research design and methodology of the study.

## **CHAPTER 3**

### **Research design and methodology**

#### **3.1 INTRODUCTION**

This chapter describes the research design and methodology of the study, and includes the research setting, population, sample and sampling, data collection and analysis, validity and reliability, and ethical considerations. The study focused on professional nurses' knowledge of culture-competent care in selected wards at hospitals in Mopani District, Limpopo Province.

#### **3.2 RESEARCH SETTING**

A research setting is a specific location where data collection occurs. The study was conducted at selected hospitals in the Mopani District, which is situated in the North-eastern part of the Limpopo Province, 70 kilometres from Polokwane (the capital of Limpopo Province).

The study was conducted with the respondents in a natural setting in the medical and oncology wards and outpatient departments of the five selected hospitals. The researcher is a nurse educator and responsible for accompaniment of students in the selected hospitals.

#### **3.3 RESEARCH DESIGN**

A research design is “a blueprint for conducting a study that maximizes control over factors that could interfere with the validity of the findings. It guides the researcher in implementing a study in a way that is most likely to achieve the intended goal” (Burns & Grove 2009:218). Polit and Beck (2008:765) define a research design as the overall plan for addressing the research, including specifications for enhancing the study's integrity. The study design should yield the strongest possible evidence to answer the research question (Polit & Beck 2008:248).

In this study, the researcher adopted a quantitative, descriptive design to determine professional nurses' knowledge of culture-competent care

Quantitative research is "a formal, objective, systematic process in which numerical data are used to obtain information about the world" (Burns & Grove 2009:22). Polit and Beck (2008:18) describe quantitative research as "the investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design". The researcher chose a quantitative design because it provided a systematic way to collect data and to analyse it using statistics.

The purpose of descriptive studies is to provide an accurate portrayal or account of characteristics of a particular individual, situation, or group. Descriptive studies are a way of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorising information. Descriptive studies are conducted when little is known about a phenomenon (Burns & Grove 2005:26). A quantitative descriptive design was chosen as an appropriate method to determine professional nurses' knowledge of culture-competent care. Little is known about the knowledge of professional nurses about culture-competent care in Mopani District. Campinha-Bacote's (2002) model of the process of cultural competence in the delivery of healthcare services guided the study and the development of the questionnaire.

### **3.4 RESEARCH METHODOLOGY**

Polit and Beck (2008:765) refer to research methodology as the techniques used to structure a study and to gather and analyse information in a systematic way. Burns and Grove (2009:719) define research methodology as "the process or plan for conducting the specific steps of the study". This study used quantitative research methods to determine the respondents' knowledge of culturally competent nursing care.

#### **3.4.1 Population**

A population is all the elements, individuals, objects or substances that meet certain criteria for inclusion in the study (Burns & Grove 2005:40). Polit and Beck (2008:761) define a population as the entire set of individuals or objects having some common

characteristics. The population in the study comprised professional nurses working in the medical and oncology wards and outpatient departments in five hospitals in Mopani District. The population consisted of 250 professional nurses (see table 1.2) working in the selected hospitals who met the inclusion criteria. To be included in the study, the respondents had to be professional nurses.

- Involved with direct nursing care of patients from diverse cultures.
- Working in medical and oncology wards and the outpatient departments in the five selected hospitals.

### **3.4.2 Sample and sampling**

A sample consists of “elements of the population considered for actual inclusion in the study or a subset of measurements drawn from a population in which the researcher is interested” (De Vos et al 2005:194).

Polit and Beck (2008:765) define sampling as the process of selecting a portion of a population to represent the entire population. Polit & Beck (2008:766) define probability sampling as “a selection process in which each element in the population has an equal, independent chance of being selected for the sample”. Probability sampling was used to select the desired number of professional nurses. This ensured that every member of the population had a probability of higher than zero of being selected for the sample (Burns & Grove 2009:349).

Stratified random sampling was used. The population (N=250) was divided into subgroups or strata according to a variable or variables of importance to the study, so that each element of the population belonged to one and only one stratum (Brink 2009:130). In the study the researcher divided the professional nurses according to hospitals. Each hospital formed a stratum. The researcher used a name list from the manager’s office of all professional nurses working in the medical and oncology wards and the outpatient department in the hospital and assigned a number to each one. The researcher selected every alternative number from the list. Fifty percent of the population formed the sample (n=125) because every second person was selected to participate in the study. Table 3.1 illustrates the sample size from each hospital.

**Table 3.1 Sample size from each hospital**

<b>Name of hospital</b>	<b>Female</b>	<b>Male</b>	<b>Total population</b>	<b>% of the total population</b>	<b>Sample size</b>
Nkhensani Hospital	39	9	48	19,2	24
Letaba Hospital	59	5	64	25,6	32
Kgapane Hospital	44	4	48	19,2	24
Van Velden Hospital	42	6	48	19,2	24
Maphuta-Malatji Hospital	39	3	42	16,8	21
<b>Total</b>	<b>223</b>	<b>27</b>	<b>250</b>	<b>100,0</b>	<b>125</b>

A sample of 125 respondents was selected to participate in the study.

### **3.5 DATA COLLECTION**

Data collection refers to the “precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypothesis of a study” (Burns & Grove 2005:73). This study used a structured data-collection approach. Polit and Beck (2008:766) state that a structured approach often takes considerable effort to develop and refine, but yields data that are relatively easy to analyse. In a quantitative study, data collection proceeds according to a pre-established plan. The researcher’s plan specifies procedures for the collection of data (Polit & Beck 2008:767). Structured methods are appropriate for in-depth examination of a phenomenon. A structured questionnaire was used to determine the respondents’ knowledge of culturally competent care. The questionnaire consisted of closed and one open-ended question, arranged according to the five constructs of Campinha-Bacote’s model. The questionnaires were distributed after consultation with operational managers to ensure that ward routines were not disturbed.

The researcher used a questionnaire because they were less expensive than interviews in terms of time and money; the respondents felt a greater sense of anonymity and were more likely to provide honest answers, and the format was standard for all the respondents (Brink 2009:147).

At the same time, the researcher was aware that using a questionnaire also had some disadvantages. For example, the researcher was unable to use probing strategies to obtain in-depth answers; the respondents could not elaborate or ask for clarification of questions, or could fail to answer some of the items, and the respondents might not be representative of the population (Brink 2009:147). To lessen the impact of these disadvantages, care was taken to develop a questionnaire that addressed the most important aspects in cultural competency according to Campinha-Bacote's model. The issue of clarity of questions was addressed through pre-testing the questionnaire for clarity and content.

### **3.5.1 Data-collection instrument**

The researcher developed the questionnaire guided by the purpose and objectives of the study, and the literature review. The questionnaire was based on the theoretical framework for the study, namely Campinha-Bacote's model on the process of culturally competent care. The researcher gave the questionnaire to the supervisors of the study and a statistician for evaluation and comment. The questionnaire was altered on the basis of their comments. The questionnaire took approximately 30 minutes to complete.

The questionnaire consisted of three sections and a total of 120 items as follows:

#### **Section 1: Biographical data**

Section 1 covered the respondents' age, gender, population, race, language, marital status and basic qualifications (Questions 1.1 to 1.15).

#### **Section 2: Culture-competent care**

Section 2 consisted of questions on the five major constructs of Campinha-Bacote's model:

**A: Cultural awareness:** Twenty closed questions (Questions 1 to 20)

**B: Cultural knowledge:** Thirty closed questions (Questions 1 to 30)

**C: Cultural skill:** Twenty closed questions (Questions 1 to 20)

**D: Cultural encounter:** Fifteen closed questions (Questions 1 to 15)

**E: Cultural desire:** Twenty closed questions (Questions 1 to 20)

### **Section 3: Experience of nursing culturally diverse patients**

Section 3 contained one open-ended question on the respondents' experiences in nursing patients of diverse cultures.

## **3.6 RELIABILITY AND VALIDITY**

The quality of a research instrument is determined by its reliability and validity.

### **3.6.1 Reliability**

Reliability refers to the consistency of the measurement result. Reliability refers to a measuring instrument's ability to yield consistent numerical results each time it is applied; it does not fluctuate unless there are variations in the variable being measured (De Vos et al 2005:162). The researcher used a structured questionnaire which ensured that all respondents answered the same questions.

The researcher conducted a pre-test in order to determine the clarity of the instructions to enable respondents to complete the questionnaire. The researcher gave the instrument to ten professional nurses working in medical wards, an oncology ward and the outpatient department at Elim Hospital to complete. Elim Hospital is situated in Vhembe District. These professional nurses were willing to participate in the pre-test and were not included in the main study. The respondents found the questionnaire too long. Accordingly, the researcher revised the questionnaire and did not specify a time for completion.

The study supervisors and a statistician assessed the questionnaire before it was pre-tested. These measures enhanced the reliability of the instrument.

### **3.6.2 Validity**

The validity of an instrument is the degree to which it measures the variable it claims to measure (De Vos et al 2005:160).

Polit and Beck (2009:458) describe content validity as the degree to which an instrument has an appropriate sample of items for the construct being measured and adequately covers the construct domain. The researcher gave the instrument to experienced researchers (study supervisors and a statistician) to evaluate to ensure that all constructs to be evaluated are represented.

Face validity refers to whether the instrument appears to measure the appropriate construct (Polit & Beck 2009:458). The questionnaire was approved by the supervisors and a statistician before being pre-tested and used for data collection. Face validity depended on their judgment.

### **3.7 DATA ANALYSIS**

A statistician analysed the data using the Statistical Package for the Social Sciences (SPSS) version 21 to obtain descriptive statistics. Descriptive statistics are used to describe and synthesize data (Polit & Beck 2008:556). The results were presented in tables and graphs.

### **3.8 ETHICAL CONSIDERATIONS**

Ethics deals with matters of right and wrong. *Collins English Dictionary* (1991:533) defines ethics as “a social, religious, or civil code of behaviour considered correct, esp. that of a particular group, profession, or individual”. Research that involves human beings as subjects should be conducted in an ethical manner to protect their rights. Polit and Beck (2008:167) emphasise that when people are used as study respondents, “care must be exercised in ensuring that the rights of the respondents are protected”. Accordingly, the researcher obtained permission to conduct the study and respected the respondents’ right to self-determination, privacy, anonymity, confidentiality, fair treatment, the right to be fully informed about the research and the right not to be

harmed in any manner (Burns & Grove 2001:196).

The rights of the respondents were protected. The researcher explained the nature and purpose of the study to the respondents. It was also explained that there was no foreseen harm to be experienced during the process of the study. The researcher reassured the respondents that participation was voluntary and that they could terminate their participation in the study at any time.

### **3.8.1 Permission to conduct the study**

The researcher obtained permission from the Higher Degrees Committee in the Department of Health Studies in the College of Human Sciences, Unisa prior to collecting the data (see Annexure B). Permission was also requested from Department of Health, Limpopo Province (see Annexure C). Permission to conduct the study was obtained from the Limpopo Department of Health Ethics Committee (see Annexure D). A letter was written to the Mopani District Office, Chief Executive Officers and Nursing Service Managers of the five hospitals requesting permission to conduct the study in the institutions. Permission was also granted. The research committee had the right to terminate the study if the safety and confidentiality of the respondents was not protected.

### **3.8.2 Self-determination**

The right to self-determination is based on the ethical principle of respect for persons as autonomous agents, who have freedom to conduct their lives as they choose without external control (Burns & Grove 2008:181). The respondents' right to self-determination was assured by explaining the purpose and significance of the study; obtaining their informed consent; emphasising that participation was free and voluntary, and that they had the right to withdraw from the study at any time. A covering letter with information on the study was provided to the respondents (see Annexure F). It also contained the researcher's contact details for any questions they might have and clarification.

After the respondents were informed about the nature and scope of the study they signed informed consent forms (see Annexure F). Informed consent is prospective respondents' agreement to voluntarily participate in a study, which is reached after they have assimilated essential information about the study (Burns & Grove 2008:201). The respondents had the opportunity to refuse to participate in the study. The final report containing anonymous information would be available to all at the end of the study.

### **3.8.3 Fair treatment, privacy, anonymity, confidentiality**

The respondents' right to fair treatment included privacy, anonymity and confidentiality (Polit & Beck 2008:173). The informed consent letters (see Annexure F) were kept separately from the questionnaires. Their privacy and anonymity were assured by using numbers instead of names. The researcher informed them that all information would be treated as strictly confidential and no information would be shared with anyone. All the respondents were treated equally and fairly. The selection of respondents and their treatment during the study was fair. There was no remuneration for the respondents.

### **3.8.4 Beneficence**

The right to protection from discomfort and harm is based on the ethical principle of beneficence, which holds that one should do good and, above all, do no harm (Burns & Grove 2005:190). The respondents might have experienced exhaustion and psychological discomfort when completing questionnaires, but during the pre-test the questionnaire was judged to be simple and easy to complete.

### **3.8.5 Scientific integrity of the research**

The researcher did not misrepresent or fabricate the findings of the study. All the information was acknowledged to prevent plagiarism.

### **3.9 LIMITATIONS OF THE STUDY**

Limitations of research include sample deficiencies, design problems and weaknesses in data collection (Polit & Beck 2008:73). The researcher identified the following limitations in the study:

- The study was conducted only in one district in Limpopo Province, namely Mopani District, which could jeopardize the generalisation of the findings.
- Only professional nurses participated in the study. Enrolled nurses and enrolled nursing auxiliaries were not involved although they also nurse patients of diverse cultures.

### **3.10 CONCLUSION**

This chapter discussed the research design and methodology of the study, including the setting, population and sample, data collection and analysis, ethical considerations and limitations.

Chapter 4 discusses the data analysis and interpretation, and research findings.

## CHAPTER 4

### Data analysis and interpretation

#### 4.1 INTRODUCTION

This chapter discusses the data analysis and interpretation of the results with reference to the literature review. The purpose of the study was to determine professional nurses' knowledge of culture-competent care in medical and oncology wards and outpatient departments at selected hospitals in Mopani District, Limpopo Province. The objectives of the study were to

- examine and determine professional nurses' knowledge of culture-competent care in medical and oncology wards and outpatient departments at selected hospitals in Mopani District, Limpopo Province
- make recommendations for an in-service training programme on culture-competent care for professional nurses working in Mopani District hospitals

The researcher selected a quantitative descriptive design and used a structured questionnaire to collect data. Data was collected from 19 October 2012 to 23 October 2012. A total of 125 questionnaires were distributed, out of which 105 completed questionnaires were returned. All the returned questionnaires were suitable for data analysis thereby giving a response rate of 84%.

The questionnaire consisted of three sections, namely:

Section 1: Demographic data

Section 2: Culture-competent care

Section 3: Personal experiences in nursing patients of diverse cultures

## 4.2 DATA MANAGEMENT AND ANALYSIS

The data from the 105 completed questionnaires were captured on an electronic database, and analysed by a statistician, using the SPSS version 21 computer program. The results were presented in frequencies, percentages, graphs and tables.

## 4.3 RESEARCH RESULTS

The results are presented systematically according to the sections of the questionnaire.

### 4.3.1 Section 1: Demographical data

The respondents' demographical data covered their age, gender, population group, language, marital status and basic qualifications.

#### 4.3.1.1 Age

The respondents were asked to indicate their age (see figure 4.1).

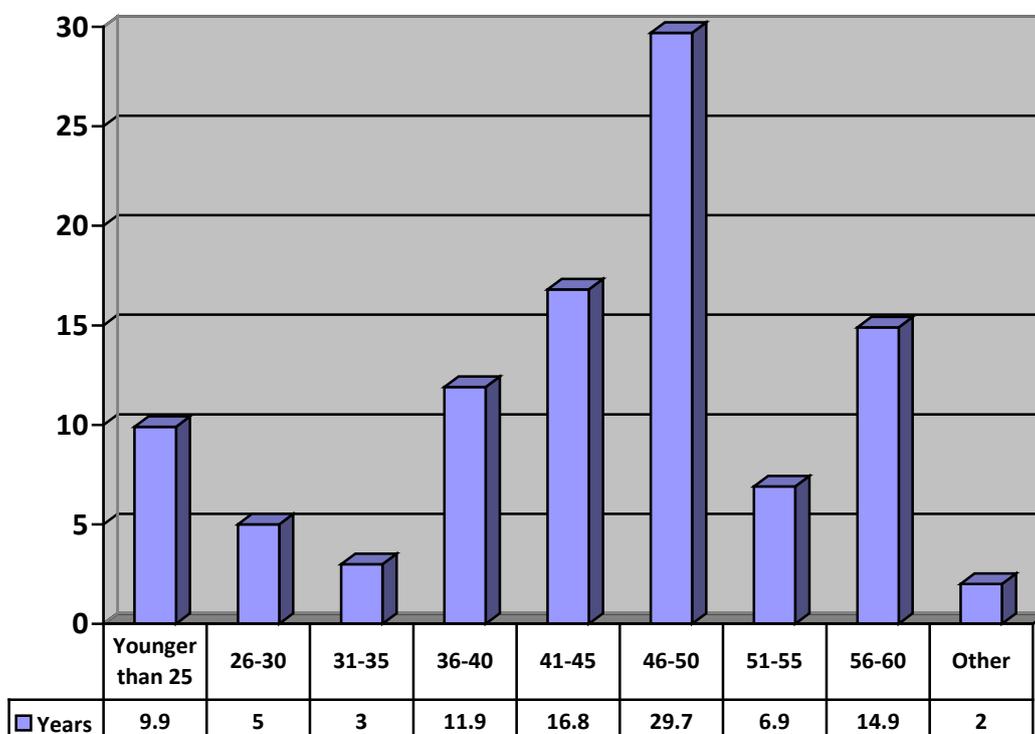
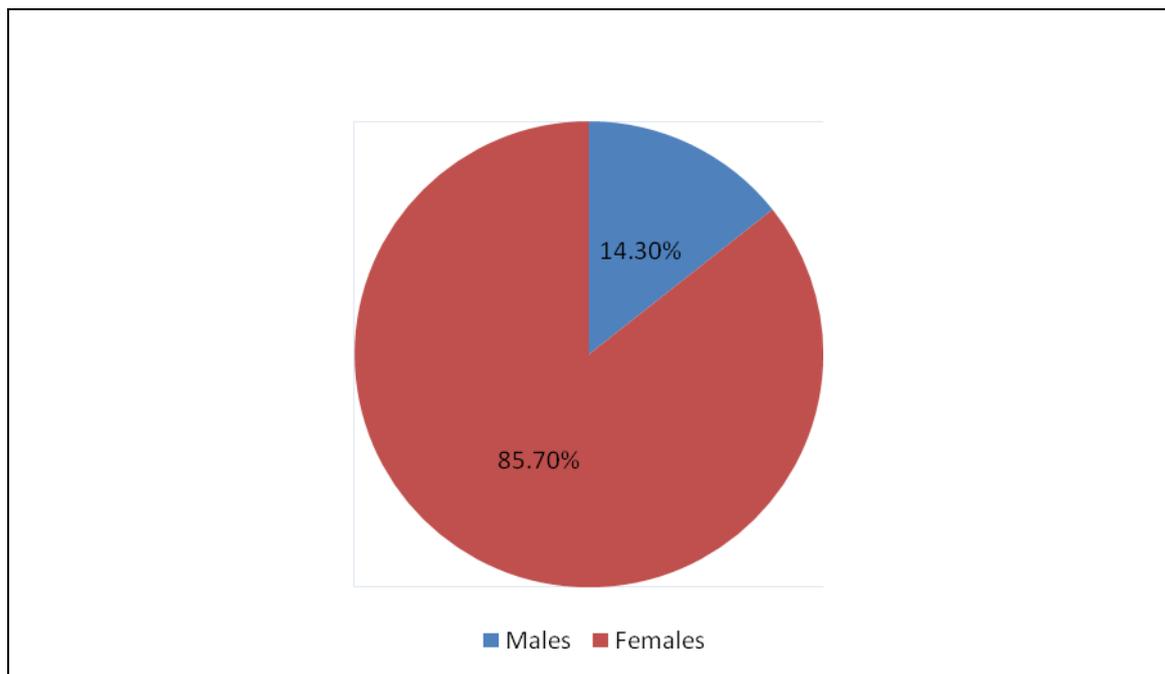


Figure 4.1 Respondents' age distribution (n=101)

Of the respondents, 9.9% (n=10) were under 25 years old; 5.0% (n=5) were 26-30 years old; 3.0% (n=3) were 31-35; 11.9% (n=12) were 36-40; 16.8% (n=17) were 41-45; 29.7% (n=30) were 46-50; 6.9% (n=7) were 51-55; 14.9% (n=15) were 56-60, and 2.0% (n=2) indicated “other”.

#### **4.3.1.2 Gender**

The respondents were asked to indicate their gender (see figure 4.1).

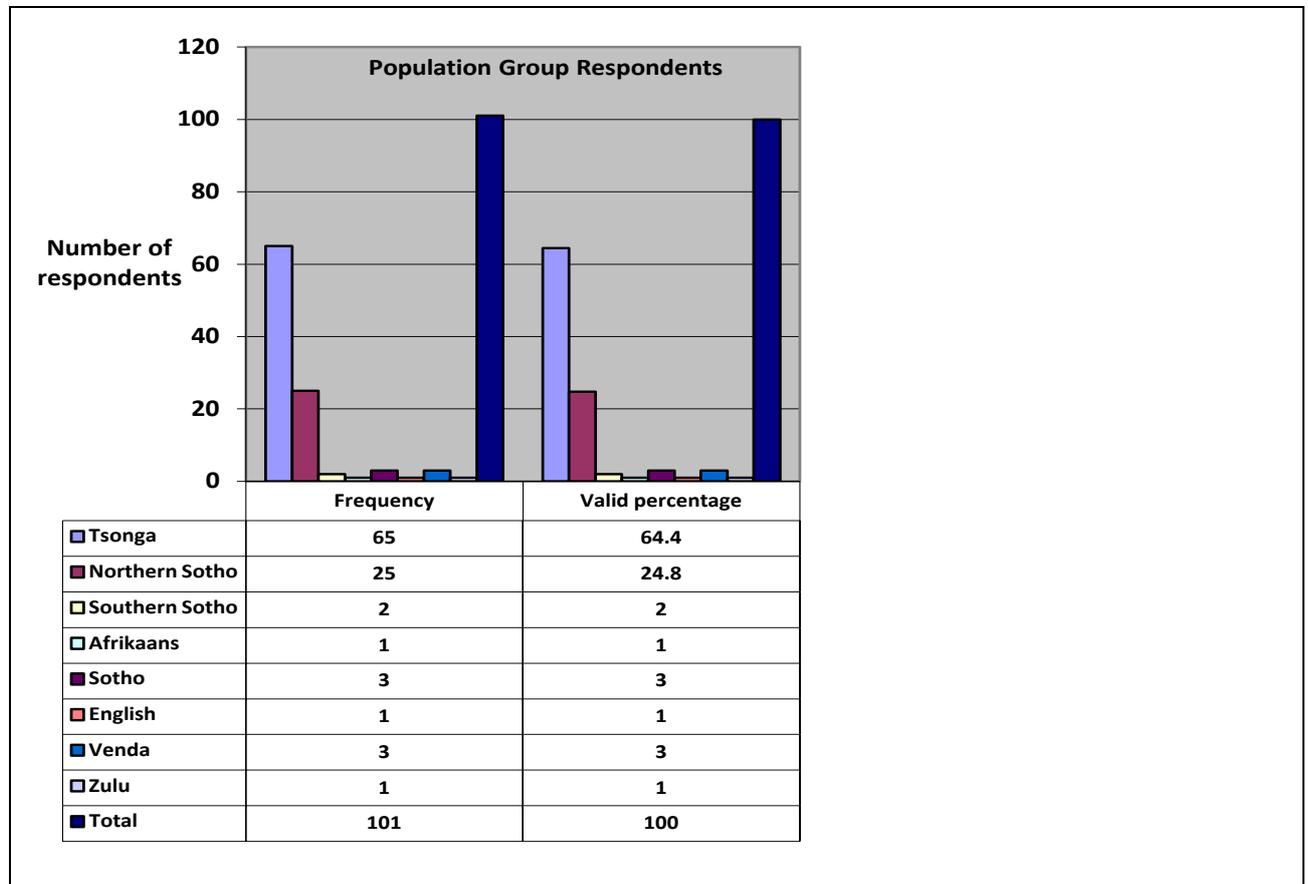


**Figure 4.2 Respondents' gender (n=98)**

Figure 4.1 indicates that of the respondents, 85,7% (n=84) were females and 14,3% (n=14) were males. This supports Wildschut and Mqolozana's (2008:13) finding that nursing in South Africa is a predominantly female profession.

### 4.3.1.3 Population group

The respondents were asked to indicate their population group (see figure 4.3).

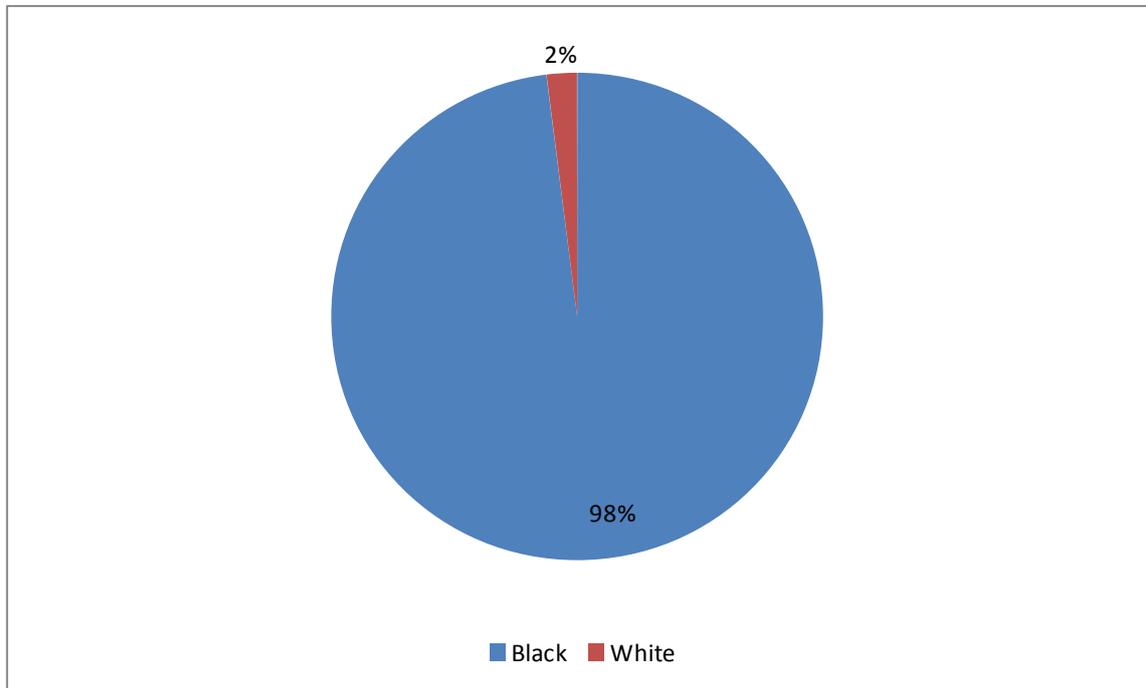


**Figure 4.3 Respondents' population group (n=101)**

The data indicated that the respondents were culturally diverse and from eight population groups. Of the respondents, 64.4% (n=65) were Tsongas; 24.8% (n=25) were Northern Sothos; 3.0% (n=3) were Vendas and Sothos, respectively; 1.0% (n=1) each were Zulus, Afrikaans and English, respectively and 2.0% (n=2) were Southern Sothos. Mopani District consists of different population groups, of whom the majority are Tsonga speaking (Mopani District Municipality 2007/2008); (see chapter 1, figure 1.3).

#### 4.3.1.4 Race

The respondents were asked to indicate their race (see figure 4.4).

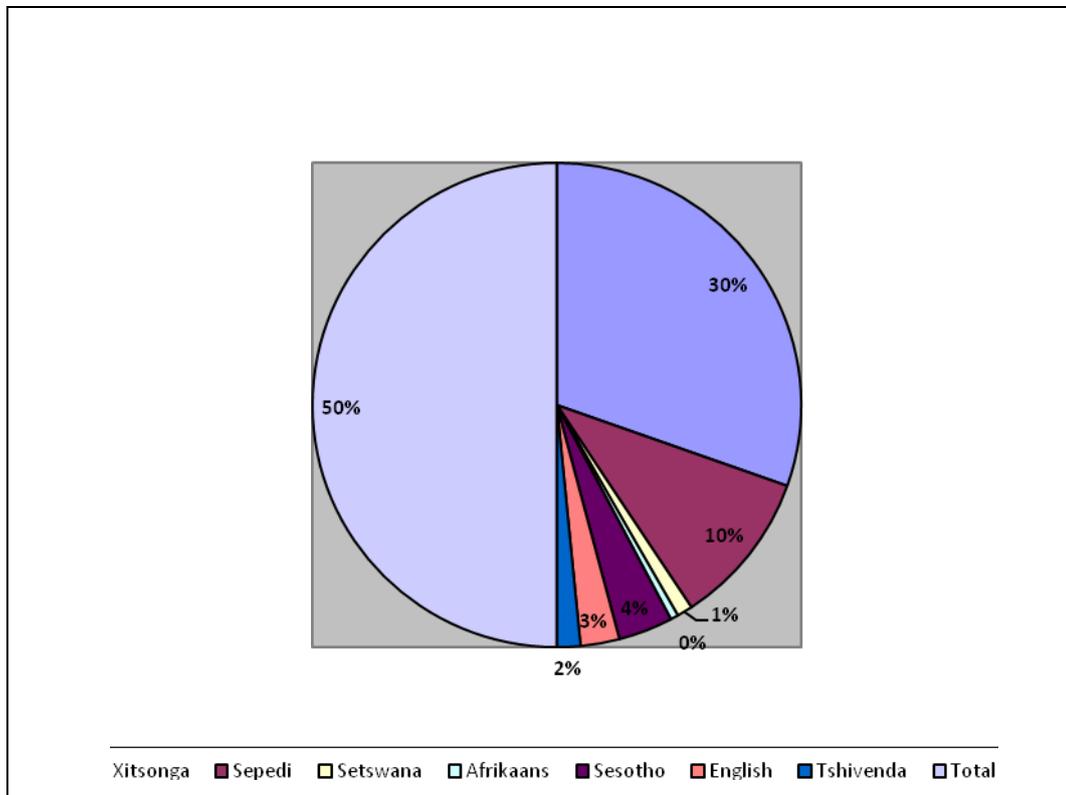


**Figure 4.4 Respondents' race (n=101)**

Of the respondents, 98.1% (n=99) were black and 1.9% (n=2) were white.

#### 4.3.1.5 Home language

The respondents were asked to indicate their home language (see figure 4.5).



**Figure 4.5 Respondents' home language (n=97)**

Regarding the respondents' home language, 60,8% (n=59) indicated Xitsonga; 20,6% (n=20) indicated Sepedi; 7,2% (n=7) indicated Sesotho; 5,2% (n=5) indicated English, and 3,1% (n=3) indicated Tshivenda. The respondents' home language reflected the demography of the people in Mopani District, namely 46.8% Xitsonga and Northern Sotho, 1.9% Afrikaans and 0,5% Venda (Mopani District Municipality 2007/2008); (see chapter 1, figure 1.3).

#### 4.3.1.6 Language spoken fluently besides home language

The respondents were asked to indicate their fluency in languages other than their home language (see table 4.1).

**Table 4.1 Respondents' language spoken fluently besides home language (n=101)**

Language spoken fluently		Frequency	Percent	Valid percent
Xitsonga		12	11.4	11.9
Sepedi		17	16.2	16.8
Setswana		1	1.0	1.0
Afrikaans		1	1.0	1.0
Sesotho		2	1.9	2.0
English		60	57.1	59.4
Tshivenda		6	5.7	5.9
Isixhosa		1	1.0	1.0
Isizulu		1	1.0	1.0
<b>Total</b>		<b>101</b>	<b>96.2</b>	<b>100.0</b>
<b>Missing</b>	<b>System</b>	<b>4</b>	<b>3.8</b>	
<b>Total</b>		<b>105</b>	<b>100.0</b>	

The study found that of the respondents, 59,4% (n=60) could speak English fluently in addition to their home language; 16.8% (n=17) could speak Sepedi; 11.9% (n=12) could speak Xitsonga; 5.9% (n=6) could speak Tshivenda, and 2.0% (n=2) could speak Sesotho. Of the respondents, 1.0% (n=1) each indicated that they could speak either Setswana, Afrikaans, Isixhosa or Isizulu fluently.

#### 4.3.1.7 Basic qualifications

The respondents were asked to indicate their basic qualifications (see table 4.2).

**Table 4.2 Respondents' basic qualifications (n=105)**

Basic nursing qualification	Frequency	Percentage
3-year diploma in general nursing	45	42.9
4-year comprehensive course	21	20.0
Degree in nursing	20	19.1
Other	19	18.1
<b>Total</b>	<b>105</b>	<b>100.1</b>

Table 4.2 shows that of the respondents, 42,9% (n=45) had a three-year diploma in general nursing; 20% (n=21) had a four-year comprehensive course; 20,0% (n=21) had a degree in nursing, and 18,1% (n=19) indicated “other”, but did not specify their basic qualifications.

#### 4.3.1.8 Post-basic qualifications

Table 4.3 lists the respondents’ post-basic qualifications.

**Table 4.3 Respondents’ post-basic qualifications**

Post-basic qualification	Yes		No		Total
	Frequency	Percentage	Frequency	Percentage	
1. Diploma in midwifery	44	48.4	47	44.8	91
2. Diploma in nursing education	13	14.6	76	85.4	89
3. Diploma in community nursing science	13	14.6	76	85.4	89
4. Diploma in nursing management	19	21.3	70	78.7	89
5. Diploma in paediatric nursing science	4	4.4	85	95	89
6. Diploma in intensive care nursing	4	4.5	85	95	89

Of the respondents, 48,4% (n=44) had post-basic diplomas in midwifery; 14,6% (n=13) in nursing education; 14,6% (n=13) in community nursing science; 21,3% (n=19) in nursing management; 4,4% (n=4) in paediatric nursing science, and 4,5% (n=4) in intensive care nursing. The four-year comprehensive diploma and the degree include midwifery and community nursing qualifications.

#### 4.3.1.9 Completion of basic training

The respondents were asked when they had completed their basic training (see table 4.4).

**Table 4.4 Respondents' date of completion of basic training (n=75)**

Period within which basic training was completed		Frequency	Percent	Valid percent
1975-1980		9	8.6	12.0
1980-1985		6	5.7	8.0
1985-1990		8	7.6	10.7
1990-1995		7	6.7	9.3
1995-2000		10	9.5	13.3
2000-2005		6	5.7	8.0
2005-2010		29	27.6	38.7
<b>Total</b>		<b>75</b>	<b>71.4</b>	<b>100.0</b>
<b>Missing</b>	<b>System</b>	<b>30</b>	<b>28.6</b>	
<b>Total</b>		<b>105</b>	<b>100.0</b>	

Table 4.4 indicates that of the respondents, 38.7% (n=29) had completed their training between 2005 and 2010; 13.3% (n=10) between 1995 and 2000; 12.0% (n=9) between 1975 and 1980; 10.7% (n=8) between 1985 and 1990; 9.3% (n=7) between 1990 and 1995, and 8.0% (n=6) each between 1980 and 1985, and 2000 and 2005, respectively.

#### 4.3.1.10 Principles of culture-competent care included in the curriculum

The respondents were asked whether principles of culture-competent care had been included in the curriculum (see table 4.5).

**Table 4.5 Principles of culture-competent care included in the curriculum (n=89)**

	Yes		No		
	Frequency	Percentage	Frequency	Percentage	Total
Inclusion of principles of culture-competent care in the curriculum	67	75.3	22	24.7	89

Of the respondents 75,3% (n=67) indicated that principles of culture-competent care were included in the curriculum and 24,7% (n=22) indicated that they were not included. In terms of SANC Regulation No 387, professional nurses should determine the health status of the patient and the physiological responses of the body to disease condition, trauma and stress, which implies nursing a patient in totality. The SANC does not spell out culture-competent care in the rules and regulations. However, the *Nurse's Pledge* emphasizes that nurses should provide quality nursing care, irrespective of race and creed, which could be interpreted as culture-competent care (SANC 2004-2013).

#### 4.3.2 Subjects covering content on transcultural nursing

The respondents were asked to indicate subjects that included transcultural nursing (see table 4.6).

**Table 4.6 Respondents' subjects that included the principles of transcultural nursing**

Subjects with content that addresses transcultural nursing	Yes		No		
	Frequency	Percentage	Frequency	Percentage	Total
1 Transcultural nursing	13	13.7	82	86.3	95
2 Ethos of nursing	62	63.3	36	36.7	98
3 Fundamental nursing science	18	19.1	76	80.9	94
4 Social science	44	45.8	52	52.2	96
5 Other	3	9.7	28	90.3	74

Of the respondents, 63.3% (n=62) indicated that principles of culturally sensitive care were included in Ethos of Nursing; 45.8% (n=44) indicated Social Science, and 19.1% (n=18) indicated Fundamental Nursing Science. Only 13.7% (n=13) of the respondents indicated that these principles were taught in a subject called Transcultural Nursing.

#### **4.3.2.1 Current college or university post-basic studies**

Table 4.7 presents the responses to whether the respondents were studying post-basic courses.

**Table 4.7 Respondents enrolled at a college or university for post-basic courses (n=90)**

	Yes		No		Total
	Frequency	Percentage	Frequency	Percentage	
Currently studying post-basic course	12	13.3	78	86.7	90

Of the respondents, 13,3% (n=12) were currently registered for post-basic studies at a college or university, while 86,7% (n=78) were not.

#### **4.3.2.2 Post-basic courses being studied**

Table 4.8 lists the post-basic courses for which respondents were enrolled.

**Table 4.8 Post-basic courses being studied (n=12)**

Post-basic course	Frequency	Percent	Valid percent
Child Nursing Science	1	1.0	8.3
Community Nursing Science	9	8.6	75.0
Clinical Nursing Science, Health Assessment, Treatment And Care	1	1.0	8.3
Oncology Nursing	1	1.0	8.3

Of the respondents registered for post-basic studies, 8.3% (n=1) were studying Child Nursing Science; 75.0% (n=9) indicated Community Nursing Science; 8.3% (n=1) indicated Clinical Nursing Science, Health Assessment and Care, and 8.3% (n=1) indicated Oncology nursing.

**4.3.2.3 Inclusion of culture-competent care**

The respondents were asked to indicate whether the post-basic courses included aspects of culture-competent care (see table 4.9).

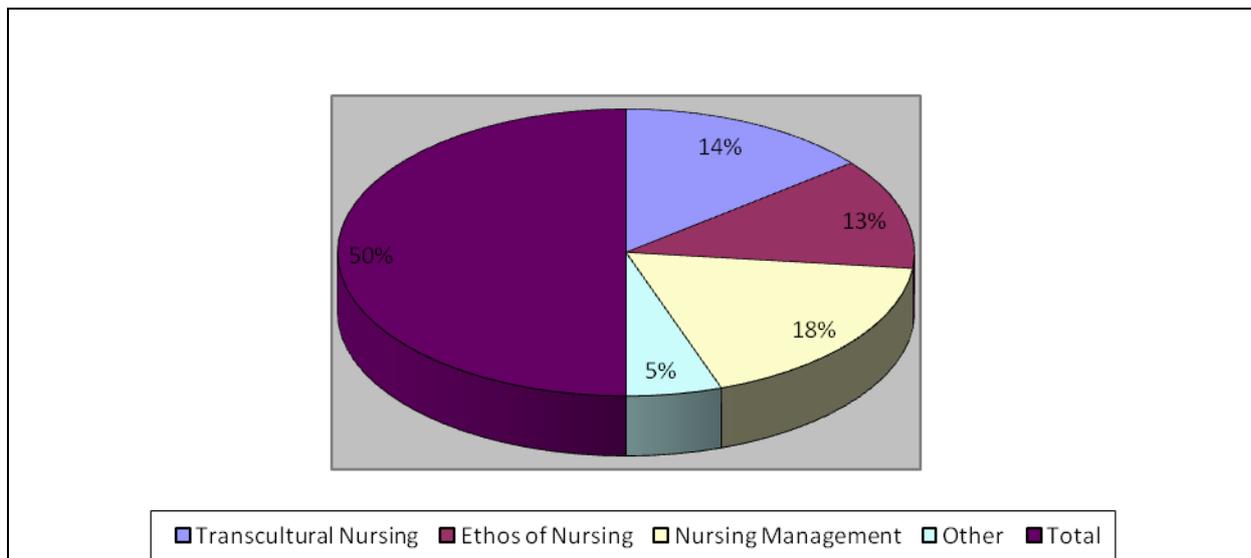
**Table 4.9 Aspects of culture-competent care included in courses (n=52)**

	Yes		No		
	Frequency	Percentage	Frequency	Percentage	Total
Course inclusion of aspects of culture-competent care	24	46.2	26	53.8	52

Of the respondents, 53.8% (n=28) indicated that the post-basic courses did not address aspects of culture-competent care while 46.2% (n=24) indicated that aspects of culture-competent care were included.

**4.3.2.4 Subjects that included information on culture-competent care**

The respondents were asked to indicate subjects that included information on culture-competent care (see figure 4.6).



**Figure 4.6 Subjects that included information on culture-competent care (n=77)**

Of the respondents, 28,6% (n=8) indicated that transcultural nursing as a subject included aspects of culture-competent care; 25,0% (n=7) indicated Ethos of Nursing; 35,7% (n=10) indicated Nursing Management, and 11.0% (n=3) indicated “Other” but did not specify.

#### **4.3.2 Section 2: Culture-competent care**

Section 2 explored the respondents’ knowledge of culture-competent care, following the five constructs of Campinha-Bacote’s model, namely

- Cultural awareness
- Cultural knowledge
- Cultural skill
- Cultural encounter
- Cultural desire

The respondents were expected to indicate the degree of agreement or disagreement with the statements. For this purpose, a Likert-type scale of SA – strongly agree; A – agree; SD – strongly disagree, and D – disagree was used.

### 4.3.2.1 Cultural awareness

Table 4.10 presents the respondents' replies to the twenty statements on cultural awareness.

**Table 4.10 Respondents' cultural awareness**

SA – strongly agree  
 A – agree  
 SD – strongly disagree  
 D – disagree,  
 F – Frequency (number)  
 (n for each row is indicated in the last column)

Cultural awareness	SA F	SA %	A F	A %	SD F	SD %	D F	D %	Total
1 I examine my own biases related to culture	34	38.6	32	36.4	11	10.5	11	10.5	88
2 I am sensitive to cultural beliefs of patients when rendering nursing care	36	38.7	24	22.9	14	15.1	19	20.4	93
3 I accept that cultural beliefs differ in cultural groups	63	65.6	25	26	4	4.2	4	4.2	96
4 I discuss new trends in developing cultural awareness with other colleagues	34	35.1	35	36.1	10	10.3	18	18.6	97
5 I have to interact with patients of diverse cultures	48	49.5	36	37.1	6	6.2	7	7.2	97
6 I appreciate the values of patients of diverse cultures when providing nursing care	51	54.3	37	39.4	1	1.1	5	5.3	94
7 I want to learn about the cultural beliefs and way of life of patients of diverse cultures	55	56.1	33	33.7	3	3.1	7	7.1	98
8 I involve family members of clients to learn about their cultural beliefs	47	47.5	32	32.3	7	7.1	13	13.1	99

<b>Cultural awareness</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>Total</b>
9 I believe that all cultural beliefs of clients are to be respected	71	71.7	15	15.2	4	4	9	9.1	99
10 I listen to cultural needs expressed by clients	46	46.5	44	44.5	4	4	5	5.1	99
11 I include the cultural needs of patients in the planning of nursing care	48	48.5	33	33.3	3	3	15	15	99
12 I believe that I should be given an opportunity to learn about the cultural values of all patients before I could nurse them	44	41.9	31	31	14	14	11	11	100
13 I believe that nurses should provide nursing care according to cultural needs of patients	30	30.6	45	45.9	8	8.2	15	15.3	98
14 I believe that interpreters should always be available in the ward to interpret language in cultural practices of patients of diverse cultures when providing nursing care	30	30.3	37	37.4	16	16.2	16	16.2	99
15 I believe that clinical allocation should prepare the student nurse to nurse patients of diverse cultures	39	39.8	41	41.8	12	12.2	6	6.1	98
16 I believe that I should allow patients of diverse cultures to perform their religious rituals and practices in the ward	22	22.7	25	25.8	27	27.8	23	23.7	97
17 I believe that I should not be expected to take part in the performance of ritual practices by the family members	40	40.8	22	22.4	15	15.3	21	21.4	98
18 I believe that nurses should be able to	55	56.1	33	33.7	3	3.1	7	7.1	98

<b>Cultural awareness</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>Total</b>
speaking different languages to be able to interact with patients of diverse cultures									
19 I believe that the same hospital attire should be provided to all patients irrespective of their diverse cultures	47	48.5	27	27.8	7	7.2	16	16.5	97
20 I should not allow patients of diverse cultures to use their traditional medication while in the ward	47	48	18	18.4	18	18.4	15	14.3	98

In item 1, 38,6% (n=34) of the respondents strongly agreed and 36,4% (n=32) agreed, while 10,5% (n=11) strongly disagreed and disagreed, respectively, with examining their own biases when nursing patients of different cultures. The majority of the respondents (75.0%; n=66) examine their own biases when providing care to patients of diverse cultures. Cultural awareness occurs when professional nurses' who are nursing patients of diverse cultures examine their own cultural backgrounds and their prejudices and biases towards cultures (Tjallinks in Tjale & De Villiers 2004:26). Pesquera, Yoder and Lynk (2008:120) maintain that individuals must truly understand what makes them do or feel things and that until they have been able to face the truth about themselves, they cannot be really sympathetic or understanding in regard to what happens to other people. In Item 2, 38,7% (n=36) of the respondents strongly agreed and 25,8% (n=24) agreed they were sensitive to patients' cultural beliefs when rendering nursing care, while 15.1% (n=14) strongly disagreed and 20,4% (n=19) disagreed. Dogan, Tschudin, Hot and Ozkan (2009:690) state that health care personnel need skills to explore the meaning of illness, determine patients' social and family contexts, and provide patient-centred and culturally competent care as an aspect of ethical responsibility.

In item 3, 65,6% (n=63) of the respondents strongly agreed and 26,0% (n=25) agreed that cultural beliefs differ among cultural groups, while 4,2% (n=4) strongly disagreed and 4,2% (n=4) disagreed. In item 4, 35,1% (n=34) of the respondents strongly agreed and 36,1% (n=35) agreed that they discussed trends in developing cultural awareness with other colleagues, while 10,3% (n=10) strongly disagreed and 18,6% (n=18)

disagreed. A total of 71.2% (n=69) indicated that they discussed trends in developing cultural awareness with colleagues. In item 5, 49,5% (n=48) strongly agreed and 37,1% (n=36) agreed that they had to interact with patients of diverse cultures, while 6,2% (n=6) disagreed and 7,2% (n=7) strongly disagreed. In item 6, 54,3% (n=51) strongly agreed and 39.4% (n=37) agreed that they appreciated the values of patients of diverse cultures when providing nursing care while 1,1% (n=1)strongly disagreed and 5,3% (n=5) disagreed. In item 7, 56.1% (n=55) strongly agreed and 33.7% (n=33) agreed that they wanted to learn about the cultural beliefs and ways of life of patients of diverse cultures while 3,1% (n=3) strongly disagreed and 7,1% (n=7) disagreed. In item 8, 47,5% (n=47) strongly agreed and 32,3% (n=32) agreed that they involved family members of patients to learn about their cultural beliefs, while 7,1% (n=7) strongly disagreed and 13,1%(n=13) disagreed. Family members can provide valuable information about cultural practices in instances where patients are too sick to do so. In item 9, 71,7% (n=71) of the respondents strongly agreed and 15,2% (n=15) agreed that all cultural beliefs of patients should be respected, while 4,0% (n=4) strongly disagreed and 9,1%(n=9) disagreed. The *Nurse's Pledge of Service* (SANC 2004-2013) stipulates that nursing care should be provided with respect for the cultural beliefs and values of the patients.

In Item 10, 46,5% (n=46) strongly agreed and 44,4% (n=44) agreed that they listened to cultural needs expressed by patients, while 4,0% (n=4) strongly disagreed and 5,1% (n=5) disagreed. Cakir (2006:154) emphasises that every culture has its own cultural norms for conservation and these norms differ from one culture to another and communication problems may arise amongst speakers who do not understand norms of other cultures.

In item 11, 48,5% (n=48) of the respondents strongly agreed and 33.3% (n=33) agreed that they incorporated patients' cultural needs when planning nursing care, while 3,0% (n=3) strongly disagreed and 15,2% (n=15) disagreed. This is in line with Leininger's standards as identified in Leininger et al (2002:41). In item 12, 72.9% (n=74) strongly agreed and agreed that they should be given the opportunity to learn about patients' cultural values before nursing them, while 14,0% (n=14) strongly disagreed and 11,0% (n=11) disagreed. In Europe, Taylor, Papadopoulos, Maerten, Peltegovva and Ziegler (2011:194) found that health care professionals need to be adequately prepared for

these experiences as an intercultural experience does not automatically lead to learning.

In item 13, 30,6% (n=30) of the respondents strongly agreed and 45,9% (n=45) agreed that nurses should provide nursing care according to patients' cultural needs, while 8,2% (n=8) strongly disagreed and 15,3% (n=15) disagreed. Sealey, Burnett and Johnson (2006:131) maintain that nurses must be prepared to provide care that is culturally competent; considering the cultural needs of the patients because the patients' compliance and response to treatment will be influenced by their culture.

In item 14, 30,3% (n=30) strongly agreed and 37,4% (n=37) agreed, while 16,2% (n=16) strongly disagreed and 16,2% (n=16) disagreed that interpreters should always be available in the ward to interpret language in cultural practices of patients of diverse cultures. Maltby (1999:249) found that the use of interpreters is not always beneficial to patients and could jeopardise patient confidentiality and accuracy of information given to patients. In item 15, 39,8% (n=39) strongly agreed and 41,8% (n=42) agreed that clinical allocation should prepare the student nurse to nurse patients of diverse cultures while 12,2% (n=12) strongly disagreed and 6,1% (n=6) disagreed. In item 16, 22,7% (n=22) strongly agreed and 25,8% (n=25) agreed that patients of diverse cultures should be allowed to perform their religious rituals and practices in the ward while 27,8% (n=27) strongly disagreed and 23,7% (n=23) disagreed. Andrews and Boyle (2008:356) explain that rituals pertain to religious practices and may include worship, prayer, participation in sacraments and fasting.

In item 17, 40,8% (n=40) of the respondents strongly agreed and 22,4% (n=21) agreed that they should not be expected to take part in the performance of ritual practices by patients' family members while 15,3% (n=15) strongly disagreed and 21,4% (n=21) disagreed.

In Item 18, 56,1% (n=55) strongly agreed and 33,7% (n=34) agreed that nurses should be able to speak different languages to be able to interact with patients of diverse cultures, while 3,1% (n=3) strongly disagreed and 7,1% (n=7) disagreed with the statement. Cakir (2006:154) maintains that if language is described as a mode of human behaviour and as culture patterned behaviour, it is evident that language is a vital constituent of culture.

In item 19, 48,5% (n=47) strongly agreed and 27.8% (n=27) agreed that the same hospital attire should be provided to all patients irrespective of their cultures, while 7,2% (n=7) strongly disagreed and 16.5% (n=16) disagreed.

In item 20, 48,0% (n=47) strongly agreed and 18,4% (n=18) agreed that patients of diverse cultures should not be allowed to use their traditional medication while in the ward, while 18,4% (n=18) strongly disagreed and 14.3% (n=15) disagreed. Tjale and De Villiers (2004:157) maintain that it is a fact of life that people that are enculturated in an indigenous health system retain their traditional health beliefs. If so, conflict could arise when patients are denied permission to use traditional medication while in hospital.

#### 4.3.2.2 Cultural knowledge

Table 4.11 presents the respondents' responses on cultural knowledge.

**Table 4.11 Respondents' cultural knowledge**

Cultural knowledge	SA F	SA %	A F	A %	SD F	SD %	D F	D %	Total
1 The hospital's staff development programme gives me the opportunity to develop a knowledge base on the cultural groups that I nurse	21	22.3	34	36.2	17	18.1	22	23.4	94
2 The hospital where I render nursing care incorporates cultural knowledge into the personnel development programme	16	17.4	42	45.7	14	15.2	20	21.7	94
3 Most of the patients of diverse cultures associate illness with punishment from the ancestors	21	22.6	30	32.3	19	20.4	23	24.7	93
4 Patients of diverse cultures express themselves well regarding their health needs	14	15.1	41	44.1	15	16.1	23	24.7	93
5 Nurse should attend seminars and workshops at colleges and universities to learn about providing culture-competent care	28	29.5	30	31.6	15	15.8	22	23.2	95
6 Cultural knowledge does not involve understanding the biological variations of a disease	16	17.4	33	35.9	20	21.7	23	25	92

<b>Cultural knowledge</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>Total</b>
7 Understanding the culture of a person does not need formal education	30	32.6	37	40.2	13	14.1	12	13	92
8 Internet, videos and formal education cannot provide cultural competency	11	11.7	25	26.6	26	27.7	32	34	94
9 Cultural knowledge received in a classroom can provide cultural competency	31	33.3	39	41.9	8	8.6	15	16.1	93
10 Cultural knowledge is not effective if there is no correlation of theory and practice	25	26.6	35	37.2	15	16.0	19	20.2	94
11 Early clinical placement is the best tool for nurses to experience culture-competent care	35	37.2	35	37.2	11	11.7	13	13.8	94
12 Cultural knowledge needs to be nurtured through continuing education and mentoring	39	41.9	40	43.0	8	8.6	6	6.5	93
13 Employers should invite guest speakers with cultural knowledge to motivate staff to deliver culture-competent care	39	41.5	37	39.4	8	8.5	10	10.6	94
14 Lectures on culturally competent care should be included in the curriculum	41	43.6	29	30.9	9	9.6	15	16.0	94
15 Topics on cultural competence are included in the in-service education programme of the hospital where I work	17	18.1	29	30.9	19	20.2	29	30.9	94
16 I consider cultural beliefs of patients when serving meals	42	44.7	30	31.9	10	10.6	12	12.8	94
17 I allow relatives to bring food from home to satisfy the cultural needs of the patient	25	27.2	28	30.4	14	15.2	25	27.2	92
18 The hospital where I work invites community members to meetings about culturally competent care	12	12.9	12	12.9	31	33.3	38	40.9	93
19 Traditional healers form part of the health care system in the hospital where I work	4	4.3	20	21.5	22	23.7	47	50.5	93
20 Posters, pictures and printed materials displayed on the notice boards in the hospital where I work inform people about cultural knowledge	9	9.9	19	20.9	26	28.6	37	40.7	91
21 If I have cultural knowledge I will plan nursing care with the patient	38	41.8	31	34.1	9	9.9	13	14.3	91

<b>Cultural knowledge</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>Total</b>
22 If I have cultural knowledge I will be able to make decisions with the patient concerning nursing care	35	38.5	34	37.4	12	13.2	10	11.0	91
23 If I have cultural knowledge I would be able to respect cultural needs of patients	45	49.5	31	34.1	7	7.7	8	8.8	91
24 If I have cultural knowledge I could understand and respect the religious beliefs of other cultures	46	50.5	29	31.9	7	7.7	9	9.9	91
25 If I have cultural knowledge I would accept patients' beliefs regarding traditional pain remedies	22	24.4	31	34.4	15	16.7	22	24.4	90
26 If I have cultural knowledge I would allow relatives to bring food to patients to satisfy cultural food preferences	31	33.7	21	22.8	19	20.7	21	22.8	92
27 If I have cultural knowledge I would allow family members of patients of diverse cultures to participate in nursing care of patient	31	33.7	28	30.4	20	21.7	13	14.1	92
28 If I have cultural knowledge I would allow a relative of a patient of diverse culture to interpret to the doctor during doctor's round	20	21.7	21	22.8	29	31.5	22	23.9	92
29 If I have cultural knowledge I would allow family members to visit at any time without consideration of hospital visiting hours	8	8.7	10	10.9	42	45.7	32	34.8	92
30 If I have cultural knowledge I would allow one relative of a patient of diverse culture to remain with the patient to provide culture-specific care	11	12.0	18	19.6	28	30.4	35	38.0	92

In item 1, 22,3% (n=21) strongly agreed and 36,2% (n=34) agreed that the hospital's staff development programme gave them the opportunity to develop a knowledge base on the cultural groups that they nursed, while 18,1% (n=17) strongly disagreed and 23,4% (n=22) disagreed. Sargent et al (2005:220) maintain that cultural competence requires a long-term commitment from students to learn about other cultures. This can be achieved through staff development programmes for students and professional nurses in hospitals.

In item 2, 17,4% (n=16) strongly agreed and 45,7% (n=42) agreed that the hospital where they rendered nursing care incorporated cultural knowledge into the personnel development programme, while 36,9% (n=34) disagreed with the statement. According to Shum (2004:4), cultural knowledge is established by practice through which knowledge is institutionally organized, certified and transmitted.

In item 3, 22,6% (n=21) strongly agreed and 32,3% (n=30) agreed that most of the patients of diverse cultures associated illness with punishment from the ancestors, while 20,4% (n=19) strongly disagreed and 24,7% (n=23) disagreed. Tjale and De Villiers (2004:147) maintain that when a natural cause does not explain a condition, a cause is associated with the supernatural, most frequently a belief in ancestral spirits.

In item 4, 15,1% (n=14) of the respondents strongly agreed and 44,1% (n=41) agreed that patients of diverse cultures expressed themselves well regarding their health needs, while 16,1% (n=15) strongly disagreed and 24,7% (n=23) disagreed.

In item 5, 29,5% (n=28) strongly agreed and 31,6% (n=30) agreed that nurses should attend seminars and workshops at colleges and universities to learn about the provision of culture-competent care, while 15,8% (n=15) strongly disagreed and 23,2% (n=22) disagreed. Pinikahana, Manias and Happel (2003:150) emphasize the importance of nurses having sound knowledge of cultural values, beliefs, practices and attitudes in order to respond effectively to the needs of patients.

In item 6, 17,4% (n=16) strongly agreed and 35,9% (n=33) agreed that cultural knowledge did not involve understanding the biological variations of a disease pattern, while 46,7% (n=43) strongly disagreed and 25,0% (n=23) disagreed. Most of the respondents (53,3%; n=49) agreed that cultural knowledge did not involve understanding the biological variations of a disease pattern. However, Tjallinks (in Tjale and De Villiers 2004:170) maintains that biological differences that exist may render specific cultural groups more susceptible to certain health problems.

In item 7, 72,5% (n=67) strongly agreed and 40,2% (n=37) agreed that understanding a person's culture did not require formal education, while 14,1% (n=13) strongly disagreed and 13,0% (n=12) disagreed. According to Cakir (2006:156), formal

education about culture is needed because it will address many aspects such as language, beliefs, values and needs of different cultural groups. In item 8, 11.7% (n=11) of the respondents strongly agreed and 26.6% (n=25) agreed that Internet, videos and formal education cannot provide cultural knowledge, while 27.7% (n=26) strongly disagreed and 34% (n=32) disagreed. Cuellar, Walsh Brennan, Vito and De Leon Siantz (2008:147) propose various teaching strategies to incorporate cultural diversity into teaching. These include lectures, discussions, case study, video tapes and role play. In item 9, 33,3% (n=31) strongly agreed and 41.9% (n=39) agreed that cultural knowledge received in a classroom can provide cultural competency, while 8.6% (n=8) strongly disagreed and 16.1% (n=15) disagreed.

In item 10, 26.6% (n=25) strongly agreed and 37.2% (n=35) agreed that cultural knowledge is not effective if there is no correlation of theory and practice, while 16.0% (n=15) strongly disagreed and 20.2% (n=19) disagreed. Papadopoulos et al (2011:194) indicate that nurse educators need to equip their nursing students with the requisite knowledge and skills to prepare them for practical experience and to foster the practice of lifelong learning. In item 11, 37.2% (n=35) strongly agreed and 37.2% (n=35) agreed that early clinical placement is the best tool for nurses to experience culture-competent care, while 11.7% (n=11) strongly disagreed and 13.8% (n=13) disagreed. Jirwe and Gerrish (2010:442) maintain that early placement of student nurses during training will prevent stereotyping and prepare them to face challenges in cross-cultural settings.

In item 12, 41.9% (n=39) of the respondents strongly agreed and 43.0% (n=40) agreed that cultural knowledge need to be nurtured through continuing education and mentoring, while 8.6% (n=8) strongly disagreed and 6.5% (n=6) disagreed. This concurs with Serrant-Green's (2001:673) finding that there is a need for cultural knowledge to be nurtured where nursing education would appear to be the ideal vehicle for carrying cultural knowledge to future nursing practice. Leuning, Swiggum, Wiegert and McCullough-Zander (2002:45) point out that cultural knowledge needs to be nurtured through continuing education and mentoring.

In item 13, 41,5% (n=39) strongly agreed and 39,4% (n=37) agreed that employers should invite guest speakers with cultural knowledge to motivate staff to deliver culture-competent care, while 8.5% (n=8) strongly disagreed and 10.6% (n=10) disagreed. Cuellar et al (2008:147) suggest the inclusion of guest speakers from diverse

backgrounds in teaching cultural diversity. In item 14, 43.6% (n=41) strongly agreed and 30.9% (n=29) agreed that lectures on culturally competent care should be included in the curriculum, while 9.6% (n=9) strongly disagreed and 16.0% (n=15) disagreed. In item 15, 18.1% (n=17) strongly agreed and 30.9% (n=29) agreed that topics on cultural competence were included in the in-service education programme of the hospitals where they worked, while 20.2% (n=19) strongly disagreed and 30.9% (n=29) disagreed.

In item 16, 44.7% (n=42) of the respondents strongly agreed and 31.9% (n=30) agreed that they considered patients' cultural beliefs when serving meals, while 10.6% (n=10) strongly disagreed and 12.8% (n=12) disagreed. In item 17, 27.2% (n=25) strongly agreed and 30.4% (n=28) agreed that they allowed relatives to bring food from home to satisfy patients' cultural needs, while 15.2% (n=14) strongly disagreed and 27.2% (n=25) disagreed.

In item 18, 12.9% (n=12) strongly agreed and 12.9% (n=12) agreed that the hospitals in which they worked invited community members to meetings about culturally competent care, while 33.3% (n=31) strongly disagreed and 40.9% (n=38) disagreed. In item 19, 25.8% (n=24) either strongly agreed or agreed that traditional healers formed part of the health care system in the hospitals where they worked, while 23.7% (n=22) strongly disagreed and 50.5% (n=47) disagreed. It is the researcher's observation that traditional healers do not form part of the health care system in Mopani District. People exercise their right to either visit formal health services or traditional healers.

In item 20, 9.9% (n=9) of the respondents strongly agreed and 20.9% (n=21) agreed that posters, pictures and printed materials displayed on the notice boards in the hospitals where they work informed cultural knowledge, while 28.6% (n=26) strongly disagreed and 40.7% (n=37) disagreed. In item 21, 41.8% (n=38) strongly agreed and 34.1% (n=31) agreed that if they had cultural knowledge they would be able to plan nursing care with the patient, while 9.9% (n=9) strongly disagreed and 14.3% (n=13) disagreed. Wilson, Sanner and McAllister (2010:72) maintain that nurses with cultural knowledge are able to interact with clients from a global perspective and are ethically obliged to provide care that is consistent with their clients' customs, beliefs and values. In item 22, 38.5% (n=35) strongly agreed and 37.4% (n=34) agreed that if they had cultural knowledge they would be able to make decisions with patients concerning

nursing care, while 13.2% (n=12) strongly disagreed and 11.0% (n=10) disagreed. Price and Cortis (2000:238) maintain that a body of cultural knowledge will enable nurses to provide holistic health care.

In item 23, 49.5% (n=45) of the respondents strongly agreed and 34,1% (n=31) agreed that if they had cultural knowledge they would be able to respect patients' cultural needs, while 7.7% (n=7) strongly disagreed and 8.8% (n=8) disagreed. In item 24, 50.5% (n=46) strongly agreed and 31.9% (n=29) agreed that if they had cultural knowledge they would understand and respect the religious beliefs of other cultures, while 7.7% (n=7) strongly disagreed and 9.9% (n=9) disagreed. Ciprietti and Fidura (2005:27) emphasise that every culture has its own individual way of dealing with health and illness, birth, delivery and death and they all need to be respected. Cultural knowledge could therefore enhance respect for individual differences. In item 25, 24.4% (n=22) strongly agreed and 34.4% (n=31) agreed that if they had cultural knowledge they would accept patients' beliefs regarding traditional pain remedies, while 16.7% (n=15) strongly disagreed and 24,4% (n=22) disagreed. Holistic care would include patients' beliefs regarding pain relief. According to Price and Cortis (2000:238) a body of cultural knowledge will enable nurses to provide holistic health care.

In item 26, 33.7% (n=31) strongly agreed and 22.8% (n=21) agreed that if they had cultural knowledge they would allow relatives to bring food to patients to satisfy cultural food preferences, while 20.7% (n=19) strongly disagreed and 22.8% (n=21) disagreed. In item 27, 33.7% (n=31) strongly agreed and 30,4% (n=28) agreed that if they had cultural knowledge they would allow family members of patients of diverse cultures to participate in the patient's nursing care, while 21.7% (n=20) strongly disagreed and 14,1% (n=13) disagreed. In item 28, 21.7% (n=20) strongly agreed and 22.8% (n=21) agreed that if they had cultural knowledge they would allow a relative of a patient of a diverse culture to interpret to the doctor during doctor's rounds while 31.5% (n=29) strongly disagreed and 23.9% (n=22) disagreed.

In item 29, 8.7% (n=8) strongly agreed and 10.9% (n=10) agreed that cultural knowledge would influence them to allow family members to visit at any time without consideration of hospital visiting hours, while 45.7% (n=42) strongly disagreed and 34.8% (n=32) disagreed. In item 30, 12,0% (n=11) strongly agreed and 19.6% (n=18) agreed that if they had cultural knowledge they would allow one relative of a patient of

diverse culture to remain with the patient to provide culture-specific care while 30.4% (n=28) strongly disagreed and 38,0% (n=35) disagreed.

#### 4.3.2.3 Cultural skill

Table 4.12 indicates the respondents' knowledge of cultural skill.

**Table 4.12 Respondents' cultural skill**

Cultural skill	SA F	SA %	A F	A %	SD F	SD %	D F	D %	TOTAL
1 Cultural differences are taken into consideration when assessing the patient's needs	39	41.9	35	37.6	13	14.0	6	6.5	93
2 Family members are involved when I obtain data from patients of diverse cultures	31	33.7	36	39.1	14	15.2	11	12.0	92
3 I involve interpreters to explain language when performing nursing procedures to patients of diverse culture	25	26.9	36	38.7	12	12.9	20	21.5	93
4 I learn about culturally competent care from other professional nurses in the ward where I work	25	26.9	43	46.2	10	10.8	15	16.1	93
5 I use the language of a client to obtain accurate data	38	41.8	43	47.3	7	7.7	3	3.3	91
6 I listen to patients to obtain relevant cultural data on the patient	41	44.6	39	42.4	8	8.7	4	4.3	92
7 I assess patients' cultural values, beliefs and practices during data collection	40	43.5	47	51.1	3	3.3	2	2.2	92
8 I assess patients' perception of their illness	46	51.1	36	40	5	5.6	3	3.3	90
9 I provide privacy to patients of diverse cultures during provision of nursing care	50	54.3	33	35.9	3	3.3	6	6.5	92
10 If the patient draws your attention to specific	35	38.5	36	39.6	11	12.1	9	9.9	91

<b>Cultural skill</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>TOTAL</b>
practices in his/her cultural group, you incorporate these customs in your nursing care plan if they are not harmful to the patient									
11 I consider the cultural norms of patients of different cultures when providing nursing care	35	37.5	40	43.0	7	7.5	11	11.8	93
12 I respect the request of patients of diverse cultures eg, a female wants to be examined by female doctors	28	30.1	47	50.5	5	5.4	13	14.0	93
13 I involve patients in decisions related to their own health	45	48.4	38	40.9	6	6.5	4	4.3	93
14 I involve patients in decisions related to their cultural belonging while in the ward	34	36.6	41	44.1	8	8.6	10	9.5	93
15 I allow interpreters to be available in the wards to assist nurses in observing the non-verbal cues of patients related to nursing care	24	26.1	34	37.0	9	9.8	25	27.2	92
16 I respect patients' personal space when communicating issues related to nursing care	34	36.6	43	46.2	8	8.6	8	8.6	93
17 I allow patients of diverse cultures to practise activities that they believe control the causation of illness	20	21.5	28	30.1	19	20.4	26	28.0	93
18 I observe non-verbal communication of patients of diverse cultures and respond by providing the care the patient requires	33	35.5	40	43.0	13	14.0	7	7.5	93
19 I provide nursing care considering cultural differences among the racial groups but not ignoring other racial groups	38	40.9	41	44.1	5	5.4	9	9.7	93
20 I order food for patients according to their cultural needs	42	45.2	35	37.6	6	6.5	10	10.8	93

<b>Cultural skill</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>TOTAL</b>
21 I ask patients of diverse cultures about their cultural beliefs about causation of illness	22	23.7	47	50.5	9	9.7	15	16.1	93
22 I allow patients of diverse cultures to explain their cultural beliefs about the severity of illness	22	23.7	42	45.2	12	12.9	17	18.3	93
23 I ask patients of diverse cultures the kind of treatments they require to treat their illness	20	22.0	31	34.1	18	19.8	22	24.2	91
24 I ask patients of diverse cultures about their fears regarding their illness	21	23.1	45	49.5	7	7.7	18	19.8	91
25 I ask patients of diverse cultures about their traditional diet	22	23.7	35	37.6	16	17.2	20	21.5	93
26 I ask patients of diverse cultures about their religious belief	35	37.6	49	52.7	2	2.2	7	6.7	93
27 I ask patients of diverse cultures their language	31	33.3	42	45.2	4	4.3	16	17.2	93
28 I involve family members when doing cultural assessment of patients of diverse cultures	23	24.7	47	50.5	8	8.6	15	16.1	93
29 I respect the intimate space of patients of diverse cultures when doing cultural assessment	26	28.0	45	48.4	8	8.6	14	15.1	93
30 I respect the personal space of patients of diverse cultures when doing cultural assessment	33	35.5	43	46.2	11	11.8	6	6.5	93

In item 1, 41.9% (n=39) of the respondents strongly agreed and 37.6% (n=35) agreed that cultural differences were taken into consideration when assessing patients' needs, while 14.0% (n=13) strongly disagreed and 6.5% (n=6) disagreed. Walton (2011:27) indicates that health providers could incorporate health beliefs into the education process of students to promote culture-competent care. In item 2, 33.7% (n=31) strongly agreed and 39.1% (n=36) agreed that family members were involved when obtaining data from patients of diverse cultures, while 15.2% (n=14) strongly disagreed

and 12.0% (n=11) disagreed. Involving family members in obtaining data assists professional nurses to plan nursing care considering cultural needs, especially if the patient is very ill. In item 3, 26.9% (n=25) strongly agreed and 38.7% (n=36) agreed that they involved interpreters to explain language when performing nursing procedures to patients of diverse cultures, while 12.9% (n=12) strongly disagreed and 21.5% (n=20) disagreed. According to Cakir (2006:154), culture and language are used as mediums through which culture is expressed. If there is difficulty between professional nurses and patients in understanding the language, planning of nursing care will be difficult.

In item 4, 26.9% (n=25) strongly agreed and 46.2% (n=43) agreed that they gained knowledge about culturally competent care from other professional nurses in the ward where they worked, while 10.8% (n=10) strongly disagreed and 16.1% (n=15) disagreed. In item 5, 41.8% (n=38) strongly agreed and 47.3% (n=43) agreed that they used patients' language to obtain accurate assessment data, while 7.7% (n=7) strongly disagreed and 3.3% (n=3) disagreed. Jirwe, Gerrish and Emami (2010:436-444) found that not using patients' language could affect nurse and patient, resulting in the risk of giving limited information when explaining procedures to the patient.

In item 6, 44.6% (n=41) strongly agreed and 42.4% (n=39) agreed that they listened to patients to obtain accurate, relevant cultural data, while 8.6% (n=8) strongly disagreed and 4.3% (n=4) disagreed. According to Tjale and de Villiers (2004:26), patients are unique and this requires healthcare professionals to be sensitive when collecting cultural data. In Item 7, 43.5% (n=40) strongly agreed and 51.1% (n=47) agreed that they assessed patients' cultural values, beliefs and practices during data collection, while 3.0% (n=3) strongly disagreed and 2.0% (n=2) disagreed. Walton (2011:29) indicates that values are individualized and culture determined, and differ in each patient, thus necessitating individual assessment of patients.

In item 8, 51.1% (n=46) strongly agreed and 40% (n=36) agreed that they assessed patients' perceptions of their illness, while 5.6% (n=5) strongly disagreed and 3.3% (n=3) disagreed. Tjale and De Villiers (2004:144) maintain that some patients perceive illness as having a natural cause while others perceive illness as having a supernatural cause. Maier-Lorentz (2008:39) points out that culture-competent nurses are respectful of others' cultural habits, especially in health care. Furthermore, various beliefs are

based on a specific culture's perspective of the individual's relationship with the environment.

In item 9, 54.3% (n=50) strongly agreed and 35.9% (n=33) agreed that they provided privacy to patients of diverse cultures during provision of nursing care, while 3.3% (n=3) strongly disagreed and 6.5% (n=6) disagreed. According to Maier-Lorentz (2008:39), nurses should realize that space and distance between themselves and patients are very important to consider when providing care to individuals from cultures that are different from their own. In item 10, 38.5% (n=35) strongly agreed and 39.6% (n=36) agreed that if patients drew their attention to specific practices in their cultural group that were not harmful to the patient, they incorporated these practices in their nursing care plan, while 12.1% (n=11) strongly disagreed and 9.9% (n=9) disagreed. According to Maier-Lorentz (2008:40), cultural assessment is an effective way to obtain pertinent information about important aspects of care.

In item 11, 37.5% (n=35) of the respondents strongly agreed and 43% (n=40) agreed that they considered the cultural norms of patients of different cultures when providing nursing care, while 7.5% (n=11) strongly disagreed and 11.8% (n=11) disagreed. According to Maier-Lorentz (2008:38), having knowledge of patients' cultural perspectives enables nurses to provide more effective and appropriate care. In item 12, 30.1% (n=28) strongly agreed and 50.5% (n=47) agreed that they respected the request of patients of diverse cultures, while 5.4% (n=5) strongly disagreed and 14.0% (n=13) disagreed. Tjale and de Villiers (2004:38) indicate that cultural knowledge will equip professional nurses to respect the patients' requests regarding cultural issues. In item 13, 48.4% (n=45) strongly agreed and 40.9% (n=38) agreed that they involved patients in decisions related to their health, while 6.5% (n=6) strongly disagreed and 4.3% (n=4) disagreed.

In item 14, 36.6% (n=34) of the respondents strongly agreed and 44.1% (n=41) agreed that they involved patients in decisions related to their cultural belonging while in the ward, while 8.6% (n=8) strongly disagreed and 10.8% (n=10) disagreed. In item 15, 26.1% (n=24) strongly agreed and 37% (n=34) agreed that they allowed interpreters to be available in the wards to assist nurses in observing patients' non-verbal cues related to nursing care, while 9.8% (n=9) strongly disagreed and 27.2% (n=25) disagreed. Maier-Lorentz (2008:38) emphasises that communication goes far beyond verbal and

written communication. Non-verbal cues play a vital role in conveying messages and this varies considerably among cultures. Thus, failure to understand verbal and non-verbal communication may require interpreters to be present in the wards to assist. In item 16, 36.6% (n=34) strongly agreed and 46.2% (n=43) agreed that they respected patients' personal space when communicating issues related to nursing care, while 8.6% (n=8) strongly disagreed and 8.6% (n=8) disagreed. Giger and Davidhizar (2002:185) argue that each person has their own territorial behaviour. Violation of a patient's intimate and personal space can cause discomfort and may result in a patient refusing treatment.

In item 17, 21.5% (n=20) strongly agreed and 30.1% (n=28) agreed that they allowed patients of diverse cultures to practise activities that they believed controlled the causation of illness, while 20.4% (n=19) strongly disagreed and 28% (n=26) disagreed. Professional nurses with cultural knowledge will allow patients to engage in cultural activities that will enhance their health. Woods (2010:718) maintains that nurses are obliged to be aware of and sensitive to individuals' and groups' cultural beliefs, values and practices. In item 18, 35.5% (n=33) strongly agreed and 43% (n=40) agreed that they observed non-verbal communication of patients of diverse cultures and responded by providing the care the patients required, while 14% (n=13) strongly disagreed and 7.5% (n=7) disagreed. In item 19, 40.9% (n=38) strongly agreed and 44.1% (n=44) agreed that they provided nursing care considering cultural differences among racial groups but not ignoring other racial groups, while 5.4% (n=5) strongly disagreed and 9.7% (n=9) disagreed. Festini, Focardi, Bisogni, Mannini and Neri (2009:221) found that providing nursing care to people with different cultural backgrounds has the potential to create problems for nurses and to increase the level of difficulty perceived in their daily work.

In item 20, 45.2% (n=42) strongly agreed and 37.6% (n=35) agreed that they ordered food for patients according to their cultural needs, while 6.5% (n=6) strongly disagreed and 10.8% (n=10) disagreed. In item 21, 23.7% (n=22) strongly agreed and 50.5% (n=47) agreed that they asked patients of diverse cultures about their cultural beliefs about causation of illness while 9.7% (n=9) strongly disagreed and 16.1% (n=15) disagreed.

In item 22, 23.7% (n=22) strongly agreed and 45.2% (n=42) agreed that they allowed patients of diverse cultures to explain their cultural beliefs about the severity of illness, while 12.9% (n=12) strongly disagreed and 18.3% (n=17) disagreed. In item 23, 22.0% (n=20) strongly agreed and 34.1% (n=31) agreed that they asked patients of diverse cultures about the kind of treatment they required to treat their illness, while 19.8% (n=18) strongly disagreed and 24.2% (n=22) disagreed. In item 24, 23.1% (n=21) strongly agreed and 49.5% (n=45) agreed that they asked patients of diverse cultures about their fears regarding their illness, while 7.7% (n=7) strongly disagreed and 19.8% (n=18) disagreed. In item 25, 23.7% (n=22) strongly agreed and 37.6% (n=22) agreed that they asked patients of diverse cultures if they required to be given their traditional diet, while 17.2% (n=16) strongly disagreed and 21.5% (n=20) disagreed. In item 26, 37.6% (n=35) strongly agreed and 52.7% (n=49) agreed that they asked patients of diverse cultures about religious beliefs, while 2.2% (n=2) strongly disagreed and 7.5% (n=7) disagreed.

In item 27, 33.3% (n=31) of the respondents strongly agreed that they ask patients of diverse cultures their language, 45.2% (n=42) agreed, 4.3% (n=4) strongly disagreed and 17.2% (n=16) disagreed. In item 28, 24.7% (n=23) strongly agreed and 50.5% (n=47) agreed that they involved family members when doing cultural assessment of patients, while 8.6% (n=8) strongly disagreed and 16.1% (n=15) disagreed. In item 29, 28% (n=26) strongly agreed and 48.4% (n=45) agreed that they respected the intimate space of patients of diverse cultures when doing cultural assessment, while 8.6% (n=8) strongly disagreed and 15.1% (n=14) disagreed. In item 30, 35.5% (n=33) strongly agreed and 46.2% (n=43) agreed that they respected the personal space of patients of diverse cultures when doing cultural assessment, while 11.8% (n=11) strongly disagreed and 6.5% (n=6) disagreed.

#### **4.3.2.4 Cultural encounter**

Table 4.13 indicates the respondents' experience of cultural encounter.

**Table 4.13 Respondents' cultural encounter**

<b>Cultural encounter</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>TOTAL</b>
1 I cannot communicate well with patients of diverse cultures	5	5.4	16	17.4	31	33.7	40	43.5	92
2 I cannot interpret the verbal and non-verbal cues of patients of diverse cultures when providing nursing care	8	8.7	20	21.7	25	27.2	39	42.4	92
3 I allow patients of diverse cultures to explain their health problems to the interpreters during data collection	30	32.6	32	34.8	12	13.0	18	19.6	92
4 I observe a silent moment that a patient of diverse culture does as a means of communication	26	28.0	34	36.6	13	14.0	20	21.5	93
5 I interact well with patients of diverse cultures	32	34.8	34	37.0	14	15.2	12	11.4	92
6 I consider that there is a need to learn about different languages of patients of diverse cultures	49	52.7	30	32.3	5	5.4	9	9.7	93
7 I believe that poor communication is a language barrier that may have a negative effect in health care of patients of diverse cultures	53	57.6	26	28.3	7	7.6	6	6.5	92
8 I create time to listen to patients of diverse cultures	44	48.9	35	38.9	6	6.7	5	5.6	90

<b>Cultural encounter</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>TOTAL</b>
9 I want to learn much about cultural experiences of the patients that is different than my own	29	31.9	31	34.1	8	8.8	23	25.3	91
10 I believe that poor communication can cause a doctor to write wrong prescriptions	59	64.1	25	27.2	6	6.5	2	2.2	92
11 I believe that interpreters who do not know medical terms can interpret wrong information	50	54.3	32	34.8	5	5.4	5	5.4	92
12 I believe that language barriers can lead to a patient taking wrong treatment	50	54.3	30	32.6	7	7.6	5	5.4	92
13 I believe that language barriers can lead patients to misunderstand diagnoses	38	41.3	26	28.3	14	15.2	14	15.2	92
14 I believe that avoidance of eye contact during communication by patients of diverse cultures is a cultural means of showing respect	41	44.6	34	37.0	11	12.0	6	6.5	92
15 I listen to tone of voice when talking to patients of diverse cultures because the tone may express emotions	28	30.4	36	39.1	10	10.9	18	19.6	92

In item 1, 5.4% (n=5) of the respondents strongly agreed and 17.4% (n=16) agreed that they could not communicate well with patients of diverse cultures, while 33.7% (n=31) strongly disagreed and 43.5% (n=40) disagreed. Maier-Lorentz (2008:38) maintains that although nurses cannot master many languages, understanding the cues used by different cultures may be beneficial for providing culturally competent care. In item 2, 8.7% (n=8) strongly agreed and 21.7% (n=20) agreed that they could not interpret the verbal and nonverbal cues of patients of diverse cultures when providing nursing care, while 27.2% (n=25) strongly disagreed and 42.4% (n=39) disagreed. Cakir (2006:154) stresses that communication problems may arise among speakers who do not know or share the norms of another culture. This implies that professional nurses may sometimes have difficulty interpreting the verbal and non-verbal cues of other languages. In item 3, 32, 6% (n=30) strongly agreed and 34.8% (n=32) agreed that they allowed patients of diverse cultures to explain their health problems to the interpreters during data collection, while 13,0% (n=12) strongly disagreed and 19.6% (n=18) disagreed. Jirwe et al (2010:438) state that lack of a shared language could limit the information given when explaining procedures thereby creating problems for both nurse and patient.

In item 4, 28,0% (n=26) strongly agreed and 36.6% (n=34) agreed that they observed a silent moment that patients of diverse culture did as a means of communication, while 14,0% (n=13) strongly disagreed and 21,0% (n=20) disagreed. Maier-Lorentz (2008:38) maintains that cross-cultural communication involves several aspects that should be understood in order to achieve cultural competency. In item 5, 34.8% (n=32) strongly agreed and 37,0% (n=34) agreed that they interacted well with patients of diverse cultures, while 15,2% (n=14) strongly disagreed and 11.4% (n=12) disagreed. Jirwe et al (2010:438) found that when there is satisfactory communication with the patient or the relatives through verbal and non-verbal means, health care professionals feel satisfied with the care they provided to the patient and the encounter. In item 6, 52.7% (n=49) strongly agreed and 32,3% (n=30) agreed that there was a need to learn about different languages of patients of diverse cultures, while 5,4% (n=5) strongly disagreed and 9.7% (n=9) disagreed. Cakir (2006:154) indicates that to solve communication problems, it is necessary to learn about culture during nurse training. In item 7, 57.6% (n=53) strongly agreed and 28,3% (n=26) agreed that poor communication was a language barrier that may have a negative effect in health care of patients of diverse cultures, while 7.6% (n=7) strongly disagreed and 6.5% (n=6) disagreed. Jirwe et al

(2010:439) maintain that lack of understanding of patients' language could lead to omissions by health professionals when explaining procedures to them. In item 8, 48.9% (n=44) strongly agreed and 38.9% (n=35) agreed that they created time to listen to patients of diverse cultures, while 6.7% (n=6) strongly disagreed and 5.6% (n=5) disagreed. Camphinha-Bacote (2002:182) indicates that cultural encounters involve direct interaction with patients from diverse cultural groups. In item 9, 31.9% (n=29) strongly agreed and 34.1% (n=31) agreed that they wanted to learn about cultural experiences of patients that were different to their own, while 8.8% (n=8) strongly disagreed and 25.3% (n=23) disagreed. In item 10, 64.1% (n=59) strongly agreed and 27.2% (n=25) agreed that poor communication could cause a doctor to write a wrong prescription, while 6.5% (n=6) strongly disagreed and 2.2% (n=2) disagreed. Campinha-Bacote (2002:182) stresses that the use of untrained interpreters, friends or family members may pose a problem due to lack of knowledge of medical terminology and disease entities. In item 11, 54.3% (n=50) strongly agreed and 34.8% (n=32) agreed that interpreters who did not know medical terms could interpret wrong information, while 5.4% (n=5) strongly disagreed and 5.4% (n=5) disagreed.

In item 12, 54.3% (n=50) strongly agreed and 32.6% (n=30) agreed that language barriers could lead a patient to take wrong treatment, while 7.6% (n=7) strongly disagreed and 5.4% (n=5) disagreed. In item 13, 41.3% (n=38) strongly agreed and 28.3% (n=26)% agreed that language barriers could lead patients to misunderstand diagnosis, while 15.2% (n=14) strongly disagreed and 15.2% (n=14) disagreed. Jirwe et al (2010:439) point out that difficulty often occurred amongst patients of diverse cultures due to misinterpretation of health workers' explanations. In item 14, 44.6% (n=41) strongly agreed and 37.0% (n=34) agreed that avoidance of eye contact during communication by patients of diverse cultures was a cultural means of showing respect, while 12.0% (n=11) strongly disagreed and 6.5% (n=6) disagreed. According to Maier-Lorentz (2008:39), eye contact is an important nonverbal means of communication and the variables differ amongst many cultures. In addition, it is essential for nurses to understand that several meanings may be attached to direct eye contact in order to communicate effectively with their patients. In item 15, 30.4% (n=28) strongly agreed and 39.1% (n=36) agreed that they listened to the tone of voice when talking to patients of diverse cultures because the tone may express emotions, while 10.9% (n=10) strongly disagreed and 19.6% (n=18) disagreed.

### 4.3.2.5 Cultural desire

Table 4.14 presents the respondents' perceptions of cultural desire.

**Table 4.14 Respondents' cultural desire**

Cultural desire	SA F	SA %	A F	A %	SD F	SD %	D F	D %	TOTAL
1 I am motivated to provide culture-competent care as part of my own identity and ideals	18	19.6	50	54.3	10	10.9	14	15.2	92
2 I am motivated to provide culture-competent care because it is required by management	20	21.7	42	45.7	11	12.0	19	20.7	92
3 I impose Eurocentric nursing care as I have been trained in that norm	12	13.2	42	46.2	16	17.6	21	23.1	91
4 I do not want to provide nursing care to patients of diverse cultures	5	5.4	22	23.7	30	32.3	36	38.7	93
5 I provide culturally competent care when reminded by peers	12	12.9	28	30.1	23	24.7	30	32.3	93
6 I am interested in nursing patients that are of different cultures to mine	26	28	40	43	9	9.7	18	19.4	93
7 I have good relationships with patients of diverse cultures while providing nursing care	36	38.7	47	50.5	5	5.4	5	5.4	93
8 I involve patients to teach me their language when providing nursing care	37	39.8	48	51.6	4	4.3	4	4.3	93
9 I accept that patients differ according to cultural beliefs, values and practices while providing patient care	47	50.5	38	40.9	4	4.3	4	4.3	93
10 I listen to patients' perceptions of a problem before planning nursing care	37	39.8	49	52.7	5	5.4	2	2.2	93
11 I listen to the patient's individual perception of the problem, being non-judgmental	42	45.2	43	46.2	4	4.3	4	4.3	93
12 I always probe patients of diverse cultures to tell me more about their problems so that I can plan nursing care considering their cultural needs	35	37.6	50	53.8	2	2.2	6	6.5	93

<b>Cultural desire</b>	<b>SA F</b>	<b>SA %</b>	<b>A F</b>	<b>A %</b>	<b>SD F</b>	<b>SD %</b>	<b>D F</b>	<b>D %</b>	<b>TOTAL</b>
13 I am willing to learn more about different cultures of patients in my care	51	54.8	34	36.6	5	5.4	3	3.2	93
14 I involve interpreters during doctor's rounds to clarify verbal and non-verbal cues from patients	30	32.3	40	43	10	10.8	13	14	93
15 I involve interpreters to teach me languages of patients of diverse cultures	32	34.4	40	43	8	8.6	13	14	93
16 I ask my colleagues to teach me more about culturally competent nursing care	31	33.7	45	48.9	7	7.6	9	9.8	92
17 I am motivated to read books and articles about culturally competent nursing care to gain more knowledge	34	36.6	47	50.5	2	2.2	10	10.8	93
18 I involve patients of diverse cultures to pray in the morning before we start with the routine so that we can learn about the religion of other cultures	38	41.3	31	33.7	8	8.7	15	16.3	92
19 I see each patient as a unique human being	55	59.8	36	39.1	0	0	1	1.1	92
20 I accept the cultural differences of patients	51	56.7	32	35.6	2	2.2	5	5.6	90

In item 1, 19.6% (n=18) of the respondents strongly agreed and 54.3% (n=50) agreed that they were motivated to provide culture-competent care as part of their own identity and ideals, while 10.9% (n=10) strongly disagreed and 15.2% (n=14) disagreed. Tortumluoglu (2006:11) maintains that cultural desire is the spiritual pivotal construct of cultural competence that provides the energy source and foundation for one's journey towards culture competence. In item 2, 21.7% (n=20) strongly agreed and 45.7% (n=42) agreed that they were motivated to provide culture-competent care because it is required by management, while 12% (n=11) strongly disagreed and 20.7% (n=19) disagreed. Tortumluoglu (2006:11) emphasises that cultural desire requires commitment in the case of health professionals who may have realized their incompetence by attending workshops on cultural diversity and then strive to become culturally competent when providing nursing care to patients of diverse cultures but not through being required by management. In item 3, 13.2% (n=12) strongly agreed and 46.2% (n=42) agreed that they practised Eurocentric nursing care as they had been

trained in that norm, while 17.6% (n=16) strongly disagreed and 23.1% (n=21) disagreed. Tortumluoglu (2006:11) indicates that cultural competence is the process not the end point of becoming culturally competent, in which one continually strives to achieve the ability to work within the context of an individual, family or community from a different background. Consequently, even if professional nurses are trained according to Eurocentric nursing care principles, they can strive to become culturally competent when nursing patients of diverse cultures. In item 4, 5.4% (n=5) strongly agreed and 23.7% (n=22) agreed that they did not want to provide nursing care to patients of diverse cultures, while 32.3% (n=30) strongly disagreed and 38.7% (n=36) disagreed. According to Campinha-Bacote (2002:182), cultural desire is the motivation of the health care provider to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and familiar with cultural encounter.

In item 5, 12.9% (n=12) strongly agreed and 30.1% (n=28) agreed that they provided culturally competent care when reminded by peers, while 24.7% (n=23) strongly disagreed and 32.3% disagreed. In item 6, 28% (n=26) strongly agreed and 43% (n=40) agreed that they were interested in nursing patients of different cultures to them, while 9.7% (n=9) strongly disagreed and 19.4% (n=18) disagreed. In item 7, 38.7% (n=36) strongly agreed and 50.5% (n=47) agreed that they had good relationships with patients of diverse cultures while providing nursing care, while 5.4% (n=5) strongly disagreed and disagreed, respectively.

In item 8, 39.8% (n=37) strongly agreed and 51.6% (n=48) agreed that they involved patients to teach them their language when providing nursing care, while 4.3% (n=4) strongly disagreed and 4.3% (n=4) disagreed. Tortumluoglu (2006:8) maintains that cultural desire involves the commitment to learn to become culturally competent. In item 9, 50.5% (n=47) strongly agreed and 40.9% (n=38) agreed that they accepted that patients differed according to cultural beliefs, values and practices while providing patient care, while 4.3% (n=4) strongly disagreed and disagreed, respectively. Maier-Lorentz (2008:39) argues that culture-competent nurses would understand various cultural health beliefs and provide care that included consideration for these differences.

In item 10, 39.8% (n=37) strongly agreed and 52.7% (n=49) agreed that they listened to patients' perceptions of a problem before planning nursing care, while 5.4% (n=5) strongly disagreed and 2.2% (n=2) disagreed. According to Maier-Lorentz (2008:39),

culturally competent nurses are respectful of others' health habits, especially in health care, and their nursing care plan should be individualized to account for various cultural differences. In item 11, 45.2% (n=42) strongly agreed and 46.2% (n=43) agreed that they listened to patients' individual perceptions of the problem, being non-judgmental, while 4.3% (n=4) strongly disagreed and disagreed, respectively. Dogan et al (2009:684) maintain that health care personnel should be aware of or gain skills to understand variations in beliefs and illness and that the skills required should be addressed in undergraduate nursing education. In item 12, 37.6% (n=35) strongly agreed and 53.8% (n=50) agreed that they always probed patients of diverse cultures to tell them more about their problems so that they could plan nursing care considering their cultural needs, while 2.2% (n=2) strongly disagreed and 6.5% (n=6) disagreed. In item 13, 54.8% (n=51) strongly agreed and 36.6% (n=34) agreed that they were willing to learn more about the different cultures of patients in their care, while 5.4% (n=5) strongly disagreed and 3.2% (n=3) disagreed. Tortumluoglu (2006:8) is of the opinion that nurses may have to attend workshops to gain knowledge about culturally competent nursing care. In item 14, 32.3% (n=30) strongly agreed and 43.0% (n=40) agreed that they involved interpreters during doctor's rounds to clarify verbal and non-verbal cues from patients, while 10.8% (n=10) strongly disagreed and 14.0% (n=13) disagreed. According to Diamond and Jacobs (2009:189), the use of professional interpreters improves the quality of care for patients resulting in higher patient satisfaction, fewer errors in communication, reduced disparities in the utilization of services, and improved clinical outcomes.

In item 15, 34.4% (n=32) strongly agreed and 43% (n=40) agreed that they involved interpreters to teach them languages of patients of diverse cultures, while 8.6% (n=8) strongly disagreed and 14% (n=13) disagreed. Diamond and Jacobs (2009:189) recommend that cross-cultural education be incorporated in the training of all health professionals. Dogan et al (2009:684) stress that cultural skills should be addressed during basic nursing training. In item 16, 33.7% (n=31) strongly agreed and 48.9% (n=45) agreed that they asked their colleagues to teach them more about culturally competent nursing care, while, 7.6% (n=7) strongly disagreed and 9.8% (n=9) disagreed. In item 17, 36.6% (n=34) strongly agreed and 50.5% (n=47) agreed that they were motivated to read books and articles about culturally competent nursing care to gain more knowledge, while 2.2% (n=2) strongly disagreed and 10.8% (n=10) disagreed. Tortumluoglu (2006:8) found that nurses attended workshops, read articles

or books on culture-competent care if they had cultural desire. In item 18, 41.3% (n=38) strongly agreed and 33.7% (n=31) agreed that they involved patients of diverse cultures to pray in the morning before starting with routine tasks, while 8.7% (n=8) strongly disagreed and 16.3% (n=15) disagreed. Prayer, according to Andrews and Boyle (2008:356) is a ritual relevant to religious beliefs which are entrenched in culture.

In item 19, 59.8% (n=55) strongly agreed and 39.1% (n=36) agreed that they saw each patient as a unique being, while 1.1% (n=1) disagreed. In item 20, 56.7% (n=51) strongly agreed and 35.6% (n=32) agreed that they accepted patients' cultural differences, while 2.2% (n=2) strongly disagreed and 5.6% (n=5) disagreed. Giger and Davidhizar (2002:185) postulate that each patient is unique and should be assessed according to their cultural differences.

#### **4.3.3 Section 3: Respondents' personal experience in nursing patients of diverse cultures**

Section 3 of the questionnaire consisted of an open-ended question about the respondents' experiences (challenges and/or advantages) when nursing patients of diverse cultures.

<b>Advantages experienced by the respondents when nursing patients of diverse cultures</b>	<b>Challenges experienced by the respondents when nursing patients of diverse cultures</b>
<ul style="list-style-type: none"> <li>• Learning the language of patients of diverse cultures.</li> <li>• Learning how relatives of diverse cultures support their family members when they are sick.</li> <li>• Learning how to interpret non-verbal communication.</li> <li>• Learning about the diet of patients of diverse cultures.</li> </ul>	<ul style="list-style-type: none"> <li>• Language was a challenge when obtaining data, leading to misinterpretation of the information given by the patients.</li> <li>• Language was a challenge when interpreting to the doctor during doctor's rounds.</li> <li>• Misinterpreting patients' non-verbal communication.</li> <li>• Patients' refusing to eat hospital diet because they preferred their cultural food.</li> <li>• Dietician not having knowledge and ingredients to prepare diet preferred by patients of diverse cultures. This was solved by allowing relatives to bring cultural diet from home.</li> <li>• Lack of skill in providing culturally competent care.</li> <li>• Relatives of patients of diverse cultures preferring to always be in the ward with their relatives thereby disturbing the ward routine, e.g. bathing of patients.</li> </ul>

All the respondents described experiencing difficulty in providing culture-competent care due to language, communication, lack of skill, patients' refusing hospital diet, and relatives preferring to be in the ward with the patient thus disturbing the ward routine. The respondents also referred to difficulty in provision of nursing due to communication problems between professionals and patients during planning of nursing care. Maier-Lorentz (2008:37) acknowledges that the ever-increasing multicultural population in the United States of America poses significant challenges to nurses providing individualised and holistic care to their patients.

At the same time the respondents found it advantageous to learn how relatives of diverse cultures supported their family members during hospitalisation; how to interpret non-verbal communication; about diverse cultural diet, and patients' languages.

#### **4.4 CONCLUSION**

This chapter discussed the data analysis and interpretation and the results, with reference to the literature review. The results were presented in tables and figures.

Chapter 5 presents the findings and makes recommendations for practice and further research.

## **CHAPTER 5**

### **Findings and recommendations**

#### **5.1 INTRODUCTION**

This chapter briefly presents the conclusions and findings, and makes recommendations for nursing education and practice, an in-service training programme, and further research.

The purpose of the study was to determine professional nurses' knowledge of culture-competent care in medical and oncology wards and outpatient departments at selected hospitals in Mopani District, Limpopo Province. The objectives were to

- determine professional nurses' knowledge of culture-competent care in medical and oncology wards and outpatient departments at selected hospitals in Mopani District, Limpopo Province
- make recommendations for an in-service training programme on culture-competent care for professional nurses working in Mopani District hospitals

A quantitative descriptive research design was used to collect data from 105 professional nurses in the five selected hospitals.

#### **5.2 FINDINGS AND CONCLUSIONS**

The findings are summarised according to the sections of the questionnaire and Campinha-Bacote's model.

## **5.2.1 Respondents' demographical information**

One hundred and five (n=105) respondents returned completed questionnaires. The demographical data covered the respondents' age, gender, population, race, language, marital status and basic qualifications. The study found that of the respondents,

- 65.7% (n=69) were over 40 years old
- 85,7% (n=84) were females and 14,3% (n=14) were males
- 64.4% (n=65) were Tsongas followed by 24.8% (n=25) Northern Sothos
- 60,8% (n=59) spoke Xitsonga and 20,6% (n=20) spoke Sepedi as their home language
- 59,4% (n=60) spoke English fluently besides their home language
- 75,3% (n=67) indicated that principles of culture-competent care were included in the curriculum when they did their basic training
- only 38.7% (n=29) had completed their training after 2005, hence the respondents were considered to be experienced professional nurses because most had been professional nurses for longer than five (5) years at the time of data collection

## **5.2.2 Conclusions according to the five constructs of Campinha-Bacote's model**

In order to reach meaningful conclusions, the researcher grouped "strongly agree" and "agree" responses together and presented them as "agree", and "strongly disagree" and "disagree" responses were presented as "disagree". The most significant findings are presented in the conclusions.

### **5.2.2.1 Cultural awareness**

Of the respondents, 91.6 % (n=88) agreed that they accepted that cultural beliefs differed among cultural groups and 93.7% (n=88) agreed that they appreciated the values of patients of diverse cultures when providing nursing care. The majority of the respondents agreed that they believed that all patients' cultural beliefs should be respected (86.9%; n=86) and that nurses should be able to speak different languages to be able to interact with patients of diverse cultures (89.8%; n=88). However, 35.5%

(n=33) disagreed that they were sensitive to patients' cultural beliefs when rendering nursing care, and 67.7% (n=67) disagreed that they should allow patients of diverse cultures to perform their religious ritual practices in the ward. The findings indicated that most of the respondents were aware that patients differed and that they must respect their cultural differences when providing nursing care, but disagreed that they should allow patients of diverse cultures to perform their religious ritual practices in the ward. Campinha-Bacote (2002:182) states that cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background. Furthermore, cultural awareness is the process which involves the recognition of one's biases, prejudices and assumptions about individuals who are different. Without being aware of the influence of one's own cultural or professional values, there is a risk that the health care provider may engage in cultural imposition. Cultural imposition is the tendency of an individual to impose their beliefs, values, and patterns of behaviour on another culture (Campinha-Bacote 2002:182).

#### **5.2.2.2 Cultural knowledge**

Of the respondents, 84.9% (n=79) agreed that cultural knowledge needed to be nurtured through continuing education and mentoring, and 74.5% (n=70) agreed that cultural competency could be reached if knowledge was included in the curriculum. Of the respondents, 74.1% (n=88) agreed that early clinical placement was the best tool for nurses to gain experience in culture-competent care. The clinical environment is not used optimally to support cultural knowledge, however, as 69.3% (n=63) disagreed that posters, pictures and printed materials depicting cultural knowledge were displayed on the notice boards in the hospitals where they worked. In addition, 41.5% (n=39) disagreed that the hospital staff development programmes gave them the opportunity to develop a knowledge base on the cultural groups that they nursed and 36.9% (n=34) disagreed that the hospitals incorporated cultural knowledge into the personnel development programmes. Moreover, 42.4% (n=39) disagreed that they allowed relatives to bring food from home to satisfy patients' cultural needs. Campinha-Bacote (2002:182) describes cultural knowledge as the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. Based on the findings, it is clear that the respondents acknowledged the need for in-service training, seminars and workshops to enhance their knowledge on providing culture-competent

care to patients of diverse cultures. The integration of culture-competent care throughout the curriculum for nurse education and training would equip nurses with knowledge and skills to provide culture-competent care.

#### **5.2.2.3 Cultural skill**

Of the respondents, 86.2% (n=80) agreed that they obtained relevant cultural data by listening to the patient while 95.0% (n=87) agreed that they assessed patients' cultural values, beliefs and practices during data collection. According to Campinha-Bacote (2002:182), cultural skill is the ability to collect relevant cultural data regarding the patient's presenting problem as well as accurately performing culturally based physical assessment. Based on the findings, the respondents were able to collect cultural data, but needed to be empowered with knowledge to gain competency in providing culture-competent care.

#### **5.2.2.4 Cultural encounter**

Of the respondents, 83% (n=79) agreed that there was a need to learn about different languages of patients of diverse cultures. In addition, 85.9% (n=79) agreed that poor communication was a language barrier that might negatively affect the health care of patients of diverse cultures while 91.3% (n=84) agreed that poor communication could potentially contribute to incidents where doctors wrote wrong prescriptions. Campinha-Bacote (2002:182) emphasises that direct interacting with clients from diverse cultural groups will refine or modify one's existing beliefs about different cultural groups. Communication with patients of diverse cultures is very important. Language problems could potentially lead to misinterpretation of procedures and doctors' prescriptions.

#### **5.2.2.5 Cultural desire**

Of the respondents, 87.1% (n=81) agreed that they were motivated to read books and articles about culturally competent nursing care to gain knowledge and 92.5% (n=86) agreed that they listened to patients' perceptions of a problem before planning nursing care. According to Campinha-Bacote (2002:182), cultural desire is the motivation of the

health care provider to want rather than to have to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and familiar with cultural encounter. The findings indicated that the respondents were interested in learning about the provision of culture-competent care by reading books.

### **5.3 LIMITATIONS OF THE STUDY**

The study was restricted to Mopani District in Limpopo Province, and to professional nurses even though enrolled, auxiliary and student nurses also nurse patients of diverse cultures. These limitations could jeopardise the generalisation of the findings.

### **5.4 RECOMMENDATIONS**

Based on the findings, the researcher makes the following recommendations for nursing education, practice and an in-service training programme on culture-competent care for professional nurses working in Mopani District, Limpopo, and further research.

#### **5.3.1 Nursing education**

This study found that some respondents had not received lectures on the provision of culture-competent care during their training. It is recommended that the basic curriculum for nurse training should include the following aspects of culture-competent care:

- Principles of transcultural nursing
- Culture-competent care
- Cultural knowledge
- Cultural awareness
- Cultural encounter
- Cultural skill
- Cultural desire

### **5.3.2 Nursing practice**

It was found that, to a large extent, the in-service education programmes in the selected hospitals did not include aspects of culture-competent care. It is recommended that

- nurse managers should facilitate culture-competent practice by providing books, posters and pamphlets on culture-competent care in tearooms and duty rooms throughout the hospitals
- orientation programmes for newly employed professional nurses should include lectures on the provision of culture-competent care
- nurse managers should encourage staff to attend workshops on transcultural nursing

### **5.3.3 In-service training programme on culture-competent care for professional nurses working in Mopani District, Limpopo**

An in-service training programme is a programme provided by institutions for employees to increase their skills and competence in a specific area. The in-service training programme on culture-competent care should address the five constructs of Campinha-Bacote's model (2002), namely cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire. The purpose of the in-service training programme would be to empower professional nurses with knowledge and skills to provide culture-competent care.

The in-service training programme should include the following topics on culture-competent care:

- An introduction to cultural diversity, including cultural values and beliefs.
- An overview of cultural competence in nursing, including defining and assessing cultural competence.
- An overview of specific cultural practices in the society, including cultural practices in childbirth, feeding practices, verbal communication and non-verbal communication.
- Cultural assessment and the nursing process.

- Mentoring on culture-competent care, including:
  - ♦ Cultural awareness
  - ♦ Cultural knowledge
  - ♦ Cultural skill
  - ♦ Cultural encounter
  - ♦ Cultural desire
- Spiritual and religious factors that impact on culturally appropriate care.

#### **5.3.4 Further research**

It is recommended that further research be conducted on the following topics:

- An examination of professional nurses' knowledge of cultural diversity and cultural competence in Limpopo Province.
- An investigation into factors that hamper professional nurses' provision of culture-competent care.
- A comparison of the cultural competence of professional nurses exposed to and ones not exposed to in-service education and training in culture-competent care.
- Enrolled nurses and enrolled auxiliary nurses and student nurses' perceptions of nursing patients of diverse cultures.

#### **5.5 CONCLUSION**

This study found that not all nurses who participated in the study received lectures on the provision of culture-competent care during their basic training. It was further found that to a large extent, hospitals that were included in the study did not address aspects of culture-competent care in their in-service education programmes. Mopani District hospitals admit patients from diverse cultural backgrounds. Hospital management should cultivate a culture of respect for the diversity of patients and staff at the different health care institutions and empower nurses with knowledge to provide culture-competent care to all patients. In-service training programmes on cultural diversity and culture-competent care would facilitate this process.

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Annexure A

Letter for intention to submit the proposal

Annexure B

Approval from the University of South Africa

## Annexure C

Letter for seeking consent to conduct research from  
the Limpopo province

Annexure D

Permission letter from Limpopo Department of Health  
to conduct the study

Annexure E

Questionnaire

Annexure F

Informed consent

Annexure G

Letter of intent to submit the dissertation

Annexure H

Letter from the editor

## ANNEXURE A: LETTER FOR INTENTION TO SUBMIT THE PROPOSAL

Box 4423  
Giyani  
0826  
LIMPOPO  
04 March 2011

Inquiries :  
Manganyi T  
Cell : 0783381021  
Email : thokozi@webmail .co.za

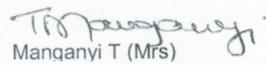
Research Ethics Committee  
Department of Health Studies  
P.O.BOX 392  
UNISA  
0003  
To : Research Ethics Committee.  
Department of Health Studies.

**INTENTION TO SUBMIT RESEARCH PROPOSAL FOR APPROVAL BY  
THE ETHICS COMMITTEE.**

**RESEARCH TITLE : THE KNOWLEDGE OF PROFESSIONAL NURSES ON  
THE PRINCIPLES OF TRANSCULTURAL NURSING IN MOPANI  
DISTRICT.**

I hereby apply to submit the research proposal on the above mentioned topic  
to the UNISA Ethics Committee for approval.

Thanking you in anticipation.

  
Manganyi T (Mrs)

# ANNEXURE B: APPROVAL FROM THE UNIVERSITY OF SOUTH AFRICA

.07/04/2011 08:35 0124294440

HEALTH STUDIES



**UNIVERSITY OF SOUTH AFRICA**  
**Health Studies Higher Degrees Committee**  
**(HSHDC)**  
**College of Human Sciences**  
**ETHICAL CLEARANCE CERTIFICATE**

Date of meeting: 10 March 2011 Project No: 4218-193-3  
Project Title: The knowledge of professional nurses about transcultural nursing in Mopani District, Limpopo.  
Researcher: Thokozile Manganyi  
Degree: Master of Arts in Health Studies Code: DIS702M  
Supervisor: Prof MJ Oosthuizen  
Qualification: D Litt et Phil  
Joint Supervisor: Mrs JE Tjallinks

**DECISION OF COMMITTEE**

Approved  Conditionally Approved

*E Potgieter*  
Prof E Potgieter  
RESEARCH COORDINATOR

*M Bezuidenhout*  
Prof MC Bezuidenhout  
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

## ANNEXURE C: LETTER FOR SEEKING CONSENT TO CONDUCT RESEARCH FROM THE LIMPOPO PROVINCE

Enquiries : Manganyi T	P.O.Box 4423
Tel/Fax 015 812 0330	Giyani
Cell : 0783381021	0826
Email : thokozi@webmail.co.za	04.03.2011

To : The Research Ethics Committee  
Limpopo Department of Health and Social Development.

**REQUEST FOR APPROVAL TO CONDUCT A RESEARCH IN MOPANI DISTRICT IN ORDER TO FULFIL THE REQUIREMENT FOR OBTAINING A MASTERS IN HEALTH STUDIES : MANGANYI T 80594077**

1. I am a Lecturer working in Limpopo College of Nursing Giyani Campus at General Nursing Science Component and I am currently studying at the University of South Africa (UNISA).
2. I hereby wish to conduct my research within the Department of Health. I believe that the findings and recommendations thereof will, if implemented, contribute to the body of knowledge on continuous quality improvement initiatives.
3. Authorization is requested to conduct a research project on The knowledge of professional nurses on the principles of transcultural nursing in Mopani District hospitals, Limpopo Province to obtain a Masters in Health Studies.
4. The research report and the article will be forwarded to the Department of Health.
5. Your approval will be highly appreciated.

Thanking you in anticipation.

  
Manganyi T (Mrs)

**ANNEXURE G: LETTER OF INTENT TO SUBMIT THE DISSERTATION**

PO Box 4423  
Giyani  
0826  
04 October 2012

Inquiries:

Manganyi T

Cell: 0783381021

Email: thokozil@webmail.co.za

The Higher Degrees Committees in Departments in the College of Human Sciences  
Department of Health Studies  
P.O.Box 392  
UNISA  
0003

To: The Higher Degrees Committees in Departments in the College of Human Sciences  
Department of Health Studies

**INTENTION TO SUBMIT RESEARCH DISSERTATION BY JUNE 2013**

**RESEARCH TITLE: THE KNOWLEDGE OF PROFESSIONAL NURSES ABOUT CULTURE COMPETENT CARE IN THE SELECTED MEDICAL WARDS, ONCOLOGY WARDS AND OUTPATIENT DEPARTMENTS AT MOPANI DISTRICT, LIMPOPO PROVINCE.**

I hereby apply to submit the research dissertation on the above mentioned topic to The Higher Degrees Committees in Departments in the College of Human Sciences for approval.

Thanking you in anticipation.

Manganyi T

Student no: 4218 1933

**ANNEXURE D: PERMISSION LETTER FROM LIMPOPO DEPARTMENT OF HEALTH**



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref: 4/2/2

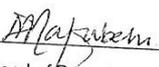
22 July 2011  
Manganyi T  
University of South Africa  
Pretoria  
0001

Greetings,

Re: Permission to conduct the study titled: The knowledge of professional nurses towards transcultural nursing at Mopani District, Limpopo Province.

1. The above matter refers.
2. The permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
  - Further arrangement should be made with the targeted institutions.
  - In the course of your study there should not be any action that will disrupt the services
  - After completion of the study, a copy of the report should be submitted to the Department to serve as a resource
  - You should be prepared to assist in the interpretation and implementation of study recommendations where possible

Your cooperation will be highly appreciated

  
\_\_\_\_\_  
Head of Department  
Department of Health  
Limpopo Province

## ANNEXURE F: INFORMED CONSENT

### INFORMED CONSENT

**Research title: The knowledge of professional nurses about Culture Competent Care in the selected Medical Wards, Oncology wards and Outpatients departments at Mopani District, Limpopo Province.**

Researcher T.Manganyi

Phone: 0783381021

Work: (015-812)-0330

The purpose of the study is to determine the knowledge of professional nurses working in the selected medical wards, oncology wards and outpatient departments in Mopani District, Limpopo Province. The hospitals selected are Nkhensani Hospital, Letaba Hospital, Van Velden Hospital, Maphuta –Malatji and Kgapane Hospital at Limpopo Province. Questionnaires will be provided to you to answer. The information will not be shared with other respondents and final report containing anonymous quotations will be available to all at the end of the study.

THIS IS TO CERTIFY THAT I \_\_\_\_\_

Hereby agree to participate as a volunteer in the above mentioned research.

I understand that there will be no health risks to me resulting from my participation in the research.

I hereby give my permission to participate in the study.

I understand that the information may be published but my name will not be associated with the research.

I understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

Name of Participant \_\_\_\_\_ Name of the researcher \_\_\_\_\_

Student number \_\_\_\_\_

Signature \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_

## **PARTICIPANT INFORMATION LEAFLET**

### **INTRODUCTION**

You are invited to volunteer for research study. The reason for selection is that you have experience in nursing patients of diverse cultures in medical wards. The information leaflet is to assist you to decide if you would like to participate. Before you agree to take part you should fully understand what is involved. You are not forced to take part in this study. You have the right to participate voluntarily and withdraw if you are not satisfied with the information provided.

#### **What is the purpose of the study?**

To explore and describe the knowledge of professional nurses working in Mopani District about Culture Competent Care in the selected Medical Wards at Mopani District.

#### **What is the research question?**

Do professional nurses in the selected medical wards in Mopani District have knowledge about culture competent care?

#### **What are my rights as participant?**

The participant has the right to decide voluntarily whether to participate in the study or not. You have the right to be treated fairly before, during and after the study. You have the right to withdraw from the study anytime without any prejudicial treatment.

**May any of this study procedures results in discomfort or inconveniences?**

Discomfort may result since a questionnaire requires the respondents to think and write the information required in the questionnaire. It may require time from the respondents to be able to complete the questionnaire.

**Are there any warnings or restrictions concerning my participation in the study?**

The respondents will be anonymous in the study. No names will be written in the questionnaires when they are returned.

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27 September 2013

**TO WHOM IT MAY CONCERN**

I hereby certify that I have edited Thokozile Manganyi's master's dissertation on professional nurses' knowledge of culture-competent care in medical and oncology wards and outpatient departments of selected hospitals in Mopani District, Limpopo Province, for language and content.

*IM Cooper*

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